



I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
William E. Hopkins
Executive Director of the Board

BEFORE THE BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS

In the Matter of § AGREED
Registered Nurse License Number 614586 §
issued to NORMA CAROL POTTER § ORDER

An investigation by the Board of Nurse Examiners for the State of Texas, hereinafter referred to as the Board, produced evidence indicating that NORMA CAROL POTTER, hereinafter referred to as Respondent, Registered Nurse License Number 614586, may have violated Section 301.452(b)(10), Texas Occupations Code.

An informal conference was held on August 17, 2006, at the office of the Board of Nurse Examiners, in accordance with Section 301.464 of the Texas Occupations Code.

Respondent appeared in person. Respondent was represented by William E. Hopkins, Attorney at Law. In attendance were Katherine A. Thomas, MN, RN, Executive Director; E. Joy Sparks, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; and J. L. Skylar Caddell, RN,C, Lead Investigator.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license.
2. Respondent waived notice and hearing, and consented to the entry of this Order.
3. Respondent is currently licensed to practice professional nursing in the State of Texas.
4. Respondent received a Certificate in Practical Nursing from the Kansas City Board of Education, Kansas City, Missouri, on May 8, 1970, and received an Associate Degree in Nursing from Penn Valley Community College, Kansas City, Missouri, on December 12, 1992. Respondent was licensed to practice practical nursing in the State of Missouri on July 31, 1970, was licensed to practice professional nursing in the State of Missouri on March 11, 1993, and was licensed to practice professional nursing in the State of Texas on March 17, 1995.

5. Respondent's nursing employment history includes:

1970	Staff Nurse, Licensed Practical Nurse (LPN)	St. Luke's Hospital Kansas City, Missouri
1971	Unknown	
1972 - 1975	Staff Nurse, LPN	Spelman Memorial Hospital Smithville, Missouri
1976	Staff Nurse, LPN	Cameron Community Hospital Cameron, Missouri
1977	Unknown	
1978 - 1979	Charge Nurse, LPN	Windsor Estates Independence, Missouri
1980 - 1986	Not employed in nursing	
1987	Weekend Relief Nurse, LPN	Glennon Place Nursing Center Kansas City, Missouri
1988 - 1993	Staff Nurse, LPN / Registered Nurse (RN)	Carondelet Manor Nursing Center Kansas City, Missouri
1993 - 1995	Director of Nursing	Glennon Place Nursing Center Kansas City, Missouri
11/1995 - 12/2005	Director of Nursing	Retama Manor West Nursing Center San Antonio, Texas
01/2006 - Present	Not employed in nursing	

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as the Director of Nursing for Retama Manor West Nursing Center, San Antonio, Texas, and had been in this position for ten (10) years and one (1) month.

7. On or about July 7, 2004, while employed as the Director of Nursing for Retama Manor West Nursing Center, San Antonio, Texas, Respondent failed to immediately investigate a reported medication error when a Staff Licensed Vocational Nurse (LVN) informed her at 8:45 a.m. that Resident VG may have received an excessive overdose of Morphine 200 mg. Instead of presuming that an overdose had been administered and immediately assessing the resident, documenting her findings, and then notifying the prescribing physician so that orders could have possibly been obtained to counteract and/or manage the Morphine overdose, Respondent proceeded on an assumption that there had been a documentation error regarding

the amount of morphine administered to the resident. Respondent instructed the Staff LVN to call hospice and to initiate an error report. As a result, the Staff LVN administered two (2) additional doses of Morphine before the resident expired shortly after 1:00 p.m. that afternoon, from what would later be determined by autopsy to be an accidental, inadvertent overdose of morphine. Respondent's conduct may have contributed to the resident's demise.

8. On or about July 7, 2004, while employed as the Director of Nursing for Retama Manor West Nursing Center, San Antonio, Texas, Respondent failed to document her assessment and pronouncement of the death of the aforementioned Resident VG in the medical record, as required. Respondent's conduct resulted in an incomplete medical record.
9. On or about July 8, 2004, through July 19, 2004, while employed as the Director of Nursing for Retama Manor West Nursing Center, San Antonio, Texas, Respondent failed to ensure that the incidental medication error and subsequent death of the aforementioned Resident VG was accurately reported to the appropriate State and local authorities, including the Bexar County Medical Examiner's Office and the Texas Department of Aging and Disability Services, as required, after she pronounced the resident deceased and the next day affirmed that a significant overdose of Morphine had actually been administered prior to the resident's death. Respondent's conduct may have been deceptive and denied investigative and regulatory officials information needed to regulate safe and effective delivery of patient care.
10. Formal Charges were filed on May 17, 2006.
11. Formal Charges were mailed to Respondent at her address of record on May 18, 2006.
12. In response to the incidents in Findings of Fact Numbers Seven (7) through Nine (9), Respondent states that upon being notified of the incident by the Staff LVN she went to the resident and verified briefly that the resident's oxygen saturation was 68%. Respondent states she then went to the medication cart and checked how much of the Morphine remained in the bottle, and states that since 23+ ml remained in the bottle, there was more than there should have been if the overdoses of Morphine had been administered. However, according to the narcotic inventory record, there should have been 27.5 ml remaining in the bottle if all doses had been correctly administered. Respondent states her greatest errors were that she assumed that the Staff LVN had contacted hospice and was taking direction from them, and that she did not document her own entries in the medical record to validate those of the Staff LVN. Regarding the failure to report the resident's death to appropriate authorities, Respondent asserts that although she had been employed in the facility in excess of ten (10) years, she remained unaware of any such reporting requirements.

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CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.455, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violations of Section 301.452(b)(10), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§ 19.1010(f)(3), 19.1923(b), and 217.12(1),(2),(4)&(16).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 614586, heretofore issued to NORMA CAROL POTTER, including revocation of Respondent's license to practice professional nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Board of Nurse Examiners, that Registered Nurse License Number 614586, previously issued to NORMA CAROL POTTER, to practice professional nursing in Texas is hereby SUSPENDED for a period of two (2) years with the said suspension STAYED and Respondent is hereby placed on PROBATION for two (2) years with the following agreed terms of probation:

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate privilege, if any, to practice professional nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license is encumbered by this order, Respondent may not work outside the State of Texas pursuant to a multistate licensure privilege without the written permission of the State of Texas and the Board of Nursing in the party state where Respondent wishes to work.

(1) RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas as amended, Texas Occupations Code §§301.001 *et seq.*, the Rules and Regulations Relating to Professional Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.01 *et seq.* and this Order.

(2) RESPONDENT SHALL deliver the wallet-sized license issued to NORMA CAROL POTTER, to the office of the Board of Nurse Examiners within ten (10) days of the date of this Order for appropriate notation.

(3) RESPONDENT SHALL, within one (1) year of the suspension being stayed, successfully complete a course in Texas nursing jurisprudence. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) contact hours in length. The course's content shall include the Nursing Practice Act, standards of practice, and documentation of care. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found on the Board's website, www.bne.state.tx.us (under BNE events).*

(4) RESPONDENT SHALL, within one (1) year of the suspension being stayed, successfully complete a course in physical assessment. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. RESPONDENT SHALL perform physical assessments on live patients in a clinical setting for a minimum of twenty-four (24) hours. The clinical component SHALL focus on tasks of physical assessment only and shall be provided by the same Registered Nurse who provides the didactic portion of this course. To be approved, the course shall

cover all systems of the body. Performing assessments on mock patients or mannequins WILL NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found on the Board's website, www.bne.state.tx.us (under BNE events).*

(5) RESPONDENT SHALL, within one (1) year of the suspension being stayed, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found on the Board's website, www.bne.state.tx.us (under BNE events).*

(6) RESPONDENT SHALL, within one (1) year of the suspension being stayed, successfully complete a course in nursing ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) contact hours in length. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: principles of nursing ethics; confidentiality; and professional boundaries. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to verify RESPONDENT's successful completion of the course. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Board approved courses may be found on the Board's website, www.bne.state.tx.us (under BNE events).*

(7) RESPONDENT SHALL, within one (1) year of the suspension being stayed, successfully complete a course in "Incident Reporting and Investigations," a 4.2 contact hours workshop presented in various locations by the Texas Department of Aging and Disability Services. In order to receive credit for completion of this workshop, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this workshop to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following website: www.dads.state.tx.us/business/ltr/Training/jointtraining.cfm or by contacting Lynn.Cooper@dads.state.tx.us.*

(8) IT IS FURTHER AGREED, SHOULD RESPONDENT be convicted of or receive a deferred order for any offense in association with Findings of Fact Numbers Seven (7) through Nine (9), said judicial action will result in further disciplinary action including possible revocation of Respondent's license to practice professional nursing in the State of Texas.

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A REGISTERED NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE PROBATIONARY PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE A REGISTERED NURSE LICENSE WILL NOT APPLY TO THIS PROBATIONARY PERIOD.

(9) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the probation conditions on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the probation conditions on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(10) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(11) For the first year of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse. Direct supervision requires another professional nurse to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(12) For the remainder of the probation period, RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(13) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT's capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) months for two (2) years of employment as a nurse.

IT IS FURTHER AGREED that, upon full compliance with the terms of this Order, RESPONDENT SHALL be issued an unencumbered license to practice professional nursing in the State of Texas.

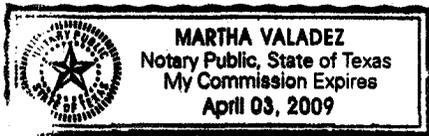
RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice professional nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 6 day of Sept, 2006
Norma Carol Potter
NORMA CAROL POTTER, Respondent

Sworn to and subscribed before me this 6 day of September, 2006.

SEAL



Martha Valadez
Notary Public in and for the State of TEXAS

Approved as to form and substance.
[Signature]
William E. Hopkins, Attorney for Respondent

Signed this 12th day of September, 2006.

WHEREFORE, PREMISES CONSIDERED, the Board of Nurse Examiners for the State of Texas does hereby ratify and adopt the Agreed Order that was signed on the 6th day of September, 2006, by NORMA CAROL POTTER, Registered Nurse License Number 614586, and said Order is final.

Effective this 19th day of October, 2006.

A handwritten signature in cursive script, appearing to read "Katherine A. Thomas", is written over a horizontal line.

Katherine A. Thomas, MN, RN
Executive Director on behalf
of said Board