Agenda Item: 8.6.3
Board Meeting on January 19, 2023
Prepared by: Jena Abel

In the Matter of Jill Meredith

Type of Case: Hearing; Respondent was represented by counsel.

Nature of Allegations: Staff alleged that Respondent failed to perform and/or document a complete assessment of a pediatric patient's medical history and presenting symptoms of gastrointestinal illness.

ALJ's Finding: Insufficient evidence to support a violation.

Board Action: Move to close the case due to insufficient evidence, take no action against Respondent's licenses, and dismiss the formal charges against Respondent's licenses.

Texas Board of Nursing

1801 Congress Avenue, Ste. 10-200, Austin, Texas 78701
Phone: (512) 305-7400 Fax: (512) 305-7401 www.bon.texas.gov
Katherine A. Thomas, MN, RN, FAAN
Executive Director

December 13, 2022

Jill Meredith
c/o Jordan Parker, Attorney
600 West 6th Street, Suite 300
Fort Worth, Texas 76102-3685

Re: In the Matter of License Numbers RN 622606, AP126871, and Rx 16893
SOAH Docket No. 507-21-3239

Dear Ms. Meredith:

The Proposal for Decision, issued by Administrative Law Judge Rodriguez, along with Staff's recommendations, will be presented to the Board for consideration during the next scheduled Board meeting on **January 19, 2023.** Please find enclosed herein copies of the materials that are proposed to be presented to the Board by Staff.

Pursuant to 22 Tex. Admin. Code §213.23(c), parties shall have an opportunity to file written exceptions and/or briefs with the Board. An individual wishing to file written exceptions and/or a brief for the Board's consideration must do so **no later than 15 calendar days prior** to the date of the next regularly scheduled meeting where the Board will deliberate on the default decision. The Board will not consider any written exceptions and/or briefs submitted in violation of these requirements.

If you wish to file written information for the Board to consider at its **January 19, 2023**, meeting, your written materials must be received in the Board's offices **no later than January 3, 2023.**

Should you have any questions regarding this matter, please contact Jena R. Abel, Deputy General Counsel, at 512-305-6822.

Sincerely,

Katherine A. Thomas, MN, RN, FAAN
Executive Director

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

October 17, 2022

Jacqueline A. Strashun **VIA EFILE TEXAS**
Texas Board of Nursing

Jordan M. Parker **VIA EFILE TEXAS**
Cantey Hanger LLP

RE: Docket Number 507-21-3239.TBN; Texas Board of Nursing Nos. 622606 & AP126871; Texas Board of Nursing v. Jill R. Meredith

Dear Parties:

Please find attached a Proposal for Decision in this case.

Exceptions and replies may be filed by any party in accordance with 1 Texas Administrative Code section 155.507(b), a SOAH rule which may be found at www.soah.texas.gov.

CC: Service List

SOAH Docket No. 507-21-3239 **Suffix: TBN**

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS BOARD OF NURSING,
PETITIONER
V.
JILL R. MEREDITH, APRN,
RESPONDENT

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SOAH Docket No. 507-21-3239 **Suffix: TBN**

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS BOARD OF NURSING,
PETITIONER
V.
JILL R. MEREDITH, APRN,
RESPONDENT

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) brought this action against Respondent Jill R. Meredith, an Advanced Practice Registered Nurse (APRN), alleging that she failed to perform and/or document a complete assessment of one pediatric patient's medical history and presenting symptoms of gastrointestinal illness. The Administrative Law Judge (ALJ) concludes that Staff failed to prove its allegations and recommends that Respondent receive no sanction.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

Notice and jurisdiction were not disputed and are set out in the Findings of Fact and Conclusions of Law herein without further discussion here.

ALJ Susan Rodriguez convened the hearing on the merits on May 16-17, 2022, via videoconference from the State Office of Administrative Hearings (SOAH). Assistant General Counsel Jacqueline Strashun represented Staff. Respondent appeared and was represented by Jordan Parker and Scharli Branch. The record closed on August 19, 2022, after the parties submitted written closing arguments.

II. STAFF'S FORMAL CHARGES AND APPLICABLE LAW

A. Staff's Formal Charges

In its First Amended Formal Charges, Staff alleges that on or about February 12, 2020, in the course of her employment as a Pediatric Nurse Practitioner by Baylor Scott & White Hemingway Clinic, Respondent failed to perform and/or document a complete assessment of one pediatric patient's medical history and presenting symptoms of gastrointestinal illness. Staff argues that this alleged failure created an incomplete medical record and may have deprived the patient's subsequent providers of complete and accurate information regarding the patient's medical condition.

B. Applicable Law

Under the Nursing Practice Act (Act), found in chapter 301 of the Texas Occupations Code (Code), the Board is authorized to take disciplinary action against a nurse for, among other things, unprofessional conduct that is likely to deceive, defraud, or injure a patient or the public;[1] and failure to meet minimum standards of nursing practice.[2] Staff asserts that Respondent's conduct is grounds for disciplinary action under both Code provisions, as well as pursuant to Board Rules 217.11 and 217.12.[3]

Board Rule 217.11 addresses minimum standards of nursing practice. Staff alleged Respondent is subject to discipline under the following provisions:

- Board Rule 217.11(1)(A): Failure to know and conform to the Act and the Board's rules as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;
- Board Rule 217.11(1)(B): Failure to implement measures to promote a safe environment for clients and others; and
- Board Rule 217.11(1)(D): Failure to accurately and completely report and document client status including signs and symptoms, nursing care rendered, physician orders, administration of medications and treatments, client responses, and contacts with other health care team members concerning significant events regarding the client's status.

[1] Code § 301.452(b)(10).

[2] Code § 301.452(b)(13). This provision was moved without change after the conduct in this case to section 301.452(b)(14) in the current statute.

[3] The Board's rules, found in title 22, part 11, chapters 211-228 of the Texas Administrative Code, are referred to in this Proposal for Decision as "Board Rule_____."

In addition, specific minimum standards of nursing practice apply to APRNs, as promulgated in the Board's rules. Staff alleges that Respondent violated these requirements of APRNs:

- Practice in an advanced nursing practice role and specialty in accordance with authorization granted under Board Rule Chapter 221 (relating to practicing in an APRN role) and standards set out in that chapter;[4] and
- Prescribe medications in accordance with prescriptive authority granted under Board Rule Chapter 222 (relating to APRNs prescribing), and standards set out in that chapter and in compliance with state and federal laws and regulations relating to prescription of dangerous drugs and controlled substances.[5]

Staff also alleged violations of the following provisions of Board Rule 217.12, which addresses unprofessional conduct:

- Board Rule 217.12(1)(A): Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board Rule 217.11;
- Board Rule 217.12(1)(B): Failing to conform to generally accepted nursing standards in applicable practice settings;
- Board Rule 217.12(1)(C): Improper management of client records; and
- Board Rule 217.12(4): Conduct that may endanger a client's life, health, or safety.

Board Rule 213.33 includes a disciplinary matrix (Matrix) that categorizes violations into tiers and sanction levels. The Board and SOAH are required to

[4] 22 Tex. Admin. Code § 217.11(4)(A).

[5] 22 Tex. Admin. Code § 217.11(4)(B).

consult the Matrix in all disciplinary matters.[6] The Matrix includes aggravating and mitigating factors that must be considered in determining the appropriate sanction for specific violations.[7] Board Rule 213.33 includes additional factors that the Board and SOAH must consider in determining the appropriate disciplinary sanction.[8]

Staff had the burden of proving its allegations by a preponderance of the evidence.[9]

III. EVIDENCE

Staff had 20 exhibits admitted into evidence[10] and called five witnesses at the hearing. Respondent called three witnesses and had five exhibits admitted into evidence.[11]

A. Background

Respondent was licensed as a registered nurse in 1995. She obtained her APRN license and was certified as a pediatric nurse practitioner in 2014.[12] Respondent has been employed at Baylor Scott & White Hemingway Clinic in

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[6] Board Rule 213.33(b)-(c).

[7] Board Rule 213.33(b).

[8] Board Rule 213.33(c).

[9] 1 Tex. Admin. Code § 155.427.

[10] Staff Exhibits 6 and 6c were designated confidential.

[11] Respondent's Exhibit 12 was designated confidential.

[12] Resp. Ex. 16; Tr. Vol. 2 at 340-41.

Temple, Texas, since 2015.[13] Respondent has also worked as an outpatient transplant nurse, a clinical research nurse, and a research manager.[14]

The patient at issue in this case is a 15-year-old male who previously saw Dr. Christopher Craig at Hemingway Clinic on February 3, 2020, with a four-day history of constipation.[15] The patient was negative for nausea and diarrhea.[16] Dr. Craig diagnosed the patient with acute constipation, instructed him to double the Miralax he was already taking, and told him to come back if his symptoms worsened or did not improve in three to four days.[17]

Overnight from February 11 into February 12, the patient woke up with dry heaving, vomiting, and one episode of loose stool.[18] Karen Ramos, the patient's mother, made an appointment with Dr. Craig and took the patient to Hemingway Clinic on February 12. Ms. Ramos was mistaken about the date of the appointment with Dr. Craig, which was not until February 13, but clinic staff arranged for the patient to be seen as a walk-in patient for an acute care visit.[19] Respondent discussed the patient's symptoms with the patient, and Ms. Ramos and performed a physical examination of the patient. She documented in the medical record that his abdomen was soft and that bowel sounds were normal.[20]

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[13] Tr. Vol. 2 at 340.

[14] Resp. Ex. 16.

[15] Staff Ex. 6 at 20. The events at issue all occurred in February 2020 unless otherwise noted. Throughout this Proposal for Decision, the patient at issue will be referred to as "the patient."

[16] Staff Ex. 6 at 20.

[17] Staff Ex. 6 at 22-23.

[18] Staff Ex. 6 at 3, 27.

[19] Staff Ex. 6 at 3.

[20] Staff Ex. 6 at 29.

Respondent also noted that the patient appeared ill and that he had abdominal pain. Respondent diagnosed the patient with a viral illness and prescribed Zofran for nausea.[21]

The Zofran helped with the patient's nausea, but Ms. Ramos thought his condition was worsening. On the afternoon of February 13, she took him to an urgent care clinic where he was seen by physician assistant (PA) Larissa Williams. Ms. Williams also noted that the patient's abdomen was soft and non-distended with no palpable masses and normoactive bowel sounds.[22] Ms. Williams offered to take an x-ray, but Ms. Ramos declined. Ms. Williams then told Ms. Ramos that the patient needed further evaluation at an emergency room, so Ms. Ramos took the patient to the emergency room at Seton Medical Center Harker Heights where he was evaluated by PA Dianne Sherrill.[23] On examination Ms. Sherrill found that the patient's abdomen was soft with no distention or mass and normal bowel sounds, with guarding and pain in the lower right quadrant of the abdomen.[24] Ms. Sherrill ordered a CT scan that showed a suspicious mass with partial bowel obstruction in the patient's abdomen.[25] The patient was referred to McLane Children's Medical Center (MCMC) where he underwent emergency surgery to remove the mass, which was diagnosed as Burkitt Lymphoma.[26] The patient underwent additional

[21] Staff Ex. 6 at 29-30.

[22] Staff Ex. 7 at 69.

[23] Staff Ex. 7 at 69; Staff Ex. 10.

[24] Staff Ex. 10 at 5.

[25] Staff Ex. 10 at 7-8.

[26] Tr. Vol. 1 at 75-77; Resp. Ex. 12 at 21.

surgery and chemotherapy, and at the time of the hearing was in remission and doing well.[27]

B. Testimony

1. Karen Ramos

Karen Ramos is the patient's mother.[28] Ms. Ramos is a certified medical assistant (MA) who works at Baylor Scott & White in the cardiology department.[29] She typically accompanies her son to his medical appointments.[30]

At a visit with Dr. Craig at Hemingway Clinic in January 2020 for unrelated complaints, Dr. Craig told the patient to take Miralax for constipation.[31] The patient saw Dr. Craig on February 3, this time for a four-day history of constipation with stomach pain. Ms. Ramos was present at this visit.[32] Dr. Craig told the patient to double the Miralax and return if his condition worsened or did not improve in three to four days.[33]

On February 11 the patient woke up in the middle of the night with dry heaving, vomiting, and one episode of loose stool.[34] Ms. Ramos made an

[27] Tr. Vol. 1 at 166-67.

[28] Tr. Vol. 1 at 35.

[29] Tr. Vol. 1 at 36-37.

[30] Tr. Vol. 1 at 42.

[31] Tr. Vol. 1 at 44-45.

[32] Tr. Vol. 1 at 42-43.

[33] Staff Ex. 6 at 20-23; Tr. Vol. 1 at 48-49.

[34] Tr. Vol. 1 at 185.

appointment with Dr. Craig and took the patient to the clinic on February 12.[35] When they arrived, Ms. Ramos was informed that the appointment with Dr. Craig was not until February 13. She felt it was urgent for the patient to be evaluated and asked if he could be seen on a walk-in basis.[36] According to Ms. Ramos, by then the patient was pale, clammy, and sweaty.[37] He brought a bowl into the clinic with him because of ongoing vomiting.[38]

A medical assistant took the patient's vital signs. According to Ms. Ramos, when Respondent entered the room and before examining the patient, she announced that he had constipation and that there was a stomach bug going around.[39] Ms. Ramos disagreed, testifying that she explained the patient's symptoms, brought up the February 3 visit, and described the vomit to Respondent because it was black and tarry, which she felt was abnormal; in her complaint to the Board, however, Ms. Ramos did not mention that the vomit was black and tarry.[40] She testified that she also asked Respondent for imaging to see if the patient's bowels were obstructed.[41] Respondent told her that imaging was unnecessary.[42]

Respondent examined the patient by listening to his abdomen with a stethoscope and palpating his abdomen, which Ms. Ramos said caused him to

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[35] Tr. Vol. 1 at 53.

[36] Tr. Vol. 1 at 55.

[37] Tr. Vol. 1 at 53.

[38] Tr. Vol. 1 at 54-55.

[39] Tr. Vol. 1 at 57, 61.

[40] Tr. Vol. 1 at 62; Staff Ex. 11.

[41] Tr. Vol. 1 at 62-63; Staff Ex. 11.

[42] Tr. Vol. 1 at 63.

grimace in pain.[43] When the patient was laying down on the exam table, Ms. Ramos could see his stomach protruding.[44] Ms. Ramos testified that no other physical exam was performed, so anything in the medical records denoting additional examination was falsified by Respondent.[45]

According to Ms. Ramos, Respondent diagnosed the patient with constipation and a viral illness, and she prescribed Zofran and told him to double the Miralax.[46] Ms. Ramos testified that she told Respondent that the Miralax was not working and questioned increasing it.[47] She denied receiving a copy of the after-visit summary or instructions when she and the patient left the clinic that day.[48]

The Zofran helped with the patient's vomiting and he was able to rest more, but when he woke up on February 13 he looked worse.[49] According to Ms. Ramos, the patient was pale, he complained of more pain, and he was not eating or drinking.[50] Even though it had been less than 24 hours since the appointment with Respondent, Ms. Ramos testified that she tried to get an appointment with Dr. Craig, but he was not available.[51] Later that afternoon, Ms. Ramos took the

[43] Tr. Vol. 1 at 63-64.

[44] Tr. Vol. 1 at 64.

[45] Tr. Vol. 1 at 190-92.

[46] Tr. Vol. 1 at 67, 69.

[47] Tr. Vol. 1 at 66.

[48] Tr. Vol. 1 at 159.

[49] Tr. Vol. 1 at 69.

[50] Tr. Vol. 1 at 70.

[51] Tr. Vol. 1 at 71.

patient to an urgent care clinic where he was examined by Ms. Williams.[52] Ms. Williams told Ms. Ramos that the urgent care clinic was not equipped to treat the patient and advised them to go "immediately" to the emergency department at the hospital next door.[53] According to Ms. Ramos, Ms. Williams documented portions of the physical exam that she did actually not perform, and her documentation of the patient's complaints was inaccurate.[54]

Ms. Ramos then took the patient to the Seton Harker Heights emergency room where he was seen by Ms. Sherrill.[55] According to Ms. Ramos, Ms. Sherrill's documentation regarding the patient is also incorrect because the patient's abdomen was not flat, the bowel sounds were not normal, and his skin was not warm or dry.[56] The patient underwent a CT scan and had lab tests done. When the results came back, a physician advised Ms. Ramos that the patient needed to go to MCMC for emergency surgery.[57] The patient had surgery that night, underwent chemotherapy, and at the time of the hearing was in remission and doing well.[58]

2. Hayden Stagg, M.D.

Dr. Stagg is a pediatric surgeon at MCMC where he cared for the patient.[59] Dr. Stagg testified that the CT scan from Seton Harker Heights showed that the

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[52] Tr. Vol. 1 at 71; Staff Ex. 7 at 69-70.

[53] Tr. Vol. 1 at 72.

[54] Tr. Vol. 1 at 203-06.

[55] Tr. Vol. 1 at 74; Staff Ex. 10.

[56] Tr. Vol. 1 at 210-12.

[57] Tr. Vol. 1 at 75.

[58] Tr. Vol. 1 at 77; 166-67.

[59] Tr. Vol. 1 at 82-83.

patient had a bowel obstruction with a mass, a condition that normally requires surgical correction.[60] Dr. Stagg was able to palpate the mass when he examined the patient but did not know if the mass could be palpated prior to that.[61]

Dr. Stagg reviewed Respondent's medical records for the patient and found them to be standard and complete and said he was not deprived of any information.[62] Dr. Stagg also said that in a patient making complaints like nausea, vomiting, and diarrhea, exam findings such as tenderness, guarding, or rebound would only be documented in the records if they were present.[63] Dr. Stagg testified that if a pediatric patient's parent requested testing or imaging, the provider should document why it was or was not being ordered, and should explain the decision to the parent.[64]

3. Dianne Sherrill, PA

Ms. Sherrill is a PA who evaluated the patient in the emergency department at Seton Harker Heights on February 13.[65] His vital signs were very stable, and he complained of abdominal pain for the past day and difficulty having a bowel movement with inability to pass gas.[66] Ms. Sherrill determined that the patient's complaints were "fairly acute," so she did not look at any records from prior

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[60] Tr. Vol. 1 at 87-89.

[61] Tr. Vol. 1 at 128.

[62] Tr. Vol. 1 at 120-21.

[63] Tr. Vol. 1 at 122-23.

[64] Tr. Vol. 1 at 143-44.

[65] Staff Ex. 10.

[66] Tr. Vol. 1 at 279-80; Staff Ex. 10 at 3.

providers because she did not think they would help with her evaluation.[67] The patient had pain around his belly button and the right lower abdomen with guarding.[68] She did not feel any masses or lumps upon palpating his abdomen, and bowel sounds were normal.[69] The patient also reported that he had had a very small bowel movement that day, February 13, with no passage of gas, and that he had had a normal bowel movement the day before.[70] Ms. Ramos reported that the patient had nausea and vomiting, and had been given medications for nausea and constipation but had not been able to keep them down.[71] Ms. Sherrill ordered lab tests, intravenous fluids and medications, and a CT scan.[72] Once the results were back, Ms. Sherrill and her attending physician strongly recommended that the patient be transferred to a pediatric hospital for further evaluation.[73]

4. Jill Meredith, APRN

Respondent was licensed as a nurse in 1995. She earned her master's degree in nursing and was certified as a pediatric nurse practitioner in 2014. She began working at the Hemingway Clinic in 2015.[74] Prior to that, Respondent worked as a chronic care clinician, clinical research nurse, and as a charge nurse on a pediatric

[67] Tr. Vol. 2 at 315.

[68] Tr. Vol 1 at 281.

[69] Tr. Vol. 1 at 281; Tr. Vol. 2 at 301.

[70] Tr. Vol. 1 at 271-82.

[71] Tr. Vol. 1 at 283.

[72] Tr. Vol. 1 at 284.

[73] Tr. Vol. 2 at 310-11.

[74] Tr. Vol. 2 at 340-41.

hematology/oncology/cardiology unit. Most of her career has been spent in pediatrics.[75]

Respondent saw the patient one time on February 12, 2020, and Ms. Ramos was present throughout the visit.[76] Respondent did not make any addendum to her medical records for that date.[77] According to Respondent, the symptoms the patient complained of on February 12 were new within the last 12 hours.[78] He awoke during the night before, was dry-heaving and started vomiting, and had one loose stool.[79] He also reported that he had gone to school that day and gone to bed that night and everything was fine, but he woke up in the middle of the night not feeling well. That information is not documented in the medical record.[80] The medical assistant told Respondent that the patient had vomited while in the clinic, but Respondent did not witness him getting sick.[81] Respondent does not recall that Ms. Ramos described the vomit, but she did recall that the patient had a bowl and what Respondent saw looked like normal stomach contents.[82] Respondent denied that she declared that the patient had a viral illness when she walked in the room.[83]

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[75] Resp. Ex. 16.

[76] Tr. Vol. 2 at 348.

[77] Tr. Vol. 2 at 343.

[78] Tr. Vol. 2 at 348-49.

[79] Tr. Vol. 2 at 350.

[80] Tr. Vol. 2 at 351.

[81] Tr. Vol. 2 at 346.

[82] Tr. Vol. 2 at 355-56.

[83] Tr. Vol. 2 at 344.

Respondent asked the patient if he was in pain, and he also informed the medical assistant of his pain.[84] According to Respondent, the patient was not specific about the location of his pain but complained of a stomach ache.[85] Constipation was not discussed at this visit, but Ms. Ramos mentioned that the patient had seen Dr. Craig a week earlier, and Respondent saw the note about that visit in the electronic medical records.[86] Respondent testified that she did not consider the patient's complaints to relate to an ongoing gastrointestinal issue because they were acutely different from his previous complaints and had just recently started.[87]

Respondent performed a physical exam of the patient, noting that the patient's abdomen was soft and bowel sounds were normal.[88] No other findings of the abdominal exam were documented because none were present.[89] Respondent testified that if she had gleaned any other information from the exam, she would have documented it.[90] Respondent testified that she typically documents by exception when performing an exam in a primary care setting.[91]

Respondent diagnosed the patient with a viral illness because his reported symptoms were acute, having come on approximately six hours before the visit;

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[84] Tr. Vol. 2 at 347.

[85] Tr. Vol. 2 at 347.

[86] Tr. Vol. 2 at 348-49.

[87] Tr. Vol. 2 at 358.

[88] Tr. Vol. 2 at 353.

[89] Tr. Vol. 2 at 447-448.

[90] Tr. Vol. 2 at 353.

[91] Tr. Vol. 2 at 447.

and his symptoms were common and included nausea, vomiting, and some diarrhea.[92] She discussed the diagnosis with the patient and Ms. Ramos. Respondent prescribed Zofran, and testified that there was no discussion at this visit about Miralax.[93] The medical records show that Zofran was a new medication as of this visit and that Respondent made no changes to the prescription of Miralax.[94] Respondent testified that she had authority to order lab tests and imaging, and that the only imaging available at Hemingway Clinic was flat x-ray films.[95] Neither imaging studies nor lab tests were indicated, Respondent said, and none were ordered.[96]

At the end of the visit Respondent prepared the patient and Ms. Ramos to go home and manage his symptoms. She provided instructions on how to take the Zofran and what to do if the symptoms failed to improve.[97] Respondent printed several pages of after-visit instructions and information and attached it to their discharge paperwork.[98]

Respondent was aware that her supervising physician, Dr. Kunz, received an email from Ms. Ramos on February 14 because Dr. Kunz shared the email with her.[99] Respondent testified that, contrary to Ms. Ramos's email, she did not

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[92] Tr. Vol. 2 at 345-46.

[93] Tr. Vol. 2 at 357-58.

[94] Staff Ex. 6 at 22-23, 30.

[95] Tr. Vol. 2 at 354.

[96] Tr. Vol. 2 at 355.

[97] Tr. Vol. 2 at 364.

[98] Tr. Vol. 2 at 450-51; Staff Ex. 6 at 36-41.

[99] Tr. Vol. 2 at 359-60.

observe the patient wince when she palpated his abdomen, and testified that if she had noted tenderness on exam she would have documented it.[100] Regarding Respondent's written response to the Board, the reason it includes negative findings that are not in the medical record is because those findings were not appreciable on exam. She was able to say in her written response that there was no targeted tenderness and no mass on palpation because it was not documented at the time of her exam, meaning that those findings were not present on exam.[101]

Respondent has never intentionally documented inaccurate information and believed her documentation for this visit to be complete.[102] Respondent testified that given the information she had at the time of the visit, she would not have done anything differently with respect to her care and treatment of the patient.[103]

5. Heather Skrivanek, APRN, Ph.D.

Dr. Skrivanek was Respondent's retained expert. She graduated from the University of Texas with a Bachelor of Science in nursing in 1995 and has been licensed by the Board since 1996. She obtained her master's degree in nursing with a concentration as a primary care pediatric nurse practitioner. She obtained her Doctor of Philosophy degree in child and adolescent psychiatry in 2012.[104] She was certified as a pediatric nurse practitioner in 2005.[105] Dr. Skrivanek is currently an

[100] Tr. Vol. 2 at 360.

[101] Tr. Vol. 2 at 362-63.

[102] Tr. Vol. 2 at 390-91.

[103] Tr. Vol. 2 at 377-78.

[104] Tr. Vol. 2 at 400-01; Staff Ex. 15.

[105] Tr. Vol. 2 at 401.

assistant clinical professor and the director of the Pediatric Nurse Practitioner and Neonatal Nurse Practitioner Programs at the University of Texas at Arlington.[106]

Dr. Skrivanek testified that when the patient saw Respondent he complained of acute nausea and vomiting with one loose stool. This was an episodic visit in which the patient sought treatment for an acute problem rather than a comprehensive visit.[107] Dr. Skrivanek said she would not expect Respondent to have utilized the findings from the patient's office visit with Dr. Craig on February 3 because the complaints were different. On February 3, the patient complained of four days of constipation, but on February 12, he complained of nausea, vomiting, and one loose stool. These were different presentations and Respondent did not need to address the February 3 visit, unless the patient complained to her of ongoing constipation.[108]

The documented history of present illness and review of systems both include a subjective review of the patient's history and, Dr. Skrivanek said, Respondent would have ascertained that information by asking questions of the patient and Ms. Ramos.[109] The Past Medical History portion of the record is where chronic illness or significant findings are documented and is not intended to be a recap of each prior visit.[110]

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[106] Tr. Vol. 2 at 402.

[107] Tr. Vol. 2 at 435.

[108] Tr. Vol. 2 at 432-33.

[109] Tr. Vol. 2 at 427-28.

[110] Tr. Vol. 2 at 413.

Dr. Skrivanek testified that documentation by exception means to document pertinent positive findings of an assessment, while omitting from the documentation findings that are normal and are expected to be normal.[111] In the case of a normal exam, only the abdominal softness and bowel sounds would be documented.[112] If an abdominal exam revealed an abnormality, such as guarding or a mass, those findings would be documented.[113] According to Dr. Skrivanek, documentation by exception is a standard, appropriate, and reasonable way for a pediatric nurse practitioner to document an abdominal exam in a primary care setting.[114]

Respondent's note that the patient's abdomen was soft is a normal finding indicating that there was no guarding, the abdomen was not rigid, and there was no acute abdominal pain.[115] When Respondent documented "bowel sounds are normal" it meant bowel sounds were not hyper- or hypoactive.[116] According to Dr. Skrivanek, Respondent's documentation of her care and treatment of the patient was complete, reasonable, and appropriate, and was not in violation of the Act.[117]

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[111] Tr. Vol. 2 at 416.

[112] Tr. Vol. 2 at 416.

[113] Tr. Vol. 2 at 415-17.

[114] Tr. Vol. 2 at 416.

[115] Tr. Vol. 2 at 414-15.

[116] Tr. Vol. 2 at 415.

[117] Tr. Vol. 2 at 420-21.

6. Christopher Craig, M.D.

Dr. Craig is a board-certified pediatrician who has worked with Respondent at the Hemingway Clinic since October 2018.[118] Dr. Craig characterized Respondent as one of the most competent nurse practitioners he has ever known.[119] He praised her integrity, work ethic, and compassion for patients.[120]

Dr. Craig saw the patient on February 3 for a complaint of constipation over four days.[121] The patient was already taking Miralax for constipation on an as-needed basis.[122] Dr. Craig instructed the patient to increase Miralax and return if his symptoms worsened or failed to improve in the next three to four days.[123]

According to Dr. Craig, for an acute visit, an abdominal exam would include listening to and palpating the abdomen.[124] Pertinent positive findings like rebound pain, guarding, or tenderness, would be documented, and if Respondent had observed a pertinent positive finding on her exam, it would have been documented.[125] Negative findings would not be documented.[126] Dr. Craig testified

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[118] Tr. Vol. 1 at 226-27.

[119] Tr. Vol. 1 at 227.

[120] Tr. Vol. 1 at 227-28.

[121] Tr. Vol. 1 at 234-35.

[122] Tr. Vol. 1 at 235.

[123] Tr. Vol. 1 at 238-39.

[124] Tr. Vol. 1 at 236-37.

[125] Tr. Vol. 1 at 243-44.

[126] Tr. Vol. 1 at 236-37.

that this method of documenting by exception is reasonable and standard for pediatricians and APRNs.[127]

Dr. Craig reviewed Respondent's records for the patient's visit on February 12. The patient was seen for an acute care visit.[128] According to Dr. Craig, the patient's presentation on February 12 was different than his presentation on February 3 and the visit with Respondent was for a new problem.[129] Based on the patient's complaints and Respondent's exam, Dr. Craig determined that there was no indication for Respondent to order imaging.[130] He agreed with Respondent's diagnosis of viral illness and her prescription of anti-nausea medication.[131] Dr. Craig testified that the care and treatment provided to the patient by Respondent was reasonable and prudent, and that her documentation was appropriate, standard, and complete.[132]

7. Jolene Zych, RN, APRN, Ph.D.

Dr. Zych was the Board's expert and has been employed by the Board since 1999 as a nurse consultant.[133] She holds a general registered nurse (RN) license and is also licensed as an APRN but has not worked in a clinical setting since 1999.[134]

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[127] Tr. Vol. 1 at 236.

[128] Tr. Vol 1 at 250.

[129] Tr. Vol. 1 at 240-41.

[130] Tr. Vol. 1 at 244.

[131] Tr. Vol. 1 at 244-45.

[132] Tr. Vol. 1 at 241, 247.

[133] Tr. Vol. 2 at 460-61.

[134] Tr. Vol. 2 at 468, 542.

Dr. Zych also holds a Ph.D. in public policy and administration.[135] Some of her duties include assisting with development of rules and regulations, newsletters, and other documents for the Board's consideration. She also works with the advisory committee on advanced practice nursing and the enforcement and legal teams.[136]

Dr. Zych agreed that the practice of nursing involves the exercise of clinical judgment in both the actual care provided and the documentation of nursing care.[137] She testified that the Board's rules require nurses to keep accurate and complete records, a standard that is set by the Board. She agreed that the Board's rules do not define "complete" or "accurate."[138] Dr. Zych is not aware of any rule or statement issued by the Board that prohibits documenting by exception.[139]

Dr. Zych's criticisms of Respondent's documentation are generally limited to the abdominal exam.[140] Dr. Zych agreed that a "soft" abdomen is considered normal, but in the absence of more documentation about Respondent's findings, she cannot be sure that Respondent performed a full abdominal assessment.[141] There is no documentation of whether Respondent's exam revealed distention, guarding, targeted tenderness, or if there was a mass that could be palpated.[142] Dr. Zych also testified that although that information is absent from the records,

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[135] Tr. Vol. 2 at 467-68.

[136] Tr. Vol. 2 at 461.

[137] Tr. Vol. 2 at 537.

[138] Tr. Vol. 2 at 555.

[139] Tr. Vol. 2 at 575.

[140] Tr. Vol. 2 at 561.

[141] Tr. Vol. 2 at 473-74.

[142] Tr. Vol. 2 at 483; Staff Ex. 6 at 1.

Respondent included it in her written response to the Board, causing concern that Respondent's records are not accurate.[143]

Dr. Zych testified other information she considered relevant to the patient's complaints is absent from the records. According to Dr. Zych, the information omitted from Respondent's records that could be important in making decisions about treatment, and whether more robust intervention is needed, includes:

- Information provided to Respondent by Ms. Ramos about her observations;
- the number of times the patient vomited, whether he vomited while at the clinic, and whether vomiting occurred in relation to intake of food, drink, or medication;
- what the vomitus looked like;
- when the patient last ate or drank;
- whether Respondent continued or discontinued the patient's Miralax; and
- information about education provided to the patient and Ms. Ramos, such as what to expect, what to watch out for, and when to return to the clinic.[144]

Dr. Zych was also critical that Respondent did not document any information about the patient's history of constipation because his complaints on February 12 were also gastrointestinal symptoms. According to Dr. Zych, that information could help Respondent determine if the patient's symptoms on

[143] Tr. Vol. 2 at 473.

[144] Tr. Vol. 2 at 476-78; 480-81; 487.

February 12 were new symptoms or if they represented a worsening of his prior condition.[145]

Dr. Zych testified that it was unclear whether Respondent provided patient education or after-visit instructions.[146] She did acknowledge that Respondent documented that she "discussed home management of symptoms," which she said is insufficient because it is not clear if the entire contents of the after-visit instructions were discussed. Instead, Dr. Zych said, Respondent should have documented that she "discussed management of all items included in after-care instructions."[147]

Regarding Ms. Ramos's testimony about the falsified medical records, Dr. Zych testified that it was unlikely that Respondent and the two physician assistants who saw the patient on February 12 and 13 all falsified their records.[148]

8. Javier Kane, M.D.

Dr. Kane is a pediatric hematologist-oncologist and palliative care physician, and he is currently employed by Baylor Scott & White.[149] Dr. Kane has known Respondent for several years and knows her to be a conscientious, competent, and dedicated provider.[150] Dr. Kane testified that Respondent's documentation of the

[145] Tr. Vol. 2 at 479-80.

[146] Tr. Vol. 2 at 555-56.

[147] Tr. Vol. 2 at 561-63; 565-66.

[148] Tr. Vol. 2 at 568-69.

[149] Tr. Vol. 2 at 506-07.

[150] Tr. Vol. 2 at 517.

February 12 visit was appropriate and complete, and that as a subsequent provider he was not deprived of any information he needed.[151]

He testified that the patient was diagnosed with a type of cancer called Burkitt Lymphoma, which is a very rare and aggressive malignancy with a dramatic rate of growth that can cause the tumor to double in size in about 25 hours. In that timeframe, Dr. Kane said, the tumor can go from causing nausea, vomiting, and loose stools to causing an obstruction that requires emergency treatment.[152]

IV. ANALYSIS

Staff alleges that on or about February 12, 2020, Respondent failed to perform and/or document a complete assessment of one pediatric patient's medical history and presenting symptoms of gastrointestinal illness. Staff argues that this alleged failure created an incomplete medical record and may have deprived the patient's subsequent providers of complete and accurate information regarding the patient's medical condition.

A. Documentation of Medical History

The first part of the Board's charge alleges that Respondent did not perform and/or document a complete assessment of the patient's medical history. The analysis of this charge necessarily requires consideration of whether a complete assessment of the patient's medical history was required at the visit the patient had with Respondent. The ALJ finds that Staff failed to establish this violation.

[151] Tr. Vol. 2 at 516-17.

[152] Tr. Vol. 2 at 508-09; 511; 530-31.

The medical history at issue in Staff's charge is the patient's visit with Dr. Craig on February 3, 2020, for a complaint of four days of constipation. Dr. Craig diagnosed the patient with acute constipation, told the patient to increase the amount of Miralax he was taking and to come back if his symptoms worsened or did not improve in three to four days. When the patient returned and saw Respondent on February 12, he had different complaints of nausea, vomiting, and one loose stool. Respondent credibly testified that when she saw the patient, she knew about his February 3 visit with Dr. Craig. Aside from seeing the note in the electronic medical record and Ms. Ramos telling her about that visit, however, there was no discussion of constipation at the visit on February 12. Constipation is not included in the history of present illness, where the patient's subjective complaints were documented, nor is there credible evidence that the patient or Ms. Ramos informed Respondent that Miralax was not working.

Dr. Zych testified that the patient's complaints to Respondent were gastrointestinal in nature so Respondent should have evaluated his history of constipation more thoroughly. Respondent and Dr. Craig testified, however, that his complaints were inconsistent with the complaints he made on February 3. Moreover, the patient and Ms. Ramos told Respondent that the symptoms came on during the night before, and therefore had been present for less than 12 hours.

The ALJ finds that, based on the information she had on February 12, it was reasonable for Respondent to conclude that the patient's complaints were new and unrelated to his prior complaint of constipation. It was also reasonable for her to determine that further assessment of the patient's history of constipation was not

necessary to evaluate and treat what she decided was a different, acute issue. Accordingly, the ALJ determines that Staff did not meet its burden of proving that Respondent failed to perform and/or document a complete assessment of the patient's medical history.

B. Documentation of Presenting Symptoms

The second part of the Board's charge relates to the assessment and documentation of the patient's presenting symptoms of gastrointestinal illness. In her testimony, Dr. Zych limited her criticism of Respondent's documentation to three areas: education and information provided by Respondent to Ms. Ramos and the patient, information provided by Ms. Ramos and the patient to Respondent, and the physical exam.

1. Patient Education and Instructions

Respondent documented in the chart that she "discussed course of viral illness" and "discussed home management of symptoms." According to Respondent, she verbally instructed the patient about starting his new medication, when to begin taking fluids and how much, how long the virus might last, and when to seek emergency treatment.

Respondent also provided Ms. Ramos with at least six pages of printed materials before she left the clinic, including a summary of the visit, medication instructions, what to do at home, when to contact a healthcare provider, and when to get emergency help. Ms. Ramos denied receiving the printout, but the medical records show that it was printed four minutes before the patient was checked out of

the clinic following his visit. This is consistent with Respondent's credible testimony that she printed the materials and attached them to the patient's discharge paperwork.

Dr. Zych did not express an opinion of whether Respondent provided the printed materials to Ms. Ramos. She did, however, opine that Respondent should have documented that she "discussed management of all items included in after-care instructions" instead of documenting that she "discussed home management of symptoms." The ALJ finds that there is no meaningful difference between these two statements and agrees with Respondent that this is an unreasonable criticism. There was no assertion by Ms. Ramos that the discussions did not occur nor was there evidence that Respondent was required to discuss the entire contents of the after-visit materials. The ALJ finds that the Board failed to meet its burden of proving that Respondent's documentation about the education and information she provided to the patient and Ms. Ramos was in violation of the Act or the Board's rules.

2. Information Provided to Respondent by Ms. Ramos

Staff's charge in this respect is based on Ms. Ramos's claims that certain information was discussed at the February 12 visit that is not reflected in the medical records. Ms. Ramos testified that she asked Respondent to order lab tests and imaging, and specifically that she wanted imaging to see what, if anything, was obstructing the patient's bowels. Respondent could not recall whether Ms. Ramos requested lab tests or imaging, but nothing was documented in the records because she determined that imaging and lab tests were not indicated.

There was no testimony or evidence presented that Ms. Ramos was concerned about a possible bowel obstruction, or that Respondent suggested the patient might have a bowel obstruction, at the visit on February 12. Bowel obstruction was not noted as one of the patient's chief complaints, and it does not appear in the subjective history of present illness. According to the records, Ms. Ramos never mentioned that she was concerned about a possible bowel obstruction to any of the providers the patient saw on February 12 or 13. It is unclear, then, why Ms. Ramos would ask or expect Respondent to order imaging for a possible medical condition that was never discussed with her.

Ms. Ramos further testified that she told Respondent that the patient's vomit looked black or tarry. Respondent could not recall this, but she did remember that what she saw in the patient's bowl looked like normal stomach contents. Dr. Zych opined that Respondent's failure to include that description in the medical records was a violation.

In her complaint to the Board, Ms. Ramos said that the vomit looked like bile and did not mention that it was black or tarry. Vomit that looks like black coffee grounds is one of the symptoms that may represent an emergency requiring immediate medical help, according to the after-visit instructions provided by Respondent. If Respondent was told or saw that the patient had black, tarry vomit, it stands to reason that she would have taken steps to address it right away and included that information in the records. It seems implausible that Respondent, described by her physician colleagues as exceedingly competent and conscientious, would have failed to document information about such a serious symptom. For

these reasons, the ALJ cannot determine that Respondent was provided this information by Ms. Ramos but failed to document it.

3. Physical Examination

There is no dispute that Respondent performed an abdominal examination on the patient and noted only that his abdomen was soft with normal bowel sounds. Staff argues that Respondent's documentation of the physical exam was not accurate or complete because it lacked information about whether Respondent observed distention, guarding, rebound, or a mass. Dr. Zych was also critical that negative findings not reported in the medical records were nonetheless included in Respondent's written response to the Board.

Respondent testified that she documented her abdominal exam by exception, so she did not document findings that were not present on exam. Therefore, she argues, a notation that the abdomen was soft and bowel sounds were normal is a "complete" record because the absence of discussion of distention, guarding, rebound, or a mass means that those findings were not observed during her exam. For the same reason, Respondent was able to include additional information in her response to the Board. Based on her method of documenting, Respondent could review the record and see that there was no distention, no guarding, no rebound, and no mass because those findings were not documented.

Dr. Skrivanek and Dr. Kane testified that when documenting by exception, pertinent positive findings are documented but negative findings are not. They also testified that documentation by exception is a standard, appropriate, and

reasonable method for documenting by an APRN. Dr. Skrivanek, Dr. Craig, and Dr. Kane all testified that Respondent's documentation from February 12 was complete. Dr. Stagg and Dr. Kane, both of whom treated the patient after Respondent, testified that Respondent's documentation did not deprive them of any information they needed. Although neither Dr. Stagg nor Dr. Kane were familiar with the Board's documentation requirements, Staff's charge contemplates that Respondent's documentation might impact subsequent providers. Their opinions about her documentation, therefore, are relevant and must be considered.

Dr. Zych, on the other hand, testified that documenting by exception necessarily creates incomplete medical records because some information will always be omitted. Dr. Zych acknowledged that a "soft" abdomen would be considered normal. However, she maintained that the patient's records are nonetheless incomplete because Respondent did not document all the negative findings that contributed to the normal finding. Without that information, Dr. Zych said, she cannot be sure that Respondent performed a full abdominal exam.

The ALJ declines to conclude that Respondent did not perform a complete abdominal exam. Staff does not dispute that Respondent palpated the patient's abdomen and listened to it with a stethoscope, and no evidence was presented to establish that a full abdominal exam requires more than that.

The ALJ further finds that the evidence fails to establish a violation related to Respondent's documentation of the physical exam. Regarding the accuracy of

the documentation, there is no credible evidence that the documented findings were inaccurate; in fact, two subsequent providers who saw the patient the day after Respondent also documented that his abdomen was soft with normal bowel sounds. Moreover, there is no evidence that the Board prohibits documenting by exception; its only requirement is that nurses "accurately and completely report and document" information including signs and symptoms. Respondent, therefore, was free to exercise her clinical judgment to determine how to document the findings of the patient's physical exam. By all accounts, a soft abdomen with normal bowel sounds is considered a normal exam, and the ALJ rejects Staff's argument that the records are incomplete because Respondent did not document the negative findings of an otherwise normal exam. Therefore, it is the ALJ's determination that Respondent's documentation of the physical exam is accurate and complete and does not violate the Act or the Board's rules.

The ALJ concludes that Staff failed to prove its charges by a preponderance of the evidence and enters the following findings of fact and conclusions of law in support of this determination.

V. FINDINGS OF FACT

1. Jill R. Meredith (Respondent) holds two licenses issued by the Texas Board of Nursing (Board): Advanced Practice Registered Nurse License No. AP126871 and Registered Nurse License No. 622606.

2. Respondent has been a registered nurse (RN) since 1995 and an Advanced Practice Registered Nurse (APRN) since 2014. Respondent is a Certified Pediatric Nurse Practitioner – Primary Care and has held that certification since 2014.

3. Since 2015, Respondent has worked at Baylor Scott & White Hemingway Clinic in Temple, Texas.

4. The patient in this case is a 15-year-old male.

5. On February 3, 2020, the patient's mother, Karen Ramos, took him to see Dr. Christopher Craig for a four-day history of constipation.

6. Dr. Craig diagnosed the patient with acute constipation and increased his medication from 8.5 g of Miralax to 17 g of Miralax as directed.

7. Dr. Craig instructed the patient and Ms. Ramos to return to the clinic if the patient's' symptoms worsened or did not improve in three to four days.

8. On February 12, 2020, Ms. Ramos took the patient for an appointment with Dr. Craig for complaints of nausea, vomiting, and one loose stool, all of which started the previous night.

9. Ms. Ramos was mistaken about the appointment date, and the patient did not have an appointment with Dr. Craig on February 12, 2020.

10. Ms. Ramos was concerned about the patient's symptoms, so she requested for the patient to be seen on a walk-in basis that day.

11. A medical assistant took the patient's vital signs and recorded information about the patient's subjective complaints in the medical record before the patient was seen by Respondent.

12. Respondent saw in the electronic medical records that the patient had seen Dr. Craig on February 3 for constipation.

13. Respondent discussed the patient's current symptoms and complaints with the patient and Ms. Ramos. Respondent's documentation regarding the information provided by the patient and Ms. Ramos was accurate and complete.

14. Respondent appropriately determined that the current complaints were new and acute, and unrelated to the previous complaint of constipation. Respondent reasonably concluded that no further assessment of the patient's prior complaint of constipation was necessary.

15. Respondent performed a physical examination, including palpating the patient's abdomen and listening for bowel sounds using a stethoscope.

16. Respondent documented her findings that the patient's abdomen was soft and that bowel sounds were normal.

17. Respondent's documentation of the findings of her physical examination was accurate and complete.

18. Respondent diagnosed the patient with a viral illness and prescribed Zofran for nausea.

19. Respondent discussed at-home management of the patient's symptoms and provided information to the patient and Ms. Ramos on signs and symptoms to watch out for, and when to seek additional medical care. Respondent printed instructions for at-home care and an after-visit summary, which were provided to the patient and Ms. Ramos before they left the clinic on February 12, 2020.

20. Respondent's discussion of the patient education and information she provided is accurately and completely documented in the patient's medical record.

21. On January 20, 2022, the Staff of the Board issued its First Amended Notice of Hearing along with its First Amended Formal Charges.

22. Together, the First Amended Notice of Hearing and the First Amended Formal Charges contained a statement of the time, place, and nature of the hearing on the merits; a statement of the legal authority and jurisdiction under which the hearing on the merits was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the factual matters asserted.

23. The hearing on the merits convened on May 16-17, 2022, before Administrative Law Judge Susan Rodriguez via the Zoom videoconferencing platform. Staff was represented by Assistant General Counsel Jacqueline Strashun. Respondent appeared and was represented by Jordan Parker and Scharli Branch. The record closed on August 19, 2022.

VI. CONCLUSIONS OF LAW

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. Code ch. 301.

2. The State Office of Administrative Hearings has jurisdiction over the hearing in this matter, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.

3. Respondent received timely and proper notice of the hearing on the merits. Tex. Occ. Code § 301.454; Tex. Gov't Code §§ 2001.051-.052.

4. Staff had the burden of proof by a preponderance of the evidence. 1 Tex. Admin. Code § 155.427.

5. A nurse is subject to discipline for unprofessional or dishonorable conduct that is likely to deceive, defraud, or injure a patient or the public. Tex. Occ. Code § 301.452(b)(10).

6. "Unprofessional conduct" under 22 Texas Administrative Code section 217.12(1)(A), (B), (C), and (4) includes:

   - Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice;

   - failing to conform to generally accepted nursing standards in applicable practice settings;

   - improper management of client records; and

   - conduct that may endanger a client's life, health, or safety.

7. A nurse is subject to discipline for failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that the Board finds exposes a patient or other person unnecessarily to risk of harm. Tex. Occ. Code § 301.452(b)(13).

8. The minimum acceptable standards of nursing practice, under 22 Texas Administrative Code section 217.11(1)(A), (B), and (D) include:

- Know and conform to the Texas Nursing Practice Act and Board rules as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;

- implement measures to promote a safe environment for clients and others; and

- accurately and completely report and document the client's status including signs and symptoms, nursing care rendered, physician orders, administration of medications and treatments, client responses, and contacts with other health care team members concerning significant events regarding the client's status.

9. In addition, specific minimum standards of nursing practice apply to APRNs. Under 22 Texas Administrative Code section 217.11(4), APRNs are required to:

- Practice in an advanced nursing practice role and specialty in accordance with authorization granted under Board rules and standards relating to practicing in an APRN role; and

- prescribe medications in accordance with prescriptive authority granted under Board rules and standards relating to prescribing by APRNs, and in compliance with state and federal laws and regulations relating to prescription of dangerous drugs and controlled substances.

10. Respondent did not violate 22 Texas Administrative Code section 217.11(1)(A), (B), (D), or (4).

11. Respondent did not violate 22 Texas Administrative Code section 217.12(1)(A), (B), (C), or (4).

12. Respondent did not violate Texas Occupations Code section 301.452(b)(10).

13. Respondent did not violate Texas Occupations Code section 301.452(b)(13).

VII. ALJ RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that no sanction be imposed against Respondent under the disciplinary matrix.

SIGNED October 17, 2022.

Susan Rodriguez
Presiding Administrative Law Judge

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Associated Case Party: Tx Board of Nursing

Name	BarNumber	Email	TimestampSubmitted	Status
Cynthia L LoCastro		cynthia.locastro@bon.texas.gov	10/17/2022 3:44:33 PM	SENT
JACQUELYN STRASHUN		JACKIE.STRASHUN@BON.TEXAS.GOV	10/17/2022 3:44:33 PM	SENT

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

November 10, 2022

Jacqueline A. Strashun **VIA EFILE TEXAS**

Jordan M. Parker **VIA EFILE TEXAS**

RE: Docket Number 507-21-3239.TBN; Texas Board of Nursing v. Jill R. Meredith

Dear Parties:

Please be advised that the time period to file exceptions to the Proposal for Decision (PFD) issued in the above-referenced hearing has expired and neither party filed exceptions. *See* 1 Tex. Admin. Code § 155.507(b). Therefore, the Administrative Law Judge recommends that the PFD be adopted as written. Because SOAH has concluded its involvement in the matter, the case is being returned to the **Texas Board of Nursing**. *See* Tex. Gov't Code § 2003.051(a).

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Associated Case Party: JILLRMEREDITH

Name	BarNumber	Email	TimestampSubmitted	Status
Scharli Branch		sbranch@canteyhanger.com	11/10/2022 2:45:13 PM	SENT

Case Contacts

Name	BarNumber	Email	TimestampSubmitted	Status
JACKIE STRASHUN		JACKIE.STRASHUN@BON.TEXAS.GOV	11/10/2022 2:45:13 PM	SENT
JORDAN M. PARKER		JPARKER@CANTEYHANGER.COM	11/10/2022 2:45:13 PM	SENT

Associated Case Party: Tx Board of Nursing

Name	BarNumber	Email	TimestampSubmitted	Status
Cynthia L LoCastro		cynthia.locastro@bon.texas.gov	11/10/2022 2:45:13 PM	SENT
JACQUELYN STRASHUN		JACKIE.STRASHUN@BON.TEXAS.GOV	11/10/2022 2:45:13 PM	SENT