DOCKET NUMBER 507-12-1517

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	§	
NUMBER 646767	§	**OF**
ISSUED TO	§	
HARRY CECIL WISEMAN	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: HARRY CECIL WISEMAN
c/o MARC MEYER, ATTORNEY
33300 EGYPT LANE, SUITE B200
MAGNOLIA, TX 77354

ROY G. SCUDDAY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on July 19-20, 2012, the Texas Board of Nursing (Board) considered the following items: (1) The Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt all of the Findings of Fact and Conclusions of Law in the PFD, including Findings of Fact Numbers 6 and 16, as modified by the ALJ in his final letter ruling of May 4, 2012, regarding the registered nursing license of Harry Cecil Wiseman without changes; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. Exceptions were filed by the Respondent on April 17, 2012. Staff did not file a response to the Respondent's exceptions to the PFD nor did Staff file exceptions to the PFD. On May 4, 2012, the ALJ issued a final letter ruling, in which he modified Findings of Fact Numbers 6 and 16.

The Board, after review and due consideration of the PFD, Respondent's exceptions to the PFD, the ALJ's final letter ruling of May 4, 2012, Staff's recommendations, and the presentation by the Respondent during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD, including Findings of Fact Numbers 6 and 16, as modified by the ALJ in his final letter ruling of May 4, 2012 as if fully set out and separately stated herein. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Sanction

The Board finds that Respondent's conduct, as described in the adopted Findings of Fact and Conclusions of Law, specifically in adopted Findings of Fact Numbers 12

through 15 and adopted Conclusions of Law Numbers 7 and 8, posed a serious risk of harm to the patients on the Unit. Although the Respondent adopted an observation plan to perform observation checks on the patients every 15 minutes, he failed to properly assess sleeping patients at close enough proximity to confirm that they were in no physical distress[1]. Further, the Respondent did not actually conduct the observation checks every 15 minutes[2]. Additionally, the Respondent created an inaccurate medical record by documenting that he did conduct the observation checks every 15 minutes, despite the fact that he did not do so[3]. The Respondent's conduct resulted in an unsafe environment for the patients[4].

The Board recognizes, however, that circumstances outside of the Respondent's control, as described in adopted Findings of Fact Numbers 6 and 7, may have also contributed to the events of that evening. As described in adopted Findings of Fact Numbers 6 through 9, the Respondent reported the understaffing of the Unit to his direct supervisor and, in collaboration with her, adopted an observation plan that was designed to provide the safest environment for all of the patients.

After reviewing the aggravating and mitigating factors in this matter, the Board finds that, pursuant to the Board's Disciplinary Matrix, and the Board's rules, including 22 Tex. Admin. Code §213.33(e) and (f), the Respondent's conduct warrants a Warning with Stipulations. The Board finds that, as part of its stipulations, the Respondent should complete remedial education courses in nursing jurisprudence and ethics, physical assessment, documentation, and critical thinking. These courses are designed to correct the Respondent's demonstrated deficiencies and to ensure that he is safe to continuing practicing nursing in this state[5].

IT IS THEREFORE ORDERED, that RESPONDENT SHALL receive the sanction of a WARNING WITH STIPULATIONS, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER ORDERED that, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

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[1] See adopted Findings of Fact Numbers 8 and 13.

[2] See adopted Finding of Fact Number 14.

[3] See adopted Findings of Fact Numbers 14 and 15.

[4] See adopted Finding of Fact Number 13.

[5] See Page 11 of the PFD, wherein the ALJ states that remedial education should suffice to "enable the Respondent to know what type of observations are necessary to determine whether a sleeping patient is in physical distress, and how to fill out checklists when the actual rounds times vary from the form". The remedial education courses imposed by the Board will review the appropriate standards for assessing and observing patients' major systems, for correctly and appropriately documenting nursing care rendered; for reviewing the requirements and expectations of the Board regarding the minimum standards of nursing practice and professional conduct; and for critically thinking and problem solving.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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

On or about June 21, 2012, RESPONDENT completed a course in critical thinking, which would have been a requirement of this Order.

IT IS FURTHER ORDERED: that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and 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. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. 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 at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html*.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, 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 at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, 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 at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

(4) RESPONDENT SHALL pay an administrative reimbursement in the amount of one hundred fifty nine dollars and sixty cents ($159.60). RESPONDENT SHALL pay this administrative reimbursement within forty five (45) days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

(5) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). 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 stipulations on RESPONDENT'S license(s). 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.

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IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

Entered this 20th day of July, 2012.

TEXAS BOARD OF NURSING

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR FOR THE BOARD

Attachment: Proposal for Decision; Docket No. 507-12-1517 (April 2, 2012).

I certify this to be a true copy of the records on file with the Texas Board of Nursing.
Date: 7/24/12
Signed:

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

April 2, 2012

Katherine A. Thomas, M.N., R.N.
Executive Director
Texas Board of Nursing
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701

VIA INTER-AGENCY

RE: Docket No. 507-12-1517; In the Matter of Permanent Certificate No. 646767 Issued to Harry Cecil Wiseman

Dear Ms. Thomas:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 TEX. ADMIN. CODE § 155.507(c), a SOAH rule which may be found at www.soah.state.tx.us.

Sincerely,

Roy G. Scudday
Administrative Law Judge

RGS/ap
Enclosures
XC: R. Kyle Hensley, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA INTER-AGENCY
Dina Flores, Legal Assistant TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – (with 1 CD; Certified Evidentiary Record) – VIA INTER-AGENCY
Marc M. Meyer, Law Office of Marc Meyer, PLLC, 33300 Egypt Lane, Suite B-200, Magnolia, TX 77354-2739 – VIA REGULAR MAIL

SOAH DOCKET NO. 507-12-1517

IN THE MATTER OF PERMANENT CERTIFICATE NO. 646767 ISSUED TO	§	BEFORE THE STATE OFFICE
	§	
	§	
	§	OF
	§	
HARRY CECIL WISEMAN, Respondent	§	
	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff of the Texas Board of Nursing (Staff/Board) brought action against Harry Cecil Wiseman (Respondent) seeking the issuance of a warning. This proposal for decision finds that Respondent should receive a warning.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The hearing convened February 28, 2012, before Administrative Law Judge (ALJ) Roy G. Scudday in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by R. Kyle Hensley, Assistant General Counsel. Respondent was represented by attorney Marc M. Meyer. The record was held open until March 19, 2012, to allow Staff to submit an affidavit of costs.

Matters concerning notice and jurisdiction were undisputed. Those matters are set out in the Findings of Fact and Conclusions of Law.

II. DISCUSSION

A. Background

Respondent has been licensed in Texas as a Registered Nurse (RN) since 1997. On September 10, 2010, Staff sent Respondent a Notice of Formal Charges filed against him. On February 16, 2012, Staff sent Respondent a First Amended Notice of Hearing.

B. Staff's Charges

Staff's made the following charges against Respondent:

Charge I

On or about July 6, 2009, while employed as a Charge Nurse with Texas West Oaks Hospital in Houston, Texas, Respondent failed to ensure that Patient No. 2018020 received 1:1 observation, which requires an assigned staff member to be within arm's length of the patient at all times, as ordered, from midnight until approximately 0300 hours. Respondent found out at midnight that the patient was on 1:1 observation; however, because the unit was short-staffed and the patient was asleep, Respondent instructed the Mental Health Worker to perform 15-minute observation checks on all the patients, instead of staying with Patient No. 2018020. This action constitutes grounds for disciplinary action in accordance with TEX. OCC. CODE (Code) § 301.452(b)(10) & (13), and is a violation of 22 TEX. ADMIN. CODE (TAC) §§ 217.11(1)(A), (1)(B), (1)(C), (1)(M), & (1)(S), and 217.12(1)(A), (1)(B), & (4).

Charge II

On or about July 6, 2009, while employed as a Charge Nurse with Texas West Oaks Hospital in Houston, Texas, Respondent failed to ensure that 15-minute patient observation rounds were appropriately performed by the Mental Health Worker from midnight until 0300 hours, and failed to appropriately perform 15-minute observation rounds himself after 0300 hours. Although facility policy required that staff observe sleeping patients at close enough proximity to confirm that they were in no physical distress, instead both the Mental Health Worker and Respondent only observed the patients from the doorways of their rooms. Patient No. 92801 was found unresponsive by the on-coming Mental Health Worker at the end of the shift and it was determined that the patient had died earlier in the shift. Respondent's conduct resulted in an unsafe environment for patients that may have contributed to the demise of Patient No. 92801. This action constitutes grounds for disciplinary action in accordance with Code § 301.452(b)(10) & (13), and is a violation of 22 TAC §§ 217.11(1)(A), (1)(B), (1)(M), & (1)(S), and 217.12(1)(A), (1)(B), & (4).

Charge III

On or about July 6, 2009, while employed as a Charge Nurse with Texas West Oaks Hospital in Houston, Texas, Respondent falsely documented the times that he performed the 15-minute observation rounds in Patient Medical Record No. 92081. Respondent's conduct was deceptive and resulted in an inaccurate

medical record. This action constitutes grounds for disciplinary action in accordance with Code § 301.452(b)(10) & (13), and is a violation of 22 TAC §§ 217.11(1)(A), (1)(B), & (1)(D), and 217.12(1)(A), (1)(B), (1)(C) & (6)(A).

During the hearing, a fourth charge was dropped by Staff.

C. Evidence

1. Undisputed Facts

Texas West Oaks Hospital (Hospital) is a psychiatric inpatient facility in Houston, Texas. On July 6, 2009, at 7:00 p.m., Respondent started his shift as a medication nurse in the Geriatric Unit (Unit), which consists of 20 beds and, on that night, had 12 patients. At 11:00 p.m., Respondent took over the duties of Charge Nurse for the Unit for the 11-7 shift. Although he was supposed to receive a report from Ms. Woodham, the Charge Nurse going off duty, Respondent did not receive such a report. In addition to Respondent, the Unit had a Staff Relief Nurse, Ekeate Omon, and a Mental Health Worker, Melony Bell. Respondent notified his immediate supervisor, House Supervisor Joan Sheehan, that the Unit needed another staff member to properly care for the patients, and was told by her that she would try to find someone.

At approximately 12:05 a.m., while reviewing the patient charts, Respondent discovered that Patient 2018020 in Room 208B had been ordered by her physician to have 1:1 observation, i.e., that a staff member should be within arm's length of the patient at all times. Respondent contacted Ms. Sheehan regarding the 1:1 observation requirement and again requested additional staff, but was told by Ms. Sheehan that she was unable to find anyone else and to do the best he could. Respondent then directed Ms. Bell to conduct 15-minute observation checks of all the patients, including Patient 2018020, while Respondent conducted chart checks from his station from which he could see Patient 2018020. At 3:00 a.m., Respondent directed Ms. Bell to begin the 1:1 observation of Patient 2018020, who had tried to get out of bed, while Respondent began conducting the 15-minute observation rounds himself.

At approximately 7:15 a.m., the Mental Health Worker for the next shift found Patient 92081 in Room 203B to be unresponsive. Respondent proceeded to call a Code Blue and observed that rigor mortis was beginning to set in on the patient, suggesting that she had died earlier during the shift.

2. Respondent's Testimony

Respondent testified that he had been working as a psychiatric nurse at the Hospital since February 2009. During that time he had worked with Ms. Omon on several occasions and found her to be very hard to work with. She would disappear for periods of time and he had written her up on several occasions. He had also requested that Ms. Sheehan replace Ms. Omon but had been told that it was not possible to do so. He stated that Ms. Omon was unavailable to help on several occasions on the July 6 -7 shift when the incident occurred.

Respondent testified that, due to the staff shortage that night, Ms. Sheehan had directed him to not provide the 1:1 observation of Patient 2018020 while she was asleep, so that he directed Ms. Bell to begin the 1:1 observation only after Patient 2018020 woke up around 3:00 a.m. At that time he began performing the 15-minute rounds, but agreed that, because he was so busy, he did not actually conduct the rounds every 15 minutes. He admitted that he filled in the checklist for those rounds for each 15-minute interval rather than note the actual times he performed the rounds.[1]

In regard to the method of conducting the 15-minute observation rounds, Respondent stated that he had not entered the rooms or pulled down the covers of the patients, but relied on either observing or hearing the patient breathing. When he observed Patient 92081, he could not observe her breathing because of her position in the bed, but he did hear breathing and assumed that it was she and not her roommate.

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[1] Bd. Ex. 10, p. 41.

3. Melony Bell's Testimony

Ms. Bell was the Mental Health Worker on the 11-7 shift the night of the incident. She testified that, because of the short-staffing, she was asked to perform the 15-minute observation rounds as well as her other normal duties of updating charts and taking vital signs. She stated that she understood that on the rounds she was required to step into the room far enough to determine if the patient were breathing, which she did. She stated that she thought Patient 92081 was breathing when she last observed her prior to beginning the 1:1 observation of Patient 2018020 at 3:00 a.m.

4. Margaret Pung's Testimony

Ms. Pung has been a registered nurse for 20 years. At the time of the incident, she was Chief Nursing Officer for the Hospital. She testified that when Respondent could not get Ms. Sheehan to provide additional staff, he should have contacted Ms. Pung. She pointed out that the Hospital Policy provided that 15-minute observations required that staff "make direct visual contact with patients and confirm they are in no danger or distress" and that "sleeping patients will be observed at close enough proximity to confirm that they are in no physical distress."[2] (After the incident in question, the Hospital Policy was changed to add the following: "Observations may not be completed standing in the doorway, or at a distance, particularly for patients who are sleeping. It is expected that staff conducting 15 minute observations will enter the room, approach the patient and check their identity, respirations, and to ensure that they are not in distress.")[3]

Ms. Pung pointed out that the Hospital Policy further provided that 1:1 observation required "a staff member of the same sex to be within arm's length of the patient at all times."[4]

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[2] Bd. Ex. 8, p. 18.

[3] Resp. Ex. 1, p. 3.

[4] Bd. Ex. 8, p. 18.

Ms. Pung stated that when Respondent realized he was unable to provide the 1:1 observation for Patient 2018020, he should have invoked "safe harbor."

Ms. Pung testified that, after review of the incident, Respondent was terminated for falsifying the rounds checklist. She stated that Ms. Omon was also terminated for stating that she had taken Patient 92081's vital signs when she had not. She further stated that Ms. Sheehan received a written reprimand.

5. Ray Hollis' Testimony

Ray Hollis is a registered nurse who was serving as Director of Regulatory Compliance for the Hospital at the time of the incident. He testified that he conducted the review of the incident and determined that Respondent had not accurately filled out the rounds checklist. He stated that Respondent should have noted on the checklist why he was unable to make the rounds at 15-minute intervals, and that he should have called his supervisor when he found out that he could not make the rounds as required.

6. Jane Burdsall's Testimony

Respondent offered the testimony of Jane Burdsall who has been a registered nurse for 45 years with extensive psychiatric and administrative experience. She testified that it is within the standard of nursing practice to use a modified 1:1 observation such as was used by Respondent while the patient was asleep, with the approval of the Nursing Supervisor. She said by doing so under the circumstances Respondent provided the safest environment possible for the patients on the Unit.

Ms. Burdsall agreed that observing patients from the doorway did not meet the standard of observation to determine if they were in distress. She stated that she was not aware that a nurse could leave some 15-minute intervals blank on the rounds checklist, and was of the opinion that a nurse could be written up for doing so.

7. Denise Benbow's Testimony

Staff offered the testimony of Denise Benbow, a Nursing Consultant for the Board. Ms. Benbow has been a Registered Nurse for 28 years with experience in diverse areas. As a Nursing Consultant for the Board, Ms. Benbow assists the Enforcement and Legal Divisions with case reviews and testifies as an expert witness in State Office of Administrative Hearings (SOAH) hearings.

Ms. Benbow testified that, by not providing the 1:1 observation from 12:00 a.m. to 3:00 a.m., Respondent put the patient at risk, thereby violating the minimum standard of nursing practice. She stated that when Respondent did not get additional staff assistance from Ms. Sheehan, he should have gone up the chain of command until he did so or invoke "safe harbor." She further testified that, when he did conduct his rounds, Respondent should have verified that Patient 92081 was breathing, and he should have accurately shown the times on the rounds checklist when he made the rounds.

D. Analysis

Code § 301.452(b)(10) provides that a person is subject to disciplinary action for "unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public." Code § 301.452(b)(13) provides that a person is subject to disciplinary action for "failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the board's opinion, exposes a patient or other person unnecessarily to risk of harm."

The Board rule at 22 TAC § 217.11 provides as follows:

> (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:
>
> (A) Know and conform to the Texas Nursing Practice Act and the board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;
>
> (B) Implement measures to promote a safe environment for clients and others;

(C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same;
(D) Accurately and completely report and document:
(i) the client's status including signs and symptoms;
(ii) nursing care rendered;
(iii) physician, dentist or podiatrist orders;
(iv) administration of medications and treatments;
(v) client response(s); and
(vi) contacts with other health care team members concerning significant events regarding client's status;

. . . . . .

(M) Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications;

. . . . . .

(S) Make assignments to others that take into consideration client safety and that are commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made;

The Board rule at 22 TAC § 217.11 provides the following:

(1) Unsafe Practice--actions or conduct including, but not limited to:
(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 Rule 217.11.
(B) Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;
(C) Improper management of client records;

. . . . . .

(4) Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established.

. . . . . .

(6) Misconduct--actions or conduct that include, but are not limited to:
(A) Falsifying reports, client documentation, agency records or other documents; . . . .

Charge I. Staff alleges that by instructing Ms. Bell to perform 15-minute observation checks on all the patients instead of providing the 1:1 observation of Patient No. 2018020 Respondent violated 22 TAC §§ 217.11(1)(A), (1)(B), (1)(C), (1)(M), & (1)(S), and 217.12(1)(A), (1)(B), & (4). Basically, Staff argues that Respondent should have invoked "safe harbor" when he determined that he was not going to be provided the extra staffing that would

enable him to provide the 1:1 observation and provide the necessary level of care to promote the safety of the other patients.

The process regarding "safe harbor" is set forth in the Board rule at 22 TAC § 217.20.[5] Based on the rule's procedures, Staff's position seems to be that when Respondent became aware of the 1:1 observation order for Patient 2018020, and determined that Ms. Sheehan would not provide additional staffing to enable the unit to operate properly if he followed that order, Respondent should have invoked "safe harbor" before adopting the modified observation plan developed by Ms. Sheehan and Respondent. Because he failed to provide the 1:1 observation from 12:05 until 3:00 and because he did not invoke "safe harbor", Staff asserts that Respondent created an unsafe environment for the patient.

Respondent's position is that he was placed in an impossible position as charge nurse to provide a 1:1 observation of Patient 2018020 and provide the necessary observations of the other patients on the Unit. He felt that the plan developed with Ms. Sheehan provided the safest environment possible for the patients on the Unit under the circumstances. In addition, Respondent stated that he thought it would be better to do the best he could rather than make matters worse by invoking "safe harbor." Respondent also believed that if he had invoked "safe harbor" he would have been terminated for doing so.

Under the circumstances existing on the Unit that night, Respondent made the best of a very bad situation. He made the best use of the staff at his disposal, a psychiatric technician and an erratic registered nurse, to provide the best care possible. While his actions may not have been in complete compliance with the letter of the rules, particularly in following the 1:1 observation requirement of Patient 2018020 while she was asleep, he was certainly acting within the spirit of the rules by providing the safest environment for all the patients on the Unit

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[5] The rule provides that a nurse must notify his or her supervisor that he or she is invoking "safe harbor" if the nurse determines that his or her performance of a requested conduct or assignment would constitute a violation of the Code or Board rules. The rule provides that the notice must be made: (1) in writing and (2) before the nurse engages in the conduct or performs the assignment. The rule further provides that a nurse who invokes "safe harbor" in good faith may not be suspended, terminated, or otherwise disciplined by the employer and may not be disciplined by the Board for engaging in the conduct while awaiting the determination of a peer review committee.

by following the plan agreed to by his House Supervisor. His invocation of "safe harbor" would not have added to the safety of the environment in any way. Accordingly, Respondent did not violate 22 TAC §§ 217.11(1)(A), (1)(B), (1)(C), (1)(M), & (1)(S), and 217.12(1)(A), (1)(B), & (4) by not providing the 1:1 observation between 12:05 a.m. and 3:00 a.m.

Charge II. Staff alleges that Respondent violated 22 TAC §§ 217.11(1)(A), (1)(B), (1)(M), & (1)(S), and 217.12(1)(A), (1)(B), & (4) by observing the patients only from the doorways of their rooms. Specifically, Respondent and Ms. Bell, working at the direction of Respondent, failed to observe sleeping patients at close enough proximity to confirm that they were in no physical distress.

The Hospital Policy at the time of the incident required that the nurse make direct visual contact with patients and confirm they are in no danger or distress, and further that sleeping patients should be observed at close enough proximity to confirm that they are in no physical distress. Both Ms. Bell and Respondent admitted that: (1) they didn't go into the room of Patient 92081, (2) her position in the bed prevented them from seeing her breathing, and (3) they thought they heard her breathing. This was clearly not sufficient to confirm that the patient was sleeping and not in physical distress. The patient died at some point when either Ms. Bell or Respondent were making the 15-minute rounds. One of them could have discovered her distress had they proceeded far enough into the room to determine if she were actually breathing. Accordingly, Respondent violated 22 TAC §§ 217.11(1)(A), (1)(B), (1)(M), & (1)(S), and 217.12(1)(A), (1)(B), & (4).

Charge III. Staff alleges that by falsely documenting the times that he performed the 15-minute observation rounds, Respondent's conduct was deceptive and resulted in an inaccurate medical record, in violation of 22 TAC §§ 217.11(1)(A), (1)(B), & (1)(D), and 217.12(1)(A), (1)(B), (1)(C) & (6)(A). Respondent asserts that the checklist form was such that there was no way for him to note the actual times of his rounds in variance of the 15-minute intervals.

When it became obvious to Respondent that he was not going to be able to conduct the rounds at 15-minute intervals, he could have put the accurate times in the time columns on the

form and written a comment at the bottom of the form instead of filling the form out inaccurately. However, there is nothing to indicate that he filled out the form inaccurately in an attempt to deceive the hospital as opposed to taking a shortcut. Accordingly, Respondent was in violation of 22 TAC §§ 217.11(1)(A), (1)(B), & (1)(D), and 217.12(1)(A), (1)(B), & (1)(C), but not § 217.12(6)(A).

The Disciplinary Matrix of the Board at 22 TAC § 213.33(b) provides that discipline for unprofessional or dishonorable conduct that is likely to injure a patient pursuant to Code § 301.452(b)(10) and for failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient unnecessarily to risk of harm pursuant to Code § 301.452(b)(13) will be determined based on the seriousness of the offense. Ms. Benbow testified that due to the aggravating factor that a patient died, the offense should be considered a Second Tier Offense. She also stated that in view of the mitigating factors of a system failure due to the understaffing and that Respondent has no other incidents that question his competence Sanction Level I would be appropriate. That sanction level calls for a Warning or Reprimand with Stipulations that may include supervised practice.

Staff argues that the appropriate sanction in this case is a Warning to last for a period of one year, remedial education, and indirect supervision. Respondent asserts that there is no basis for the requirement of indirect supervision.

The remedial education requirement should suffice to enable Respondent to know what type of observations are necessary to determine whether a sleeping patient is in physical distress, and how to fill out checklists when the actual rounds times vary from the form. Accordingly the ALJ agrees with Staff's recommendation but does not agree that Staff has shown the need for indirect supervision because such supervision would not seem to be necessary to accomplish these goals.

E. Costs

Staff submitted an affidavit setting forth the administrative costs of this proceeding in the amount of $1,163.49. These costs may be assessed against Respondent pursuant to Code § 301.461.

III. FINDINGS OF FACT

1. Harry Cecil Wiseman (Respondent) has been licensed as a registered nurse by the Texas Board of Nursing (Staff/Board) since 1997.

2. On September 10, 2010, Staff sent Respondent a Notice of Formal Charges filed against him.

3. On February 16, 2012, Staff mailed a Notice of Hearing to Respondent.

4. The notice of hearing contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

5. The hearing convened February 28, 2012, in the William P. Clements Building, 300 West 15th Street, Austin, Texas.

6. Texas West Oaks Hospital (Hospital) is a psychiatric inpatient facility in Houston, Texas. On July 6, 2009, at 7:00 p.m., Respondent started his shift as a medication nurse in the Geriatric Unit (Unit), which consists of 20 beds and, on that night, had 12 patients. At 11:00 p.m., Respondent took over the duties of Charge Nurse for the Unit for the 11-7 shift. Although he was supposed to receive a report from Ms. Woodham, the Charge Nurse going off duty, Respondent did not receive such a report. In addition to Respondent, the Unit had a Staff Relief Nurse, Ekeate Omon, and a Mental Health Worker, Melony Bell. Respondent notified his immediate supervisor, House Supervisor Joan Sheehan, that the Unit needed another staff member to properly care for the patients, and was told by her that she would try to find someone.

7. At approximately 12:05 a.m., while reviewing the patient charts, Respondent discovered that Patient 2018020 in Room 208B had been ordered by her physician to have 1:1 observation, i.e., that a staff member should be within arm's length of the patient at all times. Respondent contacted Ms. Sheehan regarding the 1:1 observation requirement and again requested additional staff, but was told by Ms. Sheehan that she was unable to find anyone else. Respondent and Ms. Sheehan agreed that the best plan was to not provide

the 1:1 observation of Patient 2018020 while she was asleep, with Respondent observing her from his station.

8. After the discussion with Ms. Sheehan, Respondent directed Ms. Bell to conduct 15-minute observation checks of all the patients, including Patient 2018020, while Respondent conducted chart checks at his station from which he could see Patient 2018020. At 3:00 a.m., Respondent directed Ms. Bell to begin the 1:1 observation of Patient 2018020, who had tried to get out of bed, while Respondent began conducting the 15-minute observation rounds himself.

9. The observation plan adopted by Respondent and Ms. Sheehan provided the safest possible environment for the patients on the Unit due to the circumstances caused by the understaffing of the Unit on that shift.

10. At approximately 7:15 a.m., the Mental Health Worker for the next shift found Patient 92081 in Room 203B to be unresponsive. Respondent proceeded to call a Code Blue and observed that rigor mortis was beginning to set in on the patient, suggesting that she had died earlier during the shift.

11. When Ms. Bell conducted the 15-minute observation rounds from 12:00 a.m. to 3:00 a.m., she only observed Patient 92081 from the doorway of her room and thought the patient was breathing when she last observed her prior to beginning the 1:1 observation of Patient 2018020 at 3:00 a.m.

12. About 3:00 a.m. Respondent began performing the 15-minute rounds. He did not enter the rooms or pull down the covers of the patients, but relied on either observing or hearing the patient breathing. When Respondent observed Patient 92081, he could not observe her breathing because of her position in the bed, but he did hear breathing and assumed that it was the patient and not her roommate.

13. The method of conducting the 15-minute rounds by both Respondent and Ms. Bell prevented them from observing sleeping patients at close enough proximity to confirm that they were in no physical distress, resulting in an unsafe environment for the patients.

14. Because he was so busy performing his duties as Charge Nurse as well as having to conduct the 15-minute rounds, Respondent did not actually conduct the rounds every 15 minutes. He filled in the checklist for those rounds for each 15-minute interval rather than note the actual times he performed the rounds.

15. Respondent's conduct in filling out the 15-minute rounds checklist resulted in an inaccurate medical record.

16. Staff incurred administrative costs in this contested case in the amount of $1,163.49.

IV. CONCLUSIONS OF LAW

1. The Texas Board of Nursing (Board) has jurisdiction over this matter pursuant to TEX. OCC. CODE (Code) ch. 301.

2. The State Office of Administrative Hearings has jurisdiction over the hearing in this proceeding, including the authority to issue a proposal for decision with proposed findings of fact and conclusions of law, pursuant to TEX. GOV'T CODE ch. 2003.

3. Notice of the hearing on the merits was provided as required by Code § 301.454 and by the Administrative Procedure Act, TEX. GOV'T CODE §§ 2001.051 and 2001.052.

4. Respondent is subject to disciplinary action by the Board pursuant to Code § 301.452(b)(10) and (13).

5. Staff had the burden of proof by a preponderance of the evidence.

6. Based on Findings of Fact Nos. 6-9, Respondent did not violate 22 TEX. ADMIN. CODE (TAC) §§ 217.11(1)(A), (1)(B), (1)(C), (1)(M), & (1)(S), and 217.12(1)(A), (1)(B), & (4).

7. Based on Findings of Fact Nos. 10-13, Respondent violated 22 TAC §§ 217.11(1)(A), (1)(B), (1)(M), & (1)(S), and 217.12(1)(A), (1)(B), & (4).

8. Based on Findings of Fact Nos. 10-13, Respondent violated 22 TAC §§ 217.11(1)(A), (1)(B), & (1)(D), and 217.12(1)(A), (1)(B), & (1)(C).

9. Respondent is subject to being assessed the administrative costs of this contested case pursuant to Code § 301.461.

V. RECOMMENDATION

Based upon the above findings of fact and conclusions of law, the ALJ recommends that Respondent be issued a warning for a period of one year without indirect supervision, required to take remedial education, and be assessed administrative costs in the amount of $1,163.49.

SIGNED April 2, 2012.

ROY G. SCUDDAY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

DOCKET NO. 507-12-1517

IN THE MATTER OF	§	
REGISTERED NURSE	§	BEFORE THE TEXAS STATE
LICENSE NUMBER 646767	§	
ISSUED TO HARRY CECIL WISEMAN,	§	OFFICE OF ADMINISTRATIVE HEARINGS
RESPONDENT	§	

RESPONDENTS EXCEPTIONS TO THE PROPOSAL FOR DECISION

TO THE HONORABLE ADMINISTRATIVE LAW JUDGE:

NOW COMES the Respondent, Harry Cecil Wiseman, through his attorney, to file these Exceptions to the Proposal for Decision.

EXCEPTIONS

Technical Corrections in the Undisputed Facts: In the first paragraph, the third sentence reads; "Although he was supposed to receive a report from Ms. Terilynn Woodham ("Woodham"), the Charge Nurse going off duty, Respondent did not receive such a report."[1] However, the Charge Nurse whom the Respondent relieved was not Woodham, but another nurse named "Ade" (unknown last name).[2] Woodham was the medication nurse that the Respondent relieved at 6:45 p.m., and from whom he did receive a report at that time.[3] At 11:00 p.m., Respondent relieved "Ade", but did not receive a report from this nurse.[4] Therefore Ms. Woodham should not have been listed as the Charge Nurse and Ms. Ade should have been listed as the Charge Nurse in this sentence. Additionally, Respondent started his shift at 6:45 p.m., rather than 7:00 p.m., as is stated in the second sentence.

Finding of Fact No. Six (6): Finding of Fact No. Six (6) reads in part: "Although he was supposed to receive a report from Ms. Woodham, the Charge Nurse going off duty, Respondent

[1] Proposal for Decision (PFD), at 3.

[2] Record, at 13:25.

[3] Board Exhibit 7, at 10.

[4] Record, at 16:30.

did not receive such a report."[5] The error in this Finding of Fact has been discussed, *supra*, in the section regarding Technical Corrections in the Undisputed Facts.[6] Therefore Ms. Woodham should not have been listed as the Charge Nurse and Ms. Ade should have been listed as the Charge Nurse in Finding of Fact No. Six (6). Additionally, Respondent started his shift at 6:45 p.m., rather than 7:00 p.m.

Sanction Recommendations: The Recommendation contains an assessment of administrative costs in the amount of $1,163.49. Respondent does not dispute that the Board may attempt to recover administrative costs pursuant to Texas Occupations Code §301.461. However, Respondent asserts that certain costs assessed are inappropriate, no supported by the evidence presented or not authorized by statute or rule and that the Recommendation should be that the Respondent is liable for an assessment of administrative costs not to exceed $54.80.

Subpoena for Harry Wiseman: Respondent excepts to inclusion of the cost of a subpoena requiring the Respondent to appear at this hearing. There is no evidence that the Respondent would not have appeared at the hearing as the Respondent was well aware of the hearing, as evidenced by his receipt of the Notice of Hearing and subsequent representation by counsel. Therefore was no credible reason for the Board to subpoena the Respondent.

Postage/Certified Mail Costs: Respondent generally excepts to all postage costs as not supported by evidence. The attached documentation of costs includes no evidence that these mailings occurred, nor to the specific cost for these mailings, but only a general "Postage Price Calculator." Additionally, Respondent excepts to the cost for sending the "Formal Charges" as the mailing of Formal Charges occurs before the matter has been docketed and is not a cost of the administrative hearing.

Witness Fees and Expenses: Respondent excepts to the costs incurred by the witnesses as not authorized by statute or rule because there is no evidence that the witnesses were subpoenaed to appear. The Board's rules only require reimbursement of witness who is

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[5] PFD, at 12.

[6] *See* discussion *supra* p. 1.

subpoenaed to appear at a hearing.[7] The Board's rules refer to the section of the Administrative Procedures Act which applies to witness expenses, which also states that a witness is entitled to receive expenses when the witness is "subpoenaed or otherwise compelled to attend a hearing . . ."[8] Respondent was not provided evidence that these parties were subpoenaed by the Board before the hearing, nor did the Board elicit any testimony during the hearing that the witnesses were subpoenaed to appear. Finally, the expense affidavit filed by the Board contains no evidence that any of the witnesses were subpoenaed by the Board to appear.

If the witness expenses are found to be allowed costs, Respondent also specifically excepts to the evidence provided by the Board regarding to the mileage paid to Melony Bell. Ms. Bell also drove from the Houston area, but her mileage reimbursement is 50% higher than for the other witnesses. Based on her stated address, the round trip mileage from the Respondents residence to the location of the hearing is 339.7 miles.[9] This would indicate a reimbursement for mileage of no more than $188.53, based on the current IRS mileage reimbursement rates, as referenced under the Board's rules.[10]

General Exceptions: Notwithstanding any ruling on the previous exceptions, the Respondent generally excepts to the imposition of 100% of the administrative costs in this matter. Initially, there were four charges contained in the First Amended Formal Charges. During

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[7] 22 Tex. Admin. Code §213.12. The rule states in part that "A witness who is not a party to the proceeding and who is subpoenaed to appear at a deposition or hearing or to produce books, papers, or other objects, shall be entitled to receive reimbursement for expenses incurred in complying with subpoena as set by the legislature in the APA, Texas Government Code Annotated §2001.103."

[8] Texas Government Code §2001.103.

[9] This mileage was determined using Yahoo! Maps and the following page exhibits this determination: http://maps.yahoo.com/#q1=12903+Kingston+Point+Ln%2C+Houston%2C+TX++77047-2541&q2=301+W+15th+St%2C+Austin%2C+TX++78701-1622&lat=38.44777174658948&lon=-95.23234605789185&zoom=9&mvt=m&trf=0&q3=12903+Kingston+Point+Ln%2C+Houston%2C+TX++77047-2541.

[10] The Board allows for reimbursement "equal to the maximum fixed mileage allowance specified in the revenue rulings issued by the Internal Revenue Service under the federal income tax regulations as announced by the Texas Comptroller for going to and returning from the place of the hearing or deposition if the place is more than 25 miles from the person's place of residence, and the person uses the person's personally owned or leased motor vehicle for the travel." 22 Tex. Admin. Code §213.12.

the hearing, the Board abandoned one of the Charges.[11] And in the Proposal for Decision, Respondent was found to have not violated the Nursing Practice Act with regards to Charge I as contained in the First Amended Formal Charges.[12] Therefore, if Respondent was only found to have violated the Nursing Practice Act in two of the four charges, or 50% of the matters brought in the hearing. Therefore it would be the equitable resolution to this matter for the Respondent to be liable for no more than 50% of the administrative costs taxed in this matter.

PRAYER FOR RELIEF

Respondent, Harry Cecil Wiseman prays that the honorable Administrative Law Judge:

1. Change Finding of Fact No. Six (6) to read "Texas West Oaks Hospital (Hospital) is a psychiatric facility in Houston, Texas. On July 6, 2009, at 6:45 p.m., Respondent started his shift as a medication nurse in the Geriatric Unit (Unit), which consists of 20 beds and, on that night, had 12 patients. At 11:00 p.m., Respondent took over the the duties of Charge Nurse for the Unit for the 11-7 shift. Although he was supposed to receive a report from Ms. Ade (unknown last name), RN, the Charge Nurse going off duty, Respondent did not receive such a report. In addition to Respondent, the Unit had a Staff Relief Nurse, Ekate Omon, and a Mental Health Worker, Melony Bell. Respondent notified his immediate supervisor, House Supervisor Joan Sheehan, that the Unit needed another staff member to properly care for the patients, and was told by her that she would try to find someone."

2. Change Recommendation to include reimbursement for administrative costs not to exceed $54.80; AND

3. Propose to the Texas Board of Nursing in a Decision all relief at law or in equity to which Respondent is entitled.

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[11] PFD, at 3.

[12] Id., at 14. This is Conclusion of Law No. Six (6).

Respectfully submitted,

By: _____

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CERTIFICATE OF SERVICE

This is to certify that on the 17th day of April, 2012, a true and correct copy of the above and foregoing document was served on the following individual(s) at the location(s) and in the manner indicated below:

Docketing Division
State Office of Administrative Hearings
William P. Clements Building
300 W. 15th Street, Suite 504
Austin, TX 78701-1649
VIA FACSIMILE AT 512-322-2061

R. Kyle Hensley, Assistant General Counsel
Texas Board of Nursing
333 Guadalupe, Suite 3-460
Austin, TX 78701
VIA FACSIMILE AT 512-305-8101

Marc M. Meyer

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

May 4, 2012

Katherine A. Thomas, M.N., R.N.
Executive Director
Texas Board of Nursing
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701

VIA FACSIMILE NO. 512/305-8101

RE: Docket No. 507-12-1517; In the Matter of Permanent Certificate No. 646767 Issued to Harry Cecil Wiseman

Dear Ms. Thomas:

I have reviewed Respondent's Exceptions filed April 17, 2012, to the Proposal for Decision (PFD) issued in the above-referenced case. Inasmuch as no reply was filed by Staff, I have determined that the following changes be made to the Findings of Fact and Recommendation:

6. Texas West Oaks Hospital (Hospital) is a psychiatric inpatient facility in Houston, Texas. On July 6, 2009, at 6:45 p.m., Respondent started his shift as a medication nurse in the Geriatric Unit (Unit), which consists of 20 beds and, on that night, had 12 patients. At 11:00 p.m., Respondent took over the duties of Charge Nurse for the Unit for the 11-7 shift. Although he was supposed to receive a report from the Charge Nurse going off duty, Respondent did not receive such a report. In addition to Respondent, the Unit had a Staff Relief Nurse, Ekeate Omon, and a Mental Health Worker, Melony Bell. Respondent notified his immediate supervisor, House Supervisor Joan Sheehan, that the Unit needed another staff member to properly care for the patients, and was told by her that she would try to find someone.

16. Staff incurred administrative costs in this contested case **that may be assessed against Respondent** in the amount of **$159.60**.

The Board may modify the Conclusions of Law as it determines necessary. However, for the reasons expressed in the PFD, my recommendation remains unchanged, except that the assessed administrative cost amount should be reduced to $159.60. Thank you for your attention to this matter.

Yours truly,

Roy G. Scudday
Administrative Law Judge

RGS/ap
XC: R. Kyle Hensley, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA FACSIMILE NO. 512/305-8101
Dina Flores, Legal Assistant TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA FACSIMILE NO. 512/305-8101
Marc M. Meyer, Law Office of Marc Meyer, PLLC, 33300 Egypt Lane, Suite B-200, Magnolia, TX 77354-2739 – VIA FACSIMILE NO. 866/839-6920