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

Executive Director of the Board

DOCKET NUMBER 507-11-5125

IN THE MATTER OF	**§**	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	**§**	
NUMBER 720476	**§**	**OF**
ISSUED TO	**§**	
RICHARD ARLEN OLIVEIRA	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: RICHARD ARLEN OLIVEIRA
C/O MARLOW J. MULDOON, III AND
JAMES M. STEWART
1701 N. MARKET ST., STE 200 L.B. 42
DALLAS, TX 75202

THOMAS H. WALSTON
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 27-28, 2011, 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 the PFD regarding the registered nursing license of Richard Arlen Oliveira with 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. No exceptions were filed by any party.

The Board has authority to review and modify the PFD in accordance with the Government Code §2001.058(e). The Board, after review and due consideration of the

PFD, Staff's recommendations, and the presentation by the Respondent during the open meeting, if any, has determined that Finding of Fact Number One (1) contains a technical error. Finding of Fact Number One (1) incorrectly references the Respondent's nursing license number. As such, the Board finds that the PFD should BE MODIFIED under the authority of §2001.058(e)(3) to correct this technical error in Finding of Fact Number One (1).

IT IS, THEREFORE, ORDERED THAT the PFD signed on September 2, 2011, is hereby MODIFIED under the authority of the Government Code §2001.058(e) for the reasons outlined above, in order to correct the technical error in Finding of Fact Number One (1).

Amended Finding of Fact Number One (1)

IT IS FURTHER ORDERED THAT FINDING OF FACT NUMBER ONE (1) is AMENDED and ADOPTED as follows:

5. Richard Arlen Oliveira (Respondent) holds a registered nurse (RN) license (Certificate Number 720476) issued on September 2, 2005, by the Texas Board of Nursing (the Board).

IT IS FURTHER ORDERED THAT Findings of Fact Numbers 2 through 23 and Conclusions of Law Numbers 1 through 7 contained in the PFD of September 2, 2011, are ADOPTED without modification. All proposed findings of fact and conclusions of law filed by any party or the ALJ not specifically adopted herein are hereby DENIED.

IT IS, THEREFORE, ORDERED THAT Permanent Certificate Number 720476, previously issued to **RICHARD ARLEN OLIVEIRA**, to practice nursing in the State of Texas be, and the same is hereby, REVOKED.

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

Entered this 28th day of October, 2011.

TEXAS BOARD OF NURSING

KATHERINE A. THOMAS, MN, RN

EXECUTIVE DIRECTOR FOR THE BOARD

Attachment: Proposal for Decision; Docket No. 507-11-5125 (September 2, 2011).

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

September 2, 2011

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.** 507-11-5125; In the Matter of Permanent Certificate Number 720476 Issued to Richard Arlen Oliveira

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,

Thomas H. Walston
Administrative Law Judge

THW:nl
Enclosures
XC: Jena Abel, Assistant General Counsel, TBN, 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 Certified Evidentiary Record) – VIA INTER-AGENCY
Marlow J. Muldoon, III, and James M. Stewart, Stewart Stimmel, LLP, 1701 N. Market, Suite 200, L.B. 42, Dallas, TX 75202 – VIA REGULAR MAIL

SOAH DOCKET NO. 507-11-5125

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE	§	
NUMBER 720476	§	OF
ISSUED TO	§	
RICHARD ARLEN OLIVEIRA	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The Staff of the Texas Board of Nursing (Staff/Board) seeks to revoke the registered nurse (RN) license of Richard Arlen Oliveira (Respondent) based on the California Board of Registered Nursing's (CBRN) revocation of Respondent's California RN license for gross negligence and incompetence. Staff filed a Motion for Summary Disposition with supporting evidence, but Respondent did not file a response. The Administrative Law Judge (ALJ) granted Staff's motion and, by this Proposal for Decision, recommends that the Board revoke Respondent's RN license.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The Board has jurisdiction over this matter under TEX. OCC. CODE ANN. (Code) Chapter 301. SOAH has jurisdiction over all matters relating to the conduct of a hearing in this proceeding, including the preparation of a proposal for decision with findings of fact and conclusions of law, pursuant to TEX. GOV'T CODE ANN. Chapter 2003.

Staff sent formal charges to Respondent on September 16, 2010, and Respondent's attorney filed an answer and request for a hearing. On May 23, 2011, Staff sent notice to Respondent of a hearing on the merits scheduled for August 3, 2011.

On July 1, 2011, Staff filed a Motion for Summary Disposition with supporting evidence, pursuant to 1 TEX. ADMIN. CODE (TAC) § 155.505. Respondent did not file a response. On July 26, 2011, the ALJ granted Staff's motion for summary disposition, closed the record, and canceled the hearing on the merits.

II. DISCUSSION

A. Background / Overview

Respondent was licensed as an RN in California in 2001 and in Texas in 2005.[1] In March 2010, the CBRN brought a disciplinary action against Respondent arising from an incident that occurred in late 2004.[2] The CBRN alleged that on December 27, 2004, Respondent initiated dialysis treatment on a patient without a clear view of the access site at all times.[3] After about two hours, the catheter fell out, and Respondent saw a pool of blood on the bed and on the floor. Other nurses came to the room, assessed the patient, and called a code when they could not get a pulse. The patient became hemodynamically unstable and died the following day. Based on these events, the CBRN accused Respondent of gross negligence and incompetence, thereby causing or substantially contributing to the patient's death.[4]

Pursuant to its procedures, the CBRN mailed its Accusation and other materials on March 29, 2010, to Respondent's California address of record and to a second address in Allen, Texas, that the CBRN obtained from an investigative report. Respondent did not file a Notice of Defense or request an administrative hearing within the applicable time limit. Therefore, on June 21, 2010, the CBRN adopted a default decision to revoke Respondent's California RN license. The CBRN order became final on July 21, 1010, and Respondent is not eligible to petition for license reinstatement until at least July 22, 2013.[5]

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[1] Staff Exs. 1 and 2.

[2] Staff Ex. 3.

[3] Staff Ex. 3.

[4] Staff Ex. 3.

[5] State's Ex. 3.

Staff filed Formal Charges against Respondent on September 16, 2010, based on the CBRN's actions. Respondent filed an answer through his attorney, James M. Stewart, which alleged that since 2008, Respondent had not lived at either address where the CBRN mailed the Accusation and the Default Order. He denied knowledge of the CBRN action until he received the Formal Charges in this case. Therefore, Respondent alleged in his answer that he was denied due process by the CBRN.[6]

Staff filed its motion for summary disposition seeking revocation of Respondent's Texas RN license based on Code § 301.452(b)(8) and the Board's Disciplinary Matrix at 22 TAC § 213.33. As previously noted, Respondent did not respond to Staff's motion, challenge Staff's summary disposition evidence, or file summary disposition evidence in his own behalf.

B. Summary Disposition Evidence

Staff filed extensive summary disposition evidence. It included Respondent's CBRN licensure record; his Texas licensure record; an affidavit (with attachments) from Kami Pratab, a Legal Support Analyst for the CBRN, which described the CBRN's procedures and actions taken against Respondent; the CBRN's Accusation, Default Decision and Order, Final Order, records concerning service by mail, and other materials; and an affidavit from Denise Benbow, a Nursing Practice Consultant with the Board, which explained why revocation of Respondent's RN license is appropriate under the Board's rules and Disciplinary Matrix. Staff's summary disposition evidence established that no genuine issue of material fact exists concerning the following:

- On January 31, 2001, Respondent was issued RN License No. 76729 to practice professional nursing in California. (Staff Ex. 1)
- On September 2, 2005, Respondent was issued RN License No. 720476 to practice professional nursing in Texas. (Staff Ex. 2)

[6] Respondent's Answer.

- On March 29, 2010, the Executive Director of the CBRN filed an Accusation against Respondent for his involvement in the dialysis treatment of a patient who died as a result of becoming hemodynamically unstable during the treatment. Specifically, CBRN alleged that on December 27, 2004, Respondent provided dialysis services to the patient without a clear view of the catheter access site; the catheter became dislodged; the patient lost a large amount of blood; and the patient died the following day. The CBRN alleged that the acts and omissions of Respondent amounted to gross negligence and incompetence. (Staff Ex. 3)

- In accordance with California procedures, the CBRN mailed a copy of the Accusation on March 29, 2010, by certified mail and first class mail, to Respondent's address of record in California. The CBRN also mailed the Accusation to a second address for Respondent in Allen, Texas, that was obtained from an investigative report. (Staff Ex. 3)

- On March 29, 2010, the CBRN also mailed to Respondent, at the same addresses, a Statement to Respondent, a Notice of Defense form, and a Request for Discovery. (Staff Ex. 3)

- Respondent did not file a Notice of Defense or request an administrative hearing in response to the Accusation. (Staff Ex. 3)

- In accordance with CBRN's procedures, a Default Decision and Order (Order) was prepared and sent on May 23, 2010, to the members of the CBRN for a vote. The CBRN voted on June 21, 2010, to adopt the Order to revoke Respondent's California RN license. The revocation became effective July 21, 2010, thirty days after the vote to adopt the Order. (Staff Ex. 3)

- The CBRN mailed the Order on June 21, 2010, to Respondent's address of record and to the second address described previously, by certified and first class mail. (Staff Ex. 3)

- Respondent never appealed or requested a modification of the CBRN's revocation of his California RN license. (Staff Ex. 3)

- Respondent is not eligible for reinstatement of his California RN license until July 22, 2013. (Staff Ex. 3)

- Respondent's conduct, as described by the CBRN, would constitute a violation of the Texas Nursing Practice Act and could have resulted in revocation of Respondent's Texas license, had the event occurred in Texas. (Staff Ex. 7)

- For disciplinary action under Code § 301.452(b)(8), the Board's Disciplinary Matrix at 22 TAC § 213.33(b) classifies the CBRN's revocation of Respondent's California RN license as a Second Tier Offense, Sanction Level I. Under the matrix, the disciplinary options for this offense are revocation, denial of licensure, or voluntary surrender. (Staff Exs. 6 and 7)

- Because Respondent is not a licensure applicant, denial of licensure is not an available disciplinary option. Respondent has not offered to voluntarily surrender his Texas license. The only remaining disciplinary option under the Board's Disciplinary Matrix is revocation of Respondent's Texas RN license. (Staff Exs. 6 and 7)

C. Applicable Law

The Board may take disciplinary action when a licensee's license is revoked by another jurisdiction. TEX. OCC. CODE § 301.452 (b)(8) states:

> (b) A person is subject to denial of a license or to disciplinary action under this subchapter for:
>
> . . .
>
> (8) revocation, suspension, or denial of, or any other action relating to, the person's license or privilege to practice nursing in another jurisdiction; . . . .

22 TAC § 213.27 concerns good professional character, including the effect of a disciplinary order issued by another jurisdiction. It provides in relevant part:

> . . .
>
> (b) Factors to be used in evaluating good professional character in . . . disciplinary matters are:
>
> . . .

(4) Any revocation, suspension, or denial of, or any other adverse action relating to, the person's license or privilege to practice nursing in another jurisdiction.

. . .

(d) The following provisions shall govern the determination of present good professional character and fitness of a Licensee . . . who has been licensed to practice nursing in any jurisdiction and has been disciplined . . . in that jurisdiction.

(1) A certified copy of the . . . order of adverse licensure action from the jurisdiction is prima facie evidence of the matters contained in such order . . . and is conclusive evidence that the individual in question has committed professional misconduct as alleged in such order . . . .

(2) An individual disciplined for professional misconduct in the course of practicing nursing in any jurisdiction . . . (disciplined individual) is deemed not to have present good professional character and fitness . . . .

(3) The only defenses available to a . . . Licensee under section (d) are outlined below and must be proved by clear and convincing evidence:

(A) The procedure followed in the disciplining jurisdiction was so lacking in notice or opportunity to be heard as to constitute a deprivation of due process.

(B) There was such an infirmity of proof establishing the misconduct in the other jurisdiction as to give rise to the clear conviction that the Board, consistent with its duty, should not accept as final the conclusion on the evidence reached in the disciplining jurisdiction.

(C) The deeming of lack of present good professional character and fitness by the Board during the period required under the provisions of section (d) would result in grave injustice.

(D) The misconduct for which the individual was disciplined does not constitute professional misconduct in Texas.

(4) If the Board determines that one or more of the foregoing defenses has been established, it shall render such orders as it deems necessary and appropriate.

The Board's Disciplinary Matrix and other factors to be considered for imposition of disciplinary sanctions are contained in 22 TAC § 213.33. For disciplinary action under Code § 301.452(b)(8), the Disciplinary Matrix provides that a Second Tier Offense occurs when revocation in another jurisdiction is based on a practice violation that could result in a similar sanction (revocation) in Texas. Sanction Level I for this Second Tier Offense includes revocation, denial of licensure, or voluntary surrender as the appropriate disciplinary options. Other factors listed in section 213.33, to be considered in conjunction with the Penalty Matrix, include, among other things, actual or potential harm to patients, evidence of present fitness to practice, the

seriousness of the violation, and evidence of good professional character as set forth and required by 22 TAC § 213.27.

D. ALJ's Analysis

An ALJ may issue a proposal for decision by summary disposition if the summary disposition evidence shows there is no genuine issue as to any material fact and a party is entitled to a decision in its favor as a matter of law. 1 TAC § 155.505(a). Staff provided competent summary disposition evidence that the CBRN revoked Respondent's California RN license in 2010 for gross negligence and incompetence that resulted in the death of a patient. Further, under 22 TAC § 213.27(d)(1), the certified copy of the CBRN Order included in Staff's summary disposition evidence is conclusive evidence that Respondent committed the professional misconduct as alleged in the CBRN order.

Staff's summary disposition evidence established that service upon Respondent by the CBRN was proper under California law. The CBRN's rules required Respondent to file his current mailing address with the CBRN and to notify it within 30 days after any change.[7] CAL. GOV'T CODE § 11505(c) provides that service by a state agency of an accusation and accompanying information is effective if an agency rule requires the respondent to file the respondent's address with the agency and to notify the agency of any change, and if a registered letter containing the accusation and accompanying material is mailed to the respondent at the latest address on file with the agency. The affidavit of Kami Pratab established that she followed these procedures without deviation when she served Respondent with the CBRN Accusation, Default Order, and other documents.[8]

In his answer to Staff's Formal Charges, Respondent alleged that he was denied due process by the CBRN. This is an affirmative defense under 22 TAC § 213.27(d)(3). However, a party that relies on an affirmative defense must provide summary disposition evidence in support of the

[7] 16 CAL. CODE OF REGULATIONS § 1409.1.

[8] Staff Ex. 3.

defense.[9] Respondent's Answer does not constitute summary disposition evidence on his behalf.[10] As noted previously, Respondent did not file any summary disposition evidence, and he did not object to or otherwise challenge Staff's evidence. Therefore, Respondent has not raised a genuine issue of material fact concerning his affirmative defense.

Staff's summary disposition evidence also established that revocation of Respondent's Texas nursing license is the appropriate disciplinary action. Under 22 TAC § 213.27(d)(1), the certified copy of the CBRN Order is conclusive evidence that Respondent committed gross negligence and incompetence that resulted in the death of a patient. These same acts and omissions, had they occurred in Texas, could have resulted in the revocation of Respondent's Texas nursing license. Therefore, under the Board's Disciplinary Matrix contained in 22 TAC § 213.33(b), Respondent has committed a Second Tier Offense, Sanction Level I. The prescribed disciplinary action for this offense is either revocation, denial of licensure, or voluntary surrender. Because Respondent is not an applicant for a license, denial of licensure does not apply. Likewise, he has not voluntarily surrendered his license, so the only remaining sanction under the Disciplinary Matrix is revocation of his license.

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[9] *Brownlee v. Brownlee*, 665 S.W.2d 111, 112 (Tex. 1984); *Brown v. Aztec Rig Equip., Inc.*, 921 S.W.2d 835, 845 (Tex. App. – Houston [14th Dist.] 1996, writ denied).

[10] *Hidalgo v. Surety Savings & Loan Ass'n*, 462 S.W.2d 540, 545 (Tex. 1971).

Summary disposition is not granted lightly, as it deprives a party of an evidentiary hearing on the merits. Also, the summary disposition process can be confusing to *pro se* respondents. In this case, however, an attorney represents Respondent. Further, Staff's summary disposition evidence is extensive, and it established that Respondent's California nursing license was revoked by the CBRN for gross negligence and incompetence that resulted in the death of a patient. Staff's summary disposition evidence also established that revocation of Respondent's Texas nursing license is the appropriate disciplinary action under the Board's Disciplinary Matrix and rules. In contrast, Respondent did not respond to Staff's Motion for Summary Disposition, he presented no summary disposition evidence, and he did not object to or challenge Staff's summary disposition evidence.

Staff's Motion for Summary Disposition and summary disposition evidence established that Respondent is subject to disciplinary action under Code § 301.452(b)(8) and that revocation of Respondent's Texas Nursing license is the appropriate disciplinary sanction. Therefore, the ALJ granted Staff's Motion for Summary Disposition and, by this Proposal for Decision, recommends that the Board revoke Respondent's Texas Permanent Certificate Number 720476.

III. FINDINGS OF FACT

1. Richard Arlen Oliveira (Respondent) holds a registered nurse (RN) license (Certificate Number 72046) issued on September 2, 2005, by the Texas Board of Nursing (the Board).

2. On January 31, 2001, Respondent was issued California RN License No. 76729 by the California Board of Registered Nursing (CBRN).

3. On March 29, 2010, the Executive Director of the CBRN filed an Accusation against Respondent for his involvement in the care of an elderly dialysis patient who died as a result of becoming hemodynamically unstable during dialysis treatment.

4. The Accusation alleged that on December 27, 2004, Respondent provided dialysis services to the patient without a clear view of the catheter access site; the catheter became dislodged; the patient lost a large amount of blood; and the patient died the following day.

5. The Accusation alleged that the acts and omissions of Respondent amounted to gross negligence and incompetence.

6. In accordance with California procedures, the CBRN sent a copy of the Accusation on March 29, 2010, by certified mail and first class mail to Respondent's address of record in California. The CBRN also mailed the Accusation to a second address for Respondent in Texas that was obtained from an investigative report.

7. On March 29, 2010, the CBRN also mailed to Respondent at the same addresses a Statement to Respondent, a Notice of Defense form, and a Request for Discovery.

8. Respondent did not file a Notice of Defense or request an administrative hearing in response to the CBRN Accusation.

9. In accordance with CBRN's procedures, a Default Decision and Order (Order) was prepared and sent on May 23, 2010, to the members of the CBRN for a vote. Based upon the Accusation, the CBRN voted on June 21, 2010, to adopt the Order to revoke Respondent's California RN license.

10. The revocation of Respondent's California RN license became effective July 21, 2010, thirty days after the vote to adopt the Order.

11. The CBRN mailed the Order on June 21, 2010, to Respondent's address of record and to the second address described previously, by certified and first class mail.

12. Respondent never appealed or requested a modification of the CBRN's revocation of his California RN license.

13. Respondent is not eligible for reinstatement of his California RN license until July 22, 2013.

14. Respondent's conduct made the basis of the CBRN Accusation and Order would constitute a violation of the Texas Nursing Practice Act and could have resulted in revocation of Respondent's Texas license, had the event occurred in Texas.

15. Under the Board's Disciplinary Matrix, the revocation of Respondent's California RN license constituted a Second Tier Offense, Sanction Level I. The disciplinary options for this violation are revocation, denial of licensure, or voluntary surrender.

16. Because Respondent is not a licensure applicant, denial of licensure is not an applicable disciplinary option.

17. Respondent has not voluntarily surrendered his Texas license.

18. The appropriate disciplinary option under the Board's Disciplinary Matrix is revocation of Respondent's Texas RN license.

19. On May 23, 2011, Staff for the Board served Respondent with formal charges and a notice of hearing that stated the date, time, and location of the hearing, referenced the applicable law, and contained a short, plain statement of the facts asserted against him.

20. On July 1, 2011, Staff filed a Motion for Summary Disposition against Respondent with supporting summary disposition evidence.

21. The deadline for Respondent to file a response to the Motion for Summary Disposition was July 15, 2011.

22. Respondent did not file a response to Staff's Motion for Summary Disposition, and he did not challenge Staff's summary disposition evidence or file summary disposition evidence in his own behalf.

23. By Order No. 1, the ALJ granted Staff's Motion for Summary Disposition on July 26, 2011.

IV. CONCLUSIONS OF LAW

1. The Texas State Board of Nursing (Board) has jurisdiction to discipline its licensees under TEX. OCC. CODE (Code) Chapter 301.

2. The State Office of Administrative Hearings has jurisdiction to conduct this contested case hearing and issue a proposal for decision under TEX. GOV'T CODE ANN. ch. 2003.

3. Respondent received proper notice of the hearing as required by TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. Staff's Motion for Summary Disposition complied with the requirements of 1 TEX. ADMIN. CODE (TAC) § 155.505.

5. An administrative law judge may issue a proposal for decision on all or part of a contested case by summary disposition if the summary disposition evidence shows there is no genuine issue as to any material fact and a party is entitled to a decision in its favor as a matter of law. 1 TAC § 155.505(a).

6. There is no genuine issue as to any material fact and the Staff is entitled to a decision in its favor as a matter of law.

7. The Board is authorized to take disciplinary action against Respondent because Respondent's California RN license was revoked by the California Board of Registered Nursing. TEX. OCC. CODE § 301.452(b)(8).

V. RECOMMENDATION

Based upon the Findings of Fact and Conclusions of Law, the Board should revoke Respondent Richard Arlen Oliveira's RN license, Certificate Number 720476.

SIGNED September 2, 2011.

THOMAS H. WALSTON
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

STATE'S EXHIBIT 6

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RICHARD OLIVEIRA** **5329 Cherry Ridge Drive** **Camarillo, CA 93012** **931 Panther Lane** **Allen, TX 75013** **Registered Nurse License No. 576729** RESPONDENT	Case No. 2010-479 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about March 29, 2010, Complainant Louise R. Bailey, M.Ed.,RN, in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2010-479 against Richard Oliveira (Respondent) before the Board of Registered Nursing.

2. On or about January 31, 2001, the Board of Registered Nursing (Board) issued Registered Nurse License No. 576729 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on September 30, 2006 and has not been renewed.

3. On or about March 29, 2010, Kami Pratab, an employee of the Board of Registered Nursing, Department of Consumer Affairs, served by Certified and First Class Mail a copy of the Accusation No. 2010-479, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is: 5329 Cherry Ridge Drive, Camarillo, CA 93012 and to 931 Panther Lane, Allen, TX 75013.

A copy of the Accusation is attached as Exhibit A, and is incorporated herein by reference.

4. Service of the Accusation was effective as a matter of law under the provisions of

Government Code section 11505, subdivision (c).

On or about April 12, 2010, the Certified Mail documents addresssed to 5329 Cherry Ridge Drive, Camarillo, CA 93012 were returned, and on April 8, 2010, the First Class Mail documents were returned, both marked by the U.S. Postal Service, "Not Deliverable as addressed, unable to forward."

5. Business and Professions Code section 2764 states:

The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with an investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

6. Government Code section 11506 states, in pertinent part:

(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived his right to a hearing on the merits of Accusation No. 2010-479.

7. California Government Code section 11520 states, in pertinent part:

(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

8. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the evidence on file herein, finds that the allegations in Accusation No. 2010-479 are true.

9. The total costs for investigation and enforcement in connection with the Accusation are $5,428.50 as of April 26, 2010.

//

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Richard Oliveira has subjected his Registered Nurse License No. 576729, to discipline.

2. A copy of the Accusation is attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation:

a. Violation of Business and Professions Code section 2761(a)(1) - Unprofessional Conduct, Gross Negligence.

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RICHARD OLIVEIRA** **5329 Cherry Ridge Drive** **Camarillo, CA 93012** **931 Panther Lane** **Allen, TX 75013** **Registered Nurse License No. 576729** Respondent	Case No. 2010-479 **ORDER**

IT IS SO ORDERED that Registered Nurse License No. 576729, heretofore issued to Respondent Richard Oliveira, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on July 21, 2010.

It is so ORDERED June 21, 2010.

Ann L Bayuta

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

Attachment:

Exhibit A: Accusation No. 2010-479

Exhibit A

Accusation No. 2010-479

EDMUND G. BROWN JR.
Attorney General of California
KAREN B. CHAPPELLE
Supervising Deputy Attorney General
RENE JUDKIEWICZ
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State Bar No. 141773
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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: RICHARD OLIVEIRA 5329 Cherry Ridge Drive Camarillo, CA 93012 931 Panther Lane Allen, Texas 75013 Registered Nurse License No. RN 576729 Respondent.	Case No. 2010-479 A C C U S A T I O N

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about January 31, 2001, the Board issued Registered Nurse License Number RN 576729 to Richard Oliveira (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on September 30, 2006.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act (§ 2700 et seq.).

5. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a . . . licensed nurse . . . for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual . . . licensed nursing functions."

6. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

7. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

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8. California Code of Regulations, title 16, section 1443.5 states, in pertinent part:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

. . . .

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family . . . ."

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL BACKGROUND

10. At all times relevant herein, Respondent was employed as a registered nurse by Dialysis-Stat Medical Group, Inc., of Simi Valley, California, a service which provided dialysis services to hospitalized patients.

11. On or about December 27, 2004, Respondent was the nurse for patient T.D., a 78-year-old female, undergoing dialysis for end stage renal disease, at Sherman Oaks Hospital.

12. At approximately 1800 hours, Respondent initiated treatment and charted patient T.D.'s vital signs, including blood pressure, heart rate, blood flow rate, UF (ultrafiltration) rate, venous pressure, arterial pressure, heparin and fluids. T.D. was Respondent's only assigned patient on the subject night.

13. Patient T.D.'s blanket was covering the dialysis access site (right vascular catheter). Respondent tried to explain to patient T.D. that he needed to see the catheter, but the patient did not speak English.

14. Respondent did not ask hospital staff for an interpreter or translator, or ask if any of patient T.D.'s family was present who could translate.

15. Respondent went on with the dialysis, even though he did not have a clear view at all times of the access site.

16. At approximately 1830 hours, Respondent adjusted the patient T.D.'s catheter as there were some catheter flow problems.

17. Between approximately 1940 and 2010 hours, Respondent believed he saw patient T.D. move.

18. At approximately 2010 hours, he went to the head of the bed, and noticed patient T.D.'s face was pale. He lifted the blanket and noted the catheter was dislodged. He moved her hand and the catheter fell out. He noticed a pool of blood on the bed. He applied pressure at the site. The bleeding did not stop.

19. He went to the door and called for help and when he came back he saw blood on the floor. Other nurses came to the room, assessed the patient, and called a code when they could not get a pulse.

20. Patient T.D. became hemodynamically unstable and was unable to be resuscitated. She died on December 28, 2004.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

21. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), as defined under California Code of Regulations, title 16, section 1442, in that on or about December 27, 2004, while on duty as a registered nurse at Sherman Oaks Hospital, Respondent failed to exercise the standard of practice which, under similar circumstances, would have been exercised by a competent registered nurse, thereby causing or substantially contributing to the death of patient T.D., by failing to communicate vital information to patient T.D.; failing to maintain visible contact with patient T.D.'s catheter site throughout the entire dialysis procedure; and failing to notice when patient T.D.'s catheter became dislodged. Complainant refers to and by this reference incorporates the allegations set forth in paragraphs 10 through 20, above, as though set forth fully.

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SECOND CAUSE FOR DISCIPLINE

(Incompetence)

22. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), as defined by California Code of Regulations, title 16, sections 1443 and 1443.5, in that on or about December 27, 2004, Respondent demonstrated acts of incompetence. Complainant refers to and by this reference incorporates the allegations set forth in paragraphs 10 through 20, above, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 576729, issued to Respondent Richard Oliveira;

2. Ordering Respondent to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/29/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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This certifies that this is a true and correct copy of records on file in this office pertaining to:

Richard Oliveira

BOARD OF REGISTERED NURSING,

Laurie Brunner
Enforcement Program