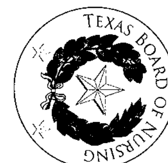

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.

Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Privilege to Practice from	§	AGREED
Wisconsin Registered Nurse License Number 188818	§	
& Texas Registered Nurse License Number 782521	§	
issued to	§	
GEORGE ONGERI ONGERA, Respondent	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of GEORGE ONGERI ONGERA, Privilege to Practice from Wisconsin Registered Nurse License Number 188818 and Texas Registered Nurse License Number 782521, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Sections 301.452(b)(10)&(13) and 304.001, Article 3, Texas Occupations Code. Respondent waived informal proceedings, notice and hearing, and agreed to the entry of this Order offered on June 19, 2012, by Katherine A. Thomas, MN, RN, FAAN, Executive Director.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived informal proceedings, notice and hearing, and agreed to the entry of this Order.

3. Respondent holds a license to practice professional nursing in the State of Texas, which is currently in MSR Invalid status. Respondent is currently licensed to practice professional nursing in the State of Wisconsin, a member of the Nurse Licensure Compact.

4. Respondent received a Baccalaureate Degree in Nursing from Winona State University, Winona, Minnesota, on December 11, 2009. Respondent was licensed to practice professional nursing in the State of Texas on March 9, 2010. Respondent was licensed to practice professional nursing in the State of Wisconsin on April 13, 2012.

5. On or about May 15, 2012, Respondent declared the State of Wisconsin as his home state and his license to practice professional nursing in the State of Texas was placed in MSR Invalid status.

6. Respondent's nursing employment history includes:

01/2010 - 02/2010	Graduate Nurse	Baylor University Medical Center Dallas, Texas
03/2010 - 06/2010	Registered Nurse	Baylor University Medical Center Dallas, Texas
07/2010 - Present	Unknown	

7. At the time of the initial incident, Respondent was employed as a Registered Nurse with Baylor University Medical Center, Dallas, Texas, and had been in this position for two (2) months.

8. On or about May 10, 2010, while employed with Baylor University Medical Center, Dallas, Texas, in the Intensive Care Unit (ICU), Respondent failed to document decreased urine output or need for placement of Foley catheter for Patient Medical Record Number 00772995-002. Respondent's conduct resulted in an inaccurate, incomplete medical record which subsequent care givers would rely on for further care.

9. On or about May 10, 2010, while employed with Baylor University Medical Center, Dallas, Texas, in the Intensive Care Unit (ICU), Respondent failed to appropriately titrate down the Levophed being administered to Patient Medical Record Number 00772995-002 in response to the patient's hypertension. Respondent's conduct may have put the patient at risk for the clinical complications of hypertension, including stroke.

10. On or about May 13, 2010, while employed with Baylor University Medical Center, Dallas, Texas, in the Intensive Care Unit (ICU), Respondent failed to document the temperature of Patient Medical Record 00312821008 every four hours. Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on his documentation to provide further care.

11. On or about May 13, 2010, while employed with Baylor University Medical Center, Dallas, Texas, in the Intensive Care Unit (ICU), Respondent failed to document the tolerance of Patient Medical Record Number 01269837-003 to ventilator weaning and documented inappropriately due to his knowledge deficit of ventilator modes. Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on his documentation to provide further care.

12. On or about May 13, 2010, while employed with Baylor University Medical Center, Dallas, Texas, in the ICU and caring for Patient Medical Record Number 01269837-003, Respondent failed to administer a Colace enema, as ordered by the physician. The enema was administered by the oncoming nurse. Respondent's failure to administer a treatment which was ordered by the physician could have resulted in non-efficacious treatment.

13. In response to the incidents in Findings of Fact Numbers Seven (7) through Eleven (11), Respondent states that the doctors were made aware of the decreased urine output of Patient Medical Record Number 00772995-002. Respondent states that the blood pressure of Patient Medical Record Number 00772995-002 was labile. He was weaning her off the Levophed slowly so that her blood pressure would not drop. Respondent states that patients had a white board in their room which the nurses could use to jot down information when they did not have access to the patient's chart, and that he used this board to jot down the temperature for Patient Medical Record Number 00312821008 at 1100. Respondent states that he only received training on the ventilators during his critical care internship. He states that there was always a respiratory therapist on the floor for the ventilated patients. Respondent states that when the ventilator changed to CPAP, he initially wrote down a tidal volume of 550, but the nurse supervisor pointed out that there was no tidal volume in CPAP mode. Respondent states that the Colace enema was not one of his priorities. By the time he was ready to do the enema, he discovered that the supplies were not on the floor. He ordered the supplies, but by shift change, the supplies had still not arrived.

14. The Board finds that subsequent to the aforementioned incidents, Respondent has received recent evaluation reflecting a high standard of quality of work and knowledge of his position.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555 and 304.001, *et seq.*, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A),(1)(B),(1)(C),(1)(D)&(1)(M) and 217.12(1)(A),(1)(B),(1)(C)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b) and 304.001, Article 3, Texas Occupations Code, to take disciplinary action against Privilege to Practice from Wisconsin Registered Nurse License Number 188818 and Texas Registered Nurse License Number 782521, heretofore issued to GEORGE ONGERI ONGERA, including revocation of Respondent's license(s) and/or privilege(s) to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of a REMEDIAL EDUCATION 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 AGREED and 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.

IT IS FURTHER AGREED and 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 AGREED and 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 State of Texas and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED 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 <u>not</u> 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: <u>http://www.bon.texas.gov/disciplinaryaction/stipscourses.html</u>.*

(2) 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 <u>not</u> 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.*

(5) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

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.

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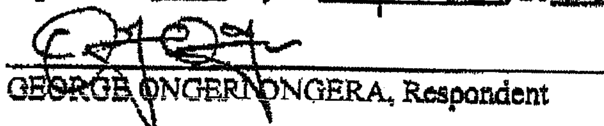
CONTINUED ON NEXT PAGE.

RESPONDENT'S CERTIFICATION

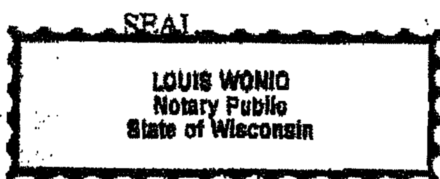
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid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

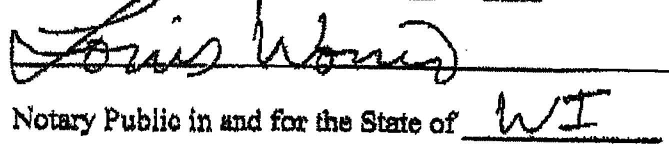
Signed this 12 day of September, 2012.



GEORGE ONGERONGERA, Respondent

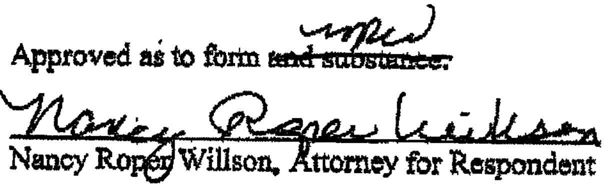
Sworn to and subscribed before me this 12th day of September, 2012.





Notary Public in and for the State of WI

Approved as to form ~~and substance.~~



Nancy Roper Willson, Attorney for Respondent

Signed this 14th day of September, 2012.

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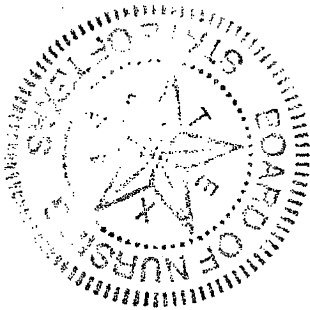
WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby ratify and adopt the Agreed Order that was signed on the 12th day of September, 2012, by GEORGE ONGERI ONGERA, Privilege to Practice from Wisconsin Registered Nurse License Number 188818 and Texas Registered Nurse License Number 782521, and said Order is final.



Effective this 19th day of September, 2012.

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