DOCKET NUMBER 507-12-2227

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	§	
NUMBER 568893	§	**OF**
ISSUED TO	§	
TONYA JOYLYNN TOWNSEND	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: TONYA JOYLYNN TOWNSEND
c/o MARC M. MEYER, RN, JD
33300 EGYPT LANE, SUITE B200
MAGNOLIA, TX 77354-2739

AMI L. LARSON
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 18-19, 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 the PFD regarding the registered nursing license of Tonya Joylynn Townsend 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. Respondent filed exceptions to the PFD on July 16, 2012. Staff filed a response to Respondent's exceptions to the PFD on July 31, 2012. On August 22, 2012, the ALJ issued her final letter ruling, in which she declined to make any changes to the PFD or her recommended sanction.

The Board, after review and due consideration of the PFD, Respondent's exceptions to the PFD, Staff's response to Respondent's exceptions to the PFD, Staff's recommendations, and Respondent's presentation during the open meeting and recommendations, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD 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.

Recommendation for Sanction

Although the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact or

conclusions of law[1], the Board agrees with the ALJ's conclusion that the appropriate sanction in this matter is a five year suspension, enforced for the first year, and probated for the remaining four years, subject to probationary conditions determined by the Board.

The Board further agrees with the ALJ that the Respondent's conduct, as described in the adopted Findings of Fact and Conclusions of Law, constitutes a second tier, sanction level II sanction for her violations of the Occupations Code §301.452(b)(10) and (13). After reviewing the aggravating and mitigating factors discussed by the ALJ in the PFD, the Board agrees with the ALJ that licensure suspension is more appropriate in this matter than licensure revocation[2].

The Respondent's conduct was serious in nature and caused at least potential, if not actual, harm to an eight year old disabled child and his mother[3]. Further, the Respondent has denied any wrongdoing and has failed to accept responsibility for her behavior or attempt to determine how to prevent such behavior in the future[4]. Of greater concern, the patient who was harmed was extremely vulnerable. Not only was he a young child, but he was severely disabled and developmentally delayed, and was unable to communicate verbally or defend himself[5]. Finally, the Respondent did not provide sufficient evidence of good professional conduct, as required by 22 Tex. Admin. Code §213.27[6].

The Board recognizes, however, that the Respondent has practiced as a nurse in good standing for 30 years and has not been the subject of any prior disciplinary action[7]. Further, the Respondent had been up all night providing care to the child, who was unusually fussy. As the ALJ points out, although there is no excuse for the Respondent's conduct, the events of that particular night may have triggered the Respondent's seemingly

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[1] The Board, not the ALJ, is the final decision maker concerning sanctions. Once it has been determined that a violation of the law has occurred, the sanction is a matter for the agency's discretion. Further, the mere labeling of a recommended sanction as a conclusion of law or as a finding of fact does not change the effect of the ALJ's recommendation. As such, the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact and conclusions of law. The choice of penalty is vested in the agency, not in the courts. An agency has broad discretion in determining which sanction best serves the statutory policies committed to the agency's oversight. The propriety of a particular disciplinary measure is a matter of internal administration with which the courts should not interfere. *See Texas State Board of Dental Examiners vs. Brown*, 281 S.W. 3d 692 (Tex. App. - Corpus Christi 2009, pet. filed); *Sears vs. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751 (Tex.App. - Austin 1988, no pet); *Firemen's & Policemen's Civil Serv. Comm'n vs. Brinkmeyer*, 662 S.W.2d 953, 956 (Tex. 1984); *Granek vs. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 781 (Tex.App. - Austin 2005, pet. denied); *Fay-Ray Corp. vs. Tex. Alcoholic Beverage Comm'n*, 959 S.W.2d 362, 369 (Tex.App. - Austin 1998, no pet.).

[2] The Board's Disciplinary Matrix authorizes either licensure suspension or revocation for second tier, sanction level II sanctions related to §301.452(b)(10) and (13).

[3] See Page 20 of the PFD.

[4] *Id.*

[5] See Page 21 of the PFD.

[6] See adopted Conclusion of Law Number 7.

[7] See Page 20 of the PFD.

uncharacteristic and isolated behavior[8].

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 an Enforced Suspension for one year, followed by a probated suspension for four years, with probationary conditions to include remedial education courses, employment restrictions, supervised practice, and employer reporting. These conditions are designed to remediate the Respondent's conduct and monitor her practice to ensure that she is capable of practicing nursing safely. Further, these conditions are consistent with Board policy and precedent in cases involving an enforced suspension of an individual's license.

IT IS THEREFORE ORDERED, that Registered Nurse License Number 568893, previously issued to TONYA JOYLYNN TOWNSEND, to practice nursing in Texas is/are hereby SUSPENDED and said suspension is ENFORCED until one year has elapsed from the date this Order becomes final.

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.

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 the 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.

IT IS FURTHER ORDERED, that, upon the expiration of one year from the date this Order becomes final, the Suspension will be STAYED, and RESPONDENT will be placed on PROBATION for four (4) years under the following terms of probation:

(1) 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.

(2) RESPONDENT SHALL pay all re-registration fees, if applicable, and RESPONDENT'S licensure status in the State of Texas will be updated to reflect the applicable conditions outlined herein.

(3) RESPONDENT SHALL, within one (1) year of the suspension being stayed, 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

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[8] *Id.*

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*

(4) RESPONDENT SHALL, within one (1) year of the suspension being stayed, 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.*

(5) RESPONDENT SHALL, within one (1) year of the suspension being stayed, successfully complete a course in "Detecting and Preventing Abuse and Neglect ...," a five (5) contact hour workshop presented in various locations by the Texas Department of Aging and Disability Services. In order to receive credit for completion of this workshop, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this workshop to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding Board-approved courses may be found at the following Board website address: http://www.bon.texas.gov/disciplinaryaction/stipscourses.html.*

IT IS FURTHER ORDERED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING PROBATION CONDITIONS FOR FOUR (4) YEAR(S) OF EMPLOYMENT. THE LENGTH OF THE PROBATIONARY PERIOD WILL BE EXTENDED UNTIL FORTY EIGHT (48) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

(6) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the probation conditions 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 probation conditions 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.

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

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

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

(10) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for four (4) year(s) of employment as a nurse.

IT IS FURTHER ORDERED that if during the period of probation, an additional allegation, accusation, or petition is reported or filed against the Respondent's license(s), the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

IT IS FURTHER ORDERED, 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 9th day of October, 2012.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-12-2227 (June 29, 2012).

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

June 29, 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. 507-12-2227; In the Matter of Permanent Certificate No. 568893 Issued to Tonya Joylynn Townsend

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,

Ami L. Larson
Administrative Law Judge

ALL/lh
Enclosures
XC: John Legris, 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 1 CD & Certified Evidentiary Record) – **VIA INTER-AGENCY**
Marc M. Meyer, RN, JD, Law Office of Marc Meyer, PLLC, 33300 Egypt Lane, Suite B200, Magnolia, TX 77354-2739 - **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-12-2227

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 568893 ISSUED TO	§	BEFORE THE STATE OFFICE
	§	
	§	
	§	OF
	§	
TONYA JOYLYNN TOWNSEND, Respondent	§	
	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff of the Texas Board of Nursing (Staff/Board) brought this action against Tonya Joylynn Townsend (Respondent) seeking to revoke her license as a registered nurse[1] based on allegations that Respondent violated the Nursing Practice Act and Board's rules by hitting a patient for whom she was providing nursing care. This proposal for decision finds that Staff met its burden of proof to establish the alleged violations and recommends that Respondent's license be suspended for five years, with the first year of suspension enforced, and the remaining four years of suspension probated and subject to any terms, conditions and restrictions that the Board deems appropriate and necessary to protect the public.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The hearing took place on May 3, 2012, before Administrative Law Judge (ALJ) Ami L. Larson in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by John F. Legris, Assistant General Counsel. Respondent was represented by attorney Marc M. Meyer. The record closed at the conclusion of the hearing that day.

Matters concerning notice and jurisdiction were undisputed. Therefore, those matters are set forth in the Findings of Fact and Conclusions of Law sections below without discussion.

[1] In its notice of hearing, Staff indicated that it would also be seeking to recover the costs of the proceedings in this matter. However, because Staff offered no evidence to establish the cost of the proceedings, and did not argue at the hearing that such costs should be imposed against Respondent; the ALJ does not address this issue.

II. UNDISPUTED FACTS

Respondent has been licensed as a nurse since approximately 1980 and received her Texas registered nurse's license in 1991. Respondent worked continuously as a nurse for several hospitals and as a disability examiner before becoming employed as a nurse by Pediatric Services of America, Inc. (PSA) in 2002. Initially, Respondent intended to work only part-time for PSA, but in 2003, when she began taking care of Leslie and Darryl Clark's child, A.C., she decided to work full-time with A.C. as her only patient.

Respondent provided nursing care for A.C. for more than 7 years, beginning when he was 12 months old. A.C. was born with hydrocephalus. Consequently, his brain is underdeveloped, and he is legally blind and unable to communicate verbally. A.C. requires a tracheostomy for breathing and a gastric tube for feeding as well as 24-hour skilled nursing care. Although A.C. was 8 years old at the time of the alleged incident in 2010, his mental functioning remained equivalent to that of an 18- to 24-month-old child.

On October 15, 2010, A.C. underwent an outpatient surgical procedure. Respondent worked an overnight shift providing care for A.C. from approximately 8:00 p.m. on the evening of October 15, 2010, until approximately 5:30 a.m. the morning of October 16, 2010. What happened on the morning of October 16, 2010, is in dispute.

III. SUMMARY OF EVIDENCE PRESENTED[2]

A. Staff's Evidence

Staff offered 14 exhibits and presented the testimony of four witnesses.

[2] A large number of Staff's exhibits consist of Respondent's employment records, most of which were not discussed by the parties and do not appear pertinent to the issues to be determined. Only the evidence relevant to the disputed issues is summarized here.

1. Testimony of Leslie Clark

Ms. Clark is married to Darryl Clark and has two children, one of whom is A.C. Ms. Clark testified that on the morning of October 16, 2010, she woke up at approximately 5:15 and realized that she had forgotten to prepare A.C.'s bottles the night before. Therefore, she got up to prepare the bottles. She could hear A.C. crying at that time, but did not find that to be unusual since he often cried when his diaper was being changed. Once the bottles were prepared, Ms. Clark went to A.C.'s room to give a bottle to Respondent. When Ms. Clark opened the door to A.C.'s room, she observed A.C. crying. Ms. Clark testified that she stood there for a second and Respondent was unaware that she was there. She observed Respondent pick up the corrugated plastic tubing used to connect A.C.'s tracheostomy to the nebulizer machine, which makes humid air for A.C. to breathe to help thin his secretions. Ms. Clark stated that she then saw Respondent hit A.C. three to five times on his diapered bottom with the tubing, which was disconnected from the machine at that time.

Ms. Clark then stated "what the 'f' are you doing hitting my baby?" Because Respondent had not seen that Ms. Clark was there, she was startled when Ms. Clark spoke. Respondent immediately turned around and said "I'm sorry." At that point, Ms. Clark said to Respondent "you need to get the 'f' out of my house," and threw the bottle she had in her hand at Respondent. According to Ms. Clark's testimony, Respondent kept saying she was so sorry and begging Ms. Clark to please not call the police or nursing agency because she could lose her license. Ms. Clark stated that she called PSA to report what had happened and spoke to their answering service. While Ms. Clark was on the phone, Respondent continued to beg and plead with her to not report the incident. Ms. Clark testified that she gave all of the information to the answering service and the director of PSA ultimately called her back. According to Ms. Clark's testimony, her husband dealt with Respondent while she was on the phone with the director of PSA.

When Ms. Clark asked her why she was hitting A.C., Respondent stated it was because he had a fever. Ms. Clark testified that Respondent's explanation did not make any sense to her. She stated that there was no breathing treatment being given when she walked into A.C.'s room

that morning. She could tell because the nebulizer machine was not running as it would have been during a breathing treatment and the "trach" end of the tube was not connected, as it would have been during a treatment. She also testified that A.C. received regularly scheduled breathing treatments every 8 hours, at 6:00 a.m, 2:00 p.m. and 10:00 p.m. She stated that it would not be standard to give him an additional breathing treatment if he were running a fever.

According to Ms. Clark, A.C. is usually cooperative with his breathing treatments, but not always. Sometimes he pulls the tubing away and, if it is not put on properly, the tubing can become disconnected. Additionally, she noted that sometimes A.C. grabs the mask and holds it tightly, but she stated that she has never had any problem getting it back from him and the tubing has never hit him. However, she stated that, on that morning, she did not observe A.C. pull the tubing out or fan himself with it, nor did she see him fighting with the Respondent to try to get the tubing from her. She stated that A.C. was wearing a diaper while he was being hit and there were no marks left on A.C. from the incident.

Ms. Clark stated that Respondent had worked for her for 7 or 8 years and she had never seen Respondent hit A.C. before. In fact, she testified, she trusted Respondent enough to list her as the emergency contact person for A.C. during the time that the Clark family did not have a car, but Respondent did. Ms. Clark further acknowledged that she had given all positive evaluations for Respondent and, up until this incident, had always thought highly of her.

The day after the incident, Ms. Clark called the police reported what had occurred. She explained that she did not make a police report the same day because she was too emotional and did not know what to do. She further acknowledged that she sent a text message to Respondent two days after the incident saying that she forgave Respondent and wished her and her family well. Ms. Clark explained that she sent the message after talking to her father, grandmother, and uncle, who is a pastor. She stated that her family advised her that forgiveness is always something to keep in mind and that it is a Christian thing to do.

2. Testimony of Darryl S. Clark

Mr. Clark testified that he is married to Leslie Clark, and A.C. is their child. On the morning of October 16, 2010, Mr. Clark was awakened to a back-and-forth exchange between his wife and Respondent. He asked what happened and heard his wife telling Respondent to "get out of my blanking house." Mr. Clark testified that he heard Respondent say she did not hit A.C. and his wife still told her to get out of the house. According to Mr. Clark, Respondent then said, "I'd never hit him; I'd never hit him." Mr. Clark also testified that he heard Respondent say that she would go to jail or lose her license if she were reported and that she would never touch A.C. again. At that point, Mr. Clark told Respondent she had to leave the house immediately. His wife was on the telephone trying to report the incident to the nursing agency at that time.

Mr. Clark testified that he said to Respondent "you know how my wife is," and explained that he meant that they are very protective of their kids and that Ms. Clark is more protective than he is. He testified that he never told Respondent that he knew she had not struck A.C. and never told Respondent to call PSA and explain herself.

Mr. Clark stated that he works the night shift and generally sleeps during the day, so he does not deal with A.C.'s nurses. He further testified that he helps care for A.C. and that A.C. is usually cooperative, but occasionally gets a "little fidgety" and sometimes he pulls on his tubing. Mr. Clark testified that A.C. might hold the tubing over his head, but neurologically he is unable to swing it hard.

3. Testimony of Amy Hillen

Ms. Hillen testified that she is the administrator in charge of running the Austin location of PSA Healthcare, which provides home healthcare services. Ms. Hillen is licensed to practice nursing in Texas. Ms. Hillen stated that she is familiar with Respondent because she was an employee of PSA Healthcare for 7 or 8 years, during which time she provided one-on-one in-home nursing care to medically fragile children.

On October 16, 2010, Ms. Hillen received a call from Leslie Clark, who reported that she wanted Respondent removed from her home because she had observed Respondent whipping her child with blue corrugated plastic tubing. Ms. Hillen then directed her staffing coordinator to ask Respondent to leave the home, and Ms. Hillen stayed on the phone with Ms. Clark until Respondent had left.

Later that morning, a few hours after the incident, Ms. Hillen spoke to Respondent at the PSA office. At Ms. Hillen's request, Respondent gave a written statement about what had happened that morning. Ms. Hillen then filed a report with the Texas Board of Nursing and the Texas Department of Aging and Disability Services based on the events described by Ms. Clark.

Ms. Hillen testified that, before the October 16, 2010 incident, she was not aware of any problems or concerns about Respondent during the time she worked for PSA. For most of that time, A.C. was Respondent's only patient, and the Clark family gave Respondent consistently positive reviews.

4. Testimony of Bonnie Cone

Ms. Cone is employed as a Nursing Consultant for Practice by the Texas Board of Nursing and has been licensed as a registered nurse in Texas since 1990. Her job duties include interpreting and working with the Nursing Practice Act and Board rules and assisting constituents and stakeholders. Additionally, Ms. Cone teaches the nursing jurisprudence course and travels throughout Texas giving presentations. Ms. Cone also serves as the designee of the Executive Director to chair informal conferences held by the Board.

Ms. Cone testified that she reviewed all of the exhibits admitted as evidence in this matter and listened to all of the testimony presented by Staff's witnesses. According to Ms. Cone, the allegations against Respondent are very serious and, if true, constitute violations of the Nursing Practice Act and Board's rules. Ms. Cone explained that "nurses are the most trusted professionals among healthcare providers" and that, "first and foremost, nurses must maintain the safety of patients." Ms. Cone stated that she was unable to imagine a legitimate reason for a

nurse to strike a child. Nurses, she said, have the responsibility to be level-headed and "to take a 360 degree view of a patient." There is no reason why a nurse should harm or strike a patient. According to Ms. Cone, even though A.C. was wearing a diaper when he was allegedly struck and no marks were left, the aggressive act of hitting him with the tubing constitutes an act of abuse.

Ms. Cone explained that she believes Respondent's alleged conduct violated the various rules and statutes cited by the Board in its Formal Charges. Specifically, she noted that A.C. was unable to defend himself or fend off Respondent, and his crying demonstrated that he suffered emotional harm. She further stated that Respondent's actions constituted threatening and violent behavior in the workplace, and that she failed to implement measures to promote a safe environment for clients and others, as required by the Board's rules.

Additionally, Ms. Cone discussed the various sanctions that could be imposed against Respondent for the alleged violations pursuant to the Board's disciplinary matrix. Ms. Cone noted that she did not find any applicable mitigating circumstances, but believed that the patient's vulnerability constituted an aggravating factor. Based on her analysis of the relevant factors, Ms. Cone concluded that Respondent's conduct constitutes a second-tier offense that falls under sanction level II of the Matrix. Accordingly, she testified, revocation of Respondent's license is the appropriate sanction. Ms. Cone acknowledged that Respondent had a long history of good work as a nurse prior to the incident at issue here. Nonetheless, she opined, the seriousness of Respondent's conduct during this incident outweighs her prior history of good conduct and warrants the revocation of her license.

5. Audio Tape of Ms. Clark's Telephone Call to PSA

An audio CD of the recorded call made by Ms. Clark to the PSA answering service on the morning of October 16, 2012, just after the incident had taken place, was admitted into evidence and was played, in part, during the hearing.[3] There is no dispute that the parties' voices on the

[3] Staff Ex. 14.

recording are Ms. Clark (LC), Respondent (R), and the PSA answering service representative (PSA).

In the background of the recording, while Ms. Clark was trying to report the incident to PSA, Respondent can be heard begging Ms. Clark not to report her. The content of the recorded call is as follows:

PSA: Thank you for calling PSA, this is Linda, how can I help you?
LC: Yes, um, yeah, I need the nurse on call please. This is an emergency.
R: Please don't.
PSA: Ma'am, what's your name?
LC: Excuse me?
PSA: Your name?
LC: Leslie.
R: Please don't.
PSA: Phone number, starting with area code?
LC: Area code 512 (recites phone number).
R: Leslie, please don't.
PSA: What's patient's last name?
R: Leslie, I will never come back again.
LC: I'll call your husband (inaudible) leave – do not come back to my house again. You are done! But I'm still reporting you to PSA.
PSA: What's the nurse's name?
LC: I can't hear you ma'am.
PSA: Okay, what's the patient's last name?
LC: Clark, C-L-A-R-K.
PSA: What's the patient's first name?
LC: (states and spells A.C.'s first name)
PSA: (repeats spelling of A.C.'s first name)
R: I'm begging you, please.
LC: Yes, ma'am.
R: Leslie, I'm begging you -- I'm begging you, please don't do this! Leslie, look . . .
LC: Get your hands off me!
R: Please don't do this to me; Leslie, my kids, my husband – I'm the only one working.
LC: Then you should have thought of that before you put your hands on my child!
R: Please, I will promise I will never, I will never touch him again. I beg you, never!
PSA: This call is being recorded, ma'am.
R: Please . . . (inaudible)
PSA: This call is being recorded. I can hear her plainly.
LC: I need the nurse please. You can hear her begging.
PSA: I can hear her plainly; I heard what she said.
LC: She already hears, she hears you pleading to me. She said you have to be reported.
R: (Inaudible)

LC: You did it to yourself.
R: (Inaudible)
PSA: Okay, uh, the reason for the call?
LC: Babe! My floor needs to be cleaned; she pissed all over my floor.
PSA: Ma'am?
LC: Excuse me, ma'am?
PSA: Okay, um, what's going on?
LC: I can't hear you, you're breaking up.
PSA: Okay, um . . .
LC: No way, you're not misunderstanding nothing (inaudible); get out of my face. Man, she happened to get (inaudible) on me.
PSA: You caught her doing what?
LC: I, um, I caught her hitting my baby with, um, with his, um, his um breathing tube and she says the reason she was hitting him was because he was running a fever. Well I told her that's no excuse to be hitting my baby.
PSA: Okay, you caught the nurse hitting your child with his, with the breathing tube?
LC: With his breathing tube.
PSA: Okay, I'm paging it out for you right now.
LC: I didn't hear you.
PSA: Jennifer will be calling you back.
LC: Okay, thank you.
PSA: Mmm hmm. I'm calling myself because I heard the nurse.

B. Respondent's Evidence

Respondent offered one exhibit, Ms. Clark's voluntary written statement to the Board regarding the incident, and testified on her own behalf. Respondent testified that she has been licensed and has worked as a nurse continuously since 1980, but has not worked as a nurse since this incident. Before she began working for PSA Healthcare in approximately 2001, Respondent held various nursing positions in hospital settings, including working as a staff nurse, a charge nurse, and a head nurse. She was recruited by PSA, in approximately 2001, and resigned from hospital work, electing instead to work in the private sector. From approximately 2003 until 2010, Respondent worked full-time for PSA Healthcare, with A.C. as her only patient.

Respondent testified about the events of October 15 and 16, 2010. She stated that A.C. had undergone an outpatient surgical procedure on October 15, so he was not feeling his best and had copious secretions when she began her shift at 8:00 p.m. that night. Respondent testified that she was busy with A.C. "all through the night" keeping his respirations up, suctioning, and

performing chest compressions to remove his secretions. She explained that A.C. was known to develop upper respiratory infections because of his tracheostomy and he was taking an expensive inhalation antibiotic, Tobramycin, because of that. She stated that she applied oxygen to A.C. at approximately midnight, when she put him to bed that night. At approximately 8:30 p.m., 10:00 p.m. and 2:00 a.m., she gave him Albuterol treatments. Respondent testified that, at approximately 4:00 a.m., she took and documented A.C.'s temperature, which she said was elevated.[4]

Respondent indicated that on the morning of October 16, 2010, when A.C. was getting his treatments, he was very fussy, crying and more restless than normal. Respondent stated that he pulled his tubing out and used his left hand to fan it across his chest and in the air. According to Respondent, if A.C. was fussy or mad or did not like something, it was not unusual for him to remove his mask and tubing. That morning, she stated, she was busy with him and was trying to feed him and administer his medicines. She tried to get the tubing out of his hand, but when she pulled it out of his hand, the tube "flopped back." Respondent testified that Ms. Clark came in just as she was reconnecting the tube to the tracheostomy to try to save the medicine she had already begun to administer.

Respondent testified that she was startled when Ms. Clark "busted open the door" and she told Ms. Clark that A.C. was running a fever and she was working with him to try to get his fever down. Respondent stated that Ms. Clark had a full bottle of milk in her hand, which she threw at Respondent. She described Ms. Clark as being very agitated and said Ms. Clark was screaming, yelling, and cursing. Respondent testified that, in an effort to de-escalate Ms. Clark she said, "Leslie, calm down, I'm trying to help [A.C.]." She testified that she told Ms. Clark that she would leave. Respondent testified that Ms. Clark said she was going to call the nursing agency and she asked Ms. Clark if they could talk about it. Respondent asserted that she was simply trying to de-escalate Ms. Clark and explain what had happened. She testified that she was concerned that Ms. Clark would make a mountain out of a molehill and that the situation would get blown out of proportion. Respondent stated that she wanted to talk to Ms. Clark and was

[4] Staff Exh. 9, p. 165.

worried about her own reputation. She stated that she had never been written up or accused of any misconduct in the past. Respondent said she was not trying to hide anything or prevent Ms. Clark from calling the agency. She testified that she was simply trying to explain herself and calm the situation down.

According to Respondent, Mr. Clark told her, "You know what Leslie's like and she's done this to me, too." Respondent stated that Mr. Clark told her that she should call the agency and tell them her side of the story. She denied that Mr. Clark ever asked her to leave. Respondent stated that she completed her charting for A.C. after she had been asked to leave and while Ms. Clark was on the phone. She explained that she felt she could not leave without completing her charting because she could not abandon her patient. After leaving the Clarks' home shortly after 6:00 a.m. on October 16, 2010, Respondent went home. She then went to the PSA office at 8:00, when it opened, and met with Amy Hillen.

Respondent testified that she never hit A.C. or threatened him. She explained that when she told Ms. Clark that she would never touch him again, she meant it in terms of having taken care of him for almost 8 years. She stated that neither Mr. nor Ms. Clark had ever been unhappy with her services before. In fact, she stated, Ms. Clark always tried to seek out Respondent and find out if she was available to care for A.C. Respondent testified that after this incident, Ms. Clark sent her a text messaging saying "I'm sorry this happened and I wish you and your family well."

Respondent also testified that she was hospitalized in January and February of 2011. She was initially hospitalized for knee surgery, but her hospitalization was extended due to serious complications that arose, which included a massive pulmonary embolism. Respondent stated that eventually, following her hospitalization, she received a letter from Board Staff asking her to undergo a forensic evaluation with a polygraph component to determine whether she posed any danger to the community and to assist the Board in determining her present fitness to practice nursing. She stated that the letter, which was dated February 24, 2011, must have arrived during the time that she was ill and she was unable to undergo the requested evaluation.

IV. APPLICABLE LAW

A nurse may be subject to disciplinary action by the Board, including license revocation, for violating the Nursing Practice Act or the Board's rules;[5] engaging in unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure a patient or the public;[6] or failing to care adequately for a patient or 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.[7]

The Board's rules further explain what constitutes unprofessional conduct. Specifically, the rules indicate that unprofessional conduct includes the following acts:

- Unsafe practice, including carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;[8]
- Careless or repetitive conduct that may endanger a client's life, health, or safety, regardless of actual injury;[9]
- Misconduct including causing or permitting physical, emotional or verbal abuse or injury or neglect to the client or the public;[10] and
- Misconduct including threatening or violent behavior in the workplace.[11]

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[5] Tex. Occ. Code § 301.452(b)(1).

[6] Tex. Occ. Code § 301.452(b)(10).

[7] Tex. Occ. Code § 301.452(b)(13).

[8] 22 Tex. Admin. Code § 217.12(1)(B).

[9] 22 Tex. Admin. Code § 217.12(4).

[10] 22 Tex. Admin. Code § 217.12(6)(C).

[11] 22 Tex. Admin. Code § 217.12(6)(F).

Additionally, the Board's rules set forth the minimum standards of nursing practice for all types of nurses.[12] At a minimum, among other things, all nurses must know and comply with the Nursing Practice Act and Board's rules.[13]

The Nursing Practice Act authorizes the Board to request a nurse to consensually undergo an evaluation by a Board-approved practitioner under Tex. Occ. Code § 301.4521(f). A nurse may refuse to consent to being evaluated pursuant to such a request.[14]

The Board's rules further provide that a person who seeks to obtain or retain a license to practice professional nursing shall provide evidence of good professional character which, in the judgment of the Board, is sufficient to insure that the individual can consistently act in the best interest of patients/clients and the public in any practice setting.[15] Such evidence must establish that the person is able to:

- distinguish right from wrong;
- think and act rationally;
- keep promises and honor obligations;
- be accountable for his or her own behavior;
- practice nursing in an autonomous role with patients/clients, their families, significant others, and members of the public who are or may become physically, emotionally, or financially vulnerable;
- recognize and honor the interpersonal boundaries appropriate to any therapeutic relationship or healthcare setting; and
- promptly and fully self-disclose facts, circumstances, events, errors, and omissions when such disclosure could enhance the health status of patients/clients or the public or could protect the patients/clients or the public from unnecessary risk of harm.[16]

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[12] 22 Tex. Admin. Code § 217.11.

[13] 22 Tex. Admin. Code § 217.11 (1)(A).

[14] Tex. Occ. Code § 301.4521(f).

[15] 22 Tex. Admin. Code § 213.27(b)(2).

[16] 22 Tex. Admin. Code § 213.27(2)(A) through (G).

When determining the appropriate penalty/sanction to be imposed in disciplinary matters, the Board and ALJ must consider the following factors in conjunction with the Disciplinary Matrix (Matrix) adopted by the Board:[17]

- evidence of actual or potential harm to patients, clients, or the public;
- evidence of lack of truthfulness or trustworthiness;
- evidence of practice history;
- evidence of present fitness to practice;
- whether the person has been subject to previous disciplinary action and, if so, the history of compliance with any prior actions;
- the length of time the person has practiced;
- the actual damages, physical, economic, or otherwise, resulting from the violation;
- the deterrent effect of the penalty imposed;
- attempts by the licensee to correct or stop the violation;
- any mitigating or aggravating circumstances, including those specified in the Disciplinary Matrix;
- the extent to which system dynamics in the practice setting contributed to the problem;
- whether the person is being disciplined for multiple violations;
- the seriousness of the violation;
- the threat to public safety;
- evidence of good professional character; and
- any other matter that justice may require.

The Matrix lists other aggravating and mitigating factors for various violations, which may be considered in addition to the factors set forth above.[18] Additionally, the Matrix instructs the Board to consider taking more severe disciplinary action against those being disciplined for multiple violations or who have been the subject of prior disciplinary action than would be taken

[17] 22 Tex. Admin. Code § 213.33(b). Only the factors potentially relevant to this case are set forth here.

[18] 22 Tex. Admin. Code § 213.33(b).

against a person found to have committed only a single violation or who has no history of prior disciplinary action.[19]

V. ANALYSIS

At issue in this case is a single incident, which Staff alleges constitutes a violation of multiple provisions of the Nursing Practice Act and Board's rules. The first issue to be determined, therefore, is whether the alleged incident of Respondent's hitting A.C. with the blue plastic tubing on October 16, 2010, occurred. If so, it must then be determined whether Respondent's conduct violates the provisions of the Nursing Practice Act and Board's rules such that she may be subject to disciplinary action. And finally, if Respondent's conduct is found to constitute one or more violations of the applicable law, then it must be determined what, if any, disciplinary action should be taken against her as a result.

A. What happened on October 16, 2010?

Respondent and Ms. Clark are the only people who were present and have personal knowledge about what happened when Ms. Clark first entered A.C.'s bedroom that morning. Each testified to different versions of the events at issue. Ms. Clark testified that she entered A.C.'s room and observed Respondent whip A.C. several times with the blue plastic tubing that connects his tracheostomy to the nebulizer breathing machine. Respondent denied hitting A.C. and testified that he had pulled the tubing out of the machine and had been waving it around. She asserted that she had taken the tubing from A.C. and reconnected it when Ms. Clark entered the room. Both women presented as articulate and intelligent people. But only one of their opposing accounts can be factually accurate. Based on all of the evidence, the ALJ finds that Ms. Clark's version of events is more credible than Respondent's under all of the circumstances, and particularly in light of the recorded call to PSA.

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[19] 22 Tex. Admin. Code § 213.33(b).

An evaluation of a person's demeanor is often useful in determining his or her credibility. The respective demeanors of Ms. Clark and Respondent during the recorded call to PSA and at the hearing are significant here. While Ms. Clark was on the phone trying to report the incident to PSA, Respondent was begging and pleading with her not to do so. That evidence is particularly compelling because Respondent's demeanor and statements during that call belie her subsequent testimony that she was simply trying to de-escalate Ms. Clark and explain what had happened. While Ms. Clark was on the phone, Respondent sounded utterly panicked and desperate. She did not ask Ms. Clark to calm down or state that Ms. Clark had misunderstood the situation. Nor did she try to explain what had occurred. Instead she continuously begged and pleaded with Ms. Clark to not report her to PSA and she frantically promised that she would leave and would never touch A.C. again. Respondent's words and demeanor while Ms. Clark was on the phone with PSA are not consistent with someone who believed there had simply been a misunderstanding and was trying to be reasonable and calm the situation. Instead, Respondent's reaction is consistent with someone who knew she had made a terrible mistake, had been caught doing so, and was terrified about the potential consequences.

Ms. Clark's demeanor, on the other hand, has been continuously consistent with her version of the events. As one would expect, she was extremely angry when she observed Respondent hitting her child. She was so angry, in fact, that she threw the bottle of milk in her hand at Respondent and demanded that Respondent leave her house immediately. Her anger was evident as well during her phone conversation with PSA that morning. It is also relevant that Ms. Clark has not second-guessed what she observed that morning. The next day, she reported the incident to the police. But as angry as she was about what had happened, Ms. Clark had nonetheless known and liked Respondent for many years. Therefore, after speaking with her family and considering her religious beliefs, Ms. Clark sent Respondent a text message expressing her forgiveness of Respondent and wishing Respondent and her family well. This is consistent with the reaction of a kind and religious person who had experienced a very upsetting incident with someone they had previously known and liked for many years.

At the hearing, two years after the incident, Ms. Clark's demeanor was very credible as well. She did not appear to be hostile toward or angry with Respondent any longer. Instead, she

appeared to be matter-of-fact and she remained certain about what she had observed. She candidly acknowledged that A.C. was wearing a diaper when he was hit by Respondent and that no marks were left on him. She did not appear to embellish the facts to bolster her version of events, but rather she explained clearly what she had seen and why Respondent's response did not make sense to her. Ms. Clark also cried uncontrollably and appeared to be profoundly anguished during the hearing while listening to the recording of her call to PSA on the day of the incident and Respondent's begging in the background. It seems, from Ms. Clark's demeanor during and after the events at issue, that the whole incident has been extremely traumatic to her and was not something that she fabricated or chose to have happen.

In determining credibility, it is also useful to consider the overall situation and potential motives of each party. Respondent had worked for the Clarks taking care of A.C. for more than 7 years without any problems. In fact, until this incident, Ms. Clark had always trusted Respondent, praised her work, and actively sought out Respondent to care for A.C. There is no evidence to suggest that Ms. Clark had ever complained or had concerns about Respondent or any of A.C.'s other caregivers in the past. The Clark family was familiar with Respondent and had come to rely on and value her over many years. If anything, having Respondent stop caring for A.C. would cause difficulty for the Clark family because it would require them to find and get used to a new nurse, who would have to learn what Respondent already knew about the family's routines and how to properly provide the care necessary for A.C. It seems unlikely that Ms. Clark would have reacted the way she did unless she was certain that she had seen Respondent hit A.C.

Respondent, on the other hand, was aware that she had a great deal to lose in this situation. A.C. was her only client. Additionally, as she stated while Ms. Clark was on the phone with PSA that morning, she was the only one in her family who was working to provide financial support for her husband and children at that time. Respondent acknowledged that the Clark family had always been pleased with her work and she offered no possible motive for Ms. Clark to overreact or accuse her of having done something she did not do.

Additionally, Respondent acknowledged that she had been busy caring for A.C. and trying to manage his copious secretions all through the night before the incident occurred. She stated that A.C. was very fussy and crying and was more restless than normal because of an outpatient procedure he had just undergone. Ms. Clark testified that the breathing machine was not on when she entered the room, but Respondent stated that A.C. had pulled the blue tubing out from the machine as she was trying to administer his antibiotic medication. She testified that the medication was very expensive and that she had reconnected the tube to salvage as much of the medication as she could when Ms. Clark entered the room. In either event, it is undisputed that Respondent was up all night caring for a child who was totally dependent and very fussy. It is more credible to believe that Respondent briefly lost control under those circumstances than it is to believe that Ms. Clark misunderstood or lied about what she observed.

Based on all of the evidence in the record, and for the reasons stated above, the ALJ finds that the preponderance of the evidence establishes that, on the morning of October 16, 2010, while she was on duty providing nursing care for A.C., Respondent hit A.C. on his diapered bottom with the blue plastic tubing used to connect his tracheostomy to his breathing machine.

B. Does Respondent's conduct violate the Nursing Practice Act and Board's rules as alleged?

Staff alleged, in its Notice of Hearing and Formal Charges, that Respondent's conduct violated the Nursing Practice Act and Board's rules because it constituted: 1) unprofessional or dishonorable conduct that is likely to injury a patient or the public and 2) a failure to care adequately for a patient or conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient or other person unnecessarily to risk of harm.

1. Unprofessional Conduct

The Nursing Practice Act authorizes the Board to take disciplinary action against licensees who engage in unprofessional or dishonorable conduct that is likely to injure a patient or the public. Under the Board's rules, unprofessional conduct includes permitting physical or

emotional abuse or injury to a client or the public and threatening or violent behavior in the workplace. Actual injury need not be established for conduct to be considered unprofessional.

Although A.C. did not suffer any visible injury, Respondent's conduct was nonetheless physically and emotionally abusive to A.C., particularly in light of the undisputed evidence that he was completely dependent, vulnerable, and incapable of defending himself. Additionally, her behavior constituted violent behavior in the workplace. Accordingly, based on the evidence in the record, the ALJ finds that Respondent's conduct was unprofessional and dishonorable and constituted a violation of the applicable law, thereby subjecting her to disciplinary action by the Board.

2. Failure to Conform to the Minimum Standards of Acceptable Nursing Practice

Because Respondent's conduct constitutes a failure to conform to the Nursing Practice Act and Board's rules as described above, it also constitutes a failure to conform to the minimum standards of acceptable nursing practice according to the Board's rules.[20] Accordingly, she is subject to discipline on this basis as well.

C. What, if any, disciplinary action should be taken against Respondent?

Board Staff argued that Respondent's license should be revoked based on the alleged violations. Respondent denied the allegations and argued that no disciplinary action is warranted. As discussed above, the ALJ has found that the alleged violations were established by a preponderance of the evidence and, therefore, Respondent is subject to disciplinary action by the Board. It remains to be determined, however, what, if any, disciplinary action should be taken against Respondent for the established violations, which were based on a single incident.

Although the Board's rules enumerate certain factors that must be considered when determining the appropriate sanction in any given case, the rules do not make clear specifically

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[20] 22 Tex. Admin. Code § 217.11(1)(A).

how those factors are to be considered or weighed. Similarly, the Matrix contains various offense tiers and sanction levels for each type of violation, but does not explain specifically how to determine which offense tier or sanction level is appropriate in any given case.

In support of its recommendation for revocation, Board Staff relied on the testimony of Ms. Cone, who works as a nursing consultant for the Board. Ms. Cone testified that she looked at mitigating circumstances in this case and found none. Then, she stated, she looked at aggravating circumstances and reviewed each one, particularly the patient's vulnerability. Ms. Cone explained that, because there were no mitigating factors present, she believed that this case should be considered a second-tier offense and should be sanctioned under level two of the Matrix, which calls for revocation of Respondent's license. Ms. Cone further opined that the seriousness of Respondent's conduct warrants revocation notwithstanding the fact that Respondent has worked for 30 years as a nurse with positive evaluations and without any history of prior incidents or disciplinary action.

An evaluation of the required factors set forth in the Board's rules in light of the evidence in this case reveals that there are some mitigating and some aggravating circumstances here. The evidence demonstrates that Respondent's actions caused at least potential, if not actual, harm to A.C., and also traumatized Ms. Clark. Additionally, Respondent has denied any wrongdoing and has not accepted responsibility for her behavior or attempted to determine how to prevent such behavior in the future. However, Respondent has practiced as a nurse in good standing for 30 years and had not been subject to any prior disciplinary action. And, although there is no excuse for what Respondent did, she had been up all night providing continuous care by herself to an unusually fussy child, which may have triggered her unlawful behavior.[21] It is also relevant to note that even though Respondent's conduct violates more than one applicable statute, she engaged in only a single incident of misconduct.

For unprofessional conduct and standard of care violations, the Matrix sets forth several additional factors that may be considered. Although they are categorized as aggravating and

[21] The Matrix and the Board's rules contemplate consideration of the extent to which system dynamics in the practice setting contributed to the problem. 22 Tex. Admin. Code § 213.33(c)(12).

mitigating, it appears that several of the factors can be either aggravating or mitigating depending on the evidence in any given case. For example, among the factors listed by the Matrix as "aggravating" are "number of events" and "prior complaints or discipline for similar conduct." But Respondent has had no prior complaints or discipline and this was an isolated event. It seems, therefore, that those factors would be mitigating rather than aggravating in this particular case.

Another circumstance listed by the Matrix as aggravating for these violations is patient vulnerability. Based on the evidence in the record in this case, that is indeed an aggravating circumstance because A.C. was extremely vulnerable. Not only was he a young child, but also he was severely disabled and developmentally delayed, and completely unable to communicate verbally or defend himself.

Based on the offense tier descriptions for unprofessional conduct violations, it appears that the facts of this case most closely fall under the second offense tier, which addresses a nurse's "failure to comply with a substantive Board rule regarding unprofessional conduct resulting in serious risk to patient or public safety, . . . or unethical behavior which places patient or public at risk of harm." And, because of the seriousness of the violation, it appears that Sanction Level II is appropriate. The appropriate sanction for that violation, therefore, is either suspension or revocation.

The same is true for the standard of care violation, which also seems to fall most closely under the Matrix second offense tier, which addresses practice below the minimum standard of care with patient harm or risk of harm. Sanction Level II for that offense tier also calls for either license revocation or suspension.

Because Respondent has not provided sufficient evidence to establish her good professional character in light of the incident at issue, revocation would not be an inappropriate sanction in this case. However, given Respondent's long and blemish-free history of work as a nurse, the isolated nature of this incident, and the fact that it is unclear from the evidence what, if

any, future risk Respondent poses to the public,[22] it would arguably be more appropriate to impose a one-year enforced suspension followed by a four-year probated suspension subject to any terms, conditions and restrictions that the Board deems appropriate and necessary to protect the public.

VI. FINDINGS OF FACT

1. Tonya Joylynn Townsend (Respondent) was licensed as a nurse in 1980 and received her Texas registered nurse's license from the Texas Board of Nursing (Board) in 1991.

2. Respondent has no prior history of any disciplinary action.

3. Respondent worked as a nurse for several hospitals and as a disability examiner before becoming employed as a nurse by Pediatric Services of America, Inc. (PSA) in 2002.

4. While employed by PSA, Respondent provided nursing care for A.C. for more than 7 years, beginning when A.C. was 12 months old.

5. A.C. was born with hydrocephalus. Consequently, his brain is underdeveloped and he is legally blind and unable to communicate verbally.

6. A.C. requires a tracheostomy for breathing and a gastric tube for feeding, as well as 24-hour skilled nursing care.

7. Although A.C. was 8 years old in October 2010, his mental functioning was equivalent to that of an 18- to 24-month-old child.

8. On October 15, 2010, A.C. underwent an outpatient surgical procedure.

9. Respondent worked an overnight shift providing care for A.C. at the Clark's home from approximately 8:00 p.m. until approximately 5:30 a.m. the morning of October 16, 2010.

10. During Respondent's overnight shift on October 15 and 16, 2010, A.C. had copious secretions, and he was very fussy, crying, and more restless than usual while getting his treatments.

11. Respondent was busy caring for A.C. all through the night keeping his respirations up, suctioning, and performing chest compressions to remove his secretions.

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[22] The Board previously requested that Respondent undergo an evaluation to allow the Board to determine whether she poses a risk to the public and is currently fit to practice nursing (which she did not undergo due to illness).

12. At approximately 5:30 a.m., on October 16, 2010, Respondent hit A.C. several times on his diapered bottom with the corrugated blue plastic tubing used to connect his breathing machine to his tracheostomy.

13. Leslie Clark, A.C.'s mother, observed Respondent hitting A.C. with the tubing and observed A.C. crying.

14. Upon observing the incident, Ms. Clark immediately demanded that Respondent leave the Clarks' home at once and called PSA to report the incident.

15. While Ms. Clark was on the phone with PSA, Respondent frantically begged and pleaded with Ms. Clark not to report her to PSA, and Respondent promised that she would leave and would never touch A.C. again.

16. On December 17, 2010, Staff of the Board sent Respondent a Notice of Formal Charges filed against her.

17. On December 1, 2011, Staff sent a Notice of Hearing to Respondent.

18. 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.

19. On February 24, 2011, Board Staff sent Respondent a letter requesting that she consent to submit to a forensic evaluation with a polygraph component to evaluate her behavior and predict the likelihood that she will engage in such behavior again and to determine if she poses any danger to the community and whether she is presently fit to practice nursing.

20. Respondent was hospitalized in February 2011 because of acute complications following knee surgery, and she did not undergo the requested evaluation.

21. The hearing convened May 3, 2012, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. All parties appeared and participated in the hearing. The record closed at the conclusion of the hearing on the same day.

VII. CONCLUSIONS OF LAW

1. The 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. The Board may request a nurse to consensually undergo an evaluation by a Board-approved practitioner. A nurse may refuse to consent to undergo an evaluation pursuant to such request. Tex. Occ. Code § 301.4521(f).

5. Based on the above Findings of Fact and Conclusions of Law, Respondent is subject to disciplinary action by the Board based on her conduct which violated Tex. Occ. Code §§ 301.452(b)(10) and (13).

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

7. Based on the above Findings of Fact and Conclusions of Law, Respondent has failed to sufficiently establish good professional character. 22 Tex. Admin. Code § 213.27(b)(2).

8. In determining the appropriate sanction to be imposed in disciplinary matters, the Board and ALJ must consider the factors set forth in the Board's rules and the Disciplinary Matrix adopted by the Board. 22 Tex. Admin. Code §§ 213.27(b)(2)(A) through (G), 213.33.

VIII. RECOMMENDATION

Based upon the above Findings of Fact and Conclusions of Law, the ALJ recommends that Respondent's license be suspended for five years with the first year of suspension enforced and the remaining four years of suspension probated and subject to any terms, conditions and restrictions that the Board deems appropriate and necessary to protect the public.

SIGNED June 29, 2012.

AMI L. LARSON
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

DOCKET NO. 507-12-2227

IN THE MATTER OF	§	
PERMANENT CERTIFICATE	§	BEFORE THE TEXAS STATE
NUMBER 568893	§	
ISSUED TO TONYA JOYLYNN TOWNSEND,	§	OFFICE OF ADMINISTRATIVE HEARINGS
RESPONDENT	§	

RESPONDENTS EXCEPTIONS TO THE PROPOSAL FOR DECISION

TO THE HONORABLE ADMINISTRATIVE LAW JUDGE:

NOW COMES the Respondent, Tonya Joylynn Townsend, through her attorney, to file these Exceptions to the Proposal for Decision.

EXCEPTIONS

Finding of Fact No. Nineteen (19) & Twenty (20): Finding of Fact Numbers Nineteen (19) & Twenty (20) relate to the request by the Board that the Respondent undergo a forensic evaluation with a polygraph component. This request was part of Staff's exhibits and requested the Respondent to undergo a forensic evaluation with polygraph component.[1] Notwithstanding the issues of admissibility of polygraph examinations, the Nursing Practice Act does not allow the Board to take action on or consider the refusal to undergo a psychological evaluation unless the Board 1) informs the nurse of the request, 2) if the nurse refuses the request, holds a hearing with the State Office of Administrative Hearings (SOAH) to determine if probable cause exists to order the nurse to undergo the evaluation, and 3) obtain an probable cause order from SOAH requiring the evaluation.[2] If the nurse refuses the evaluation after receiving the order from SOAH, then the Board may impose discipline for a refusal to undergo an examination.[3] However, in this case, the Board only requested an evaluation under the authority of Tex. Occ. Code §301.4521(f), which is not subject to the probable cause requirement or subject to any presumptions regarding the Respondent. Therefore, the existence of this request and the refusal

[1] See Staff's Exhibit 5

[2] Texas Occupations. Code §301.4521(b)–(d).

[3] Tex. Occ. Code §301.4521(e).

or inability of the Respondent to complete the requested evaluation is irrelevant unless the Respondent is attempting to introduce evidence of an evaluation performed outside of the framework contemplated by Section 4521 of the Nursing Practice Act, which the Respondent did not attempt to do. Therefore, the Respondent respectfully requests the Administrative Law Judge delete Finding of Fact Numbers Nineteen (19) & Twenty (20).

Sanction Recommendations: The Recommendation contains a recommendation for a five year suspension with the first year enforced and the following four years probated.[4] Respondent excepts to this as exceedingly harsh in the light of Respondent's lack of negative incidents over her 30-year practice history and is tantamount to a revocation of the Respondent's license. While the Respondent maintains that she did nothing to warrant disciplinary action in this matter, she acknowledges that the Administrative Law Judge, in her role as the finder of fact, has chosen to find that the Respondent was more likely than not responsible for her actions as alleged by Ms. Clark.[5]

In the ALJ's analysis of the facts, she engages in a long discussion of the disciplinary matrix and the factors affecting the placement of the behavior of the Respondent in the matrix, both aggravating and mitigating. The Respondent, based on the foregoing finding of fact, does not except to the judgment of the ALJ in placing this matter as a Second Tier, Sanction Level II.[6] In discussing where within this sanction level to place her recommendation, however, the ALJ seemingly flips the burden of proof and places that burden on the Respondent, stating "[b]ecause Respondent has not provided sufficient evidence to establish her good professional character in light of the incident at issue, revocation would not be an inappropriate sanction in this case."[7] However, it is not up to the Respondent to prove that revocation is inappropriate, but rather for the Staff to prove that revocation is appropriate, as the Staff has the burden of proof.[8]

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[4] PFD, at 24.

[5] *Id*, at 18.

[6] *Id*, at 21.

[7] *Id*.

[8] *See id*, at 24. Conclusion of Law No. Six clearly states that Staff has the burden of proof in this matter. *Id*.

In addressing the factors, Staff completely ignored any potential mitigating factors in coming up with their recommendation for revocation. As part of their rationale for revocation, Staff's expert witness, Bonnie Cone, opined that the only factor she reviewed was the vulnerability of the patient.[9] Ms. Cone then stated that there were "no mitigating factors present,"[10] and that because of this, the Respondent's license should be revoked.[11]

The ALJ, however, rightfully considered other factors as contemplated in 22 TEXAS ADMINISTRATIVE CODE §213.33(c). The ALJ indicated that the potential for harm to the patient was an aggravating factor, but this factor was already considered in placing the action in a Tier Two, Sanction Level II and should not be used to enhance the sanction within that sanction level.[12] As the ALJ noted, there were several factors that can be considered mitigating in this case: the 30 years of practice in good standing by the Respondent; the lack of prior disciplinary action; the fact this was a single incident and a potential systems issue related to the time of this event and the stress of providing continuous care for an difficult patient.[13] Based on the foregoing, the Respondent respectfully excepts to the ALJ's characterization that revocation would not be inappropriate, because there is a lack of evidence, outside of this single act, of poor professional character that would support the sanction of a revocation of the Respondent's license.

In addition, the Respondent points out that under the Board's rules, the recommended sanction proposed by the ALJ is tantamount to a revocation of the Respondent's license. The Nursing Practice Act provides that a person whose license has been revoked may apply for reinstatement on the first anniversary of the date of the revocation.[14] In recommending an

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[9] *id*, at 20.

[10] *id*.

[11] *id*.

[12] *See id*, at 21. The ALJ quotes the Disciplinary Matrix where the conduct results in "serious risk for patient or public safety." *id*.

[13] *id*.

[14] TEXAS OCCUPATIONS CODE §301.467(b)(1).

enforced suspension, the ALJ is requiring the respondent to be separated from any employment in nursing essentially for the same amount of time as if the Respondent had her license revoked.

In recommending the enforced suspension, the ALJ also appears to be giving weight to the fact the Respondent did not undergo a psychological examination when requested by the Board,[15] concluding that there may be a future risk to the public that would make enforcement of the first year reasonable. Since there is no statutory authority in the Nursing Practice Act which allows any presumption from a refusal to undergo psychological evaluation absent a finding of probable cause under Tex. Occ. Code §301.4521 and considering the aforementioned mitigating circumstances, it is reasonable to find that this was a one-off aberrant event where there is no elevated risk to the public and therefore the public would be reasonably protected by a fully probated suspension subject to the terms and conditions set by the Board. Therefore, Respondent respectfully requests that the ALJ revise the final paragraph of section V(C) to reflect the above discussion and change her recommendation for sanction to a fully probated suspension for a time period to be determined by the Board and any terms, conditions and restrictions that the Board deems appropriate and necessary to protect the public.

PRAYER FOR RELIEF

Respondent, Tonya Joylynn Townsend prays that the honorable Administrative Law Judge:

1. Delete Finding of Fact Numbers Nineteen (19) & Twenty (20);
2. Revise the final paragraph of section V(C) to reflect the arguments contained in this Exceptions to the Proposal for Decision;
3. Change the recommendation for sanction to a fully probated suspension for a time period to be determined by the Board and any terms, conditions and restrictions that the Board deems appropriate and necessary to protect the public; AND
4. Propose to the Texas Board of Nursing in a Decision all relief at law or in equity to which Respondent is entitled.

[15] *id*, at 22. *Also see* the discussion regarding Finding of Fact Numbers Nineteen (19) and Twenty (20) *supra*, at 1–2.

Respectfully submitted,

By:_____

Marc M. Meyer
State Bar No. 24070266
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CERTIFICATE OF SERVICE

This is to certify that on the 16th day of July, 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

John Legris, Assistant General Counsel
Texas Board of Nursing
333 Guadalupe, Suite 3-460
Austin, TX 78701
VIA FACSIMILE AT 512-305-8101

_____
Marc M. Meyer

SOAH DOCKET NO. 507-12-2227

IN THE MATTER OF	§	BEFORE THE
PERMANENT CERTIFICATE	§	
NUMBER 568893	§	STATE OFFICE OF
ISSUED TO	§	
TONYA J. TOWNSEND	§	ADMINISTRATIVE HEARINGS

STAFF'S RESPONSE TO RESPONDENT'S EXCEPTIONS TO PROPOSAL FOR DECISION

TO THE ADMINISTRATIVE LAW JUDGE:

COMES NOW, Staff of the Board of Nursing (hereinafter "Staff") and files this, Staff's Response to Respondent's Exceptions to Proposal for Decision, and would show the Administrative Law Judge as follows:

I.

In response to Respondent's Exceptions, Staff would argue that Findings of Fact 19 and 20 are correct and should not be deleted from the Proposal for Decision (PFD). The Board Staff requested but did not require the Respondent to undergo a forensic evaluation. At the hearing, Respondent testified that she was unable to complete the evaluation because of complications of knee surgery. There is nothing in Section 301.4521(f) which precludes Staff from offering evidence concerning the request or a Respondent's refusal or inability to comply with the request. Section 301.4521(f) is the voluntary, not the mandatory procedure.

II.

With regard to the sanction recommended by the Administrative Law Judge (ALJ), Staff believes that the ALJ's reasoning was sound and the recommended sanction is appropriate. Although Staff's expert witness, Bonnie Cone, RN, MSN, testified that there were no mitigating factors. The ALJ nevertheless concluded that there were some. Staff argued for revocation; the ALJ

recommended the lesser sanction of one (1) year enforced suspension followed by four (4) years of probated suspension. The recommended sanction is therefore not exceedingly harsh. The ALJ should deny Respondent's request to modify the recommended sanction.

The ALJ should also decline to revise the final paragraph of the Proposal for Decision Section V. C. to reflect arguments made by Respondent in her Exceptions to the Proposal for Decision.

TEXAS BOARD OF NURSING

John F. Legris, Assistant General Counsel
State Bar No. 00785533
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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing ***Staff's Response to Respondent's Exceptions to Proposal for Decision*** was sent via Facsimile and Certified Mail on July 31, 2012, to:

Marc Meyer, Attorney
Law Office of Marc Meyer, PLLC
33300 Egypt Lane, Suite B-200
Magnolia, TX 77354-2739

Via Facsimile: (866) 839-6920 & First Class Mail

John F. Legris, Assistant General Counsel

State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

August 22, 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 (512) 305-7401

RE: Docket No. 507-12-2227; *Texas Board of Nursing v. Tonya Townsend*

Dear Ms. Thomas:

Please be advised that on July 16, 2012, Respondent filed exceptions to the Proposal for Decision issued June 29, 2012. Board Staff filed a written response to the exceptions on July 31, 2012. After reviewing Respondent's exceptions, Staff's reply, and the law applicable to this case, I do not recommend any changes to the Proposal for Decision.

Sincerely,

Ami L. Larson
Administrative Law Judge

ALL:dan

cc: John Legris, TBN, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – **VIA FACSIMILE (512) 305-8101**
Dina Flores, Legal Assistant, TBN, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 - **VIA FACSIMILE (512) 305-8101**
Marc M. Meyer, RN, JD, Law Office of Marc Meyer, PLLC, 33300 Egypt Lane, Suite B200, Magnolia, TX 77354-2739 – **VIA FACSIMILE (866) 839-6920**