IN THE MATTER OF PERMANENT REGISTERED NURSE LICENSE NUMBER 621332 ISSUED TO WILLIAM E. RAY	§ § § §	BEFORE THE TEXAS BOARD OF NURSING ELIGIBILITY AND DISCIPLINARY COMMITTEE

ORDER OF THE BOARD

TO: William E. Ray
1913 Hilltop Drive
Waco, TX 76710

During open meeting held in Austin, Texas, on March 19, 2013, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, Chapter 301 of the Texas Occupations Code, for retention of Respondent's license(s) to practice nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by reference for all purposes and the Staff's recommended sanction of revocation by default. This Order

will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN.CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Registered Nurse License Number 621332, previously issued to WILLIAM E. RAY, to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

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.

Entered this 19th day of March, 2013.

TEXAS BOARD OF NURSING

BY: Katherine A. Thomas

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Attachment: Formal Charge filed December 31, 2012.

CERTIFICATE OF SERVICE

I hereby certify that on the 21 day of March, 2013, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested
William E. Ray
1913 Hilltop Drive
Waco, TX 76710

Via USPS First Class Mail
William E. Ray
Rt. 1, Box 1
Lincoln, MO 65338

BY: Katherine A. Thomas
KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

In the Matter of Permanent	§	**BEFORE THE TEXAS**
Registered Nurse License	§	
Number 621332	§	
Issued to WILLIAM E. RAY,	§	
Respondent	§	**BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, WILLIAM E. RAY, is a Registered Nurse holding License Number 621332 which is in delinquent status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about June 25, 2012, Respondent received Findings of Fact, Conclusions of Law, and Disciplinary Order from the Missouri State Board of Nursing wherein Respondent's license to practice professional nursing in the State of Missouri was Revoked due to findings of incompetency and gross negligence. A copy of the Findings of Fact, Conclusions of Law, and Disciplinary Order issued by the Missouri State Board of Nursing, dated June 25, 2012, is attached and incorporated by reference as part of this charge.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license/s to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 Tex. Admin. Code §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1200.00).

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.texas.gov/disciplinaryaction/discp-matrix.html.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order(s) which is attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Findings of Fact, Conclusions of Law, and Disciplinary Order issued by the Missouri State Board of Nursing, dated June 25, 2012.

Filed this 3rd day of December, 2012.

TEXAS BOARD OF NURSING

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Assistant General Counsel
State Bar No. 24036103
Lance Robert Brenton, Assistant General Counsel
State Bar No. 24066924
John R. Griffith, Assistant General Counsel
State Bar No. 24079751
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
Nikki Hopkins, Assistant General Counsel
State Bar No. 24052269
John F. Legris, Assistant General Counsel
State Bar No. 00785533
TEXAS BOARD OF NURSING
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6811
F: (512) 305-8101 or (512)305-7401

Attachments: Findings of Fact, Conclusions of Law, and Disciplinary Order issued by the Missouri State Board of Nursing, dated June 25, 2012.

D/2012.06.19

BEFORE THE STATE BOARD OF NURSING
STATE OF MISSOURI

STATE BOARD OF NURSING, Petitioner,		
vs.	Case Number	2008-006504
	AHC	10-1594 BN
WILLIAM RAY, Respondent.		

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCIPLINARY ORDER

This Board filed a complaint with the Administrative Hearing Commission seeking authority to discipline the nursing license of William Ray. The Administrative Hearing Commission entered a Decision in this matter on October 28, 2011, finding cause for this Board to discipline the nursing license of William Ray. The Board convened a hearing on June 14, 2012, at its regular meeting in Jefferson City to determine what discipline, if any, should be imposed on Respondent's nursing license.

Respondent, though duly notified of the time and place of the hearing, failed to appear in person or by counsel. The Board was represented by Cotton Walker. Ian Hauptli acted as legal advisor to the Board. Evidence was adduced, exhibits were received and the matter was taken under advisement. The Board now enters its findings of fact, conclusions of law and disciplinary order in this matter:

FINDINGS OF FACT

1. The State Board of Nursing (Board) is an agency of the State of Missouri created and established pursuant to §335.021 RSMo with the function of executing and enforcing the provisions of Chapter 335 RSMo, the Nursing Practice Act, for the purpose of safeguarding the public health.

2. William Ray holds a license from this Board as a registered professional nurse, RN 133205. Respondent's license was current and active at all times relevant herein. However, Respondent's license expired April 30, 2009, and remains lapsed at this time.

3. Respondent was employed as a registered nurse with Bothwell Regional Health Center ("Center") in Sedalia, Missouri until December 1, 2008.

4. The Center has certain policies and procedures that nurses must follow for patient care.

5. During Respondent's employment with the Center, Respondent had several unexcused absences, including but not limited to August 28, 29, 2008, September 20, 2008, and November 6, 2008.

6. On September 15, 2008, patient, W.J.U, was admitted with an allergic reaction.

7. The physician ordered that patient, W.J.U., receive Epinephrine IM (intramuscular).

8. On September 15, 2008, Respondent gave the patient, W.J.U., Epinephrine IV (intravenous) against the physician's orders.

9. On September 15, 2008, Respondent met with the Nurse Director to discuss clarification on orders, not recognizing wrong route for medication and to double check on unusual medication.

10. On October 29, 2008, Respondent was responsible for the care of patient, H.G.S.

11. The physician had ordered that patient, H.G.S., was to receive Diflucan 400 mg IVPB (intravenous piggyback) once daily. This was noted in the patient's chart.

12. Respondent failed to check the patient, H.G.S.'s, chart and missed giving the patient his medication.

13. On October 31, 2008, Respondent met with the Nurse Director to discuss the missed medication and checking a patient's chart.

14. On November 19, 2008, Respondent was caring for patient, R.A.C.

15. On November 19, 2008, patient, R.A.C.'s, blood glucose level had fallen below 60 mg/dl (hypoglycemia).

16. On November 19, 2008, Respondent failed to notify the attending physician, get an order from the physician, and provide the patient with proper nutrients.

17. On November 19, 2008, Respondent gave patient, R.A.C, amp D50 IV to increase the patient's blood sugar level. This was against the Center's policy and procedure for a patient with hypoglycemia.

18. The amp D50 IV raised the patient's blood sugar to around 200, higher than normal range.

19. Respondent's employment with the Center was terminated on December 1, 2008.

20. Respondent's failure to follow proper procedures and follow physician's orders could have resulted in injury to a patient.

21. The Board proceeded with a hearing upon a properly filed complaint that Respondent failed to respond to and he was properly notified that the Board would hold a discipline hearing on June 14, 2012. The Board considered the evidence presented at

the hearing and the Decision of the AHC and determines that discipline is appropriate to be imposed against Respondent's nursing license.

22. The Board finds that this Disciplinary Order is issued to safeguard the public health.

CONCLUSIONS OF LAW

23. The Board has jurisdiction to discipline Respondent's license pursuant to the provisions of §335.066.2(5) and (12) RSMo, as amended, which provides:

> 2. The Board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:
>
> > (5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096;
> >
> > (12) Violation of any professional trust or confidence;

24. The Board has jurisdiction to discipline Respondent's license pursuant to §335.066.3 RSMo Cum. Supp. 2010, which provides:

> After the filing of such complaint, the proceedings shall be conducted in accordance with the provisions of chapter 621, RSMo. Upon a finding by the administrative hearing commission that the grounds provided in subsection 2 of this section, for disciplinary action are met, the board may, singly or in combination, censure or place the person named in the complaint on probation on such terms and conditions as the board deems appropriate for a period not to exceed five years, or may suspend, for a period not to exceed three years, or revoke the license, certificate, or permit.

25. Section 324.045.1 RSMo Cum. Supp. 2011 provides:

> Notwithstanding any provision of chapter 536, in any proceeding initiated by the division of professional registration or any board, committee, commission, or office within the division of professional registration to determine that appropriate level of discipline or additional discipline, if any, against a licensee of the board, committee, commission, or office within the division, if the licensee against whom the proceeding has been initiated upon a properly pled writing filed to initiate the contested case and upon proper notice fails to plead or otherwise defend against the proceeding, the board, commission, committee, or office within the division shall enter a default decision against the licensee without further proceedings. The terms of the default decision shall not exceed the terms of discipline authorized by law for the division, board, commission, or committee. The division, office, board, commission, or committee shall provide the licensee notice of the default decision in writing.

26. "[G]rounds for discipline specified in such a professional-licensing statute should be liberally construed to protect the public." Professional licensing statutes are not penal in nature and the "powers conferred upon boards of health to enable them effectively to perform their important functions in safeguarding the public health should receive a liberal construction." *Koetting v. Bd. of Nursing*, 314 S.W.3d 812, 819 (Mo. App. 2010).

ANALYSIS

Respondent's nursing license is subject to discipline as a result of failing to follow physicians' orders and failing to follow his employer's policies and procedures for caring for patients with hypoglycemia. Respondent's actions constituted incompetency, gross negligence and violated professional trust and confidence between his patients and his employer. Respondent's actions in failing to follow physicians' orders and the employer's policies and procedures could have compromised the care of his patients

and could have resulted in death. Respondent failed to appear for his disciplinary hearing before the Board; thus, presented no evidence to mitigate his actions.

The Board is charged with executing and enforcing the Nursing Practice Act for the purpose of safeguarding the health of the public. The Board therefore finds and concludes that the appropriate level of discipline for the license of William Ray is revocation in order to safeguard the health of the public.

DISCIPLINARY ORDER

The Board has found that William Ray has failed to plead or otherwise defend against the action initiated upon a properly pled writing and upon proper notice by the Board that a disciplinary hearing was scheduled against him on June 14, 2012 at 9:00 a.m. to determine the appropriate level of discipline, if any, to be assessed against the license of William Ray for his violations of the nursing practice act.

27. The Missouri State Board of Nursing enters its Order and **REVOKES** the nursing license of Respondent, William Ray, RN 133205.

28. The Board will maintain this Order as an open and public record of the Board as provided in Chapters 335, 610 and 620, RSMo. The Board will report this Order to data banks, other appropriate entities and in its newsletter. This is a disciplinary action against Respondent's license. The original of this document shall be kept in the Board's file and its contents shall be disclosed to the public upon proper request.

ENTERED THIS 25th DAY OF JUNE 2012.

STATE BOARD OF NURSING

Lori Scheidt

Lori Scheidt
Executive Director

Before the
Administrative Hearing Commission
State of Missouri

STATE BOARD OF NURSING,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 10-1594 BN
	)	
WILLIAM E. RAY,	)	
	)	
Respondent.	)	

DECISION

We grant the State Board of Nursing's ("the Board") motion for summary decision.[1] William E. Ray is subject to discipline because he was incompetent, grossly negligent, and violated a professional trust.

Procedure

On August 24, 2010, the Board filed a complaint seeking to discipline Ray's license. After several failed attempts to serve Ray, Ray was served with our notice of complaint/notice of hearing on June 25, 2011 by certified mail. Ray did not file an answer. On September 19, 2011, the Board filed a motion for summary decision. We gave Ray until October 5, 2011 to respond, but he did not.

The Board cites the request for admissions that was served on Ray on August 10, 2011. Ray did not respond to the request. Under Supreme Court Rule 59.01, the failure to answer a

[1]The Board refers to it as "summary disposition." Our rules refer to "summary decision" instead of summary determination or disposition. Regulation 1 CSR 15-3.446(6).

request for admissions establishes the matters asserted in the request, and no further proof is required.[2] Such a deemed admission can establish any fact or any application of law to fact.[3] That rule applies to all parties, including those acting *pro se*.[4] Section 536.073[5] and our Regulation 1 CSR 15-3.420(1) apply that rule to this case.

Findings of Fact

1. Ray was registered by the Board as a registered professional nurse ("RN"). His license was current and active and was so at all relevant times.

2. Ray was employed as an RN at Bothwell Regional Health Center ("Bothwell") in Sedalia, Missouri.

3. Ray had unexcused absences on the following dates: August 28, 2008, August 29, 2008, September 20, 2008, and November 6, 2008.

4. On September 15, 2008, patient W.J.U. was admitted with an allergic reaction. The physician ordered W.J.U to receive Epinephrine IM (intramuscular). This order was noted in the patient's chart. Ray failed to follow the orders and instead administered W.J.U. Epinephrine IV (intravenous).

5. On October 29, 2008, Ray was caring for patient H.G.S. The physician orders said H.G.S. was to receive Diflucan 400 mg IVPB (intravenous piggyback) once daily. These orders were noted on the patient's chart. Ray failed to check H.G.S.'s chart and did not administer this medication to H.G.S.

6. Bothwell has policies and procedures for patients with hypoglycemia.[6]

---

[2] ***Killian Constr. Co. v. Tri-City Constr. Co.***, 693 S.W.2d 819, 827 (Mo. App., W.D. 1985).
[3] ***Linde v. Kilbourne***, 543 S.W.2d 543, 545-46 (Mo. App., W.D. 1976).
[4] ***Research Hosp. v. Williams***, 651 S.W.2d 667, 669 (Mo. App., W.D. 1983).
[5] RSMo 2000. Statutory references, unless otherwise noted, are to RSMo Supp. 2010.
[6] The Board does not provide us with the specific policies and procedures.

7. On November 19, 2008, Ray was caring for patient R.A.C. R.A.C.'s blood glucose level had fallen below 60 mg/dl.[7] When a person's blood glucose level falls below 60 mg/dl it is called hypoglycemia.

8. Ray administered R.A.C. amp D50 IV[8] to increase the patient's blood glucose level. Doing so raised the patient's blood glucose to around 200, which is higher than the normal range. This was against Bothwell's policy and procedure for a patient with hypoglycemia.

9. Ray was terminated from Bothwell on December 1, 2008.

Conclusions of Law

We have jurisdiction to hear this complaint.[9] The Board has the burden to prove facts for which the law allows discipline.[10] We may decide this case without a hearing if the Board establishes facts that entitle it to a favorable decision and Ray does not raise a genuine issue as to such facts.[11]

Ray admitted facts and that those facts authorize discipline. But statutes and case law instruct that we must "separately and independently" determine whether such facts constitute cause for discipline.[12] Therefore, we independently assess whether the facts admitted allow discipline under the law cited.

The Board alleges that there is cause for discipline under § 335.066.2:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew of has surrendered his or her certificate of registration nor authority, permit or license for any one or any combination of the following causes:

---

[7]The Board does not provide what this stands for.
[8]The Board does not provide what this stands for.
[9]Section 621.045.
[10]*Missouri Real Estate Comm'n v. Berger*, 764 S.W.2d 706, 711 (Mo. App., E.D. 1989).
[11]Regulation 1 CSR 15-3.446(6)(A).
[12]*Kennedy v. Missouri Real Estate Commission*, 762 S.W.2d 454, 456-57 (Mo. App., E.D. 1988).

(5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096;

* * *

(12) Violation of any professional trust or confidence[.]

Professional Standards – Subdivision (5)

The Board alleges Ray's conduct constituted incompetency, misconduct, and gross negligence in the performance of the functions or duties of a nurse.

Incompetency is a general lack of professional ability, or a lack of disposition to use an otherwise sufficient professional ability, to perform in an occupation.[13] We follow the analysis of incompetency in a disciplinary case from the Supreme Court, ***Albanna v. State Bd. of Regis'n for the Healing Arts***.[14] Incompetency is a "state of being."[15] The disciplinary statute does not state that licensees may be subject to discipline for "incompetent" acts. Although a licensee may be guilty of repeated instances of gross negligence and other violations of the standards of practice, that is not necessarily sufficient to establish incompetency unless the acts flowed from the licensee's incompetence, that is, being unable or unwilling to function properly as a nurse. An evaluation of incompetency necessitates a broader-scale analysis, one taking into account the licensee's capacities and successes.[16] Ray repeatedly failed to follow physician orders with patients W.J.U. and H.G.S. Ray also failed to follow Bothwell's procedures with patient R.A.C. His behavior shows that he did possess a state of being for an unwillingness to adhere to the standards of his profession. Therefore, we find there was incompetency.

---

[13] ***Tendai v. Missouri State Bd. of Regis'n for the Healing Arts***, 161 S.W.3d 358, 369 (Mo. banc 2005).
[14] 293 S.W.3d 423 (Mo. banc 2009).
[15] *Id.* at 435.
[16] *Id.* at 436.

Misconduct means "the willful doing of an act with a wrongful intention[;] intentional wrongdoing."[17] The Board provides no evidence that any of Ray's acts were intentional. Therefore, we find no misconduct.

In a statute setting forth causes for disciplining professional engineers and which is identical to § 335.066.2(5), the Court of Appeals defined "gross negligence" as follows:[18]

> The Commission defined the phrase in the licensing context as "an act or course of conduct which demonstrates a conscious indifference to a professional duty." This definition, the Commission found, requires at least some inferred mental state, which inference may arise from the conduct of the licensee in light of all surrounding circumstances. Appellants have posited a definition purportedly different that would define the phrase as "reckless conduct done with knowledge that there is a strong probability of harm, and indifference as to that likely harm." We are not persuaded that the two definitions are in fact different. An act which demonstrates a conscious indifference to a professional duty would appear to be a reckless act or more seriously a willful and wanton abrogation of professional responsibility.[6] The very engineer would appear to make evidence to him the probability of harm from his conscious indifference to professional duty and conscious indifference includes indifference to the harm as well as to the duty.
>
> Footnote 6: Sec. 562.016.4 RSMo 1986, defines "reckless" in the criminal context as when a person "disregards a substantial and unjustifiable risk that circumstances exist or that a result will follow and such disregard constitutes a gross deviation from the standard of care which a reasonable person would exercise in the situation." We do not note any substantial difference between that definition and the Commission definition of gross negligence, except the latter is shorter.

There is an overlap between the required mental state for misconduct and for gross negligence to the extent that misconduct can be shown for the licensee's "indifference to the natural consequences" of his or her conduct and that gross negligence requires the licensee's conscious indifference to a professional duty or standard of care. Nevertheless, proving

---

[17] *Missouri Bd. for Arch'ts, Prof'l Eng'rs & Land Surv'rs v. Duncan*, No. AR-84-0239 (Mo. Admin. Hearing Comm'n Nov. 15, 1985) at 125, *aff'd*, 744 S.W.2d 524 (Mo. App., E.D. 1988).

[18] *Duncan v. Missouri Bd. For Arch'ts, Prof'l Eng'rs & Land Surv'rs*, 744 S.W.2d 524, 533 (Mo. App., E.D. 1988).

misconduct does not necessarily prove gross negligence because to prove gross negligence the Board must establish the professional duty or standard of care from which the licensee deviated. As an RN, Ray had a professional duty to follow physician orders. Ray failed to do so when he failed to follow physician orders. The requirement to follow physician orders in this case was simple and easy. Failing to follow physician orders placed patients' health at risk and showed an extreme sense of apathy. Thus, the failure to follow simple, easy physician orders in this case is an act so egregious that is constituted gross negligence.

Violation of Professional Trust – Subdivision (12)

The Board alleges that Ray's conduct violated the relationship of professional trust or confidence with Ray's employer and patients. Professional trust is the reliance on the special knowledge and skills that professional licensure evidences.[19] It may exist not only between the professional and her clients, but also between the professional and her employer and colleagues.[20] As an RN, Ray developed a professional trust with his patients and with Bothwell. This trust required Ray to follow physician orders, which Ray failed to do. We agree that Ray's conduct was a violation of professional trust.

Summary

Ray is subject to discipline under § 335.066.2(5) and (12). We cancel the hearing.

SO ORDERED on October 28, 2011.

Sreenivasa Rao Dandamudi

SREENIVASA RAO DANDAMUDI
Commissioner

[19] *Trieseler v. Helmbacher*, 168 S.W.2d 1030, 1036 (Mo. 1943).
[20] *Cooper v. Missouri Bd. of Pharmacy*, 774 S.W.2d 501, 504 (Mo. App., E.D. 1989).