BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of	§	AGREED
Vocational Nurse License Number 190647	§	
issued to JAMEL E WOOLFOLK	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of JAMEL E WOOLFOLK, Vocational Nurse License Number 190647, hereinafter referred to as Respondent.

This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Order.

The Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

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

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

3. Respondent's license to practice as a vocational nurse in the State of Texas is in current status.

4. Respondent received a Certificate in Vocational Nursing from Texarkana College, Texarkana, Texas, on August 15, 2003. Respondent was licensed to practice vocational nursing in the State of Texas on September 24, 2003.

5. Respondent's nursing employment history includes:

09/03 - 08/04	LVN	Christus St. Michael Hospital Texarkana, Texas

Respondent's nursing employment history continued:

09/03 - 02/05	LVN	Linden Healthcare Linden, Texas
11/04 - 02/05	LVN	The Springs Hughes Springs, Texas
02/05 - 07/05	LVN	Odyssey Hospice Houston, Texas
07/05 - 10/05	LVN	The Vosswood Houston, Texas
10/05 - 04/06	LVN	Brighton Gardens Houston, Texas
05/06 - 10/06	LVN	Oahu Care Facility Honolulu, Hawaii
08/06 - 06/07	LVN	Healthcare Training Honolulu, Hawaii
02/07 - 06/07	LVN	Nursefinders Honolulu, Hawaii
09/07 - 06/09	LVN	At Home Healthcare Texarkana, Texas
05/09 - 01/10	LVN	Brighton Gardens Houston, Texas
01/10 - 02/11	LVN	Paramount Healthcare Houston, Texas
02/11 - Present	LVN	Supplemental Healthcare Houston, Texas
04/14 - 09/14	LVN	MHMRA of Harris County Houston, Texas
09/14 - Present	LVN	Epic Healthcare Houston, Texas

Respondent's nursing employment history continued:

10/14 - Present	LVN	Q Staff Houston, Texas

6. On or about March 3, 2011, Respondent's Hawaii practical nurse license was Revoked through a Final Order issued by the Hawaii Board of Nursing, Honolulu, Hawaii. The Hawaii Board of Nursing adopted a Hearing Officer's recommended decision as its Final Order. A copy the Hearing Officer's Findings of Fact, Conclusions of Law, and Recommended Order dated December 21, 2010, and a copy of the Board's Final Order dated March 3, 2011, are attached and incorporated, by reference, as part of this Order.

7. On or about November 15, 2012, Respondent submitted a renewal application to the Texas Board of Nursing in which she provided false, deceptive, and/or misleading information, in that she answered "no" to the following question:

"Has any licensing authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a nursing license, certificate or multi-state privilege held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?"

Respondent failed to disclose that on or about March 3, 2011, her Hawaii practical nurse license was Revoked by the Hawaii Board of Nursing, Honolulu, Hawaii. Respondent's conduct was deceiving and could have affect the Board's decision to renew her license.

8. On or about September 26, 2014, Respondent submitted an employment application to Mental Health Mental Retardation of Harris County, Houston, Texas, in which she provided false, deceptive, and/or misleading information, in that she answered "no" to the following questions:

"Have you ever been discharged or asked to resign because of unsatisfactory conduct or performance of duties?"

"To the best of knowledge, have you ever been found to be the perpetrator of a confirmed case of client abuse or neglect in any previous employment?"

Respondent failed to disclose that on or about March 3, 2011, her Hawaii practical nurse license was Revoked by the Hawaii Board of Nursing, Honolulu, Hawaii. The revocation was due to unfitness/incompetence by reason of negligence, habits, or other causes which caused her to be terminated by Oahu Care Facility, Honolulu, Hawaii. Respondent's conduct was deceiving and could have affect the decision to offer employment.

9. In response to the conduct outlined in Findings of Fact Numbers Six (6) through Eight (8), Respondent states that she thought she was being truthful under her assumption that the question only pertained to the State of Texas.

10. Respondent, by her signature to this Order, expresses her desire to voluntarily surrender her license(s) to practice nursing in the State of Texas.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555 , the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient cause pursuant to Section 301.452(b)(8)&(10), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number 190647, heretofore issued to JAMEL E WOOLFOLK, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

4. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

5. Under Section 301.453(d), Texas Occupations Code, as amended, the Board may impose conditions for reinstatement of licensure.

6. Any subsequent reinstatement of this license will be controlled by Section 301.453(d), Texas Occupations Code, and 22 TEX. ADMIN. CODE §213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

TERMS OF ORDER

NOW, THEREFORE, IT IS AGREED and ORDERED that the **VOLUNTARY SURRENDER** of Vocational Nurse License Number 190647, heretofore issued to JAMEL E WOOLFOLK, to practice nursing in the State of Texas, is accepted by the Texas Board of Nursing.

In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice vocational nursing, use the title "vocational nurse" or the abbreviation "LVN" or wear any insignia identifying his/herself as a vocational nurse, or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a vocational nurse during the period in which the license is surrendered.

2. RESPONDENT SHALL NOT petition for reinstatement of licensure until one (1) year has elapsed from the date of this Order.

3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

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

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes final when accepted by the Executive Director at which time the terms of this Order become effective and a copy will be mailed to me.

Signed this 11 day of January, 2015.

Jamel E. Woolfolk

JAMEL E WOOLFOLK, Respondent

Sworn to and subscribed before me this 11th day of January, 2015.

SEAL

NOTARY PUBLIC STATE OF TEXAS
Clarence Bearden
Commission Expires
07-11-2017

Clarence Bearden

Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby accept the voluntary surrender of Vocational Nurse License Number 190647, previously issued to JAMEL E WOOLFOLK.

Effective this 16th day of January, 20 15.

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

BOARD OF NURSING
OFFICE OF ADMINISTRATIVE HEARINGS
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

In the Matter of the License to Practice Nursing of JAMEL WOOLFOLK, Respondent.	)	RNS 2007-4-L BOARD'S FINAL ORDER

BOARD'S FINAL ORDER

On or about June 19, 2009, the duly appointed Hearings Officer submitted his Findings of Fact, Conclusions of Law and Recommended Order in the above-captioned matter to the Board of Nursing ("Board") and to the parties. The parties were subsequently provided an opportunity to file exceptions; however, no exceptions were filed.

Upon review of the entire record of this proceeding, the Board adopts the Hearings Officer's recommended decision as the Board's Final Order. Accordingly, the Board finds and concludes that the preponderance of the evidence established that Respondent Jamel Woolfolk ("Respondent") violated Hawaii Revised Statutes §§457-12(a)(3) and (a)(6) with respect to *each* of the 14 residents referred to in the Findings of Fact.

Accordingly, for the violations found, Respondent's license is hereby revoked and Respondent shall immediately submit all indicia of licensure as a nurse in the State of Hawaii to the Executive Officer of the Board. In addition, Respondent shall pay a fine of $28,000.00 within ninety (90) days of the Board's Final Order by mailing a certified check or

money order payable to the "State of Hawaii, Compliance Resolution Fund" to the Regulated Industries Complaints Office, Department of Commerce and Consumer Affairs, 235 South Beretania Street, ninth floor, Honolulu, Hawaii 96813. Payment of the fine shall be made a condition for relicensure following the period of revocation of license.

DATED: Honolulu, Hawaii, MAR 3 2011.

STEPHEN A. KULA, Ph.D, NHA
Chairperson

PATRICIA A. LANGE-OTSUKA
Ed.D., MSN, APRN-BC, CNE
Vice Chairperson

JAEDA R. ELVENIA, MSN, RN
Board Member

CECILIA P.S. MUKAI, Ph.D., APRN
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AMY STONE MURAI, MS, APRN
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JAMES S. HOBAN, JR, MBA, BA
Board Member

DENISE L. COHEN, MSN, BSN, APRN
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Board Member

BOARD OF NURSING
OFFICE OF ADMINISTRATIVE HEARINGS
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
STATE OF HAWAII

In the Matter of the License to Practice Nursing of JAMEL WOOLFOLK, Respondent.	)	RNS 2007-4-L HEARINGS OFFICER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDED ORDER

HEARINGS OFFICER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDED ORDER

I. INTRODUCTION

On June 19, 2009, the Department of Commerce and Consumer Affairs, through its Regulated Industries Complaints Office ("Petitioner"), by and through its attorney, Diane R. Corn, Esq., filed a petition for disciplinary action against the nursing license of Jamel Woolfolk ("Respondent"). The matter was duly set for hearing, and the notice of hearing and pre-hearing conference was transmitted to the parties.

On April 6, 2010, the hearing in the above-captioned matter was convened by the undersigned Hearings Officer pursuant to Hawaii Revised Statutes ("HRS") Chapters 91, 92 and 457. Petitioner was represented by its attorney, Diane R. Corn, Esq. Respondent appeared by telephone.[1]

Having reviewed and considered the evidence and arguments presented at the hearing, together with the entire record of this proceeding, the Hearings Officer hereby renders the following findings of fact, conclusions of law and recommended order.

[1] Respondent did not call in until approximately 9:25 a.m., 16 minutes after the hearing had commenced.

II. FINDINGS OF FACT

1. Respondent was originally licensed by the Board of Nursing ("Board"), as a licensed practical nurse, License No. LPN 15531, on April 10, 2006. Respondent's license expired on June 30, 2009.

2. Respondent was employed by Oahu Care Facility ("OCF"), a residential care facility in September 2006.

3. After staff at OCF noted that Respondent had been spending long periods of time at the nursing station and significantly less time on her medication passes in contrast with the other staff, an investigation was initiated.

4. On or about September 21, 2006, Respondent documented in the Medical Administration Record ("MAR") that all medications had been administered during her shift. However, a pill count of medications for all residents on Respondent's daily assignment both before her shift started and again after it was completed showed that 7 of the 20 residents had not received their medication from Respondent.

5. Respondent was required to check the blood sugars of 2 residents using the accucheck machines during her shift and document the blood glucose levels in each resident's MAR. However, none of the stored readings matched with any readings Respondent had documented in the residents' MAR on September 21 and 22, 2006. Rather, the readings stored in the machine matched the blood sugar levels that had been documented on previous shifts. A review of the other accucheck machine on the floor matched the blood glucose levels taken by the other nurse on the unit for the residents and did not match any of the levels Respondent had documented in the MAR.

6. On September 22, 2006, Respondent signed out her 1:00 p.m. medications before her 10:30 a.m. break; however, medication counts for 5 residents were unchanged during her shift.

7. On September 22, 2006, OCF administrators met with Respondent to discuss her nursing practices. The meeting was documented in a memorandum by the then Director of Nursing.

Met with Jamel today to inform her that we had received information concerning her nursing practice from various staff members. Such concerns included whether or not she was giving administering medications or performing blood glucose checks as ordered by the MD. I shared with Jamel results of the initial investigation which concluded that on Thursday, September 21, 2006, Jamel withheld medications from 7 residents although she did sign them out as having been given. She also did not check the blood sugars of 2 residents (one blood sugar ordered daily and 1 ordered weekly) but signed them out and included blood sugar results as if they had been done.

I asked Jamel why she had not given the medications or performed the blood sugar checks. She initially did not answer and then stated that she had. She also stated that she used the accucheck machine on her medication cart.

I informed Jamel that we did a pill count before she arrived at work and after she left. The results showed that the same medications that were in the blister packs before she arrived at work, for those 7 residents, were still there after she left. We also told her that we reviewed her MAR while she was on her break at 10:30AM and found that her 1:00 PM medications for later that day were already signed out. Also, the accuchek on her cart has a memory of the last 10 accucheks that were done. None of the glucoses that she had documented and signed out were in the memory of the accuchek machine. We also had checked the other accuchek machine on the unit in case she had used that, but the glucose values were not stored in that machine as well.

When Jamel was asked why she didn't administer those medications or test the blood sugars, she had no answer. She also had no answer when I asked her why she had signed out her 1PM medications before 10:30AM. Jamel mentioned that sometimes she does that. This was something that we had discussed the previous week with her when she received her second written warning for medication error and falsification of a medical record.

Jamel was notified that she was being put on Administrative Leave of Absence with pay, pending further investigation and that I would be in touch with her after the investigation is completed. Jamel then stood up and left the office.

* * * *

8. On September 29, 2006, Respondent's employment at OCF was terminated.

III. CONCLUSIONS OF LAW

Petitioner has charged Respondent with violating the following provisions of the HRS and Hawaii Administrative Rules ("HAR"):

> §457-12 Discipline; grounds; proceedings; hearings. (a) In addition to any other actions authorized by law, the board shall have the power to deny, revoke, limit, or suspend any license to practice nursing as a registered nurse or as a licensed practical nurse applied for or issued by the board in accordance with this chapter, and to fine or to otherwise discipline a licensee for any cause authorized by law, including but not limited to the following:
>
> * * * *
>
> (3) Unfitness or incompetence by reason of negligence, habits, or other causes;
>
> * * * *
>
> (6) Unprofessional conduct as defined by the board in accordance with its own rules;

Respondent has been charged with unfitness, incompetence and engaging in unprofessional conduct. Respondent's deliberate falsification of records, her repeated failure to properly administer medication to and test the glucose levels of residents, and her unwillingness to acknowledge any of her errors, are more than sufficient to establish Respondent's unfitness and incompetence to hold a license and constitutes unprofessional

conduct in violation of HRS §§457-12(a)(3) and (6). The Hearings Officer is also mindful that by entering false blood sugar levels in the records and failing to administer medications as directed, Respondent jeopardized the safety and well-being of the residents under her care. Respondent's conduct was nothing short of egregious.

IV. RECOMMENDED ORDER

Based on the foregoing findings and conclusions, the Hearings Officer recommends that the Board find and conclude that the preponderance of the evidence established that Respondent violated HRS §§457-12(a)(3) and (a)(6) with respect to *each* of the 14 residents referred to in the Findings of Fact.

Accordingly, for the violations found, the Hearings Officer recommends that Respondent's license be revoked and that Respondent be required to immediately submit all indicia of licensure as a nurse in the State of Hawaii to the Executive Officer of the Board. The Hearings Officer further recommends that Respondent be ordered to pay a fine of $28,000.00[2] within ninety (90) days of the Board's Final Order by mailing a certified check or money order payable to the "State of Hawaii, Compliance Resolution Fund" to the Regulated Industries Complaints Office, Department of Commerce and Consumer Affairs, 235 South Beretania Street, ninth floor, Honolulu, Hawaii 96813. Payment of the fine shall be made a condition for relicensure following the period of revocation of license.

DATED at Honolulu, Hawaii: DEC 21 2010.

CRAIG H. UYEHARA
Administrative Hearings Officer
Department of Commerce
and Consumer Affairs

[2] In arriving at an appropriate fine, the Hearings Officer also credits the testimony of Sharon A. Takiguchi, RN, MS, APRN, ABD. Takiguchi noted, among other things, that the letter from Respondent to explain her side was even more disconcerting because Respondent does not admit any wrongdoing but rather, attempts to point the finger at others in the system to deflect her own misconduct. According to Takiguchi, Respondent "does not appear to understand the gravity of the situation and the possible effect her actions have on patients."