DOCKET NUMBER 507-15-0748

IN THE MATTER OF REGISTERED NURSE LICENSE NUMBER 706387, ISSUED TO TAMMY JEANETTE MARCOM	**§ § § § §**	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: TAMMY JEANETTE MARCOM
C/O ELIZABETH HIGGINBOTHAM, ATTORNEY
ONE CASTLE HILLS
1100 NW LOOP 410, SUITE 700
SAN ANTONIO, TX 78213

HENRY D. CARD
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on July 20-21, 2017, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Respondent's exceptions to the PFD; (3) Staff's response to Respondent's exceptions to the PFD; (4) the ALJ's final letter ruling of January 19, 2017; (5) Staff's recommendation that the Board adopt the PFD with changes; and (6) 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. The Respondent filed exceptions to the PFD on December 23, 2016. Staff filed a response to Respondent's exceptions to the PFD on January 9, 2017. On January 19, 2017, the ALJ issued a final letter ruling, in which he declined to make any changes to the PFD.

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; the ALJ's final letter ruling of January 19, 2017; Staff's recommendations; and the presentation by the Respondent during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD without modification 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 that the most appropriate sanction in this matter is a probated suspension of the Respondent's license for a two year time period, to include probationary requirements[2].

The Board finds that the Respondent's conduct collectively warrants a second tier, level II sanction for her violations of §301.452(b)(10) and §301.452(b)(13). For a second tier, level II sanction for a violation of §301.452(b)(10) and §301.452(b)(13), the Board's Disciplinary Matrix[3] authorizes either licensure suspension or revocation. Based upon the aggravating and mitigating factors in this case, the Board agrees with the ALJ and finds that a probated suspension with probationary requirements is the most appropriate sanction.

The Board views an individual's violations of the Nursing Practice Act (NPA) and/or Board rules collectively. If multiple violations of the NPA and/or Board rules are present in a single case, the Board is statutorily required to consider taking a more severe action than it would otherwise impose[4].

In determining the appropriate sanction in this case, the Board must consider the aggravating and mitigating factors. The Respondent's conduct, as outlined in adopted Findings of Fact Numbers 11-18 and Conclusions of Law Numbers 5-7 raise serious concerns about the Respondent 's ability to practice nursing safely. The Respondent verbally, emotionally, and physically abused a vulnerable patient[5]. The patient was very ill, with multiple co-morbidities, and had stopped breathing several times during his stay at the hospital[6]. The patient suffered emotional and physical pain as a result of the Respondent's actions[7]. Additionally, as noted by the ALJ, there were prior commentaries in the Respondent's personnel records regarding her aggression and inflexibility in dealing

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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] See page 26 of the PFD.

[3] 22 Tex. Admin. Code §213.33(b).

[4] Tex. Occ. Code §301.4531.

[5] See adopted Findings of Fact Numbers 15-17 of the PFD.

[6] See adopted Finding of Fact Number 11 of the PFD.

[7] See adopted Finding of Fact Number 18 of the PFD.

with other people[8]. This raises concerns about the Respondents' ability to conform her behavior to the minimum standards of nursing practice in the future.

The Board recognizes that the Respondent has no prior disciplinary history with the Board and that the ALJ noted that there were other comments in the Respondent's personnel records describing the Respondent as a proficient and skilled nurse[9].

Therefore, after carefully reviewing and considering the aggravating and mitigating factors in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix[10] and the Board's rules, including 22 Tex. Admin. Code §213.33(e) and §213.32, that the Respondent's registered nurse license should be subject to a two year probated suspension, to include probationary requirements.

The Board agrees with the majority of the probationary requirements recommended by the ALJ. The Board agrees with the ALJ that the Respondent should be required to complete a remedial education course in nursing jurisprudence and ethics, critical thinking, and anger management[11]. The Board also agrees that a fine of $1,000.00 is appropriate[12]. Due to the seriousness of the Respondent's conduct and the fact that actual harm occurred to the patient as a result, the Board agrees with the ALJ that the Respondent's practice should be subject to direct supervision for the first year of the Order and to indirect supervision for the remainder of the Order. Further, the Board agrees with the ALJ that the Respondent should not be permitted to practice in intensive critical care areas or on night shifts for the first year of the Order. The Board also agrees that employer notifications are necessary to effectuate the supervisory requirements of the Order. Additionally, although not specifically recommended by the ALJ, the Board finds that quarterly employer reports are also necessary to ensure compliance with the Order. These requirements are supported by the evidence in the record and are authorized by, and consistent with, the provisions of 22 Tex. Admin. Code §213.33(e)(6)[13].

Finally, although the Board agrees with the ALJ that the Occupations Code §301.461 authorizes the Board to assess the costs of the hearing against the Respondent, the Board

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[8] See adopted Finding of Fact Number 19 of the PFD.

[9] See adopted Finding of Fact Number 20 of the PFD.

[10] 22 Tex. Admin. Code §213.33(b).

[11] See 22 Tex. Admin. Code §213.33(f), which requires individuals subject to a Board Order to participate in a program of education or counseling prescribed by the Board, which at a minimum, must include a review course in nursing jurisprudence and ethics.

[12] See 22 Tex. Admin. Code §213.32.

[13] 22 Tex. Admin. Code §213.33(e)(6) provides that a suspension, either enforced or probated, may include reasonable probationary stipulations, such as the completion of remedial education courses, at least two years of supervised practice, limitations of nursing activities, and periodic Board review.

declines the imposition of those costs[14].

IT IS THEREFORE ORDERED that Registered Nurse License Number 706387, previously issued to **TAMMY JEANETTE MARCOM**, to practice nursing in Texas is hereby **SUSPENDED**, with the suspension **STAYED** and Respondent is hereby placed on **PROBATION,** in accordance with the terms of this Order, for a minimum of two (2) years **AND** until Respondent fulfills the requirements of this Order.

I. APPLICABILITY OF ORDER

A. This Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

B. This Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

C. Respondent may not work outside the State of Texas in another nurse licensure compact party state without first obtaining the written permission of the Texas Board of Nursing and the Board of Nursing in the nurse licensure compact party state where Respondent wishes to work.

II. COMPLIANCE WITH LAW

While under the terms of this Order, 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.

III. REMEDIAL EDUCATION COURSE(S)

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the effective date of this Order, unless otherwise specifically indicated**:

A. **A Board-approved course in Texas nursing jurisprudence and ethics that 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. Home study courses and video programs will not be

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[14] HB 2950, enacted by the 85th Texas Legislature, effective 9/1/17, will prohibit the Board from imposing upon a Respondent the administrative costs of conducting a hearing. Although not effective at the time of the entry of this Order, the Board declines to impose against the Respondent the costs of this hearing in compliance with the spirit of HB 2950.

approved.

B. **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.

C. **A Board approved anger management class** comprised of not less than eight (8) hours in duration. The class content must include information addressing staying in control, managing stress, avoiding negative influences, and developing behavior change plans.

In order to receive credit for completion of this/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider. *Information about Board-approved courses and Verification of Course Completion forms are available from the Board at www.bon.texas.gov/compliance.*

IV. MONETARY FINE

RESPONDENT SHALL pay a monetary fine in the amount of one thousand dollars ($1,000). RESPONDENT SHALL pay this fine within ninety (90) days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

V. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse, providing direct patient care in a licensed healthcare setting, for a minimum of sixty-four (64) hours per month for eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse 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 period and will not count towards completion of this requirement.

A. **Notifying Present and Future Employers**: RESPONDENT SHALL notify each present employer in nursing and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.

B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.

C. **Direct Supervision:** For the first year [four (4) quarters] 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). 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.

D. **Indirect Supervision:** For the remainder of the Order, 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.

E. **Nursing Performance Evaluations:** 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 and these reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month quarterly period for eight (8) quarters [two (2) years] of employment as a nurse.

F. **No Critical Care:** For the first year [four (4) quarters] of employment as a Nurse under this Order, RESPONDENT SHALL NOT practice as a nurse in any critical care area. Critical care areas include, but are not limited to, intensive care units, emergency rooms, operating rooms, telemetry units, recovery rooms, and labor and delivery units.

G. **No Night Shift:** For the first year [four (4) quarters] of employment as a Nurse under this Order, RESPONDENT SHALL NOT practice as a nurse on the night shift.

VI. RESTORATION OF UNENCUMBERED LICENSE(S)

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 may be eligible for nurse licensure compact privileges, if any.

Entered this 21st day of July, 2017.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-15-0748 (December 7, 2016).

State Office of Administrative Hearings

Lesli G. Ginn
Chief Administrative Law Judge

December 7, 2016

Katherine A. Thomas, M.N., R.N.
Executive Director
Texas Board of Nursing
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701

VIA INTERAGENCY

RE: Docket No. 507-15-0748;
Texas Board of Nursing v. Tammy Jeanette Marcom

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,

Henry D. Card
Administrative Law Judge

HDC/km
Enclosures

xc: John F. Lefris, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA INTERAGENCY
Kathy A. Hoffman, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD(s); Certified Evidentiary Record) – VIA INTERAGENCY
Elizabeth L. Higginbotham, R. N. J. D.; Higginbotham & Associates, L.L.C.; One Castle Hills, 110 NW Loop 410, Suite 700, San Antonio, TX 78213 – VIA REGULAR MAIL

SOAH DOCKET NO. 507-15-0748

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
TAMMY JEANETTE MARCOM, Respondent	§	ADMINISTRATIVE HEARINGS

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SOAH DOCKET NO. 507-15-0748

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
TAMMY JEANETTE MARCOM, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks disciplinary action against Tammy Jeanette Marcom (Respondent) for alleged violations of the Nursing Practice Act[1] and the Board's rules. Specifically, Staff contends Respondent emotionally, verbally, and physically abused a patient on or about February 6-7, 2014. Respondent denies the allegations.

The Administrative Law Judge (ALJ) finds that the preponderance of the credible evidence supports the allegations. Therefore, he concludes that Respondent violated the Texas Occupations Code (Code) and the Board's rules, although he concludes that Respondent's actions did not violate all of the rules cited by Staff. The ALJ recommends the imposition of the disciplinary sanctions recommended by Staff. Those sanctions include a two-year probated suspension of Respondent's license, monitoring requirements and practice restrictions during the suspension period, certain remedial education courses, and an administrative fine of $1,000. The ALJ also recommends that the costs of the proceeding at the State Office of Administrative Hearings (SOAH) be assessed against Respondent.

I. JURISDICTION AND PROCEDURAL HISTORY

The Board's jurisdiction was undisputed and is set out in the Conclusions of Law without further discussion.

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[1] Texas Occupations Code (Code) ch. 301.

After timely and adequate notice, the hearing on the merits convened on May 10, 2016, before ALJ Henry D. Card at SOAH's offices in Austin, Texas. Staff was represented by John Legris, Assistant General Counsel. Respondent was represented by attorney Elizabeth Higginbotham, R.N. The hearing continued on May 11, 2016, was recessed, and was reconvened and finally adjourned on June 17, 2016. The record closed on October 7, 2016, with the filing of Staff's Response to Respondent's Closing Argument.

II. ALLEGATIONS AND PROPOSED SANCTIONS

Staff's allegations against Respondent are set out below:

CHARGE I.

On or about February 6, 2014, through February 7, 2014, while employed as a Registered Nurse with Midland Memorial Hospital, Midland, Texas, Respondent emotionally and/or verbally abused Patient Medical Record Number 4000075920 by stating, "the patient had been a pain in the a** all night." Additionally, Respondent shouted at the patient stating, "he was a stupid man and a stupid Mexican." Respondent's conduct was likely to injure the patient in that it could have resulted in the patient suffering from emotional distress and physical injury.

CHARGE II.

On or about February 6, 2014, through February 7, 2014, while employed as a Registered Nurse with Midland Memorial Hospital, Midland, Texas, Respondent physically abused Patient Medical Record Number 4000075920 by roughly inserting a Flexi-Seal into the Patient, which caused the patient pain. Respondent told the aforementioned patient that if he pulled it out again it would be worse next time. Respondent's conduct was likely to injure the patient in that it could have resulted in the patient suffering from emotional distress and physical injury.

Staff alleged that the actions described in Charges I and II constitute grounds for disciplinary action under Code § 301.452(b)(10) and (13) and violated the Board's rules at 22 Texas Administrative Code (TAC) §§ 217.11(1)(A), (B) and 217.12(1)(A) and (B), (4), and (6)(C) and (F).

Staff recommended that Respondent's license be subject to a suspension for two years but that the suspension be probated, that monitoring requirements and practice restrictions be imposed on Respondent during that period, that Respondent be required to take certain remedial education courses, and that Respondent be assessed an administrative fine of $1,000. Staff also recommended that the costs of the hearing be assessed against Respondent.

III. APPLICABLE LAW

Code § 301.452(b)(10) and (13) states:

> (b) A person is subject to denial of a license or to disciplinary action under this subchapter for:
>
> (10) unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public; . . .
>
> (13) failure to care adequately for a patient or to 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.

The Board's rules at 22 TAC §§ 217.11 (1)(A) and (B) and 217.12(1) (A) and (B), (4), and (6)(C and (F) state:

> 22 TAC § 217.11.
>
> (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:
>
> (A) Know and conform to the Texas Nursing Practice Act and the board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;
>
> (B) Implement measures to promote a safe environment for clients and others . . . .

22 TAC§ 217.12.

(1) Unsafe Practice--actions or conduct including, but not limited to:

(A) Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Rule 217.11.

(B) Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;

(4) Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established.

(6) Misconduct--actions or conduct that include, but are not limited to:

(C) Causing or permitting physical, emotional or verbal abuse or injury or neglect to the client or the public, or failing to report same to the employer, appropriate legal authority and/or licensing board;

(F) Threatening or violent behavior in the workplace . . . .

The factors to be considered in determining sanctions and penalties are set out in the Board's rule at 22 TAC § 213.33.

Staff had the burden of proof in this proceeding.[2]

IV. EVIDENCE AND ARGUMENTS

A. Background

Respondent is a registered nurse and holds License Number 706387. She has been licensed since 2004. On February 6-7, 2014,[3] Respondent was working in the Critical Care Unit (CCU) of Midland Memorial Hospital (Hospital) in Midland, Texas. Respondent was assigned

[2] 1 Tex. Admin. Code (TAC) §155.427.

[3] The shift at issue on those days lasted from 7:00 p.m. February 6 to 7:00 a.m. February 7, 2014. Tr. Vol. II at 59.

to three patients in Rooms 544, 547, and 548 in an area of the CCU known as "the Hook" because it juts out perpendicularly from the main part of the CCU.[4] The events at issue in this case allegedly occurred in Room 547 and involved Patient Medical Record Number 4000075920, referred to throughout the hearing as "Mr. V." Mr. V was a very ill patient, with multiple comorbidities, who had stopped breathing several times during his stay in the Hospital and ultimately passed away there.[5] On February 6-7, 2014, Mr. V required a Flex-Seal, which is a fecal management device inserted into a patient's rectum to collect fecal matter and prevent diarrhea from soiling the patient.[6]

B. Staff's Direct Evidence

Staff presented several documents into evidence, including personnel records of Respondent and medical records of Mr. V. Staff also presented the testimony of Scott Turner, Nichole Porter, Angela Nielsen, who were registered nurses at the Hospital and were working on the February 6-7 shift; and of Stacey Cropley, Ph.D., R.N., who is the lead nursing consultant for practice for the Board.

Mr. Turner has been a registered nurse for ten years. He testified that he and Respondent had worked together for many years and that he had considered them to be friends. Mr. Turner stated that he was taking care of one of his patients during the February 6-7 shift, but went to help Respondent at her request. Upon entering the room, he testified, Respondent was at the foot of the bed and using curse words about Mr. V's Flexi-Seal coming out. Mr. Turner said that he told Respondent she should not be saying things like that. Mr. Turner then saw that Mr. V was in emotional distress, with his eyes full of tears. Asked to be more specific, Mr. Turner testified:

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[4] Staff Ex. 12 is a map of the CCU.

[5] Tr. Vol. I. at 45.

[6] Staff Ex. 13 is an example of a Flexi-Seal.

> To the best of my recollection, sir, it was something to the effect, I asked, what was going on, and she responded, the d*** Flexi-Seal or the f***ing Flexi-Seal—I don't remember which word, but one of those—had come out and he had s*** all over himself.[7]

Mr. Turner stated that Respondent was at the foot of Mr. V's bed when she made those comments, rather than at a nursing station or teaming station that would have been outside the patient's hearing. Mr. Turner stated that Mr. V was awake and alert at the time and understood English. Mr. Turner testified that he told Respondent that she should not be talking to a patient that way, and left the room after Ms. Porter and Ms. Nielsen came in.[8]

Mr. Turner testified that although Mr. V was generally a cooperative patient, Mr. V had pulled out his Flexi-Seal in the past. When questioned about the procedures for inserting a Flexi-Seal, Mr. Turner stated that lubricant must always be used to insert a Flexi-Seal in a patient, regardless of how many times it has come out.[9]

Mr. Turner stated that although he did not report the incident regarding Respondent's language immediately, he reported it about 15 minutes later to Amber Branum, who was the team leader that night, and at some point to Cari Johnson, who was a clinical manager.[10]

On cross-examination, Mr. Turner acknowledged that the act of pulling out a Flexi-Seal could have been painful for Mr. V or for any patient. Mr. Turner also acknowledged that a nurse is required to document significant events regarding a patient's status but that Mr. V's medical records do not contain any mention of the incident he described. He also agreed that a statement he provided to the Board on March 25, 2014, did not mention that he had reported the incident earlier.[11]

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[7] Tr. Vol. I at 41-42. The language is spelled out completely in the transcript.

[8] Tr. Vol. I at 42-45.

[9] *Id.* at 46-48.

[10] *Id.* at 50-51, 60.

[11] *Id.* at 53-58, 64; Respondent Ex. 1.

Ms. Porter has been a registered nurse since December of 2012 and worked at the Hospital from January of 2013 to July of 2014. Ms. Porter testified that Respondent asked her and Ms. Nielsen to assist in cleaning up Mr. V and to help her while Respondent re-inserted the Flexi-Seal. According to Ms. Porter, when she entered the room, Respondent was yelling about Mr. V. Ms. Porter testified:

> Tammy was at this time yelling things like, this is a stupid man, he is a stupid Mexican, you are going to pay for this, this is going to be a lot of fun when I put this back in, you should never had taken it out; several, just terrible things to this man. I looked at his face and he was—he was very upset, he was, like, trembling; he had tears in his eyes, and he looked like he had just been through so much hearing all of this from Tammy yell at him.[12]

Ms. Porter testified that she has inserted a Flexi-Seal into a patient. Ms. Porter stated that Respondent at first did not have any lubricant to use in inserting the Flexi-Seal and that Ms. Porter handed her some, which Respondent used. Then, according to Ms. Porter:

> [Respondent] began to insert the Flexi-Seal forcefully, very forcefully, excessively. And the patient was crying and shaking, and she was still yelling that this is what—talking very loudly at that point, but at that point, just saying, this is what you get, you pulled it out, this is what we have to do, now you are going to get it.[13]

Ms. Porter testified that Respondent also told Mr. V that she would "tie his penis in a knot" if he pulled out his Foley.[14] She described Respondent's comments toward the patient as a "constant barrage of, Mexican, stupid man, this is your fault." Ms. Porter stated that Mr. V, Respondent, Ms. Nielsen, and she were in the room when those comments were made and when the Flexi-Seal was being re-inserted. Although Mr. V's wife was often present at the Hospital, she was not present at that time.[15]

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[12] Tr. Vol. I at 72.

[13] *Id.* at 71-73.

[14] *Id.* at 73. A Foley is a catheter that is inserted into the urethra to collect urine.

[15] *Id.* at 76.

Ms. Porter stated that she was shocked by Respondent's comments. She testified that there was no question in her mind that Respondent's manner of inserting the Flexi-Seal "was wrong and I wished I could physically stop her doing it." She described Respondent's actions as possibly "criminal." She did not believe her impressions would be different if she had been a more experienced nurse at the time.[16]

Ms. Porter testified that, after checking on her patients, she went to an office shared by the managers and found no one there, then returned later to find Cari Johnson and Brenda Evans, the director of critical care, visiting. She "peeked her head in and said, I need to speak to somebody as soon as, and they just kind of waved me off." Later, she said, she found the office shut and locked. Ultimately, after her shift was over, she found Ms. Branum in the parking garage and told her about the incident. During her description, Ms. Johnson joined them in Ms. Branum's car.[17]

On cross-examination, Ms. Porter stated that the incident has occurred around 5:00 a.m. on February 7.[18] Ms. Porter acknowledged that, despite her belief that Mr. V had been verbally and physically assaulted, she did not stop Respondent from inserting the Flexi-Seal. She did not call the house supervisor. She did not document the incident in Mr. V's medical records. She agreed that she did not insist on speaking with the managers right away when she first saw then in their office. A later report she made about the incident, on March 24, 2014, did not specifically mention the statement about tying Mr. V's penis in a knot, although she did offer in the latter report to provide more details.[19]

Ms. Nielsen was employed at the Hospital from approximately January of 2013 to March of 2014. Ms. Nielsen recalled hearing Respondent's voice raised in the patient's room:

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[16] *Id.* at 76-77.

[17] *Id.* at 78-86.

[18] It was generally agreed that the re-insertion of Mr. V's Flexi-Seal occurred around 4:30 a.m. on February 7.

[19] Tr. Vol. I at 90-106; Respondent Ex. 2.

> I recall hearing her say, I can't believe you did this, you are such a stupid man, and that caught my attention. And as she walked out of the room, she stated he's a Mexican or stupid Mexicans, plural, I can't recall which it was.[20]

Ms. Nielsen testified that she said hello to Mr. V when she walked into the room and Respondent told her, "don't be nice to him, he's been a pain in the ass all night." Ms. Nielsen believed Mr. V looked fearful. Ms. Nielsen testified that Respondent stated "I'm not going to use lubricant on that guy" after Ms. Porter handed her the lubricant. Respondent did use lubricant when inserting the Flexi-Seal, however. Ms. Nielsen stated, however:

> Ms. Marcom proceeded to insert the Flexi-Seal into the patient in a way that I felt was fairly rough, rougher than necessary, and when she finished putting the Flexi-Seal in, Nichole and I rolled Mr. V back on his back. And at that point, we noticed that he was crying and Ms. Marcom said, have you ever see a grown man cry before.[21]

Ms. Nielsen had been a registered nurse for approximately a year and two months at the time of the alleged incident and had inserted a Flexi-Seal into a patient. She believed that she would not have perceived Respondent's actions differently had she been a more experienced nurse.[22]

Ms. Nielsen said she and Ms. Porter spoke about the incident and Ms. Porter volunteered to report it. She stated Ms. Porter later told her she had not been able to report it right away, but texted her the next morning to say she had reported it to Ms. Branum and Ms. Johnson. Ms. Nielsen also reported it the next day, February 8, 2014, to her manager, Amber Sanchez, and subsequently filled out an online incident report. Ms. Nielsen described herself as "shocked," "outraged," and "traumatized" by Respondent's comments to Mr. V.[23]

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[20] Tr. Vol. I at 125.

[21] *Id.* at 125-29.

[22] *Id.* at 129-30.

[23] *Id.* at 130-33. The online incident report was admitted into evidence as Respondent Ex. 4.

On cross-examination, Ms. Nielsen agreed that her report stated she first heard raised voices in Mr. V's room around 10:00 p.m. on February 6. She acknowledged that she did not immediately report the incident herself or contact the house supervisor. She agreed that she did not note the incident in Mr. V's chart and did not go back and check on Mr. V's welfare. Although she considered the incident to be emotional and physical abuse, she did not consider it to be a medical emergency that required immediate action.[24]

Dr. Cropley testified that Respondent's actions, if proven, would be violations of Code § 301.452(b)(10) and (13) and of 22 TAC §§ 217.11(1)(A) and (B) and 217.12 (1)(A) and (B), (4), and (6)(C) and (F).

The Board's rule at 22 TAC § 213.33 sets out the factors to be considered in determining sanctions and penalties.[25] In determining the sanctions she proposed, Dr. Cropley cited both aggravating and mitigating factors. Aggravating factors included actual harm to the patient, his vulnerable condition, the seriousness of the allegations, Respondent's experience in the nursing profession, and previous commentaries in her personnel records about Respondent being aggressive and inflexible in her dealing with other people. Mitigating factors were several comments in the same records describing Respondent as a proficient and skilled nurse.

In Dr. Cropley's opinion, the violations of Code § 301.452(b)(10) and (13), if proved, warranted second-tier, level 2 sanctions. That sanction level includes the possibility of suspension. Dr. Cropley recommended that Respondent's license be suspended for two years, with the suspension probated. Respondent would be required to have direct supervision during the first year and indirect supervision for the second year. Dr. Cropley also recommended that Respondent not work in an intensive critical care area or night shift, and that she be required to take courses in nursing jurisprudence and ethics, critical thinking, and anger management. She would be required to show the Board Order to current and future employers. Finally,

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[24] *Id.* at 136-45.

[25] The Board's disciplinary matrix is at 22 TAC § 213.33(b).

Dr. Cropley recommended that Respondent be assessed an administrative fine of $1,000 under 22 TAC § 213.32.[26]

On cross-examination, Dr. Cropley stated that she had not reviewed any particular proposal for decision or Board orders in reaching her recommendations. She acknowledged that she had not yet heard Respondent's version of events and that her recommendations were conditioned upon the allegations being proved. She agreed that Mr. V's medical records did not document the alleged incident for an incoming nurse to assess, although Respondent herself had noted that Mr. V was in pain from his medical condition and might require medication. She also agreed that sometimes investigations reveal that allegations against a nurse are false and that all the relevant information must be considered.[27]

C. Respondent's Evidence and Arguments

Respondent also offered several documents into evidence, including affidavits from various witnesses. Respondent presented testimony from Amber Sanchez, Amber Branum, Cari Johnson, Denae Sims (who was another nurse working in the CCU on February 6-7, 2014), and Respondent herself.[28]

Ms. Sanchez is a clinical supervisor at the Hospital. On February 9, 2014, Ms. Sanchez performed a rounding, or survey, with Mr. V and his wife. The rounding did not ask about the alleged incident of February 6-7, 2014, but asked more general questions about the quality of care the patient had received. According to the form and Ms. Sanchez's testimony, Mr. V and his wife answered several questions, including the following:

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[26] Tr. Vol. I at 152-63.

[27] *Id.* at 163-74.

[28] Respondent also presented testimony from Board supervising investigator Christen Werley and Board investigator Lakeisha Artley-Jenkins. Their testimony pertained to discovery and evidentiary disputes between the parties rather than to the facts of the case, and therefore is not summarized in this Proposal for Decision.

Question: Have your nurse listened and addressed your questions and concerns?
Answer: Yes.

Question: Has staff kept you informed and included you in decision related to your care?
Answer: Yes.

Question: Are we managing your pain appropriately?
Answer: Yes.

Question: If you were to rate our customer services would you rate us good, excellent, or exceptional?
Answer: Good.

Although asked, Mr. and Mrs. V did not provide additional information on how to improve the Hospital's service.[29]

Ms. Sanchez described Respondent as an outspoken, strong patient advocate, although sometimes lacking in patience. She also stated that she had asked Ms. Nielsen on February 8 about the alleged incident with Mr. V and instructed her to file the incident report.[30]

Ms. Branum, who was the team leader or charge nurse on February 6-7, 2014, testified that during the shift no one voiced any concerns to her about patient safety or complained to her about Respondent. She said that the only complaint she heard during the shift was from Respondent herself, about difficulties in getting lab results. Ms. Branum confirmed that Ms. Porter approached her in the parking garage to complain about Respondent. Ms. Branum described Ms. Porter's demeanor as "meek and timid" and "not sure if she should talk to me; if what she was telling me was actually what she saw." Ms. Branum stated that Ms. Porter was laughing and talking normally and that Ms. Branum did not believe from the conversation that the patient was in any danger. Ms. Branum stated she texted Ms. Johnson, who joined them in her car and was "as shocked as I was" at Ms. Porter's description. Ms. Branum testified that, if the incident occurred as described, she or Ms. Johnson should have been informed immediately,

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[29] Tr. Vol. II at 37-39; Respondent Ex. 13.

[30] Tr. Vol. II at 41-43, 55-56.

the patient should have been reassigned, and the incident should have been noted in the patient's medical record. She stated that she saw Ms. Porter in Ms. Johnson's office during the February 6-7 shift, but Ms. Porter did not report the alleged incident. Ms. Branum did not believe the incident really occurred.[31]

In an affidavit she signed on March 24, 2014, in the course of the Board's investigation into the alleged incident, Ms. Branum stated: "Tammy Marcom is a wonderful above reproach nurse. Allegations & stories changed many times." In her testimony, Ms. Branum clarified that she was referring to stories and allegations by Ms. Porter and Ms. Nielsen. She also testified that Mr. Turner had not reported the alleged event to her within 15 minutes of its occurrence.[32]

On cross-examination, Ms. Branum agreed that she had not been in Mr. V's room during the period in question and had no first-hand knowledge of whether the incident had occurred.[33]

Ms. Johnson testified that Ms. Porter was in her office at least four times during the shift, from approximately 11:30 pm. to 3:30 a.m. She stated that Ms. Porter was always there on personal matters and did not complain about any inappropriate behavior from Respondent. She testified that neither Mr. Turner nor Ms. Nielsen reported any inappropriate behavior. Ms. Johnson said that Ms. Porter did stick her head into the office around 4:30 a.m., when Ms. Evans was also there. Although they told her to come in, she declined and said she wanted to talk with Ms. Johnson before she left. Ms. Johnson stated that Ms. Porter did not seem distraught, but was smiling and laughing.[34]

After Ms. Johnson clocked out, she was called to Ms. Branum's car to converse with Ms. Porter. According to Ms. Johnson, Ms. Porter told them that Respondent "had been angry all night, ranting and raving up and down the hallways," and had come across "very forcefully

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[31] *Id.* at 66-78, 93.

[32] *Id.* at 81-82; Respondent Ex. 6.

[33] Tr. Vol. II at 92.

[34] *Id.* at 104-11, 116.

when inserting the rectal tube" into Mr. V. Ms. Johnson said Ms. Porter wanted to remain anonymous, "and she really didn't know if she was making this a bigger deal than what should be." Ms. Johnson described Ms. Porter's demeanor as "very dismissive." Ms. Johnson confirmed that she was shocked, partly because she had not heard any ranting or raving or excessive noise.[35]

Ms. Johnson testified that she asked Ms. Porter if she had ever inserted a Flexi-Seal on somebody who was awake and that she said she had not. Ms. Johnson stated that anyone who has had a Flexi-Seal put in them and has pulled it out would be likely to clench their buttocks, which would require some force to insert it. Then, according to Ms. Johnson, Ms. Porter "was like, well, I don't know. Then maybe it didn't happen." As she herself noted, Ms. Johnson was not present in Mr. V's room at the time of the alleged incident.[36]

Ms. Sims was working at the CCU during the February 6-7, 2014 shift. She stated that she had seen Ms. Porter in Ms. Johnson's office around 4:00 a.m. on February 7, 2014, and that Ms. Porter had not expressed any concerns about the care being provided by Respondent. She stated she had seen both Ms. Nielsen and Mr. Turner during the shift as well, and neither had expressed any concerns about Respondent. She described Respondent as a great educator of other nurses and did not feel she would abuse or harm a patient in any way. She stated she had personally inserted a Flexi-Seal into Mr. V and that it had been very difficult because he was a large person and tended to tense his buttocks to keep the Flexi-Seal from entering. Ms. Sims noted that the staff, including Respondent, did not feel that Ms. Evans, the director, was approachable.[37]

Respondent testified that she worked as a registered nurse at the Hospital CCU from 2004 until she resigned in February 2014. She stated that she was frustrated about her assignments during the shift of February 6-7 because she had three very critical patients who were not in

[35] *Id.* at 116-17.

[36] *Id.* at 121-22, 127.

[37] Tr. Vol. III at 9-24.

adjacent rooms. She also noted that she was more experienced than most of the other nurses on the Hook during that shift, except one other who was recovering from knee surgery.[38]

Respondent described Mr. V as a large man, who had to have a Flexi-Seal because of his diarrhea. His buttocks were excoriated and his stomach was tight and swollen, "like a tin snare." He was not on pain medication because of the potential side effects.[39]

Respondent stated that during the shift she complained to one of the other nurses, outside Mr. V's hearing, that the doctors were not being forthright with Mr. V and his family about his medical condition.

> A: And I said, "Rhonda." I said, "All of the doctors are treating this family like they are stupid because they are Mexicans and they cannot understand the man's prognosis and diagnosis, and that's not true. . . .
>
> Q: Did you ever call the patient a "stupid Mexican?"
>
> A: No.
>
> Q: Did you ever call the patient a "stupid man?"
>
> A: No.[40]

Respondent testified that in the morning of February 7, she discovered that Mr. V's Flexi-Seal was out and that his sling and bed were covered with liquid stool. After assessing the situation, she realized she needed help, found Mr. Turner in the hallway, and told him there that Mr. V had "pulled out his fucking Flexi-Seal." Mr. Turner agreed to help, but said he needed some time, so Ms. Porter and Ms. Nielsen volunteered to help instead.

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[38] *Id.* at 42-49.

[39] *Id.* at 52-57.

[40] *Id.* at 80.

A: And they enter. And I'm like, "Hey, Mr. V, we are going to help clean you up."

And Nichole says, "Do you need me to get some water-soluble stuff for you?

And I'm, like, "Well, he's been a little 'toot' tonight." And I'm looking directly at him. I'm looking over my left shoulder. "He's been a little 'toot' tonight. I really shouldn't.

And I'm still digging through supplies. And then I find some, and I look over there and I said, "oops, look, we are going to use it." And I bring it over, and I put it with the Flexi-Seal.

Q: So was that your attempt to bring a little levity into the situation.

A: Yes, definitely. Well, humor into it. Because he knows this isn't going to be fun. He had just had one put in earlier in the day.[41]

Respondent described Mr. V as being in pain and "tensing really, really, really tight" when she and the other nurse were cleaning him before re-inserting the Flexi-Seal. During the process of insertion, she stated, Mr. V was "fighting. No one wants a Flexi-Seal placed in them. It's not a pleasant experience." Respondent stated the Mr. V was clinching his buttocks and she was pushing to make sure the Flexi-Seal was inserted far enough.[42]

Respondent testified that later in the shift she discovered that Mr. V had the Flexi-Seal around his leg again and was attempting to pull it out. At that point, she told him:

A: "Don't do that. You really need this. You have breakdown on your bottom. It wasn't fun last time when we did it. If you pull it out again, it's going to be just as unpleasant going back the next time."

Q: Was that your attempt to teach the patient about –

A: To remind him about how painful it is.

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[41] *Id.* at 94-95.

[42] *Id.* at 97-99.

Q: Did you deliberately injure this patient?

A: No. I did not.[43]

In general, Respondent denied calling Mr. V names as alleged by Staff and her co-workers. She denied being unnecessarily rough or forceful with Mr. V when inserting the Flexi-Seal, which was a difficult process that required some force.[44]

On cross-examination, Respondent admitted that she was frustrated that Mr. V's Flexi-Seal had come out. She denied being impatient or frustrated with Mr. V himself, however. She reiterated that she had never called Mr. V any of the names alleged by Staff or threatened Mr. V in any way. She stated that the testimony of Mr. Turner, Ms. Porter, and Ms. Nielsen was untrue.[45]

D. Staff's Rebuttal Evidence

Ms. Evans testified in rebuttal for Staff. Ms. Evans confirmed that Ms. Porter had looked into the manager's office on February 7 while she and Ms. Johnson were conversing. Ms. Porter said that she would come back because they were busy. Ms. Evans described Ms. Porter's demeanor as "calm." Ms. Evans expressed the opinion that Ms. Johnson and Ms. Branum were not truthful people and should not be believed although they were under oath. She also believed that Ms. Sanchez sometimes is "challenged with telling the truth."

On cross-examination, Ms. Evans acknowledged that a nurse who observes abuse is obligated to report it immediately, although she observed that a new nurse might be intimidated by a more experienced nurse. She also acknowledged that sometimes nurses are required to perform tasks that are painful to patients.[46]

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[43] *Id.* at 108.

[44] *Id.* at 109.

[45] *Id.* at 117, 122-25.

[46] *Id.* at 157-58, 162.

V. ALJ'S ANALYSIS

A. Charge I

To reiterate, Charge I states:

> On or about February 6, 2014, through February 7, 2014, while employed as a Registered Nurse with Midland Memorial Hospital, Midland, Texas, Respondent emotionally and/or verbally abused Patient Medical Record Number 4000075920 by stating, "the patient had been a pain in the a** all night." Additionally, Respondent shouted at the patient stating, "he was a stupid man and a stupid Mexican." Respondent's conduct was likely to injure the patient in that it could have resulted in the patient suffering from emotional distress and physical injury.

Although their testimony was not identical, Mr. Turner, Ms. Porter, and Ms. Nielsen provided very similar descriptions of the events in Mr. V's room during the morning of February 7, 2014. All three characterized Respondent as yelling at and verbally abusing Mr. V about his having pulled out the Flexi-Seal. Although Respondent denied the charges, it was in her self-interest to do so. Respondent's co-workers did not appear to have any ulterior motive to fabricate allegations against Respondent. Ms. Porter's story was bolstered, moreover, by the undisputed fact that she attempted to speak with Ms. Johnson in the managers' office shortly after the incident occurred, although she did not actually report it to Ms. Branum until later that morning. The ALJ found Mr. Turner, Ms. Porter, and Ms. Nielsen to be credible.

The ALJ does not ascribe any weight to the results of the rounding conducted by Ms. Sanchez on February 8. Although Mr. and Mrs. V did not complain about their treatment at the Hospital, the questions asked in the survey were very broad and did not relate specifically to the events of February 6-7.

The ALJ finds that Respondent verbally and emotionally abused Mr. V during the morning of February 7, 2014. The evidence established that Respondent's actions were contrary to the minimum standards of nursing practice, failed to promote a safe environment for Mr. V,

and caused or were likely to have caused emotional injury and distress. Although the language itself was not violent, it could easily have been perceived as threatening. The ALJ concludes, as did Dr. Cropley, that Respondent's actions violated Code § 301.452(b)(10) and (13) and violated the Board's rules at 22 TAC §§ 217.11(1)(A) and (B) and 217.12(6)(C) and (F).

The ALJ concludes that Respondent's language did not violate 22 TAC §§ 217.12(1)(A) and (B) and (4), however. The evidence did not demonstrate that Respondent's actions were careless or repetitive, or that she exhibited an inability to perform in accordance with acceptable nursing standards. Nor did the abusive language actually endanger Mr. V's life, health, or safety, despite its emotional effect.

B. Charge II

Charge II states:

> On or about February 6, 2014, through February 7, 2014, while employed as a Registered Nurse with Midland Memorial Hospital, Midland, Texas, Respondent physically abused Patient Medical Record Number 4000075920 by roughly inserting a Flexi-Seal into the Patient, which caused the patient pain. Respondent told the aforementioned patient that if he pulled it out again it would be worse next time. Respondent's conduct was likely to injure the patient in that it could have resulted in the patient suffering from emotional distress and physical injury.

Respondent provided evidence that Mr. V could have been in pain from his removal of the Flexi-Seal and from his general medical condition. She also provided evidence that force was necessary to re-insert the Flexi-Seal and that the process itself was intrinsically uncomfortable and painful for an unsedated patient such as Mr. V.

Nevertheless, because the ALJ finds Ms. Porter and Ms. Nielsen to be more credible regarding the issue of verbal and emotional abuse, he finds them to be more credible regarding Respondent's insertion of the Flexi-Seal with undue force. The totality of the circumstances, including Respondent's demeanor and language, add credence to the charge that Respondent used excessive force during that process. Whether or not Ms. Porter and Ms. Nielsen should

have physically stopped Respondent or noted the event in Mr. V's chart, they felt strongly enough about it that they agreed to report it to a supervisor, and Ms. Porter did so. Respondent's overly forceful insertion of the Flexi-Seal was abusive toward Mr. V, even if it did not create a medical emergency. The ALJ does not find that Respondent was abusive in informing Mr. V that it would be more painful if he pulled the Flexi-Seal out again, however.

The ALJ finds that Respondent did physically abuse Mr. V during the morning of February 7, 2014. The evidence established that Respondent's actions were contrary to the minimum standards of nursing practice, failed to promote a safe environment for Mr. V, and caused or were likely to have caused physical injury and distress. The ALJ concludes, as did Dr. Cropley, that Respondent's actions violated Code § 301.452(b)(10) and (13) and violated the Board's rules at 22 TAC §§ 217.11(1)(A) and (B) and 217.12(4) and (6)(C) and (F).

The ALJ concludes that Respondent's actions did not violate 22 TAC §§ 217.12(1)(A) and (B), however. As with Charge I, the evidence did not demonstrate that Respondent's actions were careless or repetitive, or that she was unable to perform in accordance with acceptable nursing standards.

C. Recommended Sanctions

Dr. Cropley recommended that Respondent's license be suspended for two years, with the suspension probated; that Respondent be required to have direct supervision during the first year and indirect supervision for the second year of the probated suspension; that Respondent not work in an intensive critical care area or night shift; and that Respondent be required to take courses in nursing jurisprudence and ethics, critical thinking, and anger management. Dr. Cropley recommended that Respondent be required to show the Board Order to current and future employers and that Respondent be assessed an administrative fine of $1,000.

Dr. Cropley's recommendations were contingent upon the violations being proved. The ALJ has concluded that the violations were proved. He considers Dr. Cropley's analysis to be

persuasive and the proposed sanctions to be warranted based on the evidence, and recommends that those sanctions be imposed.

D. Costs of the Proceeding

Code § 301.461 authorizes the Board to assess a person who violated the Nursing Practice Act the administrative costs of conducting the hearing. Staff's Notice of Hearing included notice that Staff would seek to impose those costs on Respondent. Staff's Estimated Affidavit of Administrative Costs was admitted into evidence at the hearing.[47] Staff subsequently filed a Final Affidavit of Administrative Costs, with accompanying invoices and receipts.[48] That affidavit listed the following costs:

Court Reporter's Fees:	
$75 per hour x 16 hours (May 10, 11 and June 17, 2016)	$ 1,200.00
Transcript Fee:	
518 pages @ 3.90/page (May 10, 11 and June 17, 2016):	$ 2,020.20
Binding Fee & Administrative Fee	65.00
E-tran Fee (2 @ $20)	40.00
Delivery charge (3)	24.00
TOTAL COST	$ 3,349.20
One-Half of Total Cost to be Paid by Respondent's counsel	$-1,674.60
COURT REPORTER AND TRANSCRIPT TOTAL COST	**$ 1,674.60**
Witness Expenses:	
Attendance at Hearing for Witnesses	$ 210.00
Witness Mileage ($306.72, $372.49, $272.16, $381.24)	1,332.61
Witness Meals: May 10-11, 2016	185.59
June 17-18, 2016	46.37
Witness Lodging: May 10-11, 2016 (6 x $135)	810.00
June 17-18, 2016 (2 x $135)	270.00
Witness Miscellaneous Expenses (parking, etc.)	126.00
WITNESS EXPENSE-TOTAL COST:	$ 2,980.57
TOTAL COSTS ($1,674.60 + $2,980.57):	**$4,655.17**

[47] Staff Ex. 14; Tr. Vol. I at 32-36, 182-83.

[48] The Final Affidavit of Administrative Costs, with attachments, is admitted into evidence as Staff Ex. 14A.

The invoices and receipts attached to the Final Affidavit of Cost support the costs set out in the affidavit.[49] The ALJ concludes that Staff proved both of its allegations against Respondent. Therefore, the ALJ recommends that $4,655.17 in costs of the proceeding be assessed against Respondent pursuant to Code § 301.461.

VI. CONCLUSION

The ALJ finds that Respondent verbally and emotionally abused Mr. V on February 7, 2014. He concludes that Respondent's actions violated Code § 301.452(b)(10) and (13) and violated the Board's rules at 22 TAC §§ 217.11(1)(A) and (B) and 217.12 (6)(C) and (F).

The ALJ also finds that Respondent physically abused Mr. V on February 7, 2014. He concludes that Respondent's actions violated Code § 301.452(b)(10) and (13) and violated the Board's rules at 22 TAC §§ 217.11(1)(A) and (B) and 217.12(4) and (6)(C) and (F).

The ALJ recommends that Respondent's license be suspended for two years, with the suspension probated; that Respondent be required to have direct supervision during the first year and indirect supervision for the second year of the probated suspension; that Respondent not work in an intensive critical care area or night shift; and that Respondent be required to take courses in nursing jurisprudence and ethics, critical thinking, and anger management. The ALJ recommends that Respondent be required to show the Board Order to current and future employers and that Respondent be assessed an administrative fine of $1,000. The ALJ further recommends that $4,655.17 in costs of the proceeding be assessed against Respondent.

VII. FINDINGS OF FACT

1. Tammy Jeanette Marcom (Respondent) is a registered nurse and holds License Number 706387 issued by the Texas Board of Nursing (the Board).

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[49] Some receipts included as attachments were not included as costs in Staff's Final Affidavit. *See, e.g.*, Staff Ex. 14A at 5, 18.

2. Respondent has been licensed since 2004.

3. Based on events that were alleged to have occurred on February 6-7, 2014, the Board's staff (Staff) brought Formal Charges against Respondent, which led to a hearing before the State Office of Administrative Hearings (SOAH).

4. Staff's allegations against Respondent are set out below:

CHARGE I.

On or about February 6, 2014, through February 7, 2014, while employed as a Registered Nurse with Midland Memorial Hospital, Midland, Texas, Respondent emotionally and/or verbally abused Patient Medical Record Number 4000075920 by stating, "the patient had been a pain in the a** all night." Additionally, Respondent shouted at the patient stating, "he was a stupid man and a stupid Mexican." Respondent's conduct was likely to injure the patient in that it could have resulted in the patient suffering from emotional distress and physical injury.

CHARGE II.

On or about February 6, 2014, through February 7, 2014, while employed as a Registered Nurse with Midland Memorial Hospital, Midland, Texas, Respondent physically abused Patient Medical Record Number 4000075920 by roughly inserting a Flexi-Seal into the Patient, which caused the patient pain. Respondent told the aforementioned patient that if he pulled it out again it would be worse next time. Respondent's conduct was likely to injure the patient in that it could have resulted in the patient suffering from emotional distress and physical injury.

5. Notice of the SOAH hearing was sent to Respondent on November 6, 2014.

6. The notice 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 factual matters asserted.

7. The hearing on the merits convened on May 10, 2016, before Administrative Law Judge Henry D. Card at SOAH's offices in Austin, Texas. Staff was represented by John Legris, Assistant General Counsel. Respondent was represented by attorney Elizabeth Higginbotham, R.N. The hearing continued on May 11, 2016, was recessed, and was reconvened and finally adjourned on June 17, 2016. The record closed on October 7, 2016, with the filing of Staff's Response to Respondent's Closing Argument.

8. On February 6-7, 2014, Respondent was working in the Critical Care Unit (CCU) of Midland Memorial Hospital (Hospital) in Midland, Texas.

9. Respondent was assigned to three patients in Rooms 544, 547, and 548 in an area of the CCU known as "the Hook" because it juts out perpendicularly from the main part of the CCU.

10. Patient Medical Record Number 4000075920 (Mr. V) was in Room 547 of the CCU.

11. Mr. V was a very ill patient, with multiple comorbidities, who had stopped breathing several times during his stay in the Hospital and ultimately passed away there.

12. On February 6-7, 2014, Mr. V required a Flexi-Seal, which is a fecal management device inserted into a patient's rectum to collect fecal matter and prevent diarrhea from soiling the patient.

13. During the morning of February 7, 2014, Mr. V pulled out his Flexi-Seal, which led to his sling, bed, and person being covered with loose stool.

14. During the morning of February 7, 2014, Respondent, in Mr. V's hearing, called him " a pain in the ass," "a stupid man," and "a stupid Mexican."

15. During the morning of February 7, 2014, Respondent verbally and emotionally abused Mr. V.

16. During the morning of February 7, 2014, Respondent used excessive force when re-inserting Mr. V's Flexi-Seal.

17. During the morning of February 7, 2014, Respondent physically abused Mr. V.

18. Mr. V suffered emotional and physical pain from Respondent's actions.

19. Aggravating factors in determining possible sanctions against Respondent included actual harm to the patient, his vulnerable condition, the seriousness of the allegations, Respondent's experience in the nursing profession, and previous commentaries in her personnel records about Respondent being aggressive and inflexible in her dealing with other people.

20. Mitigating factors in determining possible sanctions against Respondent were several comments in Respondent's personnel records describing Respondent as a proficient and skilled nurse.

VIII. CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter. Tex. Occ. Code ch. 301.

2. SOAH 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. Tex. Gov't Code ch. 2003.

3. Respondent received timely and adequate notice of the hearing on the merits. Tex. Occ. Code (Code) § 301.454; Tex. Gov't Code §§ 2001.051-.052.

4. Staff had the burden of proof by a preponderance of the evidence. 1 Tex. Admin. Code (TAC) § 155.427.

5. Respondent's verbal and emotional abuse of Mr. V on February 7, 2014 violated Code § 301.452(b)(10) and (13) and violated the Board's rules at 22 TAC §§ 217.11(1)(A) and (B) and 217.12(6)(C) and (F).

6. Respondent's physical abuse of Mr. V on February 7, 2014 violated Code § 301.452(b)(10) and (13) and violated the Board's rules at 22 TAC §§ 217.11(1)(A) and (B) and 217.12(4) and (6)(C) and (F).

7. The Board is authorized to take disciplinary action against Respondent pursuant to Code § 301.452(b)(10) and (13) and the Board's rules at 22 TAC §§ 217.11(1)(A), (B) and 217.12(1)(A), (B), (4), and (6)(C), (F).

8. The Board is authorized to suspend Respondent's license, impose conditions on Respondent's practice, and impose an administrative fine against Respondent pursuant to its rules at 22 TAC §§ 213.32 and 213.33.

9. The Board is authorized to assess the administrative costs of conducting the hearing against Respondent pursuant to Code § 301.461.

IX. RECOMMENDATION

Based on the above Findings of Fact and Conclusions of Law, the ALJ recommends that Respondent's license be suspended for two years, with the suspension probated; that Respondent be required to have direct supervision during the first year and indirect supervision for the second year of the probated suspension; that Respondent not work in an intensive critical care area or night shift; and that Respondent be required to take courses in nursing jurisprudence and ethics, critical thinking, and anger management. The ALJ recommends that Respondent be required to show the Board Order to current and future employers and that Respondent be assessed an administrative fine of $1,000. The ALJ further recommends that $4,655.17 in costs of the proceeding be assessed against Respondent.

SIGNED December 7, 2016.

HENRY D. CARD
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

DOCKET NO. 507-15-0748

In the Matter of Permanent	§	**BEFORE THE TEXAS**
Certificate Number 706387	§	
Issued to	§	**STATE OFFICE OF**
Respondent TAMMY JEANETTE MARCOM	§	**ADMINISTRATIVE HEARINGS**

RESPONDENT'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

TO THE HONORABLE ADMINISTRATIVE LAW JUDGE:

COMES NOW, RESPONDENT, TAMMY JEANETTE MARCOM, and files this, her EXCEPTIONS TO THE PROPOSAL FOR DECISION in this case, issued on December 7, 2016 mailed by SOAH and received by counsel on December 14, 2016.

This case turns on the credibility of the witnesses. Evidentiary facts must first be established by applying the rule of credibility to the witnesses with ultimate facts determined and conclusions drawn. The parties, however, may still submit any exceptions, objections, or other responses to the proposal for decision to SOAH and the referring agency as the ALJ has the power to review such documents and make changes to the original proposal sent to the referring agency. As to issues of fact, a finding may be inferred only by determination that the evidence preponderates in favor of its existence. In this case, the totality of the evidence preponderates in favor of Tammy Marcom.

EXCEPTION SECTION C. Dr. Cropley's Testimony Restricted

Respondent was denied the ability to obtain all the data that Dr. Cropley testified that she reviewed in accordance with the Rules of Evidence.

UNDER TRCP 194.2, TRE 702 and TRE 705 disclosure of the underlying facts or data that form the basis of an expert's opinion must be disclosed. In this case Dr. Cropley unequivocally testified that she reviewed Respondent's first four responses to Staff's Requests for Disclosures. (Tr. V1 175:7-177:10).

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a formal hearing, that we have done discovery in this case?
A Yes.
Q Have you looked at any of Ms. Marcom's responses to discovery?
A Yes, I have.
Q Which ones?
A I have Answers 1 through 4, I believe.
Q Just so that I'm clear about that, you are aware

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that Ms. Marcom retained an investigator to go out and interview the various fact witnesses in this case, correct?
A I'm aware of that as of today, yes.
Q Have you had the opportunity to listen to any of those tape-recorded statements?
A No, I have not.
Q Are you aware that the people who gave those tape-recorded statements signed a sworn declaration?
A No, I'm not aware of that.
MR. LEGRIS: I object, Your Honor. I mentioned this morning that we were going to be filing an objection to the introduction of any of these interviews, whether in the form of the audio disk or in the form of the transcripts or the notes on various bases. So these questions assume facts not in evidence, they assume documents not in evidence; this witness has purposely not seen the fifth response to discovery provided by the Respondent for that very reason, because they are not in evidence and we are going to hopefully keep them out of evidence. So until you rule, Dr. Cropley will not see these.
JUDGE CARD: I'm going to overrule the objection to those questions as long as we are not getting into testimony to the substance of those. I don't want to

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hear that.
MS. HIGGINBOTHAM: And I believe I simply asked --
JUDGE CARD: I'll overrule that particular objection, but I understand something is coming tomorrow.
MS. HIGGINBOTHAM: Thank you.
Q (BY MS. HIGGINBOTHAM) What portion of the Board of Nursing's investigative file did you review?
A I just reviewed the exhibits and statements 1

10 through 4 from Ms. Marcom.
In Discovery Respondent provided five (including her Original Responses) to supplemental sets

answers of to Requests for Disclosures.

Marcom, Tammy - Vol. 1, (Pages 12:23 to 13:6)

12

23 Further, in looking down the road in this
24 hearing to tomorrow, Staff intends to interpose an
25 objection to any and all of the interviews conducted by

13

1 Ms. Roque of the various witnesses. These were provided
2 to Staff on a CD a couple of weeks ago, and I have
3 listened to every single one of these. They were provided
4 to us as the Respondent's Fifth Supplemental Response to
5 Petitioner's Request for Disclosure in written form Friday
6 around 4:00 p.m. before the weekend, that just occurred.

The Expert testified that she had seen the first four sets of disclosures that Respondent made. Then,

counsel for the BON "corrected" her testimony with a speaking objection.

Marcom, Tammy - Vol. 1, (Pages 177:19 to 178:12)

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19 MR. LEGRIS: I misspoke. Dr. Cropley has
20 not seen 4 because 4 did, in fact, include the handwritten
21 notes and the declarations in accordance with the Texas
22 Civil Practice and Remedies Code, the unsworn declarations
23 signed by the various individuals interviewed by Ms. Roque
24 that came with the audio CD.
25 So, no, I may have misspoke if I had said

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1 she had seen the fourth; she's not seen the fourth or the
2 fifth; the fifth being the transcripts we received at 4:00
3 p.m. last Friday.
4 MS. HIGGINBOTHAM: And with all due respect,
5 I think it was the witness' testimony.
6 THE WITNESS: It was my testimony, and I
7 apologize.
8 Q (BY MS. HIGGINBOTHAM) So are you changing your
9 testimony?
10 A I have seen 1 through 3. I have not seen
11 anything related to the disk and the witnesses that
12 Ms. Roque has spoken with.

Under Texas Rule of Evidence 705, Respondent has the legal right to examine and cross examine

an expert witness on what she testified to under oath that she reviewed. The witness confirmed

that it was her testimony that she reviewed four sets of Discovery answers. (Id; Tr. V 1 191:20-194:4). Mr. Legris then "corrected" Ms. Cropley's testimony with speaking objections that coached the witness into changing her testimony[1]. Dr. Cropley's review of Respondent's discovery responses is not privileged or confidential and Respondent was denied the right over proper legal objections to examine the materials much less examine the witness on those responses. In disclosures, Staff disclosed that the expert had also reviewed the Investigative file.

Marcom, Tammy - Vol. 1, (Pages 190:11 to 192:23)

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I want an investigator in this courtroom tomorrow morning with the investigative file that this lady has reviewed. There's no reason to hide it. We are having a hearing based on this. You are saying that my client -- among being stoned and hung out in front of the SOAH building, that we don't have a right to have the evidence that she's basing a sanction on. No.

MR. LEGRIS: That's not correct, Your Honor. Dr. Cropley has not reviewed the investigative file. Now, in the disclosures, it says there was a misprint because it said, we will have her review the investigative file, but down in a lower paragraph, it qualifies it; it says, those portions of the investigative file that are not considered confidential under law or privilege.

She's testified under oath that she did not

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review the investigative file that Ms. Artley compiled. She's only seen the documents that enforcement prepared and that the legal department, including the attorneys in the legal department, have certified as the exhibits, i.e., the evidence that is produced against the Respondent for purposes of this case.

Defense counsel is not entitled to a fishing expedition through the investigative file to look through confidential memos. Now, being an old Air Force lawyer myself, you know, I know what that's like. I used to try to get the confidential notes of officers and special investigations from the police in criminal cases, and sometimes you would get them and sometimes you wouldn't. But for purposes of the statute that governs the Texas

[1] Unfortunately, this was not the first or last time this happened V1 24:1-26:10. The rounding report portrays the patient's experience on that shift was objected to, minimized or in some fashion covered up.

Board of Nursing and the Nursing Practice Act, it makes it specifically confidential.

And so I don't have the authority to produce it, even if you should so order it, because that would require an interlocutory appeal.

MS. HIGGINBOTHAM: My response is whatever an expert reviews, it's coming in. I have the opportunity and the right to examine it. Her testimony until Mr. Legris changed her testimony from his table today was that she has seen my disclosures, the first disclosure and four supplements.

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JUDGE CARD: Well --

MS. HIGGINBOTHAM: I want to know what her opinion is based on. Whatever she's reviewed, we are not going to hide it over at 333 Guadalupe.

MR. LEGRIS: But their responses to our disclosures is not our investigative file; that's what they produced.

JUDGE CARD: Ms. Higginbotham, you agree with Mr. Legris' description of the statute and the rule?

MS. HIGGINBOTHAM: I am not going to argue about what the statute says, but --

JUDGE CARD: I haven't looked at it, but you don't disagree on that?

MS. HIGGINBOTHAM: No. But what a witness has reviewed and what he has disclosed that she's basing her testimony on, I absolutely have a right to do that.

MR. LEGRIS: She's not reviewed the investigative file. Absolutely. I'll get on the witness stand and swear to that.

JUDGE CARD: You are not a witness.

MS. HIGGINBOTHAM: You are not a witness.

JUDGE CARD: I think she said that, too.

MR. LEGRIS: She did.

Marcom, Tammy - Vol. 1, (Pages 192:24 to 194:11)

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MS. HIGGINBOTHAM: Well, after being corrected. So the issue is, where is the file? Can we

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agree that Ms. Artley is going to be here tomorrow with the portions of the investigative file that Mr. Legris has sanitized tomorrow?

MR. LEGRIS: We can agree that Ms. Artley will be here tomorrow. The portions of the investigative file that she's reviewed or disclosable, you have before you. That's all you get. That's all she gets. Anything

further goes to the executive director and the general counsel. It's beyond my authority. I can't comply with any orders that you might issue with all due respect.

JUDGE CARD: Well, I want to go back and look at the Diaz case.

MR. LEGRIS: It's from 2009.

JUDGE CARD: Texas Board of Nursing versus Diaz?

MR. LEGRIS: Yes. It was a three-day hearing, and it was in the spring or early summer of 2009.

JUDGE CARD: Okay.

MR. LEGRIS: It's only one. I mean, this has come up many times.

MS. HIGGINBOTHAM: And, Your Honor, while you are up, look at Bagley-Krenek that Judge Smith decided because --

JUDGE CARD: Bagley?

MS. HIGGINBOTHAM: Amy Bagley-Krenek, in re;

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it went to the Third Court of Appeals. In that case, the expert testified that she reviewed the investigative file, the entire thing got attached, copied, and put in the record.

JUDGE CARD: And when was that?

MR. LEGRIS: That case went on for years.

MS. HIGGINBOTHAM: I have slept since then.

JUDGE CARD: Are we talking Judge Rebecca Smith or --

MS. HIGGINBOTHAM: Katherine Smith. It was Katherine Smith.

That is grounds for retrial as Respondent was denied her legal right to fully examine the expert witness that the Agency relied on and this Court deferred to in making not only findings of fact but conclusions of law and recommending sanctions. Counsel for the BON identified for the record precisely what was in the 4th Supplement to Disclosures Respondent provided.

Marcom, Tammy - Vol. 2, (Pages 47:23 to 48:4)

47

MR. LEGRIS: I want to respond to that, because these were provided -- the audio CD of Ms. Roque's interviews with these witnesses was provided to us with

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the Respondent's Fourth Supplemental Response to disclosures. The transcripts were provided with Respondent's Fifth Supplemental Response to our

4 disclosures.

Staff even tried belatedly to keep the evidence of its own investigation that it submitted in open court as Exhibit 8 of its 902(10) out of evidence.

Marcom, Tammy - Vol. 2, (Pages 20:4 to 23:14)

20

4 Q (BY MS. HIGGINBOTHAM) You are now looking at
5 what I have marked as Exhibit 8-A. Do you recognize that
6 document?
7 A Yes, ma'am.
8 Q What is it?
9 A It's an e-mail correspondence from Cari Johnson
10 to Brenda Evans.
11 Q Did you collect that during your investigation?
12 A Yes, ma'am.
13 MS. HIGGINBOTHAM: I offer 8-A.
14 MR. LEGRIS: I have a question. Why 8A as
15 opposed to 9?
16 MS. HIGGINBOTHAM: I did that because Brenda
17 Evans, in her affidavit, says, "I have handed requests for
18 affidavits, voluntary statements to Nichole Porter, Scott
19 Turner, Amber Branum, Amber Sanchez. Unable to contact
20 Angela Nielsen. No answer from Cari Johnson. Both no
21 longer work for Midland Memorial Hospital."
22 But obviously, this was gathered by Brenda
23 Evans in her investigation.
24 So this is Cari Johnson's statement.
25 JUDGE CARD: It's fine.

21

1 MR. LEGRIS: Okay.
2 JUDGE CARD: I don't understand the
3 numbering, but that's okay.
4 MR. LEGRIS: Can I see it one more time,
5 please, R-8A?
6 MS. HIGGINBOTHAM: Sure.
7 MR. LEGRIS: I'm going to object to this
8 exhibit. This is essentially a hearsay document from
9 someone who I believe the Respondent plans to call as a
10 witness in this case. And, I think, Your Honor, you need
11 to hear ostensibly from this witness under oath and
12 subject to cross-examination before a hearsay statement
13 from the witness is produced to you and for you.
14 This was not obtained, initially. This is
15 not on a Board of Nursing affidavit. It is true that it
16 ultimately made its way into our investigation, as

conducted by Ms. Artley, but it is not of the same quality in terms of its reliability as the affidavits that were offered previously. That would be R-6 and R-7 and R-8. Because those are actually sworn statements, even though -- even though they are from witnesses that the Respondent intends to call here this morning to testify.

So we would object to R-8A the e-mail from Cari Johnson as being a hearsay statement, an out-of-court statement pertaining to the events of this case.

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MS. HIGGINBOTHAM: The irony of this, Your Honor -- may I approach and just show you. This has a Number 22 on the bottom. This is Page 22 of the Staff's Exhibit 8 of their 902-10. So --

JUDGE CARD: Which was not admitted or offered.

MS. HIGGINBOTHAM: Yesterday, it wasn't. It is today.

MR. LEGRIS: We didn't offer it, for that reason.

MS. HIGGINBOTHAM: It was filed. But I'm offering it.

MR. LEGRIS: No. It wasn't filed.

JUDGE CARD: It was put on my desk.

MR. LEGRIS: It was put in -- as a courtesy and as a convenience, all of the proposed exhibits were placed on your desk, Your Honor, and on everyone else's desk. But they weren't offered until I offered them on the record. And I only offered Pages 21 through the end, precisely because these are hearsay statements and I was aware of that fact.

What goes into the -- sometimes the 902-10 documents that are, by statute now, only required -- by Rule -- excuse me -- only required to be served on opposing counsel, an opposing party -- not filed with the

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court -- are not necessarily identical with what is offered as an exhibit on the day of trial, as I'm sure you know.

So we only offered the pages we offered. We're objecting to that.

JUDGE CARD: I understand. I think -- well, go ahead.

MS. HIGGINBOTHAM: This is a business record. It's been proven up by affidavit by Brenda Evans herself, who said this is part of the 60 pages. This is Page 22.

JUDGE CARD: I'm going to -- I rule that it was not offered. I'm going to go ahead and admit it, though, and overrule the objection.

EXCEPTION SECTION V. A. CHARGE I Analysis

Your Honor acknowledges that the testimony of the three "witnesses" (Porter Nielson and Turner) was not identical, they provided three very similar descriptions and states that he found the witnesses credible. All three characterized Respondent yelling at and verbally abusing Mr. V. about pulling out his Flexiseal.

The APA establishes a basic format for "fact" review by stating that findings, inferences, conclusions or decisions must be reasonably supported by substantial evidence looking at "reliable and probative evidence in the record as a whole." TEX. GOV'T CODE ANN. § 2001.174(2)(E) (West 2015). The "administrative findings, inferences, conclusions, or decisions" may not be "arbitrary" or "capricious." See id. § 2001.174(2)(F). Attorneys invoke the "Rule" and it was invoked in this case but only at the time of trial; these witnesses especially Porter and Nielson admitted speaking to one another and provided their statements to Brenda Evans, the BON's "contact" in this case.

In this case, Mr. Turner was not even in the room when the Flexiseal was reinserted based on the testimony and out of court statements. (Tr.V1 44:23-45:2; V1 63:11-13: V1 70:3-10; V1 126:25-127:7; R-1; R-2; R-3; R-4). To the contrary, Ms. Marcom's nursing notes in the medical records that contains the legal description of the patient care events that occurred in Mr. V's room throughout the entire night to the next morning stand as uncontroverted. (Staff's Ex.10 204-212; 222-226; 276-283; 290).

The Flexiseal didn't come out until later in the shift (State Ex. 10 Page 205). On the witness stand he claims that he reported the event related to the Flexiseal 15 minutes after it happened but he couldn't have because he was not even in the room .

Vol. 1, (Pages 56:12 to 57:16)

Q Well, in your direct examination, you said, I told her, Tammy, that she shouldn't be talking that way, and then I left the room.

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A Okay.

Moreover, when Amber Branum the very person he claimed to have reported it to **first**, confronted him the next day about WHY HE DIDN'T COME TO HER IF IT REALLY HAPPENED **(Tr.V.2 66:14-16)** your Honor sustained Mr. Legris' objection based on hearsay. Given the gaping inconsistencies in Turner's testimony, the answer was obvious without regard to the Court sustaining the objection.

Marcom, Tammy - Vol. 2, (Page 68:7 to 68:18)

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Q Did you admonish Mr. Turner for not reporting anything to you that he thought may have been a concern?
A I addressed it.
Q Did you tell him that that was inappropriate if, in fact, that happened.
A Yes.
Q Did you believe that any of that happened?
MR. LEGRIS: Objection. What the witness believed or didn't believe is not factual as pertains to what occurred on that night.
JUDGE CARD: Overruled. I'll allow that.
THE WITNESS: No.

Ms. Branum testified that **no one** reported anything to her until after the shift was over **(Tr. V2 67:17-25)**. She testified that Scott Turner was not being truthful when he said that he reported it to her within 15 minutes of the event happening. **(Tr. V.2 82:5-11).** Mr. Turner also claimed for the first time in open court that he provided comfort to Mr. V. **(Tr. V.1 57:9-16)**

Marcom, Tammy - Vol. 1, (Pages 63:25 to 65:1)

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Q Do you understand that standards of nursing

practice, the minimum standards, and I'm going to read to you from the rule, 217.11 (m), as a registered nurse, you are required to institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.

That includes their emotional condition; does it not?

A Yes, ma'am.

Q You did nothing, correct?

A No, ma'am, that's not correct.

Q Have you ever told anybody else something different about what happened that night?

A No, ma'am.

Q Are you sure about that?

A Not that I can recall, ma'am.

Q So it is your testimony in this courtroom under oath, sir, that you reported this to Amber Branum and Cari Johnson within 15 minutes of it happening?

A Approximately, yes, ma'am.

Q Where does it say that in your sworn statement at Respondent's 1?

A Are you talking about on this here?

Q Yes.

A It doesn't say that I reported it here.

Mr. Turner was impeached with the incredibility of that trial testimony by his prior inconsistent statement R-1, as were Ms. Porter and Ms. Nielson with their inconsistent statements. **Vol. 1, (Pages 57:20 to 58:24)Tr V1 99:15-101:7; Tr V 1 Tr V 1 143:4-145:7; R-1-R-4).**

Ms. Porter testified that when she and Ms. Nielson entered Mr. V's room that Ms. Marcom was yelling about Mr. V. which would mean that at that point Scott Turner was out of the room and on his way to report Tammy Marcom to both Amber Branum and Cari Johnson. Porter claimed that she tried twice to find Amber Branum but did not do so until she was in the parking lot and told Amber Branum and then Cari Johnson in Amber's car. Neither she or Nielson intervened to stop the behavior, did not call the house supervisor and did not document the incident or try to comfort the patient or check on him later. Turner, Porter, and Nielson were obligated by the Hospital's

policy to "Stop the Line" to protect the patient (Staff's Exhibit 7 pages 45-51) and call a supervisor (Staff's Exhibit 7 pages 47-49; TR. V3 128:6-18).

Marcom, Tammy - Vol. 1, (Pages 85:14 to 86:7)

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Q And again, what time did the shift end?
A At 7:00.
Q Fine. Did anyone else join you in the car?
A Yes. About halfway through explaining the incident that I witnessed, Cari Johnson just popped up, jumped in the backseat. I don't know if she was already out there or she just came down, but she got in the back seat.
Q So did you then begin from the beginning and tell the story again?
A I did. Amber Branum said, Cari, this is not good, you have to listen to what Nichole is telling me.

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Cari got in, and I started from the beginning.
Q So shortly after the shift ended around 7:00 a.m. in the morning, you made a report of the incident to Cari Johnson, who is a clinical manager, and Amber Branum, who was the leader and acting clinical manager, on that very shift?
A Yes.

Marcom, Tammy - Vol. 1, (Pages 90:14 to 96:21)

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Q All right. Around -- I believe you testified that this event happened at 5:00 in the morning?
A Around 5:00 in the morning, yes. I don't know what time specifically.
Q And was it your impression, Ms. Porter, that this patient was having emotional distress?
A Yes, this patient was very upset.
Q And isn't it true that we are trained as registered nurses to make a nursing diagnosis and then formulate a plan and implement things to help a patient with whatever they happen to be experiencing?
A That is true.

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Q What was your nursing diagnosis that night for this patient?
A Patient had been verbally assaulted, and by the time they were done, he was physically assaulted.
Q All right. And so you formulated a nursing diagnosis of potential for emotional or physical harm; is

that right?
A Correct.
Q And what were your interventions that you planned on helping to alleviate that emotional and physical trauma?
A I helped Tammy return the patient to a more comfortable state, and I immediately went to go report what had happened to this patient so that Tammy wasn't his nurse anymore.
Q Let me rephrase my question. Perhaps I wasn't clear.
A Okay.
Q What did you do to help this man that you claim had been verbally and physically assaulted?
MR. LEGRIS: Objection. The question has been asked and answered. The witness just testified that she assisted the Respondent in making the patient more comfortable, putting him in a more comfortable position and she went to report Tammy's actions so that Tammy

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Marcom would be removed from being the patient's nurse. Those are definitive steps that this witness took that are responsive to the question. The fact that Ms. Higginbotham doesn't like the answer doesn't mean she gets to ask the question over again, Your Honor.
JUDGE CARD: I will allow it this time and see if there's anything she forgot.
Overruled.
Q (BY MS. HIGGINBOTHAM) Precisely, what did you do to check on Mr. V to see if he was still in pain or if he was still upset? What did you do?
A I didn't need to check on Mr. V. I returned him to the most comfortable position I could put him in in clean linens, and I left to record it, is what I did.
Q Let me make sure I understand your testimony. So you have observed a person who you believe has been abused; you did not ask him, are you okay, are you in any pain, what can I do for you; you didn't say any of those things to him, did you?
A It wasn't necessary. It was very apparent.
Q So it's your testimony that whatever this extreme distress was ended after his Flexi-Seal was -- the procedure was completed and the linens were changed; is that right?
A Did it end? No, it didn't end. She still was

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his nurse; he still endured whatever it was that happened

when I wasn't in there.
Q And you understand, Ms. Porter, because you went through an intense orientation at Midland Memorial Hospital that you had the power to stop the line, to intervene right there; you knew that, didn't you?
A I guess I could have physically grabbed her; I did not do that.
Q In fact, you didn't say a word to her, did you?
A I intervened by giving her a lubricant, I intervened by reporting her. She was very angry.
Q And back to my question about what you did with Mr. V. You didn't document your nursing diagnosis, your interventions or plan or evaluation anywhere in that chart, did you?
A In his chart, no.
Q In fact, madam, if you would turn with me to Exhibit No. 10, do you see the first page there where it says there's 963 pages?
A On Exhibit No. 10?
Q Yes, ma'am.
A No. Oh, I do see it, yes.
Q Okay. Is it your understanding that Mr. V was admitted to the hospital on December 24th of 2013?
A I have no idea what his admission date was.

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Q All right. Well, if you would look with me, I'm going to represent to you, ma'am, that the first 303 pages of records that we have here are orders, nurse's notes and physician progress notes. Could you turn with me to Page 304. It's at the lower right-hand part of the page.
A Okay.
Q Do you see there where there is a new diagnosis that says, knowledge deficit?
A I see it.
Q At the top of that page, this is a nursing diagnosis; is it not?
A It is.
Q And if you will turn with me to Page 762. Do you see at the bottom of the page where it says, entry dated 2/6/2014 nursing care plan update and review?
A At the bottom of 762?
Q Yes, ma'am. 762. I'm about two-thirds of the way down --
A I see it, yes.
Q All right. If you would just keep flipping through those pages with me to Page 766.
A Okay.

Q Nothing new in that nursing care plan documented by you, correct?
A Documented by -- is there anything added by me in this chart?
Q Yes, ma'am.
A Is what you are asking me?
Q Yes, ma'am.
A No, I didn't document in his chart.
Q You didn't do it, did you?
A I did not document in his chart.
Q And if you didn't document it, you didn't do it; isn't that right?
A I have heard that saying before.
Q Do you understand that the Nurse Practice Act and the rules and regulations that govern your practice in this state require you to accurately and completely document the nursing process, which includes nursing diagnosis, interventions and patient response? You know that, don't you?
A Yes.
Q And instead of caring for this man and asking him if he was all right, you went downstairs to smoke again, didn't you?
A No. Absolutely I did not. You don't document care in another patient's -- I assisted, I helped him.
Q Are you sure about that?
A I reported the incident; I did not go down and smoke.
Q But you can't tell us how many times you were gone from the floor, can you?
A I didn't leave the floor one more time after that took place for sure.
Q And who is your witness to that?
A Anyone else that was there. I mean, I didn't go down there. There was nothing for them to witness me --
Q Ma'am, if your managers say that they saw you several times that night and you said not one word about this until the parking lot, are they lying?
A That is not the truth. The very next time I saw a manager, it was reported to the manager.
Q So when you were sitting in Cari Johnson's office talking about your divorce and the fact that you had been off your Paxil and didn't know it, how many times did that happen?
A I'm not sure what you are talking about.

Q So if Ms. Johnson gets on the witness stand and says that's what happened, she's lying; is that right?
A Yes, that's not true. I'm not sure that would be her testimony.

Marcom, Tammy - Vol. 1, (Pages 99:23 to 101:14)

99

Q Is everything that's documented there correct? Is it true and correct or was Marnelle wrong?
A I would say that I definitely told her about what

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happened, and she worded it however she needed to, however she arranged it. There's some things that don't sound -- I don't think it -- I don't think it shows within that night that Tammy's behavior went from inappropriate to then illegal at that point. I think this doesn't really show that.
Q Well, it doesn't say -- you didn't tell Marnelle what you testified to here in court today if you pull this one out, I will tie your penis in a knot. That's not anywhere in here, is it?
A I don't see that in here, no.
Q And would you agree with me that two days after the incident, your recollection would be clearer than it is here in this courtroom today?
A Would I agree that my recollection would be more clear?
Q On February 8th.
A My recollection is clear today.
Q So you have no explanation for why this business about tying Mr. V's penis in a knot is not in your sworn statement and it's not anywhere in what you told Marnelle; is that correct?
A In my sworn statement I state that there are other details that are not included in this and I would be happy to talk about them. The Marnelle statement, there

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are not -- it is not included in there.
Q The other thing that's conspicuously missing, Ms. Porter, is that you claimed that you went and reported this immediately or that you tried to. That's not in any of your statements, is it?
A It is not stated in either one of these papers that I reported this. This was me reporting it.
Q Tell me where else I could look to find any evidence to corroborate what you are telling me right now, anywhere.
A I know that Angela witnessed me doing that; I

know that Brenda can tell you that I did that; I know that Cari can tell you that I did that, and Amber can tell you when I did that.

Marcom, Tammy - Vol. 1, (Pages 101:15 to 105:19)

101

Q Ms. Porter, when you left Midland Memorial Hospital, where did you go to work in July of 2014?
A For hospice.
Q You got fired from that job, didn't you?
A Yes, I did get fired from that job.
Q For falsifying patient visits; isn't that right?
A No.
Q Why did you get fired, Ms. Porter?
A A patient required something on a Saturday, and I didn't go do that on that Saturday that I was supposed to be working.

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Q So yet, again, you failed to meet the needs of a patient; is that right?
A No, that's not right. Again -- what did you say was your statement? I failed to meet the needs of the patient?
Q Again. On February 6th –
A I didn't return to that patient's home that day.
Q And you never went back into Mr. V's room to check on him the night of February 6th?
A No.
Q In the Midland Memorial Hospital system, is there a house supervisor on duty at night?
A Yes.
Q How do you access the house supervisor?
A I'm sure there is a number you can call. I don't remember anymore.
Q Have you ever had to call the house supervisor before?
A I'm sure I have for something.
Q But you didn't feel on this night that this was a sufficient emergency in your opinion to call the house supervisor, correct?
A I looked for my manager. I looked for a manager.
Q My question was: You did not call the house supervisor, did you?

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A I didn't call the house supervisor, no, I didn't.
Q Did you have a Nextel phone or some way of accessing Amber Branum who is your team leader that night?
A I'm not sure if I was assigned one that night.

Because of my location, they don't always give you one.
Q So you are a brand new nurse?
A I was a nurse for a year at this time.
Q So you got one year of experience?
A Uh-huh.
Q And you are working in an ICU?
A Correct.
Q And it's your testimony that you didn't have somebody in the chain of command that you could immediately access if you needed help?
A At that time, I did not. That's what I was looking for.
Q How many other nurses were on duty that night?
A I don't have any idea.
Q Could you flip back to Exhibit No. 8 with me, please?
A Okay.
Q Would you please turn to Page 56?
A Okay.
Q This has been represented as the assignments for the 7P to 7A shift on February 6th of 2014. Do you have

any reason to quarrel with that?
A No.
Q All right. When -- there's a name, and then there's -- do you see the line where it says, phone?
A Yes.
Q What is that?
A This would be an extension to the phone that I was assigned on that night.
Q So for Amber Branum, if you called 5023, you could get the team leader, correct?
A You could call the team leader.
Q Could you leave messages on that phone?
A I don't have any idea.
Q So for Angela Nielsen, 5029, how long was Angela Nielsen a nurse on this night?
A I don't know how long she was a nurse.
Q About the same as you?
A I don't have any idea how long she was a nurse.
Q How about Carl Haller?
A I know he's been there for a while; I don't know how long.
Q Courtney Lopez, do you know how long that person has been a nurse?
A No.
Q CJ Sterling, any idea?

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A No.
Q Denae Sims, any idea how long Denae has been a nurse?
A No.
Q Dino Reyes, do you know how long that person has been a nurse?
A Fairly new.
Q All right. How about Scott Turner?
A He's been a nurse for some time.
Q Justina Collum, how long has Justina been a nurse?
A I don't know.
Q How about Khristie Prince?
A For a very long time.
Q All right. So you did not try to talk to Khristie, Scott, Denae or Amber Branum about what you said was happening in that room; is that right?
A I attempted to speak to Amber Branum as the team leader about what happened.

The entire story truly makes no sense because if Mr. Turner was truthful about reporting to Ms. Branum and Ms. Johnson 15 minutes after the event, Porter and Nielson would still in the patient's room helping bathe the patient and reinsert a Flexiseal and change the linens and one or both of them would have immediately entered that room to rescue the patient.

EXCEPTION SECTION V. A. Your Honor states that Respondent's co-workers did not appear to have any ulterior motive to fabricate allegations against Respondent.

That analysis ignores the obvious culpability of Turner, Porter and Nielson in violating the Practice Act Rules and Regs and the Facility's very specific policy in failing to provide a safe environment of care and immediately reporting to prevent emotional or physical harm to a patient they claimed was abused in front of their own eyes which was an emergency according to their own Director Brenda Evans.

Vol. 3, (Page 142:1 to 142:3) BRENDA EVANS
Q Do you or do you not believe, as a registered nurse, that patient abuse is

an emergency?
A I agree it is.
Every nurse had a duty to that patient to promote a safe environment of care and to not cause or fail to prevent emotional or physical harm to any patient.

Marcom, Tammy - Vol. 1, (Pages 166:22 to 167:12) Stacey Cropley
Q And this testimony that we heard today by the various nurses of, oh, that's not my patient, I didn't have to do anything about that, that's not how the Board sees it; isn't that right?

167

A It depends on what you are inferring.
Q Are you aware of the Board's position statement, duty to a patient in any setting?
A Yes. But if you are referring to a nurse's duty to document or a nurse's duty to report?
Q Let's start with the nurse's duty to provide a safe environment.
A Absolutely.
Q The Board's position statement says that the particular assignment of a patient to a nurse isn't relevant, does it?
A That's correct.

Marcom, Tammy - Vol. 1, (Page 169:5 to 169:17)

169

Q (BY MS. HIGGINBOTHAM) The rules and regulations that you just cited, 217.11, that required documentation of the nursing process, that is not qualified by saying in an incident report?
A A nurse is responsible to document under 217.11(1)(D), completely report the client's status including their signs and symptoms, nursing care that has been rendered, physician, dentist or podiatrist's orders, administration of medications and treatments, the client's response and contact with other health team members concerning significant events regarding the client's status. It's not prescriptive about where that documentation occurs.

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Q Do you see that a nursing assessment was done by Kayla Melendez?
A Yes, I do.
Q And she was not assigned to this patient, correct; this was Ms. Marcom's patient?
A Apparently. I would have to go back and look at the roster again, but yes.

Marcom, Tammy - Vol. 1, (Page 56:12 to 56:19) **Scott Turner**

56

Q You are a registered nurse and you've been a registered nurse for how many years?
A 10 years, ma'am.
Q And you understand that it's your responsibility to take care of whoever happens to be in the environment of care, especially if you see someone who is in distress, correct?
A Right.

Marcom, Tammy - Vol. 1, (Pages 143:4 to 144:1) Angela Nielson

143

Q So is it your testimony, Ms. Nielsen, that you observed what is described in this courtroom to be a horrific event and –
A Yes.
Q -- did nothing until 24 hours later?
A I'm sorry?
Q You did nothing until 24 hours later?
A I guess you could say that. I don't know what I could have done to undo the words that she said. All I could do was report it to my manager what I had seen. I was not his nurse at the time; I don't know what kind of injuries he may have had that evening with Tammy as his nurse. I just know that I reported it the next night what I had seen, but I didn't feel that I was authorized to go in there and start assessing for injuries basically.
Q Are you aware, Ms. Nielsen, that it's a violation of the Nurse Practice Act to cause or allow emotional or physical harm to happen to a patient?
A I'm somewhat familiar with it now, just because of this incident.
Q Did you call your house supervisor that night for assistance to report this?

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A No.

Ms. Marcom testified that Ms. Porter failed to notice that her patient had experienced a cardiac arrhythmia and she notified her about it. Ms. Porter was incredibly hostile and argumentative on cross examination about that issue and denied "talking to Tammy about it" and then said she didn't

remember if it happened at all. (V 1 112:2-14) Porter's testimony was likewise self serving. With regard to their credibility and whether or not the three "eye" witnesses had a motive to fabricate the allegations, the record as a whole must be considered. According to Ms. Branum, the statements and stories of both Nielson and Porter changed several times and as evidenced extensively above, changed again in open court. Recall that every nurse had a duty to promote a safe environment of care to every patient in the environment without regard to who the assigned nurse was. The BONs expert testified specifically to that.

Q Let's start with the nurse's duty to provide a safe environment.
A Absolutely.
Q The Board's position statement says that the particular assignment of a patient to a nurse isn't relevant, does it?
A That's correct.

Recall that every nurse testified that they had a statutory duty to document and report any assessment intervention or care of a patient in the medical record. EVERY nurse testified to that including the BON's expert (Tr. V 1 166: 1-168:8). Recall that the hospital had a policy to stop the line (States Ex 7) as well as telephones to communicate to other nurses and their superiors. Recall that Brenda Evans stated that patient abuse was an Emergency and had to be reported. (Tr. V.3 142-1-3). The three nurses Turner, Nielson and Porter did nothing to provide emotional support, pain medication or even go back to check on a person who they each claimed to have witnessed in emotional and physical distress when they had not only a statutory duty as well as a work imposed requirement[2] to do so and do it immediately. (TR. V 1 102:8-103:1; TR V 1 56:15-

[2] Marcom, Tammy - Vol. 1, (Pages 59:2 to 60:5)

59
Q (BY MS. HIGGINBOTHAM) Sir, if you could pick up Exhibit No. 8 again or turn in that book to the tab.
A Okay.
Q Can you turn with me to Page 35? And they are paginated on the lower-right hand.

57:15; TR. V 1 91:9-92:20; TR. V 1 141:20-144:1; Tr. V3 143:6-9). Nor did these witnesses document ANYTHING in the records, call or notify management until one witness had a happenstance parking lot meeting that was reticent at best as described by the Ms. Branum first who spoke to her.

Marcom, Tammy - Vol. 2, (Page 70:3 to 70:24)

70

Q When you first -- let me strike that. When were you first approached by anybody about this alleged behavior in Room 547?
A Was walking to the car, all the way out to my -- in the parking garage, before anybody ever approached, said anything or made any inclination that anything was wrong or had happened that night.
Q All right. And who approached you?
A Nichole Porter.
Q And what was the demeanor of Ms. Porter when she approached you?
A Uncertainty. Not sure if she should talk to me; if what she was telling me was actually what she saw. Was -- it was that. It was -- well, very meek and timid. So

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A Okay.
Q Do you recognize this as the policy and procedure of Midland Memorial Hospital in effect on February 6th and 7th, 2014?
A Yes, ma'am.
Q And if we look at Bullet Point Number 3, disruptive behavior is described as "Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power." Did I read that correctly?
A Yes, sir.
Q "Such behaviors include reluctant or refusal to answer questions, return phone calls or pages, condescending language or voice intonation and impatience with questions." Did I read that correctly?

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A Exactly.
Q If we go to the last sentence, "All intimidating and disruptive behaviors are unprofessional and should not be tolerated."
A Yes, ma'am.

she just seemed very unsure of herself, and kept saying that, "I'm not sure, I'm not sure."
Q So she wasn't crying or frantic or upset?
A No.
Q Was she smoking a cigarette?
A Yes.
Q Was anybody with her?
A No.

Lest we forget the testimony of Mr. Turner, who in open court claimed he had already told both Branum and Johnson. The uncontroverted testimony of the Team Leader Amber Branum was that **if** in fact the event happened that the nurses in the room witnessing the event would have a responsibility to come to her or Cari Johnson **immediately** so the patient could be reassigned to someone else. (Tr. V.2 71:23-73:7). None of that happened. Moreover, these witnesses gave statements to their employer that were INCONSISTENT with their trial testimony where they claimed to have done all of those statutorily required tasks as licensed professional registered nurses.

Hence, the motive your honor is two-fold. First and foremost the Court took judicial notice of the Board's Statute and Rules. If a nurse fails to promote a safe environment of care to any patient; causes or fails to prevent emotional or physical harm to any patient or provides information that is false and misleading with regard to the practice of nursing, not only is the Nurse Practice Act violated, the minimum standards of practice and the professional conduct rules are also violated. When the three nurses made those statements, Midland Memorial was signing their paychecks, Brenda Evans is the Director Mr. Turner and Ms. Porter work for her. When a lawyer from the Board of Nursing who granted that nurse a license calls the witnesses up and starts the questioning process, how likely is it that any nurse is going to recant their earlier statement (which by the way has no support in the medical records) and admit to the BON lawyer that the statement they gave under oath is a lie? I submit that the answer to that question is NEVER. What we have here is

obviously deliberate ignorance by the BON of the facts of that night because they picked the horse they were going to ride no matter what the truth is. And so it goes and the witness ends up being subpoenaed to testify and again is put in the position of having no choice but to continue the lie. It should not be lost on this Court that the response of Brenda Evans to the testimony of anyone and everyone who didn't support her investigation was that they were in some form or fashion "liars".

Denae Sims wasn't lying about being afraid to tell the truth and quitting her job for fear of reprisal.

Marcom, Tammy - Vol. 3, (Pages 23:22 to 25:23)

Q (BY MS. HIGGINBOTHAM) Why did you decide to leave?
JUDGE CARD: Are we talking 2014?
Q (BY MS. HIGGINBOTHAM) 2014.

24

A I believe '14. When I first started with the people that I started with, they taught me an incredible amount, and we had wonderful teamwork. We really worked well together and got to do some amazing things together. And as time went on, with management changes, it just had become a very hostile environment. I felt unsafe in trying to care for patients, and I also felt like at any moment I could be targeted, and I didn't want to stay in a facility that I felt like my license could be on the line. I did not feel like I could express myself to my director and did not agree with certain circumstances that were happening at the time at all.

Cari Johnson and Nicole Porter's testimony is diametrically opposed about how many times as well as what was discussed that night. (Tr. V2 134:24-135:16). Your Honor's comment in analysis that Ms. Porter's story was "bolstered by the undisputed fact that she attempted to speak with Ms. Johnson in the manager's office shortly after the incident occurred" fails to take into account the close personal friendship Porter and Johnson, in addition to the numerosity as well as the very personal nature of the previous ongoing discussions that night which would cause Porter to not

enter Johnson's office again when she saw Brenda Evans there. Johnson testified that she and Nicole Porter were friends, and as she described it "close" "I mean very close" (Tr. V 2 106:7-108:3). On the other hand, Ms. Porter was evasive about her contact with Cari Johnson that night and when asked if what Ms. Johnson would say about the number and nature of their personal interactions that night, she hedged. **(TR. V 1 96: 11-21)**

Q Ma'am, if your managers say that they saw you several times that night and you said not one word about this until the parking lot, are they lying?
A That is not the truth. The very next time I saw a manager, it was reported to the manager.
Q So when you were sitting in Cari Johnson's office talking about your divorce and the fact that you had been off your Paxil and didn't know it, how many times did that happen?
A I'm not sure what you are talking about.
Q So if Ms. Johnson gets on the witness stand and says that's what happened, she's lying; is that right?
A Yes, that's not true. I'm not sure that would be her testimony.

Denae Sims saw both Cari and Nicole in Cari's office and also observed Ms. Nielson and Mr. Turner.

Marcom, Tammy - Vol. 3, (Pages 11:21 to 14:4) DENAE SIMS

11

Q Did you have contact with Nichole Porter that night?
A I believe I did.
Q Do you know when?
A I would say later, maybe 4:00 a.m.

12

Q Tell me about that.
A We -- I believe we both had gone into Cari Johnson's office. Nothing specific in conversation, just, I would say, talk about life.
Q When you say "talk about life," any specific topics that you recall?
A She was going through a divorce at the time and, I believe, a custody battle.
Q Did she ever say anything about concerns

regarding Tammy Marcom's care of any patient that night?
A No. There was no conversation over patients or care in that office.
Q What was her demeanor? Was she tearful?
A I would say she was emotional, as she spoke about what was going on in her life at the time.
Q How long did that interaction in Cari Johnson's take?
A I would say maybe 15, 20 minutes.
Q During that time period, did anybody else come into Cari Johnson's office?
A No. Not while I was in there, no.
Q Did you see Ms. Porter after that for the rest of the shift?
A I don't believe I saw her until we were getting ready to leave at the end of work.

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Q Did she say anything to you then about concerns over Tammy Marcom's behavior in the unit?
A No.
Q What was her demeanor at the end of the shift?
A I believe the same, just emotional but ready to go home after work.
Q Was she still talking about her personal life?
A Yes.
Q Did you see Angela Nielsen during that shift?
A I did.
Q When?
A Probably every time I went over to the hook side from where I was at. She had patients over there.
Q All right. Did she express any concern to you about Tammy Marcom's care of any patient that evening?
A No, ma'am.
Q What was Angela's demeanor that night?
A Pretty normal. I mean, I wouldn't say she was in a bad mood or emotional or anything like that, just in work mode.
Q All business, essentially?
A Yes.
Q Did you have the opportunity to see Scott Turner that night?
A I did. He was working, I believe, in the hook as well.

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Q Did he make any comment to you about Tammy Marcom's behavior in the unit that evening?
A No.

Angela and Nicole were seen together leaving to smoke or take breaks by managers.

Marcom, Tammy - Vol. 2, (Pages 73:8 to 74:18)

73

Q You said that while you were in the hook, you noticed that Ms. Porter and Ms. Nielsen were not where they were supposed to be. Do you know where they were?

A Unfortunately, as a team leader and running the floor, I can't leave the floor. So to go look for them is inappropriate, but you can ask around. And a lot of times -- we are supposed to give a little report when we leave the floor so that their patients can be properly cared for, because it's considered patient abandonment, which, it was my understanding, did not happen.

But there were several times we were off the floor, smoking. Angela had had extracurricular activities at work several times.

MR. LEGRIS: Objection.

THE WITNESS: I'm sorry.

MR. LEGRIS: This is, once again, the attempt of the Respondent, through this witness, to impugn the character of one of Staff's witnesses, impermissibly.

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As opposed to focusing on the character of a witness for truthfulness or untruthfulness, there's an attempt about to be made, perhaps, based upon what I hear here, to besmirch the morals, perhaps, of the witness or the integrity of the witness. She's about to talk about extracurricular activities. Based on -- I just would object to her answering that particular question that way.

MS. HIGGINBOTHAM: I think she gets to explain her answer. I asked her where were they?

JUDGE CARD: Well --

MR. LEGRIS: She doesn't know.

JUDGE CARD: If you have personal knowledge of where they were, you can answer. Otherwise I will sustain.

THE WITNESS: Okay. When I asked where they were, I was told by two different nurses that they were probably off the floor, smoking.

JUDGE CARD: Okay.

Your Honor commented on the evidence of how much Ms. Porter may have been off the floor smoking as a "red-herring" (Tr V 3 143-22-144:2). Leaving an assignment without getting coverage for patients is patient abandonment and another violation of Board Rules.

So yes, there is plenty of not only motive for but proof of untruths. Recall that Tammy "fussed at" Nicole about calling the doctor for a patient with a change in cardiac rhythm. (Tr V 3 103:10-104:10).

There was ample evidence that Tammy Marcom was a nurse who held others accountable for caring for patients and Nicole Porter knew it.

EXCEPTION SECTION V. A. Your Honor goes on to state that "Although Respondent denied the charges it was in her self interest to do so.

The testimony of a Petitioner and a Respondent is by its very nature "self-serving" but that does not make it inherently unreliable, especially if it is consistent and unimpeached. Consideration of all of the testimony and development of the record produces a sound basis for making a credibility determination. In this case every one of Staff's witnesses was impeached with prior inconsistent statements. Not only was Ms. Marcom's testimony consistent, it is unrefuted in the medical record which is the legal record of care of Mr. V. and corroborated by the witnesses Cari Johnson, Amber Sanchez, Amber Branum and Denae Sims. Your Honor made no factual determinations about why Ms. Marcom's testimony was not credible save and except for the self serving reason. This fails to take into account the corroboration of her testimony by 963 pages of medical records, the patient's own statements about the care he had gotten that shift within 14 hours of these alleged events as well as the testimony of the witnesses that stand uncontroverted.

EXCEPTION SECTION V. A. Your Honor ascribed no weight to the results of the rounding report conducted by Ms. Sanchez the day after this event stating "although Mr. and Mrs. V.

did not complain about their treatment at the Hospital, the questions asked in the survey were very broad and did not relate specifically to the events of February 6-7.

Ms Amber Sanchez who was the clinical manager for Midland Memorial Hospital specifically utilized a hospital created business record for the purpose of investigating the allegations made against Tammy Marcom less than 18 hours after the alleged events.

Marcom, Tammy - Vol. 2, (Pages 37:17 to 38:7)

37

Q All right. And explain to the Administrative Law Judge how that report came about?
A After I had heard, as far as, like, hearsay, what had happened, at the time we were doing rounds on a rounding app that the hospital used. There were different sets of -- you could go into different categories under Critical Care. And the one I had chose was Patient Experience, are specific questions. It's a scripted question, and you supply the answers. So I thought,

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ideally, it's -- they want us to round on every patient every day. Some of what day shift doesn't get done, we try to get done at night before it gets too late.
I knew I needed to make it in this room and do a rounding. That way if there was anything they could tell me that maybe Mr. V had told his wife or something that he could state at the time, it would at least come up, so –

Ms. Sanchez used the specific format as well as an interpreter to give Mr. and Mrs. V. the opportunity to speak openly "if there was anything he needed to state or his wife needed to state, you know that could at that time; especially feeling more comfortable with someone speaking Spanish to them. (Tr.V.2 40: 12-19). When asked why she did not ask about the specific incident Ms. Sanchez was very clear in her response "Because I at that time---so everything was hearsay, you know. I wasn't there at that time. You know, I thought that this was an opportunity to open up the door to have him state something, you know, or his wife, possibly, if they knew anything. (Tr.V.2 46:9-16). Someone needed to attend to that patient and determine of in fact the events

occurred and Ms. Sanchez utilized a hospital procedure to accomplish it. Ms. Evans was missing in action.

Your Honor misses the point that the most important person in that room the patient himself had no complaints about his care and treatment provided by Tammy Marcom or anyone else. Id.; accord testimony by Brenda Smith who did an investigation that did not include the patient and his wife. (Tr. V3 124:20-135:20). Ms. Evans did not deny the substance of the Rounding Report's contents which is specific discourse by the facility with the patient who was alleged to have been abused. Asking open ended questions such as those asked gives much more opportunity for the person being asked to give full, open honest answers. In determining the greater weight of credible testimony, the testimony of a single witness, and in this case the alleged victim, gave sufficient credibility to establish that the ultimate facts were favorable to Tammy Marcom and corroborated. Not only was information in the rounding report unrefuted, the medical records at Staff's Exhibit 10 ((Staff's Ex.10 188-195 PHYSICIAN DOCUMENTATION and EX 10 204-212; 222-226; 276-283; 290) are very clear and corroborate what is in that rounding report that the patient had no complaints of pain when assessed again during that shift, that was the case when he was seen immediately by another nurse, one of his physicians said "the patient looks considerably better today" Id. At 188. He was alert and oriented and the only medication for pain was Tylenol IV. Id at 190. If your Honor had not overruled the objection based on what the expert reviewed as the factfinder he would have learned that Mrs. V. was in fact questioned specifically about the allegations made on February 6 and 7 and she did not waiver in her assertion about what she and her husband recalled told Amber Sanchez and Mr. Esteban Barrientos the interpreter about the care her husband received was true and that she had no knowledge of anyone cursing at or harming her husband.

EXCEPTION ANALYSIS D. Staff's Rebuttal Evidence Brenda Evans

Marcom, Tammy - Vol. 1, (Page 24:17 to 24:20)

24

17 **MR. LEGRIS: And Exhibit No. 8 for**
19 **departmental records from Midland Memorial Hospital**
20 **consisting of 60 pages, certified by Brenda Evans**

Ms. Evans was the Board's investigative contact in this case (Tr. V 2 28:14-18) and was not only extremely evasive and frankly nonresponsive on cross examination (Tr. V.3 137:1-162:17), her sole purpose in testifying was only to bolster her "investigation" and cast aspersions on the witnesses Branum, and Johnson opining that they are not truthful people and should not be believed even though they were under oath. She also stated that she believed that Ms. Sanchez was "challenged with telling the truth". She had to say that to try and discredit the rounding report. The most incredible part of her entire testimony came from her begrudging acknowledgement that the "Rounding Report" (Respondent's Exhibit 9) was an official hospital record that Ms. Evans left out of the Staff's Exhibit 8 of Departmental records on purpose but that a manager Amber Sanchez was not authorized to use it. Given the fact that Evans was the BON's contact for all of the investigative materials delivered to the BON in response to subpoenas in this case, the fact that she sent more than a thousand records to the BON save and except that one speaks volumes. She went to great length to excuse Turner's, Porter's and Nielson's complete and total failure to follow the Nurse Practice Act Rules and Regulations and Hospital Policy (Tr. V3 156:24:157:11). She tried to disavow her own affidavit and emails. (Tr. V3 7-148:24). The BON tried to shield her bias by objecting vigorously to the revelation of her identity as the person providing the materials to the BON through yet more speaking objections. (Tr. V.2 26:11-28:18). Her "investigation" incredibly never included talking to the patient or his family or following up in any way to ensure that the alleged harm was rectified. (Tr. V3 124:20-135:20). When a party with special knowledge of a disputed issue fails, without explanation, to testify about that issue, a judge may

infer that the party knew its testimony would not support its claim. *Thompson v. Deloitte & Touche, L.L.P.*, **902 S.W.2d 13**,18 (Tex. App.--Houston [1st Dist.] 1995, no writ). Evans claims she did an investigation and had special knowledge of what the patient himself as well as his wife had to say about whether or not he was harmed emotionally or physically. She testified that the patient was on a ventilator when in fact he was not, which is why he could speak to Angela Nielson, Tammy Marcom and Amber Sanchez. But Brenda said the patient was "vented" but had "tears in his eyes" (which just so happens to match Scott Turner's statement that the patient was on a ventilator during that shift when he was not because he could speak to Amber Sanchez and his doctors who described him as on a nebulizer and awake and alert. (Staff's Ex 10 p 188-195).

Marcom, Tammy - Vol. 1, (Page 126:3 to 126:8) Nielson

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Q So the night before, you had a conversation with the patient, you chitchatted with him, you got to know each other?
A Yes.
Q Did he speak English then?
A Yes, he did.

EXCEPTION FINDING OF FACT 14 15 and 18 and CONCLUSION OF LAW 5, 7, 8 and 9. Respondent objects to this Finding as it is not supported by a preponderance of credible evidence (see all of the above Exceptions for rationale referenced herein and included for every purpose as if sited verbatim) based on the unreliability and inconsistent testimony of Scott Turner, Angela Nielson and Nicole Porter compared to the testimony of Tammy Marcom, Denae Sims, Amber Branum, Amber Sanchez and Cari Johnson about what happened that night as well as the inability of Respondent to fully examine Dr. Cropley. Evidentiary facts must first be established by applying the rule of credibility to the witnesses. *Consolidated Edison Co. v. NLRB*, 305 U.S. 197 (1939) (holding that such evidence is what a reasonable mind might consider to as adequate to

support a conclusion). The APA establishes a basic format for "fact" review by stating that findings, inferences, conclusions or decisions must be reasonably supported by substantial evidence looking at "reliable and probative evidence in the record as a whole." TEX. GOV'T CODE ANN. § 2001.174(2)(E) (West 2015).

EXCEPTION FINDING OF FACT 15 and CONCLUSION OF LAW 5 , 7, 8 and 9. Respondent objects to this Finding and its accompanying Conclusion of Law as not supported by a preponderance of credible evidence (see all of the above Exceptions for rationale referenced herein and included for every purpose as if sited verbatim) based on the unreliability and inconsistent testimony of Scott Turner, Angela Nielson and Nicole Porter compared to the testimony of Tammy Marcom, Denae Sims, Amber Branum, Amber Sanchez and Cari Johnson about what happened that night as well as the inability to fully examine Dr. Cropley. Evidentiary facts must first be established by applying the rule of credibility to the witnesses. *Consolidated Edison Co. v. NLRB*, 305 U.S. 197 (1939) (holding that such evidence is what a reasonable mind might consider to as adequate to support a conclusion). The APA establishes a basic format for "fact" review by stating that findings, inferences, conclusions or decisions must be reasonably supported by substantial evidence looking at "reliable and probative evidence in the record as a whole." TEX. GOV'T CODE ANN. § 2001.174(2)(E) (West 2015).

EXCEPTION FINDING OF FACT 16 and 17 and CONCLUSIONS OF LAW 6,7,8 and 9. Respondent objects to these Findings and its accompanying Conclusions of Law as it is not supported by a preponderance of credible evidence (see all of the above Exceptions for rationale referenced herein and included for every purpose as if sited verbatim) based on the unreliability and inconsistent testimony of Scott Turner, Angela Nielson and Nicole Porter compared to the testimony of Tammy Marcom, Denae Sims,

Amber Branum, Amber Sanchez and Cari Johnson about what happened that night as well as the inability to fully examine Dr. Cropley. Evidentiary facts must first be established by applying the rule of credibility to the witnesses. *Consolidated Edison Co. v. NLRB*, 305 U.S. 197 (1939) (holding that such evidence is what a reasonable mind might consider to as adequate to support a conclusion). The APA establishes a basic format for "fact" review by stating that findings, inferences, conclusions or decisions must be reasonably supported by substantial evidence looking at "reliable and probative evidence in the record as a whole." TEX. GOV'T CODE ANN. § 2001.174(2)(E) (West 2015).

EXCEPTION FINDING OF FACT 17 and 18 and its accompanying Conclusions of Law 6,7,8 and 9. Respondent objects to these Finding as it is not supported by a preponderance of credible evidence (see all of the above Exceptions for rationale referenced herein and included for every purpose as if sited verbatim) based on the unreliability and inconsistent testimony of Scott Turner, Angela Nielson and Nicole Porter compared to the testimony of Tammy Marcom, Denae Sims, Amber Branum, Amber Sanchez and Cari Johnson about what happened that night as well as the inability to fully examine Dr. Cropley. Evidentiary facts must first be established by applying the rule of credibility to the witnesses. *Consolidated Edison Co. v. NLRB*, 305 U.S. 197 (1939) (holding that such evidence is what a reasonable mind might consider to as adequate to support a conclusion). The APA establishes a basic format for "fact" review by stating that findings, inferences, conclusions or decisions must be reasonably supported by substantial evidence looking at "reliable and probative evidence in the record as a whole." TEX. GOV'T CODE ANN. § 2001.174(2)(E) (West 2015).

EXCEPTION FINDING OF FACT 18 and its accompanying Conclusion of Law. Respondent objects to this Finding as it is not supported by a preponderance of credible

evidence (see all of the above Exceptions for rationale referenced herein and included for every purpose as if sited verbatim) based on the unreliability and inconsistent testimony of Scott Turner, Angela Nielson and Nicole Porter compared to the testimony of Tammy Marcom, Denae Sims, Amber Branum, Amber Sanchez and Cari Johnson about what happened that night as well as the inability to fully examine Dr. Cropley. Evidentiary facts must first be established by applying the rule of credibility to the witnesses. *Consolidated Edison Co. v. NLRB*, 305 U.S. 197 (1939) (holding that such evidence is what a reasonable mind might consider to as adequate to support a conclusion). The APA establishes a basic format for "fact" review by stating that findings, inferences, conclusions or decisions must be reasonably supported by substantial evidence looking at "reliable and probative evidence in the record as a whole." TEX. GOV'T CODE ANN. § 2001.174(2)(E) (West 2015).

EXCEPTION FINDING OF FACT 19.

CONSIDERATION OF PERSONNEL RECORDS OF Ms. MARCOM THAT PREDATED HER NURSING LICENSURE IS ERROR. This was objected to as violative of Rule of Evidence 404b and overruled inappropriately.

RULE 404: CHARACTER EVIDENCE NOT ADMISSIBLE TO PROVE CONDUCT; EXCEPTIONS; OTHER CRIMES (a) Character Evidence Generally. Evidence of a person's character or character trait is not admissible for the purpose of proving action in conformity therewith on a particular occasion, except: (1) Character of accused. Evidence of a pertinent character trait offered: (A) by an accused in a criminal case, or by the prosecution to rebut the same, or (B) by a party accused in a civil case of conduct involving moral turpitude, or by the accusing party to rebut the same; (2) Character of victim. In a criminal case and subject to Rule 412, evidence of a pertinent character trait of the victim of the crime offered by an accused, or by

the prosecution to rebut the same, or evidence of peaceable character of the victim offered by the prosecution in a homicide case to rebut evidence that the victim was the first aggressor; or in a civil case, evidence of character for violence of the alleged victim of assaultive conduct offered on the issue of self-defense by a party accused of the assaultive conduct, or evidence of peaceable character to rebut the same; (3) Character of witness. Evidence of the character of a witness, as provided in rules 607, 608 and 609. (b) Other Crimes, Wrongs or Acts. Evidence of other crimes, wrongs or acts is not admissible to prove the character of a person in order to show action in conformity therewith. It may, however, be admissible for other purposes, such as proof of motive, opportunity, intent, preparation, plan, knowledge, identity, or absence of mistake or accident, provided that upon timely request by the accused in a criminal case, reasonable notice is given in advance of trial of intent to introduce in the State's case-inchief such evidence other than that arising in the same transaction.

Plaintiff's testimony about what happened in Mr. V's room stands uncontroverted. Moreover, the medical records which are State's Exhibit 10 were not controverted in any way by any witness and support Plaintiff's version of the facts.

The Board's disciplinary Matrix sets forth the "C" factors to be utilized, which include *prior discipline by the Board*, not extraneous offenses contained in a personnel record that have nothing to do with the practice of nursing especially when they occur before a nurse was even licensed. Looking at an entire employment history to uncover some "dirt" to tarnish credibility at trial, in violation of Tex. R. Evid 404(b).

Personnel records

Marcom, Tammy - Vol. 1, (Pages 26:8 to 28:12)

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MR. LEGRIS: Thank you.
JUDGE CARD: And I think Page 2 is kind of stuck on the back, but we will all agree to ignore it.

MR. LEGRIS: Thank you, sir.

Next, Your Honor, we have as Staff's Exhibit 9 for identification, the personnel records of the Respondent consisting of 294 pages. And we would argue that the personnel records of the Respondent are relevant to an ultimate determination by Your Honor concerning any sanction to be imposed in this case, are relevant for purposes of the expert witnesses' analysis, as well. Because under the Board's rules, in particular, I believe it's Rule 213.33, Sub C, the Administrative Law Judge and the ultimate Board of Nursing that makes determinations in these cases must consider a number of other factors, as well as whether or not the Respondent is found to have committed the allegations or the violations, I should say, in the charges.

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And so we sometimes refer to these in our day-to-day practice as the C factors for that particular subparagraph. But the C factors involve things such as evidence of the Respondent's prior nursing practice, evidence of practice history, present fitness to practice, length of time the person has practiced, et cetera. These are found again at Board Rule 213.33 at the conclusion of the Board's disciplinary matrix, Subparagraph C. And there are 18 of those factors.

So it's -- I would submit -- similar to an employment law case, it's almost impossible for an expert witness to make an informed recommendation as to sanction without adverting to Ms. Marcom's prior history as reflected in her personnel records, whether that history reflects positive evaluations or the occasional counseling or negative comment from a supervisor.

So Staff will offer all 294 pages at this time.

MS. HIGGINBOTHAM: Your Honor, let me say that a lot of this is 404(B) evidence, but at the same time, we are talking about charges that the Board of Nursing has not brought based on what's in these records. So for them to pile on now and say, this is proof that you are a bad girl and we need to really punish you now, now we are sliding down the slope into Rule 406. And when we

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look at all the investigation that Ms. Roque did, if Mr. Legris wants this in, the door is wide open, and we are going to drive an 18-wheeler through it with evidence of her habit, of her character in the community, how her peers saw her, how other people who worked with her, their

opinion of her nursing practice.
So with that understanding, I don't have any objection.
JUDGE CARD: I guess we will cross that bridge when we come to it. 9 is admitted.

EXCEPTION FINDING TAMMY MARCOM CAUSED EMOTIONAL OR PHYSICAL PAIN TO THE PATIENT

See all of the above Exceptions for rationale referenced herein and included for every purpose as if sited verbatim.

Marcom, Tammy - Vol. 3, (Pages 22:8 to 23:7) DENAE SIMS
Q Despite the best efforts to be gentle, sometimes we cause patients discomfort. Would you agree with that?
A I do. I agree.
Q Would you agree that most everything we do to people when they're in the hospital is not comfortable for them?
A I would agree.
Q Putting in IVs, giving shots --
A Absolutely.
Q -- shocking people, turning them when they don't feel like turning, all those things are uncomfortable, aren't they?
A Absolutely. Even though they are ultimately for their benefit, it's still very, very uncomfortable.
Q This gentleman, Mr. V, during the two months that he was in the hospital, how many times do you think you were in his room, either caring for him yourself or helping with him?

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A Several times. I charged quite a bit then. And whether I was on that side or not, I did have to round, check on everybody. And we all had to work as a team to make sure all the patients were taken care of. So I personally had him as a patient a couple of shifts, and then assisted several times, whether it be cleaning him up or inserting -- reinserting a Flexi-Seal.

Marcom, Tammy - Vol. 1, (Pages 109:4 to 110:12) NICOLE PORTER

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Q And you are aware that after that device is placed, there's a balloon that's filled up with almost two

ounces of water?
A There is a retention pouch that holds 45 at the max.
Q All right. And one ounce is 30 CCs, correct?
A Right.
Q So it's an ounce and a half of fluid?
A Yes.
Q And if a patient is to pull that out, do you believe that would cause the patient pain if that device -- if the retention device was still inflated?
A It would depend on their muscle tone, but yes.
Q Did you know that Mr. V had his first Flexi-Seal inserted during the day shift of February 6th?
A I don't have any idea when he got the first Flexi-Seal.
Q That would be important for you to know how traumatized his anal/rectal region would be; would you agree with that?
A What would be important to know? When he received the first one?

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Q How many times this had been -- this procedure had been done to him to cause him discomfort? You didn't know, did you?
A I don't feel that's important.
Q And do you have an opinion in your nursing judgment about whether chronic diarrhea with an ulcer on the buttocks can be painful to a patient?
A I'm sure that that's painful.
Q And you didn't assess Mr. V to determine if he had any of those conditions, did you?
A No. I assisted holding the patient so Tammy could place the Flexi-Seal.

The patient had an existing care plan (Ex 10 page 483 began on 1/08/2014) noting that he had unresolved pain and was on IV Tylenol and had difficulty maintaining his oxygen levels for which he was on a *bipap*[3] machine. He did not tolerate turning, plus how painful it was for him to move and hold himself due to his fluid filled upper extremities. (Tr. V. III 32-112:13; accord Ex. 10 page 179.) No further incidents occurred with Mr. V. during shift report, where Ms. Marcom

[3] This patient was not on a ventilator Cf Brenda Evans " Tr V 3 156:24-157:11; accord Scott Turner's statement R-1.

advised Kareena Tucker RN, the nurse taking over patient care for the morning, that patient had pulled out flexiseal and has been shifting himself down in bed multiple times pulling on the flexiseal. (Tr. V. III 32-112:13). Kareena expressed "Yes he does that all the time." (Tr. V. III 32-112:13). Ms. Marcom also advised Ms. Tucker that the patient was uncomfortable after pulling out his flexiseal and having it reinserted. She not only documented all of her care, she reported to the oncoming shift what had transpired over her shift and alerted the nurse to address pain management with the doctor if the IV Tylenol wasn't holding Mr. V. (Tr. V. III 32-112:13). The patient was physically seen by Dr. Oliver at 0740 in the morning and no pain was noted and no pain medication was prescribed; the IV Tylenol that was already being given was not changed. (Staff's Ex. 10 pages 181-187).

Marcom, Tammy - Vol. 1, (Pages 172:17 to 173:18)

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Q And we talked about the pain that this gentleman was having. If you could turn with me to Page 276.
A Okay. I am there.
Q Up at the top of this page, it says, there is an ulcer to the left buttocks, stage is a 2, clean and dry, intact.
A Uh-huh.
Q And your experience as a nurse and as a manager, do patients experience pain when they have break down on

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their buttocks area and they are laying on their back?
A Yes.
Q Are you aware that in report, Ms. Marcom notified her oncoming RN that she felt that this patient may need pain medication?
A I'm not aware of that.
Q If the records indicate that, would you have any reason to doubt it?
A No, I wouldn't have any reason to doubt that if it's in the record.
Q Did you know that this patient was not on any pain medication at all?
A I didn't see any pain medication administered.
Q And you haven't heard Ms. Marcom about her discussions with the physicians about why they didn't want

16 to give this man medication?
17 A No, I didn't have the opportunity to hear her
18 testimony.

Dr. Cropley did read all 963 pages of Staff's Exhibit 10 which is the medical records that clearly indicate that there is nothing documented about this patient having pain that was not caused by his other premoribid conditions as well as him pulling out a Flexiseal with a balloon that was inflated with 1.5 oz of water and a bed sore on his buttocks. The records at Staff's Ex 10 speak for themselves and corroborate Ms. Marcom's testimony.

EXCEPTION REQUEST FOR FINDINGS OF FACT BASED ON THE RECORD. If the Court resists deleting Findings of Fact 14-19, Respondent requests that the following findings be added:

20. Scott Turner had a duty to provide a safe environment of care for Patient Mr. V.

21. Angela Nielson had a duty to provide a safe environment of care for Patient Mr. V.

22. Nicole Porter had a duty to provide a safe environment of care for Patient Mr. V.

23. Scott Turner had a duty to prevent emotional or physical harm to Patient Mr. V.

24. Angela Nielson had a duty to prevent emotional or physical harm to Patient Mr. V.

25. Nicole Porter had a duty to prevent emotional or physical harm to Patient Mr. V.

26. Scott Turner had a duty to document assessment and interventions for Mr. V. in accordance with 22 TAC 217.11 (d).

27. Angela Nielson had a duty to document assessment and interventions for Mr. V. in accordance with 22 TAC 217.11 (d).

28. Nicole Porter had a duty to document assessment and interventions for Mr. V. in accordance with 22 TAC 217.11 (d).

EXCEPTION COSTS FINDING

See all of the above Exceptions for rationale referenced herein and included for every purpose as if cited verbatim which would exonerate Ms. Marcom.

Staff submitted evidence of its costs in this case as Exhibit 12 and Respondent objected. Mr. Legris was never cross-examined on the reasonableness or necessity of the costs that were

ultimately submitted that included things such as a wardrobe for Mr. Scott Turner, clothing for Ms. Porter and food and lodging for Ms. Evans ***and her two children***. There is a state per diem for expenses and personal care items and clothing are most certainly not included.

Staff expecting reimbursement for clothing a witness (shirt, tie, pants, socks and shoes for Mr. Turner; other clothing items for Ms. Porter to include swim coverup) should shock the conscience of any tribunal reviewing this case.

It is one thing to say that a losing party should have to pay administrative costs because it refused to settle a case and forced an Agency to litigate and prove the Charges to waste time. It is quite another to force a licensee to pay the costs in a case that was hotly contested for years to begin with and culminated in an orchestrated mistruth that included literally "dressing up" witnesses and staging testimony.

We are back to credibility; the evidence presented to this Court by Staff was an orchestrated production right down to the wardrobing of the witnesses.

REOPENING THE RECORD TO INLCUDE RESPONDENT'S FOUR RESPONSES TO DISCLOSURES

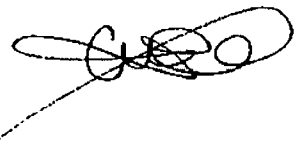
In the interest of fairness, Respondent should be able to reopen the record and examine the Board's expert on what she testified that she reviewed before her testimony was contradicted by speaking objection. In the alternative, Respondent should be able to submit that information to this Court as the harm that has occurred must be rectified and a complete record be made given the Court's commentary about the rounding report above.

PRAYER

Because there is not a preponderance of credible evidence supporting any of the findings of fact that Tammy Marcom verbally emotionally or physically abused Mr. V., an amended PFD based on all of the evidence should issue and Ms. Marcom be relieved of any proposal for discipline or monetary fine or imposition of costs.

Respectfully submitted,

HIGGINBOTHAM & ASSOCIATES LLC



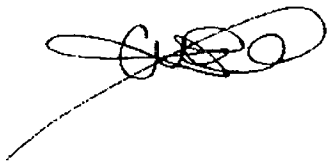
By: _____

Elizabeth L. Higginbotham, RN, JD
State Bar No. 00787694
One Castle Hills
1100 N.W. Loop 410, Suite 700
San Antonio, Texas 78213-2256
Tel. (210) 366-8871
Fax (866) 250-4443

ATTORNEY FOR RESPONDENT

CERTIFICATE OF SERVICE

This is to certify that a true and correct copy of the foregoing instrument has been forwarded to Mr. John Legris, Assistant General Counsel for Petitioner via Facsimile (512) 305-8101 and U.S. First Class Mail on December 23, 2016.



_____

ELIZABETH L. HIGGINBOTHAM, RN, JD

SOAH DOCKET NO. 507-15-0748

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE	§	
NUMBER RN 706387	§	OF
ISSUED TO	§	
TAMMY JEANETTE MARCOM	§	ADMINISTRATIVE HEARINGS

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

COMES NOW, Staff of the Texas Board of Nursing (hereinafter "Staff" or "Board"), and files this, *Staff's Response to Respondent's Exceptions to the Proposal for Decision* (PFD) in the above-styled matter.

I.

Respondent's first Exception is that she was denied the ability to obtain all the data that Dr. Cropley testified she had reviewed in accordance with the rules of evidence. As a result, Respondent requests reopening of the record to include Respondent's four (4) responses to Staffs Request for Disclosure. Dr. Cropley initially testified that she had seen and reviewed Responses 1 through 4 of the Respondent to Staff's Request for Disclosures. She later corrected herself indicating that she had seen Responses 1 through 3 (See Transcript Vol. 1, page 178, lines10-12). Respondent's Fourth Supplemental Response was dated April 14, 2016. It contained information concerning Respondent's expert witness, Ms. Roque, including Ms. Roque's case notes, as well as a CD containing Ms. Roque's witness interviews. Respondent's Fifth Supplemental Response was dated May 6, 2016, and contained typed transcripts of Ms. Roque's interviews as set forth on the aforementioned CD.

II.

Dr. Cropley clearly testified that she had seen Responses 1 through 3 and further stated: "I have not seen anything related to the disk and the witnesses that Ms. Roque has spoken with," (Transcript Vol 1, page 178, lines 10-12). Dr. Cropley also testified that she had not listened to any of the recordings (Transcript Vol 1, page 176, lines 5-7). Since Responses 1 through 3 were provided to Staff by Respondent's counsel, Respondent's counsel obviously had ample opportunity to review these materials prior to providing them to Board Staff. Moreover, Respondent's counsel did have an opportunity to cross-examine Dr. Cropley concerning these materials during the hearing. Thus, there is no basis for Respondent's claim that she was denied access to everything reviewed by Dr. Cropley and there is no basis for reopening the record at this time.

III.

As counsel for the Respondent points out in her Exceptions, the resolution of this case depended upon the Administrative Law Judge's (ALJ's) assessment of the credibility of the witnesses. Counsel for Respondent continues to argue that Staff's three key witnesses, Scott Turner, Nichole Porter, and Angela Nielsen, were impeached at the hearing by their prior "inconsistent"statements. This assertion is obviously incorrect. The prior statements of these three witnesses may not have been identical with their trial testimony, but they were not inconsistent. The ALJ's assessment of credibility in the PFD is correct. These three Staff witnesses testified truthfully.

IV.

The vast majority of Respondent's Exceptions are nothing more than a reiteration of Respondent's Closing Arguments. Staff would submit that those Arguments were not persuasive when first reviewed by the ALJ; they remain unpersuasive today. Staff would argue that the ALJ's

Findings of Fact Nos. 14, 15, 16, 17, 18, and 19 are correct and should remain unchanged. Staff would argue further that Conclusions of Law Nos. 5, 6, 7, 8, and 9 are correct and should remain unchanged.

V.

Specifically, with regard to Finding of Fact No. 19, Respondent argues that she objected at trial to the ALJ's consideration of personnel records of Ms. Marcom's behavior which occurred prior to her licensure as a nurse. Although overruled by the ALJ at the hearing, Respondent still argues that consideration of this material violated Texas Rule of Evidence 404(b). Staff would respond that the information submitted from the Respondent's personnel records included evidence of the Respondent's behavior as a nurse at Midland Memorial Hospital, as well as evidence of her behavior at the very same facility, Midland Memorial Hospital, in a different capacity. Staff would submit that this evidence was not offered to prove that the Respondent, Ms. Marcom, acted in conformity therewith on the occasion set forth in the Formal Charges, but rather was offered during the sanction portion of the hearing as an aggravating factor. This is permitted by the Board's Disciplinary Matrix and in accordance with the "C Factors" of Board Rule 213.33.

VI.

Respondent argues that the medical records of the patient in this case corroborate the testimony of the Respondent, Ms. Marcom. Staff submits that these same medical records do not corroborate Ms. Marcom's testimony as to what occurred in the patient's room for following reason: Ms. Marcom herself prepared the medical record entries in question and intentionally omitted any reference to what she herself had done to the patient in his room.

VII.

On page 42 of Respondent's Exceptions, Respondent asks the ALJ to include additional Findings of Fact in the PFD. Staff would argue that there is no need for additional Findings of Fact in this case. The proposed Findings of Fact are irrelevant to this proceeding, as the Board of Nursing is not investigating any of the individuals named in Respondent's proposed Findings of Fact Nos. 20 through 28. The subject of this case was the behavior of the Respondent, Tammy Marcom.

VIII.

With regard to costs, although Scott Turner attempted to claim for certain items of clothing on his travel voucher, those items were explicitly denied when he was reimbursed for his expenses. See in this regard the attached copy of Mr. Turner's Witness Allowance Form. At the bottom of this form the undersigned affixed his signature dated June 5, 2016 and included the annotation, "*Excluding costs for clothing."

IX.

On her Witness Allowance Form, Nichole Porter purchased certain food items from Walmart at the same time that she purchased certain items for herself which were non-reimbursable. Staff approved a total of $29.68 for payment for meals for three days for Ms. Porter.

X.

With regard to the Witness Allowance Form of Brenda Evans, although she claimed $155.25 for May 9th; $155.25 for May 10th; $190.47 for June 16th; and $149.16 for June 17th, Ms. Evans was nevertheless was reimbursed at the Texas State rate of $135 per night. This is reflected on the *Final Affidavit of Administrative Costs*. Moreover, her meal costs were modest. See for instance her claim form for June 16 and 17, 2016. Ms. Evans's total for all meals amounted to $46.37.

Similarly, her claim for meals for May 9 and 10, 2016, amounted to $26.70. Certainly these are reasonable amounts.

Respectfully submitted,

TEXAS BOARD OF NURSING

John F. Legris, Assistant General Counsel
State Bar No. 00785533
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6823
F: (512) 305-8101

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 provided by Facsimile: (866) 250-4443, on this, the 9th day of January, 2017, to: Elizabeth L. Higginbotham, RN, JD; One Castle Hills, 1100 NW Loop 410, Suite 700, San Antonio, TX 78213.

John F. Legris, Assistant General Counsel

TEXAS BOARD OF NURSING
333 Guadalupe Ste 3-460
Austin, Texas 78701
Main Phone 512-305-7400 Fax 512-305-7401
Web address: www.bon.state.tx.us

WITNESS ALLOWANCE FORM

Witness/Deponent Name: Horace Scott Turner	**Witness/Deponent Social Security #:**
Witness/Deponent Address & Phone # :	**Hearing/Deposition Regarding:** TAMMY JEANETTE MARCOM - RN 706387 May 10-11, 2016

PLEASE REVIEW FORM INSTRUCTIONS BEFORE COMPLETING. INCOMPLETE OR INCORRECT FORMS WILL DELAY PAYMENT.

Attendance at hearing/giving deposition at $30.00 per day 5/10/16 5/11/16 (Date(s)) = $ 60.00

Mileage incurred from personally owned/leased vehicle at 54 cents per mile 689.8 (Total # of miles) = $ 372.49

Meal expense 5/9 $56.12 (Date/Amount) 5/10 $20.82 (Date/Amount) _____ (Date/Amount) = $ 76.94

Lodging expense 5/9 $149.50 (Date/Amount) 5/10 $149.50 (Date/Amount) _____ (Date/Amount) = $ 299.00

Transportation expense _____ (Expense/Date(s)) = $ ~~0~~

Other expense i.e. parking, gas, etc. ~~Gas~~/Parking 5/9 ~~$304.44~~ $218.56 ~~$328.56~~ clothes ~~Gas~~ 5/12 $49.88 (19) (Parking Expense/Date/Amount) = ~~$633.88~~ $ 237.56 391.44 749.98

GRAND TOTAL $ ~~403.86~~

Horace Scott Turner, WITNESS/DEPONENT, appeared personally before me at Comfort Community FCU, and swore that the above was true, correct and unpaid.

Witness my hand and seal of office on this 10th day of May, 2016.

DOROTHY FLORES
Notary ID 12896083-9
My Commission Expires
April 9, 2020

Dorothy Flores
Notary Public in and for Midland County, Texas.

FOR AGENCY USE ONLY:
AGENCY APPROVAL

I certify that the above claim for mileage and per diem of the WITNESS/DEPONENT incurred pursuant to TEX. GOV'T CODE, ANN. § 2001.003(7), 2001.103(Vernon 2000) is true, correct and unpaid.

APPROVED FOR PAYMENT BY _____ DATE June 5, 2016

*excluding costs for clothing.

SOAH DOCKET NO. **507-15-0748**

IN THE MATTER OF	§	BEFORE THE
PERMANENT CERTIFICATE	§	
NUMBER 706387	§	STATE OFFICE OF
ISSUED TO	§	
TAMMY JEANETTE MARCOM	§	ADMINISTRATIVE HEARINGS

FINAL AFFIDAVIT OF ADMINISTRATIVE COSTS

BEFORE ME, the undersigned authority, personally appeared John F. Legris, the affiant, a person whose identity is known to me. After I administered an oath to affiant, affiant testified:

1. My name is John F. Legris, Assistant General Counsel for the Board of Nursing ("BON"). I am over 18 years of age, of sound mind, capable of making this affidavit, and personally acquainted with the facts stated in it.

2. The BON is entitled to recover the administrative costs incurred in this matter under the Occupations Code §301.461.

3. The following administrative costs were incurred as part of the administrative hearing in this matter:

Court Reporter's Fees:	
$75/hr * 16 hours (May 10, 11, & June 17, 2016)	$1,200.00
Transcript Fee:	
518 Pages @ 3.90/page (May 10, 11, & June 17, 2016)	$2,020.20
Binding Fee & Administrative Fee	65.00
E-tran Fee (2 @ $20)	40.00
Delivery charge (3)	24.00
TOTAL COST	$3,349.20
One-half of Total Cost to be Paid by Respondent's counsel	$-1,674.60
COURT REPORTER AND TRANSCRIPT TOTAL COST:	$ 1,674.60

Witness Expenses:		
Attendance at Hearing for Witnesses		$ 210.00
Witness Mileage: ($306.72, $372.49, $272.16, $381.24)		1, 332.61
Witness Meals:	May 10 - 11, 2016	185.59
	June 17-18, 2016	46.37
Witness Lodging:	May 10-11, 2016 (6 x $135)	810.00
	June 16-17, 2016 (2 x $135)	270.00
Witness Miscellaneous Expenses (parking, etc.)		126.00
WITNESS EXPENSES - TOTAL COST:		$ 2,980.57

COURT REPORTER AND TRANSCRIPT TOTAL COST:	$ 1,674.60
WITNESS EXPENSES - TOTAL COST:	$ 2,980.57
TOTAL COSTS:	$ 4,655.17

4. Documentary evidence supporting the final amount of costs is attached and filed with this *Final Affidavit of Costs* prior to the closing of the record.

John F. Legris, Assistant General Counsel

SWORN TO AND SUBSCRIBED before me on the 23rd day of September, 2016.

NOTARY PUBLIC IN AND FOR THE STATE OF TEXAS

CYNTHIA L. LOCASTRO NOTARY PUBLIC WITHOUT BOND STATE OF TEXAS EXPIRES AUGUST 6, 2019

State Office of Administrative Hearings

Lesli G. Ginn
Chief Administrative Law Judge

January 19, 2017

Katherine A. Thomas, M.N., R.N.
Executive Director
Texas Board of Nursing
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701

VIA FACSIMILE

RE: Docket No. 507-15-0748;
Texas Board of Nursing v. Tammy Jeanette Marcom

Dear Ms. Thomas:

The Administrative Law Judge (ALJ) has reviewed Ms. Marcom's Exceptions to Proposal for Decision (PFD) and Staff's Response to Respondent's Exceptions. The ALJ agrees with Staff's Response. Therefore, the ALJ respectfully recommends that no changes be made to the PFD.

Sincerely,

Henry D. Card
Administrative Law Judge

HC/km

xc: John F. LeGris, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA FACSIMILE**
Elizabeth L. Higginbotham, R. N. J. D.; Higginbotham & Associates, L.L.C.; One Castle Hills, 1100 NW Loop 410, Suite 700, San Antonio, TX 78213 – **VIA FACSIMILE**