In the Matter of	§	**BEFORE THE TEXAS**
Licensed Vocational Nurse	§	
License Number 198685,	§	
Issued to	§	
Timothy Okechukwu Nwokorie	§	**BOARD OF NURSING**

BOARD OF NURSING TEXAS

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

Executive Director of the Board

NUNC PRO TUNC ORDER OF THE BOARD

An Order of the Board was entered for Timothy Okechukwu Nwokorie on July 20, 2018. The Order, however, contained a typographical error in the effective date of the Order on page 1. Upon notice and hearing, administrative agencies, like the Courts, have the power to enter nunc pro tunc orders where it can be seen by reference to a record that what was intended to be entered, but was omitted by inadvertence or mistake, can be corrected upon satisfactory proof of its rendition provided that no intervening rights will be prejudiced. *Railroad Comm'n v. McClain*, 356 S.W.2d 330, 334 (Tex. App.--Austin 1962, no writ) (citing *Frankfort Ky. Nat. Gas Co. v. City of Frankfort*, 276 Ky. 199, 123 S.W.2d 270, 272).

The Executive Director, as agent of the Texas Board of Nursing, after review and due consideration of the record and the facts therein submits and enters the corrected Order. Respondent received due process regarding his license; therefore, his rights have not been prejudiced.

NOW, THEREFORE, IT IS ORDERED that the corrected Order of the Board is hereby approved and entered on the dates set forth below.

Order effective July 20, 2018.

Entered this 14th day of August, 2018.

BY: Katherine A. Thomas

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

DOCKET NUMBER 507-18-1199

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
LICENSED VOCATIONAL NURSE	§	
LICENSE NUMBER 198685,	§	**OF**
ISSUED TO	§	
TIMOTHY OKECHUKWU NWOKORIE	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: TIMOTHY OKECHUKWU NWOKORIE
C/O MARC M. MEYER
33300 EGYPT LANE, SUITE C600
MAGNOLIA, TX 77354

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on July 19-20, 2018, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. No exceptions were filed by any party.

The Board, after review and due consideration of the PFD; Staff's recommendations; and the recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. 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 licensure revocation.

The ALJ found that the Respondent's conduct warrants a third tier, level II sanction,

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[1] Pursuant to Tex. Occ. Code. §301.459 (a-1), although the Administrative Law Judge may make a recommendation regarding an appropriate an action or sanction, the Board has the sole authority and discretion to determine the appropriate action or sanction.

for his violations of §301.452(b)(10) and (13)[2]. Licensure revocation is authorized by a third tier, level II sanction for a violation of §301.452(b)(10) and (13).

The ALJ noted several aggravating factors in this matter. First, the Respondent's conduct carries a clear risk of serious physical or emotional harm[3]. The patient at issue was vulnerable, in that she was an amputee and asleep when the Respondent assaulted her[4]. Further, the Respondent's conduct was not minor and distressed the patient[5]. The ALJ did not note any mitigating factors.

After carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix[6] and the Board's rules, including 22 Tex. Admin. Code §213.33, that the most appropriate sanction in this case is licensure revocation.

IT IS, THEREFORE, ORDERED THAT Permanent Certificate Number 198685, previously issued to Timothy Okechukwu Nwokorie, to practice nursing in the State of Texas be, and the same is hereby, REVOKED.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multi-state privileges, if any, to practice nursing in the State of Texas.

FURTHER, pursuant to the Occupations Code §301.467, RESPONDENT is not eligible to petition for reinstatement of licensure until at least one (1) year has elapsed from the date of this Order. Further, upon petitioning for reinstatement, RESPONDENT must satisfy all then existing requirements for relicensure.

Entered this 20th day of July, 2018.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-18-1199 (April 12, 2018).

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[2] See pages 10-12 of the PFD.

[3] See page 11 of the PFD.

[4] *Id.*

[5] See adopted Finding of Fact Number 20 and pages 11-12 of the PFD.

[6] 22 Tex. Admin. Code §213.33(b).

DOCKET NUMBER 507-18-1199

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
LICENSED VOCATIONAL NURSE	§	
LICENSE NUMBER 198685,	§	**OF**
ISSUED TO	§	
TIMOTHY OKECHUKWU NWOKORIE	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: TIMOTHY OKECHUKWU NWOKORIE
C/O MARC M. MEYER
33300 EGYPT LANE, SUITE C600
MAGNOLIA, TX 77354

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on April 19-20, 2018, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. No exceptions were filed by any party.

The Board, after review and due consideration of the PFD; Staff's recommendations; and the recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. 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 licensure revocation.

The ALJ found that the Respondent's conduct warrants a third tier, level II sanction,

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[1] Pursuant to Tex. Occ. Code. §301.459 (a-1), although the Administrative Law Judge may make a recommendation regarding an appropriate an action or sanction, the Board has the sole authority and discretion to determine the appropriate action or sanction.

for his violations of §301.452(b)(10) and (13)[2]. Licensure revocation is authorized by a third tier, level II sanction for a violation of §301.452(b)(10) and (13).

The ALJ noted several aggravating factors in this matter. First, the Respondent's conduct carries a clear risk of serious physical or emotional harm[3]. The patient at issue was vulnerable, in that she was an amputee and asleep when the Respondent assaulted her[4]. Further, the Respondent's conduct was not minor and distressed the patient[5]. The ALJ did not note any mitigating factors.

After carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix[6] and the Board's rules, including 22 Tex. Admin. Code §213.33, that the most appropriate sanction in this case is licensure revocation.

IT IS, THEREFORE, ORDERED THAT Permanent Certificate Number 198685, previously issued to Timothy Okechukwu Nwokorie, to practice nursing in the State of Texas be, and the same is hereby, REVOKED.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multi-state privileges, if any, to practice nursing in the State of Texas.

FURTHER, pursuant to the Occupations Code §301.467, RESPONDENT is not eligible to petition for reinstatement of licensure until at least one (1) year has elapsed from the date of this Order. Further, upon petitioning for reinstatement, RESPONDENT must satisfy all then existing requirements for relicensure.

Entered this 20th day of July, 2018.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-18-1199 (April 12, 2018).

---

[2] See pages 10-12 of the PFD.

[3] See page 11 of the PFD.

[4] *Id.*

[5] *See* adopted Finding of Fact Number 20 and pages 11-12 of the PFD.

[6] 22 Tex. Admin. Code §213.33(b).

State Office of Administrative Hearings

Lesli G. Ginn
Chief Administrative Law Judge

April 12, 2018

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

RE: Docket No. 507-18-1199; Texas Board of Nursing v. Timothy Okechukwu Nwokorie

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.texas.gov.

Sincerely,

Pratibha J. Shenoy
Administrative Law Judge

PJS/mle
Enclosures
xc: John Vanderford, 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; Certified Evidentiary Record) – **VIA INTERAGENCY**
Mark M. Meyer, 33300 Egypt Lane, Ste. C600, Magnolia, TX 77354 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-18-1199

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
TIMOTHY OKECHUKWU NWOKORIE, LVN LICENSE NO. 198685, Respondent	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to revoke the Licensed Vocational Nurse (LVN) credential held by Timothy Okechukwu Nwokorie (Respondent) because he allegedly engaged in sexual misconduct with a patient (the Patient). The Administrative Law Judge (ALJ) concludes that Staff met its burden to prove the allegation by a preponderance of the evidence, and recommends that the Board revoke Respondent's license.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

On December 1, 2017, the Board issued an order temporarily suspending Respondent's license pursuant to Texas Occupations Code (Code) § 301.455, and Staff filed a formal charge and sent Respondent notice of a probable cause hearing, which convened on December 18, 2017. On December 21, 2017, the ALJ issued Order No. 1 upholding the temporary suspension.

The hearing on the merits convened on January 29, 2018, before ALJ Pratibha J. Shenoy at the State Office of Administrative Hearings (SOAH) facilities in Austin, Texas. Assistant General Counsel John Vanderford represented Staff, and attorney Mark M. Meyer represented Respondent, who did not appear. The hearing concluded that day and the record closed March 13, 2018, with the filing of Staff's reply brief.[1]

[1] In Order No. 2, issued January 30, 2018, the ALJ set out the agreed briefing deadlines. Staff timely filed its closing brief on February 16, 2018. On March 5, 2018, 10 days after the deadline for his response brief, counsel for Respondent filed a motion for additional time, asserting that Staff did not object. Respondent also requested an extension of time for Staff to file a reply. Respondent's response brief filed March 5, 2018, is treated as timely-filed. Staff's reply brief filed March 13, 2018, is also treated as timely, and the record closed on that date.

Matters of notice and jurisdiction were undisputed and are therefore set out in the Findings of Fact and Conclusions of Law without further discussion.

II. STAFF'S FORMAL CHARGE AND APPLICABLE LAW

Staff filed a single formal charge with respect to the alleged sexual misconduct. Staff charges that during an alleged encounter on November 16-17, 2016, while he was working at Modern Senior Living in Dallas, Texas (the Facility), Respondent groped the Patient's breasts, exposed his penis to her, climbed on top of her and tried to pull off her blankets, and attempted to shove his hand between her thighs, all while the Patient struggled and resisted.

The Board may discipline a nurse for, among other things, unprofessional conduct (pursuant to Code § 301.452(b)(10)) or failure to conform to the minimum standards of acceptable nursing practice in a manner that the Board finds exposes a patient or other person unnecessarily to risk of harm (pursuant to Code § 301.452(b)(13)). Staff asserts that Respondent's conduct is grounds for disciplinary action under both Code provisions, as well as pursuant to a number of Board rules. Board Rule 217.11[2] discusses minimum acceptable standards of nursing practice, three of which Staff alleged were not met by Respondent:

- **Board Rule 217.11(1)(A)**: Nurses must know and conform to the Texas Nursing Practice Act, the Board's rules and regulations, and federal, state, or local laws, rules, or regulations affecting the nurse's current area of nursing practice;
- **Board Rule 217.11(1)(B)**: Nurses must implement measures to promote a safe environment for clients and others; and
- **Board Rule 217.11(1)(J)**: Nurses must know, recognize, and maintain professional boundaries of the nurse-client relationship.

[2] 22 Tex. Admin. Code § 217.11(1)(A). For ease of reference, the Board's rules, found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code, shall be referred to as "Board Rule ____."

With respect to Board Rule 217.12[3] addressing unprofessional conduct, Staff asserts that Respondent's conduct was unprofessional as defined by six subsections:

- **Board Rule 217.12(1)(A)**: Carelessly failing, repeatedly failing, or exhibiting an inability to perform nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board Rule 217.11;
- **Board Rule 217.12(1)(B)**: Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;
- **Board Rule 217.12(6)(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 the Board;
- **Board Rule 217.12(6)(D)**: Violating professional boundaries of the nurse/client relationship including but not limited to physical, sexual, emotional, or financial exploitation of the client;
- **Board Rule 217.12(6)(E)**: Engaging in sexual conduct with a client, touching a client in a sexual manner, requesting or offering sexual favors, or language or behavior suggestive of the same; and
- **Board Rule 217.12(6)(F)**: Threatening or violent behavior in the workplace.

Board Rule 213.33 sets out a disciplinary matrix (Matrix) that is intended to match the severity of the sanction imposed to the nature of the violation at issue, taking into account mitigating and aggravating factors.[4] The Matrix classifies offenses by tier and sanction level, and must be consulted by the ALJ and the Board in determining the appropriate sanction. In addition, the Board has issued Disciplinary Sanctions for Sexual Misconduct (Sexual Misconduct Policy), a policy statement addressing sexual misconduct whether or not it results in a criminal charge or conviction. The Sexual Misconduct Policy states that sexual misconduct "toward patients is never acceptable" and is grounds for "limitation, denial, or revocation of licensure."[5]

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[3] 22 Texas Administrative Code § 217.12 was revised effective February 25, 2018. This Proposal for Decision cites the rule in effect in November 2016, when the alleged conduct occurred.

[4] 22 Tex. Admin. Code § 213.33; *see also* Tex. Occ. Code § 301.4531 (requiring the Board to adopt a schedule of sanctions).

[5] Disciplinary Sanctions for Sexual Misconduct, available at http://www.bne.state.tx.us/pdfs/publication_pdfs/Disciplinary%20Sanctions%20for%20Sexual%20Misconduct.pdf

For purposes of the hearing on the merits, Staff must prove its allegations by a preponderance of the evidence,[6] a more exacting standard than is required to establish probable cause to continue a temporary suspension.[7]

III. DISCUSSION

By agreement of the parties, the testimony and exhibits presented at the probable cause hearing were admitted into evidence at the hearing on the merits. Specifically, as memorialized in Order No. 2, Staff's Exhibits 1, 6, 7, and 9[8] were admitted for all purposes. Staff's Exhibits 2, 2a, 3, 4, and 5 were admitted for purposes of notice and jurisdiction only. Staff Exhibit 8 was admitted with the ALJ sustaining Respondent's objections to hearsay on pages 110-11 and 116-17. Staff called two witnesses: the patient (the Patient)[9] and Walter L. Reed, the Facility Administrator. Respondent did not call any witnesses or offer any documentary evidence.

A. Evidence

1. The Patient's Testimony

The Patient testified that, in November 2016, she had lived at the Facility for just over two years. She entered the Facility for rehabilitation following amputation of her right leg at the knee. She was familiar with Respondent, who had been among the nurses caring for her for approximately the past year. However, she said that prior to the incident in question, she had never had any negative interactions with Respondent, and she had no reason to attempt to damage his career or reputation with false allegations.

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[6] 1 Tex. Admin. Code § 155.427.

[7] Establishing probable cause requires only a "reasonable belief in the existence of facts on which a claim is based and in the legal validity of the claim itself." *Black's Law Dictionary* (10th ed. 2014); *see also Modern Dictionary for the Legal Profession* (3rd Ed. 2001) (defining "probable cause" in civil cases as "facts and circumstances which cause a reasonable person to conclude . . . that a cause of action does exist").

[8] At the probable cause hearing, Respondent reserved the right to make further objections at the hearing on the merits to hearsay that might be contained within Staff Exhibit 9. However, Respondent made no such objections and Staff Exhibit 9 was admitted for all purposes.

[9] The Patient testified by telephone.

The Patient shared her room with another female resident. On November 16, 2016, the Patient went to sleep at her usual bedtime, between 10:30 and 11:00 p.m. She said she is a light sleeper, and after she fell asleep that night, the next thing she recalls is waking up around 2:30 a.m. to find Respondent touching her. The Patient at first thought she was struggling in a dream, but woke up to realize that Respondent was groping her breasts and she was trying to push him away. She said he held his erect, naked penis in his hand and told her to look at it, though she kept looking away. Respondent tried to lie down on top of the Patient with the covers between them, and he also reached under the covers and tried to push his hand between the Patient's thighs. The Patient said she kept struggling and after some time Respondent left, but he told her he would be back around 4:30 a.m.

After Respondent left, the Patient lay awake for hours. She said she was in shock and could not believe what had just taken place. The Patient testified that after a few hours the night charge nurse, Pascal Igwe, came in to check her roommate's blood sugar. She did not say anything to Mr. Igwe about Respondent's actions because she was "still in a state of shock and disbelief." After the morning shift change, a female aide came into the room and the Patient asked to see the Administrator (Mr. Reed) as soon as possible. Shortly thereafter, the Patient met with Mr. Reed and narrated the events of the previous night.

The Patient said she was not physically harmed by Respondent's actions, but it was a shocking and disturbing experience. Since the incident, the Patient said, she now wonders where else this type of misconduct may be going on. She noted that there are residents at the Facility who have dementia or other impairments that might make them unable to report a violation if Respondent (or another nurse) engaged in similar behavior with them.

The Patient was asked on cross-examination whether she recalled that Mr. Igwe evaluated her on the morning of November 17, 2016, and that he entered a nursing note with a time stamp of 4:41 a.m. that states, "Patient rested well all night, denied any acute distress noted [sic]."[10] She said she did not recall that interaction. She was also questioned as to whether she

[10] Staff Ex. 6 at 93.

initially told Mr. Reed that the incident took place shortly after 4:00 a.m. The Patient reiterated that it was around 2:30 a.m. when she woke up to Respondent touching her.

2. Mr. Reed's Testimony

Mr. Reed has been the Facility's Administrator since March 2010. He said he was in a meeting around 9:00 a.m. on November 17, 2016, when a staff member told him he was needed for an urgent matter. Mr. Reed immediately met with the Patient in his office. He described her as alert and oriented, and said that she had no health issues that would affect her memory or perceptions. Mr. Reed was present in the hearing room during the Patient's telephone testimony. He testified that the description of events that the Patient testified to was consistent with the description she gave him when he met with her right after the incident.

After meeting with the Patient, Mr. Reed retrieved the video from the camera in the hallway outside the Patient's room.[11] He reviewed the period from approximately midnight on November 16, 2016, to around 6:00 a.m. on November 17, 2016. Mr. Reed said that Respondent was assigned to cover the "400 hallway" and the first room on the "500 hallway," giving Respondent around 30 rooms to monitor during the night. That should have been enough to keep Respondent quite busy, Mr. Reed noted. The Patient's room was on the 500 hallway and was not one of the rooms assigned to Respondent.

Mr. Reed said he observed on the video that around 2:41 a.m., Respondent went up to the Patient's closed door, opened the door, and walked straight in. That was already a problem, Mr. Reed said, because Facility staff are supposed to knock and announce their presence before entering a resident's room. Also, according to Mr. Reed, the call light above the Patient's door can be seen on the video and it was not illuminated, indicating that neither the Patient nor her roommate had called for help. Around 2:47 a.m., the video shows a female staff member approaching a board that is on the wall near the door to the Patient's room, and stopping at the board. Then, at 2:48 a.m., Respondent is seen exiting the Patient's room and walking away.

[11] Staff Ex. 7 is a DVD containing the hallway video. Portions of it were played at the probable cause hearing during Mr. Reed's testimony.

After watching the video, Mr. Reed summoned Respondent to his office and called the police at the same time. Respondent at first told Mr. Reed that he regularly checked on all residents, even those not assigned to him. He said he entered the Patient's room because he saw the Patient's roommate with her leg dangling over the side of the bed and wanted to remind her not to get out of her bed. Mr. Reed challenged that explanation, noting that on the video the Patient's door was closed and Respondent could not have seen inside the room. Respondent then gave a different explanation that Mr. Reed also thought was suspect. Shortly thereafter, police arrived and Mr. Reed ended his interview. He testified that, based on the Patient's account, the video, and Respondent's unconvincing explanations, he had sufficient basis to terminate Respondent's employment and did so, effective immediately.

Mr. Reed was asked on cross-examination whether any law enforcement agency or lawyer had requested the full video from the night of November 16, 2016, through the following morning. He said no such request had been made, and indicated that he had provided police with only the relevant portion of the recording that showed Respondent entering and exiting the Patient's room. Mr. Reed added that he observed on video a female aide entering the Patient's room around 6:00 a.m. on November 17, 2016. He acknowledged that Mr. Igwe signed a note at 4:41 a.m. on November 17, 2016, indicating that the Patient had rested well and had no complaints, but he said he did not see Mr. Igwe entering the room on the video.

Finally, Mr. Reed agreed that there is a discrepancy in the time frame the Patient reported that the incident occurred, and that at first she told him she looked at her phone and it was a few minutes after 4:00 a.m. when it happened. Mr. Reed attributed the confusion regarding the time to the Patient's shock and distress, but reiterated that the Patient has no cognitive or memory deficits and her statement to him immediately after the incident was consistent with her hearing testimony.

3. Dallas Police Department Records[12]

Dallas Police Department (DPD) officers responded to Mr. Reed's call on the morning of November 17, 2016, and interviewed Mr. Reed, the Patient, and other Facility staff.[13] The DPD records indicate Respondent was arrested on a charge of attempted sexual assault and removed from the premises by the officers.

The DPD Investigation Report and Prosecution Reports (DPD Reports) are consistent with the testimony of the Patient and Mr. Reed, and in particular note that the Patient stated the incident occurred at approximately 2:30 a.m.[14] The DPD investigators reviewed the video of the Facility hallway provided by Mr. Reed and noted that at 2:47 a.m., a nurse who had stopped at a "computer kiosk hanging on the wall two doors down" from the Patient's room is seen moving "a chair to get to the kiosk, which may have made a noise."[15] The DPD Reports surmise that the noise may have interrupted Respondent during the attempted assault, as he is seen leaving the Patient's room very shortly thereafter, at 2:48 a.m.[16]

According to the DPD Reports, Respondent "did not make any notations on his night report" that could explain "why he had been in [the Patient's] room," and he also failed to advise the nurse who was actually assigned to cover the Patient's room of any problem requiring additional attention.[17]

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[12] As previously noted, Respondent did not make any hearsay or other objections to Staff Exhibit 9, containing the Dallas Police Department investigation and prosecution reports, investigatory documents prepared by the Texas Department of Aging and Disability Services (now part of the Texas Health and Human Services Commission), arrest records for Respondent, and various other documents.

[13] It is unclear from the reports in evidence whether Respondent consented to an interview with DPD officers.

[14] Staff Ex. 9 at 13.

[15] The hallway video does not record sound. Staff Ex. 9 at 5.

[16] Staff Ex. 9 at 6, 13.

[17] Staff Ex. 9 at 6.

B. Analysis

Respondent asserts that Staff has not met its burden because of inconsistencies in Staff's evidence. Specifically, Respondent contends that the Patient initially told Mr. Reed the incident occurred at 4:05 a.m. and changed her account to 2:30 a.m. only after Mr. Reed viewed the hallway video. Further, Mr. Igwe documented at 4:41 a.m. that the Patient said she "rested well," which is inconsistent with her having been assaulted. Respondent also questions why the Patient did not make an outcry immediately and instead waited to speak to Mr. Reed. Finally, Respondent contends that the Facility jumped to conclusions without conducting a proper inquiry, such as ruling out Mr. Igwe as a possible perpetrator.

The burden of proof in this case rests with Staff, and it is not Respondent's responsibility to prove that he did not commit the assault. However, the ALJ disagrees with Respondent's contentions and finds that Staff established by a preponderance of the evidence that Respondent engaged in sexual misconduct with the Patient.

There is no indication in the record when Mr. Reed told the Patient that the video shows Respondent entering her room at 2:41 a.m. instead of 4:05 a.m., or whether he told her that at all. Her testimony that the incident occurred at 2:30 a.m. is consistent with what she told the DPD officers who investigated the same morning. It also is possible that the Patient was referring to Respondent's comment that he would be back around 4:30 a.m., and Mr. Reed misunderstood her. Most importantly, an inconsistency in the Patient's recollection of the exact time of the incident is not determinative, given that she was jarred awake in the middle of the night during a traumatic situation. What is crucial in this case is her clear narration of the specific actions Respondent took, which was consistent and unwavering from the time of the initial investigation.

The Patient knew who Mr. Igwe was and also was familiar with Respondent, who had been one of her caregivers for the past year. She was steadfast in identifying Respondent as her assailant. Although Mr. Igwe apparently made a nursing note at 4:41 a.m., he is not seen on the video entering the Patient's room. Rather, the video is consistent with the Patient's account. Respondent can be seen entering the Patient's room without knocking and without hesitating at

2:41 a.m., and leaving at 2:48 a.m. He made no notations on his night report that would have explained why he needed to be in the Patient's room for seven minutes, and he did not notify the assigned nurse of any need for attention.

Even if the Patient did tell Mr. Igwe around 4:41 a.m. that she was fine, it is not unreasonable that shock prevented the Patient from immediately making an outcry. She did ask for help from the first female attendant she saw, she met with Mr. Reed right away to make a report, and she cooperated fully with the police investigation that morning.

Respondent's actions as established by Staff constitute violations of the Code and Board rules, whether or not Respondent is ultimately convicted of a crime.[18] Of the various provisions cited by Staff in its Notice of Hearing, the actions at issue are most specifically addressed as unprofessional conduct under Code § 301.452(b)(10) and Board Rules 217.11(1)(B), requiring nurses to promote a safe environment for clients, and 217.11(1)(J), requiring nurses to maintain professional boundaries of the nurse-client relationship. Respondent's conduct is also a failure to meet minimum practice standards set forth in Code § 301.452(b)(13) and Board Rules 217.12(6)(C), prohibiting a nurse from causing physical, emotional, or verbal abuse or injury to the client, and 217.12(6)(D), prohibiting violations of the professional boundaries of the nurse-client relationship, including physical, sexual, or emotional exploitation of the client.

Whether analyzed under Code § 301.452(b)(10) or (13), the Matrix designates Respondent's conduct as a Third Tier offense.[19] For the reasons discussed below, the sanction of revocation is most appropriate in either analysis.

A First Tier offense under Code § 301.452(b)(10) is an isolated failure to comply with Board rules without adverse patient effects, or involving minor, unethical conduct where no

[18] Respondent's response brief states that Respondent "is still under jeopardy in a criminal proceeding related to this matter." Resp. Response Brief at 5. Sanctions are required to be imposed by the Code following initial and final conviction of certain crimes, but are inapplicable at this time given the pendency of the criminal proceeding. *See* Code § 301.4535 (Required Suspension, Revocation, or Refusal of License for Certain Offenses).

[19] 22 Tex. Admin. Code § 213.33.

patient safety is at risk, and a Second Tier offense includes a personal relationship that violates the professional boundaries of the nurse/patient relationship. Respondent's actions were not minor, distressed the Patient, and put her at physical and emotional risk, so the First Tier is inappropriate. Respondent and the Patient did not have a personal relationship, taking the conduct out of the Second Tier. The Third Tier, which covers sexual or sexualized contact with a patient, is most accurate. Under the Third Tier, Sanction Level I lists licensure denial or revocation of license as possible sanctions. Sanction Level II applies where an emergency suspension of nursing practice is required based on a continuing and imminent threat to public health and safety, and may ultimately result in license revocation.

In Order No. 1, the ALJ found that the suspension of Respondent's license should be extended until a final resolution of this case, based on the existence of probable cause to believe that Respondent's continued practice as a nurse would pose a continuing and imminent threat to the public welfare. There is no evidence in the record of mitigating factors, and the aggravating factor of patient vulnerability applies, given that the Patient is an amputee and was asleep when Respondent assaulted her. Accordingly, the seriousness of Respondent's misconduct warrants a Third Tier, Sanction Level II disciplinary action.

Similarly, pursuant to the Matrix, the Third Tier is the most appropriate classification of Respondent's conduct under Code § 301.452(b)(13). A First Tier offense is practice below the minimum standard with "a low risk of patient harm," and a Second Tier offense is practice below the minimum standard with "patient harm or risk of patient harm." A Third Tier offense is practice below the minimum standard with "a serious risk of harm or death that is known or should be known." Sexual misconduct such as that committed by Respondent carries a clear risk of serious physical or emotional harm, making his conduct a Third Tier offense. Sanction Level I within the Third Tier lists denial of licensure or revocation of license as possible sanctions. Just as with Code § 301.452(b)(10), the Third Tier, Sanction Level II listed in the Matrix for Code § 301.452(b)(13) is applicable when an emergency suspension of nursing practice is required based on a continuing and imminent threat to public health and safety, and

may ultimately result in license revocation. A Third Tier, Sanction Level II disciplinary action is thus appropriate under Code § 301.452(b)(13).

The Sexual Misconduct Policy addresses a number of hypothetical factual situations and directs that in most cases, the appropriate sanction is based on a consideration of all relevant circumstances. Accordingly, the ALJ relies in this case on the more specific guidance found in the Matrix. In support of the recommended sanction of revocation, the ALJ makes the following findings of fact and conclusions of law.

IV. FINDINGS OF FACT

1. Timothy Okechukwu Nwokorie (Respondent) has been a nurse since 2002 and was issued Licensed Vocational Nurse (LVN) License No. 198685 by the Texas Board of Nursing (Board) on June 9, 2005.

2. On the night of November 16, 2016, Respondent was employed as a nurse at Modern Senior Living in Dallas, Texas (the Facility), and was assigned 30 patient rooms to monitor.

3. A female resident of the Facility (the Patient) had entered the Facility for rehabilitation after amputation of her right leg at the knee.

4. The Patient's room was not one of the rooms assigned to Respondent.

5. At what she believed was approximately 2:30 a.m. on November 17, 2016, the Patient woke up to find Respondent groping her breasts as she struggled to push him away.

6. Respondent held his erect, naked penis in his hand and told the Patient to look at it, while she kept looking away.

7. Respondent tried to lie down on top of the Patient with the covers between them, and he reached under the covers and tried to push his hand between the Patient's thighs.

8. The Patient kept struggling and after some time Respondent left, but he told the Patient he would be back around 4:30 a.m.

9. As documented on the video recording from the hallway outside the Patient's room, at 2:41 a.m. Respondent walked straight to the Patient's door and entered the room without first knocking and announcing his presence as required by Facility policy.

10. The call light above the Patient's door was not illuminated, indicating that neither the Patient nor her roommate called for help.

11. Respondent exited the Patient's room at 2:48 a.m.

12. Respondent did not make any notations on his night report regarding why he was in the Patient's room for seven minutes, and he did not advise the nurse assigned to cover the Patient's room of any need for attention.

13. The Patient was in shock and disbelief after the incident and lay awake for several hours.

14. At the morning shift change, a female aide entered the Patient's room and Patient requested to meet with Walter L. Reed, the Facility Administrator, as soon as possible.

15. The Patient gave Mr. Reed a clear and detailed account of Respondent's conduct.

16. After meeting with the Patient, Mr. Reed called the Dallas Police Department (DPD) and also spoke to Respondent, who could not give a plausible explanation for his presence in the Patient's room.

17. Mr. Reed terminated Respondent's employment, effective immediately.

18. The Patient gave DPD officers a statement consistent with her statement to Mr. Reed about Respondent's actions.

19. The Patient had no health issues that affected her memory or perceptions.

20. Although the Patient reported being physically unharmed by Respondent, she experienced shock, disbelief, and distress as a result of his conduct.

21. DPD officers arrested Respondent after their investigation on November 17, 2016. The Facility reported the incident to the Board, among other regulatory agencies.

22. On December 1, 2017, the Board issued an Order of Temporary Suspension of Respondent's license, and Board staff (Staff) filed a formal charge against Respondent and sent Respondent notice of a probable cause hearing, which convened on December 18, 2017, at the State Office of Administrative Hearings (SOAH) in Austin, Texas.

23. On December 21, 2017, a SOAH Administrative Law Judge (ALJ) issued an order upholding the temporary suspension of Respondent's license based on a finding that probable cause existed to believe that the continued practice of nursing by Respondent constituted a continuing and imminent threat to the public welfare. Respondent's license remains under suspension until the Board issues a final order in this case.

24. On December 22, 2017, Staff sent Respondent a Notice of Final Hearing. 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 either a short, plain statement of the factual matters asserted or an attachment that incorporates by reference the factual matters asserted in the complaint or petition filed with the state agency.

25. The hearing convened at SOAH on January 29, 2018, before ALJ Pratibha J. Shenoy. Assistant General Counsel John Vanderford represented Staff. Attorney Mark M. Meyer represented Respondent, who did not appear. The hearing concluded that day and the record closed March 13, 2018, with the filing of the final written brief.

V. CONCLUSIONS OF LAW

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. Code ch. 301.

2. SOAH has jurisdiction over contested cases referred by the Board, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.

3. Respondent received adequate and proper notice of the hearing on the merits. Tex. Occ. 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 § 155.427.

5. Respondent is subject to sanction because he committed unprofessional conduct by failing to promote a safe environment for a client and failing to maintain professional boundaries of the nurse-client relationship. Tex. Occ. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.11(1)(B), (J).

6. Respondent is also subject to sanction because his conduct failed to meet minimum practice standards that prohibit a nurse from causing physical, emotional, or verbal abuse or injury to a client and prohibit violations of the professional boundaries of the nurse-client relationship, including physical, sexual, or emotional exploitation of the client. Tex. Occ. Code § 301.452(b)(13); 22 Tex. Admin. Code § 217.12(6)(C), (D).

7. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license, and which may include assessment of a fine. Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

8. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Administrative Code § 213.33 and the

Board's Disciplinary Matrix, as well as the Board policy discussed in Disciplinary Sanctions for Sexual Misconduct. 22 Tex. Admin. Code § 213.33; *see also* http://www.bne.state.tx.us/pdfs/publication_pdfs/Disciplinary%20Sanctions%20for%20Sexual%20Misconduct.pdf

VI. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board revoke LVN License No. 198685 issued to Timothy Okechukwu Nwokorie.

SIGNED April 12, 2018.

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS