DOCKET NUMBER 507-18-1454

IN THE MATTER OF PERMANENT CERTIFICATE NUMBERS 897182 & 160523, ISSUED TO ERIC SANCHEZ	§	BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

OPINION AND ORDER OF THE BOARD

TO: ERIC SANCHEZ
C/O MARC M. MEYER, ATTORNEY
LAW OFFICE OF MARC MEYER PLLC
33300 EGYPT LANE, STE C-600
MAGNOLIA, TX 77354

MICHAEL J. O'MALLEY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 23-24, 2020, the Texas Board of Nursing (Board) considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; Respondent's exceptions to the PFD; the ALJ's final letter ruling of November 19, 2019; Staff's recommendation to the Board regarding the PFD and order; and 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. On October 11, 2019, the Respondent filed exceptions to the PFD. On November 19, 2019, the ALJ issued his 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; the ALJ's final letter ruling; 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

Pursuant to Tex. Occ. Code. §301.459 (a-1), an Administrative Law Judge may make a recommendation regarding an appropriate action or sanction. The Board,

however, has the sole authority and discretion to determine the appropriate action or sanction.

The Board agrees with the ALJ that the Respondent's conduct warrants a third tier, level I sanction for his violations of §301.452(b)(10) and (13).[1] Licensure revocation is authorized by the Board's Disciplinary Matrix[2] for a third tier, sanction level I violation of §301.452(b)(10). Either licensure revocation or licensure suspension is authorized by the Board's Disciplinary Matrix for a third tier, sanction level I violation of §301.452(b)(13). In this case, the Board agrees with the ALJ that licensure revocation is the most appropriate sanction.

Although the Respondent produced evidence that he has a record of good performance as a nurse and two of his colleagues testified that he is a good nurse and is very professional[3], these mitigating factors do not overcome the serious nature of his misconduct and the risk of serious emotional harm to the patient[4]. Further, as recognized by the ALJ, the Board's Sexual Misconduct Policy provides that sexual misconduct with a patient is never acceptable.[5]

Therefore, 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 and the Board's rules, including 22 Tex. Admin. Code §213.33, that licensure revocation is the most appropriate sanction in this matter.

IT IS, THEREFORE, ORDERED THAT Permanent Certificate Numbers 897182 and 160523, previously issued to ERIC SANCHEZ, to practice nursing in the State of Texas be, and the same are 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 23rd day of January, 2020.

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[1] See pages 10-11 of the PFD.
[2] See 22 Tex. Admin. Code §213.33(b).
[3] See page 11 of the PFD.
[4] See pages 10-11 of the PFD.
[5] See page 11 of the PFD.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-18-1454 (September 12, 2019)

State Office of Administrative Hearings

September 12, 2019

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. 507-18-1454, *Texas Board of Nursing v. Eric Sanchez*

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 Texas Administrative Code § 155.507, a SOAH rule which may be found at www.soah.texas.gov.

Respectfully,

Michael J. O'Malley
Administrative Law Judge

MJO/rmc
Enclosures

xc: John L. Vanderford, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA INTERAGENCY**
Elizabeth Tschudi, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (Certified Evidentiary Record) – **VIA INTERAGENCY**
Marc M. Meyer, Law Office of Marc Meyer, PLLC 33300 Eqypt Lane Sutie C-600 Magnolia, TX 77354 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-18-1454

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
ERIC SANCHEZ, **RN LICENSE NO. 897182** **LVN LICENSE NO. 160523,** **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to revoke the Licensed Vocational Nurse (LVN) and Registered Nurse (RN) licenses held by Eric Sanchez (Respondent) because he allegedly engaged in sexual misconduct with a patient (referred to as MA). 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 Mr. Sanchez's licenses.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

The hearing on the merits convened on June 25, 2019, before ALJ Michael J. O'Malley at the State Office of Administrative Hearings facilities in Austin, Texas. Assistant General Counsel John Vanderford represented Staff, and attorney Mark M. Meyer represented Mr. Sanchez. The hearing concluded that day and the record closed August 5, 2019, with the filing of post-hearing briefs.

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 September 27, 2016, while he was working at Valley

Baptist Medical Center, Brownsville, Texas (facility), Mr. Sanchez knelt down by MA's bed with his hands moving around near MA's genital area. MA was a psychiatric patient.

The Board may discipline a nurse for, among other things, unprofessional conduct (pursuant to Texas Occupations Code (Code) § 301.452(b)(10))[1] 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 Mr. Sanchez'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, two of which Staff alleged were not met by Mr. Sanchez:

- **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.

With respect to Board Rule 217.12[3] addressing unprofessional conduct, Staff asserts that Mr. Sanchez'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(4)**: Careless or repetitive conduct that may endanger a client's life, health, or safety;

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[1] Texas Occupations Code § 301.452(b)(10) was amended in 2017, but the change has no substantive impact on this case.

[2] For ease of reference, the Board's rules, found in title 22, chapters 211 to 228 of the Texas Administrative Code, shall be referred to as "Board Rule ____."

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

- **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.

Board Rule 213.33(b) 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.[5] 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."[6]

For purposes of the hearing on the merits, Staff must prove its allegations by a preponderance of the evidence.[7]

III. DISCUSSION

Staff's Exhibits 1, 2, 2a, 2b, 3, 4, 4a, 5, 6, 7, 8, and 9 were admitted. Staff called five witnesses: Irma Joyce De La Garza, Manuel Medina, Susan Soto, Robert S. Guevara, M.D., and

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[4] 22 Tex. Admin. Code § 213.33.

[5] 22 Tex. Admin. Code § 213.33(c).

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

[7] 1 Tex. Admin. Code § 155.427.

Linda Laws. Respondent's Exhibits 1 and 2 were admitted. Mr. Sanchez testified on his own behalf and called two witnesses: Vilma Robles and Ricardo Ibarra.

A. Evidence

1. Irma Joyce De La Garza's Testimony and Manuel Medina's Testimony

Irma Joyce De La Garza, a Mental Health Technician (MHT) at the facility, testified that on September 27, 2016, she was checking on her patients and arrived at MA's room when she noticed that the door was closed. She testified that when she opened the door, it hit the bathroom door, making a noise. Ms. De La Garza stated that she saw Mr. Sanchez kneeling at MA's bedside with his face at MA's private area.[8] Ms. De La Garza indicated that she was astonished and left the room very distraught. When she left the room, Ms. De La Garza saw Manuel Medina, another MHT at the facility. She testified that she pleaded with Mr. Medina to go check on MA.[9]

Mr. Medina testified that he went to MA's room and the door was closed, which he found unusual because of safety concerns that might develop at a psychiatric hospital.[10] He testified that the door to MA's room hit the bathroom door, similar to what Ms. De La Garza described.[11] Mr. Medina testified that when he entered the room he saw Mr. Sanchez down on one knee close to MA's genital area. He also noted that MA had a towel across his genitals and his shorts were down, and he saw that Mr. Sanchez had his hands under the towel. Mr. Medina further stated that Mr. Sanchez quickly got up and stated that he was attending to MA because MA was not feeling well.[12]

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[8] Transcript (Tr.) at 15.

[9] Tr. at 20.

[10] Tr. at 36.

[11] Tr. at 37.

[12] Tr. at 37.

Ms. De La Garza testified that she returned to MA's room about ten minutes later (after Mr. Medina had left) and the door was closed again. She stated that she saw Mr. Sanchez kneeling at MA's bed with his head at MA's genitals and Mr. Sanchez's hands were moving. Ms. De La Garza stated that she told Mr. Sanchez to leave the room because at this point she saw sexual contact between Mr. Sanchez and MA. Ms. De La Garza indicated that Mr. Sanchez left the room and told her he was sorry and would not do it again.[13]

2. Susan Soto's Testimony

Susan Soto, Director of Nurses at the facility, testified that Ms. De La Garza and Mr. Medina came to her office to report that they observed Mr. Sanchez touching MA in a sexual manner. Ms. Soto stated that she realized that she had to immediately assess the situation, so she and Mr. Medina went to MA's room. She stated that, when she entered the room, MA was on his bed with his shorts and underwear down around his knees, a towel was across his midsection, and his chest was bare. Ms. Soto assessed MA, and she asked him what had happened. Ms. Soto testified that MA told her that a man had come to his room, asked him to lie down, and started to massage him on his head, neck, and chest before moving down to his thighs and genital area. Ms. Soto maintained that there was no medical reason that Mr. Sanchez should be examining MA's genital area. Ms. Soto stated that she believed there was a legitimate outcry of sexual contact committed by Mr. Sanchez. Ms. Soto indicated that she then contacted Robert S. Guevara, M.D., the attending physician, for instructions on how to proceed with MA.[14] Dr. Guevara sent MA to the emergency room that evening to be evaluated and indicated that he would evaluate MA in the morning.

3. Robert S. Guevara, M.D.'s Testimony

Dr. Guevara testified that he arrived at the facility the next morning to examine MA. He indicated that Ms. Soto accompanied him and that he was concerned about a potential acute change

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[13] Tr. at 21-30.

[14] Tr. at 52-56.

given MA's condition and the recent events. Dr. Guevara testified that he asked MA what had happened, and MA stated that an individual had examined him and then began touching him on various parts of his body, including his genital area, and that he felt uncomfortable talking about it. Dr. Guevara testified that, based on his conversation with MA and his assessment, MA's outcry of sexual contact was credible.[15]

4. Linda Laws's Testimony

Linda Laws, nurse consultant for the Board and Staff's expert witness, testified that revocation of Mr. Sanchez's licenses is the appropriate sanction in this case. She testified that Mr. Sanchez violated professional boundaries because he did not act in the best interest of a vulnerable patient. Ms. Laws indicated that it is an extreme boundary violation, even if consensual, for a nurse to have sexual contact with a patient. She further stated that nurses have a certain set of skills and patients trust that nurses will use those skills in the most trustworthy and professional way. In evaluating the facts in this case, Ms. Laws opined that Mr. Sanchez violated minimum standards of the nursing practice. Specifically, she concluded that he did not provide a safe environment and did not maintain professional boundaries. Ms. Laws also found that the vulnerability of MA, as a psychiatric patient, was an aggravating factor. Ms. Laws found that Mr. Sanchez's conduct is a third tier offense under the Board's disciplinary matrix under Texas Occupations Code § 301.452(b)(10), because it involves sexual or sexualized contact with a patient. Under the third tier sanction level, a level 1 offense involving sexual contact with a patient should result in the revocation of a nurse's licenses, according to Ms. Laws.[16]

5. Mr. Sanchez's Testimony

Mr. Sanchez testified that, on September 27, 2016, he was preparing for his upcoming shift when another nurse, Ms. Comilang, asked him to check on MA because she needed to finish some

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[15] Tr. at 68-70.

[16] Tr. at 88-90, 92-96.

tasks before the shift change and because MA had been crying all day. Mr. Sanchez indicated that he initially walked MA around the unit several times, but MA insisted that he be taken back to his room even after Mr. Sanchez offered to take him to a quiet room with more staff present. Mr. Sanchez claimed that when he took MA back to his room, Mr. Sanchez knelt next to MA's bed and anyone entering the room would not be able to see MA. Mr. Sanchez recalled that Ms. De La Garza entered the room and she stated that he should not be attending to MA. He also recalled Mr. Medina entering the room, and Mr. Sanchez told him he was trying help MA with a crisis. Mr. Sanchez denied touching MA in a sexualized way, and he also denied that MA took off his shorts. Mr. Sanchez explained that MA's bed did not have any bed linens because it was against policy to have bed linens in the room due to the high rate of suicide attempts among the patients at the facility. Mr. Sanchez admitted he apologized to Ms. De La Garza when she confronted him in the hallway because he felt threatened by her. Mr. Sanchez remembered that Becky Tresnicky, the facility administrator, informed him that he was on administrative leave while an investigation was conducted. He stated that a few days later he was terminated from the facility.[17] Since Mr. Sanchez's termination, he has worked at Palms Behavioral Health and has received good evaluations on his nursing skills.[18]

6. Vilma Robles's Testimony and Ricardo Ibarra's Testimony

Vilma Robles hired Mr. Sanchez to work at the facility and she worked with him at Palms Behavioral Health after he left the facility. She testified that Mr. Sanchez has always been professional with patients. Although Ms. Robles was not at the facility when the incident occurred, she stated that, in the years that she has worked with Mr. Sanchez, she had never seen any behavior consistent with the allegations in this case. Ricardo Ibarra, a licensed clinical social worker, worked with Mr. Sanchez at the facility and at Palms Behavioral Health. He testified that

[17] Tr. at 111-22.

[18] Respondent Ex. 2.

Mr. Sanchez has always been professional and he has never witnessed any professional boundary issues regarding Mr. Sanchez.[19]

B. ALJ's Analysis

Mr. Sanchez asserts that Staff did not meet its burden of proof because Staff's witnesses never actually saw Mr. Sanchez touch MA's genitals, claiming instead that MA's shorts were down or that Mr. Sanchez's hands were under a towel. Mr. Sanchez also argues that Ms. De La Garza testified that MA covered himself with a sheet when she entered but, as Mr. Sanchez testified, there were no bed linens on the bed because it was against policy given the increased risk of suicide with bed linens. Mr. Sanchez also disputes that Ms. De La Garza entered the room more than once because he only recalls her entering one time. Mr. Sanchez contends that Ms. De La Garza, Mr. Medina, and Ms. Soto should have taken immediate action if they truly believed Mr. Sanchez was inappropriately touching MA. Mr. Sanchez maintains that Dr. Guevara's testimony is not credible because he did not assess MA for almost 16 hours after the incident. Mr. Sanchez insists that he did not violate any Board rules or statutes because he did not have any sexual contact with MA.

The burden of proof in this case rests with Staff. The ALJ disagrees with Mr. Sanchez's assessment of the evidence and finds that Staff established by a preponderance of the evidence that Mr. Sanchez engaged in sexual misconduct with MA.

To begin with, MA was not Mr. Sanchez's patient and he was not assigned to care for MA that day.[20] Mr. Sanchez testified that Ms. Comilang asked him to watch MA while she completed some of her duties before departing for the day.[21] Although Mr. Sanchez's explanation does not seem unreasonable, there is no evidence to corroborate that Ms. Comilang asked Mr. Sanchez to watch MA. In addition, Mr. Sanchez repeatedly closed the door while attending to MA, which

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[19] Tr. at 143-49.

[20] Tr. at 52.

[21] Tr. at 111.

was unusual given the safety concerns at the psychiatric facility.[22] Furthermore, Mr. Sanchez opened the bathroom door so that a banging sound occurred when the bedroom door opened, thus alerting him that someone was entering the room.[23] Moreover, if MA was in such distress as Mr. Sanchez claimed, it would make sense for Mr. Sanchez to have reached out to other staff for help, instead of isolating himself in a room with a psychiatric patient whom he knew very little about.

Importantly, the testimonies of Ms. De La Garza, Mr. Medina, and Ms. Soto all corroborate each other. These witnesses testified that based on what they observed—Mr. Sanchez kneeling by the bedside, Mr. Sanchez's hand under a towel/sheet near MA's genital area, MA's shorts down by his knees, etc.—they believed Mr. Sanchez was engaging in inappropriate sexual contact with MA. Despite Mr. Sanchez's claim that these individuals did not take immediate action, the evidence shows that they acted quickly and decisively, given the nature of the situation. Although there are some variations in the testimony as to what they saw (a sheet versus a towel, for example), all three witnesses testified that Mr. Sanchez was engaging in inappropriate sexual contact with MA.[24] In addition, MA's statements corroborate the witnesses' observations. MA stated to Ms. Soto shortly after the incident that a man came to his room, began to massage his head, neck, and chest, and then massaged his genital area.[25] Ms. Soto believed MA's statement to be a credible outcry of sexual misconduct by Mr. Sanchez because there would be no reason Mr. Sanchez needed to examine MA's genital area. Finally, when Dr. Guevara assessed MA the next morning, MA stated that a man examined him on various parts of his body, including his genital area, which Dr. Guevara believed to be a credible outcry.[26]

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[22] Tr. at 14, 53.

[23] Tr. at 14-15.

[24] The variations/inconsistencies in the testimony of Staff witnesses noted by Mr. Sanchez do not overcome the overwhelming and consistent evidence that the witnesses saw Mr. Sanchez engaging in inappropriate sexual behavior.

[25] Tr. at 54.

[26] Tr. at 69-70.

Mr. Sanchez's actions as established by Staff constitute violations of the Code and Board rules. 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. Mr. Sanchez'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)(D), prohibiting violations of the professional boundaries of the nurse-client relationship, including physical, sexual, or emotional exploitation of the client, and 217.12(6)(E), touching a client in a sexual manner.

Whether analyzed under Code § 301.452(b)(10) or (13), the Matrix designates Mr. Sanchez's conduct as a Third Tier offense.[27] 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 patient safety is at risk, and a Second Tier offense includes a personal relationship that violates the professional boundaries of the nurse/patient relationship. Mr. Sanchez's actions were not minor, upset MA, and put him at emotional risk, so the First Tier is inappropriate. Mr. Sanchez and MA 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.

Similarly, pursuant to the Matrix, the Third Tier is the most appropriate classification of Mr. Sanchez'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

[27] 22 Tex. Admin. Code § 213.33.

known." Sexual misconduct such as that committed by Mr. Sanchez creates a risk of serious 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 I listed in the Matrix for Code § 301.452(b)(13) is most applicable. A Third Tier, Sanction Level I disciplinary action is thus appropriate under Code § 301.452(b)(13).

The Sexual Misconduct Policy provides that sexual misconduct with a patient is never acceptable and that each case will be considered on an individual basis. In this case, the ALJ relies on the more specific guidance found in the Matrix, recognizing the Board policy that sexual misconduct is never acceptable.

Mr. Sanchez has a record of good performance as a nurse[28] and two colleagues testified that Mr. Sanchez is a good nurse and very professional, which are mitigating factors to be considered. However, given the serious nature of the misconduct, Mr. Sanchez's actions warrant a Third Tier, Sanction Level I disciplinary action of revocation.

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. Eric Sanchez was issued his Licensed Vocational Nurse (LVN) License No. 160523 by the Texas Board of Nursing (Board) in October 1996, and the Board issued his Registered Nurse (RN) License No. 160523 in April 2016.

2. On September 27, 2016, Mr. Sanchez was employed as a nurse at Valley Baptist Medical Center (facility) in Brownsville, Texas.

3. Patient MA was a psychiatric patient at the facility on September 27, 2016.

4. Mr. Sanchez went to MA's room, although MA was not one of his patients.

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[28] Respondent Exs. 1, 2.

5. Mr. Sanchez closed MA's bedroom door, although it was not an accepted practice at the facility to close the bedroom door because of safety concerns.

6. Mr. Sanchez also opened the bathroom door in the bedroom so that if the bedroom door opened, it would bang against the bathroom door and make a loud noise.

7. While in MA's room, Mr. Sanchez knelt down by MA's bed with his hands moving near MA's genital area.

8. Irma Joyce De La Garza (a Mental Health Technician (MHT)), Manuel Medina (another MHT), and Susan Soto (Director of Nurses) witnessed Mr. Sanchez near MA's bedside engaging in inappropriate sexual contact with MA.

9. MA told Ms. Soto and Robert S. Guevara, M.D., that a man came to his room and massaged various parts of his body, including his genital area.

10. Becky Tresnicky, facility administrator, placed Mr. Sanchez on administrative leave during the investigation of the incident, and he was terminated a few days later.

11. On October 24, 2018, Board Staff sent Mr. Sanchez a First Amended 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.

12. The hearing convened at the State Office of Administrative Hearings (SOAH) on June 25, 2019, before Administrative Law Judge Michael J. O'Malley. Assistant General Counsel John Vanderford represented Staff. Attorney Mark M. Meyer represented Mr. Sanchez. The hearing concluded that day, and the record closed August 5, 2019, with the filing of written briefs.

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. Mr. Sanchez 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. Mr. Sanchez 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. Mr. Sanchez is 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)(D), (E) (2016).

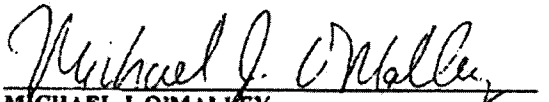
7. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license. Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

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 Administrative Law Judge recommends that the Board revoke LVN License No. 160523 and RN License No. 897182 issued to Eric Sanchez.

SIGNED September 12, 2019.



MICHAEL J. O'MALLEY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARING

DOCKET NO. 507-18-1454

IN THE MATTER OF	§	
PERMANENT CERTIFICATE	§	BEFORE THE TEXAS STATE
NUMBER RN 897182 & LVN 160523	§	
ISSUED TO ERIC SANCHEZ,	§	OFFICE OF ADMINISTRATIVE HEARINGS
RESPONDENT	§	

RESPONDENT'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

TO THE HONORABLE JUDGE OF SAID COURT:

NOW COMES Respondent, Eric Sanchez, and files this response to Staff of the Texas Board of Nursing's ("Staff") exceptions to the Proposal for Decision:

ALJ Analysis

As an initial matter, Respondent takes exception to how the Administrative Law Judge (ALJ) in this case assessed the evidence. First, Respondent notes that the ALJ properly states that the burden of proof lies with Staff of the Board of Nursing (Staff). But immediately the ALJ discusses the reasons that the Respondent was even in the room of patient MA.[1] The Respondent's testimony as to why he was in the room was the only testimony on that fact, and the ALJ did find the explanation plausible.[2] But the ALJ then states there is no testimony to corroborate the fact – but there doesn't need to be testimony to corroborate that fact for the ALJ to accept it as credible as Staff would have the burden to show that it is not credible. To the extent that any of the ALJ's further analysis, the Findings of Fact, or the Conclusions of Law rest on an assertion that the Respondent was in patient MA's room for any other reason that what the Respondent testified too at the hearing, Respondent respectfully excepts to this analysis.

Finding of Fact No. Five (5):

Finding of Fact No. Five (5) asserts that the Respondent closed patient MA's bedroom door. However, in response to questioning by the ALJ, Respondent testified that he does not recall closing the door, and that he believes that the door was actually closed by either Ms. De La Garza

[1] Proposal for Decision (PFD), at 8.

[2] *Id.*

or Mr. Medina.[3] Apparently there is a video of the hallway where the patient MA's bedroom is located,[4] but Staff did not show the video, and it is unclear if the video would actually show if the door was open or closed.[5] Therefore, Respondent argues that the question if the door to the bedroom was open or closed is not clear, and since Staff has the burden of proving the facts of this case, the evidence does not support a Finding of Fact that patient MA's bedroom door was closed by the Respondent. Therefore, Respondent respectfully requests that Finding of Fact No. Five (5) be deleted.

Finding of Fact No. Six (6):

Finding of Fact No. Six (6) asserts that the Respondent opened a bathroom door in patient MA's bedroom so that it would make a loud noise if the bedroom door was opened. This finding of fact is not supported by the evidence. In addition, the ALJ appears to state that Mr. Sanchez opened the bathroom door in the room "so a banging sound occurred when the bedroom door opened, thus alerting him that someone was entering the room."[6] But the Respondent later testified that he did not open the bathroom door at all.[7] In addition, as argued above with regards to Finding of Fact No. Five (5) regarding the bedroom door, the Respondent asserts that in order to believe that he opened the bathroom door to make a loud noise when the bedroom door was opened, first you would have to have evidence that the Respondent has also closed the bedroom door, which the Respondent continues to deny.[8] Therefore, Respondent excepts to any assertion that he opened the bathroom door, and also Respondent excepts to the statement that he opened the bathroom door to cause it create a loud noise when the bedroom door was opened. Respondent respectfully requests that Finding of Fact No. Six (6) be deleted.

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[3] Transcript (Tr.), at 134.

[4] Tr., at 138.

[5] Tr., at 139.

[6] PDF, at 9. Citing Tr. at 14–15.

[7] Tr., at 135. Earlier, Respondent testified that the doors in the rooms were older and sometimes did not stay completely shut, even without intervention to open the door. Tr, at 116.

[8] Add footnote.

Finding of Fact No. Eight (8):

Finding of Fact No. Eight (8) asserts that there were three witnesses that testified that Respondent was "engaging in inappropriate sexual contact" with patient MA. But this is not what the witnesses testified too, as indicated in the PFD and in their testimony. Ms. Soto, the Director of Nurses at the facility, could only testify to what Ms. De La Garza, Mr. Medina, and patient MA told her, so she did not witness any inappropriate sexual contact with patient MA, only that an outcry was made.[9] Ms. De La Garza also never testified that she saw any direct sexual contact between Respondent and patient MA, only that she allegedly saw the sheet move.[10] Mr. Medina also testified that "I didn't really see much what he was doing," while characterizing it as sexual contact.[11] But under cross-examination, Mr. Medina admitted he never saw direct contact between the Respondent and patient MA's genitals.[12]

In addition, Respondent clearly testified that if he was where Ms. De La Garza and Mr. Medina said he was in the room, there is no way they could have seen him touching the patient because that area would he was in between the patient and the door, and thus the patient was obscured somewhat from the sightline of the door.[13] Therefore, Respondent argues that any assertion that any witnesses could testify that there was "sexual contact" between the Respondent and patient MA is not supported by the evidence.

Finally, Respondent excepts to the ALJ's attempt to diminish the significant differences in the testimony of Ms. De La Garza and Mr. Medina. Specifically, the ALJ does note that there are some variations in testimony, such as the issue of whether there was a sheet or a towel in the room.[14] But Respondent argues that this ignores the fact that he later provided uncontroverted testimony that because the patient was a suicide risk, and they were on the day shift, there were

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[9] Respondent makes no claim that the outcry from patient MA is something that should have been ignored. In fact, it was quite consistent with his pathology that he would have aberrant sexual thoughts.

[10] Tr., at 24.

[11] Tr., at 37.

[12] Tr., at 46.

[13] Tr., at 116.

[14] PFD, at 9.

no bed linens or towels in the room.[15] Respondent argues that these inconsistencies are vitally important because they raise what is essentially a fatal flaw in Staff's case in that if Ms. De La Garza and Mr. Medina stated they did not see actual contact between the Respondent and patient MA's genitals because Respondent's hands were obscured by a sheet or towel, and there were no sheets or towels in the room, as Respondents uncontroverted testimony shows was the policy for a patient such as patient MA, then the only conclusion that can be drawn is that Ms. De La Garza and Mr. Medina were not truthful. Therefore, Respondent argues there is not sufficient evidence that the Respondent had sexual contact with patient MA, and Respondent respectfully requests that Finding of Fact No. Eight (8) be deleted.

Finding of Fact No. Seven (7):

Finding of Fact No. Seven (7) asserts that the Respondent knelt by patient MA's bed with his hands moving near patient MA's genital area. For the same reasons asserted with regards to Finding of Fact No. Eight (8), Respondent denies that while has was kneeling that his hands were moving near patient MA's genital area. Respondent respectfully requests that Finding of Fact No. Seven (7) be deleted.

Conclusion of Law No Five (5):

Conclusion of Law No. Five (5) has two findings that state the Respondent failed to promote a safe environment for a client and failed to maintain professional boundaries, and thus violated Section 301.452(b)(13) of the Nursing Practice Act and violated the minimum standards of nursing practice.

With regards to Board Rule 217.11(1)(J),[16] the rules require a nurse to maintain professional boundaries of the nurse-client relationship. Respondent argues that absent a Finding of Fact that shows the Respondent had inappropriate sexual contact with patient MA, then there is no violation of professional boundaries. The only allegation in this case relates to inappropriate sexual contact. As the Respondent has argued above, the evidence does not support Finding of

[15] Tr., at 118–19.

[16] The Board Rules are cited correctly, but Board Rule 217.11 refers to the minimum standards of nursing practice. A violation of Board Rule 217.11 is a violation of Section 301.452(b)(13) of the Nursing Practice Act.

Fact No. Eight (8), which is the finding of fact that there was inappropriate sexual contact between the Respondent and patient MA. Thus, Respondent asserts that there can be no violation of Board Rule 217.11(1)(J).

With regards to Board Rule 217.11(1)(B), the rules require a nurse to promote a safe environment for patient MA. Respondent argues that this Board Rule is essentially derivative of the requirements of Board Rule 217.11(1)(J). Since the Respondent argues that there is no violation of Board Rule 217.11(1)(J), Respondent also asserts that there can be no violation of Board Rule 217.11(1)(B). In order for there to be a violation of Section 301.452(b)(13) of the Nursing Practice Act, there must be a violation of Board Rule 217.11. Therefore, Respondent argues that since there is no violation of Board Rule 217.11, Conclusion of Law No. Five should be amended to indicate that there is no violation of Section 301.452(b)(13) of the Nursing Practice Act.

Conclusion of Law No Six (6):

Conclusion of Law No. Six (6) has two findings that state the Respondent caused physical, emotional or verbal abuse or injury to a client and failed to maintain professional boundaries, including physical, sexual, or emotional exploitation of a patient, and thus violated Section 301.452(b)(10) of the Nursing Practice Act and thus committed unprofessional conduct.[17]

With regards to Board Rule 217.12(6)(D), the rules require a nurse to maintain professional boundaries of the nurse-client relationship. Respondent argues that absent a Finding of Fact that shows the Respondent had inappropriate sexual contact with patient MA, then there is no violation of professional boundaries. The only allegation in this case relates to inappropriate sexual contact. As the Respondent has argued above, the evidence does not support Finding of Fact No. Eight (8), which is the finding of fact that there was inappropriate sexual contact between the Respondent and patient MA. Thus, Respondent asserts that there can be no violation of Board Rule 217.12(6)(D).

With regards to Board Rule 217.12(6)(E), the rules prohibit sexual conduct with a patient, touching a client in a sexual manner, or other behaviors suggestive of the same. Respondent argues that absent a Finding of Fact that shows the Respondent had inappropriate sexual contact with

[17] The Board Rules are cited correctly, but Board Rule 217.12 refers to unprofessional conduct rule. A violation of Board Rule 217.12 is a violation of Section 301.452(b)(10) of the Nursing Practice Act.

patient MA, then there is no violation of professional boundaries. The only allegation in this case relates to inappropriate sexual contact. As the Respondent has argued above, the evidence does not support Finding of Fact No. Eight (8), which is the finding of fact that there was inappropriate sexual contact between the Respondent and patient MA. Thus, Respondent asserts that there can be no violation of Board Rule 217.12(6)(E). In order for there to be a violation of Section 301.452(b)(10) of the Nursing Practice Act, there must be a violation of Board Rule 217.12. Therefore, Respondent argues that Conclusion of Law No. Five should be amended to indicate that there is no violation of Section 301.452(b)(10) of the Nursing Practice Act.

Sanction Recommendation

As the Respondent argues above, there is not enough evidence to show by a preponderance of the evidence that the Respondent violated the Board of Nursing rules or the Nursing Practice Act. Based on testimony of Linda Laws, Staff's expert witness, this means there should be no disciplinary action recommended in this case.

Respectfully submitted,

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CERTIFICATE OF SERVICE

This is to certify that on the 11th day of October, 2019, a true and correct copy of the above and foregoing document was served on the following individual(s) at the location(s) and in the manner indicated below:

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State Office of Administrative Hearings

Kristofer Monson
Chief Administrative Law Judge

November 19, 2019

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

RE: Docket No. 507-18-1454, *Texas Board of Nursing v. Eric Sanchez*
Exceptions Letter

Dear Ms. Thomas:

On September 12, 2019, the Administrative Law Judge (ALJ) issued the Proposal for Decision (PFD) in this case. On October 11, 2019, Eric Sanchez, Respondent, filed exceptions to the PFD. On October 15, 2019, Staff of the Texas Board of Nursing (Staff) requested an extension of time to file its reply to exceptions. In Order No 10, the ALJ granted Staff's request and extended the deadline to file a reply to exceptions to November 12, 2019. Staff did not file a reply to exceptions.

In the PFD, the ALJ found that Staff met its burden of proof. Respondent takes issue with many of the facts that the ALJ found to credible based on the testimony of Staff's witnesses. For example, Respondent disputes the following facts found to be true by the ALJ: that Respondent closed patient MA's bedroom door; that Respondent opened the bathroom door in MA's bedroom so that a loud noise occurred when the bedroom door opened; that the Staff witnesses saw Respondent near MA's bedside engaging in inappropriate sexual contact with MA; and that Respondent knelt down by MA's bedside with his hands moving near MA's genital area. Respondent also objects to the conclusions of law that Respondent failed to maintain professional boundaries, failed to promote a safe environment, and caused injury to MA. Finally, Respondent argues that the evidence does not support any sanction in this case.

As thoroughly explained and analyzed in the PFD, the ALJ found Staff witnesses to be credible; therefore, Staff met its burden of proof. Based on the witnesses' testimony and other credible evidence, the ALJ found that Respondent engaged in inappropriate sexual conduct with MA. Therefore, the findings of fact and conclusions of law support the ALJ's conclusion and sanction recommendation.

Accordingly, the ALJ does not recommend any changes to his PFD based on Respondent's exceptions, and the PFD is now ready for consideration.

Respectfully,

Michael J. O'Malley
Administrative Law Judge

MJO/nm
Enclosures

xc: John L. Vanderford, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA INTERAGENCY**
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