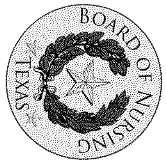

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.

Executive Director of the Board

DOCKET NUMBER 507-19-3433

IN THE MATTER OF PERMANENT CERTIFICATE	**§**	**BEFORE THE STATE OFFICE**
NUMBER 330947, ISSUED TO	**§**	**OF**
JOSE ORLANDO DIAZ	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: JOSE ORLANDO DIAZ
6900 CURRY DR.
THE COLONY, TX 75056

KATHRYN LEWIS
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on July 23, 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; Staff's response to Respondent's exceptions to the PFD; the ALJ's letter ruling dated April 3, 2020; 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. Respondent filed exceptions to the PFD on March 3, 2020. Staff filed a response to Respondent's exceptions to the PFD on March 5, 2020. On April 3, 2020, the ALJ issued a final letter ruling, in which she 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 letter ruling dated April 3, 2020 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 ALJ found that the Respondent's conduct warrants a second tier, sanction level II sanction for his violations of §301.452(b)(10) and (13)[1]. Either licensure suspension or revocation is authorized under a second tier, sanction level II sanction. The Board agrees with the ALJ that a probated suspension is the most appropriate sanction in this case[2].

Respondent's conduct was not isolated or minor, but instead involved a series of incidents that caused distress and posed a serious risk of harm to the sister of a patient[3]. While these actions were aimed at the patient's sister, Respondent's contact was made possible by his nurse-patient relationship with the patient[4]. Respondent abused his role as a caregiver to the patient by his conduct towards the patient's sister[5]. The Board recognizes, however, that the ALJ found mitigating factors. These include lack of evidence of injury; Respondent's practice history, which does not show any other disciplinary actions; and Respondent's reportedly successful subsequent employment as a nurse[6].

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(e)(6), that a probated suspension for two years is the most appropriate sanction in this matter.

The Board finds that the Respondent's probated suspension should complete remedial education courses in nursing jurisprudence and ethics, professional boundaries, and critical thinking[7]. These courses are intended to inform the Respondent of the standards and requirements applicable to nursing practice in Texas and to prevent future violations from occurring. The Board agrees with the ALJ that Respondent's practice should be subject to supervision. The Board further finds that the Respondent's practice should be subject to direct supervision for the first year of the Order and indirect supervision for the duration of the Order. The Board further agrees with the ALJ that the Respondent's practice should be limited so that he may only care for adult patients while under the terms of the Order. These supervisory requirements are intended to prevent additional violations from occurring and to ensure that any deficiencies in the

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[1] See pages 13-14 of the PFD.

[2] See pages 14-15 of the PFD.

[3] See page 14 of the PFD.

[4] See page 15 of the PFD.

[5] See *id.*

[6] See page 15 of the PFD.

[7] 22 Tex. Admin. Code §213.33(f) requires every order issued by the Board to include participation in a program of education, which at a minimum, shall include a review course in nursing jurisprudence and ethics; see also 22 Tex. Admin. Code §213.33(e)(10).

Respondent's practice can be discovered quickly and remediated appropriately. The employer notification and quarterly reporting requirements are necessary to ensure the Respondent is complying with the terms of the Order and successfully completes the terms of the order. The Board also agrees with the ALJ that the Respondent should be required to undergo counseling to address the areas of concern identified during Respondent's evaluation with Dr. Proctor[8]. These requirements are authorized by 22 Tex Admin. Code §213.33(e)(6)[9] and are consistent with Board precedent.

IT IS THEREFORE ORDERED that Vocational Nurse License Number 330947, previously issued to JOSE ORLANDO DIAZ, to practice nursing in the State of Texas is/are hereby **SUSPENDED** and said suspension is **STAYED** and RESPONDENT is hereby placed on **PROBATION** for a minimum of two (2) years **AND** until RESPONDENT fulfills the additional requirements of this 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. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state.

I. 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 Nursing Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 *et seq.*, and this Order.

II. UNDERSTANDING BOARD ORDERS

Within thirty (30) days of entry of this Order, RESPONDENT must successfully complete the Board's online course, "Understanding Board Orders", which can be accessed on the Board's website from the "Discipline & Complaints" drop-down menu or directly at: *http://www.bon.texas.gov/UnderstandingBoardOrders/index.asp*. Upon successful completion, RESPONDENT must submit the course verification at the

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[8] See pages 8-9 of the PFD.

[9] 22 Tex. Admin. Code §213.33(e)(4) authorizes reasonable probationary stipulations that may include remedial education courses and practice for at least two years under the direction of a nurse designated by the Board, as well as limitations on nursing activities/practice settings and counseling.

conclusion of the course, which automatically transmits the verification to the Board.

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 and video programs will not be approved.

B. **The course "Professional Boundaries in Nursing,"** a 3.0 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

C. **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.

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. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a licensed vocational nurse (LVN) n the State of Texas, providing direct patient care in a clinical 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 vocational nurse (LVN) license will not apply to this period and will not count towards completion of this requirement. **RESPONDENT may only provide nursing care to adult patients/clients while under the terms of this Order.**

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 of 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 individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual 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.

V. **Therapy.** While working as a nurse under the terms of this Order, RESPONDENT SHALL participate in therapeutic sessions with a therapist possessing credentials approved by the Board. RESPONDENT SHALL CAUSE the therapist to submit written reports, on forms provided by the Board, as to the RESPONDENT'S progress and capability to safely practice nursing. The report must indicate whether or not the RESPONDENT'S stability is sufficient to provide direct patient care safely. Such reports are to be furnished each and every month for three (3) months. If therapy is recommended beyond the initial three (3) months, the reports shall then be required at the end of each three (3) month quarterly period for the remainder of the probation period, or until RESPONDENT is dismissed from therapy.

VI. FURTHER COMPLAINTS

If, during the period of probation, an additional allegation, accusation, or petition is reported or filed against RESPONDENT'S license(s), the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

VII. SUBSEQUENT CRIMINAL PROCEEDINGS

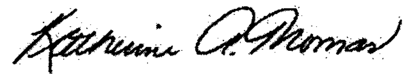
IT IS FURTHER ORDERED, should the RESPONDENT'S conduct, as outlined in the findings of fact in the PFD and adopted by this Order, result in subsequent judicial action, including a deferred disposition, RESPONDENT may be subject to further disciplinary action, up to, and including, revocation of RESPONDENT'S license(s) to practice nursing in the State of Texas

VIII. 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, subject to meeting all existing eligibility requirements in Texas Occupations Code Chapter 304, Article III, RESPONDENT may be eligible for nurse licensure compact privileges, if any.

Entered this 23rd day of July, 2020.

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision; Docket No. 507-19-3433 (February 18, 2020)

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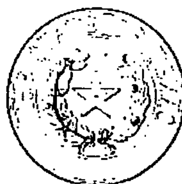

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

February 18, 2020

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. 507-19-3433; Texas Board of Nursing v. Jose Orlando Diaz

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, a SOAH rule which may be found at www.soah.texas.gov.

Sincerely,

KATHRYN LEWIS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

KL/mm
Enclosures
xc: Helen Kelley, 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 – **VIA INTERAGENCY**
Jose Diaz, 6900 Curry Dr., The Colony, Texas 75056 – **VIA REGULAR MAIL**

P.O. Box 13025 Austin, Texas 78711-3025 | 300 W. 15th Street Austin, Texas 78701
Phone: 512-475-4993 | Fax: 512-475-4994
www.soah.texas.gov

SOAH DOCKET NO. 507-19-3433

TEXAS BOARD OF NURSING, Petitioner	§	**BEFORE THE STATE OFFICE**
	§	
	§	
v.	§	**OF**
	§	
JOSE ORLANDO DIAZ, LVN LICENSE NO. 330947, Respondent	§	
	§	
	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) at the Texas Board of Nursing (Board) proposes disciplinary action against the Licensed Vocational Nurse (LVN) license held by Jose Orlando Diaz (Respondent) for failing to conform to the minimum acceptable standards of nursing practice, violating the boundaries of the nurse-patient relationship, and unprofessional conduct.

The Administrative Law Judge (ALJ) concludes Staff met its burden of proof by a preponderance of the evidence. Accordingly, the ALJ recommends the Board sanction Respondent with a two-year probated suspension of his nursing license, and (1) a course in nursing jurisprudence and ethics; (2) restriction to work solely with adult patients; (3) restriction to work only in supervised settings; and (4) counseling focused on increasing insight into the nature of the conduct underlying the allegations.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

Notice and jurisdiction were undisputed, and are set forth in the Findings of Fact and Conclusions of Law. ALJ Kathryn J. Lewis convened a hearing on the merits on August 5-6, 2019, and September 12, 2019, at the State Office of Administrative Hearings (SOAH) in Austin, Texas.

Assistant General Counsel Helen Kelley appeared, and represented Staff. Respondent was represented before and during the hearing by attorney Rex A. Manaster. Respondent informed the ALJ after the hearing that he was no longer represented by Mr. Manaster, and was given an opportunity to find other counsel to file closing arguments. Respondent instead represented himself for the remainder of the case. The record closed on December 20, 2019, after the parties filed closing briefs.

II. STAFF'S FORMAL CHARGE AND APPLICABLE LAW

In April 2018, Respondent was employed as an LVN with Epic Health Care in Dallas, Texas, and assigned to provide skilled nursing care to patient S.D. Staff's formal charge asserts Respondent violated the boundaries of the nurse-patient relationship by giving C.D., the patient's 17-year-old sister, a note with a heart and his phone number on it. Staff contends Respondent's conduct was likely to injure S.D. because it could have created confusion between Respondent's needs and those of his patient, and because S.D. could experience delayed distress.[1]

The Texas Nursing Practice Act, Texas Occupations Code title 3, subtitle E, chapter 301, gives the Board authority to discipline nurses for, among other things, (1) unprofessional conduct in the practice of nursing that is likely to deceive, defraud, or injure a patient, or the public,[2] and (2) failure to conform to the minimum acceptable standards of nursing practice in a manner that exposes a patient, or other person, unnecessarily to risk of harm.[3] These statutory provisions are elaborated in the Board's rules. Specifically, Staff asserted violations of:

- **22 Texas Administrative Code § 217.11(1)(A)** (requiring nurses to know, and conform to, the Texas Nursing Practice Act, Board rules and policies, and federal, state, and local laws, rules, or regulations affecting current area of nursing practice);
- **22 Texas Administrative Code § 217.11(1)(J)** (requiring nurses to know, recognize, and maintain professional boundaries of the nurse-patient relationship);
- **22 Texas Administrative Code § 217.12(1)(A)** (sanctioning careless, or repeated, failure, or inability to perform nursing in conformity with the minimum standards of acceptable practice); and
- **22 Texas Administrative Code § 217.12(6)(D)** (sanctioning violations of the professional boundaries of the nurse-patient relationship, including sexual, emotional, or financial exploitation of a patient, or a patient's significant other(s)).[4]

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[1] Staff Exhibit (Staff Ex.) 3; Respondent Ex. 5.

[2] Tex. Occ. Code § 301.452(b)(10).

[3] Tex. Occ. Code § 301.452(b)(13).

[4] *Id.*

"Professional boundaries" are appropriate limits which should be established by the nurse in the nurse-patient relationship due to the nurse's power and the patient's vulnerability. Maintenance of boundaries refers to providing nursing within the limits of the nurse-patient relationship that promotes patient dignity, independence, and best interests, and requires nurses to refrain from inappropriate involvement in a patient's personal relationships, and/or pursuit of personal gain at a patient's expense.[5]

If the Board finds a nurse committed sanctionable conduct, the Board will enter an order imposing one or more sanctions listed in Texas Occupations Code § 301.4531), up to and including licensure denial, revocation, suspension, and/or other disciplinary action.[6] The Board may also require the nurse to submit to care, counseling, or treatment by a health provider designated by the Board as a condition of obtaining, or renewing, his or her license, to include: (1) an educational program, including a remedial one, or counseling; or (2) practice for a specified period under the direction of a nurse designated by the Board.[7]

Board Rule 213.33(b) sets out a disciplinary matrix (Matrix), which classifies offenses by Tier and Sanction Level. The Matrix is designed to match the severity of the sanction imposed with the nature of the violation, taking into account mitigating and aggravating factors.[8]

Staff must prove its charge by a preponderance of the evidence.[9]

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[5] 22 Tex. Admin. Code § 217.1(29).

[6] Tex. Occ. Code § 301.453(a)(1)-(7).

[7] Tex. Occ. Code § 301.453(b).

[8] 22 Tex. Admin. Code § 213.33; *see also* Tex. Occ. Code § 301.4531.

[9] 1 Tex. Admin. Code § 155.427.

III. DISCUSSION

Staff offered eleven exhibits, which were all admitted, and called five witnesses. Respondent offered twenty exhibits, of which fifteen were admitted.

Staff called the patient's sister, C.D.; Sharon Downs, who is C.D.'s and S.D.'s mother; and Respondent. Staff also called Dr. Timothy Proctor, a forensic psychologist and testifying expert, and Dr. Jolene Zych, a Board consultant and expert in nursing practice, policy, and ethics.

Respondent testified on his own behalf during the presentation of his case. He also called Scott Doherty, Board Investigator, to testify about complaint investigation procedures.

A. Fact Witnesses

1. C.D., the Patient's Sister

Staff called C.D., the patient's 17-year-old sister, who lives in the Downs family home with her parents and four siblings between the ages of five and sixteen. C.D. testified by phone about her communications with Respondent, and how certain interactions made her uncomfortable.

C.D. said Respondent watched her walk down the stairs, told her she was beautiful, and said he was surprised she did not have a boyfriend. He gave C.D., and each of her siblings, $20 gift cards for Christmas. Respondent also gave C.D. $100 for her 17th birthday. She found this gift unsettling due to the amount, and because her siblings did not receive similar gifts on their birthdays.

C.D. testified she initially ignored Respondent's request for a birthday hug, but agreed after several requests. She stated the hug made her particularly uncomfortable because it was a chest-to-chest hug, rather than shoulder-to-shoulder. C.D. noted that Respondent did not hug her siblings.

C.D. testified about an incident in March 2018, when Respondent came upstairs and knocked on her bedroom door. This was unusual because he worked with S.D. on the ground floor, and Respondent's regular duties did not take him upstairs. It was time for Respondent's shift to end, and he always gave an end-of-shift report. C.D. did not normally receive end-of-shift reports, and Respondent's presence on the second floor outside her bedroom door made her uncomfortable.

C.D. also described an incident in April 2018, when Respondent threw her a note while they were in the car while her mother drove. It read, "I heart C," and had a phone number on it. This incident caused C.D. to feel particularly unsafe around Respondent because she believed he had a sexual interest in her. She reported this incident to her mother, which led to Respondent's termination.

Finally, C.D. testified Respondent's behavior caused her significant distress, and she feels bad about the stress and pain it caused her parents because they were worried about her. It was also difficult to find a permanent nurse for S.D. to replace Respondent.

2. Sharon Downs, S.D.'s and C.D.'s Mother

Mrs. Downs testified by phone about her interactions with Respondent before and after she became aware of his inappropriate actions towards C.D. She also testified about her interactions with her daughter after she learned about the note.

Mrs. Downs said Respondent was referred by a case manager to provide S.D. with skilled nursing services. He worked one shift a week on Sundays for approximately one and a half to two years. In addition to S.D. and C.D., the Downs family has three other children. S.D. requires skilled nursing inventions at home, including medication administration; ongoing vital signs and other assessments related to a kidney transplant; and monitoring of several other medical disabilities. S.D. has a developmental disability and is "non-verbal."

Mrs. Downs testified S.D.'s complex medical needs have required home-based skilled nursing interventions since birth. Home health services generally involves shift work. As a result,

it was not uncommon for different nurses to work with S.D. in a given week. Mrs. Downs attempted to keep these relationships professional, but when a nurse regularly worked with S.D., the family may come to know him or her better over time. This was the case with Respondent, with whom she was professional to ensure her son received proper care, but with whom she also developed a "friendly" relationship. When S.D.'s nursing needs were met, and Respondent had time during his shift, the two would speak about his family, and growing up in El Salvador.

Respondent gave S.D. gifts, including a walker and racecar bed, which Mrs. Downs did not find inappropriate. She stated he also gave each sibling a $20 gift card for the holidays. When Respondent mentioned he wanted to give C.D. a gift of $100 for her birthday, Mrs. Downs told him he did not need to do that. She testified she was not aware Respondent had given C.D. the money until her daughter's deposition.

Mrs. Downs explained that she was generally responsible for handling S.D.'s nursing staff, rather than her husband. She stated she would not characterize Mr. Downs's behavior towards Respondent as overprotective of C.D. She instead observed a friendly and appropriate relationship between Respondent and Mr. Downs. Mrs. Downs testified she usually spoke with Respondent at the end of his shift to receive a report, rather than her husband. On rare occasions, when neither she nor her husband were available, C.D. might receive end-of-shift report from Respondent.

Mrs. Downs testified she was generally aware of Respondent's comments about her daughter's appearance, but she did not have a full picture of the impact on C.D. until later. Had she known, she would have intervened sooner. She further testified she first became aware Respondent made C.D. feel unsafe after he gave her daughter the note, and after C.D. confirmed the note had Respondent's phone number on it. Mrs. Downs reported the incident to his employer, and Respondent did not return to the Downs family home.

3. Respondent

Respondent testified about his employment history and providing skilled nursing care to S.D. He said that he liked working with S.D., and for the Downs family. Respondent also described his interactions with C.D.

Respondent testified his behaviors towards C.D. were appropriate and professional, and he disputed he made one or more sexual overtures towards her. Respondent insisted this case was nothing but a misunderstanding between himself, C.D., and Mrs. Downs, and stated he felt the misunderstanding may stem from Mr. Downs's overprotective nature. Respondent attributed certain behavior to cultural differences between himself and the Downs family, or perhaps his intentions were misunderstood because English is not his first language. He further testified he felt as a grandfather would towards C.D., and denied needing counseling to gain insight into his conduct.

Finally, Respondent testified his lack of intent to harm or scare C.D. was not fairly considered by his former employer before he was fired, or by the Board throughout the investigative process. He added that since being terminated from employment with Epic Health care, he has continued working as a nurse without incident.

B. Staff's Expert Witnesses

1. Dr. Timothy James Proctor, Ph.D., ABPP

Dr. Timothy Proctor is board certified in forensic psychology. He testified regarding his clinical impressions and opinions, treatment recommendations, and recommended limitations on Respondent's license.

Dr. Proctor is a licensed sex offender treatment provider, and completed a sex offender evaluation of Respondent in September 2018. He testified Respondent does not have a known or suspected history of sexual violence, or other sexual misconduct. Dr. Proctor further explained

Respondent is not a sex offender, and was not charged with a criminal offense in connection with the conduct alleged here.

Dr. Proctor said he reviewed the records Staff provided, and evaluated Respondent for over four hours on July 30, 2018, including two hours of clinical interview and two hours of psychological testing. The evaluation was designed to determine if Respondent can perform the essential job functions of nursing in a safe and effective manner.

Evaluation methods included clinical review, observation/mental status examination, and personality testing using the Personality Assessment Inventory (PAI). Dr. Proctor explained the PAI is the only assessment he used with Respondent because other assessments evaluate a propensity to re-offend after being charged with, or convicted, of a crime, which is not the case here. According to Dr. Proctor, the PAI is a short assessment that is more appropriate in a civil context, like here, where the Board alleges Respondent committed a licensure violation. Further, because English is Respondent's second language, Dr. Proctor chose the PAI because its language and questions are straightforward, and the test better accounts for linguistic differences.

Dr. Proctor testified the PAI provided two key pieces of information, the first being whether Respondent responded in a forthright manner on this portion of the evaluation, and in a manner that would not deceive the evaluator. The results indicated Respondent approached the test by denying minor faults and flaws, and presented himself in an overly favorable manner. Dr. Proctor opined Respondent's responses suggested he was not being honest. The second piece of information the PAI yielded was whether Respondent may have psychological difficulties not specific to sexual disorders, or other dysfunction. Based on the results of this part of the evaluation, Dr. Proctor had concerns about Respondent's ability to safely and effectively perform the essential job functions of nursing practice, and he recommended stipulations on Respondent's license.

Finally, Dr. Proctor pointed to concerning behaviors, including Respondent's secrecy in giving C.D. the note, and its inappropriate content given her relationship to the patient, and her age. Due to Respondent's failure to acknowledge wrongdoing, or even see the situation from

another perspective, Dr. Proctor recommended counseling. He also recommended Respondent work under supervision, and only with adults, for a period of two years.

2. Jolene Zych, Ph.D., RN, WHNP-BC, Nursing Consultant, APRN

Dr. Jolene Zych, a Board nursing consultant, is an Advanced Practice Registered Nurse (APRN), and an expert in nursing standards. In addition to bachelors and master's degrees in nursing, she has a Ph.D. in public policy and administration. Her duties include answering questions from the public, legislators, and nurses on a range of nursing practice topics. Dr. Zych is familiar with Board rules and policies with respect to all levels of nursing practice.

Dr. Zych testified concerning the boundaries in the nurse-patient relationship, and the importance of maintaining appropriate boundaries with patients, and family members, because of the power the nurse has over a patient's care. She explained that educating a patient, and his or her family members, to assist them in making informed choices, is a nurse's duty. A nurse must, however, maintain professional boundaries so as not to abuse the power differential in these relationships. Dr. Zych said that maintaining boundaries in the relationships between a nurse, his or her patient, and the patient's family, is also critical to ensuring a patient receives appropriate home-based care. Boundary violations involving sexual misconduct are addressed in Board rules and policies, and the ethical code governing the profession.

Dr. Zych testified the Board's goal in disciplining licensees is remedial, rather than punitive, and the goal of any Board intervention is protecting the public from nursing practice that may harm a patient, or family member(s).

Dr. Zych explained Board policy on consideration of mitigating and aggravating factors. She testified Respondent's lack of understanding of the nature of his conduct is an aggravating factor. She said Board rules and policies indicate a nurse's intent, or motive, underlying the conduct is not relevant, contrary to Respondent's argument. The Board also considers as aggravating factors the repeated instances of conduct, and S.D.'s, and his family members', enhanced vulnerability due to S.D.'s extensive home-based nursing needs. Dr. Zych explained the

Board requires a licensee to engage in certain mitigating steps, including rehabilitative efforts. Here, Respondent did not voluntarily seek counseling, or other rehabilitative services.

Dr. Zych testified regarding the disciplinary sanctions and stipulations sought, based on the Matrix. She explained the purpose of the Matrix is to give guidance to the Board and to SOAH when considering disciplinary action against a nurse. The Matrix addresses various behaviors, and sets out different Sanction Levels (I, II, and III) for different types of conduct. It then classifies the conduct into Tiers (I, II, and III), depending on the conduct's severity and number of instances. The Matrix then prescribes the appropriate range of disciplinary sanction(s).

Dr. Zych testified the unprofessional conduct alleged here does not fall under the first tier of offenses because Respondent engaged in repeated acts of unethical, and/or unprofessional conduct, which is best classified as a second tier offense. Dr. Zych further explained Sanction Level II is most appropriate here, in light of the potential for serious injury to S.D. and C.D.

Finally, Dr. Zych concurred with Dr. Proctor's recommendation concerning Respondent's nursing license, including a two-year probated suspension, which would allow Respondent to continue to practice as an LVN, subject to any restriction(s) the Board imposes.

C. Scott Michael Dehorty, Board Investigator

Respondent called as a witness Scott Dehorty, who is an experienced Board Investigator, including in investigations with a sexual component. His job duties include reviewing complaints and giving notice to licensees, issuing subpoenas and affidavits, and implementing any law enforcement instructions concerning a particular nurse.

Mr. Doherty testified about the investigatory process generally, including how nurses receive notice of the complaint, and investigation, that includes the specific allegation(s), and are given an opportunity to respond. He testified Respondent was given such an opportunity during the investigation. Mr. Doherty explained that Board investigation teams include an investigator, supervisor, and director of enforcement. The team in this case did not seek additional evidence

before filing formal charges, and also requested a sex offender evaluation. The investigative process followed a typical course for an alleged boundary violation, according to Mr. Doherty.

Mr. Doherty testified he did not speak with C.D. because she was a minor, and instead interviewed Mrs. Downs. Both C.D. and her mother provided witness statements and deposition testimony. Finally, Mr. Doherty testified he interacted with Dr. Proctor, who is not a Board employee, only to transfer evidence in advance of Respondent's evaluation.

IV. ANALYSIS

The Texas Board of Nursing regulates the practice of nursing in Texas. Board standards establish a minimum acceptable level of nursing practice for each level of licensure. Failure to meet these standards may result in Board action against a nurse's license. The evidence demonstrated Respondent engaged in unprofessional conduct in the practice of nursing with regard to his interactions with C.D., and failed to demonstrate knowledge of applicable law, regulations, and Board rules and policies. Respondent also failed to conform his conduct to the minimum standards of acceptable practice by violating professional boundaries.

A. Texas Occupations Code Violations

1. **Texas Occupations Code § 301.452(b)(10)** (unprofessional conduct that is likely to deceive, defraud, or injure a patient or the public)

Staff alleged Respondent's conduct was likely to injure S.D. because it could have created confusion between Respondent's needs and those of his patient. Staff further alleged Respondent's conduct may have caused S.D. delayed distress. S.D. is an individual whose complex medical needs require extensive home-based skilled nursing care. He is non-verbal, and relies on caregivers to meet all needs. However, the evidence did not establish an injury to S.D. stemming from Respondent's conduct or nursing care.

The statute contemplates injury not only to the patient, but to others. The evidence showed that C.D. was harmed by Respondent's conduct. She experienced distress at what she believed

were sexual overtures, and was scared in her home as a result. The ALJ concludes Respondent's conduct as to C.D. is grounds for discipline under Texas Occupations Code § 301.452(b)(10).

2. **Texas Occupations Code § 301.452(b)(13)** (failure to adequately care for a patient, or conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient, or other person, unnecessarily to risk of harm)

The evidence showed Respondent failed to conform his conduct to \ minimum standards of nursing practice by exposing his patient's family member to harm. He treated C.D. in an unwelcome manner, made her uncomfortable, and caused her distress. The ALJ concludes Respondent's conduct is grounds for discipline under Texas Occupations Code § 301.452(b)(13).

B. Violations of Specific Board Rules

1. **22 Texas Administrative Code § 217.11(1)(A)** (requiring nurses to know and conform to the Texas Nursing Practice Act, Board rules and policies, and federal, state, or local laws, rules, or regulations affecting current practice area)

Respondent demonstrated unfamiliarity with certain principals of maintaining appropriate professional boundaries with patients, and family members, so as to avoid disrupting the power dynamics in the nurse-caregiver relationship(s), and failed to conform his conduct to applicable legal provisions. The ALJ concludes Respondent's conduct is grounds for discipline under 22 Texas Administrative Code § 217.11(1)(A).

2. **22 Texas Administrative Code § 217.11(1)(J)** (requiring nurses to know, recognize, and maintain professional boundaries of the nurse-patient relationship)

LVNs must know, recognize, and maintain professional boundaries of the nurse-patient relationship.[10] Respondent failed to maintain professional boundaries by interacting with C.D. in a manner that demonstrated lack of understanding of professional boundaries, and how to form and maintain them. The ALJ concludes Respondent's conduct is grounds for discipline under 22 Texas Administrative Code § 217.11(1)(J).

[10] 22 Tex. Admin. Code § 217.11(1)(J).

3. **22 Texas Administrative Code § 217.12(1)(A)** (careless, or repeated, failure, or inability to perform nursing in conformity with the minimum standards of acceptable practice)

Board Rule 217.12(1)(A) prohibits conduct such as careless or repeated failure, or otherwise showing an inability to perform nursing in conformity with the minimum standards of acceptable practice as set out in Board Rule 217.11.[11] As discussed above, Respondent's conduct crossed professional boundaries in violation of Board Rule 217.11(1)(A) and (J) with respect to his interactions with C.D. Therefore, Respondent is subject to discipline under Texas Administrative Code § 217.12(1)(A).

4. **22 Texas Administrative Code § 217.12(6)(D)** (violation of professional boundaries of the nurse-patient relationship, including sexual, emotional, or financial exploitation of a patient, or a patient's significant other(s))

Respondent's conduct towards C.D. violated professional boundaries. He acted in an inappropriate manner towards her given her age and her relationship to the patient. The ALJ concludes Respondent is subject to disciplinary action under Texas Administrative Code § 217.12(6)(D).

C. Sanction Analysis

The evidence established Respondent competently provided skilled nursing services to S.D., and this conduct met minimum acceptable professional standards.[12] The below discussion therefore focuses on Respondent's actions towards S.D.'s older sister, C.D., and whether his conduct is sanctionable.

Dr. Zych testified that, analyzed under Texas Occupations Code § 301.452(b)(10), or § 301.452(b)(13), a Tier II, Sanction Level II classification is appropriate, and concurred with Dr. Proctor's recommendations regarding Respondent's nursing license. The ALJ agrees.

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[11] 22 Tex. Admin. Code § 217.12(1)(A).

[12] Tex. Admin. Code § 217.12(1)(A).

A Tier I offense under Texas Occupations Code § 301.452(b)(10), is an isolated failure to comply with Board rules without adverse patient effects, or conduct involving minor, unethical conduct, where patient safety is not at risk.[13] A Tier III offense involves failure to comply with a substantive Board rule resulting in "serious patient harm," repeated acts of unethical behavior, or unethical behavior that results in harm to a patient, or public.

Respondent's conduct best fits in Tier II. It was not isolated, or minor, and instead involved a series of incidents that made C.D., an underage girl, uncomfortable, and caused her distress, taking the conduct out of Tier I. Respondent's actions posed a serious risk of harm to C.D.'s emotional state, and thus could be classified in Tier III. However, the minimum sanctions the Matrix prescribes for Tier III are suspension or revocation. Respondent's conduct supports a probated license suspension, but did not rise to the level requiring revocation. Tier II also covers unprofessional conduct "resulting in serious risk to patient or public safety," and best matches these facts. Within Tier II, Sanction Level II calls for denial or suspension. Dr. Zych opined only the latter is appropriate here, and the ALJ agrees. The proposed restrictions would allow Respondent to continue supervised practice for a period of time sufficient to allow for counseling. The ALJ endorses the recommended sanction and stipulations.

Tier II is also the most appropriate classification under Texas Occupations Code § 301.452(b)(13). A Tier I offense is practice below minimum standards with "low risk of patient harm," and a Tier III offense is practice below minimum standards with "serious risk of harm or death that is known, or should be known." Tier II covers practice falling below minimum standards with "patient harm, or risk of patient harm." Respondent's conduct did not injure his patient, S.D., but injured C.D. For these reasons, the ALJ recommends Tier II, Sanction Level II, as prescribed by the Matrix.[14]

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[13] The applicable sanction tiers and levels are listed in the Matrix. 22 Tex. Admin. Code § 217.33(b).

[14] Sanction Level II (Tier II) is similar to Sanction Level I (Tier II), which lists license denial, suspension, revocation, and voluntary surrender as possible options. The ALJ finds only suspension suitable, because Respondent appears capable of remediating his practice issues with counseling aimed at gaining insight into his conduct.

The Board considers aggravating and mitigating factors, including the number of events, and patient vulnerability.[15] Respondent's conduct towards C.D. crossed professional boundaries in separate incidents in March and April 2018. C.D. felt other conduct by Respondent was sexual in nature, and this made her uncomfortable. While his inappropriate behaviors were aimed at C.D., rather than S.D., Respondent's contact with C.D. was made possible by the nurse-patient relationship with S.D. He abused his role as a caregiver to S.D. by his conduct towards S.D.'s family member.

Board Rule 213.33(c) directs the Board to consider mitigating factors. These include lack of evidence of injury to S.D.; Respondent's practice history, which does not show any other disciplinary actions; and his reportedly successful employment as a nurse since leaving Epic Health Care. A course in nursing jurisprudence and ethics is required as a part of all Board orders under Board Rule 213.33(f), and is therefore required in this case.

The ALJ agrees with the recommended sanction and stipulations, and makes the following Findings of Fact and Conclusions of Law.

V. FINDINGS OF FACT

1. The Texas Board of Nursing (Board) issued Licensed Vocational Nurse (LVN) License No. 330947 to Jose Orlando Diaz (Respondent) on June 24, 2013.

2. Respondent was born and raised in El Salvador. His native language is Spanish, but he speaks English. Respondent first obtained an LVN license in 2000, and worked in the Veterans Affairs system for approximately fifteen years before transitioning to home health care.

3. Respondent does not have a history of sexual violence, or other sexual misconduct, and is not a sex offender.

4. Respondent was hired by Epic Health Care in January 2016 to provide home health services. He worked in the Downs family home for approximately one and a half to two years providing skilled nursing services to S.D. Respondent worked with S.D. on the ground floor, and did not usually come up to the second floor.

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[15] Tex. Occ. Code §§ 301.452(b)(10); (b)(13).

5. S.D. has four siblings, including C.D., who was seventeen years old in 2018. Her bedroom is on the second floor. Except on rare occasions, Respondent gave an end-of-shift report to Mr. or Mrs. Downs. In March 2018, he came upstairs and knocked on C.D.'s bedroom door to present end-of-shift paperwork. This interaction made her uncomfortable.

6. Respondent gave S.D. and his siblings, including C.D., $20 gift cards around the holidays. He also gave C.D. $100 for her birthday, which she found unsettling due to the amount, and because her siblings did not receive similar birthday gifts.

7. C.D. was troubled by Respondent's repeated requests for a birthday hug but eventually acquiesced. The hug made C.D. uncomfortable because it was a chest-to-chest hug rather than shoulder-to-shoulder. Respondent did not hug C.D.'s siblings.

8. C.D. was also distressed by other interactions with Respondent, including when he watched her walk down the stairs, told her she was beautiful, and said he was surprised she did not have a boyfriend.

9. In April 2018, Respondent was in the car with C.D. while Mrs. Downs drove, and he gave C.D. a note that read, "I heart C" with his phone number on it. C.D. told her mother, and Mrs. Downs reported the incident to Respondent's employer. He was later fired.

10. Respondent now works at another home health care company providing skilled nursing care to a medically complex patient.

11. (Staff) of the Board opened an investigation into Respondent's conduct and referred Respondent for a sex offender evaluation as part of the investigation. A board certified forensic psychologist conducted a psychological evaluation in July 2018 and submitted a report in September 2018, recommending sanctions and other restrictions, to include counseling aimed at increasing Respondent's insight into his conduct.

12. On May 29, 2019, Staff sent Respondent a Notice of Hearing and Formal Charges. The notice and formal charges 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 incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

13. On August 5-6 and September 12, 2019, Administrative Law Judge (ALJ) Kathryn J. Lewis convened the hearing on the merits at the State Office of Administrative Hearings (SOAH) in Austin, Texas. Assistant General Counsel Helen Kelley represented Staff. Respondent appeared at the hearing and was represented by attorney Rex A. Manaster. After the hearing, Respondent represented himself for the remainder of the case. The record closed on December 20, 2019, with the filing of closing briefs.

VI. CONCLUSIONS OF LAW

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

2. SOAH has jurisdiction over contested cases referred by the Board, including 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 proper notice of the hearing on the merits. Tex. Occ. Code §§ 301.454, .458; 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 failed to meet minimum standards of nursing practice requiring nurses to know and conform to the Texas Nursing Practice Act and Board rules, and to recognize and maintain professional boundaries of the nurse-patient relationship. Tex. Occ. Code § 301.452(b)(13); 22 Tex. Admin. Code § 217.11(1)(A), (J).

6. Respondent is also subject to sanction because he committed unprofessional conduct by repeated failure to perform nursing in conformity with minimum standards of nursing practice, including violating the professional boundaries of the nurse-patient relationship. Tex. Occ. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.12(1)(A), (6)(D).

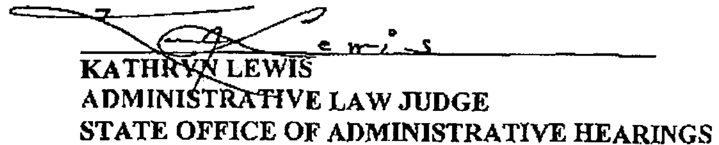
7. The Board may impose a disciplinary sanction which can range from remedial education to revocation of a nurse's license and which may include requiring the nurse to submit to care, counseling, or treatment by a health provider designated by the Board as a condition of obtaining or renewing a license. 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(c) and the Board's Disciplinary Matrix (22 Texas Administrative Code § 213.33(b)). In this case, the Board may consider aggravating factors such as the number of events and patient vulnerability. The Board may also consider as mitigating factors the lack of evidence of harm to the patient, S.D.; Respondent's practice history showing no other disciplinary actions before 2018; and Respondent's successful employment as a nurse after his employment with Epic Health Care ended in April 2018.

VII. RECOMMENDATION

Based on the above Findings of Fact and Conclusions of Law, the ALJ recommends the Board sanction Respondent as follows: a two-year probated sentence, to include (1) a course in nursing jurisprudence and ethics; (2) restriction to work solely with adult clients, and under supervision; (3) counseling focused on increasing insight into the nature of the conduct underlying the allegations; and (4) such other provisions as the Board sees fit to prescribe.

SIGNED February 18, 2020.



KATHRYN LEWIS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

C 7

JOE O DIAZ

972 922 8282 | orlewisville@hotmail.com | 6900 Curry Dr., The Colony, TX 75056

March 3, 2020

State Office of Administrative Hearing
Austin Office
State of Texas
300 West 15th St. Ste. 504
Austin, TX 78701

Re: SOAH DOCKET NUMBER 507-19-3433-- **RIGHT TO A FAIR TRIAL.**

Sent via fax #512 322 2061

Dear SOAH:

Before the inability of this court to figure out the truth about the matters herein presented and after 3 days of deliberations and yet you still producing wrong and deceitful information, I have no choice but to appeal to my constitutional right of the **"Sixth Amendment".** The key for a fair trial in this matter was a good objective psychological evaluation. The Board manipulated about what information the psychologist needed to produce. So, the psychologist showed confusion and had testified that because of Defendant received a gift, then it was the main factor for Respondent to be at fault. He also stated he did not interview the Defendant because he had enough written information. And he admitted of not having the adequate test for this kind of evaluation.

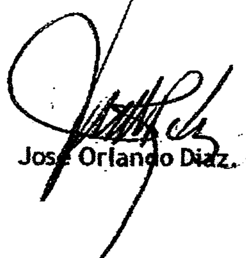
A note was written with "I (heart) C, text me _ ____ (phone number)) Mr. Manaster, Attorney, explained me that for the US culture is delivered in a romantic way. However, for Hispanic culture is delivered in either romantic way or in a friendly way. Well in this particular case it was done in a friendly way, mainly because there is no indication of any other event or approach directed in that way. The whole idea was to maintain a good patient relation and family relation in good terms. So, this action was merely of a cultural crush. Beside I needed to keep her phone number in the case I needed to remind her to come down and get the end-of-shift report. She did not realize about the time and left me waiting for good two and a half hours, once.

The note was written and delivered within 3 minutes and had no explanation about the purpose of it so created confusion leading to this complaint

I am doing my own self-defense and I have previously requested information on how to get transcripts since November 5, 2019 and I never received any response.

Therefore, I now demand this court admit and attach a second psychologist evaluation from an independent provider of my selection as an effort to bring a fair trial.

Sincerely,



José Orlando Diaz.

Cc: Hellen Kelley

Sent via fax #512 305 8101

Amendment VI

1. In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the state and district wherein the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the assistance of counsel for his defense.

2. Right to a fair trial

A trial which is observed by trial judge without being partial is a fair trial. Various rights associated with a fair trial are explicitly proclaimed in Article 10 of the Universal Declaration of Human Rights, the Sixth Amendment to the United States Constitution, and Article 6 of the European Convention of Human Rights, as well as numerous other constitutions and declarations throughout the world. There is no binding international law that defines what is not a fair trial; for example, the right to a jury trial and other important procedures vary from nation to nation.

In administrative proceedings[edit]

Both the European Court of Human Rights and the Inter-American Court of Human Rights have clarified that the right to a fair trial applies not only to judicial proceedings, but also administrative proceedings. If an individual's right under the law is at stake, the dispute must be determined through a fair process.

JOSE O DIAZ

972 922 8282 | orleiwisville@hotmail.com | 6900 Curry Dr, The Colony, TX 75056

November 5, 2019

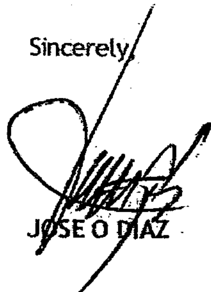
STATE OFFICE OF ADMINISTRATIVE HEARINGS
AUSTIN OFFICE
STATE OF TEXAS
300 WEST 15TH ST. STE 504
AUSTIN, TX 78701

Re: SOAH DOCKET NUMBER: 507-19-3433

Dear SOAH:

I am requesting a copy of the transcript of the case against the Texas Board of Nursing. Please let me know how much the cost will be and the instructions on how to pay it.

Sincerely,



JOSE O DIAZ

1
2 BEFORE THE STATE OFFICE
3 OF
4 ADMINISTRATIVE HEARINGS

5 TEXAS BOARD OF NURSING, 6 Plaintiff, 7 vs. 8 JOSE ORLANDO DIAZ, 9 Defendant	Case No.: 507-19-3433 PROPOSAL FOR DECISION

10 The staff (stuff) at the Texas Board (Board) of Nursing proposes disciplinary action against the
11 License Vocational Nurse (LVN) license held by Jose Orlando Diaz (Respondent) for failing to conform to the
12 minimum acceptable standards of nursing practice, violating the boundaries of the nurse-patient relationship, and
13 unprofessional conduct.
14 The Administrative Law Judge (ALJ) concludes Staff met its burden of proof by a preponderance
15 of the evidence. Accordingly, the ALJ recommends the board sanction Respondent with a two-year probated
16 suspension of his nursing license, and (1) a course in nursing jurisprudence and ethics; (2) restriction to work solely
17 with adult patients; and (3) counseling focused on increasing insight into the nature of the conduct underlying the
18 allegations.
19
20 **I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY**
21
22 Notice and jurisdiction were undisputed and are set forth in findings of Fact and Conclusions of
23 Law. ALJ Kathryn J Lewis convened a hearing on the merits on August 5-6, 2019, and September 12, 2019, at the
24 State Office of Administrative Hearings (SOAH) in Austin, Texas.
25 Assistant General Counsel Hellen Kelley appeared, and represented Staff. Respondent was
26 represented before and during the hearing by attorney Rex A Manaster. Respondent informed the ALJ after the
27 hearing that he was no longer represented by Mr. Manaster, and was given an opportunity to find other counsel to
28

file closing arguments. Respondent instead represented himself for the reminder of the case. The record closed on December 20, 2019, after the parties filed closing briefs.

II. STAFF'S FORMAL CHARGE AND APPLICABLE LAW

In April 2018, Respondent was employed as an LVN with Epic Health Care in Dallas, Texas, and assigned to provide skilled nursing care to patient S.D. Staff's formal charge asserts Respondent violated the boundaries of the nurse-patient relationship by giving C.D., the patient's 17-year-old sister, a note with a heart and his phone number on it. Staff contends Respondent's conduct was likely to injure S.D. because it would have created confusion between Respondent's needs and those of his patient, [x2] and because S.D. could experience delayed distress. [1; y2]

The Texas Nursing Practice Act, Texas Occupations Code title 3, subtitle E, chapter 301, gives the Board authority to discipline nurses for, among other things, (1) unprofessional conduct in the practice of nursing that is likely to deceive, defraud, or injure a patient, or the public. These statutory provisions are elaborated in the Board's rules. Specifically, Staff asserted violations of:

- **22 Texas Administrative Code article 217.11(1)(A)** (requiring nurses to know, and conform to, the Texas Nursing Practice Act, Board rules and policies, and federal, state, and local laws, rules, or regulations affecting current area of nursing practice).
- **22 Texas Administrative Code article 217.11(1)(J)** (requiring nurses to know, recognize, and maintain professional boundaries of the nurse-patient relationship).
- **22 Texas Administrative Code article 217.12(1)(A)** (sanctioning careless, or repeated, failure, or inability to perform nursing in conformity with the minimum standards of acceptable practice); [z2] and
- **22 Texas Administrative Code article 217.12(6)(D)** (sanctioning violations of the professional boundaries of the nurse-patient relationship, including sexual, emotional, or financial exploitation of a patient's significant other(s). [4; p3]

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[1] Staff exhibit (staff ex.) 3; Respondent ex. 5.

[2] Tex. Occ. Code article 301.452(b)(10).

[3] Tex. Occ. Code article 301.452(b)(13).

[4] Id

-x[2] The Board and ALJ still producing deceitful information about this case. After three days of deliberations. Respondent had no romantic nor sexual affair with C.D. Respondent was focusing on patient care thoroughly.

-y[2] Respondent states Patient had already been on a lot of distress due to his medical condition. Nursing care may help him to soothe some of that distress. Respondent was not to cause stress to S.D.

-z[2] Respondent states had only compliments of an excellent nursing service during the course of employment at the Downs. Statements by C.D. was shockingly surprising.

-p[3] Respondent states never had any romantic nor sexual affair with C.D. Relationship was merely of a friendship.

"Professional boundaries" are appropriate limits which would be stablished by the nurse in the nurse-patient relationship due to nurse's power and the patient's vulnerability. Maintenance of boundaries refers to providing nursing within the limits of the nurse-patient relationship that promotes patient dignity, independence, and best interests, and requires nurses to refrain from inappropriate involvement in a patient's personal relationships, and/or pursuit of personal gain at a patient's expenses[5].

If the board finds a nurse committed sanctionable conduct, the board will enter an order imposing one or more sanctions listed in Texas Occupations Code (article 301.4531), up to and including licensure denial, revocation, suspension, and/or other disciplinary action.[6] The Board may also require the nurse to submit to care, counseling, or treatment by a health provider designated by the Board as a condition of obtaining or renewing, his or her license, to include: (1) an educational program, including a remedial one, or counseling; or (2) practice for a specified period under the direction of a nurse designated by the Board.[7]

Board rule 213.33(b) sets out a disciplinary matrix (Matrix), which classifies offenses by Tier and Sanction Level. The Matrix is designed to match the severity of the sanction imposed with the nature of the violation, taking into an account mitigating and aggravating factors.[8]

Staff must prove its charge by a preponderance of the evidence and without coercion or extortion but merely by the presented evidences, with a clear, and impartial process.

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[5] 22 Tex. Admin. Code art. 217.1(29).

[6] Tex. Occ. Code art.301.453(a)(1)-(7).

[7] Tex. Code art. 301.453(b)

[8] Tex. Adm. Code art. 213.33; see also Tex. Occ. Code art. 301.4531

[9] Tex. Admin. Code

III. DISCUSSION

Staff offered eleven exhibits, which were all admitted, and called five witnesses. Respondent offered twenty exhibits, of which fifteen were admitted.

Staff called the patient's sister, CD, ; Sharon Downs, who is C.D.'s and S.D.'s mother; and Respondent, Staff also called Dr. Timothy Proctor, a forensic psychologist and testifying expert, and Dr. Jolene Zych, a Board consultant and expert in nursing practice, policy, and ethics.

Respondent testified on his own behalf during the presentation of his case. He also called Scott Doherty, Board investigator, to testify about complaint investigation procedures.

A. Fact Witnesses

1 2 3

1. **C.D., the patient's Sister**

Staff called C.D., the patient's 17-year-old sister, who lives in the Downs family home with her parents and four siblings between the ages of five and sixteen. C.D. testified by phone about her communications with Respondent, and how certain interactions made her uncomfortable [p].

C.D. said Respondent frequently watched her walk down the stairs. On one occasion, he told her she was beautiful, and said he was surprised she did not have a boyfriend [r]. He gave C.D., and each of her siblings, $20 gift card for Christmas and on birthdays [s]. Respondent also gave C.D. $100 for her birthday. She found this gift unsettling due to the amount, and because her siblings did not receive similar gifts on their birthdays.

C.D. testified she initially ignored the Respondent's request for a birthday hug but agreed after several requests [t]. She stated the hug made her particularly uncomfortable because it was a chest-to-chest hug, rather than shoulder-to-shoulder [u]. C.D. noted that Respondent did not hug her siblings.

C.D. testified about an incident in March 2018, when Respondent came upstairs and knocked on her bedroom door. This was unusual because he worked with S.D. on the ground floor, and Respondent's shift to end, and he always gave an end-of-shift report. C.D. did not normally receive end-of-shift reports, and respondent's presence on the second floor outside her bedroom door made her uncomfortable [w].

C.D. also described an incident in April 2018, when Respondent threw her a note while they were in the car while her mother drove. It read "I heart C" and had a phone number on it. This incident cause C.D. to feel particularly unsafe around respondent because she believed he had a sexual interest in her. She reported this incident to her mother, which led to Respondent's termination. [v]

Finally, C.D. testified Respondent's behavior caused her significant distress, and she feels bad about the stress and pain it caused her parents because they were worried about her. It was also difficult to find a permanent nurse for S.D. to replace Respondent [w].

25 26 27

28

P - Respondent stated that prior the issue of the note, which happened on the last day of work, relationship was uttermost of excellent with Mrs. Downs and C.D. They both expressed gratitude about his nursing service.

r- Respondent stated Ms. Downs confessed him a big concern about her daughter not being able to make friends at school. She did not know how to help her. I questioned C.D. while she was babysitting her baby sister in the living room. She said having no desire to meet with nobody at school.

The stairs ended right by Respondent working area (SD room and kitchen). Standing by the door frame, Respondent could see anybody coming or going upstairs unexpectedly.

S- Respondent stated 'giving' is a blessing inherited by his mom. In general, kids get very happy when they get their own money. These actions have help me to gain better interaction with family members.

T- Respondent state that C.D. statement is a lie. There was no need to request for a second time. We had a good friendly relationship before the note was written and after a gift of a $100 dollars was tendered.

U- Respondent stated Miss C.D. was leaning front wise over the countertop of the kitchen sink exposing only her upper body. And because we had a good relationship, she consented the hug.

V- Respondent states the note was written into that format because of the good friendly relationship provided that her birthday had already past and our friendly relationship was great. Respondent never gave her a reason of not trust. She was always respected. The note was made to resolve the issue of not being able to reach her for report when needed as of the two hours delayed when she did not realize the time for report.

W- Respondent states before the written note there was no worries, no problems as far as nurse-patient/family relationship. She must of a feel stressful after the fact I was fired because of her complaint. During the course of my employment, they sounded happy and with no stress. The written note was done and delivered within 3 minutes on the last day of work.

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2. Sharon Downs, S.D. 's and C.D. 's Mother

Mrs. Downs testifies by phone about her interactions with respondent before an after she became aware about his inappropriate actions towards C.D. She also testified about her interactions with her daughter after she learned about the note.

1 Mrs. Downs said Respondent was referred by a case manager to provide S.D. with skilled nursing services.
2 He worked one shift a week on Sundays for approximately one and a half or two years. In addition to S.D. and C.D.,
3 The Downs family has three other children. S.D. requires skilled nursing inventions at home, including medication
4 administration; ongoing vital signs and other assessments related to a kidney transplant; and monitoring of several
5 other medical disabilities. S.D. has a developmental disability and is "non-verbal."

6 Mrs. Downs testified S.D.'s complex medical needs have required home-based skilled nursing
7 interventions since birth. Home Health services generally involves shift work. As a result, it was not uncommon for
8 different nurses to work with S.D. in a given week. Mrs. Downs attempted to keep to keeps these relationships
9 professional, but when a nurse regularly worked with S.D., the family may come to know him or her better over
10 time. This was the case with Respondent, with whom she was professional to ensure her son received proper care,
11 but with whom she also developed a "friendly" relationship. When S.D.'s nursing needs were met, and Respondent
12 had time during his shift, the two would speak about his family, and growing up in El Salvador.

13 Respondent gave S.D. gifts, personal items, lotion, soap, mouth care, and electronics interactive toys,
14 electronic talking parrot, an electronic radio monitor car, an interacting learning tablet, which Mrs. Downs did not
15 find inappropriate. She stated he also gave each sibling a $50 gift card for the holydays. When Respondent
16 mentioned he wanted to give C.D. a gift of a $100 for her birthday, Mrs. Down told him he did not need to do that.
17 She testified she was not aware Respondent had given C.D. the money until her daughter's deposition [w].

18 Mrs. Downs explained that she was generally responsible for handling the S.D.'s nursing staff, rather than
19 her husband. She stated she would not characterize Mr. Downs's behavior towards Respondent as the overprotective
20 of C.D. She instead observed a friendly and appropriate relationship between Respondent and Mr. Downs. Mrs.
21 Downs testified she usually spoke with Respondent at the end of his shift to receive a report, rather than her
22 husband. On rare occasions, when neither she nor her husband were available, C.D. might receive an end-of-shift
23 report from Respondent.

24 Mrs. Downs testified she was generally aware of Respondent's comments about her daughter's appearance
25 but she did not have a full picture of the impact on C.D. until later. Had she known, she would of have intervened
26 sooner. She further testified she first became aware Respondent made C.D. feel unsafe after he gave her daughter the
27 note, and after C.D. confirmed the note had Respondent's phone number on it. Mrs. Downs reported the incident to
28 his employer, and Respondent did not return to the Downs family home [x].

w- Respondent states giving is a Christian's blessings. He learned it from his mom' side. Having a good interactive relationship among family members is beneficial for the patient's emotional well-being. Before the note, everything I gave was welcome and appreciated. C.D. described a normal activity of my work like a suspicious one for romantic or sexual harassment Respondent stated he practice giving with every patient's home. Respondent state giving is not an act to be penalized.

x- C.D. Shows symptoms of psychosocial pathologic problems that raised concern to her mom who stated C.D. was unable to socialize at school and she couldn't make no friends. Due to her statements, there is an indication that the only fact of Respondent's presence in the house made her uncomfortable and saw all Respondent activities at the work area, suspicious of anything within her mind.

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3. Respondent

Respondent testified about his employment history and providing skilled nursing care to S.D. He said that he liked working with S.D., and for the Downs family. Respondent also described his interactions with C.D.

Respondent testified his behaviors towards C.D. were appropriate and professional, and he disputed he made one or more sexual overture towards her. Respondent insisted this case was nothing but a misunderstanding between himself, C.D., and Mrs. Downs, and stated and stated he felt the misunderstanding may stem from Mr. Downs's overprotective nature. Respondent attributed certain behavior to cultural differences between himself and the Downs family, or perhaps his intentions were misunderstood because English is not his first language. He further testified he felt as a grandfather would towards C.D. and would agree to a second opinion from an independent Psychologist not regulated by Staff.

Finally, Respondent testified his lack of intent to harm or scare C.D. was not fairly considered by his former employer before he was fired, or by the Board throughout the investigative process. He added that since

being terminated from employment with Epic Health Care, he has continued working as a nurse for adult settings, without incident.

B. Staff's Expert Witnesses

1. Dr. Timothy James Proctor, Ph.,ABPP

Dr. Timothy Proctor is board certified in forensic psychology. He testified regarding his clinical impressions and opinions, treatment recommendations, and recommended limitations on Respondent's license.

Dr Proctor is a licensed sex offender treatment provider and completed a sex offender evaluation of Respondent in September 2018. He testified Respondent does not have a known or suspected history of sexual violence, or other sexual misconduct. Dr. Proctor further explained Respondent is not a sex offender and was not charged with a criminal offense in connection with a conduct alleged here[y].

Dr. Proctor said he reviewed the records Staff provided, and evaluated Respondent for over four hours on July 30, 2018, including two hours of a clinical interview and two hours of psychological testing. The evaluation was designed to determine if Respondent can perform the essential job functions of nursing in a safe an effective manner.

Evaluation methods included clinical review, observation/mental status examination, and personality testing using the Personality Assessment Inventory (PAI). Dr. Proctor explained the PAI is the only assessment he used with Respondent because other assessments evaluate a propensity to re-offend after being charged with, or convicted, of a crime, which is not the case here. According to Dr. Proctor, the PAI is a short assessment that is more appropriate in a civil context, like here, where the Board alleges Respondent committed a licensure violation. Further, because English is Respondent's second language, Dr. Proctor chose the PAI because its language and questions are straightforward, and the test better accounts for linguistic differences.

Dr. Proctor testified the PAI provided two key pieces of information, the first being whether Respondent responded in a forthright manner on this portion of the evaluation, and in a manner that would not deceive the evaluator. The results indicated Respondent approached the test by denying minor faults and flaws and presented himself in an overly favorable manner[z]. Dr. Proctor opined Respondent's responses suggested he was not being honest. The second piece of information the PAI yielded was whether Respondent may have psychological

difficulties not specific to sexu aldisorders, or another dysfunction. Base on the results of this part of the evaluation, Dr. Proctor had concems abou t the Respondent's ability to safely and effectively perform the essential job functions of nursing practice, and he recommended stipulations on Respondent's license.

Finally, Dr. Proctor pointed to conceming behaviors, including Respondent's secrecy in giving C.D. the note, and its inappropriate content given her relationship to the patient, and her age. Due to Respondent's failure to acknowledge wrongdoing, or even see the situation from another perspective [P1], Dr. Proctor Recommended counseling. He also recommended Respondent work under supervision, and only with adults, for a period of two years[r1].

Y.- Respondent states Dr. Proctor admitted in his testimony he does not have the proper test evaluation for this type of conduct. Sex offender evaluator is the closest test he had for this problem. He also stated that the act of giving $100 dollars to C.D. made Respondent's responsible for the accusations. This action is not necessary a clue because Respondent assure had no romantic nor sexual affair.

z.- Respondent stated that all depends on what questions they were. Respondent will not admit the wron g doings if did not happened. Dr. Proctor was following the Board own guidelines and a truthfully therapeutic test was conflictive to maintain his rehiring status.

P1.- Respondent states Dr. Proctor's failure has to do with his wrong approach to the matter since in reality was a cultural crush. Whereas Mr. Manaster, attomey, explained to me that the content of the note herein mentioned for the US culture, is normally written in a romantic context. For the Hispanic culture is written for a romantic way and/or for a friendly context. Dr. Proctor failed to find the missing link to the reality.

R1. Working under supervision is always the case of an LVN in which cannot work on his own. It is the law. Whether an LVN works in a hospital setting or in a home setting, there is always one supervisor designated to work with. Two or three supervisors may be too costly for companies. Respondent has been working with adults only since the complaint.

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2. Jolene Zych, PH.D.,RN, WHNP-BC, Nursing Consultant, APRN

Dr. Jolene Zych, a Board nursing consultant, is an Advance Practice Registered Nurse (APRN), and an expert in nursing standards. In addition to bachelors and master's degrees in nursing, she has a PH.D. in public policy and administration. Her duties include answering questions from the public, legislators, and nurses on a range of nursing practice topics. Dr. Zych is familiar with Board rules and policies with respect to all levels of nursing practice.

Dr. Zych testified concerning the boundaries in the nurse-patient relationship, and the importance of maintaining appropriate boundaries with patients, and family members, because of the power the nurse has over a patient's care. She explained that educating a patient, and his or her family members, to assist them in making informed choices, is a nurse's duty. A nurse must, however, maintain professional boundaries so as not to abuse the power differential in these relationships. Dr. Zych said that maintaining boundaries in the relationships between a nurse, his or her patient, and the patient's family, is also critical to ensuring a patient receives appropriate home base care. Boundary violations involving sexual misconduct are addressed in Board rules and policies, and the ethical code governing the profession.

Dr. Zych testified the Board's goal in disciplining licensees is remedial, rather than punitive [10], and the goal of any Board intervention is protecting the public from nursing practice that may harm a patient., or family member(s).

Dr. Zych explained the Board policy on consideration of mitigating and aggravating factors. She testified the Respondent's lack of understanding of the nature of his conduct [11] is an aggravating factor. She said the Board rules and policies indicate a nurse's intent, or motive, underlying the conduct is not relevant, contrary to Respondent's argument. The Board also considers as aggravating factors the repeated instances of conduct, and S.D.'s, and his family members', enhance vulnerability due to S.D.'s extensive home-base nursing needs [12]. Dr. Zych explained the Board requires a licensee to engage in certain mitigating steps, including rehabilitative efforts. Here respondent did not voluntarily seek counseling, or other rehabilitative services.

Dr. Zych testified regarding the disciplinary sanctions and stipulations sought, based on The Matrix. She explained the purpose of the Matrix is to give guidance to the Board and to SOAH when considering disciplinary

actions against a nurse. The Matrix addresses various behaviors, and sets out different Sanction Levels (I, II, III) for different types of conduct. It then classifies the conduct into Tiers (I, II, III), depending on the conduct's severity and number of instances. The Matrix then prescribes the appropriate range of disciplinary sanction(s).

Dr. Zych testified the unprofessional conduct alleged here does not fall under the first tier of offense because Respondent engaged in repeated acts of unethical [V1] and/or unprofessional conduct, which is best classified as a second tier offense. Dr. Zych further explained the Sanction level II is most appropriate here, in light of the potential for serious injury to S.D. and C.D.

Finally, Dr. Zych concurred with Dr. Proctor's recommendation concerning the Respondent's nursing license, including the two-year probated suspension, which would allow Respondent to continue to practice as an LVN, subject to any restriction(s) the Board imposes.

S1.- Respondent states that when a nurse is moved from one setting into another one and this nurse was successfully conducting his business but then loses $30000 dollars then the corrective action turns into a punitive one.

T1.- Respondent states he is no different than anybody else's, he will admit a wrongdoing if he did it. Whereas respondent would of be responsible to have romantic or sexual affairs with C.D., then he would of have finished this case from the beginning.

U1.- Respondent states Dr. Zych is speculating over false statements that were presented to her and must link off a romantic or sexual affair.

V1.- Respondent states not being able to see misconduct when he delivered an excellent nursing service. He claims not having no romantic nor sexual affairs with C.D.

C. Scott Michael Dehorty, Board investigator

Respondent called as a witness Scott Dehorty, who is an experience Board investigator, including in investigations with a sexual component. His job duties include reviewing complaints and giving notice to licensees, issuing subpoenas and affidavits, and implementing any law enforcement instructions concerning a particular nurse.

Mr. Doherty testified about the investigatory process generally, including how nurses receive notice of the complaint, an investigation, that includes the specific allegation(s), and are given an opportunity to respond. He testified Respondent was given such an opportunity during the investigation. Mr. Doherty explained that Board investigation teams include an investigator, supervisor, and director of enforcement. The team in this case did not seek additional evidence before filing formal charges, and also requested a sex offender evaluation. The investigative process followed a typical course for an alleged Boundary violation, according to Mr. Doherty.

Mr. Doherty testified He did not speak with C.D. because she was a minor, and instead interviewed Mrs. Downs. Both C.D. and her mother provided a witness statement and deposition testimony. Finally, Mr. Doherty testified he interacted with Dr. Proctor, who is not a Board employee [W1], only to transfer evidence in advance of Respondent's evaluation.

W1.- The board pre-qualified and instruct the psychologist what to expect. The Board hire them to be paid by the Respondents. Psychologist felt loyal to the Board.

IV. ANALISIS

The Texas Board of Nursing regulates the practice of nursing in Texas. Board standards establish a minimum acceptable level of nursing practice for each level of licensure. Failure to meet these standards may result in Board action against a nurse's license. The evidence demonstrated Respondent engaged in unprofessional in the practice of nursing with regard to his interactions with C.D., and failed to demonstrate knowledge of applicable law, regulations, and Board rules and policies. Respondent also failed to conform his conduct to the minimum standards of acceptable practice by violating professional boundaries [V1].

V1.- provided with the Analisis herein described, I could express that the whole picture of the problematic here, it got completely lost. There is a lack of critical thinking and the events were taking systematically to accuse Respondent of romantic or sexual affair.

A. Texas Occupations Code Violations

1. Texas Occupations Code article 301.452(b)(10) (unprofessional conduct that is likely to deceive, defraud, or injure a patient or the public)

Staff alleged Respondent's conduct was likely to injure S.D. because it could have created confusion between Respondent's needs and those of his patient. Staff further alleged Respondent's conduct may have cause S.D. delayed distress. S.D. is an individual whose complex medical needs require extensive home-based skilled nursing care. He is non-verbal and relies on care givers to meet all the needs. However, the evidence did not establish an injury to S.D. stemming from Respondent's conduct or nursing care[x1].

The statute contemplates injury not only to the patient, but to others. The evidence showed that C.D. was harmed by respondent's conduct or nursing care. She experienced distress at what she believed were sexual overtures and was scared in her home as a result. The ALJ concludes Respondent's conduct as to C.D. is grounds for discipline under Texas Occupations Code article 301.452(b)(10)[y1].

2. Texas Occupations Code article 301.452(b)(13) (failure to adequately care for a patient or conform to the minimum standards of acceptable nursing practice in a manner that exposes the patient, or other person, unnecessarily to risk of harm).

The evidence showed Respondent failed to conform his conduct to/minimum standards of nursing practice by exposing his patient's family member to harm. He treated C.D. in an unwelcome manner, made her uncomfortable, and caused her distress. The ALJ concludes Respondent's conduct is ground for discipline under 22 Texas Occupations Code article 301.452(b)(13)[z1].

B. Violations of Specific Board Rules

1. 22 Texas Administrative code article 217.11(1)(a) (requiring nurses to know and conform to the Texas Nursing Practice Act, Board rules and policies, and federal, state, or local laws, rules, or regulations affecting the current practice area)

Respondent demonstrated unfamiliarity with certain principals of maintaining appropriate professional boundaries with patients, and family members, so as to avoid disrupting the power dynamics in the nurse-caregiver relationship(s), failed to conform his conduct to applicable legal provisions[p2]. The ALJ concludes respondent's conduct is grounds for discipline under 22 Texas Administrative Code article 217.11(1)(A).

2. 22 Texas Administrative Code article 217.11(1)(j) (requiring nurses to know, recognize, and maintain professional boundaries of the nurse-patient relationship)

LVNs must know, recognize, and maintain the professional boundaries of the nurse-patient relationship.[10] · Respondent failed to maintain professional boundaries, and how to form and maintain them [r2]. The ALJ concludes Respondent's conduct is grounds for discipline under 22 Texas Administrative Code article 217.11(1)(j).

3. 22 Texas Administrative Code article 217(1)(A) (careless, or repeated, failure, or inability to perform nursing in conformity with the minimum standards of acceptable practice)

Board rule 217.12 (1)(A) Prohibits conduct such as careless or repeated failure, or otherwise showing an inability to perform nursing in conformity with the minimum standards of acceptable[s2] practice as set out in Board rule 217.11(1)(A) and (J) with respect to his interactions with C.D. Therefore, Respondent is subject to discipline under Texas Administrative Code article 217.12(1)(A).

4. 22 Texas Administrative Code article 217.12(6)(D) (violations of professional boundaries of the nurse-patient relationship, including sexual, emotional, or financial exploitation of a patient, or a patient's significant other(s)

Respondent's conduct towards C.D. violated professional boundaries. He acted in an inappropriate manner towards her given her age and her relationship to the patient[t2]. The ALJ concludes Respondent is subject to disciplinary action under Texas Administrative Code article 217.12(6)(D).

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[10] 22 tex. Admin. Code article 217.11(1)(j).

[11] 22 Tex. Admin. Code article 217.12(1)(A).

X1.- Respondent will not, under no circumstances, accept this accusation. The controversial note was done the very last day of employment. He did not know he was in trouble until the next day, by his supervisor. Prior this incident everything was nice and smooth like nothing ever happened. Respondent conducted a nursing service with no complication, according the supervisors and family members.

Y1.- She may have experienced some stress due to the misunderstanding, but it was released immediately after Respondent was dismissed.

Z1.- The action of writing a note was a misunderstanding of a cultural crush. Next day Respondent was dismissed. Family member was not exposed to a harm because Respondent was fired. On a cultural crush action.

P2.- Respondent states of having plenty understanding of the dynamic and professionalism of a relationship. Demonstrated along the 38 years of service to his communities he lived in. Respondent rejects all accusations presented here in this court as being untrue and deceitful.

-r2 Respondent states that prior the note everything was working perfectly. There was harmony, respect, professionalism among all the parties. This cultural crush was unexpected.

S2 Respondent states that 38 years of clean record within this work environment is the best reference that Respondent comply with the standards of nursing service. And receiving continuous compliments of an excellent job. So, this was the case here until the incident of a cultural crush.

-t2 Respondent states during employment at the Downs, He demonstrated respect and professionalism. There was not even a single complaint on the contrary within supervisors nor family members. C.D. did not show any symptom of feeling uncomfortable around Respondent's presence.

C. Sanction analysis

The evidence established Respondent competently provided skilled nursing services to S.D., and this conduct met minimum acceptable professional standards.[12] The below discussion therefore focuses on Respondent's actions toward S.D.'s older sister, C.D., and whether his conduct is sanctionable.

Dr. Zych testified that, analyzed under Texas occupations Code article 301.452(b)(10), or article 301.452(b)(13), a Tier II, Sanction Level II classification is appropriate, and concurred with Dr. Proctor's recommendations regarding Respondent's nursing license. The ALJ agrees.

A Tier I offense under Texas Occupations Code article 301.452(b)(10), is an isolated failure to comply with Board rules without adverse patient effects, or conduct involving minor, unethical conduct, where

patient safety is not at risk. [13] A Tier III offense involves failure to comply with a substantive Board Rule resulting in "serious patient harm," repeated acts of unethical behavior, or unethical behavior that results in harm to a patient, or public.[u2]

Respondent's conduct best fits in Tier II. It was not isolated, or minor, and instead involved a series of incidents that made C.D., an underage girl, uncomfortable, and cause her distress, taking the conduct out of Tier I. Respondent's actions posed a serious risk of harm to C.D.'s [v2] emotional state, and thus could be classified in Tier III. However, the minimum sanctions the Matrix prescribes for Tier III are suspension or revocation. Respondent's conduct supports a probated license suspension but did not rise to the level requiring revocation. Tier II also covers unprofessional conduct "resulting in serious risk to patient or public safety," and matches these facts. Within Tier II, sanction Level II calls for denial or suspension. Dr. Zych opined only the latter is appropriate here, and the ALJ agrees. The proposed restrictions would allow Respondent to continue supervised practice for a period of a time sufficient to allow for counseling. The ALJ endorses the recommended sanction and stipulations.

Tier II is also the most appropriate classification under Texas Occupations Code article 301.452(b)(13). A Tier I offense is practice below minimum standards with "serious risk of harm or death that is known, or should be known." Tier II covers practice falling below minimum standards with "patient harm, or risk of patient harm,: Respondent's conduct did not injure his patient, S.D., but injure C.D. For these reasons, the ALJ recommends Tier II, Sanction Level II, as prescribed by the Matrix. [14]

The Board considers aggravating and mitigating factors, including the number of events, and patient vulnerability. [15] Respondent's conduct towards C.D. crossed professional boundaries in separate incidents in March and April 2018. C.D. felt other conduct by Respondent was sexual in nature, and this made her uncomfortable.[w2] While his inappropriate behaviors were aimed at C.D., rather than S.D., Respondent's contact with C.D. was made possible by the nurse-patient relationship with S.D. He abused his role as a care giver to S.D. by his conduct towards S.D.'s family member.

Board rule 213.33(c) directs the board to consider mitigating factors. These include a lack of evidence of injury to S.D..;Respondent's practice history, which does not show any other disciplinary actions; and his reportedly successful employment as a nurse since leaving Epic Health Care. A course in nursing jurisprudence and ethics is required as part of all Board orders under Board Rule 213.33(f) and is therefore required in this case.

The ALJ agrees with the recommended sanction and stipulations and makes the following Findings of Fact and Conclusions of Law.

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[12] Tex. Admin. Code article 217.12(1)(A).

[13] The applicable sanction tiers and levels are listed in the Matrix 22 tex. Admin. Code article 217.33(b)

[14] Sanction Level II (tier II) is similar to Sanction Level I (Tier II), which lists license denial, suspension, revocation and voluntary surrender as possible options. The ALJ finds only suspension suitable, because Respondent appears capable of remediating his practice issues with counseling aimed at gaining insight into his conduct.

[15] Tex. Occ. Code article 301.452(b)(10);(b)(13).

U2 Respondent states all the incidents described by C.D. it happened, in her mind, while respondent was in the course of performing nursing service which was never interrupted nor exposed patient of any harm. No complaint whatsoever was received by all the parties involved in the care of the patient.

V2 Respondent states that Mrs. Downs expressed concern about her daughter inability to make friends at school and in concrete the male ones. C.D. never showed any symptoms of feeling uncomfortable nor having any distress when interacting with Respondent. Statements herein alleged has no basis.

-w2 Respondent states not being able to figure out about the incident but whatever it is he is sure of not have anything to do with romantic nor sexual approach. If that was the case, I wouldn't have chosen a nursing profession.

V. FINDINGS FACT

1. The Texas Board of Nursing (Board) issued License Vocational Nurse (LVN) License No.
2. 330947 to Jose Orlando Diaz (Respondent) on January 24, 2016
3. Respondent was born and raised in El Salvador. His native language is Spanish, but he speaks English. Respondent first obtained an LVN license in 2000 and worked in the Veterans Affairs System where retired in September 2015, approximately 16 years before transitioning to home health care.

4. Respondent does not have a history of sexual violence, or other sexual misconduct, and is not a sex offender.

5. Respondent was hired by Epic Health Care in January 2016 to provide home health services. He worked in the Downs family home for approximately one and a half to two years providing skilled nursing services to S.D. Respondent worked with S.D. on the ground floor and was ruled no to come up to the second floor.

6. S.D. has four siblings, including C.D., who was seventeen years old in 2018. Her bedroom is on the second floor. Except on rare occasions, Respondent gave an end-of-shift report to Mr. and Mrs. Downs. In March 2018, he came upstairs and knocked on C.D.'s bedroom door to present end-of-shift paperwork. She was unable to attend, two hours after the time, and receive report since she was busy studying. This interaction made her uncomfortable.

7. Respondent gave S.D. and his siblings, including C.D. $50 gift cards around the holidays. He also gave C.D. $100 for her birthday, which she found unsettling due to the amount, and because her siblings did not receive similar birthday gifts. However, she had no objection in taking it.

8. C.D. was troubled by Respondent's request for a birthday hug. She states the hug made her uncomfortable and consent it for courtesy. She *said* the hug made her uncomfortable.

9. In April 2018, Respondent ran into the garage started to get seat up in the van and threw a note to C.D. while Mrs. Downs went back inside to get her baby daughter. The note read "I heart C, text me and his phone number on it. C.D. told her mother, and Mrs. Downs reported the incident to Respondent's employer. He was the next day fired.

10. Respondent now works at another home health care company providing skill nursing care to an adult medically complex patient.

11. (Staff) of the Board opened an investigation into Respondent's conduct and referred Respondent for a sex offender evaluation as part of the investigation. A board-certified forensic psychologist conducted a psychological evaluation in July 2018 and submitted a report in September 2018, recommending sanctions and other restrictions, to include counseling aimed at increasing Respondent's insight into his conduct.

12. On May 29, 2019, Staff sent Respondent a Notice of Hearing and Formal Charges. The notice and formal charges contained a statement of the time, place, and nature of the hearing; a statement of the legal

1 authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of
2 the statutes and rules involved; and either a short, plain statement of the factual matters asserted or an
3 attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with
4 the state agency.

5 13. On August 5-6 and September 12, 2019, Administrative Law Judge (ALJ) Kathryn J. Lewis convene the
6 hearing on the merits at the State Office of Administrative Hearing (SOAH) in Austin, Texas. Assistant
7 General Counsel Hellen Kelley represented Staff. Respondent appeared at the hearing and was represented
8 by attorney Rex A. Manaster. After the hearing, Respondent represented himself for the reminder of the
9 case. The record closed on December 20, 2019, with the filing of closing briefs.

10 **XI. CONCLUSIONS OF LAW**

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

13 2. SOAH has jurisdiction over contested cases referred by the Board, including authority to
14 issue a Proposal for Decision with findings of fact and Conclusions of the Law. Tex. Occ
15 Code article 301.459; Tex. Gov't code ch 2003.

16 3. Respondent received proper noticed of the hearing on the merits. Tex. Code article
17 301.454, .458; Tex. Gov't Code article 2001. 051-.052.

18 4. Staff had the burden of proof by the preponderance of the evidence. 1 Tex. Admin. Code
19 Article 155.427.

20 5. Respondent is subject to sanction because he failed to meet minimum standards of
21 nursing practice requiring nurses to know and conform to the Texas Nursing Practice Act
22 and Board rules, and to recognize and maintain professional boundaries of the nurse-
23 patient relationship. Tex. Occ. Code article 301.452(b)(13); 22 Tex. Admin. Code article
24 217.11(1)(A), (J).

25 6. Respondent is also subject to sanction because he committed unprofessional conduct by
26 repeated failure to perform nursing in conformity with minimum standards of nursing
27 practice, including violating the professional boundaries of the nurse-patient relationship.

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Tex. Occ. Code article 301.452(b)(10); 22 Tex. Admin. Code article 217.12(1)(A), (6)(I)).

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 requiring the nurse to submit to care, counseling, or treatment by a health provider designated by the Board as a condition of obtaining or renewing a license. Tex. Occ. Code article 301.453; 22 Tex. Admin. Code article 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 Tex. Admin. Code article 213.33(c) and the Board's disciplinary Matrix (22 Tex. Admin. Code article 213.33(b)). In this case, the Board may consider aggravating factors such as the numbers of events and patient's vulnerability. The Board may also consider as mitigating factors the lack of evidence of harm to the patient, S.D.; Respondent's practice history showing no other disciplinary actions before 2018; and Respondent's successful employment as a nurse after his employment with Epic Health Care ended in April 2018.

VII. RECOMMENDATION

Based on the above findings of facts and conclusions of Law, the ALJ recommends the Board sanction Respondent as follows: a two-year probated, to conclude (1) a course in nursing jurisprudence and ethics; (2) restriction to work solely with adult clients; (3) counseling focused on increasing insight into the nature of the conduct underlying the allegations; (4) such other provisions as the Board sees fit to prescribe.

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10 KATHRYN LEWIS
ADMINISTRATIVE LAW JUDGE
11 STATE OFFICE OF ADMINISTRATIVE HEARINGS
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507-19-3433
3/5/2020 11:10 AM
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March 5, 2020

The Honorable Kathryn Lewis, Administrative Law Judge
State Office of Administrative Hearings
P.O. Box 13025
Austin, Texas 78711-3025

Via Electronic Filing

Re: In the Matter of Permanent Certificate No. LVN 330947
Issued to **JOSE ORLANDO DIAZ**
SOAH Docket No. **507-19-3433**

Dear Judge Lewis:

Enclosed is ***Staff's Response to Respondent's Exceptions to Proposal for Decision*** in the above-referenced matter. I am forwarding a copy to the Respondent. Thank you for your time and assistance with this case.

Sincerely,

Helen Kelley
Assistant General Counsel

Electronically Signed as Authorized by
Tex. Bus. & Comm. Code §322.007

HK/cll
Enclosure

cc: Jose Orlando Diaz, 6900 Curry Dr., The Colony, TX 75056
via first class mail

Kathleen Shipp, MSN, RN, FNP
Lubbock, *President*

David Saucedo, II
El Paso, *Vice-President*

SOAH DOCKET NO. **507-19-3433**

IN THE MATTER OF PERMANENT CERTIFICATE NO. LVN 330947 ISSUED TO **JOSE ORLANDO DIAZ**	§ § § § §	BEFORE THE STATE OFFICE ADMINISTRATIVE HEARINGS

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

COMES NOW, Staff of the Texas Board of Nursing (hereinafter "Staff" or "Board"), and submits its *Staff's Response to Respondent's Exceptions to Proposal for Decision* in the above-referenced matter as follows:

Board Staff requests that the Administrative Law Judge make no changes to the Proposal for Decision issued on February 18, 2020.

Respectfully submitted,

TEXAS BOARD OF NURSING

Helen Kelley

Helen Kelley, Assistant General Counsel
State Bar No. 24086520
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-8658; F: (512) 305-8101
Helen.Kelley@bon.texas.gov

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing *Staff's Response to Respondent's Exceptions to Proposal for Decision* was sent by first class mail on March 5, 2020, to: Jose Orlando Diaz, 6900 Curry Dr., The Colony, TX 75056.

Helen Kelley

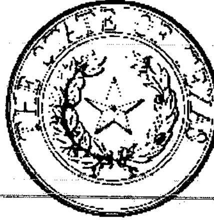
Helen Kelley, Assistant General Counsel

STATE OFFICE OF ADMINISTRATIVE HEARINGS RECEIVED ON 4/3/2020 8:43 AM

ACCEPTED
507-19-3433
4/3/2020 10:16 AM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Donnie Roland, CLERK

FILED
507-19-3433
4/3/2020 8:43 AM
STATE OFFICE OF
ADMINISTRATIVE HEARINGS
Donnie Roland, CLERK

Upload Date: 20200403101947 Account Number: 4119 Upload Description: cef9061a-85dc-46ca-bdee-3138f2d2965c-0



State Office of Administrative Hearings

Kristofer Monson
Chief Administrative Law Judge

April 3, 2020

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

VIA E-FILE TEXAS

RE: Docket No. 507-19-3433; Texas Board of Nursing v. Jose Orlando Diaz

Dear Ms. Thomas:

Procedural History

The hearing in this matter was held on August 5-6 and September 12, 2019. The Administrative Law Judge (ALJ) issued a Proposal for Decision (PFD) in favor of the Texas Board of Nursing Staff's recommendations concerning Respondent's nursing license and practice on February 18, 2020.

The ALJ recommended a two-year probated sentence, to include: (1) a course in nursing jurisprudence and ethics; (2) restriction to work solely with adult clients, and under supervision; (3) counseling focused on increasing insight into the nature of the conduct underlying the allegations; and (4) such other provisions as the Board sees fit to prescribe.

Respondent's Exceptions and Staff's Response

Respondent filed Exceptions March 3, 2020, and objects to the PFD on the following grounds: (1) violation of his right to a fair trial under the Sixth Amendment to the United States Constitution; (2) inability to obtain the hearing transcript; and (3) failure to conduct, and admit at hearing, an independent psychological evaluation.

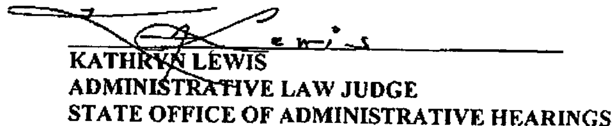
P.O. Box 13025 Austin, Texas 78711-3025 | 300 W. 15th Street Austin, Texas 78701
Phone: 512-475-4993 | Fax: 512-475-4994
www.soah.texas.gov

Staff filed a Response to Respondent's Exceptions on March 5, 2020, and sought no changes to the PFD.

The ALJ reviewed Respondent's exceptions and Staff's response, and does not recommend changes to the PFD. State Office of Administrative Hearings Rules of Procedure § 155.507(c). A Sixth Amendment challenge is not available, as this is an administrative proceeding, not a criminal matter. The Board's alleged failure to conduct an independent psychological evaluation, and the ALJ's resulting failure to admit and consider one, are Board policy matters that must be challenged in a different forum, including the rulemaking process. Respondent, then represented by counsel, also had an opportunity to cross-examine the evaluator. Finally, to the extent Respondent did not have access to the hearing transcript because he does not have counsel, he is invited to contact the State Office of Administrative Hearings for further direction.

It is ORDERED Respondent's Exceptions to the PFD are DENIED. The ALJ does not recommend changes to the PFD issued on February 18, 2020.

Sincerely,



KATHRYN LEWIS
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

KL/mm

xc: Helen Kelley, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 – **VIA E-FILE TEXAS**
Elizabeth Tschudi, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA E-FILE TEXAS**
Jose Diaz, 6900 Curry Dr., The Colony, Texas 75056 – **VIA REGULAR MAIL**