DOCKET NUMBER 507-20-2804

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 883856, ISSUED TO SHEM MIGOSI KENYANYA	**§**	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: SHEM MIGOSI KENYANYA
C/O YONG J. AN, ATTORNEY
PO BOX 19903
HOUSTON, TX 77224

STEVEN H. NEINAST
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 21-22, 2021, the Texas Board of Nursing (Board) considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; 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. No exceptions were filed by any party.

The Board, after review and due consideration of the PFD; Staff's recommendations; and the recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

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 I sanction for his violations of §301.452(b)(10) and (13)[1]. Either a Warning with Stipulations or a Reprimand with Stipulations is authorized under a second tier, sanction level I sanction[2]. The Board agrees with the ALJ that a Reprimand with Stipulations is the most appropriate sanction in this case.

Respondent's conduct was serious in nature and caused the patient actual harm[3]. Further, the patient was vulnerable, and there was a lack of documentation notating the Respondent's care[4].

The ALJ noted mitigating factors, as well. The Respondent had too high of a patient load; the patient was in distress on the prior shift, but the prior shift did not complete all of the required procedures before turning the care of the patient over to the Respondent; an Intermediate Medical Unit (IMU) bed had been ordered but not delivered; and the Respondent has no prior disciplinary history with the Board[5].

Therefore, after carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33(e)(3), that a Reprimand with Stipulations is the most appropriate sanction in this matter.

Consistent with the ALJ's recommendation, the Board finds that the Respondent should be required to complete a nursing jurisprudence and ethics course, a physical assessment course, and a critical thinking course[6]. 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 also agrees with the ALJ that the Respondent's practice should be directly supervised for the first year of the Order, and indirectly supervised for the remainder of the Order. The Board further finds it appropriate to prohibit the Respondent from working in independent practice settings, like home health or hospice, and from being employed temporarily by agencies during the pendency of the Order. These supervisory requirements are intended to prevent additional violations from occurring and to ensure that any deficiencies in the Respondent's practice can be discovered quickly and remediated appropriately. The Board also agrees with the ALJ that the Respondent should be required to inform his employers of this Order and to submit quarterly employer reports to the Board so the

---

[1] See pages 15-16 of the PFD.

[2] See 22 Tex. Admin. Code §213.33(b).

[3] See page 15 of the PFD.

[4] See *id.*

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

[6] 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.

Board can monitor the Respondent's progress and completion of the Order. These requirements are consistent with 22 Tex. Admin. Code §213.33(e)(4)[7].

IT IS THEREFORE ORDERED that RESPONDENT shall receive the sanction of **REPRIMAND WITH STIPULATIONS** in accordance with the terms of this Order.

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 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

[7] 22 Tex. Admin. Code §213.33(e)(4), which 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.

malpractice issues will not be accepted. Home study and video programs will not be approved.

B. **A Board-approved course in physical assessment** with a didactic portion of not less than six (6) hours and a clinical component of not less than twenty-four (24) hours. Both the didactic and clinical components must be provided by the same Registered Nurse. The course's content shall include physical assessment of all body systems. The clinical component SHALL include physical assessment of live patients in a clinical setting; Performing assessments on mock patients or mannequins WILL NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. Successful completion of this course requires RESPONDENT to successfully complete both the didactic and clinical portions of the course.

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 nurse in 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 registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

A. **Notifying Present and Future Employers:** RESPONDENT SHALL notify each present employer in nursing and present each with a complete copy of this Order, including all attachments, if any, within five (5) days of receipt

of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.

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

C. **Direct Supervision.** For the first year [four (4) quarters] of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

D. **Indirect Supervision:** For the remainder of employment as a Nurse under this 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. 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 21st day of January, 2021.

TEXAS BOARD OF NURSING

Katherine A. Thomas

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

Attachment: Proposal for Decision; Docket No. 507-20-2804 (September 3, 2020)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

September 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 EFILE TEXAS

RE: Docket No. 507-20-2804; Texas Board of Nursing v. Shem Kenyanya, RN

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,

Steven H. Neinast
Administrative Law Judge

SN/eh
Attachment

xc: Joanna Starr, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA EFILE TEXAS**
Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD) – **VIA EFILE TEXAS & INTERAGENCY MAIL**
Yong J. An, Attorney at Law, P.O. Box 19903, Houston, TX 77224 – **VIA EFILE TEXAS**

SOAH DOCKET NO. 507-20-2804

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
SHEM MIGOSI KENYANYA, RN, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to sanction Shem Migosi Kenyanya (Respondent), a registered nurse (RN), based on allegations that he violated the Texas Nursing Practice Act (Act)[1] and the Board rules.[2] Staff alleges that Respondent did not meet his duty to care adequately for a 74-year-old male patient (the patient) based on two allegations. First, Staff alleges that Respondent had knowledge that the patient's vital signs showed a significantly low oxygen saturation and hypotension, but Respondent failed to escalate care in a timely manner that could have allowed interventions to take place before the patient lost his pulse and died. Second, Staff alleges that Respondent failed to monitor the patient's vital signs closely, when the patient's history of two Clinical Emergency Response Team (CERT) calls in the last twenty-four hours clearly warranted close monitoring. Staff alleges that if Respondent had adequately advocated for and monitored his patient by escalating care and notifying the proper providers of a change in condition, the patient may have had a greater chance of survival, or at least less pain and distress before his demise. Staff acknowledges that "facility issues" existed that contributed to the death of the patient, such as the apparent lack of an Intermediate Medical Unit (IMU) bed to which the patient could have been transferred, and the patient may have succumbed to his condition even with timely intervention. Although the patient died while under Respondent's care, Staff does not propose revocation of Respondent's license, but instead proposes a reprimand, additional training, direct and indirect supervision, and performance evaluation reports from Respondent's employers.

---

[1] Tex. Occ. Code ch. 301.

[2] 22 Tex. Admin. Code ch. 217. All citations in this Proposal for Decision (PFD) are to the substantive provisions in effect at the time of the underlying incident in January 2019.

Respondent contends that he properly monitored the patient, communicated with his supervisors, and understood that the patient was scheduled to be moved to the IMU, where the patient would be more closely monitored.

After considering the evidence and applicable law, the Administrative Law Judge (ALJ) finds Staff met its burden of proof to show that Respondent violated the Act and Board rules, and that the appropriate sanction in this case is a reprimand, with additional training, direct and indirect supervision, and performance evaluation reports from Respondent's employers for two years.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

Notice and jurisdiction were undisputed and are therefore set out in the Findings of Fact and Conclusions of Law without further discussion. The hearing convened June 22, 2020, before ALJ Steven Neinast via the Zoom videoconferencing application. Joanna Starr, Assistant General Counsel, represented Staff. Yong J. An represented the Respondent. The record closed on August 6, 2020, when Staff filed its Rebuttal Closing Arguments.

II. STAFF'S FORMAL CHARGE

Staff's Formal Charge alleges:

> On or about January 11, 2019, while employed as a Registered Nurse with Houston Methodist Hospital, Houston, Texas, Respondent failed to thoroughly assess and monitor Patient Number 107430894 throughout his shift. The patient was awaiting a bed assignment in the Intermediate Medical Unit (IMU) after the Clinical Emergency Response Team (CERT) had been called twice in the last 24 hours for elevated heart rate (HR) and low blood pressure (BP). In addition, Respondent failed to intervene and timely notify the provider of the patient's BP of 98/61, HR of 144 and oxygen saturation of 75%, and failed to timely activate the CERT. The patient declined, became unresponsive, resuscitation was unsuccessful, and the patient expired. Respondent's conduct was likely to injure the patient in that significant changes in the patient's condition may have gone undetected and prevented a timely intervention.

III. APPLICABLE LAW

Staff asserts that Respondent should be disciplined for violating numerous provisions of the Board's rules,[3] specifically Texas Occupations Code § 301.452(b)(10) and (13), and 22 Texas Administrative Code §§ 217.11(1)(A), (1)(B), (1)(M), (1)(P), and (3)(A) and 217.12(1)(A), (1)(B), and (4).

Board rules define "unprofessional conduct" to include:

- Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice as set out in Board Rule 217.11;[4]
- Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;[5]
- Careless or repetitive conduct that may endanger a client's life, health or safety, without requiring a showing of actual injury.[6]

The Board has enacted rules that define standards of nursing practice to require that every nurse must, among other things:

- Know and conform to the Act and the Board's rules and regulations as well as all federal, state, or local laws, rules, or regulations affecting the nurse's current area of nursing practice;[7]
- Implement measures to promote a safe environment for clients and others;[8]
- Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications;[9] and

---

[3] For ease of reference, a Board rule may be cited as "Board Rule ____."

[4] 22 Tex. Admin. Code § 217.12(1)(A).

[5] 22 Tex. Admin. Code § 217.12(1)(B).

[6] 22 Tex. Admin. Code § 217.12(4).

[7] 22 Tex. Admin. Code § 217.11(1)(A).

[8] 22 Tex. Admin. Code § 217.11(1)(B).

[9] 22 Tex. Admin. Code § 217.11(1)(M).

- Collaborate with the client, members of the health care team and, when appropriate, the client's significant other(s) in the interest of the client's health care.[10]

- A registered nurse is required to assist in the determination of the healthcare needs of clients and, among other things, perform comprehensive nursing assessments regarding the health status of the client, implement nursing care, and evaluate the client's responses to nursing interventions.[11]

When a nurse has violated the Act or Board rules, the Board must impose a disciplinary sanction, which can range from remedial education to license revocation.[12] Board Rule 213.33 includes a Disciplinary Matrix that the Board and SOAH are required to use in all disciplinary matters.[13] The Disciplinary Matrix categorizes violations into tiers, and into sanction levels within tiers, based on the seriousness of the offense and risk of harm to patients or the public. The Disciplinary Matrix also lists certain aggravating and mitigating factors that must be considered. Board Rule 213.33 includes another list of factors that the Board and SOAH must consider in determining the appropriate disciplinary sanction, including evidence of actual or potential harm to patients or the public, evidence of practice history, evidence of present fitness to practice, previous disciplinary history, and the length of time the person has practiced.[14]

IV. EVIDENCE

At the hearing, Staff's ten exhibits were admitted into evidence without objection. Staff presented testimony from three witnesses: Deborah Robinson, a patient sitter; Yu Wang, a nurse practitioner (NP); and Dr. Kristin Benton, Director of Nursing for the Board. Respondent's 13 exhibits were admitted without objection. In addition to Respondent testifying on his own behalf, Respondent called one witness—Sheilah Bofil, RN.

---

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

[11] 22 Tex. Admin. Code § 217.11(3)(A).

[12] Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

[13] 22 Tex. Admin. Code § 213.33(a)-(b).

[14] 22 Tex. Admin. Code § 213.33(c).

Testimony and evidence in this case confirmed the following undisputed facts. The patient in this case was a 74-year old male who was admitted to Houston Methodist Hospital (Houston Methodist) for seizure-like activity on June 9, 2019. In the early morning and again in the afternoon of June 11, 2019, the CERT was called to the patient's room because the patient's vital signs showed a high heart rate, low blood pressure, and low oxygen saturation levels. The second CERT that day occurred at approximately 15:20.[15] By that time, the hospital staff had requested that the patient be moved to an IMU bed, but the patient was not moved because an IMU bed was not available.[16]

Respondent began his shift at 19:00 on June 11, 2019, and was responsible for five patients. The only personalized documented care entered by Respondent in the medical record for the patient is a note at 23:30 stating, among other things, that medication was given by Respondent as ordered; the patient's condition was unchanged; the patient's blood pressure was low with an oxygen level of 77%; and the patient was "awaiting a move to ICU as soon as bed is available."[17] At 23:42, a medical emergency (referred to as a "Code Blue") was initiated when the patient's heart rate stopped. Resuscitation efforts failed, and the patient was pronounced dead at 00:40 on January 12, 2019.[18]

A. Testimony of Deborah Robinson

Ms. Robinson is a patient sitter who was present in the patient's room throughout Respondent's shift while the patient was alive on June 11, 2019. She was told when she started her shift at 18:55 that the patient was "critical" and she needed to watch the patient carefully. She testified that vital signs were to be taken three times over a 12-hour shift, and that Respondent had not asked her to check the patient's vital signs more frequently. Ms. Robinson first took the

---

[15] Staff Exh. 8 at 16. The ALJ uses the 24-hour clock to correlate with the nursing notes, rather than the standard 12-hour clock.

[16] During the hearing, some witnesses sometimes referred to this bed as an "ICU" (presumably Intensive Care Unit) bed, but the Board's Notice of Violation refers to a bed in the "Intermediate Medical Unit" (IMU). *E.g.*, Staff Exh. 2 at 1. Regardless of the differing descriptions, this PFD refers to the bed (or unit) as the IMU, or the IMU bed.

[17] Staff Exh. 8 at 21.

[18] *Id.* at 21-23.

patient's vital signs at 19:19, which showed blood pressure at 98/61, respiratory rate of 16, heart pulse rate at 144 beats per minute, and oxygen saturation of 75%.[19] She testified that an oxygen saturation rate of 75% would be "concerning." Ms. Robinson recalled that Respondent was in the patient's room for approximately 15 minutes that evening. She testified that she heard Respondent talking to someone on the phone in the hallway later in the shift, but she could not hear what was said. At 23:32, with Ms. Robinson in the patient's room, a Patient Care Assistant (PCA), Barbara Zachary, took the patient's vital signs, which showed the patient's blood pressure at 85/56, heart rate at 149, and oxygen saturated at 77%.[20] Shortly after Ms. Zachary took the patient's vital signs, Ms. Robinson reported that NP Wang first came into the patient's room. Shortly after Ms. Wang arrived, the patient's heart rate began to decline quickly and then stopped shortly before midnight.

B. Testimony of NP Yu Wang

On June 11, 2019, Ms. Yu Wang was the night shift NP for numerous floors at Houston Methodist, including floor "Main 8" on which the patient was located. Ms. Wang was primarily responsible for patients on her shift who would become subject to a Code Blue cardiac arrest, a CERT call, or a psychiatric episode. At the beginning of her shift at 18:30, Ms. Wang was notified that the patient had two CERT calls earlier that day. At approximately 21:00, Ms. Wang talked to a staff person on the patient's floor regarding the patient, but she did not remember the name of that person. That staff person did not identify any change of condition for the patient and, as an NP covering multiple floors, Ms. Wang stated she would not receive alerts from individual patients who were not in a Code Blue, CERT situation, or experiencing a psychiatric episode. Ms. Wang testified that although the staff person did not advise her regarding the patient's abnormal vital signs, she ordered a comprehensive blood count (CBC) for the patient. At approximately 23:30, Ms. Wang reviewed the patient's chart to follow up on the CBC.[21] She noticed that the blood

---

[19] Staff Exh. 5 at 160-61.

[20] *Id.* at 161-62; Staff Exh. 8 at 21.

[21] The record does not reflect whether NP Wang was in the patient's room when she read the chart or at another station. The timing, however, is consistent that about the time PCA Zachary was taking the patient's vital signs, NP Wang was reviewing (or just about to review) the patient's chart.

count signs had not improved from earlier in the afternoon, and she contacted the CERT NP who had been on shift earlier in the afternoon to discuss the patient's condition. Ms. Wang then called the patient's floor to order additional vital sign measurements for the patient. Ms. Wang arrived at the patient's room at 23:40; she noticed that the patient was sweating and complaining of chest pains. The patient lost his pulse at 23:42, and Ms. Wang called a Code Blue.[22] She testified that if care had been escalated when the patient's vital signs were taken at 19:19, appropriate interventions could have been made that may have helped the patient.

C. Testimony of Dr. Kristin Benton

Dr. Benton is the Director of Nursing for the Board. She testified that nurses can protect themselves by invoking a "safe harbor" protocol by documenting that a patient is in trouble but, in the nurse's opinion, the patient was not receiving an adequate medical response. The safe harbor typically would be implemented after the nurse had attempted, but failed, to obtain additional help from the charge nurse or other providers. Dr. Benton testified that Respondent did not invoke a safe harbor during this incident, and that his single note at 23:30 does not show a "concern" for the patient other than reporting the patient's vital signs and noting his condition had not changed. She testified that, given the patient's condition, Respondent should have taken more vital signs, and the two CERTs in the prior shift should have raised concerns about the patient's ongoing condition. She also testified, however, that the charge nurse on the floor when Respondent started his shift at 19:00 should have been aware of the two prior-shift CERTs. She acknowledged that Respondent had a difficult assignment in that he was responsible for five patients, but he did not request a reduction in his patient assignments or, as noted, invoke the safe harbor. Dr. Benton could not say that Respondent's nursing care led to the patient's death, but she did not think that remedial education alone would be sufficient to address the charges in this situation.

With regard to NP Wang's responsibilities, Dr. Benton testified that it is not unusual for an NP to provide on-call assistance to hundreds of hospital patients, but that does not oblige the NP to provide bedside care to all of those patients. As Ms. Wang testified, she was not assigned to a

[22] Staff Exh. 8 at 21; *see also* Staff Exh. 5 at 94.

specific unit, such as the patient's floor, but was also on call at the hospital for any CERT calls, Code Blues, or psychiatric emergencies. Dr. Benton testified that it would have been Respondent's responsibility to notify Ms. Wang of any change in the patient's condition. Dr. Benton concluded that the potential failure or inactions of other nurses and hospital staff do not negate Respondent's duty to monitor, assess, intervene, and escalate care for his patient.

Dr. Benton acknowledged that all of the medicine and process prescriptions that were ordered from the 15:20 CERT call should have been carried out within three hours, meaning that they all should have been carried out by 19:00 when Respondent began his shift. But not all of the prescriptions had been administered by 19:00, and Respondent had to, and did, administer the earlier prescriptions. Dr. Benton also agreed that the patient's vital signs should have been taken again at 18:20—prior to Respondent's shift. Had the patient's vital signs been taken at that time, it is possible that a third CERT could have been called for this patient—just before Respondent's shift—that could have resulted in elevated care. Dr. Benton agreed that these delays in taking vital signs and promptly administering the drugs prescribed from the 15:20 CERT could serve as mitigating factors in Respondent's favor, and this situation was not a "best case" scenario. Dr. Benton nevertheless concluded that the delays from the prior shift did not excuse Respondent's apparent lack of attention to the patient once he began his shift.

Dr. Benton stated that Respondent's minimal documentation throughout his shift with regard to the patient was unusual. Dr. Benton reiterated that it is important for a bedside nurse to document changes in a patient's status and condition so that others involved in the patient's care can review the record to determine if action is necessary. In this case, the record does not show that Respondent documented or contacted anyone regarding the patient's condition until shortly before the patient lost his pulse. Dr. Benton provided examples of nurses providing proper documentation on the patient's condition, including notifications to the responsible physicians.[23] She also indicated that Respondent could have documented notification of a provider in the "Provider Notification Flowsheet."[24] Dr. Benton opined that if Respondent had asked the charge

[23] Staff Exh. 5 at 77, 82-83.

[24] Staff Exh. 5 at 129-30.

nurse for assistance, the charge nurse might have been able to locate a "floater" nurse who could assist Respondent. She conceded that it is unusual for an IMU bed not to be available within 24 hours of the initial request, but noted, regardless, the sepsis exhibited by the patient should have been taken very seriously and treated as a priority situation.

Dr. Benton also discussed the various Board rules that could apply to this situation, and mitigating factors that could weigh in Respondent's favor, such as Respondent's lack of any prior violations. She also noted the extenuating circumstances that contributed to make the situation difficult such as the lack of an available IMU bed and Respondent's number of assigned patients. Furthermore, Respondent's conduct was not a direct or sole cause of the patient's death. She testified that these mitigating factors could justify a reprimand in this case, rather than a license revocation. In the context of appropriate sanctions, Dr. Benton also discussed the Disciplinary Matrix found in the Texas Occupations Code that is used to determine the level of sanctions if a violation of Board rules is found to have occurred. As discussed in more detail below in the Analysis section of this Proposal for Decision, Dr. Benton explained that the Disciplinary Matrix directs the Board and the ALJ to consider certain mitigating factors that could result in disciplinary action that is less severe than license revocation.

D. Testimony of Respondent

Respondent received his nursing degree in 2012 from Wayland Baptist University in San Antonio, and received his RN license in 2015. He supports his wife and three sons, who remain in Kenya. He has been in the United States for 15 years. He has not faced any prior disciplinary action from the Board.

When Respondent arrived at work at 19:00, he was told the patient had had two CERTs earlier that afternoon, and there was an order to move the patient to an IMU bed. Because this patient was "very sick," Respondent testified that he began to work on providing the prescribed medications that had not yet been administered by the prior shift. He considered the patient to be a high priority. Early in his shift, Respondent was aware of the patient's concerning vital signs and stated he informed the NP of the patient's condition and need for an IMU bed. Respondent

testified that the NP told him to continue with the medications and order a CBC. According to Respondent, a doctor was not available to assess the patient.[25] Respondent stated that he remembered the conversation with NP Wang on the telephone because he was the "one who did it," and he documented this conversation: "I documented what I told her and what she told me to do. It is not possible that [I would give] medication without [an] assessment." But Respondent does not know why the record does not document this conversation. Respondent testified that he talked to the NP three or four times and "every time she said she would come" to assist with the patient. Respondent recalled that the NP came to the patient's room at around 23:30 after his third call to her. Respondent stated that he initiated a CERT call after his third call to the NP.

Respondent testified that critical patients are supposed to be handled one-on-one by a nurse. He was very busy that night, stating that he was so busy that he did not think to call a safe harbor, and he thought care was about to be elevated because the patient was supposed to be moved to an IMU bed. He explained that he was especially busy because he was required to change his garments before entering the rooms for four of his five patients. Respondent testified that his priority was to make sure the patient was going to the IMU. He stated a number of times that he ultimately concluded that no one was actually looking for an IMU bed for the patient. He also thought that the NP should have been following up on moving the patient to an IMU bed because the IMU order was from the previous shift.

Respondent testified that he also called the charge nurse about five times asking for the status of the IMU bed. He stated the charge nurse was busy and did not do follow up. Again, Respondent stated that he documented all of his conversations and actions, but does not know why they are not in the record. He concluded that "no proper management was given to this patient," but that he had done "everything I was supposed to do."

As noted by earlier witnesses, Respondent's only entry in the medical record documentation regarding the patient's status is the 23:30 entry on June 11, 2019, where he lists the

[25] Respondent stated that the unavailability of a physician is shown on Respondent's Exh. 12, but the root cause analysis in that exhibit does not appear to include such a statement. In any event, the record shows that an NP and charge nurse were on duty during Respondent's shift.

patient's vital signs and states that the patient was alert and condition unchanged.[26] Other than post-death entries regarding contacts with the patient's relatives, the only other entries in the patient's record are entries at 20:41 and 20:49 indicating Respondent replaced the patient's intravenous bags.[27] Respondent agreed that the many entries in the documentation prior to 23:30 do not reflect his calls to the NP or charge nurse, or other actions, but he testified that his typical practice is to document after talking to the provider, and his first priority was to stabilize the patient while waiting for the requested IMU bed. Respondent stated that he was placed in a position in which he had to prioritize patient care above documentation.

When asked why he did not escalate care for the patient to someone above either the NP or charge nurse, Respondent stated that he "didn't have their numbers."[28] He stated that all he could do was reach out to the NP.

Respondent concluded that if he had this episode to do over, he would first ensure that there was an IMU bed available for the patient. Other than Respondent's opinion, however, there is nothing in the record indicating that others on his floor, such as the NP or charge nurse, were not following protocols in requesting an IMU bed, and there is nothing indicating that an IMU bed was or was not available.

---

[26] Staff Exhs. 8 at 21, 5 at 93. Both exhibits state: "Patient alert to himself. Condition unchanged. Medication given as ordered. Patient had one diarrhea episode. Blood pressure low and respiration 32. Oxygen level 77. Patient awaiting to move to ICU as soon as the bed is available." This entry was electronically signed by Respondent on January 11, 2019, at 11:34 p.m. (23:34). There is a four minute difference between the same entries on Staff Exh. 8 and Staff Exh. 5. The former states this entry was made at 23:30, while the latter states 23:34.

[27] Respondent Exhs. 5, 8. Staff Exh. 5 at 154 shows that the patient was administered Vancomycin at 20:49 and Cefepime at 20:42. There is a one minute discrepancy between the times give for the Cefepime dosage on Respondent's exhibits as compared to Staff's exhibits, but this discrepancy is not material. The record includes entries by Respondent after the patient had died indicating that Respondent had contacted the patient's family. *E.g.*, Staff Exh. 5 at 94.

[28] Staff Exh. 7 at 7 is a "Clinical Chain of Command" flow chart that shows the superiors to which Respondent could have asked for help if he thought he was not receiving sufficient attention from either the NP or charge nurse.

E. Testimony of Sheila Bofil

Ms. Bofil is an RN who currently works at the MD Anderson Cancer Center, where she is a senior systems business analyst. Ms. Bofil stated that she is the main clinical IT support for management applications for use in maximizing staffing orders, specializing in patient safety. Ms. Bofil has a master's degree in Health Care Administration from Texas Woman's University, and worked at Houston Methodist from October 2015 through February 2019. At the hearing, Ms. Bofil was accepted as an expert in sepsis procedures and methods used at Houston Methodist. After reviewing the evidence in this case, Ms. Bofil concluded that there was no delay in the care of the five patients in Respondent's care.

Ms. Bofil testified that Respondent was placed in a position that set him up for failure, although she agreed that it is duty of the bedside RN to monitor the patients under their care. Ms. Bofil agreed with Dr. Benton that Respondent was carrying out medical orders that should have been completed by 18:30 by the prior shift as a result of the 15:20 CERT call. She also testified that the prior shift should have taken the patient's vital signs just before completing their shift at 19:00. If they had, and assuming the results at 19:00 were about the same as those recorded at 19:19 by Ms. Robinson, the prior shift should have called a third CERT which would result in enhanced care for the patient.

Ms. Bofil opined that there was a gap in communication between the "morning" shift and Respondent's shift, which impeded the patient's continuity of care. She also suggested that the neither of the two morning shift CERT personnel took into account all of the indicators of the sepsis, but that the blame for the patient's death in this case "should not be on one person itself." She testified that "any abnormalities should be escalated," and that nurses have a duty to advocate for their patients. She conceded, however, that there is no indication in the record that Respondent asked for relief from his patient care assignment.

On cross-examination, Ms. Bofil speculated that some actions were taken by Respondent but not documented. As also emphasized by Respondent, Ms. Bofil testified that the goal in this situation was to take care of the patients before entering data into the medical records.

V. ANALYSIS

A. Violations

The evidence showed that Respondent failed to thoroughly assess and monitor the patient throughout his shift, as alleged. The patient died approximately five hours into Respondent's shift, and little affirmative action was taken during those five hours to address the patient's condition. The ALJ finds that Respondent's conduct violated 22 Texas Administrative Code § 217.11(1)(A), (1)(B), (1)(M), (1)(P), and (3)(A) and 22 Texas Administrative Code § 217.12(1)(A), (1)(B), and (4).

The record is clear that at 19:19, just after Respondent had started his shift, the patient sitter recorded the patient's heart rate of 144, respiratory rate of 16, an oxygen saturation level of 75%, and a blood pressure of 98/61. These signs indicate a patient in distress. A request to move the patient to an IMU bed had been ordered, but there was no indication of when that move would, or could, occur. Between 20:41 and 20:49, Respondent administered two drugs to the patient through intravenous bags and, during and prior to these times, he apparently completed the procedures ordered by the earlier shift because of the 15:20 CERT call. The witnesses agree that the earlier shift should have completed its ordered procedures prior to 19:00.

At between 23:30 and 23:34, Respondent entered his only documentation of a personal observation into the medical record prior to the patient's death: "Patient alert to himself. Condition unchanged. Medication given as ordered. Patient had one diarrhea episode. Blood pressure low and respiration 32. Oxygen level 77. Patient awaiting move to ICU as soon as possible." At 23:32, however, a PCA recorded the patient's vital signs as a heart rate of 149, respiratory rate of 28, an oxygen saturation level of 77%, and a blood pressure of 85/56. Thus, at between 23:30 and 23:34, Respondent was factually correct in recording that the patient's condition was "unchanged," presumably as compared to the patient's condition at 19:19, when the patient sitter took the prior vital signs. But the vital signs taken at both 19:19 and 23:32 indicated that the patient was in an abnormal medical condition. During this four-hour period, no action was

taken affirmatively to relieve the patient's distress, other than the pre-ordered medications administered at around 20:45.

The ALJ also concludes from the record that Respondent talked to NP Wang at about 21:00. Respondent testified that this was one of four calls with her, but NP Wang does not recall other calls. NP Wang also testified that she was not notified about the patient's abnormal vital signs during this 21:00 phone conversation. The record is clear that NP Wang followed-up with the patient at about 23:32, when she reviewed the abnormal vital signs taken by the PCA at that time.

The foregoing facts raise two points. First, the patient obviously was in distress at least as early as 19:19, but nothing was done affirmatively until 23:40, at which time NP Wang addressed the patient's abnormal medical condition. Second, despite substantial testimony from Respondent that he was caring for the patient and communicating his concerns to NP Wang and the charge nurse, there is scant documentation in an extensive medical record that Respondent was attending to the patient. Respondent may well have communicated on numerous occasions with the NP and charge nurse, but these communications did not result in the patient receiving critical care. If NP Wang and the charge nurse were not responding as Respondent suggests, Respondent should have asked to be relieved of some of his other patients so he could focus on the patient, or Respondent could have invoked the safe harbor. But he did not take these actions.

B. Mitigating Factors

As Staff recognizes, the patient's death cannot be attributed solely to Respondent and, because there were numerous mitigating circumstances, the remedial action in this case should be less than termination of Respondent's RN license. There is no question that Respondent had a heavy workload, with at least two patients in isolation. Respondent claimed that four of his five patients were in isolation rooms that required him to change garments each time before entering the room. A Staff exhibit, however, shows that only two of Respondent's patients were in isolation rooms that required a garments change with each visit.[29] The point here is that Respondent had to

[29] Staff Exh. 7 at 20-21.

change his garments each time he visited at least two of his five patients that evening, and this contributed to a hectic situation. There is no question that the patient at issue in this case was in distress before Respondent began his shift, and the prior shift failed to carry out all the procedures ordered from the 15:20 CERT before turning the patient over to Respondent. There is no question that an IMU bed had been ordered for the patient, but had not been procured prior to the patient's pulse stopping shortly before midnight. In addition to Respondent's prior work history, which showed no problems or reprimands, these are all mitigating factors in Respondent's favor.

Nevertheless, it is possible that the patient would not have died on Respondent's shift if Respondent had been more proactive in caring for the patient. The facts, and mitigating factors, indicate that this situation does not warrant revocation of Respondent's RN license. Disciplinary action in the form of a reprimand and supervision, with the latter necessary to assist Respondent in better managing his patients and in documenting his care, however, are necessary.

C. The Disciplinary Matrix and Sanctions

Once violations of Board rules have been established, the ALJ then looks to the Disciplinary Matrix found in 22 Texas Administrative Code § 213.33(b) to determine the appropriate sanction. Under the Matrix table applicable to Texas Occupations Code § 301.452(b)(10), the ALJ determines that the charges in this case should be analyzed as a "Second Tier Offense" because there was a serious risk to the patient in this situation, and, unlike a "First Tier Offense," this was not simply an isolated failure to comply with Board rules "with no adverse patient effects." The ALJ next considers the appropriate sanction level by evaluating any mitigating and aggravating factors.[30] As noted, significant mitigating factors were present in this case: Respondent had no prior disciplinary history, the investigation of the facility indicated additional systems factors were present that led to the patient's death, and Respondent's patient load was too high. Aggravating factors include actual harm, severity of harm, patient vulnerability, and lack of documentation notating care provided to the patient. Because of the preponderance of mitigating factors, the ALJ agrees with Dr. Benton that a Sanction Level I is appropriate, thus

[30] Mitigating and aggravating factors to be considered in determining the sanction are listed in 22 Texas Administrative Code § 213.33(c) and in the Matrix.

requiring a "Warning or Reprimand with Stipulations which may include remedial education, [and] supervised practice." As Dr. Benton testified, Sanction Level II, which would result in a revocation of Respondent's license, is not warranted in this situation.

Under the Matrix table applicable to Texas Occupations Code § 301.452(b)(13), a Third Tier Offense is appropriate because the patient was at "serious risk of harm" and ultimately died. The same mitigating factors set out above, however, indicate that Respondent should not be subject to license revocation, one sanction warranted under a Third Tier Offense. Given in particular the mitigating factors, Dr. Benton recommended in this situation, and the ALJ agrees, that the sanction for this offense should be a reprimand.

Based on the foregoing, the ALJ agrees with Dr. Benton's ultimate recommendation that Respondent: (1) receive a reprimand requiring him to complete remedial education by taking Nursing Jurisprudence and Ethics, physical assessment, and critical thinking; (2) notify his employers of the Board's order; (3) be directly supervised for the first year and indirectly supervised for the second year after issuance of the Board's order; and (4) have his employers submit notification of employment forms to the Board and complete nursing performance evaluations for two years.

VI. FINDINGS OF FACT

1. Shem Migosi Kenyanya (Respondent) holds Registered Nurse (RN) License 883856 issued by the Texas Board of Nursing (Board).

2. Respondent has been an RN since 2015.

3. Respondent was employed by Houston Methodist Hospital (Houston Methodist) as an RN on January 11, 2019.

4. On January 11, 2019, Respondent began his shift at Houston Methodist at 19:00, where he was assigned as the bedside nurse for five patients on the floor Main 8.

5. One of the patients was a 74-year old male who was admitted to Houston Methodist for seizure-like activity on June 9, 2019 (the patient).

6. In the 24 hours prior to 19:00 on January 11, 2019, a Clinical Emergency Response Team (CERT) had twice been called to the patient's room to deal with abnormal medical conditions, including low blood pressure, abnormally low blood oxygen saturation, and a high respiratory rate. Respondent was advised of these two prior CERT calls when he began his shift.

7. The last CERT intervention at approximately 15:20 prescribed a number of medications and procedures that were not completed by the time Respondent began his shift at 19:00.

8. During the shift prior to Respondent's shift, medical personnel had requested that the patient be moved to an Intermediate Medical Unit (IMU) bed. That request remained in effect into Respondent's shift.

9. On January 11, 2019, at 19:19, the patient's vital signs indicated abnormal medical conditions including low blood pressure, abnormally low blood oxygen saturation, and a high respiratory rate.

10. At approximately 20:45, Respondent administered prescribed intravenous medications to the patient.

11. At 23:32, the patient's vital signs continued to indicate abnormal medical conditions that had not significantly improved from 19:19, including low blood pressure, abnormally low oxygen saturation, and an even higher respiratory rate.

12. Despite the abnormal vital signs indicated at 23:32, Respondent did not document any planned response for addressing the patient's condition

13. AT 23:42, a Code Blue was initiated to address the patient's abnormal medical attention.

14. The patient was pronounced dead at 00:40 on January 12, 2020.

15. Between 19:00 and the Code Blue, Respondent did not initiate a CERT call to address the patient's condition.

16. Between 19:00 at the Code Blue, Respondent did not request a reduction in his patient responsibility or the assignment of a floater nurse to assist him in dealing with the patient.

17. Between 19:00 and the Code Blue, Respondent did not initiate a "safe harbor" that would have indicated his concern that the patient was not being cared for properly.

18. If additional assistance for the patient had been requested during Respondent's shift, the patient may not have died on January 12, 2019, or at least would have suffered less pain and distress.

19. Although an IMU bed had been requested for the patient prior to Respondent's shift, and that request remained in place until the patient died, an IMU bed was not made available to the patient.

20. Respondent discussed the status of the patient, in particular the status of the request to move the patient to an IMU bed, with a Nurse Practitioner assigned to Main 8 (and other floors) during his shift.

21. Respondent may also have discussed the status of the patient with the charge nurse on Main 8.

22. There is no written documentation in the patient's medical records that Respondent discussed the patient with either the Nurse Practitioner or the charge nurse.

23. The prior shift attending to the patient should have completed the administering the prescriptions and procedures ordered by the 15:20 CERT before Respondent began his shift at 19:00.

24. Respondent's actions, or inactions, were not the sole cause of the patient's death.

25. On April 23, 2020, the Board Staff issued its Notice of Hearing, including Formal Charges, to Respondent.

26. The Notice of Hearing and Formal Charges contained a statement of the time, place, and nature of the hearing on the merits; a statement of the legal authority and jurisdiction under which the hearing on the merits was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the factual matters asserted, or an attachment that incorporates by reference the factual matters asserted in the complaint or petition filed with the state agency.

27. The hearing on the merits convened as a Zoom videoconference on June 22, 2020, before Administrative Law Judge (ALJ) Steven Neinast with the State Office of Administrative Hearings (SOAH), Texas. Joanna Starr, Assistant General Counsel, represented Staff. Respondent appeared and was represented by attorney Yong J. An. The record closed on August 5, 2020, when Staff filed its Rebuttal Closing Arguments.

VII. CONCLUSIONS OF LAW

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

2. SOAH has jurisdiction over the hearing in this proceeding, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Tex. Gov't Code ch. 2003.

3. Respondent received proper notice of the hearing on the merits. Tex. Occ. Code § 301.454; Tex. Gov't Code §§ 2001.051-.052.

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

5. Respondent is subject to sanction because he failed to conform to accepted standards of nursing practice, in that he: (1) failed to perform comprehensive nursing assessments regarding the health status of the patient, implement nursing care, and evaluate the client's responses to nursing interventions; (2) failed to implement measures to promote a safe environment for a patient; (3) failed to collaborate with the patient and members of the health care team in the interest of the patient's health care; (4) failed to institute appropriate nursing interventions that might be required to stabilize a patient's condition and/or prevent complications; and (5) failed to know and conform to the Act and the Board's rules and regulations as well as all federal, state, or local laws, rules, or regulations affecting the nurse's current area of nursing practice by failing to accurately, and completely report and document required information in the medical records. Tex. Occ. Code § 301.452(b)(13); 22 Tex. Admin. Code §§ 217.11(1)(A), (1)(B), (1)(M), (1)(P), (3)(A).

6. Respondent is also subject to sanction because he committed unprofessional conduct in the practice of nursing by: (1) carelessly failing, repeatedly failing, or exhibiting an inability to perform registered nursing in conformity with the standards of minimum acceptable level of nursing practice as set out in Board Rule 217.11; (2) carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings; and (3) engaging in careless or repetitive conduct that may endanger a client's life, health or safety, without requiring a showing of actual injury. Tex. Occ. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.12(1)(A), (1)(B), (4).

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

8. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors set forth in 22 Texas Administrative Code § 213.33(c) and the Board's Disciplinary Matrix (22 Texas Administrative Code § 213.33(b)). In this case, the Board may consider, as mitigating factors, the Respondent's work load, the unavailability of a requested IMU bed, the fact that the prior nursing shift did not take the patient's vital signs before completing their shift or administer all medications and procedures ordered from a 15:30 CERT call prior to shift end, and Respondent's practice history showing no other disciplinary actions. Aggravating factors include the lack of complete documentation regarding the patient's care and lack of documented efforts to obtain assistance in the care of the patient.

VIII. RECOMMENDATION

Based on the above Findings of Fact and Conclusions of Law, the ALJ recommends that Respondent: (1) receive a reprimand; (2) complete remedial education by taking Nursing Jurisprudence and Ethics, physical assessment, and critical thinking; (3) notify his employers of the Board's order; (4) be directly supervised for the first year and indirectly supervised for the second year after issuance of the Board's order; and (4) have his employers submit notification of employment forms to the Board and complete nursing performance evaluations for two years.

SIGNED September 3, 2020.

STEVEN H. NEINAST
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS