DOCKET NUMBER 507-20-4384

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 227266, ISSUED TO DAVID JENTRY SANDERS	**§**	**BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: DAVID JENTRY SANDERS
2205 N. CAMP ST.
SEGUIN, TX 78155

REBECCA S. SMITH
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 Warning with Stipulations is the most appropriate sanction in this case.

Respondent's conduct placed a vulnerable patient at a serious risk of harm[3]. Although the conduct was risky, there was no evidence of serious harm actually occurring, and the Respondent has no prior disciplinary action with the Board[4].

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 Warning 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[5]. This course is 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 indirectly supervised for the duration 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 Board can monitor the Respondent's progress and completion of the Order. These requirements are consistent with 22 Tex. Admin. Code §213.33(e)(3)[6].

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

I. COMPLIANCE WITH LAW

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[1] See page 7 of the PFD.

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

[3] See page 7 of the PFD.

[4] See *id.*

[5] 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.

[6] 22 Tex. Admin. Code §213.33(e)(3), which authorizes reasonable probationary stipulations that may include remedial education courses and practice for at least one year under the direction of a nurse designated by the Board, as well as limitations on nursing activities/practice settings.

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

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 four (4) quarterly periods [one (1) year] of employment. This requirement will not be satisfied until four (4) 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. **Indirect Supervision:** For the duration 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.

D. **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 four (4) quarters [one (1) year] 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. 507-20-4384 (November 19, 2020)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

November 19, 2020

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

RE: Docket No. 507-20-4384; Texas Board of Nursing v. David J. Sanders

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,

Rebecca S. Smith

Rebecca S. Smith
Administrative Law Judge

RS/tt
Enclosures

xc: Jena Abel, Deputy General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Suite 460, Austin, TX 78701 (with 1 CD of Hearing on Merits) – **VIA EFILE TEXAS & INTERAGENCY MAIL**
David J. Sanders, 2205 N. Camp St., Seguin, TX 78155 – **VIA REGULAR MAIL**

SOAH DOCKET NO. 507-20-4384

TEXAS BOARD OF NURSING, **Petitioner**	§	**BEFORE THE STATE OFFICE**
v.	§	**OF**
DAVID JENTRY SANDERS, LVN, **Respondent**	§	**ADMINISTRATIVE HEARINGS**

PROPOSAL FOR DECISION

The Staff of the Texas Board of Nursing (Board) seeks to sanction the Licensed Vocational Nurse (LVN) credential held by David Jentry Sanders (Respondent) based on allegations of substandard practice and unprofessional behavior in patient care and medication administration. Staff argues Respondent should be sanctioned with a Warning with stipulations. The Administrative Law Judge (ALJ) concludes that Staff proved its allegations by a preponderance of the evidence and recommends the Board issue a Warning with the terms described below.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

ALJ Rebecca S. Smith convened a hearing on the merits on September 23, 2020, via Zoom videoconference. Deputy General Counsel Jena Abel represented Staff, and Respondent represented himself. The hearing concluded and the record closed that day. On November 16, 2020, Respondent filed a letter further stating his position.

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

II. STAFF'S FORMAL CHARGES AND APPLICABLE LAW

The Texas Nursing Practice Act, found in chapter 301 of the Texas Occupations Code (Code), empowers the Board to discipline licensees for, among other things, unprofessional conduct (Code § 301.452(b)(10)), or practice below minimum standards of nursing care (Code § 301.452(b)(13)). Staff asserted that Respondent's conduct is grounds for disciplinary action

under both Code provisions, as well as pursuant to a number of Board rules.[1] With respect to unprofessional conduct, Staff asserts Respondent failed to comply with:

- **Board Rule 217.12(1)(A)**: careless or repeated failure or inability to practice in conformity with minimum standards set out in Board Rule 217.11.[2]
- **Board Rule 217.12(1)(B)**: failing to conform to generally accepted nursing standards in applicable practice settings.
- **Board Rule 217.12(4)**: conduct that may endanger a client's life, health, or safety.

With respect to minimum standards of nursing practice, Staff alleges Respondent did not comply with provisions that require a nurse to:

- **Board Rule 217.11(1)(A)**: know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice.
- **Board Rule 217.11(1)(B)**: implement measures to promote a safe environment for clients and others.
- **Board Rule 217.11(1)(C)**: know the rationale for and the effects of medications and treatments and correctly administer the same.
- **Board Rule 217.11(1)(M)**: institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.
- **Board Rule 217.11(2)(A)**: meet standards specific to LVNs, including utilization of a systematic approach to providing goal-directed nursing care (including data collection, focused nursing assessments, planning and modifying nursing care plans, and implementing care within an LVN's scope of practice).

Board Rule 213.33 sets out a disciplinary matrix (Matrix) intended to match the severity of the sanction imposed to the nature of the violation, taking into account mitigating and aggravating factors listed in the Matrix.[3] The 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

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

[2] A number of subsections of Board Rule 217.12 were amended effective October 17, 2019, but the subsections cited in this Proposal for Decision were unaffected.

[3] 22 Tex. Admin. Code § 213.33; *see also* Tex. Occ. Code § 301.4531 (requiring the Board to adopt a schedule of sanctions).

the public. Board Rule 213.33 includes another list of factors that the Board and the State Office of Administrative Hearings (SOAH) must consider in determining the appropriate disciplinary sanction, including evidence of potential harm to patients or the public and evidence of present fitness to practice.[4]

Staff had the burden of proving its allegations by a preponderance of the evidence, and Respondent has the burden of proving mitigating factors, if any.[5]

III. DISCUSSION

Staff called three witnesses and offered thirteen exhibits, which were admitted without objection. Respondent testified on his own behalf, but did not offer any exhibits.

A. Evidence

1. Testimony of Barbara Goodell, Advanced Practice Registered Nurse

Ms. Goodell is a nurse practitioner who holds prescriptive authority from the Board. In April 2019, she saw patients at Sorrento, a skilled nursing rehabilitation facility in San Antonio, Texas.

On April 13, 2019, which was a Saturday, Ms. Goodell entered orders electronically from her home. These orders were both for the same patient (Patient), who was mostly bed-bound during her rehabilitation. Specifically, Ms. Goodell entered orders for ertapenem, an antibiotic administered intravenously, for Patient's urinary tract infection, and 5 milligrams of Eliquis, an anticoagulant medication to decrease the chance of Patient developing deep vein thrombosis. Ms. Goodell intended that administration of both medications would begin that day. She testified that delay in administering the medications could result in harm. In the case of ertapenem, delay could lead to sepsis, which could require more serious hospitalization. Delay in administering Eliquis put Patient at risk for developing deep vein thrombosis or pulmonary embolism.

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[4] 22 Tex. Admin. Code § 213.33(c).

[5] 1 Tex. Admin. Code § 155.427.

She testified that once she entered an order electronically, she could see the order in the patient's chart. She also testified that she recalled talking to Respondent to let him know that orders for Patient would be coming.

2. Testimony of Katina Lewis, RN

In April 2019, Katina Lewis, RN, was the nursing director at Sorrento in San Antonio. She was familiar with Respondent, although she was not his immediate manager. As of the date of the hearing, she was working in the corporate office.

Ms. Lewis testified about the electronic smart board that nurses used at the facility. She testified that the smart board would flag medications and treatment needed to be administered and what doctor's orders they have. Electronic orders appeared on the smart board in real time, first with green notifications. As an incomplete order got close to being late, it would appear on the board as yellow; after one hour, it would turn red. According to Ms. Lewis, a nurse should check the smart board at the beginning and end of the shift, and also throughout the shift.

She testified that as a charge nurse, Respondent was responsible for administering medication. She also testified that every new nurse at the facility, including Respondent, received training on using the smart boards.

As for the incident in question, Ms. Lewis testified that the records showed the order for ertapenem was entered on April 13, 2019, but administration started at 10 a.m. on April 15, 2019. She testified that administration of the medication should have started the same day the order was entered. Similarly, although the order for Eliquis was entered on April 13, 2019, administration did not occur until April 15, 2019, at 9 a.m.[6]

Ms. Lewis testified that she was made aware of the situation. Sorrento's normal procedure was to make sure a nurse has the opportunity to come in and make a statement in response to

[6] The record admitted into evidence indicates that the Eliquis order was discontinued on the 15th and re-entered. Ms. Lewis testified that because the time of administration was changed, the order had to be discontinued to change the time.

allegations. She testified she received no response from Respondent after she made a telephone call to him. Respondent did not show for his shift the following weekend.

Ms. Lewis agreed on cross-examination that if a nurse is unable to complete a task on his or her shift, the nurse on the next shift should do it. She added, however, that this incomplete task should be included on the shift report at the end of the shift.

3. Testimony of Luis Tristan, LVN

In April 2019, Luis Tristan, LVN, was a unit manager at Sorrento and was Respondent's supervisor. He testified that Respondent would work double weekend shifts. Mr. Tristan did not work those shifts, but was available by telephone. He added that Respondent never mentioned any issues with using the smart board.

Mr. Tristan testified that on Monday, April 15, 2019, the day shift nurse informed him that orders were not carried out over the weekend. The day shift nurse looked at Patient's chart on the smart board and noticed there were still orders in the order section that had not been activated. (Activate means to start an order in the system.) Mr. Tristan contacted Ms. Lewis and Ms. Goodell, and made a medication error report.

He testified that an order remains on the smart board until someone activates it. He added that the smart board needs to be cleared by the end of the shift, and that as part of a shift change, the nurse should review the smart board.

After the incident, Mr. Tristan spoke to Respondent. According to Mr. Tristan, Respondent told him that he did not know he could look at the smart board to see orders. This comment surprised Mr. Tristan because Respondent had been trained on the smart boards. Mr. Tristan testified that before this incident, there had been a couple of times when Respondent had not completed his documentation and clinical notes. Mr. Tristan noted that an order will stay on the smart board until it is activated.

4. Testimony of Respondent

Respondent testified that he was unaware that it was possible for a doctor or nurse practitioner to submit an order electronically. Respondent also questioned why he was the only nurse who was reported to the Board. He noted that because another nurse also worked shifts that weekend, he was not the only nurse who was responsible. He therefore believes that Sorrento's reporting of him was personal. He also indicated that the situation with Patient was a result of Sorrento's bad management. He added that he had been a nurse for ten years without any kind of Board discipline.[7]

Respondent also testified that he did not show up for work at Sorrento the following weekend because he was told that he was taken off the schedule.

B. Analysis

1. Conduct Established

The ALJ finds that Staff proved its Formal Charge by a preponderance of the evidence. The evidence was clear that on April 13, 2019, Ms. Goodell entered electronic orders for ertapenem and Eliquis to be administered to Patient. Mr. Sanders was on duty both that day and on April 14, 2019, but did not see the orders. Neither order was initiated until April 15, 2019, when the medications were administered. Although Mr. Sanders testified that he was not aware that orders could come in the way these did, the evidence is clear that he would have seen the orders on his smart board had he checked it.

The ALJ finds that Staff proved conduct supporting disciplinary action under the following Code provisions and Board Rules:

- **Failing to initiate physician orders** (Charge 1): Code § 301.452(b)(10), (13); Board Rules 217.11(1)(A), (B), (C), (M), and 217.12(1)(A), (B), (4).

[7] Mr. Sanders' letter filed on November 16, 2020, provides greater detail about the topics addressed in his testimony.

2. Sanction Analysis

Whether Respondent's most serious conduct is analyzed as unprofessional conduct prohibited by Code § 301.452(b)(10) or as a failure to meet the minimum practice standards set out in Code § 301.452(b)(13), a Second Tier, Sanction Level I classification is appropriate under the Matrix given the serious risk of harm caused by not initiating medication orders for two days. The First Tier of the Matrix for either Code section addresses isolated failures to comply with Board rules concerning unprofessional conduct with no patient risk or adverse effects (Code § 301.452(b)(10)) and practice below the standard of care with a low risk of patient harm (Code § 301.452(b)(13)). Respondent's conduct created a serious risk to patient health.

The Third Tier under Code § 301.452(b)(10) encompasses unprofessional behavior that results in serious harm to a patient or the public, and the Third Tier under Code § 301.452(b)(13) is meant to address substandard practice with a serious risk of harm or death that is known or should be known or a significant demonstration of incompetence. The evidence does not show actual, serious harm, and Respondent's behavior was shown to be risky but not to the point of being potentially fatal. Thus, the Third Tier under either Code section is inappropriate.

The recommended sanction for this offense depends on whether the aggravating and mitigating factors establish that the offense should be considered a Sanction Level I or II. The ALJ finds the following aggravating factors may be considered by the Board: the potential harm to Patient and patient vulnerability. In addition, the ALJ finds the following mitigating factors apply: no evidence of serious harm to patients and the lack of previous Board discipline. Based on the aggravating and mitigating factors presented in this case, a Second Tier, Sanction Level I is the best fit for the conduct shown. Sanction Level II under either Code provision contemplates license denial, suspension, or revocation, and Staff did not contend that level of disciplinary action is appropriate. Sanction Level I proposes a Warning or Reprimand with stipulations. Because this is Respondent's first disciplinary action with the Board, a Warning is appropriate. With respect to the stipulations accompanying the Reprimand, the ALJ agrees with Staff's recommendations: classes in jurisprudence and ethics; a requirement that Respondent provide a copy of the Order and Warning to his employer and cause the employer to send quarterly performance reviews to the Board for one year; and one year of work with indirect supervision.

In support of the recommended sanction of a Warning with Stipulations, the ALJ makes the following findings of fact and conclusions of law.

IV. FINDINGS OF FACT

1. David Jentry Sanders (Respondent) was issued Licensed Vocational Nurse (LVN) License No. 227266 by the Texas Board of Nursing (Board) in 2010.

2. In April 2019, Respondent worked on weekends at Sorrento, a skilled nursing rehabilitation facility in San Antonio, Texas.

3. On Saturday, April 13, 2019, nurse practitioner Barbara Goodell, remotely entered electronic orders for a patient (Patient) at Sorrento. These orders were for ertapenem, an antibiotic administered intravenously, for Patient's urinary tract infection and 5 milligrams of Eliquis, to decrease the chance of Patient (who was mostly bed-bound during her rehabilitation) developing deep vein thrombosis. Ms. Goodell intended that administration of both medications would begin that day.

4. New electronic orders would appear on the smart board that nurses at Sorrento were to check at the beginning and end of their shift, as well as during their shift.

5. Electronic orders appeared on the smart board in real time, first with green notifications. As an incomplete order got close to being late, it would appear on the board as yellow; after one hour, it would turn red.

6. Ms. Goodell's orders for Patient were entered during Respondent's shift at Sorrento on April 13, 2019.

7. Respondent also worked a shift at Sorrento on the following day, April 14, 2019.

8. Respondent did not administer the ordered medication to Patient during either shift.

9. The orders were not initiated until Monday, April 15, 2019, when a different nurse noticed them and administered the medication.

10. The delay in administering the ordered medication placed Patient at a risk of serious harm. Specifically, she was at risk for developing sepsis or deep vein thrombosis.

11. Patient, who was bed-bound, was vulnerable.

12. Patient did not suffer actual harm as a result of the delay in administering medication.

13. Respondent has no prior Board disciplinary history.

14. The Staff of the Board opened its own investigation of Respondent's conduct. On August 21, 2020, Staff sent Respondent an Amended Notice of Hearing and Formal Charges. Together, these documents 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.

15. Administrative Law Judge (ALJ) Rebecca S. Smith convened the hearing via Zoom videoconference on September 23, 2020. Deputy General Counsel Jena Abel represented Staff, and Respondent represented himself. The hearing concluded and the record closed that day.

V. CONCLUSIONS OF LAW

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

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

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

4. Staff had the burden of proof by a preponderance of the evidence, and Respondent had the burden of establishing any mitigating factors. 1 Tex. Admin. Code § 155.427.

5. Respondent is subject to sanction because he committed unprofessional conduct and practiced below minimum standards of nursing care by conduct described in the Findings of Fact, including failing to initiate medication orders.

6. This conduct is subject to sanction pursuant to Texas Occupations Code § 301.452(b)(10) and (13), and 22 Texas Administrative Code §§ 217.11(1)(A), (B), (C), (M), (O), and 217.12(1)(A), (B), and (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).

9. The Board may consider as aggravating factors the potential for harm to the patient and patient vulnerability. 22 Tex. Admin. Code § 213.33(b)-(c).

10. The Board may consider as mitigating factors the lack of evidence of serious harm to patients and the lack of previous Board discipline. 22 Tex. Admin. Code § 213.33(b)-(c).

VI. RECOMMENDATION

Based on the above findings of fact and conclusions of law, the ALJ recommends that the Board issue an Order with a Warning and stipulations including: classes in jurisprudence and ethics; a requirement that Respondent provide a copy of the Order and Warning to his employer and cause the employer to send quarterly performance reviews to the Board for one year; and one year of work with indirect supervision.

SIGNED November 19, 2020.

Rebecca S. Smith

REBECCA S. SMITH
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS