BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED ORDER
Registered Nurse License Number 795034	§	
issued to DAVID JOSEPH BONNETT	§	
	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of DAVID JOSEPH BONNETT, Registered Nurse License Number 795034, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(10)&(13)*[effective through August 31, 2021]*, Texas Occupations Code.

Respondent waived notice and hearing and agreed to the entry of this Agreed Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on December 15, 2022.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived notice and hearing, and agreed to the entry of this Agreed Order.

3. Respondent's license to practice as a professional nurse in the State of Texas is in current status.

4. Respondent received a Diploma in Nursing from Covenant School of Nursing, Lubbock, Texas, on December 17, 2010. Respondent was licensed to practice professional nursing in the State of Texas on January 11, 2011.

5. Respondent's nursing employment history includes:

01/2011-01/2015	RN	Texas Tech Health Sciences Center, Lubbock, Texas

Respondent's nursing employment history continued:

02/2015-11/2015	Unknown	
12/2015-09/2017	RN	Southern Specialty Lubbock, Texas
09/2017-11/2018	RN	Garrison Geriatric Education and Care Center, Lubbock, Texas
12/2018-04/2019	RN	Windmill Village Lubbock, Texas
05/2019-03/2020	RN	Whisperwood Nursing and Rehabilitation, Lubbock, Texas
03/2020-10/2020	RN	Garrison Geriatric Education and Care Center, Lubbock, Texas
10/2020-05/2021	RN	Freedom Hospital Plainview, Texas
05/2021-08/2021	RN	Windmill Village Lubbock, Texas
08/2021	RN	Crown Point Health Suites Lubbock, Texas
09/2021-present	RN	Lubbock Hospitality Lubbock, Texas

6. On or about October 23, 2015, Respondent was issued the sanction of Reprimand with Stipulations through an Order of the Board. On or about August 22, 2018, Respondent successfully completed the terms of the Order. A copy of the October 23, 2015, Order is attached and incorporated herein by reference as part of this Agreed Order.

7. On or about August 19, 2021, while employed as a Registered Nurse with Crown Point Health Suites, Lubbock, Texas, Respondent falsely documented by pre-charting neurological assessments in the medical record of Patient LN. Respondent's conduct created an inaccurate medical record and failure to administer medications as ordered by the physician could have resulted in non-efficacious treatment.

8. In response to Finding of Fact Number Six (6) Respondent states he doesn't not know what this incident is about. He never got a peer review, and he never saw the evidence.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation(s) of 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(B),(1)(C)&(1)(D) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(1)(C),(4),(6)(A)&(6)(H).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13)*[effective through August 31, 2021]*, Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 795034, heretofore issued to DAVID JOSEPH BONNETT.

5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED that RESPONDENT SHALL receive the sanction of **REPRIMAND WITH STIPULATIONS AND FINE** in accordance with the terms 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. Until successfully completed, RESPONDENT may not practice nursing in the State of Texas except in accordance with the terms of this Order.

D. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

II. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT agrees to 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 Agreed Order.

III. 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.

IV. 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. **A Board-approved course in nursing documentation** that shall be a minimum of six (6) hours in length. The course's content shall include: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. Home study courses and video programs will not be approved.

C. **The course "Righting a Wrong,"** a 3.0 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) International Center for Regulatory Scholarship (ICRS).

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.*

V. MONETARY FINE

RESPONDENT SHALL **pay a monetary fine in the amount of two hundred fifty dollars ($250.00) within forty-five (45) days of the effective date of this Order.** Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

VI. 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. **Indirect Supervision:** 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 eight (8) quarters [two (2) years] of employment as a nurse.

VII. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Agreed Order, all encumbrances will be removed from RESPONDENT'S license(s) and/or privilege(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.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Texas Board of Nursing and a copy of this Order will be mailed to me once the Order becomes effective. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including possible revocation of my license(s) and/or privileges to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 3 day of May, 2024.

David Bonnett

DAVID JOSEPH BONNETT, RESPONDENT

Sworn to and subscribed before me this 3 day of May, 2024.

SEAL

Rasha Farah

Notary Public in and for the State of TEXAS

RASHA FARAH
Notary Public, State of Texas
Comm. Expires 10-24-2026
Notary ID 13403072-4

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 3rd day of May, 2024, by DAVID JOSEPH BONNETT, Registered Nurse License Number 795034, and said Agreed Order is final.

Effective this 11th day of June, 2024.

Kristin K. Benton, DNP, RN

Kristin K. Benton, DNP, RN
Executive Director on behalf
of said Board

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 507-15-1073

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	§	
NUMBER 795034	§	**OF**
ISSUED TO	§	
DAVID JOSEPH BONNETT	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: DAVID JOSEPH BONNETT
c/o MARC M. MEYER, ATTORNEY
33300 EGYPT LANE, SUITE C600
MAGNOLIA, TX 77354

ROY G. SCUDDAY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 22-23, 2015, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Respondent's exceptions to the PFD; (3) Staff's response to Respondent's exceptions to the PFD; (4) the ALJ's final letter ruling of June 16, 2015; (5) Staff's recommendation that the Board adopt the PFD without changes; and (6) 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 May 29, 2015. Staff filed a response to Respondent's exceptions to the PFD on June 11, 2015. On June 16, 2015, the ALJ issued his final letter ruling, in which he declined to make any changes to the PFD.

The Board, after review and due consideration of the PFD; the parties' exceptions and response; the ALJ's final letter ruling of June 16, 2015; Staff's recommendations; and the presentation by the Respondent during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD as if fully set out and separately stated herein. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

Although the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact or

conclusions of law[1], the Board agrees with the ALJ that a Reprimand with Stipulations is the most appropriate sanction in this matter.

The Board finds that the Respondent's conduct collectively warrants a second tier, sanction level I sanction, for his violations of §301.452(b)(10) and (13)[2]. For a second tier, sanction level I sanction, the Board's Disciplinary Matrix authorizes either a Warning with Stipulations or a Reprimand with Stipulations. The Board recognizes that there are some mitigating factors that should be considered. The Respondent was only licensed for a short amount of time[3] at the time of the incident and system issues were noted by the ALJ[4]. Despite these factors, however, the Board agrees with the ALJ that the nature of the Respondent's conduct[5] supports the sanction of a Reprimand with Stipulations.

Therefore, after carefully reviewing and considering the aggravating and mitigating factors in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix[6] and the Board's rules, including 22 Tex. Admin. Code §213.27 and §213.33(e), that the Respondent's license should be subject to a Reprimand with Stipulations, for two years. The Board finds that remedial education courses in critical thinking and physical assessment are necessary and appropriate to address the Respondent's failure to conduct a complete assessment of the patient and to encourage good professional judgment and critical thinking. The Board also finds that a nursing jurisprudence and ethics course is appropriate and consistent with the Board's rules[7]. Further, the Board finds that supervisory stipulations are necessary to ensure an appropriate level of accountability for the duration of the Order and to ensure that future violations of the Nursing Practice Act and Board rules do not occur. The Board finds no evidence in the record to justify a departure from the normal supervisory requirements associated with a Reprimand with Stipulations. Therefore, the Board finds that the Respondent's practice should be directly supervised for the first year of the Order and indirectly supervised for the remaining period of the Order. The Board further finds that employer notifications and quarterly employer

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[1] The Board, not the ALJ, is the final decision maker concerning sanctions. Once it has been determined that a violation of the law has occurred, the sanction is a matter for the agency's discretion. Further, the mere labeling of a recommended sanction as a conclusion of law or as a finding of fact does not change the effect of the ALJ's recommendation. As such, the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact and conclusions of law. The choice of penalty is vested in the agency, not in the courts. An agency has broad discretion in determining which sanction best serves the statutory policies committed to the agency's oversight. The propriety of a particular disciplinary measure is a matter of internal administration with which the courts should not interfere. *See Texas State Board of Dental Examiners vs. Brown*, 281 S.W. 3d 692 (Tex. App. - Corpus Christi 2009, pet. filed); *Sears vs. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751 (Tex.App. - Austin 1988, no pet); *Firemen's & Policemen's Civil Serv. Comm'n vs. Brinkmeyer*, 662 S.W.2d 953, 956 (Tex. 1984); *Granek vs. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 781 (Tex.App. - Austin 2005, pet. denied); *Fay-Ray Corp. vs. Tex. Alcoholic Beverage Comm'n*, 959 S.W.2d 362, 369 (Tex.App. - Austin 1998, no pet.).

[2] See adopted Conclusions of Law 4 and 6.

[3] See page 10 of the PFD.

[4] See adopted Findings of Fact and the ALJ's June 16, 2015 letter ruling.

[5] See pages 9-10 of the PFD, adopted Findings of Fact, and the ALJ's June 16, 2015 letter ruling.

[6] 22 Tex. Admin. Code §213.33(b).

[7] See 22 Tex. Admin. Code §213.33(f).

reports are necessary to implement the supervisory requirements of the Order. These provisions are authorized under 22 Tex. Admin. Code §213.33(e)(4)[8].

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

I. TERMS OF 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. Respondent may not work outside the State of Texas in another nurse licensure compact party state without first obtaining the written permission of the Texas Board of Nursing and the Board of Nursing in the nurse licensure compact party state where Respondent wishes to work.

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

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 courses and video programs will not be approved.

B. **The course "Sharpening Critical Thinking Skills,"** a 3.6 contact

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[8] 22 Tex. Admin. Code §213.33(e)(4) provides that a Reprimand with Stipulations may include reasonable stipulations, such as the completion of remedial education courses, at least two years of supervised practice, and periodic Board review.

hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension.

C. **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.

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, providing direct patient care in a licensed 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. Any quarterly period without continuous employment with the same employer for all three (3) months will not count towards completion of this requirement. 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 the stipulation period, 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 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 nurse who supervises the RESPONDENT and these reports shall be submitted by the supervising nurse 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 RESPONDENT may be eligible for nurse licensure compact privileges, if any.

Entered this 23rd day of October, 2015.

TEXAS BOARD OF NURSING

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

Attachment: Proposal for Decision; Docket No. 507-15-1073 (May 11, 2015).

SOAH DOCKET NO. 507-15-1073

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
DAVID JOSEPH BONNETT, Respondent	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff of the Texas Board of Nursing (Staff/Board) brought action against David Joseph Bonnett (Respondent) seeking the issuance of a written reprimand. This proposal for decision finds that Respondent should be issued a Reprimand with stipulations to be determined by the Board.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The hearing originally convened January 20, 2015, before Administrative Law Judge (ALJ) Roy G. Scudday in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by R. Kyle Hensley, Assistant General Counsel. Respondent was represented by attorney Marc M. Meyer. The hearing was recessed and reconvened on April 1, 2015. The record closed at the conclusion of the hearing.

Matters concerning notice and jurisdiction were undisputed. Those matters are set out in the Findings of Fact and Conclusions of Law.

II. DISCUSSION

A. Background

Respondent has been licensed in Texas as a Registered Nurse (RN) since January 11, 2011. On September 15, 2014, Staff sent Respondent a Notice of Formal Charges filed against him. On November 13, 2014, Staff sent Respondent a Notice of Hearing.

B. Staff's Charge

Staff made the following charge against Respondent:

> On or about December 4, 2012, while employed as a Staff Nurse with Texas Tech University Health Sciences Center, assigned to the Montford Regional Medical Facility in Lubbock, Texas, Respondent failed to intervene and notify the physician that Patient No. 636617 was experiencing a change in condition. The patient had abnormal vital signs along with black stool and dark urine, and subsequently expired from acute gastrointestinal hemorrhage. Respondent's conduct resulted in a delay in emergency treatment for the patient, and may have contributed to the patient's subsequent demise. This action constitutes grounds for disciplinary action in accordance with Tex. Occ. Code (Code) § 301.452(b)(10) & (13), and is a violation of 22 Tex. Admin. Code (TAC) §§ 217.11(1)(A), (1)(B), (1)(D), (1)(M), & (1)(P) & (3)(A), and 217.12(1)(A), (1)(B), & (4).

C. Applicable Law

Texas Occupations Code (Code) § 301.452(b)(10) provides that a licensee is subject to disciplinary action for "unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public." Code § 301.452(b)(13) provides that a person is subject to disciplinary action for "failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the board's opinion, exposes a patient or other person unnecessarily to risk of harm."

The Board rule at 22 TAC § 217.11 provides as follows:

> (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:
>
> (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;
>
> (B) Implement measures to promote a safe environment for clients and others;
>
> . . .
>
> (D) Accurately and completely report and document:
>
> (i) the client's status including signs and symptoms;

(ii) nursing care rendered;
(iii) physician, dentist or podiatrist orders;
(iv) administration of medications and treatments;
(v) client response(s); and
(vi) contacts with other health care team members concerning significant events regarding client's status;

. . .

(M) Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications;

. . .

(P) 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;

. . .

(3) Standards Specific to Registered Nurses. The registered nurse shall assist in the determination of healthcare needs of clients and shall:

(A) Utilize a systematic approach to provide individualized, goal-directed, nursing care by:

(i) performing comprehensive nursing assessments regarding the health status of the client;
(ii) making nursing diagnoses that serve as the basis for the strategy of care;
(iii) developing a plan of care based on the assessment and nursing diagnosis;
(iv) implementing nursing care; and
(v) evaluating the client's responses to nursing interventions.

. . .

The Board rule at 22 TAC § 217.12 provides that unprofessional or dishonorable behaviors include the following:

(1) Unsafe Practice--actions or conduct including, but not limited to:

(A) 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 set out in Rule 217.11;
(B) Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;

. . .

(4) Careless or repetitive conduct that may endanger a client's life, health, or safety. Actual injury to a client need not be established.

. . . .

D. Evidence

1. Undisputed Facts

Montford Regional Medical Facility (Facility) is a medical facility in the Montford Unit of the Texas Department of Corrections in Lubbock, Texas. On November 28, 2012, Patient No. 636617, a 60-year-old male prisoner, was transferred from Covenant Women's and Children's Hospital where he had undergone treatment for an apparent blood clot in his leg to the Facility.[1] The stated reason for the transfer was that the patient needed a "higher level of care."[2] The patient was placed in the Facility's medical-surgical ward, in which a charge nurse (an RN) and four other nurses (one RN and three licensed vocational nurses (LVN)) were in attendance.

The patient was admitted to the ward at 20:44 on November 28, and placed in a four-patient secured room with a locked door in which there was a small observation window. He was examined by Marion O. Williams, M.D., who prescribed aspirin, enalapril maleate, a fiber laxative, ibuprofen, methocarbonal, ranitidine, triamcinolone cream, codeine (Tylenol #3), and lovenox (a blood thinner).[3]

At 04:11 on November 29, Respondent conducted an assessment of the patient. The patient's blood pressure was 110/75, his pulse was 79, his respiration was 20/min., and his temperature was 98.8. Respondent noted that the patient complained of pain in his left leg and the left side of his neck.[4]

At 09:39 on November 29, Debra McLeod, RN, conducted an assessment of the patient. The patient's blood pressure was 102/76, his pulse was 121, his respiration was 18/min., and his temperature was 97. Nurse McLeod noted that there were no signs of stress.[5] At around 11:00

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[1] Resp. Ex. 3B at 12-16.

[2] Resp. Ex. 3B at 11.

[3] Resp. Ex. 3B at 53-59.

[4] Resp. Ex. 3B at 60-62.

[5] Resp. Ex. 3B at 67-73.

on November 29, Scott Bergfeld, M.D., examined the patient, noted that the patient had complaints about pain in his urinary tract, and ordered a chest x-ray to determine if the patient were developing pneumonia.[6] The results of the x-ray indicated that the patient's chest showed evidence of bilobar pneumonia.[7] At that time the patient was also prescribed metropolol (for an irregular heartbeat) and warfarin (a blood thinner).[8]

At 08:30 on December 3, Cayla Smith, LVN, conducted an assessment of the patient. The patient's blood pressure was 132/72, his pulse was 91, his respiration was 18/min., and his temperature was 99.4. Nurse Smith noted that he had diminished lung sounds in the lower lobes and pink urine.[9] At some point later, Nurse Smith noted that the patient's temperature had risen to 100 and notified the charge nurse.[10]

At 21:00 on December 3, Brandy Martinez, LVN, conducted an assessment of the patient. The patient's blood pressure was 108/65, his pulse was 104, his respiration was 18/min., and his temperature was 98.5. Nurse Martinez noted that the patient's urine was bloody.[11]

At 08:00 on December 4, Nurse Smith conducted an assessment of the patient. The patient's blood pressure was 107/62, his pulse was 109, his respiration was 18/min., and his temperature was 97.7. Nurse Smith noted that he had diminished lung sounds in the lower fields and pink urine. She further noted that, based on the lab results of a blood draw on December 3, the patient had an INR (time for blood to coagulate) of 8.0 (classified as critical) and had a prothrombin time (PT) of 83.1 (classified as high). Brandi George, RN, the charge nurse for the day shift, had been notified of the INR at 07:08.[12] Nurse Smith determined that the

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[6] Resp. Ex. 3B at 75.

[7] Resp. Ex. 3B at 100.

[8] Resp. Ex. 3B at 78.

[9] Resp. Ex. 3B at 173, 177.

[10] Resp. Ex. 3B at 172.

[11] Resp. Ex. 3B at 193-194.

[12] Resp. Ex. 3B at 167.

administration of the blood thinners (lovenox and warfarin) would be held until the physician was notified.[13] Dr. Bergfeld subsequently discontinued the blood thinners.[14]

At 11:52 on December 4, Dr. Bergfeld examined the patient and noted that, in addition to pneumonia, irregular heartbeat, and a blood clot in his leg, the patient was suffering from paraproteinemia (the presence of excessive amounts of paraprotein or single monoclonal gammaglobulin in the blood), and hyperbilirubin (a high level of bilirubin, a natural by-product of the breakdown of red blood cells, in the blood). Dr. Bergfeld ordered an abdominal computed tomography (CT) scan (an imaging method that uses x-rays to create pictures of cross-sections of the body) to determine if the patient had an obstruction or a tumor. He indicated that the CT scan should be expedited, i.e. performed within one month.[15] At 15:10, Dr. Bergfeld ordered that albuterol inhalations be started for the patient to treat his pneumonia.

At 20:38 on December 4, Respondent conducted an assessment of the patient. The patient's blood pressure was 97/57, his pulse was 117. Respondent did not indicate the patient's respiration and temperature. Respondent noted that the patient was jaundiced, had passed a black-colored stool positive for occult blood, was tachycardic (rapid heartbeat), looked unwell, had diminished capacity in both lungs with some crackles, and had almost black urine.[16] At 22:40 on December 4, Respondent conducted a follow-up check of the patient. The patient's blood pressure was 90/57 and his pulse was 114. Again, Respondent did not indicate the patient's respiration and temperature.

At 03:39 on December 5, Respondent found the patient to still be tachycardic, had very little movement, and noted no noticeable change in status.[17] Respondent did not indicate any vital signs for the patient or the color of the patient's urine.

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[13] Resp. Ex. 3B at 205

[14] Resp. Ex. 3B at 208.

[15] Resp. Ex. 3B at 211-213

[16] Resp. Ex. 3B at 222-223

[17] Resp. Ex. 3B at 226.

At 07:45 on December 5, during the routine morning assessment, Nurse Smith found the patient to be unresponsive to verbal communication, his skin was cold and rigid, his eyes were fixed and dilated, and he had no heartbeat. Death was pronounced at 07:50.[18] At 12:08 on December 5, Dr. Bergfeld determined that the terminal event was cardiorespiratory arrest due to pneumonia, possibly pulmonary emboli.[19] On December 6, the autopsy results showed that the cause of death was acute gastrointestinal hemorrhage with evidence of gastric varix (dilated veins in the stomach), acute pyelonephritis (kidney failure), and severe occlusive coronary atherosclerosis (thickening of artery walls as a result of invasion and accumulation of white blood cells).[20]

2. Respondent's Testimony

Respondent testified that he has been an RN since January 2011, during which time he was an employee of Texas Tech University Health Sciences Center, and that he had been assigned to the Facility's medical-surgical ward since the beginning of his employment. In addition to the Facility's medical-surgical ward, there was also a long-term care ward and an emergency infirmary. At the time of the incident, Respondent had worked in the medical-surgical ward for almost two years, and was working the night shift from 18:00 on December 4, 2012, to 06:00 on December 5, 2012.

Respondent testified that when the patient was first admitted to the ward on November 28, 2012, he was suffering from a blood clot in his leg. After admittance, the patient developed pneumonia, liver failure, and irregular heart rate, as well as other health problems. Respondent first treated the patient on the date of admission, and did not treat the patient again until the evening of December 4, 2012.

Respondent testified that, based on the lab results reviewed by Dr. Bergfeld and Nurse Smith on the morning of December 4, the patient had a high white blood cell count

[18] Resp. Ex. 3B at 227.

[19] Resp. Ex. 3B at 235.

[20] Resp. Ex. 3B at.

attributable to the pneumonia: low hemoglobin and hematocrit indicating possible internal bleeding; low platelet count indicating an inability to stop internal bleeding; blood in the urine; and a high PT and critical INR indicating that the blood was not clotting. He stated that when he began the night shift he was not informed by Nurse Smith of any critical change in the patient's condition or of any physician orders regarding monitoring of the patient.

Respondent testified that when he saw the patient at 20:38, he noted that the patient looked more yellow. He stated that at the time he came onto the shift he was advised that the patient had passed a small black stool during the day shift, but he did not consider it significant because Dr. Bergfeld had been told about the patient's internal bleeding (blood in the urine) that morning. The Facility's normal procedure was to wait until the next morning to report a small black stool as opposed to a dark pool of diarrhea that was to be reported immediately. Respondent testified that he did not note the respiration or temperature on his assessment report, but that it was noted by the medical aides who inputted the patient's vital signs in the patient's records (19/min. respiration, 97.5 temperature).[21] He stated that neither the blood pressure nor the pulse were outside the normal protocols of the Facility that would have required notification of the medical provider, in this case Dr. Bergfeld.

Respondent testified that, during the 03:39 assessment, he concentrated on the patient's breathing, and noted no change in the heart rate or physical status. He stated that, other than viewing the patient through the observation window because only an officer could open the cell door and there was not an officer available, he did not check on the patient again. Respondent stated that he did not think the patient had a severe hemorrhage at either the evening assessment or the next morning's assessment because the patient was not vomiting blood or otherwise exhibiting any evidence of gross bleeding.

Respondent noted that two inmates gave statements in which they indicated that the patient was snoring and breathing both before and after they had gone to the showers the morning of his death (approximately 06:00).[22] Respondent stated that the time between the

[21] Staff Ex. 5 at 88.

[22] Resp. Ex. 1 at 10-11.

observations of the inmates and the time that the patient was found to be cold and rigid was an unusually short time for rigor mortis to have set in. He noted that the ward did not have cardiac monitors to track the heart rate of the patients in the ward, but that the guards were supposed to visually check the patient every fifteen minutes even if he did not.

3. Melinda Hester's Testimony

Staff offered the testimony of Melinda Hester, Ph.D., a Nursing Consultant for the Board. Dr. Hester has been an RN for 36 years with experience in diverse areas and has a doctorate in Nursing Practice. As the Lead Practice Nursing Consultant for the Board, Dr. Hester assists the Enforcement and Legal Divisions with case reviews and testifies as an expert witness in hearings at the State Office of Administrative Hearings.

Dr. Hester testified that, despite the Facility's protocols, Respondent should have called in the physician after the evening assessment when he noted dark urine and was informed about the dark stool passed earlier by the patient. She stated that Respondent should not have assumed that Dr. Bergfeld was aware that the patient had signs of internal bleeding, particularly because the urine had gone from being pink to black in less than twelve hours. In her opinion, after his initial assessment, Respondent should have increased the level and frequency of his assessments to every 1-2 hours and should have notified Dr. Bergfeld of the patient's condition. As for the second assessment in the early morning, she testified that Respondent's treatment of the patient was below the minimum standards because he should have conducted a full assessment that included checking the patient's urine, blood pressure, respiration, temperature, and oxygen saturation levels.

Dr. Hester testified that if Respondent found that he was unable to provide the amount of monitoring that the patient required due to the limitations of the Facility, he should have notified the charge nurse that the patient should be transferred to a different facility where he could receive greater care.

Dr. Hester concluded that Respondent's actions violated Code § 301.452(b)(10) and (13). The Board's Disciplinary Matrix, located at 22 TAC § 213.33(b), provides that, for a violation of Code § 301.452(b)(10), the disciplinary sanction is based on the appropriate tier of the offense, the appropriate sanction level, and applicable aggravating and mitigating factors. Dr. Hester testified that this violation would be a Second Tier offense at Sanction Level I because the patient died. She stated that the fact that Respondent had only been licensed for two years should be taken into consideration as a mitigating factor. The Disciplinary Matrix for a violation of Code § 301.452(b)(13) is also based on the appropriate tier of the offense, the appropriate sanction level, and applicable aggravating and mitigating factors. Dr. Hester testified that this violation would also be a Second Tier offense at Sanction Level I because Respondent did not meet the minimum standards.

Dr. Hester stated that the appropriate sanction for the violations alleged against Respondent would be a Reprimand with stipulations that require Respondent to practice with direct supervision for one year and with indirect supervision for one year.

E. Analysis

Staff argues that, despite what other nurses and the physician had observed the morning of December 4, Respondent was required to notify the physician when the patient's urine was darker and had passed a black stool because this was an indication that the patient was suffering internal bleeding. Respondent argues that this condition was already known to the physician prior to Respondent's going on duty, and that there were no specific instructions to notify the physician of any further symptoms of bleeding.

In regard to both allegations that concern Code § 301.452, Respondent is alleged to have specifically violated the Board rule at 22 TAC §§ 217.11 and 217.12. It is apparent from the evidence in the record that Respondent did not do the following:

- perform a comprehensive nursing assessment and accurately and completely report and document the patient's status and symptoms at the 03:39 assessment because Respondent failed to document the patient's vital signs and did not make

an observation of urine in violation of the requirements of §§ 217.11 (1)(D) and 217.11 (3)(A)(i);

- collaborate with members of the health care team because Respondent did not notify the charge nurse or the physician of the need for additional monitoring at the 20:38 assessment in violation of the requirements of § 217.11 (1)(M);
- implement nursing care because Respondent failed to increase the frequency and level of assessments after the 22:40 follow-up check of the patient in violation of the requirements of § 217.11 (3)(A)(iv);
- evaluate the patient's responses to nursing interventions because Respondent failed to evaluate whether the level of bleeding had decreased as a result of stopping the administration of blood thinners at both the 20:38 and 03:39 assessments in violation of the requirements of § 217.11 (3)(A)(v)

Accordingly, Respondent did violate 22 TAC § 217.11(1)(D), (1)(M), (3)(A)(i),(iv), and (v), which violations also constitute unprofessional behavior in violation of 22 TAC § 217.12(1)(A) and (B) and (4), resulting in violations of Code § 301.452(b)(10) and (15).

Staff argues that the appropriate sanction in this case is a Reprimand while Respondent asserts that there is no basis for more than a warning. The ALJ agrees with Staff's recommendation that a Reprimand with stipulations is the appropriate sanction. It is for the Board to determine the nature of those stipulations.

III. FINDINGS OF FACT

1. David J. Bonnett (Respondent) has been licensed as a registered nurse (RN) by the Texas Board of Nursing (Board) since 2011.

2. On September 15, 2014, the staff of the Board (Staff) sent Respondent a Notice of Formal Charges filed against him.

3. On November 13, 2015, Staff mailed a Notice of Hearing to Respondent.

4. The notice of hearing 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 a short, plain statement of the matters asserted.

5. The hearing originally convened January 20, 2015, before Administrative Law Judge (ALJ) Roy G. Scudday in the William P. Clements Building, 300 West 15th Street,

Fourth Floor, Austin, Texas. Staff was represented by R. Kyle Hensley, Assistant General Counsel. Respondent was represented by attorney Marc M. Meyer. The hearing was recessed and reconvened on April 1, 2015. The record closed at the conclusion of the hearing.

6. Montford Regional Medical Facility (Facility) is a medical facility in the Montford Unit of the Texas Department of Corrections in Lubbock, Texas. In addition to a medical-surgical ward, the Facility also had a long-term care ward and an emergency infirmary.

7. At 20:44 on November 28, 2012, Patient No. 636617, a 60-year old male prisoner, was transferred from Covenant Women's and Children's Hospital where he had undergone treatment for an apparent blood clot in his leg to the Facility. The stated reason for the transfer was that the patient needed a "higher level of care."

8. The patient was placed in the Facility's medical-surgical ward, in which a charge nurse (an RN) and four other nurses (one RN and three licensed vocational nurses (LVN)) were in attendance. The Facility placed the patient in a four-patient secured room with a locked door in which there was a small observation window.

9. At 07:08 on December 4, the charge nurse for the day shift had been notified that, based on the lab results of a blood draw on December 3, the patient had an INR (time for blood to coagulate) of 8.0 (classified as critical) and a prothrombin time (PT) of 83.1 (classified as high).

10. At 08:00 on December 4, a LVN conducted an assessment of the patient. The nurse noted that the patient had diminished lung sounds in the lower fields and pink urine, noted the INR and PT, and determined that the administration of the blood thinners (lovenox and warfarin) would be held until the physician was notified. Simon Bergfeld, M.D. subsequently discontinued the blood thinners.

11. At 11:52 on December 4, Dr. Bergfeld, examined the patient and noted that, in addition to pneumonia, irregular heartbeat, and a blood clot in his leg, the patient was suffering from paraproteinemia (the presence of excessive amounts of paraprotein or single monoclonal gammaglobulin in the blood), and hyperbilirubin (a high level of bilirubin, a natural by-product of the breakdown of red blood cells, in the blood). Dr. Bergfeld ordered an abdominal computed tomography (CT) scan (an imaging method that uses x-rays to create pictures of cross-sections of the body) to determine if the patient had an obstruction or a tumor. He indicated that the CT scan should be expedited, i.e. performed within one month.

12. At 15:10 on December 4, Dr. Bergfeld ordered that albuterol inhalations be started for the patient to treat the pneumonia.

13. Respondent worked the night shift from 18:00 on December 4, 2012 to 06:00 on December 5, 2012. At 20:38 on December 4, Respondent conducted an assessment of the patient. Respondent did not indicate the patient's respiration and temperature, but the medical aides had inputted the patient's vital signs in the medical records. Neither the

blood pressure nor the pulse were outside the normal Facility protocols that would have required notification of Dr. Bergfeld.

14. At the 20:38 assessment Respondent noted the following: the patient was jaundiced, had passed a black-colored stool positive for occult blood, was tachycardic (rapid heartbeat), looked unwell, had diminished capacity in both lungs with some crackles, had almost black urine.

15. After the 20:38 assessment Respondent did not notify the charge nurse or the physician of the need for additional monitoring of the patient.

16. At 22:40 on December 4, Respondent conducted a follow-up check of the patient. Respondent did not indicate the patient's respiration and temperature. Respondent did not increase the frequency and level of his assessments of the patient.

17. At 03:39 on December 5, Respondent found the patient to still be tachycardic, had very little movement, and noted no noticeable change in status. Respondent did not indicate any vital signs for the patient or the color of the patient's urine.

18. At the 03:39 assessment Respondent did not perform a comprehensive nursing assessment and did not accurately and completely report and document the patient's status and symptoms.

19. At neither the 20:38 nor the 03:39 assessments did Respondent evaluate whether the level of patient's bleeding had decreased as a result of stopping the administration of blood thinners.

20. Other than viewing the patient through the observation window because there was not an officer available to open the cell door, after the 03:39 assessment Respondent did not check on the patient again.

21. At 07:45 on December 5, during the routine morning assessment, the patient was found to be unresponsive to verbal communication, his skin was cold and rigid, his eyes were fixed and dilated, and he had no heartbeat. Death was pronounced at 07:50.

22. At 12:08 on December 5, Dr. Bergfeld determined that the terminal event was cardiorespiratory arrest due to pneumonia, possibly pulmonary emboli.

23. On December 6, the autopsy results showed that the cause of death was acute gastrointestinal hemorrhage with evidence of gastric varix (dilated veins in the stomach), acute pyelonephritis (kidney failure), and severe occlusive coronary atherosclerosis (thickening of artery walls as a result of invasion and accumulation of white blood cells.)

IV. CONCLUSIONS OF LAW

1 The Texas Board of Nursing (Board) has jurisdiction over this matter pursuant to Tex. Occ. Code (Code) ch. 301.

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

3. Notice of the hearing on the merits was provided as required by Code § 301.454 and by the Administrative Procedure Act, Tex. Gov't Code §§ 2001.051 and 2001.052.

4. Respondent is subject to disciplinary action by the Board pursuant to Code § 301.452(b)(10) and (13).

5. Staff had the burden of proof by a preponderance of the evidence. 1 Tex. Adm. Code (TAC) § 155.427.

6 Based on the findings set forth in Findings of Fact Nos. 15-20, Respondent violated 22 TAC § 217.11(1)(D), (1)(M), (3)(A)(i),(iv), and (v), as well as 22 TAC § 217.12(1)(A) and (B) and (4), and thereby violated Code § 301.452(b)(10) and (13).

V. RECOMMENDATION

Based upon the above findings of fact and conclusions of law, the ALJ recommends that Respondent be issued a Reprimand with stipulations to be determined by the Board.

SIGNED May 11, 2015.

Roy G. Scudday

ROY G. SCUDDAY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS