

6. On June 10, 2003, Respondent's license to practice vocational nursing was suspended by the Board of Vocational Nurse Examiners for the State of Texas. A copy of the June 10, 2003, Agreed Board Order is attached and incorporated, by reference, as part of this Order.
7. On February 16, 2011, Respondent completed a Nursing Refresher course with Professional Healthcare Education Service, Inc., Houston, Texas.
8. On March 31, 2011, Respondent submitted a letter from Vicki Sferruzzo, Investigation/Monitoring Coordinator, North Carolina Board of Nursing, Raleigh, North Carolina. Ms. Sferruzzo states that Respondent's refresher course completion documentation has been received and approved in the office of the North Carolina Board of Nursing and that Petitioner's license may be reinstated with probation conditions. However, since Respondent is claiming Texas as his home state of residence, his North Carolina License cannot be reinstated per the Interstate Compact which states you must obtain licensure in the state in which you reside.

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 of Section 302.402(a)(10), Texas Occupations Code, and 22 TEX. ADMIN. CODE §239.11 (27), (A), effective through September 28, 2004.
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against vocational nurse license number 127624, heretofore issued to MICHAEL WAYNE HOOD, including revocation of Respondent's license to practice vocational nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that Vocational Nurse License Number 127624, previously issued to MICHAEL WAYNE HOOD, to practice vocational nursing in Texas is hereby suspended for a period of two (2) years with the suspension stayed and Respondent is hereby placed on probation for two (2) years with the following agreed terms of probation:

IT IS FURTHER AGREED and ORDERED that, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate privilege, if any, to practice vocational nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license is encumbered by this order the Respondent may not work outside the State of Texas pursuant to a multistate licensure privilege without the written permission of the State of Texas and the Board of Nursing in the party state where Respondent wishes to work.

(1) RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas as amended, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Vocational Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

(2) RESPONDENT SHALL, within one (1) year from the date of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It 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. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:* <http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html>.

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A LICENSED VOCATIONAL NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL PRACTICE SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH DURING THE TWO (2) YEAR PERIOD OF PROBATION. THE LENGTH OF PROBATION WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE A VOCATIONAL NURSE LICENSE WILL NOT APPLY TO THIS PROBATION PERIOD.

(3) RESPONDENT SHALL notify all future employers in vocational nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order.

(4) RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a vocational nurse.

(5) For the first year of employment as a vocational nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse or a Licensed Vocational Nurse. Direct supervision requires another professional or vocational nurse 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). The 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.

(6) For the remainder of the probation period, RESPONDENT SHALL be supervised by a Registered Nurse or 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.

(7) 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 vocational nursing. These reports shall be completed by the Registered Nurse or Licensed Vocational Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) months for three (3) years of employment as a vocational nurse.

IT IS FURTHER AGREED, that 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 shall 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 Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, 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 Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. 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 revocation of my license(s) to practice vocational nursing in the State of Texas, as a consequence of my noncompliance.

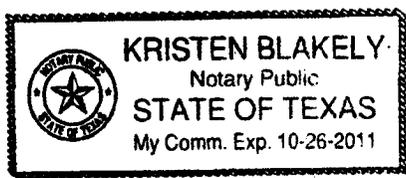
Signed this 17th day of May, 2011.

[Signature]
MICHAEL WAYNE HOOD, Respondent

Sworn to and subscribed before me this 17th day of MAY, 2011.

SEAL

[Signature]
Notary Public in and for the State of Texas



WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 17th day of May, 2011, by MICHAEL WAYNE HOOD, Vocational Nurse License Number 127624, and said Order is final.

Effective this 14th day of June, 2011.



Katherine A. Thomas, MN, RN
Executive Director on behalf
of said Board

BOARD OF VOCATIONAL
NURSE EXAMINERS

VS.

MICHAEL WAYNE HOOD

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STATE OF TEXAS

COUNTY OF TRAVIS

AGREED BOARD ORDER

On this day came to be considered by the Board of Vocational Nurse Examiners the matter of vocational nurse license number 127624 held by MICHAEL WAYNE HOOD, hereinafter called Respondent.

By letter, the Board of Vocational Nurse Examiners sent preliminary notice to Respondent of its intent to take disciplinary action with respect to said license held by Respondent, as a result of a complaint and subsequent investigation. Said investigation produced evidence indicating that Respondent has engaged in unprofessional or dishonorable conduct that, in the Board's opinion, is likely to deceive, defraud, or injure the public, in violation of Texas Occupations Code, Chapter 302, Section 302.402 (a) (10), in the following manner:

I.

a. On or about August 20, 2002, the Board of Vocational Nurse Examiners received notification of disciplinary action by the North Carolina Board of Nursing.

b. By Order of the North Carolina Board of Nursing dated July 18, 2002, Applicant's license to practice licensed practical nursing in the State of North Carolina lapsed on or about December 31, 2001. On or about July 18, 2002, the North Carolina Board of Nursing denied Reinstatement for a period of six (6) months from date of said order based on findings that the Respondent was negligent in the care he provided to resident A.N. on or about December 27, 2000 when he, knowing the resident required continuous oxygen, failed to reconnect her oxygen after placing her in a wheelchair to be taken to the living room. These actions compromised said resident's respiratory status.

AGREED BOARD ORDER
RE: MICHAEL WAYNE HOOD, LVN #127624
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c. Said Board Order stipulated that at the time of request for reinstatement of the license, the Respondent must complete an Ethical/Legal Decision making course. In addition, at the time of request for reinstatement, Respondent must appear before the Licensure Committee of the Board and show that he is safe and competent to reenter nursing.

By Respondent's signature on this Order, Respondent neither admits nor denies the truth of the matters previously set out in this Order with respect to the above-mentioned investigation. By Respondent's signature on this Order, Respondent acknowledges that they have read and understood this Order and have approved it for consideration by the Board.

By their notarized signature on this Order, Respondent does hereby waive the right to a formal Complaint, Notice of Hearing and a Public Hearing held before an Administrative Law Judge with the State Office of Administrative Hearings, and to judicial review of this disciplinary action. Notice of this disciplinary action will appear in the Board's newsletter sent to Texas employers.

ORDER OF THE BOARD

NOW THEREFORE, IT IS ORDERED, subject to ratification by the Board of Vocational Nurse Examiners that license number 127624, heretofore issued to MICHAEL WAYNE HOOD to practice vocational nursing in the State of Texas be, and the same is hereby suspended until such time as Respondent completes requirements of North Carolina Board Order and appears before the Board and shows just cause for reinstatement.

AGREED BOARD ORDER
RE: MICHAEL WAYNE HOOD, LVN #127624
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This Agreed Order shall not be effective or take effect and become enforceable in accordance with its terms until ratified by a majority of the Board present and voting, at its next regularly called session.

Dated this the 21 day of May, 2003.



Signature of Respondent

5517 FM 521

Current Address

Rosharon, Tx 77583

City, State and Zip

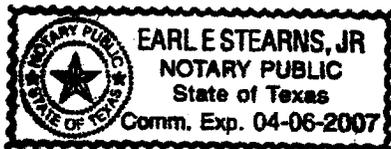
281, 431-4663

Area Code and Telephone Number

The State of Texas
County of TRAVIS

Before me, the undersigned authority, on this day personally appeared MICHAEL WAYNE HOOD, who being duly sworn by me stated that he or she executed the above for the purpose therein contained, and that he or she understood same.

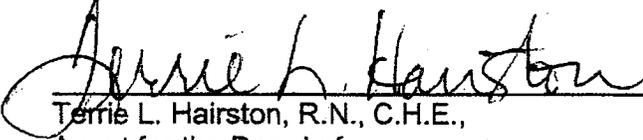
SWORN TO AND SUBSCRIBED before me on this the 21st day of May, 2003.



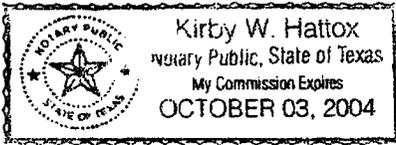


NOTARY PUBLIC IN AND FOR
THE STATE OF TEXAS

AGREED BOARD ORDER
RE: MICHAEL WAYNE HOOD, LVN #127624
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Terrie L. Hairston, R.N., C.H.E.,
Agent for the Board of
Vocational Nurse Examiners

SWORN TO AND SUBSCRIBED before me, the undersigned authority, on this the
10th day of JUNE, 2003.

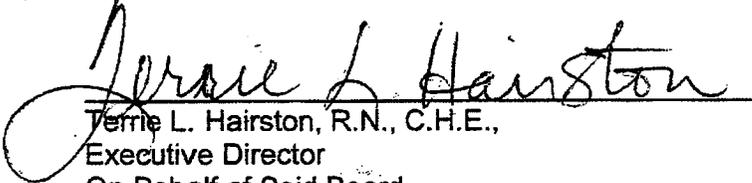



NOTARY PUBLIC IN AND FOR
THE STATE OF TEXAS

BOARD ORDER
RE: MICHAEL WAYNE HOOD, LVN #127624
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WHEREFORE, PREMISES CONSIDERED, the Board of Vocational Nurse Examiners for the State of Texas does hereby ratify and adopt the Agreed Board Order, notarized on the 21st day of May, 2003 by MICHAEL WAYNE HOOD, license number 127624 and that Said Order is Final.

Effective this 10th day of June, 2003.


Terrie L. Hairston, R.N., C.H.E.,
Executive Director
On Behalf of Said Board

BOARD ORDER
RE: MICHAEL WAYNE HOOD, LVN #127624
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CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of June, 2003, a true and correct copy of the foregoing **BOARD ORDER** was served by placement in the U.S. Mail first class mail, and addressed to the following person(s):

MICHAEL WAYNE HOOD
5517 FARM ROAD 521
ROSHARON, TEXAS 77583


Terrie L. Hairston, R.N., C.H.E.,
Executive Director
Agent for the Board of Vocational Nurse Examiners

BEFORE THE NORTH CAROLINA BOARD OF NURSING
OF THE STATE OF NORTH CAROLINA

In the matter of)

Michael Wayne Hood, LPN)

Certificate #088026)

FINAL DECISION AND ORDER

In accordance with authority vested by Article 9A, Chapter 90 of the General Statutes of North Carolina and Article 3A of Chapter 150B of the General Statutes of North Carolina, the North Carolina Board of Nursing on July 18, 2002 conducted a Hearing based on a notice to Michael Wayne Hood, LPN, by Certified Mail, to appear and show cause why his license as a licensed practical nurse should not be reinstated or other appropriate action taken under the provisions of G.S. 90-171.37 for apparent violation of G.S. 90-171.37 (4) (5) (6) (7) and (8) and Regulation 21 N.C.A.C. 36.0217(c) (10).

Appearing as witnesses on behalf of the North Carolina Board of Nursing were Teresa Chavis, CNA; Julie Tucker, RN; Laticia Tharrington, RN; and Florence Rethinan, RN, GNP; all current or former employees at the IHS of Treyburn in Durham, North Carolina. Also appearing as a witness on behalf of the North Carolina Board of Nursing was Sandra O. Best, RN, Investigator with the North Carolina Board of Nursing.

The respondent, Michael Wayne Hood, did not appear and was not represented.

Prosecuting attorney for the North Carolina Board of Nursing was John Bryant. Sitting as Administrative Law Counsel was Paul Flick. Sitting as Presiding Officer on behalf of the Board was Janice McRorie.

FINDINGS OF FACTS

From the sworn testimony of the witnesses, documents received into evidence at the Hearing, proper notice of the Hearing being given, and upon consideration of all admissible and competent evidence, it is found as a fact that:

- (1) The North Carolina Board of Nursing is mandated by statute to enforce the provisions of the Nursing Practice Act and to ensure that the public's health, safety and welfare are protected.
- (2) Michael Wayne Hood is the holder of LPN Certificate #055026 which expired on December 31, 2001.
- (3) Mr. Hood was employed at the IHS of Treyburn in Durham, North Carolina at the time of the incident which ultimately led to the Letter of Charges being issued. The Letter of Charges was sent to the licensee by Certified Mail, Return Receipt Requested on December 27, 2001. The letter was returned with a forwarding address in Stafford, Texas. The Letter of Charges was remailed to the forwarding address and was signed for by the licensee on February 16, 2002.

In the matter of)
Michael Wayne Hood, LPN)
Certificate #088026)

FINDINGS OF FACT
(continued)

The Notice of Hearing was sent to the licensee Certified Mail, Return Receipt Requested to the Stafford, Texas address on March 13, 2002. The Notice of Hearing was signed for by the licensee on March 27, 2002.

- (4) On December 27, 2000, Mr. Hood was assigned to work 7 a.m. to 7 p.m. at the IHS of Treyburn. One of the patients assigned to Mr. Hood on this date was Resident A.N. Resident A.N. was an 84 year old with a diagnosis of intracranial hemorrhage, diabetes, high blood pressure, a tracheostomy, urinary tract infection and pneumonia. The resident required continuous oxygen at 28% via her tracheostomy. Resident A.N.'s respiratory status could be compromised if she was of her oxygen.
- (5) On December 27, 2000, the housekeeping staff notified the Certified Nursing Assistant (CNA) that Room 307, the room in which Resident A.N. resided, was to be deep cleaned. When a room was deep cleaned, it involved stripping the beds, cleaning the bed frame, mattress, windows, etc. It required that the residents in that room be removed from the room in order that the deep cleaning procedure could occur. The housekeeper notified the CNA that the room would be cleaned sometime after his break. The housekeeper's break occurred around 10 a.m. The CNA understood that she had to have the resident out of bed, and out of the room prior to the time for deep cleaning.
- (6) Shortly before 10 a.m., the CNA went to Mr. Hood and told him to come unhook the resident's tubes so she could get the resident out of the bed. Mr. Hood unhooked the NG tube and the oxygen tube. The CNA, Mr. Hood and another CNA then used the Hoyer lift to assist in putting Resident A.N. in the wheelchair.

The CNA began to wheel the resident to the living room area when she noted that Mr. Hood was not behind her. The CNA went to find Mr. Hood and told him he needed to come and hook up Resident A.N.'s oxygen. Mr. Hood told the CNA that he was going on break first. The CNA told Mr. Hood that he couldn't go on break, that he needed to come hook the patient up.

When the CNA observed Mr. Hood going in the direction of the living room, she assumed he was going to hook the resident up. The CNA went about her other duties. It was approximately an hour later when it was discovered that the resident was sitting in the living room and her oxygen was not hooked up.

In the matter of)
Michael Wayne Hood, LPN)
Certificate #088026)

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FINDINGS OF FACT
(continued)

- (7) At this point, the resident was noted to not be responding. The Charge Nurse and Director of Nursing, along with the CNA, immediately got the resident back into her room and the resident was then put on the oxygen. The resident's condition immediately changed and she became ashen, cool to touch with no blood pressure and no oxygen level reading. The resident's pulse was thready and irregular. It was later determined that the resident had been off her oxygen for approximately 1 hour.
- (8) Resident A.N. was supposed to be on continuous oxygen at 28% via her tracheostomy. Mr. Hood was assigned to Resident A.N. Although, Mr. Hood assisted in getting Resident A.N. out of bed; and therefore, was aware her oxygen was not hooked up, he failed to ensure the resident's safety by reconnecting her oxygen.
- (9) Between June 23, 2000 and January 5, 2001, Mr. Hood was involved in several medication and treatment errors while employed at the IHS of Treyburn.
- (10) On December 27, 2000, Mr. Hood was negligent in the care he provided to Resident A.N. when he failed to hook up her oxygen and therefore, compromised her respiratory status.
- (11) The following exhibits were introduced on behalf of the North Carolina Board of Nursing:
- 1) The Letter of Charges dated December 27, 2001;
 - 2) The Notice of Hearing dated March 13, 2002;
 - 3) The Treatment Record for Resident A.N.;
 - 4) The Physician's Order Sheet for Resident A.N.;
 - 5) The Nurse's Notes for Resident A.N.;
 - 6) The complaint letter regarding this incident from Ms. Tharrington at IHS, Treyburn received May 3, 2001;
 - 7) A statement from Harry Unger dated December 27, 2000;
 - 8) The Notice of Corrective Action regarding the medication and treatments dated December 11, 2000;
 - 9) The Incident Reports for the medication errors.
- (12) No exhibits were introduced on behalf of the respondent.

In the matter of)

Michael Wayne Hood, LPN)

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CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board makes the following conclusions of Law:

- (1) Interpretation of the Nursing Practice Act and the determination of what constitutes safe and competent practice is within the sole province of the Board.
- (2) The North Carolina Board of Nursing has the authority to take appropriate disciplinary or remedial action upon the finding of violation of the Nursing Practice Act.
- (3) The credibility of the witnesses and the evidence is within the province of the Board who saw and heard the witnesses.
- (4) All notices were properly served as required by law and this Hearing was properly conducted.
- (5) Ultimate facts in the Administrative proceeding need be proved by credible and substantial evidence. The substantial evidence should be both clear and convincing and should be such that would lead a reasonable mind to a conclusion that a violation of the Nursing Practice Act or pertinent Administrative Regulations have occurred.
- (6) The licensee has violated G. S. 90-171.37 (4) in that he engaged in conduct that endangered the public health as evidenced by the fact that on December 27, 2000, Mr. Hood was negligent in the care he provided to Resident A.N. when he failed to hook up her oxygen; and therefore, compromised her respiratory status.
- (7) The licensee has violated G.S. 90-171.37 (5) in that he is unfit or incompetent to practice nursing by reason of deliberate or negligent acts or omissions regardless of whether actual injury to the patient is established as evidenced by the fact that on December 27, 2000, Mr. Hood was negligent in the care he provided to Resident A.N. when he failed to hook up her oxygen; and therefore, compromised her respiratory status.
- (8) The licensee has violated G.S. 90-171.37 (6) in that he engaged in conduct that deceived, defrauded or harmed the public in the course of professional activities or services as evidenced by the fact that on December 27, 2000, Mr. Hood was negligent in the care he provided to Resident A.N. when he failed to hook up her oxygen; and therefore, compromised her respiratory status.
- (9) The licensee has violated G.S. 90-171.37 (7) in that he has violated G.S. 90-171.37 (4) (5) and (6).

In the matter of)

Michael Wayne Hood, LPN)

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Certificate #088026)

CONCLUSIONS OF LAW

(continued)

- (10) The licensee has violated G.S. 90-171.37 (8) in that he did willfully violation Regulation 21 N.C.A.C. 36.0217(c) (10) in the manner found below.
- (11) The licensee did willfully violate Regulation 21 N.C.A.C. 36,0217(c) (10) in that he did abandon or neglect a client who was in need of nursing care without making reasonable arrangements for the continuation of such care as evidenced by the fact that on December 27, 2000, Mr. Hood assisted in putting Resident A.N. in a wheelchair to be taken to the living room area, a resident he knew was on continuous oxygen, and he failed to hook her back up to oxygen; and therefore, compromised her respiratory status.

In the matter of:)

Michael Wayne Hood, LPN)

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Certificate #055026)

FINAL DECISION AND ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is **ORDERED** that the LPN license of Michael Wayne Hood not be reinstated for a period of six (6) months from the date of this ORDER.

Prior to consideration for reinstatement of the license, Mr. Hood must successfully complete a Board approved Ethical/Legal Decision Making Course.

Additionally, at the time of request for reinstatement of the license, Mr. Hood must appear before the Licensure Committee of the Board and show that he is safe and competent to re-enter nursing.

In accordance with G.S. 90-171.27(d) and Board of Nursing policy derived therefrom, a fee may be assessed for disciplinary matters. In the matter involving Michael Wayne Hood, the fee will be \$725.00. All outstanding fees must be paid in full prior to reinstatement of the license.

Mr. Hood may not be listed on the Nurse Aide II Registry. Additionally, the Board will recommend to the Division of Facility Services that he not be listed as on the Nurse Aide I Registry.

This the 18th day of July, 2002,



Mary P. Johnson, RN
Executive Director
MPJ/lr