

DOCKET NUMBER 507-10-5182

IN THE MATTER OF
PERMANENT CERTIFICATE
NUMBER 196906
ISSUED TO
QUINCY JACKSON

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BEFORE THE STATE OFFICE
OF
ADMINISTRATIVE HEARING



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.
Michelle R. Thomas
Executive Director of the Board

OPINION AND ORDER OF THE BOARD

TO: QUINCY JACKSON
6035 LYNDBURST
HOUSTON, TX 77033

ANNE K. PEREZ
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on April 28-29, 2011, the Texas Board of Nursing (Board) considered the following items: (1) The Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD regarding the vocational nursing license of Quincy Jackson with changes; and (3) 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 Respondent's presentation 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, except for Conclusions of Law Numbers 8 and 9, which are not adopted by the Board and are hereby re-designated as the ALJ's

recommended sanction in this matter. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Conclusions of Law Numbers 8 and 9

The Board declines to adopt Conclusions of Law Numbers 8 and 9 because they are the ALJ's recommended sanction in this matter and are not proper conclusions of law. The Government Code §2001.058(e) authorizes the Board to change a finding of fact or conclusion of law made by the ALJ, or to vacate or modify an order issued by the ALJ if the Board determines that the ALJ did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions. The ALJ did not properly apply or interpret applicable law in this matter when she included her recommended sanction as conclusions of law. A recommendation for a sanction is not a proper conclusion of law. An agency is the final decision maker regarding the imposition of sanctions. Once it has been determined that a violation of the law has occurred, the sanction is a matter for the agency's discretion. The choice of penalty is vested in the agency, not in the courts. The agency is charged by law with discretion to fix the penalty when it determines that the statute has been violated. Thus, 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. 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...[T]he Board, not the ALJ, is the decision maker concerning sanctions. 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). Pursuant to

applicable law, the Board does not adopt Conclusions of Law Numbers 8 and 9, but instead re-designates them as the ALJ's recommended sanction in this matter.

IT IS THEREFORE ORDERED that RESPONDENT SHALL receive the sanction of a REPRIMAND WITH A FINE and 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.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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

(1) RESPONDENT SHALL, within one (1) year of entry 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>.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. 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. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: 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. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office 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>.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in "Detecting and Preventing Abuse and Neglect ...," a five (5) contact hour workshop presented in various locations by the Texas Department of

Aging and Disability Services. In order to receive credit for completion of this workshop, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this workshop to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following website: <http://www.dads.state.tx.us/providers/Training/jointtraining.cfm> or by contacting (512) 438-2201.*

(4) RESPONDENT SHALL pay a monetary fine in the amount of three thousand dollars (\$3,000.00). RESPONDENT SHALL pay this fine within one hundred eighty (180) days of entry 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.

(5) RESPONDENT SHALL pay an administrative reimbursement in the amount of seven hundred thirty six dollars and sixty nine cents (\$736.69). RESPONDENT SHALL pay this administrative reimbursement within ninety (90) days of entry 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.

IT IS FURTHER ORDERED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY FOUR (24) MONTHS HAVE ELAPSED. PERIODS

**OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF
A VOCATIONAL NURSE (LVN) LICENSE WILL NOT APPLY TO THIS STIPULATION
PERIOD:**

(6) RESPONDENT SHALL notify each present employer in 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. RESPONDENT SHALL notify all future employers in 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 future employer prior to accepting an offer of employment.

(7) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. 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 nurse.

(8) For the first year of employment as a 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.

(9) For the remainder of the stipulation 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.

(10) 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 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) month period for two (2) years of employment as a nurse.

IT IS FURTHER ORDERED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license to practice nursing

in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

Entered this 28th day of April, 2011.

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision; Docket No. 507-10-5182 (December 15, 2010).

State Office of Administrative Hearings



Cathleen Parsley
Chief Administrative Law Judge

December 15, 2010

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

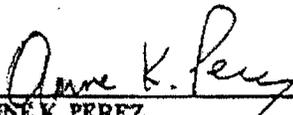
VIA INTER-AGENCY

RE: Docket No. 507-10-5182; Texas Board of Nursing v. Quincy Jackson

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(c), a SOAH rule which may be found at www.soah.state.tx.us.



ANNE K. PEREZ
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

AKP/llg
Enclosures

XC: John F. Legris, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA INTER-AGENCY
Dina Flores, Legal Assistant Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – (with 1 CD, Certified Evidentiary Record) – VIA INTER-AGENCY
Quincy Jackson; 6035 Lyndhurst Drive, Houston, TX 77033-1315-VIA REGULAR MAIL

SOAH DOCKET NO. 507-10-5182

TEXAS BOARD OF NURSING,
Petitioner

vs.

QUINCY JACKSON,
Respondent

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BEFORE THE STATE OFFICE

OF

ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) brought this disciplinary action against Quincy Jackson (Respondent), alleging that Respondent falsified skilled nursing notes for six patients in violation of the Nursing Practice Act¹ and the Board's rules.² Respondent denied the allegations. This proposal for decision finds that Respondent's conduct violated Code § 301.452 and 22 TAC §§ 217.11 and 217.12. The Administrative Law Judge (ALJ) recommends that Respondent receive a formal reprimand with probationary stipulations.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The hearing convened October 13, 2010, before ALJ Anne K. Perez in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by John F. Legris, Assistant General Counsel. Respondent appeared on his own behalf. The record closed at the conclusion of the hearing, but was reopened to receive a revised evidentiary exhibit from Staff. The record closed on October 18, 2010.

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

¹ The Nursing Practice Act is at TEX. OCC. CODE ANN. (Code) ch. 301.

² 22 TEX. ADMIN. CODE (TAC) part 11.

II. DISCUSSION

A. Background

Respondent has been licensed in Texas as an LVN since January 2005. From late November 2006 through December 2006, he was employed by Texas Quality Home Health, Inc. (TQHH), a position that required him to provide in-home scheduled skilled nursing care for Patients EC, SH, BJ, CH, JS and EN. All six of the identified patients were elderly and suffered from chronic medical conditions, such as diabetes. Skilled nursing visits are required to be conducted according to a schedule established by the patient's Plan of Care. Each of Respondent's patients required skilled nursing visits at least once, but usually twice, per week.

B. Evidence

Staff submitted multiple exhibits³ and the testimony of Gwendolyn Hawthorn, Janet Ekezie, Patient SH⁴ and Bonnie Cone. Respondent testified on his own behalf.

1. Undisputed Facts

In an employment application submitted to TQHH on November 21, 2006, Respondent listed the following prior work experience:

- Nurse Supervisor for Heartland West Houston, a rehabilitation retirement home, from February 2005 to July 2006;
- Part-time LVN for Caring Home, an assisted living facility in Houston, from January 2006 to present; and
- Part-time LVN for Country Home Health, a home health agency, from July 2006 to present.⁵

³ Absent any objection, Staff's Ex. 10 (Amended Affidavit of Estimated Administrative Costs) is admitted.

⁴ Patient SH offered telephonic testimony.

⁵ Staff's Ex. 9, at 4-5.

On November 21, 2006, Respondent executed an employment contract with TQHH that required him to work under the supervision of the agency's Director of Nursing (DON). His primary employment responsibilities included: providing skilled nursing services; reporting significant patient findings to the DON; completing skilled nursing notes for each skilled nursing visit; and, following all TQHH policies and procedures.⁶

Respondent submitted time slips to TQHH reflecting that, during the three final weeks of December 2006, he provided the following scheduled skilled nursing visits:

- **Week of December 9, 2006**—Two routine visits each with Patients SH, EN, CH, BJ, JS and EC;
- **Week of December 16, 2006**—Two routine visits each with Patients CH, BJ, EC and EN; one routine visit with JS; and
- **Week of December 23, 2006**—Two routine visits each with Patients SH, EC, and EN; one routine visit each with CH, BJ, and JS.⁷

2. **Gwendolyn Hawthorn**

Ms. Hawthorn has been a Registered Nurse (RN) for 40 years with experience in diverse areas including acute care, physical rehabilitation, teaching, admissions and in-home care. In late-2006, she was TQHH's DON, a position that required her to train, schedule, and supervise the agency's field nurses. If necessary, she arranged for substitute skilled nursing care. She also screened new patients for admission.

Ms. Hawthorn explained that when a new patient was admitted, he or she was given TQHH's telephone number and told to call the main office with any questions or concerns. In particular, patients were instructed never to call their home-care nurses directly. This practice

⁶ Staff's Ex. 9, at 2.

⁷ Staff's Ex. 6, at 11-13. Respondent's time slips also reflect scheduled skilled nursing visits for several patients not named in Staff's complaint, which are not listed; they are not relevant to this proceeding. The proposal for decision likewise contains no discussion of Respondent's patients during his first two weeks of employment (November 26, 2006 though December 8, 2006) because the DON was with Respondent for those patient visits.

allowed the agency's DON to stay informed of all patient problems and concerns. Depending upon the nature of a patient's telephone call, Ms. Hawthorn said she might contact the assigned nurse or physician, or deal with the issue herself.

The DON stated that, at the time she interviewed Respondent, because he was recommended by another TQHH nurse. She told Respondent she was looking for LVNs who were self-directed and capable of working alone, with only minimal supervision. Respondent indicated the arrangement was perfectly acceptable, as he had prior home health care experience, and asked to be assigned a full patient case load. She testified she was impressed: Respondent was clean-cut, friendly and articulate, plus he possessed pertinent experience and was eager to get to work. She hired him.

The DON indicated that when she trained Respondent, she emphasized that it was important for each skilled nursing visit to be provided according to the schedule in the patient's Plan of Care. If Respondent was ever unable to provide a scheduled skilled nursing visit, she instructed him to telephone her right away; it was not a problem to arrange for a substitute nurse, or to attend to the patient herself.

Ms. Hawthorn accompanied Respondent on all skilled nursing visits between November 27 and December 8, 2006. She introduced him to his assigned patients, demonstrated the nursing procedures necessary for each patient and observed his performance of same. She described Respondent's demeanor as professional and friendly. The patients liked him immediately.

After Respondent's first two weeks with TQHH, Ms. Hawthorn no longer accompanied him to see patients but encouraged him to call her with any questions. During the next three weeks (December 9-29, 2006), Respondent was responsible for providing scheduled skilled nursing visits for Patients EC, SH, BJ, CH, JS and EN. The DON said she had admitted each of these patients for service and was familiar with their medical conditions. All six suffered from chronic health conditions and required a "routine" visit from an LVN at least once, but usually

twice per week. "Routine" visits, she explained, are scheduled skilled nursing visits primarily for the purpose of monitoring chronic medical conditions.

Ms. Hawthorn recalled that during his first week alone in the field, Respondent called her several times to ask questions about patients. He brought no serious problems to her attention. He called less frequently during the next two weeks, she stated, but said nothing that suggested he was unable to see his patients according to schedule, except for a single occasion when he reported having car trouble. Ms. Hawthorn said she believed all was well, since Respondent continued to submit skilled nursing notes for each of his patients through the last week of December 2006. He also submitted weekly time slips for the entire month, reflecting information that was consistent with his skilled nursing assessments (patient names and dates of routine visits).⁸

Ms. Hawthorn testified she was unaware of any problem until early-January 2007, when she received calls regarding Patients EN and SH. Patient EN was legally blind and suffered from unstable diabetes and other chronic health problems, the DON said. Because Patient EN's blood sugar could suddenly rise to dangerous levels, she wore a specially-calibrated monitor to signal spikes in her blood sugar. Ms. Hawthorn explained that Patient EN's Plan of Care required skilled nursing visits twice per week, not only to monitor her chronic health problems, but to ensure that her blood sugar monitor was calibrated and functioning properly.

In early-January 2007, Patient EN's caretaker reported that Respondent had not provided skilled nursing care for Patient EN in several weeks. According to EN's caregiver, she was instructed by the Respondent to bypass TQHH's main office, and call him on his personal cellular phone with any concerns about Patient EN. When Respondent later failed to appear for Patient EN's scheduled skilled nursing visit, the caretaker called Respondent's phone and left a recorded voicemail message. According to Ms. Hawthorn, the caretaker said this scenario was repeated several times. Eventually, Respondent's voicemail became too full to accept new

⁸ Staff's Ex. 6, at 11-13.

messages and the caregiver called TQHH's main office. In the meantime, Patient EN went for several weeks without skilled nursing care.

Shortly afterwards, Patient SH telephoned TQHH's DON. Patient SH had been through stomach surgery, Ms. Hawthorn reported, and suffered from both gastric reflux disease and high blood pressure. Her osteoarthritis required regular injections for pain and to increase mobility. Patient SH had also developed acute problems after being admitted to TQHH for services. Her Plan of Care consequently required skilled nursing visits twice per week, to monitor Patient SH's chronic health conditions, check for the presence of acute symptoms and administer all required injections.

Despite Patient SH's extensive health problems, the DON said she was mentally intact. In early-January 2007, Patient SH told Ms. Hawthorn that in December 2006, Respondent had provided her with scheduled skilled nursing visits only once or twice. At that point, Ms. Hawthorn testified, she pulled Respondent's time slips, which reflected his provision of scheduled skilled nursing care for Patient SH on December 13, 15, 19, 21, 27 and 29, 2006.⁹ The same time slips showed Respondent reported providing scheduled skilled nursing care for Patient EN on December 12, 14, 19, 21, 27 and 29, 2006.¹⁰

This discovery led Ms. Hawthorn to telephone Respondent's other patients to see if they had experienced similar problems. Her inquiries of Patients BJ and CH ("The nurse has not come in a long time") were confirmed by those patients' caretakers, who told Ms. Hawthorn that Respondent had made patient visits once, or maybe twice in December 2006. When the DON contacted Patient EC, she was told, "The nurse has not come to see me." In addition, Patient JS' wife reported to Ms. Hawthorn that Respondent did not appear for all of JS' scheduled skilled nursing visits in December 2006.¹¹

⁹ Staff's Ex. 6, at 11-13.

¹⁰ *Id.*

¹¹ Staff's Ex. 6, at 2-7.

Ms. Hawthorn began an investigation. She personally visited Patients EC, SH, BJ, CH, JS and EN. During those visits, she reviewed each patient's "Home Health Book:" a book that is maintained at the patient's home, which requires the signature of any visiting health professional providing home health care. Patient EC's book had been signed by the Respondent on four occasions during December 2006. Respondent's signature appeared in his other patients' Home Health Books only once or twice that month. All of Respondent's patients described the same scenario: Respondent missed multiple scheduled skilled nursing visits; when Respondent did not appear as scheduled, the patients followed his instructions by calling his personal phone number and leaving a voicemail message; after leaving numerous messages that were not returned and finding that Respondent's voicemail was full, the patients were finally willing to complain to TQHH.

Ms. Hawthorn reported that in early January 2007, she too made repeated attempts to reach the Respondent and encountered the same problem—his voicemail was full. One time, however, he answered her call. She testified that she confronted him by stating, "I know you haven't been seeing your patients." She has not spoken with Respondent since the date of this phone call. The DON reported her investigative findings to Ms. Ekezie, TQHH's Administrator.

3. Janet Ekezie

Ms. Ekezie, TQHH's Administrator, is an RN as well as an optometrist. In 2006, she was responsible for the agency's compliance with state and federal reporting requirements, as well its payroll functions. Ms. Ekezie recalled that Respondent was employed by TQHH for approximately six weeks at the end of 2006. At the time he was hired, she also believed he had prior home health care experience.

In early to mid-January 2007, Ms. Ekezie testified, Ms. Hawthorn reported that the agency was receiving complaints. Respondent's patients were supposed to have scheduled skilled nursing visits once or twice per week, but were reporting that Respondent had seen them only once or twice during the month of December 2006. Ms. Ekezie said she attempted to

contact Respondent in January 2007, but could not leave a message because his voicemail was full.

As the facility's Administrator, Ms. Ezekie was responsible for preparing a TQHH "Complaint/Grievance Form" for each of Respondent's affected patients. She documented the name of each complaint; described the steps undertaken by TQHH to investigate, assess and remedy any patient harm; and, explained how the agency planned to prevent future occurrences of the same type.¹² Ms. Ezekie also took care of the agency's reporting requirements, which included notifying the Board of Respondent's misconduct.

Ms. Ekezie's payroll functions included the review and approval of employee time slips. She reviewed Respondent's time slips for the last three weeks of December 2006,¹³ which indicate he provided the following scheduled skilled nursing visits:

- Patient SH, four routine visits;
- Patient CH, five routine visits;
- Patient EC, six routine visits;
- Patient EN, six routine visits;
- Patient JS, four routine visits; and
- Patient BJ, five routine visits;

Based on Ms. Ekezie's approval Respondent's time slips for the last three weeks of December 2006, she indicated, TQHH paid Respondent \$30 per visit for 30 scheduled skilled nursing visits provided to Patients SH, CH, EC, EN, JS and BJ. Respondent's pay stubs for the same period reflect that he did, in fact, receive those sums from TQHH.¹⁴

¹² Staff's Ex. 6, at 2-7.

¹³ Staff's Ex. 6, at 11-13.

¹⁴ Staff's Ex. 6, at 8-9.

4. Patient SH

Patient SH offered brief testimony by telephone. She said that she received scheduled skilled nurse visits through TQHH in November and December of 2006; that she had had only one male nurse from TQHH, but could not recall his name; and the male nurse provided her with skilled nursing care on only two occasions, in total. Patient SH testified that if the male nurse reported providing her with six scheduled skilled nursing visits, his statement was false.

5. Respondent's Testimony

Respondent disagreed with much of Ms. Hawthorn's testimony. First, he clarified his employment history. He explained that while his TQHH job application¹⁵ lists Country Home Health (CCH) as a current part-time employer, when he interviewed at TQHH he told the DON that CCH's caseload was too light to give him any in-home skilled nursing assignments. In fact, Respondent testified, he told Ms. Hawthorn that his situation at CCH was the reason he desired a position with TQHH. Respondent also indicated there was another error in his employment application, in that it lists Heartland West Houston (a rehabilitation retirement home) as a former employer. Respondent said he never really left the position at Heartland West Houston, where he presently still works on a part-time basis.

Ms. Hawthorn knew he had no home health care experience, Respondent said, and she agreed to train him for a field position with TQHH. That was the reason she accompanied him on all patient visits during his first two weeks of his employment. After that he worked alone.

Respondent was adamant that he conducted each and every one of the scheduled skilled nursing visits listed on his time slips for December 2006. He disputed Ms. Hawthorn's testimony that his patients' Home Health Books' confirmed that he saw most of his patients only once or twice in December 2006. According to Respondent, there were numerous occasions that he provided scheduled skilled nursing visits when his patients' Home Health Books were

¹⁵ Staff's Ex. 9, at 4-5.

unavailable for signature. He explained that patients take their Home Health Books to in-office appointments with medical personnel, often forgetting to bring them back.

Respondent testified that the DON was angry at him for reasons that had nothing to do with missed patient visits. After he began seeing his patients one-on-one, Respondent explained, he prepared skilled nursing notes for each visit and submitted them to Ms. Hawthorn, who reviewed the agency's nursing assessments. Almost immediately, he said, she began complaining about the contents of his skilled nursing notes. The DON reportedly told Respondent that certain information did not belong in a nursing assessment and asked him to change information that he previously documented.

Respondent testified he was dismayed and upset at this turn of events. A nursing assessment is based on personal observation of the patient during a scheduled skilled nursing visit, he explained, and Ms. Hawthorn's requested revisions made him very uncomfortable. He expressed these feelings to the DON. Nonetheless, he said, she continued to pressure him to change his findings and observations as the patient's attending skilled nurse, information that Respondent insists was accurate. Ultimately, he said he refused to comply with her requests. He testified he believes it is wrong to change a patient's medical record, and the DON's request was improper. Respondent reported that when Ms. Hawthorn telephoned him at the end of December 2006, he told her he could no longer work for her.¹⁶

6. Bonnie Cone's Testimony

Ms. Cone has been a Registered Nurse for 20 years with experience in various areas including critical care, nurse education and regulation. As a Nurse Practicing Consultant for the

¹⁶ Ms. Hawthorn testified during Staff's rebuttal case. She vociferously disagreed with Respondent's explanation regarding his reasons for leaving TQHH. According to the DON, she would never, ever ask a nurse to change a nursing note and in fact, she recalled that Respondent's nursing assessments were adequate. She clarified, however, that when training a nurse to prepare skilled nursing notes, she stresses the importance (probably for Medicaid/Medicare billing purposes) of including information that is relevant to the patient's diagnosis. For example, since Patient EN's diabetes was uncontrolled, skilled nursing notes for Patient EN should address the presence or absence of diabetic symptoms, as this information is critical to her diagnosis. If a nursing assessment submitted to TQHH lacked essential information, Ms. Hawthorn said, it is true that she would instruct the attending nurse to include it.

Board, she assists the Enforcement and Legal Divisions with case reviews and testifies as an expert witness in SOAH hearings.¹⁷

Ms. Cone testified that she had reviewed TQHH's records, as well as Respondent's job application submitted to that agency. In her opinion, Respondent's actions – falsely documenting his provision of scheduled skilled nursing visits for six patients – could have resulted in non-efficacious treatment. In addition, Respondent's preparation and submission of falsified time slips was deceptive and likely to defraud TQHH of monies paid for scheduled skilled nursing visits not provided. Ms. Cone said that Respondent's misconduct is grounds for discipline under Code §301.452(b)(10) and (13) and 22 TAC §§ 217.11 and 217.12.

Ms. Cone indicated that she considered Respondent's violations within the context of the Board's Disciplinary Matrix, as set out in 22 TAC § 213.33. In her opinion, his treatment of the six identified patients rises to the level of gross neglect. She stated that an administrative fine of \$500 for each patient is therefore justified. The fact that Respondent repeatedly neglected the same patients, and then falsely documented skilled nursing care that he failed to provide, also reflects an obvious need for re-education. In Ms. Cone's view, Respondent should be required to complete the following three remedial education courses: (1) nursing jurisprudence and ethics; (2) nursing documentation; and, (3) abuse and neglect of long-term care patients.

Ms. Cone lastly stated that, given the nature of Respondent's misconduct, he is not currently safe to practice in an independent setting, including a long-term care facility. She recommends that the Board issue a formal reprimand with stipulations for a two-year period. Respondent should undergo a full year of direct supervision in a restricted practice setting, followed by another year of indirect supervision.

¹⁷ Staff's Ex. 7.

C. Analysis

1. Legal Standards

Code § 301.452(b)(10) authorizes the Board to discipline a person for unprofessional or dishonorable conduct that is likely to deceive, defraud, or injure a patient or the public. Code § 301.452(b)(13) permits disciplinary action against a person who fails to conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient unnecessarily to risk of harm. The question is whether Respondent is subject to discipline under these statutory provisions for violating two of the Board's rules. Those are 22 TAC § 217.11(1)(B) (requiring a nurse to promote a safe environment for patients); and, (1)(D) (requiring a nurse to accurately report and document a patient's status; nursing care rendered; administration of medications and treatments; and, any patient response). Also at issue is 22 TAC § 217.12(6)(A) ("unprofessional conduct" includes falsifying patient records); and (6)(H) (unprofessional conduct includes providing false information in connection with the practice of nursing).

2. Allegations

Staff alleged that Respondent violated 22 TAC § 217.11(1)(B) and (D) because he falsely documented skilled nursing notes to state that he provided skilled nursing visits for Patients EC, SH, BJ, CH, JS and EN, conduct that could have resulted in ineffective treatment or injury to those patients. Staff further alleged that Respondent's conduct was deceptive, in that his actions were likely to defraud TQHH of monies paid for skilled nursing visits not provided, in violation of 22 TAC § 217.12(6)(A) and (H).

3. Reasons for Recommendation

Staff has the burden by a preponderance of the evidence to show that Respondent's conduct falls within the above definitions of "unprofessional conduct;" that his nursing practice fell below the minimum required standard of care; and, that his conduct exposed patients

unnecessarily to risk of harm. A preponderance of the evidence is evidence that establishes the ultimate fact "with that degree of certainty as to make the conclusion reasonably probable." *State Farm Mut. Auto Ins. Co. v. Davis*, 576 S.W.2d 920, at 921 (Tex. Civ. App.—Amarillo 1979, writ ref. n.r.e.).

Ms. Hawthorn and Ms. Ezekie's description of Respondent's conduct, as well as their account of the manner in which his actions were discovered, is supported by the greater weight of the evidence. The issue of credibility is paramount, particularly since the witnesses offered testimony about events that occurred during a three-week period four years ago.

Ms. Hawthorn is no longer employed by TQHH. She has no obvious reason to be untruthful or for that matter, to appear and offer testimony. Her countenance was that of a knowledgeable, experienced nurse who is dedicated to the profession. The emotional tenor of her testimony suggests that even though four years have passed, speaking about Respondent's conduct still evokes genuine feelings of anger and outrage. As for Ms. Ezekie, her role as TQHH's present Administrator did not seem to impact her testimony. She spoke matter-of-factly about TQHH's accounting and reporting functions. It was apparent that her complaint filed with the Board was not personally motivated: she was required to fulfill her reporting responsibilities as TQHH's Administrator. In addition, she related small details that were consistent with Ms. Hawthorn's testimony, a factor that increased both witnesses' credibility.

Respondent's credibility suffers in comparison to Ms. Hawthorn and Ms. Ezekie. He offered no documentary evidence to substantiate the claim that he left TQHH because of improper pressure from Ms. Hawthorn. He offered no specific testimony about his patients, nor did he describe the information included in his nursing assessments that was objectionable to the DON. He offered no reasons (plausible or otherwise) to explain why Ms. Hawthorn would act coercively towards him. Moreover, Respondent did not dispute his patients' damaging statements purportedly made to Ms. Hawthorn, or deny that he received multiple calls from patients that were not returned. If the events actually happened as Respondent described and he was upset enough to quit his job, it is unclear why he did not report Ms. Hawthorn's conduct to the Board. The alteration of patient medical records is a serious matter. The fact that it was

Ms. Ezekie who contacted the Board significantly undermines the credibility of Respondent's testimony.

In the end, the weight of the evidence establishes that the scenario unfolded as described by Ms. Hawthorn. For reasons not explained, Respondent provided only sporadic skilled nursing visits to his TQHH patients during the final three weeks of December 2006. It appears that Respondent instructed his patients to bypass TQHH and phone him directly so the agency would be unaware of his missed skilled nursing visits. Respondent's conduct was particularly egregious because he proceeded to ignore phone calls from his patients, who were home-bound, elderly and chronically ill. Respondent's failure to provide scheduled skilled nursing care interfered with his patients' medical treatment and could have caused serious physical injury. His submission of falsified skilled nursing notes and time slips to TQHH, in addition to being deceptive and fraudulent, delayed discovery of Respondent's patient neglect by several weeks. Conduct of this type by a nurse should be addressed through Board disciplinary action.

III. RECOMMENDATION

Based upon the above discussion, the ALJ recommends that Respondent receive a formal reprimand with practice restrictions and stipulations for a period of two years, as recommended by Staff. Respondent should also be subject to an administrative fine of \$500 for each of the identified patients.

IV. FINDINGS OF FACT

1. Quincy Jackson (Respondent) has been licensed as a Licensed Vocational Nurse (LVN) by the Texas Board of Nursing (Staff/Board) since 2005.
2. On June 19, 2010, Staff sent Respondent a Notice of Formal Charges filed against him.
3. Staff mailed its Notice of Hearing to Respondent on July 26, 2010.
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 convened October 13, 2010, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. Staff was represented by John F. Legris, Assistant General Counsel. Respondent appeared on his own behalf. The record closed at the conclusion of the hearing, but was reopened to receive an evidentiary exhibit. The record closed on October 18, 2010.
6. Texas Quality Home Health, Inc. (TQHH), located in Houston, Texas, is an agency that provides home health care.
7. When TQHH admits a new patient for service, the patient is provided with the agency's main telephone number, with instructions to call the office with any questions or concerns. New patients are specifically instructed not to call their TQHH nurse directly, even if they have the nurse's phone number.
8. On November 21, 2006, Respondent applied for a field nurse position with TQHH. In his employment application, he represented he was currently a part-time LVN with Country Home Health, another home health agency in Houston.
9. On November 21, 2006, Respondent executed an employment contract with TQHH, under which he agreed to provide in-home scheduled skilled nursing visits for TQHH patients.
10. Respondent worked for TQHH for about five weeks, from late-November 2006 through the end December 2006. For the first two weeks he trained under the agency's Director of Nursing (DON), who accompanied him on scheduled skilled nursing visits. The DON introduced Respondent to his patients, demonstrated the nursing procedures required for each individual and observed Respondent's performance of same.
11. The DON's training emphasized that skilled nursing visits are required to be provided in accordance with a schedule established by the patient's Plan of Care. Respondent was informed that if he was unable to provide a scheduled skilled nursing visit, TQHH policy required him to telephone the DON so she could arrange for another nurse to see the patient on schedule.
12. In training, Respondent was informed that he was required to prepare a skilled nursing assessment for every scheduled skilled nursing visit he provided; that his skilled nursing notes were to be submitted to TQHH each week; and, that he was to submit a weekly time slip that included each patient's name along with the date of Respondent's skilled nursing visit.
13. During the three final weeks of December 2006, Respondent was solely responsible for providing scheduled skilled nursing visits for Patients EC, SH, BJ, CH, JS and EN.

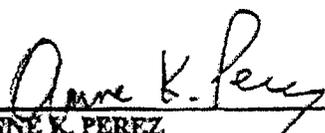
14. Patients EC, SH, BJ, CH, JS and EN were all elderly individuals suffering from chronic health conditions that require regular monitoring by nursing staff. At least two of Respondent's patients, SH and EN, were at risk for developing acute symptoms that could result in serious physical injury if not subject to medical intervention.
15. Patients EC, SH, BJ, CH, JS and EN each had a Plan of Care that required scheduled skilled nursing visits at least once, but usually twice per week.
16. In early January 2007, TQHH received complaints that Respondent was not providing scheduled skilled nursing visits in accordance with the Plan of Care for two of his patients, SH and EN.
17. TQHH's DON investigated the complaints. Ultimately, the DON personally visited not only Patients SH and EN, but Patients CH, EC, JS and BJ. Without exception, the patients and their caretakers reported that in December 2006, Respondent failed to provide multiple scheduled skilled nursing visits.
18. While at their homes, the DON reviewed each patient's "Home Health Book" (a record maintained at the patient's home that must be signed by any health care professional providing in-home care). The DON confirmed that in December 2006, Respondent's signature appeared only once or twice in Home Health Books of Patients SH, CH, EN, JS and BJ. Patient EC's book was signed by the Respondent on four occasions that month.
19. Each of Respondent's patients told the DON that Respondent had given them his cellular phone number, along with instructions to bypass TQHH's office and call him directly with any questions or concerns. The patients reported leaving numerous voicemail messages for Respondent that he did not return. TQHH began receiving complaints from Respondent's patients only after his voicemail was too full to accept new messages.
20. During the last three weeks of December 2006, Respondent submitted skilled nursing assessments for 30 scheduled skilled nursing visits, as follows:
 - Patient SH, four visits;
 - Patient CH, five visits;
 - Patient EC, six visits;
 - Patient EN, six visits;
 - Patient JS, four visits; and
 - Patient BJ, five visits.
21. Respondent did not provide a great number of the scheduled skilled nursing visits referenced in Finding of Fact No. 20.
22. Respondent's failure to provide all scheduled skilled nursing visits required for Patients SH, CH, EN, JS and BJ in December 2006, could have resulted in non-efficacious treatment.

23. Because Patients SH and EN each had medical conditions that placed them at risk for developing acute symptoms, Respondent's failure to provide the patients with all scheduled skilled nursing visits could have caused serious physical injury.
24. During the last three weeks of December 2006, Respondent submitted employee time slips that list the same patients and service dates as his skilled nursing notes for the same time period.
25. Respondent's employee time slips for the three final weeks of December are largely fabricated, as they contain a substantial number of scheduled skilled nursing visits that Respondent failed to provide.
26. Based on the falsified time slips, TQHH paid Respondent \$30 per visit for 30 scheduled skilled nursing visits provided to Patients SH, CH, EC, EN, JS and BJ.
27. Respondent accepted payment from TQHH for skilled nursing visits he did not provide for Patients SH, CH, EC, EN, JS and BJ.
28. Respondent's submission of false time slips to TQHH was deceptive and fraudulent, in that it caused TQHH to pay for scheduled skilled nursing visits that were not provided.
29. Respondent's submission of falsified skilled nursing notes and false time slips to TQHH delayed the discovery of Respondent's patient neglect for several weeks.
30. Respondent's treatment of six patients who were elderly, vulnerable and chronically ill constitutes gross neglect, and justifies imposition of a \$500 administrative fine for each patient.
31. Respondent's repeated neglect of Patients SH, CH, EC, EN, JS and BJ, and the fact that he falsely documented skilled nursing visits he did not provide, indicates Respondent's need for re-education.
32. Respondent's misconduct demonstrates that he is not currently safe to practice in an independent setting or a long-term care facility.
33. Respondent should receive a formal reprimand because of the serious nature of his misconduct.
34. Respondent's misconduct indicates that for a designated period of time, his nursing practice should be directly supervised by another licensed nurse. Subsequent to a period of direct supervision, Respondent practice as an LVN should be subject to a period of indirect supervision.
35. Staff incurred administrative costs of \$736.69 for witness expenses including lodging, meals, mileage reimbursement and car rental fees.

V. CONCLUSIONS OF LAW

1. The Texas Board of Nursing (Board) has jurisdiction over this matter pursuant to TEX. OCC. CODE ANN. (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 ANN. 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 ANN. §§ 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.
6. Based on Findings Nos. 13-23 and 29, Respondent's actions violated 22 TEX. ADMIN. CODE § 217.11.
7. Based on Findings Nos. 24-28, Respondent's actions violated 22 TEX. ADMIN. CODE § 217.12.
8. Based upon Findings of Fact Nos. 30-34 and Conclusion of Law Nos. 4, 6, and 7, the Board should issue to Respondent a formal reprimand with practice restrictions and stipulations for a period of two years, and be subject to an administrative fine of \$500 for each of the identified patients.
9. Pursuant to Finding of Fact No. 27, Respondent should be assessed \$736.69 for Staff's administrative costs of this case. TEX. GOV'T CODE ANN. § 301.461.

SIGNED December 15, 2010.



ANNE K. PEREZ
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS