



DOCKET NUMBER 507-10-3554

IN THE MATTER OF  
PERMANENT CERTIFICATE  
NUMBER 690642  
ISSUED TO  
MARSHALL INNO-CHYKE FINTAN

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§  
§

BEFORE THE STATE OFFICE  
OF  
ADMINISTRATIVE HEARINGS

*Patricia P. Roman*  
Executive Director of the 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.

OPINION AND ORDER OF THE BOARD

TO: MARSHALL INNO-CHYKE FINTAN  
3110 DOGWOOD KNOLL TRAIL  
ROSENBERG, TX 77471  
  
5711 SILVER OAK  
MISSOURI, TX 77459  
  
HUNTER BURKHALTER  
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 registered nursing license of Marshall Inno-Chyke Fintan 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. Board Staff filed exceptions to the PFD on January 6, 2011. The Respondent did not file any exceptions to the PFD nor did he respond to Staff's exceptions. The ALJ issued a final ruling letter on January 28, 2011, in which he modified Finding of Fact

Number 4. He did not, however, modify his recommendation.

The Board, after review and due consideration of the PFD, Staff's exceptions, 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, including Finding of Fact Number 4 which was modified by the ALJ in his letter ruling of January 28, 2011, but excluding Finding of Fact Number 8, which is modified by the Board, and Conclusion of Law Number 7, which is not adopted by the Board. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

#### Finding of Fact Number 8

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 Board declines to adopt Finding of Fact Number 8 as proposed by the ALJ because the finding seeks to define a term used by the Board, and as such, does not accurately reflect the Board's interpretation of "serious patient harm" as used in its Disciplinary Matrix, located at 22 Tex. Admin. Code §213.33(b), and rules, located at 22 Tex. Admin. Code §§213.33, 217.11, and 217.12. Based on Findings of Fact Numbers 2 and 3, the patient experienced seizures, had an oxygen saturation level of 35%, turned blue, and had to be resuscitated. The Board finds that these adjudicative facts constitute "serious patient harm" as used in its Disciplinary Matrix and rules. Therefore, the Board modifies and adopts Finding of Fact Number 8 as follows:

#### **Modified and Adopted Finding of Fact Number 8**

Respondent's actions did result in serious patient harm.

### Conclusion of Law Number 7

The ALJ also did not properly apply or interpret applicable law in this matter when he included his recommended sanction as a conclusion 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).

The Board rejects Conclusion of Law Number 7 because it is a recommended sanction and not a proper conclusion of law. Further, the Board retains the authority to determine the final sanction in this matter. The Board agrees with the ALJ that the Respondent violated the Occupations Code §301.452(b)(10) and (13). The Board also agrees with the ALJ that the Respondent's conduct created a serious risk of harm to the patient. The Board further agrees with the ALJ that, pursuant to its Disciplinary Matrix, the Respondent's conduct warrants a third tier, first sanction level sanction for his violation of

the Occupations Code §301.452(b)(13). However, the Board disagrees with the ALJ that the Respondent's conduct warrants a second tier, first sanction level sanction for his violation of the Occupations Code §301.452(b)(10). The Board finds that the Respondent's conduct resulted in serious patient harm, which was exhibited when the patient experienced seizures, had an oxygen saturation level of 35%, turned blue, and had to be resuscitated. The Board finds that the Respondent's conduct warrants a third tier, first sanction level sanction for his violation of the Occupations Code §301.452(b)(10). The Board also finds that the Respondent's failure to appear at the scheduled contested case hearing, as is set out in Finding of Fact Number 17, is an aggravating factor that should be considered when assessing the appropriate sanction for the Respondent's conduct. The Board finds that the appropriate sanction, based upon its Disciplinary Matrix and rules, is the revocation of the Respondent's license.

IT IS, THEREFORE, ORDERED THAT Permanent Certificate Number 690642, previously issued to MARSHALL INNO-CHYKE FINTAN, to practice nursing in the State of Texas be, and the same is hereby, REVOKED.

IT IS FURTHER ORDERED that Permanent Certificate Number 690642, previously issued to MARSHALL INNO-CHYKE FINTAN, upon receipt of this Order, be immediately delivered to the office of the Texas Board of Nursing.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multi-state privilege, if any, to practice nursing in the State of Texas.

Entered this 28<sup>th</sup> day of April, 2011.

TEXAS BOARD OF NURSING



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

# State Office of Administrative Hearings



Cathleen Parsley  
Chief Administrative Law Judge

December 23, 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

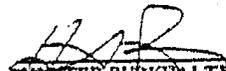
**RE: Docket No. 507-10-3554; In the Matter of Permanent Certificate  
Number 690642 Issued to Marshall Inno-Chyke Fintan**

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](http://www.soah.state.tx.us).

Sincerely,

  
HUNTER BURKHALTER  
ADMINISTRATIVE LAW JUDGE/MEDIATOR  
STATE OFFICE OF ADMINISTRATIVE HEARINGS

Hb/slc  
Enclosures

XC: Nikki Hopkins, TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 - VIA INTER-AGENCY  
Dina Flores, Legal Assistant TBN, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 - (with 1 CD;  
Certified Evidentiary Record) - VIA INTER-AGENCY  
Marshall Fintan, 5711 Silver Oak, Missouri City, TX 77459 - VIA REGULAR MAIL

IN THE MATTER OF § BEFORE THE STATE OFFICE  
PERMANENT CERTIFICATE §  
NUMBER 690642 § OF  
ISSUED TO §  
MARSHALL INNO-CHYKE FINTAN § ADMINISTRATIVE HEARINGS

**PROPOSAL FOR DECISION**

The staff of the Texas Board of Nursing (Staff/Board) brought this action seeking to impose disciplinary sanctions against Marshall Inno-Chyke Fintan (Respondent) based on allegations that he failed to meet the minimum standards in the Nursing Practice Act (Act)<sup>1</sup> and Board rules. Staff sought revocation of Respondent's license. The Administrative Law Judge (ALJ) finds that Staff proved the allegations against Respondent, but recommends lesser sanctions than license revocation.<sup>2</sup>

**I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY**

The parties did not challenge the issues of jurisdiction or notice. Those matters will be addressed in the findings of fact and conclusions of law.

On November 3, 2010, ALJ Hunter Burkhalter convened the hearing on the merits at the Austin office of the State Office of Administrative Hearings (SOAH). Staff was represented by Staff Attorney Nikki Hopkins. Respondent did not appear and was not represented at the hearing. The hearing adjourned the same day, and the administrative record was closed that day. Staff offered competent evidence establishing jurisdiction and that appropriate notice of the hearing was provided to Respondent.

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<sup>1</sup> TEX. OCC. CODE ch. 301.

<sup>2</sup> The Formal Charges against Respondent stated that Staff would also be seeking recovery of Staff's administrative costs, "in an amount of at least one thousand two hundred dollars (\$1,200.00)." However, at the hearing, Staff did not request recovery of those costs, nor did Staff present any evidence of costs. Accordingly, this Proposal for Decision does not recommend the recovery of costs.

## II. DISCUSSION

Pursuant to 1 TEX. ADMIN. CODE § 155.501, Staff moved for, and the ALJ grants, a default in this case. Accordingly, the factual allegations listed in Staff's notice of hearing are deemed admitted. Specifically, the following facts are deemed true:

- Respondent is a licensed registered nurse (RN), license number 690642, which is in current status.
- During the night of September 15, 2006 and the morning of September 16, 2006, while employed with Premier Staffing and on assignment with Memorial Hermann Southwest Hospital, in Houston, Texas, Respondent failed to report a change in status of Patient Medical Record Number 34308818 (the Patient) to the physician and charge nurse. The change in status included that, at 12:30 a.m., Respondent was unable to rouse the Patient and, at 2:00 a.m., the Patient exhibited hand jerking movements. Respondent's conduct was likely to injure the patient in that it may have delayed appropriate interventions to prevent increasing clinical complications, including possible patient demise.
- On the same date, Respondent failed to institute appropriate nursing interventions for the Patient until 6:15 a.m. when Patient was experiencing seizures, had an oxygen saturation level of 35%, and was described as blue. A code was called by the charge nurse and the patient was successfully resuscitated. Respondent's conduct unnecessarily delayed the Patient's emergent care and put the Patient at risk for demise.

Staff called Bonnie Cone to testify as to the appropriateness of the sanction sought. Ms. Cone is employed by the Board as a nursing consultant, and she has been a registered nurse for more than 20 years. Her testimony focused on the factors relevant to determining the sanction to be imposed in this case. She explained that the Patient's behavior, as reported by Respondent in the medical records -- exhibiting hand jerking movements and being unresponsive -- were indications that the Patient was experiencing an adverse reaction to medication. Ms. Cone testified that Respondent should have recognized these symptoms and intervened accordingly. Because Respondent failed to promptly intervene and notify others of these symptoms, the Patient's condition continued to deteriorate such that, by the time Respondent

notified others and intervention was initiated at 6:15 a.m., the Patient was having seizures, her oxygen saturation level (SAT) was at 35%,<sup>3</sup> and she had turned blue.

Ms. Cone testified to her belief that the Patient suffered actual harm due to the Respondent's violations. Specifically, Ms. Cone identified the harm as the fact that the Patient had to be mechanically ventilated and intubated. Ms. Cone also indicated that the patient was near death at the time intervention was initiated. Ms. Cone conceded that this was an isolated event. Staff conceded that the Patient was successfully resuscitated. Nevertheless, Ms. Cone repeatedly stressed that the "severity of the harm" suffered by the Patient was a key factor in her determination that Respondent's license should be revoked.

Ms. Cone offered the opinion that license revocation was justified pursuant to the Board's Disciplinary Matrix, found at 22 TEX. ADMIN. CODE §213.33(b). Specifically, Ms. Cone concluded that the sanction for Respondent was properly assessed, under the Disciplinary Matrix, as a "Third Tier Offense" at "Sanction Level I" for violations of TEX. OCC. CODE §§ 301.452(b)(10) and (13). As to the violation of Section 301.452(b)(10), she opined that the violation should be considered third tier because Respondent's failure to comply with a Board rule "resulted in serious patient harm." As to the violation of Section 301.452(b)(13), she asserted that the violation should be considered third tier because Respondent's actions carried a "serious risk of harm or death that is known or should be known." She did not explain why she considered the violations to be "Sanction Level I" violations.

Also admitted in evidence was a letter from Respondent to the Board in which he denied the charges against him.<sup>4</sup> In that letter, Respondent explains that the Patient was ultimately discharged from the hospital in "good condition" and with "no change in mentation [sic] to indicate cerebral damage that might have resulted from prolonged unoxxygenation [sic]."<sup>5</sup>

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<sup>3</sup> Ms. Cone explained that saturation levels should be in the 98% to 100% range.

<sup>4</sup> Staff Ex. 5.

<sup>5</sup> Staff Ex. 5 at 5.

### III. THE ALJ'S ANALYSIS AND RECOMMENDATION

Having deemed the facts alleged in the Notice of Hearing as true, the ALJ finds that Staff has proven violations of:

- TEX. OCC. CODE § 301.452(b)(10), by engaging in “unprofessional conduct” that “is likely to . . . injure a patient”; and
- TEX. OCC. CODE § 301.452(b)(13), by failing to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that . . . exposes a patient . . . unnecessarily to risk of harm;”

by Respondent, thereby warranting the imposition of sanctions against him. This does not, however, resolve all outstanding issues in the case. Rather, additional analysis must be undertaken to determine whether the sanction sought by Staff, license revocation, is warranted.

Pursuant to 22 TEX. ADMIN. CODE § 213.33(a), the Board and SOAH “shall” utilize the Board’s “Disciplinary Matrix” in “all disciplinary . . . matters.” That matrix is found as an attached graphic at 22 TEX. ADMIN. CODE § 213.33(b).

**A. Respondent’s actions constituted only a “second tier” violation of Section 301.452(b)(10)**

For violations of Section 301.452(b)(10), the matrix lists three possible “tiers” of offenses. A second tier offense is one that resulted in “serious risk to patient or public safety.” A third tier offense is one that resulted in “serious patient harm.” Ms. Cone opined that the violation in this case should be considered a third tier offense because Respondent’s failure to comply with a Board rule resulted in serious patient harm – *i.e.*, the Patient had to be mechanically ventilated and intubated. The ALJ disagrees. The evidence in this case demonstrates that only a second tier violation of Section 301.452(b)(10) occurred. That is, Respondent clearly created a serious *risk* of harm to the Patient. Fortunately, however, she did not suffer serious *actual* harm. There is no dispute that the Patient was successfully resuscitated.

There is also uncontradicted evidence in the record indicating that she was discharged from the hospital in good condition and with no lingering effects from the incident. The ALJ concludes that the discomfort imposed on the Patient by being ventilated and intubated does not constitute "serious patient harm." Indeed, the purpose of intubating and ventilating a patient is to *avoid* serious patient harm.

**B. Respondent's actions constituted a "third tier" violation of Section 301.452(b)(13)**

For violations of Section 301.452(b)(13), the matrix again lists three possible "tiers" of offenses. A third tier offense is one that carries a "serious risk of harm or death that is known or should be known." Ms. Cone opined that the violation should be considered a third tier offense. The ALJ agrees. The evidence demonstrates that Respondent created a serious *risk* of harm to the Patient, and should have known he was doing so.

**C. For his violations of Sections 301.452(b)(10) and (13), Respondent should be sanctioned at "Sanction Level I"**

Ms. Cone offered her opinion that, under the Disciplinary Matrix, Respondent's violations of Sections 301.452(b)(10) and (13) should be considered "Sanction Level I" violations. She did not, however, explain the basis for that conclusion. Nevertheless, support can be found elsewhere in the Board's rules. Pursuant to 22 TEX. ADMIN. CODE § 213.33(c), the Board and SOAH "shall" consider the following factors "in conjunction with the Disciplinary Matrix" when determining the sanction to be imposed upon a nurse, including when determining the "*sanction level*" under the Disciplinary Matrix:<sup>6</sup>

- 1) evidence of actual or potential harm to patients, clients, or the public;
- 2) evidence of a lack of truthfulness or trustworthiness;
- 3) evidence of misrepresentation(s) of knowledge, education, experience, credentials, or skills which would lead a member of the public, an employer, a member of the health-care team, or a patient to rely on the fact(s) misrepresented where such reliance could be unsafe;

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<sup>6</sup> Emphasis added.

- 4) evidence of practice history;
- 5) evidence of present fitness to practice;
- 6) evidence of previous violations or prior disciplinary history by the Board or any other health care licensing agency in Texas or another jurisdiction;
- 7) the length of time the licensee has practiced;
- 8) the actual damages, physical, economic, or otherwise, resulting from the violation;
- 9) the deterrent effect of the penalty imposed;
- 10) attempts by the licensee to correct or stop the violation;
- 11) any mitigating or aggravating circumstances;
- 12) the extent to which system dynamics in the practice setting contributed to the problem;
- 13) whether the person is being disciplined for multiple violations of the Act or its derivative rules and orders;
- 14) the seriousness of the violation;
- 15) the threat to public safety;
- 16) evidence of good professional character; and
- 17) any other matter that justice may require.

Each of these factors will be discussed in turn.

-- **Evidence of actual or potential harm to patients, clients, or the public**

There is ample evidence that Respondent's actions had the potential to cause serious harm, even death, to the Patient. Ms. Cone opined that the Patient was actually harmed by needing to be mechanically ventilated and intubated. Fortunately, these are harms of a minor and temporary nature, and the Patient did not suffer serious, lingering harm.

-- **Evidence of a lack of truthfulness or trustworthiness**

No allegation was made, or evidence produced, to suggest that Respondent behaved untruthfully.

- **Evidence of misrepresentation(s) of knowledge, education, experience, credentials, or skills which would lead a member of the public, an employer, a member of the health-care team, or a patient to rely on the fact(s) misrepresented where such reliance could be unsafe**

No allegation was made, or evidence produced, to suggest that Respondent behaved in this manner.

- **Evidence of practice history**

Staff conceded that this was an isolated event. There is no evidence of prior misbehavior by Respondent.

- **Evidence of present fitness to practice**

Outside of this event, there is no other evidence indicating unfitness to practice.

- **Evidence of previous violations or prior disciplinary history by the Board or any other health care licensing agency in Texas or another jurisdiction**

Staff conceded that this was an isolated event. There is no evidence of any prior disciplinary history by Respondent.

- **The length of time the licensee has practiced**

Respondent has been a licensed nurse since at least September 20, 2002.<sup>7</sup>

- **The actual damages, physical, economic, or otherwise, resulting from the violation**

As stated above, the Patient suffered the discomfort of having to be mechanically ventilated and intubated. Fortunately, these are harms of a temporary nature. She did not suffer serious, lingering harm. There are no allegations or evidence of economic harm.

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<sup>7</sup> Staff Ex. 1.

-- **The deterrent effect of the penalty imposed**

Certainly, if revocation is imposed, the deterrent effect upon Respondent will be complete, because he will be unable to practice as a nurse.

-- **Attempts by the licensee to correct or stop the violation**

The violations by Respondent were transitory in nature. His error lies in being insufficiently alert and responsive to the Patient's condition for several hours. He ultimately corrected or stopped the violation by reporting the Patient's condition to the appropriate authorities.

-- **Any mitigating or aggravating circumstances**

No additional circumstances, beyond those already discussed, were raised.

-- **The extent to which system dynamics in the practice setting contributed to the problem**

Because no evidence was introduced on this point, the ALJ will assume that system dynamics did not contribute to the problem.

-- **Whether the person is being disciplined for multiple violations of the Act or its derivative rules and orders**

The Respondent is being disciplined for a single event which the Staff contends constituted multiple violations of the Act and/or its derivative rules. However, because this proceeding relates only to a single event involving Respondent, the ALJ does not consider this factor as a reason to enhance to the sanction to be imposed.

-- **The seriousness of the violation**

Because it created a risk of serious harm to the Patient, this was a serious violation.

-- **The threat to public safety**

The violation itself did not create a threat to public safety (beyond the threat it posed to the Patient).

-- **Evidence of good professional character**

The evidence indicates that, but for this event, Respondent has been practicing as a registered nurse since at least late 2002 without incident.

-- **Any other matter that justice may require**

Staff is seeking license revocation, the most draconian of the sanctions it can impose. The ALJ is not convinced that such strong medicine is warranted. Staff did not present evidence demonstrating that Respondent is beyond reform as a nurse. Moreover, this is the first enforcement action against Respondent, a nurse who has apparently otherwise practiced without incident for at least eight years. Rather than revocation, the ALJ believes that imposition of a lesser array of sanctions is more appropriate. The violations committed by Respondent are of the type that might be avoided in the future if Respondent were subjected to lesser sanctions.

**D. Having concluded that Respondent committed a Section 301.452(b)(10), second tier, sanction level I violation, license revocation is not allowed for that violation.**

Pursuant to the Disciplinary Matrix, a second tier, sanction level I violation of Section 301.452(b)(10) should be punished as follows: "Warning or Reprimand with Stipulations which may include remedial education, supervised practice, and/or perform public service. Fine of \$250 or more for each violation." In other words, license revocation cannot be imposed.

- E. Having concluded that Respondent committed a Section 301.452(b)(13), third tier, sanction level I violation, license revocation, while allowed, is not warranted for that violation.

Pursuant to the Disciplinary Matrix, a third tier, sanction level I violation of Section 301.452(b)(13) should be punished as follows: "Denial, suspension of license; revocation of license or request for voluntary surrender." Thus, although license revocation can be imposed, it is not mandatory, and the lesser sanction of license suspension may be imposed. The ALJ concludes that revocation, the most punitive of possible sanctions, is not warranted based upon the evidence in the record.

In accordance with 1 TEX. ADMIN. CODE § 155.501, the ALJ grants Staff's motion for default, deems the facts contained within Board's Notice of Hearing admitted, and concludes that Respondent engaged in practices which were in violation of TEX. OCC. CODE §§ 301.452(b)(10) and (13). The ALJ recommends that Respondent's license not be revoked. Instead, the ALJ recommends that:

- Respondent's license be suspended for a period of one year; and
- Respondent be fined \$500.

### III. FINDINGS OF FACT

1. Marshall Inno-Chyke Fintan (Respondent) is a licensed registered nurse (RN), license number 690642, which is in current status.
2. On or about September 15 and 16, 2006, while employed with Premier Staffing and on assignment with Memorial Hermann Southwest Hospital, in Houston, Texas, Respondent failed to report a change in status of Patient Medical Record Number 34308818 (the Patient) to the physician and charge nurse. The change in status included that, at 12:30 a.m., Respondent was unable to rouse the Patient and, at 2:00 a.m., the patient exhibited hand jerking movements. Respondent's conduct was likely to injure the patient in that it may have delayed appropriate interventions to prevent increasing clinical complications, including possible patient demise.

3. On the same dates, Respondent failed to institute appropriate nursing interventions for the Patient until 6:15 a.m. when patient was experiencing seizures, had an oxygen saturation level of 35%, and was described as blue. A code was called by the charge nurse and the patient was successfully resuscitated. Respondent's conduct unnecessarily delayed the Patient's emergent care and put the Patient at risk for demise.
4. The Patient was successfully resuscitated and was ultimately discharged from the hospital in good condition.
5. By the actions described above, Respondent engaged in unprofessional conduct that was likely to injure a patient.
6. By the actions described above, Respondent failed to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that exposed a patient unnecessarily to a risk of harm.
7. Respondent's actions created a serious risk of harm to a patient.
8. Respondent's actions did not result in serious patient harm.
9. Respondent's actions at issue in this case were an isolated incident of improper behavior on his part.
10. Respondent has been licensed as a registered nurse since at least September 20, 2002.
11. This is the only enforcement proceeding ever pursued against Respondent.
12. On April 8, 2010, Staff served its Notice of Hearing and Formal Charges (NOH) on Respondent at 3110 Dogwood Knoll Trail, Rosenberg, Tx 77471, by certified mail, return receipt requested. This is the address shown as the last known address of Respondent per the records of the Board.
13. Respondent timely received the NOH.
14. The NOH 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.
15. The NOH contained the following language in at least 12-point boldface type: "Failure to appear at the hearing in person or by legal representative, regardless of whether an appearance has been entered, will result in the allegations contained in the formal charges being admitted as true and the proposed recommendation of staff shall be granted by default."

16. The NOH set forth that the Board was seeking revocation of Respondent's license.
17. The hearing on the merits was held on November 3, 2010, at the Austin office of the State Office of Administrative Hearings (SOAH). Staff was represented by Staff Attorney Nikki Hopkins. Respondent did not appear and was not represented at the hearing. The hearing adjourned and the administrative record was closed that day.
18. Following the admission of evidence establishing proper jurisdiction and notice, Staff moved for a default, which is granted.

#### IV. CONCLUSIONS OF LAW

1. The Texas Board of Nursing (Board) has jurisdiction over the discipline of licensed nurses in Texas. TEX. OCC. CODE ch. 301.
2. The State Office of Administrative Hearings (SOAH) has jurisdiction to conduct hearings and issue a proposal for decision in this matter. TEX. GOV'T CODE ch. 2003.
3. Notice given by Staff of the Board (Staff) to Respondent was sufficient under law. TEX. GOV'T CODE §§ 2001.051 and 2001.052.
4. Pursuant to 1 Tex. Admin. Code § 155.501, the failure of Respondent to appear at the hearing on the merits entitled the Board to have the facts in the NOH deemed admitted and to the declaration of default against Respondent.
5. Based on the above Findings of Fact, Respondent violated TEX. OCC. CODE § 301.452(b)(10), by engaging in unprofessional conduct that was likely to injure a patient.
6. Based on the above Findings of Fact, Respondent violated TEX. OCC. CODE § 301.452(b)(13), by failing to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that exposed a patient unnecessarily to risk of harm.

7. Based on the above Findings of Fact and Conclusions of Law, and based upon the factors listed in 22 TEX. ADMIN. CODE § 213.33, including the Board's Disciplinary Matrix, the Board should issue an order:
- Suspending Respondent's license for a period of one year; and
  - Fining Respondent \$500.

SIGNED December 23, 2010.



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HUNTER BURKHALTER  
ADMINISTRATIVE LAW JUDGE/MEDIATOR  
STATE OFFICE OF ADMINISTRATIVE HEARINGS