IN THE MATTER OF	§	BEFORE THE ELIGIBILITY
	§	
PERMANENT CERTIFICATE	§	AND DISCIPLINARY
	§	
NUMBER 194250	§	COMMITTEE
	§	
ISSUED TO	§	OF THE TEXAS
	§	
MICHAEL DANIEL SMITH	§	BOARD OF NURSING

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.

Executive Director of the Board

ORDER OF THE BOARD

TO: Michael Daniel Smith
2604 Midland Ave.
Syracuse, New York 13205

During open meeting held in Austin, Texas, on February 8, 2011, the Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee of the Texas Board of Nursing finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, chapter 301 of the Texas Occupations Code, for retention of Respondent's license to practice vocational nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Eligibility and Disciplinary Committee, after review and due consideration, adopts the

proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by reference for all purposes and the Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN.CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

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

NOW, THEREFORE, IT IS ORDERED that Permanent Certificate Number 194250, previously issued to MICHAEL DANIEL SMITH, to practice vocational nursing in the State of Texas be, and the same is hereby, REVOKED.

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

Entered this 8th day of February, 2011.

TEXAS BOARD OF NURSING

BY: _____

KATHERINE A. THOMAS, MN, RN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

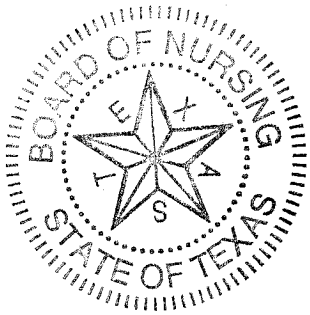
Attachment: Formal Charge filed October 6, 2010.

Re: Permanent Certificate Number 194250
Issued to Michael Daniel Smith
DEFAULT ORDER -REVOKE

CERTIFICATE OF SERVICE

I hereby certify that on the 11th day of February, 2011, a true and correct copy of the foregoing DEFAULT ORDER was served by placement in the U.S. Mail via certified mail, and addressed to the following person(s):

Michael Daniel Smith
2604 Midland Ave.
Syracuse, New York 13205



BY: Katherine A. Thomas

KATHERINE A. THOMAS, MN, RN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Texas Board of Nursing

333 Guadalupe Street, Ste. 3-460, Austin, Texas 78701
Phone: (512) 305-7400 Fax: (512) 305-7401 www.bon.state.tx.us

Katherine A. Thomas, MN, RN
Executive Director

October 11, 2010

Certified Mail No. 91 7108 2133 3938 2192 9777
Return Receipt Requested

Michael Daniel Smith
2604 Midland Ave.
Syracuse, New York 13205

Dear Mr. Smith:

Enclosed are Formal Charges which have been filed against you alleging one or more violations of Section 301.452(b) of the Nursing Practice Act, Texas Occupations Code. Within three weeks of the date of this letter, you must file a written answer to each charge admitting or denying each allegation. If you intend to deny only part of an allegation, you must specify so much of it as is true and deny only the remainder. Your answer shall also include any other matter, whether of law or fact, upon which you intend to rely for your defense. Please send your written answer to the attention of James S. Smelser, Investigator. You may obtain legal counsel at your own expense.

FAILURE TO FILE A WRITTEN ANSWER TO THE FORMAL CHARGES, EITHER PERSONALLY OR BY LEGAL REPRESENTATIVE, WILL RESULT IN THE ALLEGATIONS CONTAINED IN THE FORMAL CHARGES BEING ADMITTED AS TRUE AND THE PROPOSED RECOMMENDATION OF STAFF WILL BE GRANTED BY DEFAULT.

Please be advised that should you fail to file a written answer, the case will proceed on a default basis and it will be staff's recommendation that a default order be entered revoking your license(s) and/or nurse licensure compact privilege(s) to practice nursing in the State of Texas.

The results of any default order or formal disposition (Board Order) are public information. Results of informal and formal dispositions will appear in the Board's newsletter under the heading of "Disciplinary Action."

Should you desire to discuss this matter, you may contact James S. Smelser, Investigator, Enforcement Division, at the above address, or at (512) 305-6831.

Sincerely,

Katherine A. Thomas, MN, RN
Executive Director

KAT/jss

Enclosure: Formal Charges

09/99-DA

Members of the Board

Linda Rounds, PhD, FNP, RN
Galveston, *President*

Deborah Bell, CLU, ChFC Abilene
Kristin Benton, MSN, RN Austin
Patricia Clapp, BA Dallas
Tamara Cowen, MN, RN Harlingen
Sheri Crosby, JD, SPHR Dallas
Marilyn Davis, BSN, RN, MPA Sugar Land
Bianca Rosa Garcia, PhD, RN Corpus Christi
Richard Gibbs, LVN Mesquite
Kathy Leader-Horn, LVN Granbury
Josefina Lujan, PhD, RN El Paso
Beverley Jean Nutall, LVN Bryan
Mary Jane Salgado, MEd Eagle Pass

In the Matter of Permanent License	§	**BEFORE THE TEXAS**
Number 194250, Issued to	§	
MICHAEL DANIEL SMITH, Respondent	§	**BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, MICHAEL DANIEL SMITH, is a Vocational Nurse holding license number 194250, which is in current status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about April 14, 2010, while holding a license as a Vocational Nurse in the State of Texas, Respondent was issued a Final Order, Agency Case No. 09-062, by the Oregon State Board of Nursing and the Office of Administrative Hearings, State of Oregon, OAH Case No. 900954, wherein Respondent's license to practice practical nursing, 200730026LPN, in the State of Oregon was Revoked. A copy of the April 14, 2010 Final Order is attached and incorporated, by reference, as part of this Charge.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to revocation of Respondent's license to practice nursing in the State of Texas pursuant to the Board's rules, 22 TEX. ADMIN. CODE §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1200.00).

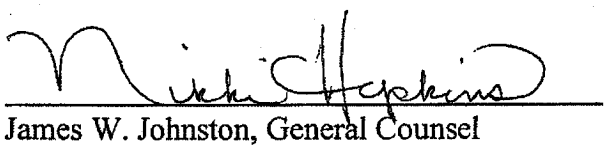
NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.state.tx.us.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.state.tx.us/disciplinaryaction/discp-matrix.html.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order which is attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Final Order by the Oregon State Board of Nursing and the Office of Administrative Hearings, State of Oregon dated April 14, 2010.

Filed this 6th day of October, 2010.

TEXAS BOARD OF NURSING



James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Renee Koslan Abel, Assistant General Counsel
State Bar No. 24036103
Lance Robert Brenton, Assistant General Counsel
State Bar No. 24066924
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
Nikki Hopkins, Assistant General Counsel
State Bar No. 24052269
John F. Legris, Assistant General Counsel
State Bar No. 00785533
TEXAS BOARD OF NURSING
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6824
F: (512) 305-8101 or (512)305-7401

Attachments: Final Order by the Oregon State Board of Nursing and the Office of Administrative Hearings, State of Oregon dated April 14, 2010.

0999/D

BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF OREGON
for the
OREGON STATE BOARD OF NURSING

IN THE MATTER OF:	) **FINAL ORDER**
	)
MICHAEL DANIEL SMITH	) OAH Case No.: 900954
	) Agency Case No.: 09-062

HISTORY OF THE CASE

On September 9, 2008, the Oregon State Board of Nursing issued a Notice of Proposed Suspension of Practical Nurse License and properly served it on the respondent, Michael Daniel Smith, LPN. The Board entered an Interim Order by Consent on October 2, 2008, prohibiting the respondent from practicing as an LPN pending further order. The Board then issued a Notice of Proposed Revocation of Practical Nurse License on February 12, 2009, and properly served it on the respondent.[1] The respondent filed a response February 26, 2009.[2]

The Board referred the matter to the Office of Administrative Hearings on March 5, 2009. Administrative Law Judge Monica Whitaker conducted a prehearing conference on May 28, 2009, memorializing that proceeding by letter issued the same day. Administrative Law Judge Stephen H. Elmore (ALJ Elmore) conducted a hearing at the Board's office in Tualatin on September 24, 2009. The respondent participated in the hearing by telephone, representing himself and testifying on his own behalf. He called no other witnesses. Assistant Attorney General Joanna Tucker Davis represented the Board. Sonja Melcher, Rick McAdams, Sheryl Nicholson, and Kimberly Wood appeared as witnesses for the Board. The record closed at the conclusion of the hearing, September 24, 2009.

On October 27, 2009, ALJ Elmore issued a proposed order, which was considered in issuing this Amended Proposed Order. On March 10, 2010, the Board issued an Amended Proposed Order, which has been incorporated into this Final Order. On March 12, 2010, the Board served a copy of its Amended Proposed Order on Respondent. Respondent did not file exceptions.

This Final Order does not change the recommended sanction of revocation. This Final Order does not change the historical facts found by ALJ Elmore. It does supplement the facts in

---

[1] The respondent argued at the hearing that the Board had never served the Notice of Proposed Revocation on him. The notice was mailed to his record address at the time, however, and the signature on the return receipt appears to be the same as the respondent's signature on his response to the notice, so I conclude that the respondent was properly served the notice.

[2] Although the response does not specifically request a hearing, the Board's attorney confirmed at the hearing that the Board was accepting the response as the respondent's hearing request.

the Proposed Order with additional findings of fact. This Final Order also modifies the Opinion section of the proposed order by adding discussion and conclusions regarding additional violations, as well as deleting a sentence in the Proposed Order on Respondent's theft of drugs from prior employers. The Board has made other changes to clarify or correct spelling, grammar, textual placement, or other similar errors.

ISSUES

1. Whether Respondent's conduct during his shift on August 19, 2008 was grossly incompetent, grossly negligent, or both, and constituted conduct derogatory to the standards of nursing in violation of ORS 678.111(1) (b), (f) and OAR 851-045-0070(1) (b), (c), (l); (2) (b); (4) (b).

2. Whether from February 2007 to on or about October 2008, Respondent diverted narcotic medications from his places of employment, in violation of ORS 678.111(1)(b),(f),(g) and OAR 851-045-0070(2)(f),(i).

3. Whether the Respondent lied to the Board regarding his diversion of narcotic medications, in violation of ORS 678.111(1) (f), (g) and OAR 851-045-0070(7) (b).

4. Whether Respondent had a physical or mental condition that makes the licensee unable to safely conduct his duties as a Practical Nurse, in violation of ORS 678.111(1) (e), (f), (g) and OAR 851-045-0070(5) (b).

5. Whether Respondent used controlled substances or intoxicating liquor in a manner to that impairs his ability to safely practice as a Practical Nurse, in violation of ORS 678.111(1)(e),(f),(g) and OAR 851-045-0070(5)(c).

6. Whether Respondent's license should be revoked.

EVIDENTIARY RULING

The respondent objected to the admission of Exhibits A1 through A13, offered by the Board, on the ground that they had not been served on him. The exhibits were mailed 20 days before the hearing and were mailed to the record address the respondent had given at the prehearing conference. The objection therefore was overruled and the exhibits were admitted. The respondent offered no exhibits.

FINDINGS OF FACT

The following findings of fact were in the Proposed Order and have not been changed in this Final Order:

1. Michael Daniel Smith has held Oregon Practical Nurse License number 200730026 since February 2007. He also is licensed as a vocational nurse in Texas. (Test. of Smith; Ex. A13.)

2. On August 19, 2008, the respondent was the nurse-in-charge of the night shift at the north wing of Care Center East, an assisted living and residential care facility in Portland, Oregon. He was responsible for attending some 30 residents of the facility. Among his nursing duties were administering intravenous and other medications, tube-feeding residents, flushing the feeding tubes, testing blood sugars, and documenting the completion of each task on the residents' charts. (Test. of Smith, Nicholson; Ex. A4.)

3. If diabetic patients do not have timely blood-sugar checks, they risk going into diabetic shock. Patients whose pain medications are not administered on time need more time for subsequent doses to "catch up," and thereby risk increased blood pressure and heart rates. Patients whose intravenous antibiotics are not administered run a greater risk of infection. (Test. of Melcher.)

4. On the night of August 19, the respondent did not carry out his job duties. The approximately 30 residents on his wing comprised a normal population, and no emergency incident occurred that would have altered the usual work-patterns of that shift. Nevertheless, the respondent failed to tube-feed three residents, failed to flush their tubes, and failed to give them water. He failed to administer intravenous antibiotics to two residents, failed to administer pain medications to two others, and failed to check the blood sugar of a diabetic resident. (Test. of Melcher, Nicholson, Smith; Exs. A4, A11.)

5. The respondent reported to the daytime nurse-in-charge that he had failed to complete many of the tasks. She asked him whether his inaction had been due to an emergency, but he said it had not. He had no other explanation for her, however, and included nothing in his scant documentation on the patient records that suggested an explanation. One of the nurses who relieved him that morning previously had worked the night shift at the same wing of the facility, and had had no problem completing all the assigned tasks. The respondent had no explanation for her, either, telling her only that he had done the best he could. (Test. of Melcher, Nicholson.)

The following are additional findings of fact, supplementing those found in the Proposed Order, made to fully and adequately set forth material evidence in the record:

1. On June 2, 2007, while working at Sheridan Care Center, Respondent reported that a box of Fentanyl patches had been tampered with and showed his supervisor an opened box of Fentanyl patches. Three Fentanyl patches were missing from the box in question. (A2).

2. On June 17, 2007, at Fern hill Estates, a Fentanyl patch was found missing after a shift worked by Respondent. It appeared that someone had tampered with the box containing the Fentanyl patches. Respondent's coworkers reported his behavior during the shift as "strange" and "bizarre." (A2).

3. When questioned by Board investigators on August 13, 2007 regarding these incidents, Respondent denied taking the Fentanyl patches at Sheridan Care Center or Fernhill Estates. Respondent further denied using cannabis, cocaine, prescription drugs or alcohol. Because of Respondent's statements to the Board, the investigation into the incidents was closed. (A2).

4. On September 28, 2008, Respondent left a note at Gleason Care Center that stated, "I Michael Smith come to make apology for stealing meds. I want to make amends face to face, but I can't come in Monday. I apologize. Mike Smith." (Testimony of Smith, Wood; A6, A7).

4. On October 2, 2008, Respondent was interviewed by Investigator Kimberly Wood as a result of an investigation into the August 19, 2008 incident at Care Center East. During that interview, Respondent admitted to stealing medications from Gleason Care Center, Fernhill Estates, Sheridan Care Center and Care Center East while working as a nurse at the various centers. Respondent stated that he was addicted to drugs, including Oxycodone, Hycomine, Fentanyl and Percocet. Respondent admitted to lying to the Board investigators on August 13, 2007 when he denied stealing the Fentanyl patches and using drugs and drinking. Respondent appeared to be under the influence of drugs at the interview. (Testimony of Wood; A6).

5. On October 27, 2008, Respondent was diagnosed as having Alcohol Dependence, Opioid Abuse and Bipolar Disorder. Respondent began treatment on November 3, 2008, but Respondent failed to follow through with the recommended treatment, denying that it was needed. His treatment providers described him as having "irregular thought patterns that had persecutory themes." (A10).

6. During the investigation, Respondent missed appointments, showed up at the Board when appointments were not scheduled, appeared to be impaired by alcohol or drugs, and expressed paranoid and bizarre thoughts. (Testimony of Wood, A6, A12).

7. During his testimony at the hearing on September 24, 2009, Respondent denied having any addictions and stated he was not in treatment for his addictions. He testified that he was not taking any medications or under active medical care for his Bipolar Disorder, but rather was treating it through diet and exercise. Respondent at the hearing expressed paranoid and bizarre thoughts, including that that there was a conspiracy against him by a local chapter of Alcoholic Anonymous, that included threatening him physically and taking his child away from him, moving his car while he was at work, and infiltrating his medical records. He said his statements to Investigator Wood at his October 2, 2008 interview regarding diversion and his addictions were not true and he was forced to say them by Alcoholics Anonymous. (Testimony of Respondent).

CONCLUSIONS OF LAW

1. Respondent's conduct during his shift on August 19, 2008 was grossly incompetent, grossly negligent, or both, and constituted conduct derogatory to the standards of nursing in violations of ORS 678.111(1) (b) & (1) (f).

OPINION

Respondent's conduct on August 19, 2008[3]

According to the pertinent provisions of ORS 678.111(1), a person's license to practice nursing may be revoked:

> for any of the following causes:
>
> * * * * *
>
> (b) Gross incompetence or gross negligence of the licensee in the practice of nursing at the level for which the licensee is licensed.
>
> * * * * *
>
> (f) Conduct derogatory to the standards of nursing.

"Gross incompetence" and "gross negligence" are not specifically defined by the statute or by the administrative rules adopted by the Board of Nursing, but "conduct derogatory to the standards of nursing" is defined by the provisions of OAR 851-045-0070. The relevant provisions of the rule include the following:

> Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:
>
> (1) Conduct related to the client's safety and integrity:
>
> * * * * *
>
> (b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment.
>
> (c) Failing to develop, implement and/or follow through with the plan of care.
>
> * * * * *

[3] The following discussion is, for the most part, unchanged from the Proposed Order. Where it has been modified, it is indicated by footnote.

(l) Failing to respect the dignity and rights of clients, regardless of social or economic status, age, race, religion, sex, sexual orientation, national origin, nature of health needs, or disability.

* * * * *

(2) Conduct related to other federal or state statute/rule violations:

* * * * *

(b) Neglecting a client. The definition of neglect includes but is not limited to carelessly allowing a client to be in physical discomfort or be injured.

* * * * *

(4) Conduct related to achieving and maintaining clinical competency:

* * * * *

(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

In this case, the respondent's conduct during his shift on August 19 was grossly incompetent, grossly negligent, or both. It was unquestionably derogatory to the standards of nursing.

The respondent was the nurse-in-charge for some 30 residents and it was his duty to attend to them. Providing food and water to those under his care were fundamentally part of his duties, yet the respondent failed to tube-feed three residents, failed to flush their tubes, and failed to give them water. He failed to administer intravenous antibiotics to two residents, causing them to run a greater risk of infection. He failed to administer pain medications to two others residents, obviously leaving them in greater pain, and leaving them at greater risk of increased blood pressure and heart rates. He failed to check the blood sugar of a diabetic resident, leaving the resident at a greater risk of going into diabetic shock.

The respondent did not explain at the time, and could not explain in the hearing, why he had failed to carry out his duties to those in his care. He testified that he felt "overwhelmed," but as a licensed practical nurse, he could not credibly explain why he had been overwhelmed when another nurse who had worked that shift had never had difficulty completing the duties of caring for the same resident population. The respondent then testified that he had been interrupted that night by a police call that took him three hours to deal with, but the record includes no evidence that he previously had even mentioned such an event. The respondent had ample opportunity to describe a police-call interruption to the nurses who succeeded him at the end of his shift, and he had ample opportunity to tell investigators about any such occurrence. He said nothing, however, until the hearing. The respondent's testimony was not credible.

The record suggests, but does not establish, that the respondent might have failed to complete his duties that night because of drug use.[4] The lack of evidence was largely due to the respondent himself, whose inconsistent, evasive, and illogical answers so scrambled the evidence that few hard conclusions could be drawn. What is clear, however, is that the respondent—for whatever reason—failed to carry out his duties. If he failed to do so because he was under the influence of drugs, that clearly would constitute gross negligence in the performance of his duties. If he failed to do so and was not under the influence, that clearly would constitute gross incompetence in the performance of his duties.

The distinction between gross negligence and gross incompetence need not be drawn, however, because the respondent's conduct was so completely derogatory to the standards of nursing. His conduct violated a number of the provisions of OAR 851-045-0070. Specifically, he failed "to take action to preserve or promote the client's safety" and to "follow through with the plan of care," thus violating the provisions of subsection (1), paragraphs (b) and (c). He failed "to respect the dignity and rights of clients," by failing to provide care, thus violating the provisions of subsection (1), paragraph (l). He violated the provisions of subsection (2), paragraph (b) by neglecting a number of clients. He failed "to conform to the essential standards of acceptable and prevailing nursing practice," by failing to perform his assigned duties, thus violating the provisions of subsection (4), paragraph (b).

Without credible explanation, the respondent engaged in "[c]onduct derogatory to the standards of nursing," and thus violated the provisions of ORS 678.111(1) (b) and (f).

This conduct, standing alone, as found in the Proposed Order, justifies revocation of Respondent's license. However, the Board also finds that he has committed further violations of the Board's statutes and rules.

Diversion

These actions are in direct violation of ORS 678.111(1)(b),(f),(g) and OAR 851-045-0070(2)(f),(i), which prohibits the unauthorized removal of narcotics or other drugs from the workplace as well as possessing and obtaining prescription or controlled drugs. The record shows that Fentanyl patches were missing during shift that Respondent worked at Sheridan Care Center on June 2, 2007 and Fernhill Estates on June 17, 2007. On October 28, 2008, Respondent left a note at Gleason Care Center apologizing for stealing medications. Respondent, in his interview with Investigator Wood on October 2, 2008, against his own interests, admitted to stealing medications from both of these centers as well as two other centers. Respondent also admitted to being addicted to a number of medications and illicit drugs. Respondent's explanation at the hearing for making these statements that he was forced to lie by Alcoholics Anonymous, was not credible. Respondent was diagnosed with Opioid Abuse. Respondent's erratic behavior with the Board, at the hearing, and during the night of August 19, 2008 are consistent with his diagnoses and his statements to Investigator Wood that he stole medications

[4] In the Proposed Order, this paragraph began with the following sentence: "The Board alleged that the respondent had stolen medications from previous institutions at which he had worked, but the record did not include sufficient evidence to support such a conclusion." As will be discussed and explained in sections below, this Final Order presents a different analysis and conclusion regarding this issue.

at these facilities. His admissions to stealing Fentanyl and other drugs from his workplace, and the corroborating evidence of the reports from Fernhill Estates, Sheridan Care Center, the note he left at Gleason Care Center, his diagnosis of Opioid dependence and his erratic behavior, all show that he diverted and used medications from his places of employment from February 2007 to on or about October 2008.

False Statements to the Board

Lying to the Board during an investigation is prohibited under ORS 678.111(1) (f), (g) and OAR 851-045-0070(7) (b). In his August 13, 2007 interview with Board investigators Respondent denied using drugs or alcohol and diverting medications from his workplace. In his October 2, 2008 interview with Investigator Wood, he admitted that he lied in his August 13, 2007 interview and that he was abusing a number of different narcotics and had stolen drugs from his workplace. These statements are directly in conflict; one must be a lie. At the hearing, Respondent stated that the statements to Investigator Wood were untrue and that he made those statements because he was forced to do so by a local chapter of Alcoholics Anonymous. This defense is not credible or persuasive. The Board finds that Respondent was untruthful in his August 13, 2007 interview in violation of Board's statutes and rules.

Untreated Addictions and Bipolar Disorder

Respondent's untreated addictions and untreated Bipolar Disorder are physical and mental conditions that impair his ability to safely practice in violation of ORS 678.111(1) (e), (f), (g) and OAR 851-045-0070(5) (b), (c). Respondent was diagnosed with Alcohol Dependence, Opioid Abuse and Bipolar Disorder. Respondent's actions from 2007 through the hearing, his erratic behavior, paranoid statements, neglect of duties, and diversion of narcotics are consistent with these diagnoses and evidence of how these untreated diagnoses render him unsafe to practice. Respondent has refused to attend treatment for his addictions and as of the hearing refused to admit to his addictions and was not taking medication or under active care for his Bipolar Disorder. As a result, Respondent cannot safely practice as a Practical Nurse.

SANCTION

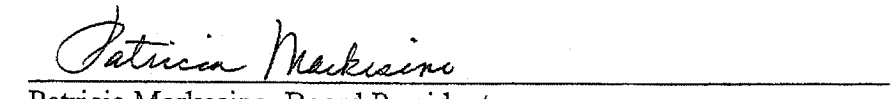
Respondent has committed multiple violations of the Board's statutes and rules. Respondent has shown that he is not able to safely practice as a Practical Nurse. Respondent's actions on the night of August 19, 2008 standing alone would be grounds for revocation. In addition, Respondent has lied to the Board, diverted drugs from his workplaces, and shown that he cannot safely practice as a licensed Practical Nurse. The Board therefore has determined that his practical nurse license should be revoked.

ORDER

On the basis of the foregoing, **IT IS HEREBY ORDERED** that the Oregon Practical Nurse License of the respondent, Michael Daniel Smith, license number 200730026LPN, is revoked.

Dated this 14 day of April 2010.

FOR THE BOARD OF NURSING
STATE OF OREGON



Patricia Markesino, Board President

APPEAL

If you wish to appeal the Final Order, after it is issued, you must file a petition for review with the Oregon Court of Appeals within 60 days after the Final Order is served upon you. *See* ORS 183.480 et seq.