

DOCKET NUMBER 507-10-3803

IN THE MATTER OF
PERMANENT CERTIFICATE
NUMBER 654171
ISSUED TO
JERRIE LYNN WEINSTEIN

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BEFORE THE STATE OFFICE
OF
ADMINISTRATIVE HEARINGS



Patricia P. Thomas
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: JERRIE LYNN WEINSTEIN
C/O JEFFREY C. GRASS, ATTORNEY
101 EAST PARK BLVD., SUITE 600
PLANO, TX 75074

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 27-28, 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 Jerrie Lynn Weinstein 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, with the exception of Conclusion of Law Number 14, which is not adopted by the Board because it is not a proper conclusion of law. All

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

Conclusion of Law Number 14

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 a conclusion of law. 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. 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. 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 14 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 believes that disciplinary action in this matter is warranted based upon the adopted Findings of Fact and Conclusions of Law Numbers 4-11 and 13. Although the Board agrees with the ALJ that the Respondent should receive a Reprimand with Stipulations, the ALJ's recommendation fails to include several probationary stipulations that are necessary for the Board to properly monitor the Respondent's practice, including employer notification and quarterly reporting. The imposition of reasonable probationary stipulations, such as employer notification and quarterly reporting, is authorized by 22 Tex. Admin. Code §213.33(b) and (e)(4) in disciplinary matters involving the issuance of a Reprimand. Further, it is the Board's policy and precedent to require such probationary stipulations in its monitoring orders where the supervised practice of a nurse is required. As such, the Board declines to adopt Conclusion of Law Number 14, as it is not consistent with the Board's rules, policies, and prior administrative decisions in this regard.

IT IS THEREFORE ORDERED that RESPONDENT SHALL receive the sanction of a REPRIMAND WITH STIPULATIONS AND 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.

IT IS FURTHER ORDERED that:

(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 "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.

(3) RESPONDENT shall pay a monetary fine in the amount of five hundred (\$500) dollars within forty five (45) 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 AGREED, 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 ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

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

(5) 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.

(6) RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(7) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT's capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) months for one (1) year 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 January, 2011.

TEXAS BOARD OF NURSING

Katherine A. Thomas

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

Attachment: Proposal for Decision; Docket No. 507-10-3803 (August 13, 2010).

DOCKET NO. 507-10-3803

IN THE MATTER OF PERMANENT § BEFORE THE STATE OFFICE
CERTIFICATE NUMBER 654171 § OF
ISSUED TO JERRIE LYNN WEINSTEIN § ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff of the Texas Board of Nursing (Staff/Board) seeks disciplinary sanctions against Registered Nurse (RN) Jerrie Lynn Weinstein (Respondent), based on allegations that Respondent spoke rudely to a patient and forcibly placed the patient back into a wheelchair. Staff alleges that Respondent's conduct exposed the patient unnecessarily to a risk of emotional, psychological and/or physical harm and thus violated sections 301.452(b)(10) and (13) of the Nursing Practice Act¹ and Board rules found at 22 TEX. ADMIN. CODE § 217.11(1)(A) and (B), and § 217.12(1)(A), (B), (4) and (6)(C).² The Administrative Law Judge (ALJ) agrees with Staff's request for disciplinary sanctions, and recommends that that Board: issue a reprimand with stipulations including the taking and passing of courses (within a one-year period from the Board order) in: (a) nursing jurisprudence and (b) long-term care abuse and neglect training; require Respondent, for a one-year period following the Board order, to be subject to indirect supervision by another RN; and impose an administrative penalty of \$500.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

On June 17, 2010, ALJ Pratibha J. Shenoy convened the hearing on the merits at the Austin office of the State Office of Administrative Hearings (SOAH). Assistant General Counsel Lance R. Brenton represented Staff, and attorney Jeffrey C. Grass represented Respondent. The hearing adjourned and the record closed the same day. The parties did not raise any issues of jurisdiction or notice. Those matters will be addressed in the findings of fact and conclusions of law.

¹ TEX. OCC. CODE ch. 301.

² For convenience, the Board's rules found at 22 Tex. Admin. Code ch. 217 are referred to as "Rule 217.xx."

II. FACTUAL BACKGROUND

A. Staff's Evidence

The charges at issue in this case arise out of events that occurred on August 19, 2009, when Patient Medical Record Number 6887 (the Patient) was being treated at Renaissance Park Multi-Care Center in Forth Worth, Texas (Renaissance Park). Respondent began working at Renaissance Park in June 2009. Staff presented the testimony of two witnesses, and offered eight exhibits, all of which were admitted without objection.

Testimony of Vicki Watson. From August 14 to September 2, 2009, Vicki Watson received inpatient care at Renaissance Park for a relapse of multiple sclerosis.³ When she took walks through the facility, she stopped at a nurses' station two or three times to talk to the Patient. The Patient had limited mobility and sat in a "hospital chair" that was placed by the nurses' station because she would cry if she felt anxious or alone. The Patient responded favorably when Ms. Watson occasionally touched the Patient's arm or stroked her hair. The nurses, according to Ms. Watson, were pleased that the Patient responded to Ms. Watson, since it could be difficult to keep the Patient calm. Ms. Watson said talking to the Patient was similar to speaking to a young child, noting that the Patient had limited mental capacity.⁴

On August 19, 2009, Ms. Watson was seated in the dining room eating lunch when she heard the Patient yell, "don't touch me" from about 25 feet away. Ms. Watson stood up and saw Respondent place her hands on the Patient's shoulders and push the Patient into her wheelchair. As Ms. Watson walked over, the Patient repeated, "stop touching me" in an agitated tone. When Ms. Watson was about 15 feet away, the Patient rose from her wheelchair again and turned towards Respondent. With a "forceful motion," Respondent "picked the Patient up, turned her, and pushed her down into the chair again," saying loudly, "sit down." Although she is not sure that the Patient was actually lifted off the ground by Respondent, Ms. Watson felt that Respondent must have taken some action of that sort in order to put the Patient back in her

³ On the hearing date, Ms. Watson was at home recuperating from an unrelated surgery, and testified by telephone.

⁴ Although none of the witnesses stated the Patient's age, they described her at various times as "elderly."

wheelchair, given the angle at which Respondent and the Patient were standing. Ms. Watson tried to comfort the Patient, but noted that the Patient became "withdrawn," took a hunched position in her wheelchair, and told Ms. Watson, "I don't want to talk to you right now."

After lunch, Ms. Watson was at an appointment with Renaissance Park's speech therapist, Stephanie Easter, and told Ms. Easter about Respondent's interaction with the Patient. Ms. Easter told Ms. Watson she could submit an "incident report" to Renaissance Park management.⁵ Ms. Watson had no prior negative interactions with Respondent.

Testimony of Stephanie Easter. Ms. Easter has worked as a speech therapist at Renaissance Park for three years. When Ms. Watson told her of the interaction between Respondent and the Patient and said she would fill out an incident report, Ms. Easter went to retrieve a blank form for Ms. Watson. As she walked down the hallway near the nurses' station, Ms. Easter saw the Patient rising from her wheelchair. Respondent grabbed the Patient's shoulders, twisted her around, and pushed her back down into the wheelchair while pointing a finger in the Patient's face and scolding her.

Ms. Easter was sufficiently "stunned" that she "stopped in her tracks" 10 to 15 feet away. As soon as Respondent noticed Ms. Easter, Respondent displayed "a complete change in demeanor and expression," switching from "angry and irritated" to "consoling and comforting." Respondent stroked the Patient's back and smiled at Ms. Easter. The Patient was crying out and clearly upset. Ms. Easter did not speak to Respondent or to the Patient, but later made a report to Renaissance Park's assistant director of nursing. Prior to this incident, Ms. Easter had not interacted with Respondent.

The Patient had come to Ms. Easter previously for speech therapy sessions. Ms. Easter noted that the Patient was "very weak" and was a "little bitty lady," probably weighing less than 100 pounds. The Patient never exhibited threatening behavior, and had just had her trachea tube

⁵ Respondent's counsel objected that Staff had failed to provide him with a copy of Ms. Watson's incident report. Although Ms. Watson said that she had prepared the report and provided it to Renaissance Park management, Staff stated that it did not have a copy of the report in its possession and did not seek to rely on the report for any purpose.

removed a couple of days earlier. Although the Patient was able to stand, she probably could not do so safely. To Ms. Easter's knowledge, the Patient was receiving treatment to recover from a stroke, and had a limited attention span; she frequently "rambled on" and needed to be redirected to stay focused during speech therapy sessions. Rather than a loud or commanding tone, Ms. Easter found that a calm demeanor elicited the best response from the Patient.

Although she felt that Respondent used "excessive" force, Ms. Easter acknowledged on cross-examination that she is unfamiliar with the standards of care applicable to nurses. She also stated that she did not observe any physical harm to the Patient as a result of the interaction with Respondent. Ms. Easter does not know if any other staff witnessed the incident, but to her knowledge, no other staff members complained to management about Respondent.

B. Respondent's Evidence

Respondent has held her RN license since 1997. She has worked as a managing RN at a correctional facility for adolescent boys, in nursing home and hospice environments, and she has approximately 11 years of "off and on" experience with elder care. On or about June 24, 2009, Respondent began working at Renaissance Park. As a charge nurse, Respondent primarily worked shifts on the facility's upper level, where she cared for residential patients. Respondent also worked two or three shifts on the lower level, where the patient population included more Medicare patients and psychiatric patients. The lower level patients were more lucrative for the facility, Respondent stated, but they were often more difficult to handle.

Respondent testified that staffing was insufficient on the lower level, with three certified nursing assistants (CNAs) and one RN caring for 20 patients. Medicare has complex paperwork requirements, so the RN working on the lower level had a more difficult load to handle. Respondent was sent to work on the lower level because a nurse on the lower level "insisted on moving to the upper level." Nurses who had a choice did not want to work on the lower level.

The Patient, according to Respondent, was about 5 feet 9 inches tall, weighed 130 pounds or more, and was not frail. She could walk with guidance, but her balance was weak and her gait

unsteady. The Patient was often seated seven to eight feet away from the nurses' station in a "geriatric chair," which was a "large pink recliner" with straps. Respondent noted that the straps were not used, as doctor's orders were required before "any type of restraint" could be used on a patient. Although Respondent thought the straps should have been used, she noted that most facilities "prided themselves" on not using restraints. The Patient was on what Respondent termed a "very low dose" of anti-psychotic medication.

On August 19, 2009, Respondent began caring for the Patient around 1:00 p.m., after the Patient attended a therapy session. The Patient was "screaming, yelling at people who tried to help her," and kept rising from the geriatric chair and "hanging from the banister" to make her way down the hallway. In Respondent's view, the Patient was having a "full psychotic episode." Respondent asked other staff for help but was not given assistance. She walked the Patient to her room and put her in her bed.

The Patient's room had a "low bed," a specialized hospital bed no more than six inches off the ground, which is used for patients who are restless or agitated and at risk of falling. Respondent had been told by other nurses that Patient frequently rolled out of her bed and also tried to leave her room. Respondent said she telephoned the Patient's family and asked unsuccessfully for permission to use "hip protectors" on the Patient to avoid fractures when the Patient rolled out of bed. When a doctor came to do rounds, Respondent noted that the Patient was refusing to take her oral medication and asked if a different medication could be prescribed, but the doctor stated that he had just begun a new medication for the Patient and would not change it at that time. Respondent reiterated her concerns to the Director of Nursing (DON), telling the DON that the Patient was "out of control." The DON said that she would speak with the doctor about the medication.

When therapy staff walked by the Patient's room and saw her rolling out of bed, they repeatedly brought the Patient to the nurses' station and would "park her there for me to watch." As a result, Respondent was required to monitor the Patient at the nurses' station as well as carry out her duties with respect to the remaining patients under her care.

At the time Ms. Watson observed the reported interaction with the Patient, Respondent noted that the hallway was quite busy, with doctors, the Director of Nursing, the facility Administrator, CNAs, and other staff walking through, staff reporting for the next shift, and patients exiting the dining room. The environment was "loud" and "somewhat chaotic," so Respondent spoke loudly to be heard over the background noise, and used an "authoritative tone" to get the Patient's attention.

Respondent denied touching the Patient "in any way that would hurt her." Rather, when the Patient got up from the geriatric chair, Respondent would "hold my hand out for her to grab," and would support the Patient back to the chair. The Patient would "flop back down" into the chair, which Respondent speculates could have made an onlooker think that Respondent pushed the Patient down into the chair. In her written answer to the Board's Formal Charges, Respondent stated, "I never touched this patient and took no action that was likely to injure her or exposed her unnecessarily to a risk of experiencing emotional, psychological, and/or physical harm."⁶ At hearing, Respondent maintained that her testimony was consistent, noting that she did not touch the patient, but held her hand out so that the Patient could initiate the contact.

When Renaissance Park management told Respondent that she had been accused of patient abuse, Respondent "had no idea what they were talking about." The Administrator and Director of Nursing suspended Respondent on August 19, 2009, and called her in a few days later when an internal investigation had concluded. Respondent said that she was not told the details of the alleged abuse but was told her employment was terminated, effective August 24, 2009. The Director of Nursing "apologized for setting me up for failure," according to Respondent, and also said that the "therapy department should have helped" with the Patient and that "changes would be made" in the future.

Respondent acknowledged that she was "annoyed" that Renaissance Park management had allowed another nurse to "take my spot" so that Respondent had to "work downstairs," but she denied that she was in an angry or annoyed state of mind during her shift. She also admitted

⁶ Staff Ex. 5.

on cross-examination that the Patient's "low dose" of medication for schizophrenia was prescribed by the doctor using his expertise, but stated that she is aware of standard and acceptable dosage levels and did not believe the Patient was adequately medicated. Given how much attention the Patient required, Respondent was not able to care for other patients and felt she was asked to do more than was safe under the circumstances.

Respondent believes that Ms. Watson misperceived the events, and that Ms. Easter embellished her account. Respondent has osteoarthritis and physically could not pick up the Patient, even if she weighed 100 pounds or less. In fact, Respondent has hand pain and has difficulty cutting her own food with a fork and knife. Despite her pain, she tries to "work smartly," asking others to lift heavy objects, and using tools to help her do her job, such as hooks designed to turn patients.

Respondent emphasized that she is well aware of patient rights, the right to be treated with dignity and the required standards of care. She agreed that if the events had occurred as described by Ms. Watson and Ms. Easter, the actions would constitute patient abuse, but firmly denied those accounts of her behavior.

III. STAFF'S CHARGES AND REQUESTED SANCTION

A. Staff's Charges

Staff alleges that Respondent violated the following provisions of the Nursing Practice Act and Board Rules:

- **Nursing Practice Act §§ 301.452(b)(10) and (13).** It is grounds for disciplinary action if a nurse engages in unprofessional conduct that is likely to injure a patient or fails to care adequately for a patient or conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient to risk of harm.
- **Rule 217.11(1)(A).** This Rule requires nurses to know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal,

state, or local laws, rules or regulations affecting the nurse's current area of nursing practice.⁷

- Among the rights of the elderly under the Texas Human Resources Code are the right to be "treated with dignity and respect for the personal integrity of the individual," including "the right to be free from physical and mental abuse." **TEX. HUM. RES. CODE § 102.003(b)-(c).**
- **Rule 217.11(1)(B).** This Rule requires nurses to implement measures to promote a safe environment for clients and others.
- **Rule 217.12(1)(A), (B), (4) and (6)(C).** Rule 217.12 addresses unprofessional conduct. Nurses are prohibited from: carelessly or repeatedly failing to practice in accordance with the minimum acceptable level of nursing standards set out in Rule 217.11; carelessly or repeatedly failing to conform to generally accepted nursing standards; careless or repetitive conduct that may endanger a client's life, health, or safety (no actual injury to a client need be established); and causing or permitting physical, emotional or verbal abuse or injury or neglect to the client or the public.

B. Requested Sanctions

Bonnie Cone, RN, has over 20 years of experience as a nurse, and currently serves as a Nursing Consultant for Practice to the Board.⁸ As part of her duties, she advises nurses, members of the public, and the Board on nursing practice issues and interpretations of Board rules. Based on her education and experience, Ms. Cone was recognized by the ALJ as an expert on the Board's rules and the Nursing Practice Act.

In preparation for this hearing, Ms. Cone reviewed basic textbooks for nurse education with respect to the care of patients with schizophrenia, and also reflected on her own experience caring for such patients. In her research and in her experience, Ms. Cone testified that a calm

⁷ The ALJ notes that the Board's Formal Charges (Staff Ex. 4 at 00006) do not specify a violation of this Rule, raising the possibility of a notice defect. However, Respondent did not object to testimony by Board witness Bonnie Cone on this Rule, thereby waiving any notice defect. Staff asked the ALJ to take administrative judicial notice of chapter 102 of the Texas Human Resources Code, which pertains to the rights of the elderly, and noted that Respondent should have been aware of and complied with the provisions contained therein. Respondent did not object, other than suggesting a written closing argument might be more appropriate to allow for a detailed response to the proffered statute (the parties subsequently agreed to oral closing arguments).

⁸ Ms. Cone's *curriculum vitae* is contained in Staff's Ex. 7.

approach is best with schizophrenic patients, since assertiveness can act as “fuel on the fire” and further agitate the patient. She also noted that the role of a nurse is to “redirect” a patient. Only in certain circumstances, as set forth in a facility’s policies and procedures, should any physical force be used. Ms. Cone described this kind of force as a “take down” in layman’s terms, and said it would be used only if there is a risk of imminent harm to the nurse, other patients, or staff. In contrast, physical force to put a patient back in a wheelchair is clearly not required.

After reviewing the case file for this docket, hearing the testimony of the witnesses, and consulting the Board’s matrix of penalty provisions found at 22 TEX. ADMIN. CODE § 213.33(b) (the Disciplinary Matrix), Ms. Cone developed Staff’s requested sanction. In so doing, Ms. Cone also considered the factors set forth at 22 TEX. ADMIN. CODE § 213.33(c). Ms. Cone noted that although Respondent’s behavior is serious, it is the first time Respondent has been charged with a violation. It is Ms. Cone’s belief that nurses such as Respondent can learn from a reprimand and can be “retrained” to resume their professional careers.

Staff seeks the following sanctions:

1. A reprimand with stipulations from the Board, which include the taking and passing of courses (within a one-year period from the Board order) in: (a) nursing jurisprudence and (b) long-term care abuse and neglect training.
2. A requirement that Respondent, for a one-year period following the Board order, be subject to indirect supervision by another RN.
3. An administrative penalty.⁹

In its formal charges, Staff also asked that Respondent be required to pay the costs of the proceeding in an amount of “at least \$1,200.00.” As part of that amount, Staff sought to recover the cost of producing witnesses, reproduction of records, Staff time, travel, and expenses. After the ALJ adjourned the hearing and closed the record, Staff sought to reopen the record to offer its Ex. 8, Affidavit of Estimated Administrative Costs. Respondent’s counsel did not object to the record being reopened or to the admission of Staff’s Ex. 8.

⁹ Staff did not set forth a penalty amount in its pleadings, and Ms. Cone did not specify that amount in her testimony. Based on the disciplinary matrix, the ALJ infers that Staff seeks an administrative penalty of \$500.

That exhibit sets forth \$323 in various witness expenses, but attaches no receipts or other documentation of costs. Moreover, the exhibit states, "documentary evidence supporting the final amount of costs incurred by the Texas Board of Nursing will be submitted prior to the closing of the record in this matter." The ALJ closed the record again immediately after admitting Staff's Ex. 8 into the record, and Staff made no further submissions. Accordingly, the ALJ finds that Staff did not provide adequate evidence of the costs incurred and declines to recommend the imposition of administrative costs.

IV. ANALYSIS AND RECOMMENDATIONS

The parties presented two sharply divergent accounts of the events of August 19, 2009. The resolution of this case rests on an evaluation of the credibility of the witnesses. The ALJ found Ms. Watson's testimony to be sincere, detailed and credible. Standing alone, however, there is a possibility that Ms. Watson's testimony is based on a misperception or a misunderstanding of Respondent's interactions with the Patient.

The credible and convincing testimony of Ms. Easter supports Ms. Watson's perceptions. In addition, Ms. Easter witnessed a separate incident from the one Ms. Watson saw, but Ms. Easter's observations were similar to and consistent with those made by Ms. Watson. It is significant that Ms. Easter, who has worked at Renaissance Park for three years, was sufficiently taken aback by what she saw that she "stopped in her tracks." Although she is not a nurse and does not know the standards of practice for nursing, Ms. Easter is a healthcare professional and has worked with other professionals at Renaissance Park for several years, observing numerous patient-staff interactions. Her reaction indicates that she observed something out of the ordinary.

Respondent's testimony, on the other hand, was inconsistent and less credible. She said that she was "annoyed" that she had to work on the lower level, and felt that she was asked to do more than was safe. Her demeanor when she described the stressful working conditions displayed frustration and irritation. Her aggravation with the Patient was clear from her description of the Patient as "having a full psychotic episode" and being "out of control." Respondent clearly felt that the Renaissance Park staff were not adequately medicating the

Patient, and she resented the lack of assistance from other staff, noting that she made numerous requests for help that went unanswered. She noted that the therapy staff would repeatedly bring the Patient to the nurses' station and would "park her there for me to watch." Despite these statements, Respondent denied that she was in an annoyed or angry mood during her shift and during her interactions with the Patient.

In her written response to the Formal Charges, Respondent clearly states, "I never touched this patient"; at hearing, she argued that the Patient touched Respondent's outstretched hand, and thus her testimony was consistent. This hair-splitting with respect to the contact only serves to undermine Respondent's credibility.

The actions that Ms. Watson and Ms. Easter observed on Respondent's part involved noticeable force. Ms. Watson acknowledged that she could not be sure that Respondent lifted the Patient off the ground, but she described Respondent using forceful gestures and a loud voice that clearly upset the patient. Ms. Easter saw Respondent grab the Patient's shoulders, twist the Patient around, and push her back into the chair while pointing a finger in the Patient's face and scolding her. These credible accounts are inconsistent with the Respondent's assertion that the Patient would "flop down" in her chair, possibly giving the impression of being pushed.

Respondent seems to imply that her own infirmities, such as osteoarthritis, would prevent her from acting in the forceful manner the other witnesses described. However, Respondent's claim that she has trouble even cutting food with a fork and knife begs the question of how Respondent could discharge her duties, including repeatedly supporting the weight of the Patient holding onto her arm to go back to the wheelchair.

Particularly striking is Ms. Easter's observation that when Respondent realized Ms. Easter was in the hallway, Respondent displayed "a complete change in demeanor and expression," switching from "angry and irritated" to "consoling and comforting." Respondent's next actions, of stroking the Patient's back and smiling at Ms. Easter, indicate that Respondent herself knew she was acting inappropriately and was troubled that her actions had been seen.

Respondent's description of the Patient's appearance and behavior contrasts significantly with that of the other witnesses. Ms. Easter, who worked directly with the Patient in speech therapy sessions, said that the Patient was probably less than 100 pounds, very weak, and was a "little bitty lady." Ms. Watson's account supports this description of the Patient, since Ms. Watson indicated that Respondent was able to lift or move the Patient forcefully. All of the witnesses referred to the Patient as "elderly." However, Respondent alleged that the Patient was 5 feet 9 inches tall, weighed 130 pounds or more, and was not frail.

Ms. Watson and Ms. Easter both found that a calm demeanor worked to engage the Patient's attention, and Ms. Cone testified that the textbook approach for treating schizophrenic patients is to use a calm approach. Respondent asserted in her written response to the Formal Charges that in her experience, "at times, schizophrenic patients have trouble responding to and understanding commands unless they are made assertively." At hearing, Respondent said that she used a loud voice because of the background noise and to get the Patient's attention. Either way, Ms. Cone noted that, on the basis of her review of basic nurse education texts and her own experience treating schizophrenic patients, an assertive manner may add "fuel to the fire" and further agitate the patient.

Importantly, there is no evidence that either Ms. Watson or Ms. Easter had any prior history with Respondent that would motivate them to falsify their accounts of Respondent's actions. No evidence indicates that either Ms. Watson or Ms. Easter stood to gain from their testimony. In addition, there is no evidence that other staff found Respondent's actions to be reasonable or appropriate. Indeed, the DON and Administrator suspended Respondent immediately and shortly thereafter terminated her employment, indicating that they took the behavior very seriously.

Respondent clearly had a difficult working environment, one that her colleagues avoided if possible. She was understandably stressed by the lack of assistance, despite her repeated requests. Respondent needed to spend quite a bit of time and attention caring for the Patient, which reduced the time available to address the needs of other patients. It is likely that the

Patient's behavior of repeatedly rising from the chair, in the midst of what Respondent described as a chaotic and loud environment, would be frustrating to Respondent.

None of these factors, however, mitigates the fact that Respondent was seen by credible witnesses to be treating a patient in a manner that fell short of minimum standards of nursing practice and exposed a patient to a risk of emotional or physical harm. Respondent, whatever the circumstances of her work, had a duty to meet the requirements of the Nursing Practice Act and the Board rules. If she felt the work environment demanded more from her than she could safely provide, Respondent was responsible for removing herself from the situation.

Based on the totality of the evidence, the ALJ finds that Staff proved, by a preponderance of the evidence, that Respondent violated Nursing Practice Act §§ 301.452(b)(10) and (13) and Board Rules 217.11(1)(B) and 217.12(1)(A), (B), (4) and (6)(C).¹⁰

The Board and the ALJ are to consider the factors set forth at 22 TEX. ADMIN. CODE § 213.33(c)¹¹ in determining an appropriate penalty or sanction. Having reviewed those factors, the ALJ agrees with Staff's requested sanction. Specifically, the evidence shows that whether or

¹⁰ As discussed above, Ms. Cone testified that Respondent's behavior constituted a violation of Rule 217.11(1)(A), which requires a nurse to know and conform to "all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice." As support for the violation, Staff asked the ALJ, and the ALJ agreed, to take administrative judicial notice of chapter 102 of the Texas Human Resources Code, pertaining to the rights of the elderly. The ALJ finds that Staff did not establish a violation of Rule 217.11(1)(A), because Staff failed to demonstrate that Respondent's behavior would constitute a violation of the Texas Human Resources Code. Behavior that violates standards set forth in the Nursing Practice Act with respect to the treatment of clients may or may not constitute abuse of the elderly or a failure to treat an elderly person with the required dignity and respect under the Human Resources Code. The statutes are not necessarily identical in their scope.

¹¹ Those factors are: (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; (4) evidence of practice history; (5) evidence of present fitness to practice; (6) whether the person has been subject to previous disciplinary action by the Board or any other health care licensing agency in Texas or another jurisdiction and, if so, the history of compliance with those actions; (7) the length of time the person 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, including those specified in the Disciplinary Matrix; (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 Nursing Practice 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 as set forth and required by 22 TEX. ADMIN. CODE § 213.27 (relating to Good Professional Character); and (17) any other matter that justice may require.

not actual harm can be established, Respondent's actions put the Patient at risk of emotional and/or physical harm. Respondent's actions indicate a lack of trustworthiness, as she failed to care properly for a patient who had limited mobility, limited mental capacity, and was recovering from a stroke. In her favor, Respondent has practiced since 1997 in a variety of settings without any evidence of a governing body taking disciplinary action against her. It should also be considered that the working environment of the "lower level" at Renaissance Park may have presented considerable challenges to Respondent; her testimony is uncontroverted with respect to the difficulty of obtaining needed help. Finally, Ms. Cone opined that nurses such as Respondent can learn from a reprimand and can be retrained to resume their careers. A reprimand, administrative penalty, and education with indirect supervision can serve to correct Respondent's behavior, as well as deter her and others from similar behavior in the future.

V. FINDINGS OF FACT

1. Jerrie Lynn Weinstein (Respondent) is a registered nurse (RN) and has been licensed since 1997.
2. On June 24, 2009, Respondent began working as a charge nurse at Renaissance Park Multi-Care Center in Forth Worth, Texas (Renaissance Park).
3. On August 19, 2009, Respondent began caring for Patient Medical Record Number 6887 (the Patient) at approximately 1:00 p.m.
4. The Patient is elderly and has limited mental capacity. The Patient was recuperating from a stroke and had limited mobility. While she could stand and walk, her balance and gait was unsteady and she was at risk of injury from falling.
5. The Patient was kept in a "geriatric chair" near a nurses' station because she would cry when she felt anxious or alone. The Patient had been diagnosed with schizophrenia and was being given medication for her condition.
6. The Patient responded favorably to conversation and touch from another patient, Vicki Watson.
7. The Patient also responded favorably to a calm approach from Stephanie Easter, a speech therapist at Renaissance Park.
8. Nursing practice textbooks recommend a calm tone and demeanor, rather than an assertive or commanding approach, for interactions with schizophrenic patients.

9. On August 19, 2009, Ms. Watson was eating lunch when she heard the Patient yell, "don't touch me" from about 25 feet away. Ms. Watson stood up and saw Respondent place her hands on the Patient's shoulders and push the Patient into her wheelchair.
10. When Ms. Watson was about 15 feet away, the Patient rose from her wheelchair again and turned towards Respondent. With a forceful motion, Respondent turned the Patient and pushed her down into the wheelchair again, saying loudly, "sit down."
11. Patient became withdrawn, took a hunched position in her wheelchair, and told Ms. Watson, "I don't want to talk to you right now."
12. Ms. Watson reported Respondent's behavior to Renaissance Park management.
13. Later that day, Ms. Easter was walking near the nurses' station when the Patient tried to rise from her wheelchair. Respondent grabbed the Patient's shoulders, twisted her around, and pushed her back down into the wheelchair while pointing a finger in the Patient's face and scolding her.
14. When Respondent noticed Ms. Easter, Respondent's demeanor and expression changed from angry and irritated to consoling and comforting. Respondent stroked the Patient's back and smiled at Ms. Easter. The Patient was crying out and clearly upset.
15. Ms. Easter reported Respondent's behavior to Renaissance Park's assistant director of nursing.
16. Neither Ms. Watson nor Ms. Easter had any prior negative interactions with Respondent or any motive to falsify their statements.
17. The testimony of Ms. Watson and Ms. Easter was credible, convincing, sincere, and consistent.
18. On August 19, 2009, Respondent made several requests to other staff for assistance with the Patient. Respondent did not receive the requested help.
19. Respondent's working environment was stressful. She was asked to do more than may have been safe under the circumstances.
20. On August 19, 2009, Renaissance Park management suspended Respondent to investigate allegations of patient abuse. On August 24, 2009, Respondent's employment at Renaissance Park was terminated.
21. There is no evidence that Respondent has been subjected to previous disciplinary actions by the Board or any other body with disciplinary authority.
22. Staff of the Texas Board of Nursing (Staff/Board) did not offer evidence to support the imposition of this proceeding's administrative costs on Respondent.

23. On December 11, 2009, Staff filed Formal Charges against Respondent, alleging that her actions on August 19, 2009, constituted violations of applicable law because her conduct was likely to injure the Patient in that it exposed the Patient unnecessarily to a risk of experiencing emotional, psychological and/or physical harm.
24. On April 23, 2010, Staff issued its Notice of Hearing, which: provided ten days' notice of the time, date, and place of the hearing; stated the legal authority and jurisdiction under which the hearing was to be held; referenced the particular sections of the statutes and rules involved; and set forth a short, plain statement of the matters asserted.
25. On June 17, 2010, Administrative Law Judge (ALJ) Pratibha J. Shenoy convened the hearing on the merits at the Austin office of the State Office of Administrative Hearings (SOAH). Assistant General Counsel Lance R. Brenton represented Staff, and attorney Jeffrey C. Grass represented Respondent. The hearing adjourned and the record closed the same day.

VI. 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 (the Nursing Practice Act).
2. The State Office of Administrative Hearings (SOAH) has jurisdiction to conduct hearings in this matter and to issue a proposal for decision with findings of fact and conclusions of law. TEX. GOV'T CODE ch. 2003.
3. Notice given by Board Staff (Staff) to Respondent was sufficient under the applicable law. TEX. GOV'T CODE §§ 2001.051 and 2001.052.
4. The Board may take disciplinary action against a nurse for "unprofessional or dishonorable conduct that, in the Board's opinion, is likely to . . . injure a patient" TEX. OCC. CODE § 301.452(b)(10).
5. The Board may take disciplinary action against a nurse for failing to "care adequately for a patient or to conform to the minimum standards of acceptable nursing practice . . . in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm." TEX. OCC. CODE § 301.452(b)(13).
6. Nurses must implement measures to promote a safe environment for clients and others. 22 TEX. ADMIN. CODE § 217.11(1)(B).
7. Nurses are prohibited from carelessly or repeatedly failing to practice in accordance with the minimum acceptable level of nursing standards set out in 22 TEX. ADMIN. CODE § 217.11. 22 TEX. ADMIN. CODE § 217.12(1)(A).

8. It is a violation of Board rules for a nurse to carelessly or repeatedly fail to conform to generally accepted nursing standards in applicable practice settings. 22 TEX. ADMIN. CODE § 217.12(1)(B).
9. Nurses may be subject to discipline for careless or repetitive conduct that may endanger a client's life, health, or safety (no actual injury to a client need be established). 22 TEX. ADMIN. CODE § 217.12(4).
10. It is a violation of Board rules for a nurse to cause or permit physical, emotional or verbal abuse or injury or neglect to a client or the public. 22 TEX. ADMIN. CODE § 217.12(6)(C).
11. Based on the Findings of Fact, on August 19, 2009, Respondent violated minimum standards of nursing practice and exposed a patient in her care to the risk of harm. Specifically, Respondent's treatment of Patient Medical Record Number 6887 (the Patient): was unprofessional and likely to injure the Patient; failed to care adequately for the Patient and to conform to the minimum standards of acceptable nursing practice in a manner that exposed the Patient unnecessarily to risk of harm; failed to promote a safe environment for the Patient; failed to meet the minimum acceptable level of nursing standards set out in 22 TEX. ADMIN. CODE § 217.11; failed to conform to generally accepted nursing standards in the practice setting; endangered the Patient's health or safety; and caused physical, emotional or verbal abuse or injury or neglect to the Patient.
12. Based on the Findings of Fact, administrative costs of this proceeding should not be imposed on Respondent.
13. Based on the above Findings of Fact and Conclusions of Law, Respondent violated sections 301.452(b)(10) and (13) of the Nursing Practice Act and Board rules found at 22 TEX. ADMIN. CODE § 217.11(1)(B) and § 217.12(1)(A), (B), (4) and (6)(C).
14. Based on the above Findings of Fact and Conclusions of Law, and based upon the factors referenced in 22 TEX. ADMIN. CODE § 213.33, the Board should: issue Respondent a reprimand with stipulations including the taking and passing of courses (within a one-year period from the Board order) in (a) nursing jurisprudence and (b) long-term care abuse and neglect training; require Respondent, for a one-year period following the Board order, to be subject to indirect supervision by another RN; and impose an administrative penalty of \$500.

SIGNED August 13, 2010.


PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS