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

**DOCKET NUMBER 507-10-0097**

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| **IN THE MATTER OF** | § | **BEFORE THE STATE OFFICE** |
| **PERMANENT CERTIFICATE** | § | |
| **NUMBER 672401** | § | **OF** |
| **ISSUED TO** | § | |
| **JEFFREY E. DURBIN** | § | **ADMINISTRATIVE HEARING** |

## OPINION AND ORDER OF THE BOARD

TO: JEFFREY E. DURBIN
C/O ELIZABETH HIGGINBOTHAM
HIGGINBOTHAM & ASSOCIATES, LLC
106 E. 6th STREET, SUITE 900
AUSTIN, TX 78701

HIGGINBOTHAM & ASSOCIATES, LLC
1100 NW LOOP 410, SUITE 500
SAN ANTONIO TX 78213

ANNE K. PEREZ
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 Jeffrey E. Durbin 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. Staff timely filed exceptions to the PFD.

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, with the exception of Conclusion of Law Number 7, 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 7

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. 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 declines to adopt the ALJ's conclusion that disciplinary action is not warranted in this matter. The Board believes that disciplinary action in this matter is warranted based upon the adopted Findings of Fact and Conclusion of Law Number 5. The Board finds that the ALJ erred in applying applicable law and the Board's rules, written policies, and prior administrative decisions in formulating her recommendation. Based upon applicable law, the Board's rules, policies, and prior administrative decisions, the Board finds that the Respondent should be required to complete remedial education courses and pay an administrative fine.

The ALJ finds that the Respondent violated the Nursing Practice Act, as is set out in the adopted Findings of Fact. Despite these findings, however, the ALJ recommends that the Board take no action against the Respondent. This recommendation is inconsistent with Board rules and written policies. Once a violation of the Nursing Practice Act or Board rules has been established, 22 Tex. Admin. Code §213.33 requires the Board and the State Office of Administrative Hearings to utilize the Board's Disciplinary Matrix to determine the appropriate disciplinary sanction. Although the Board does not disagree that the presence

of mitigating factors outweigh the presence of aggravating factors in this matter, as is set forth in Conclusion of Law Number 6, the Board does not agree that some level of disciplinary action is not warranted. After considering the mitigating factors outlined in the adopted Findings of Fact, the Board finds that the Respondent's conduct, as outlined in Conclusion of Law Number 5, warrants the lowest level of sanction provided for by 22 Tex. Admin. Code §213.33(b). The Board also finds that the ALJ's recommended sanction ignores its rules, written policies, particularly the Board's Disciplinary Sanctions for Lying and Falsification, and prior administrative decisions, and sends a message to applicants that there is no consequence for being untruthful when completing an application for licensure in Texas. The Board finds this to be unacceptable. As such, the Board finds that the Respondent's conduct warrants remedial education and an administrative fine. Further, this sanction is consistent with the Board's prior administrative decisions involving similar fact patterns.

Corrective Actions

To the extent that the ALJ discussed or commented on the availability and propriety of issuing a corrective action in this matter, the Board re-iterates that 22 Tex. Admin. Code §213.32(4) specifically states that "the opportunity to enter into an agreed corrective action is at the sole discretion of the Executive Director and is not available as a result of a contested case proceeding." The Board finds the ALJ's discussion of the imposition of a corrective action in this matter in conjunction with the testimony of the Board's Lead Nurse Practice Consultant to be improper and misplaced. The Board explicitly precluded the State Office of Administrative Hearings from considering the issuance of a corrective action in a disciplinary matter in its adopted rules. The Board rejects any conclusions or statements

made by the ALJ in the PFD regarding corrective actions, and such statements are not to be considered Board precedent or policy.

IT IS THEREFORE ORDERED that RESPONDENT SHALL receive the sanction of REMEDIAL EDUCATION WITH A FINE, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

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

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

IT IS FURTHER ORDERED that:

(1) RESPONDENT SHALL deliver the wallet-sized license(s) issued to JEFFREY E. DURBIN to the office of the Texas Board of Nursing within ten (10) days of the date of ratification of this Order.

(2) 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 <u>not</u> 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*.

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in "Detecting and Preventing Abuse and Neglect ...," a five (5) contact hour workshop presented in various locations by the Texas Department of Aging and Disability Services. In order to receive credit for completion of this workshop, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this workshop to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. Information regarding this workshop may be found at the following website: *http://www.dads.state.tx.us/providers/Training/jointtraining.cfm* or by contacting (512) 438-2201.

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in "Resident Rights and Quality of Life," a 6.0 contact hours 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.

(5) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program 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 web address: *http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary*.

(6) RESPONDENT SHALL pay a monetary fine in the amount of two hundred fifty dollars ($250). RESPONDENT SHALL pay this fine 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 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, MN, RN
EXECUTIVE DIRECTOR FOR THE BOARD

Attachment: Proposal for Decision; Docket No. 507-10-0097 (June 7, 2010).

SOAH DOCKET NO. 507-10-0097

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|---|---|---|
| IN THE MATTER OF PERMANENT CERTIFICATE NO. 672401 ISSUED TO JEFFREY E. DURBIN | § § § § § § § | BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS |

# PROPOSAL FOR DECISION

Staff of the Texas Board of Nursing (Staff/Board) brought action against Jeffrey E. Durbin (Respondent) for violating the Texas Occupations Code § 301.452[1] and 22 TEX. ADMIN. CODE (TAC) § 217.12 by providing false or misleading information in a license application filed with the Board. Staff sought to impose disciplinary action against Respondent, consisting of remedial education and an administrative penalty. Staff also urged that the Board's final order in this case be appended with the state of Kansas' final administrative determination against Respondent's nurse aide certificate. This proposal for decision recommends that no disciplinary action against Respondent's license be taken.[2]

## I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The hearing convened April 7, 2010, before ALJ Anne K. Perez in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by R. Kyle Hensley, Assistant General Counsel. Respondent was represented by Elizabeth L. Higginbotham. The record closed at the conclusion of the hearing that day.

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[1] TEX. OCC. CODE ANN. (Code, Nursing Practice Act or Act) § 301.452.

[2] Because the Administrative Law Judge (ALJ) recommends no sanctions against Respondent in the instant case, this decision does not address the propriety of appending Kansas' administrative findings to the Board's order. It is noted, however, that the requested sanction was not noticed to Respondent prior to the hearing. Whether the Board has authority to impose such a sanction is not clear. It is also noteworthy that the Kansas' administrative findings resulted from a default proceeding as opposed to a hearing on the merits.

Matters concerning notice and jurisdiction were undisputed. Those matters are therefore addressed in the Findings of Fact and Conclusions of Law without further discussion here.

## II. REASONS FOR DECISION

### A. Background

Respondent is licensed as a registered nurse. On April 10, 2009, Staff sent Respondent notice that it had filed Formal Charges against him on April 9, 2009. On September 8, 2009, Staff sent Respondent it's Notice of Hearing.

### B. Staff's Charges

Staff alleged that Respondent's Application for Initial Licensure by Examination (Application), filed with the Board on June 23, 2000, provided false, deceptive, and/or misleading information, in that Respondent attested he had never had disciplinary action taken against him by any governmental authority in any country, state or province. Staff alleged Respondent's attestation was false because on September 19, 1992, the Kansas Department of Health and Environment confirmed an administrative finding of abuse against Respondent's nurse aide credentials in that state. According to Staff, Respondent's actions constitute grounds for disciplinary action in accordance with Code § 301.452(b)(2)(8) and (10) and 22 TAC § 217.12(6)(I).

### C. Legal Standards

Code Chapter 301 regulates professional and vocational nurses. The Board may take disciplinary action against a nurse's license if the person engages in fraud or deceit in procuring a license to practice professional nursing;[3] engages in "unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public,"[4] or, if the

[3] Code § 301.452(b)(2).

[4] Code § 301.452(b)(10).

person's license to practice nursing has been subject to disciplinary action in another jurisdiction.[5] The definition of unprofessional conduct includes "failing to answer specific questions or providing false or misleading answers that would have affected the decision to license ... a nurse."[6] The appropriate penalty/sanction in disciplinary matters is subject to the Board's Disciplinary Matrix, as well as the factors contained in 22 TAC § 213.33(c).[7]

## D. Evidence

Staff submitted nine exhibits and provided the testimony of Melinda Hester. Respondent testified on his own behalf and presented eight exhibits that were admitted into evidence.

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[5] Code § 301.452(b)(8).

[6] 22 TAC § 217.12(b)(6)(I).

[7] 22 TAC § 213.33(c) provides 17 factors that shall be analyzed in determining the tier and sanction level of the Disciplinary Matrix for various violations:

(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 NPA 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 §213.27 of this chapter (relating to Good Professional Character); and
(17) any other matter that justice may require.

### 1. Undisputed Facts

Respondent was born on July 29, 1970. He was credentialed as a certified nurse aide (CNA) by the state of Kansas on July 26, 1989. In March of 1992, he was employed as a nurse aide at a mental health and mental retardation facility in Pittsburg, Kansas. Subsequent to an investigation, the Kansas Department of Health and Environment (state of Kansas) alleged that Respondent abused a patient in his care, as follows:

> On or about March 15, 1992, [Respondent] grabbed and squeezed a female resident by the neck when taking her vital signs, causing her to scream and leaving red marks afterward on her neck.

Respondent waived his right to an administrative hearing on the charges. As a result, on September 19, 1992, the state of Kansas issued a final determination, adopting the investigative findings as fact and concluding that Respondent committed abuse.[8] The information was placed in the Kansas Nurse Aide Registry for abuse and neglect ("Kansas Registry").

On June 23, 2000, Respondent submitted to the Board his initial application for licensure as a registered nurse. In the Application, Respondent attested the following statement was true: "I have never been denied licensure/certification or had disciplinary action taken against me by any governmental authority in any country, state or province."[9]

On September 8, 2008, Respondent self-disclosed to the Board the disciplinary action against his Kansas nurse aide certification. Respondent's self-disclosure included a copy of Kansas' Administrative Findings.[10]

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[8] State's Ex. 5, Notification of Change in Kansas Nurse Aide Registry Record (Kansas' Administrative Findings).

[9] State's Ex. 5.

[10] State's Ex. 6.

### 2. Melinda Hester's Testimony

Melinda Hester has been licensed as a registered nurse for 30 years. She is currently employed as the Board's Lead Consultant for Practice. She interprets the nursing practice laws and Board rules for nurses, their employers, and members of the general public, in addition to testifying as an expert witness for the Board.

Ms. Hester explained that the Board's decision whether to allow an applicant to sit for the nurse licensing examination is based on the individual's initial application.[11] In many cases, an applicant with potential ineligibilities can still receive a nursing license with stipulations. The Kansas' disciplinary action against Respondent was such a potential ineligibility, Ms. Hester testified, but his application did not disclose the matter. The Board did not learn of it until 2008, when Respondent self-disclosed his disciplinary history in Kansas.

According to Ms. Hester, Respondent's placement on the Kansas registry in 1992 was important information for the Board to have in August 2000, when it determined there were no impediments to his initial licensure. A prior disciplinary action involving patient abuse is directly related to an applicant's fitness for the nursing occupation, she said, and the information would have impacted the Board's decision whether to issue the license and, if so, under what circumstances. Respondent's falsification of the Application prevented the Board from knowing or considering all the potential consequences of its licensing decision.

Respondent's initial Texas nursing license would probably have contained probationary stipulations requiring him to submit to supervision for several years, Ms. Hester testified. The stipulation would have allowed the Board to ensure that Respondent was providing for patient safety on a daily basis, practicing in accordance with the Nursing Practice Act, and exhibiting the required character traits of honesty, trustworthiness and integrity.

[11] Ideally, Ms. Hester stated, an applicant who believes he or she may be for ineligible for licensure should petition the Board for a declaratory order of eligibility or apply for a license by endorsement on that basis. *See*, Code § 301.257 and 22 TAC § 213.30.

Ms. Hester said Respondent's false application response and prior disciplinary history violate Code § 301.452(b)(2)(8) and (10). Based on the Board's disciplinary matrix,[12] she recommends that he be required to complete remedial education courses in jurisprudence and ethics, and pay a $250 administrative penalty. She recommends further that the Board's final order be appended with a copy of Kansas' Administrative Findings.

With respect to Code § 301.452(b)(2), Ms. Hester concluded that Respondent obtained his Texas nursing license through fraud or deceit, and she considered his concealment of the Kansas' action to be obviously intentional. While any dishonesty is significant in the Board's view, she said, she sees Respondent's actions as a first-tier offense because he did not conceal an extensive criminal history. His misrepresentation was also a one-time occurrence. She testified that the sanction for a Level I offense (remedial education and/or a fine of $250), rather than a Level II offense (license revocation) is appropriate, despite several aggravating factors. The allegation was very serious. Respondent actually laid hands on a patient and caused red marks on her skin, presumably because he was angry. The incident is worrisome, Ms. Hester testified, because an incapacitated patient often provokes strong feelings in caregivers. When provoked, a nurse must be able to put aside the natural feelings of anger and irritation and protect the patient. However, several mitigating factors favor imposition of the lower level sanction: the abuse finding occurred 18 years ago; no other reports suggest that Respondent's nursing practice is unsafe; and, revocation of Respondent's license would not be in the best interests of the public.

Ms. Hester said Respondent is subject to Board discipline under Code § 301.452(b)(8) because the Kansas' action constituted discipline of his nurse aide certification, which is nursing-related. She explained that the Board has an obligation to maintain the public trust in Texas. Therefore, any disciplinary action imposed on a nursing-related license in another state should be a matter of public record in Texas. The Board's policy allows Texas employers to make informed decisions as to the employment of nurses and their placement in specific nursing positions. The same reasoning led Ms. Hester to conclude that Kansas' Administrative Findings should be attached

[12] The disciplinary matrix is published in 22 TAC § 213.33.

to the Board's final order ultimately issued in Respondent's case. Ms. Hester testified that Board discipline for Respondent's violation of § 301.452(b)(8) at sanction level II is proper because the substantive nature of the prior discipline – abuse – is very serious.

According to Ms. Hester, Respondent's false application also violated Code § 301.452(b)(10)'s prohibition against "unprofessional or dishonorable conduct ... likely to deceive, defraud, or injure a patient or the public." The Board's rule at 22 TAC § 217.12, which identifies conduct the Board considers to be unprofessional or dishonorable and therefore likely to cause harm (not necessarily actual injury) to clients or the public, defines "misconduct" to include providing "false or misleading answers that would have affected the decision to license ... a nurse."[13] Patients' lives are often dependent upon a nurse's trustworthiness. Duplicity on a license application speaks to the integrity and honesty of the applicant, she testified, and in Respondent's case, his dishonesty prevented the Board from considering circumstances that could have compromised patient safety.

Nonetheless, in Ms. Hester's opinion Respondent's violation of Code § 301.452(b)(10) is best classified as a first-tier offense subject to sanction at Level 1. Quoting directly from this category of the matrix, she described his misconduct as a one-time "failure to honestly disclose or answer questions relevant to employment or licensure."[14] Accordingly, payment of a fine and remedial education are the appropriate sanctions for his violation.

On cross-examination, Ms. Hester admitted she believes disciplinary action is the only appropriate sanction for Respondent's first-time violations of Code § 301.452(b)(2) and (10), despite the fact that both compliance failures are eligible for a corrective action (*i.e.*, non-disciplinary action) under Code § 301.652 and 22 TAC § 213.32.[15] She admitted she reached her conclusion regarding

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[13] 22 TAC § 217.12(b)(6)(I).

[14] State's Ex. 9, also published in 22 TAC § 213.33.

[15] Effective September 1, 2009, Code § 301.652 allows the Board to impose a corrective action (a fine, remedial education, or some combination of the two) upon a licensee who violates the Nursing Practice Act or Board rules. A corrective action is not a disciplinary sanction under Subchapter J, and is subject to disclosure only to the extent that a complaint is subject to disclosure under Code § 301.466. The Board's amendment of 22 TAC § 213.32, effective November 15, 2009, establishes guidelines that identify the types of violations for which a corrective action may be imposed. The decision to impose a corrective action rather than a disciplinary sanction is at the sole discretion of the

the appropriate sanctions without having seen Respondent's letter dated September 9, 2008, in which he explains the circumstances of incident in Kansas, his appeal of the state's findings, and the reasons he ultimately gave up that appeal.[16] Ms. Hester acknowledged further that she was unaware Respondent had disclosed the entire matter to the Board himself, which led to the Board's investigation and filing of Formal Charges (which do not reference Respondent's self-report). Ms. Hester conceded that, had she been aware of Respondent's self-report or seen his written "side of the story," she might have modified her recommendation regarding the appropriate sanctions.

After reviewing Respondent's written explanation and his letters of recommendation, Ms. Hester stated that her ultimate recommendation regarding sanctions remained the same. She would not have recommended a corrective action to the Board's Executive Director even if she had had previous access to Respondent's supplemental materials.[17]

Ms. Hester made several additional comments after reviewing Respondent's exhibits.[18] She indicated that his relatively young age (21) when the abuse occurred is a mitigating factor. She expressed the belief that Respondent has plainly "matured over the years." Nonetheless, Ms. Hester concluded that Respondent's actions 18 years ago "speak directly to his honesty ... and how he treats people." She agreed that he was honest in his self-disclosure to the Board, but speculated his admission occurred only because "his hand was forced;" that is, Ms. Hester implied that Respondent's self-report was not optional, but was one of several consequences he had to face when a routine background check for credentialing purposes revealed his name on the Kansas Registry.

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Board's Executive Director.

[16] Respondent's Ex. 8. The cover letter reflects that Respondent's written account was faxed to the Board's investigator, Bonnie Krznarich, on January 30, 2009.

[17] Ms. Hester characterized the option of corrective action as "neither black nor white" and one that is applied on a case-by-case basis. She acknowledged that in cases where either corrective action or disciplinary action was an available option, she herself had never recommended the former. She testified that a corrective action is appropriate only in "no-action" cases: situations in which a nurse commits a technical violation but ultimately corrects it, *e.g.*, failure to pay fees to the Board but resolving the matter through late payment. Ms. Hester said to her knowledge, a corrective action agreement was not an option in cases involving patient harm or disciplinary actions against a nurse's license in another state. She emphasized that decisions regarding corrective action are made by the Executive Director. Ms. Hester was unaware whether the Executive Director had been reviewed Respondent's case.

[18] Respondent's Exs. 1- 8.

According to Ms. Hester, the manner in which Respondent's self-disclosure to the Board came about reinforced her initial belief: that he intentionally provided false information in his initial application and would not have self-disclosed the matter if not for the results of a background check.

### 3. Respondent's Testimony

Respondent offered testimony to explain the timing of his self-disclosure. He said that between 2002 and 2008, he underwent background checks only when he became employed full-time at Texas Health Southwest (THS), and when he applied for hospital privileges to assist a surgeon in another hospital's operating room (OR). Prior to the credentialing process in 2008 that revealed his name on the Kansas Registry, he said the issue had never come up.

Once it did, Respondent testified he took full responsibility for the matter. He provided a written explanation to the requesting hospital, as well as the other hospitals where he had privileges. He disclosed the matter to the director of his department at THS, THS' Director of Nursing and every surgeon who had sponsored him. Respondent testified he realized the Board also had a right to the information, which led to his self-disclosure to the Board on September 8, 2008.

Respondent indicated his colleagues and superiors at THS had been extremely supportive, expressing appreciation for his honesty and offering to help in any way possible. Respondent was not terminated by TSH. No one there attempted to reduce his employment responsibilities. Since the information came out, Respondent reported, he applied for and was granted privileges at several additional hospitals. He is currently able to practice as a surgical assistant at 12 different hospitals. All of them know about the Kansas Administrative Findings, as well as the Board's disciplinary action against Respondent that is the subject of this hearing.

Respondent referred to his letters of recommendation from colleagues (all dated in early April 2010) and THS "Pat on the Back" awards.[19] Two Certified Registered Nurse Anesthetists (CRNAs)

[19] Respondent's Exs. 1-7.

describe him as a highly professional surgical nurse, even during stressful and/or difficult surgeries. The CRNAs' state that Respondent successfully deals with patients of all types and temperaments; that Respondent's bedside manner allows him to effectively communicate with and calm patients and their families; that Respondent handles administrative matters with speed and accuracy; Respondent has achieved a balance between work and family life; and, that Respondent consistently treats patients and their families with kindness and dignity.[20] Respondent's awards from 2006-2008 recognize his hard work during busy or short-handed hospital shifts; his flexibility and dedication to the department; his efficiency; and, his consistent willingness to perform extra tasks to help prepare for the next shift.[21] A letter written by Tammy Risner Baergen, RN, CNOR, Respondent's supervisor for four years, is very complimentary of Respondent. She states she has gotten to know him well and deeply respects him. Ms. Baergen writes in glowing terms about Respondent's work ethic, dedication, remarkable compassion for patients, intelligence, motivation, professionalism and skill, mentoring of co-workers and interpersonal skills. She mentioned how well he handles the stressful role of Charge Nurse. She indicated that the hospital's surgeons often request Respondent's assistance in the OR.[22]

Respondent testified he was formerly certified as a paramedic in both Kansas and Texas. He worked as a paramedic for over three years, including a part-time job in a Texas hospital emergency room. It was through this position, Respondent said, that he developed a profound respect for the work performed by nurses and chose to enter the nursing profession.

Respondent testified about the incident in Kansas.[23] He admitted his sworn statement in the Application ("I ... have never had had disciplinary action taken against me by any governmental authority in any county, state or province") was untrue. He attempted to explain the circumstances of events on March 15, 1992, as well as his state of mind in the years that followed.

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[20] Respondent's Exs. 2- 3.

[21] Respondent's Exs. 5-7.

[22] Respondent's Ex. 1.

[23] Portions of Respondent's September 8, 2008, written explanation were used to supplement his live testimony, which was not detailed.

Respondent was 21 years old when the incident happened. He was working two jobs, one at a restaurant and the other as a nurse aide for a mental health facility. It was spring break, he had covered multiple shifts for other employees, and he was exhausted. Rather than "call in," he arrived for his early morning Sunday shift at the facility. At a charge nurse's instructions, Respondent attempted to obtain vital signs on a patient ("V.") who was sitting in a chair in the facility's recreation room. He was palpating V.'s left radial pulse while looking at the wall clock to count the pulsations. V. scratched Respondent's arm with her right hand. He stopped, moved V.'s hands to her lap, and resumed what he was doing. He performed the same intervention when V. scratched him again, then tried measuring her pulse by palpating her right carotid pulse. V. bent over tried to bite Respondent. Frustrated at not being able to complete the task, afraid of being bitten and responding without thinking, Respondent indicated he put his hands on V.'s shoulders and pulled her upright in the chair. He then walked away and gestured at V. with his middle finger.

Respondent said the incident was investigated by the Kansas Department of Health and Environment and he cooperated by filing a report. He resigned his position at the facility. The Kansas' regulatory agency found that he had committed abuse and he appealed the finding. A telephone hearing was scheduled. Respondent learned that several of his co-workers at the facility were prepared to testify that he had "pulled V. back up in her chair by her neck, made her scream, and then gestured at her with [his] middle finger."[24] He indicated he was so deeply ashamed he did not seek support from his family or friends. Unable to afford legal counsel and afraid to face his co-workers, he did not follow through with his appeal.

The administrative finding of abuse became final and his name was added to the Kansas Registry. Respondent stated that as written, the state's official findings are "out of context" and sound far worse than what actually happened that day. But, he reiterated that "the responsibility is mine."

[24] Respondent's Ex. 8.

When the incident was revealed 16 years later, Respondent was still very ashamed but was able to react much differently. He was no longer a scared 21-year old. He had matured into a responsible adult with a professional career, a wife and children. This time, he sought help from his colleagues, friends and family. He fully disclosed the incident to the people and organizations that had a right to know about it. He tried to take responsibility for the past in every way possible. In the end, he said he hopes the Board will consider his 10-year performance as a nurse, which demonstrates that his professional character and abilities cannot be defined by a single event that happened 18 years ago.

## D. Analysis and Recommendation

The facts are not really in dispute. Respondent did not reveal the Kansas Administrative Findings on his initial application filed with the Board. He was embarrassed and ashamed, and probably afraid the disclosure would result in the denial of licensure. The Board, unaware of Respondent's disciplinary history in Kansas, issued a registered nursing license without stipulations to Respondent in August 2000. The Board did not learn of the Kansas' action until Respondent's self-disclosure in September 2008.

There is no question that the Board has a responsibility to protect the public from nurses who are unfit to practice. In order to fulfill this duty the Board's licensing decisions must take into account the type of information deliberately concealed by Respondent. His decision to withhold the information was immature, misguided and shortsighted. Although he has matured since that time, Respondent's actions do not reflect well on him.

The ALJ acknowledges that Staff proved its allegations: that Respondent misrepresented information in an application; that his dishonesty enabled him to obtain a license without stipulations; that the Board defines his misrepresentation as "unprofessional or dishonorable conduct;" and, that Respondent's nurse aide license was subject to disciplinary action in another state. Staff's recommended sanction of remedial education and a $250 penalty also conforms to the Board's disciplinary matrix. However, the Board's decision to punish or sanction Respondent for his

misconduct also requires consideration of the factors set forth in 22 TAC § 213.33(c). This analysis suggests that the recommended sanctions are unnecessarily punitive.

It is true that a finding of "abuse" is serious. In the context of family and protective service agencies, however, this term is used to describe a broad range of behaviors, some far more serious than others. In Respondent's case, the finding of abuse relates to an incident that was rather minor in scale. A patient attempted to bite Respondent and during the moment, he reacted by roughly forcing the patient to sit upright in her chair before walking away. His conduct was a one-time incident, without previous or subsequent similar occurrences. The Kansas finding states that "red marks" were left on the patient's neck, but lasting harm of any sort was neither alleged nor found. No premeditation was involved. Respondent was also very young at the time. When the incident occurred, it appears he was stretched to his personal limits. A mixture of fatigue, immaturity and ego got the best of him and he acted impulsively. He has lived with the resulting shame and regret for many years.

The incident happened almost two decades ago. During the past 13 to 14 years, Respondent has been working as a health professional with regular patient contact. There have been no reports of similar misconduct in all that time. His disciplinary record as a registered nurse in Texas is unblemished. Respondent's present fitness for nursing practice also appears to be excellent: he is a surgical nurse, gainfully employed, and respected by the nurses and physicians with whom he works. No one sees him as a threat to patients or to the public safety.

Staff's primary reason for imposing disciplinary action against Respondent's license is based on the fact that 10 years ago, he was not forthcoming about his disciplinary history in the Application. Respondent's failure to disclose the matter prevented the Board from making an informed decision about his license application, which potentially endangered both patients and the public. Staff argues that Respondent should be disciplined for the lack of honesty, integrity and trustworthiness he demonstrated 10 years ago. Also, according to the Board's expert, Respondent's conduct 18 years ago is evidence of "how he treats people."

It seems that judgments about Respondent's character are more appropriately based on all of the evidence, not just the incident in Kansas and Respondent's lack of candor a decade ago. The fact is that the Board's issuance of a nursing license to Respondent resulted in no harm. By all accounts, he has exhibited competence as a nurse and good professional character for many years. Ms. Hester speculated that Respondent's self-disclosure to the Board was forced, but no evidence supports her conjecture. There is no valid reason to deny Respondent credit for coming forward with the information, probably with the knowledge that adverse action could very well be the result.

The Board's testifying expert was unaware prior to hearing that Respondent's self-disclosure actually led to the Board's investigation. She formed her expert opinion about appropriate sanctions in this case without the benefit of Respondent's written explanation of events, which was in the Board's possession. Her expert testimony gave little or no weight to extenuating circumstances that existed 18 years ago, evidence of Respondent's good conduct for the many years since or his present fitness to practice. Her conclusion, that Respondent lacks trustworthiness and integrity, is based on an Application completed 10 years ago. Likewise, her inferences concerning "how [Respondent] treats people" is not based on any current information, but rather stems from an isolated event that occurred almost two decades ago.

One purpose of the recent legislation, which created the option of corrective action in lieu of disciplinary action, is to promote a less punitive regulatory environment for nurses. While Staff insists Respondent's long-ago dishonest application answer is no minor violation, the Board's rule at § 213.32 specifically provides that this type of violation is appropriate for corrective action. The Board's expert stated that only the most minor violations are eligible for a corrective action, but her testimony is inconsistent with the Board's implementation of Code § 301.652 as set forth in 22 TAC § 213.32.

The ALJ has no authority to recommend a corrective action, which is in the Executive Director's sole discretion. However, based on the record evidence the ALJ recommends that no disciplinary action be taken against Respondent's license.

## III. FINDINGS OF FACT

1. Jeffrey E. Durbin, (Respondent) is licensed as a professional nurse in the state of Texas and holds permanent certificate number 672401.

2. Respondent was licensed by the Texas Board of Nursing (Board) on August 29, 2000.

3. Respondent was born on July 29, 1970.

4. Respondent was credentialed as a certified nurse aide (CNA) by the state of Kansas on July 26, 1989.

5. On March 15, 1992, Respondent was 21 years old. At the time, he was working two jobs, one as a Certified Nurse Aide (CNA) at a mental health facility in Pittsburg, Kansas. On that day, it was spring break, he had worked multiple shifts for other employees and he was exhausted.

6. On March 15, 1992, Respondent was attempting to obtain vital signs on a female patient ("V.") who was sitting in a chair. The patient was not cooperative, first scratching Respondent and then attempting to bite him. Respondent was frustrated at being unable to complete the task and afraid of being bitten. He reacted without thinking and roughly forced V. to sit upright in her chair before walking away.

7. The Kansas Department of Health and Environment (state of Kansas) conducted an investigation and alleged that Respondent "grabbed and squeezed a female resident by the neck when taking her vital signs, causing her to scream and leaving red marks afterward on her neck."

8. Respondent appealed the allegation, but ultimately waived his right to a state administrative hearing on the charges.

9. Respondent's failure to pursue his appeal resulted in the state of Kansas' September 19, 1992, final determination, which adopted the Kansas Department of Health and Environment's allegation as fact and concluded that Respondent committed abuse. The information was placed in the Kansas Nurse Aide Registry.

10. Despite the serious nature of the Kansas' finding, the incident as a whole was minor in scale. Respondent's conduct was a one-time incident, without previous or subsequent similar occurrences. Lasting or serious harm to the patient was neither alleged nor found. No premeditation was involved.

11. Respondent's conduct was impulsive. He is ashamed of and deeply regrets the incident.

12. Subsequent to 1992, Respondent worked as a paramedic for three and a half years. He attended and completed nursing school.

13. On June 23, 2000, Respondent filed with the Board an Application for Licensure By Examination (Application) as a registered nurse. In the Application, Respondent attested that the following statement was true: "I have never been denied licensure/certification or had disciplinary action taken against me by any governmental authority in any country, state or province."

14. Respondent's answer on the Application described in Finding of Fact No. 13 was inaccurate.

15. The Board's issuance of a license without stipulations to Respondent in August 2000 resulted in no harm.

16. In the past 10 years, Respondent has exhibited competence as a nurse and good professional character.

17. Respondent has matured and accepts full responsibility for his misconduct in the state of Kansas and his lack of candor in the Application he submitted to the Board.

18. Respondent has no other disciplinary history. His misconduct in Kansas occurred 18 years ago and was a one-time event.

19. On September 8, 2008, Respondent self-disclosed to the Board the state of Kansas' administrative findings, resulting in an investigation.

20. On April 9, 2009, Staff of the Board filed formal charges against Respondent.

21. Staff sent a Notice of Hearing to Respondent by certified mail on September 8, 2009. Respondent timely filed an answer.

22. On April 7, 2010, Administrative Law Judge (ALJ) Anne K. Perez convened the hearing at the State Office of Administrative Hearings in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by R. Kyle Hensley, Assistant General Counsel. Respondent was represented by Elizabeth L. Higgenbotham. The record closed at the conclusion of the hearing that day.

## IV. CONCLUSIONS OF LAW

1. The Texas Board of Nursing (Board) has jurisdiction over this matter pursuant to TEX. OCC. CODE ANN. (Code) ch. 301.

2. The State Office of Administrative Hearings has jurisdiction over the hearing in this proceeding, including the authority to issue a proposal for decision with proposed findings of fact and conclusions of law, pursuant to TEX. GOV'T CODE ANN. ch. 2003.

3. Notice of the formal charges and of the hearing on the merits was provided as required by Code § 301.454 and by the Administrative Procedure Act, TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

4. Staff had the burden of proving the case by a preponderance of the evidence.

5. Based on the Findings of Fact, Respondent violated Code § 301.452(b)(2)(8) and (10) and (13) and 22 TEX. ADMIN. CODE (TAC) § 217.12(6)(I).

6. Based on the Findings of Fact, the presence of mitigating circumstances under 22 TAC § 213.33 outweigh the aggravating factors in this case.

7. Based on the Findings of Fact and Conclusions of Law, disciplinary action against Respondent is not warranted.

**SIGNED June 7, 2010.**

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

# 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*


June 22, 2010

Administrative Law Judge Anne K. Perez
State Office of Administrative Hearings
P.O. Box 13025
Austin, Texas 78711-3025

*Via Facsimile (512) 475-4994*

RE: In the Matter of Permanent Certificate Number **672401**
Issued to: **JEFFREY E. DURBIN**
Docket No. **507-10-0097**

Dear Judge Perez:

Enclosed please find ***Staff's Exceptions to Proposal for Decision***, regarding the above-entitled cause.

By copy of this letter, I am forwarding a copy of this document to the Respondent.

Please feel free to contact me at 305-6879 should you have any questions and/or concerns regarding this matter.

Sincerely,

R. Kyle Hensley

R. Kyle Hensley
Assistant General Counsel

RKH/rm
Enclosure
cc: Jeffrey E. Durbin c/o Elizabeth Higginbotham, Attorney *Facsimile (210) 377-3757*


**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

Blanca Rosa Garcia, PhD, RN Corpus Christi; Richard Gibbs, LVN Mesquite; Kathy Leader-Horn, LVN Granbury; Josefina Lujan, PhD, RN El Paso; Beverley Jean Nuttall, LVN Bryan; Mary Jane Salgado, MEd Eagle Pass

**DOCKET NO. 507-10-0097**

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|---|---|---|
| IN THE MATTER OF | § | BEFORE THE |
| PERMANENT CERTIFICATE | § | |
| NUMBER **672401** | § | STATE OFFICE OF |
| ISSUED TO | § | |
| **JEFFREY E. DURBIN** | § | ADMINISTRATIVE HEARINGS |

## STAFF'S EXCEPTIONS TO PROPOSAL FOR DECISION

TO THE HONORABLE JUDGE OF SAID COURT:

COMES NOW, Staff of the Board of Nursing and files this, Staff's Exceptions to Proposal for Decision, and would show the Administrative Law Judge as follows:

I.

Staff excepts to any discussion in this Proposal for Decision of the corrective action option as provided for in Texas Occupations Code § 301.652 and 22 TAC §213.32. As made abundantly clear in TAC §213.32(4), "the opportunity to enter into an agreed corrective action order is at the sole discretion of the Executive Director and is not available as a result of a contested case proceeding."

Over Staff's strenuous objections, testimony on the agreed corrective action was allowed during the hearing. It is Staff's continued contention that any discussion of the agreed corrective action is irrelevant to this proceeding. It is only the Executive Director who can offer a Respondent an agreed corrective action order. As in this case, by the time a Respondent has made the choice to contest the matter before the State Office of Administrative Hearings that option is unavailable.

By discussing the criteria for a corrective action in the context of the testimony of the Board's Lead Nurse Practice Consultant, the ALJ has attempted to make the corrective action something that can be utilized at SOAH. If the Board had intended for the corrective action to be included in the factors that should be considered for the imposition of sanctions in a case it would have done so explicitly in §213.33. Instead, the corrective action was purposely precluded from consideration at SOAH by §213.32(4).

II.

Staff excepts to Conclusion of Law Number 7. After determining that the Respondent lied to the Board on his initial application for licensure about being found to have abused a patient in Kansas, the correct answer cannot be that disciplinary action against the Respondent is not warranted. What is troubling in this case is that the ALJ seems to reward the Respondent for eight (8) years of continuing to hide the Kansas order from the Texas Board. While undisputed that the Respondent has had no nursing issues since his initial licensure, to explain away any possible remedy because of the age of the Respondent when the abuse happened, and his subsequent career as a nurse,

serves as a lesson to all those nurses who had orders from the Board because they were honest about their lives on their initial application for licensure. The lesson of this PFD is that there is no reason to be truthful to the people of the State of Texas.

The factors in §213.33(c) are not an equation that one simply adds up and subtracts to get to the correct sanction level. In determining that there should be no disciplinary action in this case, the ALJ seems to have balanced the aggravating factors against the mitigating factors in this case and to have determined that the mitigating factors outweigh any aggravating factors. That is an incorrect way to use the Board's Disciplinary Matrix. As Melinda Hester testified, all of the mitigating and aggravating factors were considered by the Board in determining that the correct remedy should be a Remedial Education order with a minimal fine.

The Board requests that the ALJ amend the Proposal for Decision to remove all discussion of corrective actions under §213.32. In addition, the Board requests that Finding of Law Number 7 be amended to issue a disciplinary action against the Respondent in the form of a Remedial Education order with a fine of $250.00.

TEXAS BOARD OF NURSING

R. Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6821
F: (512) 305-8101 or (512) 305-7401

## CERTIFICATE OF SERVICE

I hereby certify that a true copy of ***Staff's Exceptions to Proposal for Decision*** was sent via facsimile, on this, the 22nd day of June, 2010 to:

Jeffrey E. Durbin
c/o Elizabeth Higginbotham, Attorney
Higginbotham & Associates, L.L.C.
1100 NW Loop 410 Suite 500
San Antonio, Texas 78213

*Facsimile (210)377-3757*

R. Kyle Hensley

R. Kyle Hensley, Assistant General Counsel

# State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

December 28, 2010

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

**VIA FACSIMILE 512/692-2752**

Elizabeth Higginbotham
Attorney at Law
Higginbotham & Associates, L.L.C.
106 E. 6th Street, Suite 900
Austin, TX 78701

**VIA FACSIMILE 512/305-8101**

RE: **Docket No. 507-10-0097; In the Matter of Permanent Certificate No. 672401 Issued to Jeffrey E. Durbin**

Dear Counsel:

The purpose of this letter is to make a recommendation to the Texas Board of Nursing on a disposition of exceptions filed by Staff to the Proposal for Decision (PFD) issued in this case. After reviewing Staff's exceptions and Respondent's response, I find no reason to amend the PFD.

The PFD is ready for consideration by the Board. It is my recommendation that the Board adopt the PFD as proposed.

Sincerely,

Anne K. Perez
Administrative Law Judge

xc: R. Kyle Hensley, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA FACSIMILE
Dina Flores, Legal Assistant Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA FACSIMILE