



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.
Ramona Gaston-McNutt
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of § REINSTATEMENT
Registered Nurse License Number 690642 §
issued to MARSHALL INNO-CHYKE FINTAN § AGREED ORDER

On this day came to be considered by the Texas Board of Nursing, hereinafter referred as the Board, the Petition for Reinstatement of Registered Nurse License Number 690642, held by MARSHALL INNO-CHYKE FINTAN, hereinafter referred to as Petitioner.

An informal conference was held on December 3, 2012, at the office of the Texas Board of Nursing, in accordance with Section 301.464, Texas Occupations Code.

Petitioner appeared in person. Petitioner was represented by Elizabeth Higginbotham, RN, Attorney at Law. In attendance were Ramona Gaston-McNutt, BSN, RN, Nurse Consultant, Executive Director's Designee; Kyle Hensley, Assistant Counsel; Anthony L. Diggs, MSCJ, Director of Enforcement; and Diane E. Burell, Investigator.

FINDINGS OF FACT

1. Prior to institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Petitioner and Petitioner was given an opportunity to show compliance with all requirements of the law for retention of the license(s).
2. Petitioner waived notice and hearing, and consented to the entry of this Order.
3. Petitioner received an Associate Degree in Nursing from Excelsior College, Albany, New York, on November 1, 1997. Petitioner was originally licensed to practice professional nursing in the State of Texas on September 20, 2002.
4. Petitioner's professional nursing employment history includes:

6/93 - 7/02	PRN nurse	Trauma Nurses Trenton, New Jersey
1/99 - 5/00	LVN	Beechnut Manor Houston, Texas

Petitioner's professional nursing employment history continued:

4/01 - 1/02	RN	Frankford Hospital Philadelphia, Pennsylvania
10/01 - 4/05	LVN	CP & S Houston, Texas
5/05 - 12/06	Not employed in nursing	
1/07 - 4/11	RN	Memorial Hermann Southwest Hospital, Houston, Texas
5/11 - present	Not employed in nursing	

5. On April 28, 2011, Petitioner's license to practice professional nursing in the State of Texas was Revoked by the Texas Board of Nursing. A copy of the April 28, 2011, Opinion and Order of the Board is attached and incorporated, by reference, as a part of this Order.
6. On or about September 4, 2012, Petitioner submitted a Petition for Reinstatement of License to practice professional nursing in the State of Texas.
7. Petitioner presented the following in support of his petition:
 - 7.1. Letter of support, dated May 18, 2012, from Victor Onwumere, Director, Phan Accounting Services, Richmond, Texas, stating Petitioner worked with the agency as an Office Manager from May 2011 to December 2011. Petitioner was very industrious and a dedicated staff member. The agency had to relieve Petitioner of his position once it was noted that his name appeared on the OIG exclusion list.
 - 7.2. Letter of support, dated June 29, 2012, from Atinuke Banjo, RN, Premier Staffing, Memorial Hermann Hospital, Houston, Texas, stating she had the privilege to work in the same unit with Petitioner for a period of five (5) years as a nursing colleague. Petitioner's enthusiasm and caring personality to his patients and colleagues is exemplary. Petitioner is always very compassionate and caring to all his patients and families. He recognizes the effect and stress of critically ill and sometimes demise of patients, the reactions and response of families and their loved ones during these periods. Petitioner is a dedicated, hard worker who hardly complains and is always ready to lend a helping hand to his colleagues and other people he finds himself working with. Ms. Banjo recommends Petitioner as a competent, compassionate, dedicated and professional person of good character.
 - 7.3. Letter of support from Kate Marr, RN, stating she is a former co-worker of Petitioner, as she worked along side him as a bedside nurse and also as his charge nurse. Petitioner is a strong nurse and had always been an asset to the team. He is trustworthy and reliable both as a co-worker and a healthcare provider. The patience and compassion he shows his patients is

reflected in his care and mirrored in how he cares for their families. Petitioner is able to distinguish right from wrong. He is able to think and act rationally. He is accountable for his own behavior. As Petitioner's charge nurse, Ms. Marr has witnessed evidence of his ability to promptly and fully self-disclose facts which could enhance the health status of a patient in his care, as well as those related to a patient not assigned to his care. It is Ms. Marr's belief that Petitioner is able to practice in accordance to all legal regulations governing nursing practice; that he is able to promote a safe environment for his patients; that he knows the rational for and effects of medications and treatments that he administers. Ms. Marr feels that Petitioner can accurately and completely report and document a patient's status, his care rendered, doctor's orders, administration of medications/treatments, patient's response and his contact with other members of the healthcare team. Ms. Marr truly hopes that the Board will reconsider him for reinstatement of his nursing license.

- 7.4. Letter of support, dated June 1, 2012, from Colleen Machcinski, RN, stating she had worked with Petitioner from September 2009 until his recent incident. Petitioner is a strong nurse. Ms. Machcinski had a feeling of security when Petitioner was working the unit. Petitioner is able to distinguish right from wrong as demonstrated in many instances. Petitioner had demonstrated accountability in reporting for duty each shift. Petitioner was always a team player, pitching in to help anywhere it was needed. Petitioner was a very good communicator and worked well with all the nursing staff, physicians, and ancillary staff on a daily basis. Petitioner was very good at preventive nursing. If Petitioner saw a patient starting to decelerate, he would call the physician proactively to obtain orders, or at the very least, make the physician aware of the patient's condition and the possibility of intervention down the road.
- 7.5. Letter of support, dated May 10, 2012, from Elizabeth Pettifor, RN, stating it was a pleasure to work with Petitioner. He never complained about his assignment, often taking three (3) patients when they were short staffed. He displayed great team work, being the first to respond to codes and able to seamlessly provide exactly the care that was needed. He also exhibited great technical skills. Petitioner had great rapport with the other nurses. Petitioner was an asset to the ICU. He provided the critical care the patients required with a great attitude and competent manner.
- 7.6. Documentation of completion of a Texas nursing jurisprudence/ethics course, dated June 22, 2012, which would have been a requirement of this Order.
- 7.7. Documentation of completion of a Sharpening Critical Thinking Skills course, dated July 19, 2012, which would have been a requirement of this Order.
- 7.8. Verification of successful completion of a minimum of twenty (20) contact hours of continuing education.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Pursuant to Section 301.467, Texas Occupations Code, the Board may refuse to issue or renew a license, and may set a reasonable period that must lapse before reapplication. Pursuant to 22 TEX. ADMIN. CODE §213.26, the Board may impose reasonable conditions that a Petitioner must satisfy before reissuance of an unrestricted license.

ORDER

IT IS THEREFORE AGREED, subject to ratification by the Texas Board of Nursing, that the petition of MARSHALL INNO-CHYKE FINTAN, Registered Nurse License Number 690642, to practice nursing in the state of Texas, be and the same is hereby GRANTED, AND SUBJECT TO THE FOLLOWING STIPULATIONS SO LONG AS THE PETITIONER complies 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 the stipulations contained in this Order:

IT IS FURTHER AGREED and ORDERED that, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Petitioner to practice nursing in the State of Texas.

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

IT IS FURTHER AGREED and ORDERED that while Petitioner's license(s) is/are encumbered by this Order, Petitioner 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 Petitioner wishes to work.

(1) PETITIONER SHALL pay all re-registration fees and be issued a license to practice professional nursing in the State of Texas, which shall bear the appropriate notation. Said license issued to MARSHALL INNO-CHYKE FINTAN, shall be subject to the following agreed post-licensure stipulations:

IT IS FURTHER AGREED, SHOULD PETITIONER CHOOSE TO WORK AS A NURSE IN TEXAS, PETITIONER WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING PROBATION CONDITIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE PROBATION 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) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

(2) PETITIONER SHALL notify all future employers in nursing of this Order of the Board and the stipulations on PETITIONER's license(s). PETITIONER SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(3) PETITIONER SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the PETITIONER by the Board, to the Board's office within five (5) days of employment as a nurse.

(4) For the duration of the stipulation period, PETITIONER SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, who is on the premises. The supervising nurse is not

required to be on the same unit or ward as PETITIONER, 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 PETITIONER is currently working. PETITIONER SHALL work only regularly assigned, identified and predetermined unit(s). PETITIONER SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency with the exception of Petitioner's employment with Premier Staffing, on assignment with Memorial Hermann Southwest. PETITIONER SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(5) PETITIONER SHALL CAUSE each employer to submit, on forms provided to the PETITIONER by the Board, periodic reports as to PETITIONER's capability to practice nursing. These reports shall be completed by the nurse who supervises the PETITIONER. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for one (1) year of employment as a nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from PETITIONER'S license(s) to practice nursing in the State of Texas and PETITIONER shall be eligible for nurse licensure compact privileges, if any.

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PETITIONER'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Reinstatement Agreed Order. I certify that my past behavior, except as disclosed in my Petition for Reinstatement of Licensure, has been in conformity with the Board's professional character rule. I have provided the Board with complete and accurate documentation of my past behavior in violation of the penal law of any jurisdiction which was disposed of through any procedure short of convictions, such as: conditional discharge, deferred adjudication or dismissal. I have no criminal prosecution pending in any jurisdiction.

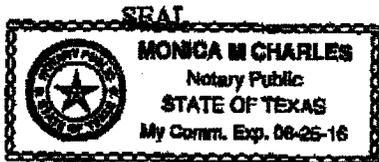
I have reviewed this Order. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I agree to inform the Board of any other fact or event that could constitute a ground for denial of licensure prior to reinstating my license to practice professional nursing in the state of Texas. I understand that if I fail to comply with all terms and conditions of this Order, my license to practice professional nursing in the State of Texas will be revoked, as a consequence of my noncompliance.

Signed this 17 day of January, 2013.

Marshall Inno-Chyke Fintan

MARSHALL INNO-CHYKE FINTAN, Petitioner

Sworn to and subscribed before me this 17 day of January, 2013.



Monica M. Charles

Notary Public in and for the State of Texas

Approved as to form and substance.

Elizabeth Higginbotham

ELIZABETH HIGGINBOTHAM, RN, Attorney for Petitioner

Signed this 21st day of January, 2013

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Reinstatement Agreed Order that was signed on the 17th day of January, 2013, by MARSHALL INNO-CHYKE FINTAN, Registered Nurse License Number 690642, and said Order is final.

Effective this 12th day of February, 2013.



Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf
of said Board

DOCKET NUMBER 507-10-3554

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

OPINION AND ORDER OF THE BOARD

TO: MARSHALL INNO-CHYKE FINTAN
3110 DOGWOOD KNOLL TRAIL
ROSENBERG, TX 77471

5711 SILVER OAK
MISSOURI, TX 77459

HUNTER BURKHALTER
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on April 28-29, 2011, the Texas Board of Nursing (Board) considered the following items: (1) The Proposal for Decision (PFD) regarding the above cited matter; (2) Staff's recommendation that the Board adopt the PFD regarding the registered nursing license of Marshall Inno-Chyke Fintan with changes; and (3) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. Board Staff filed exceptions to the PFD on January 6, 2011. The Respondent did not file any exceptions to the PFD nor did he respond to Staff's exceptions. The ALJ issued a final ruling letter on January 28, 2011, in which he modified Finding of Fact

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

The Board, after review and due consideration of the PFD, Staff's exceptions, Staff's recommendations, and Respondent's presentation during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD as if fully set out and separately stated herein, including Finding of Fact Number 4 which was modified by the ALJ in his letter ruling of January 28, 2011, but excluding Finding of Fact Number 8, which is modified by the Board, and Conclusion of Law Number 7, which is not adopted by the Board. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Finding of Fact Number 8

The Government Code §2001.058(e) authorizes the Board to change a finding of fact or conclusion of law made by the ALJ, or to vacate or modify an order issued by the ALJ, if the Board determines that the ALJ did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions. The Board declines to adopt Finding of Fact Number 8 as proposed by the ALJ because the finding seeks to define a term used by the Board, and as such, does not accurately reflect the Board's interpretation of "serious patient harm" as used in its Disciplinary Matrix, located at 22 Tex. Admin. Code §213.33(b), and rules, located at 22 Tex. Admin. Code §§213.33, 217.11, and 217.12. Based on Findings of Fact Numbers 2 and 3, the patient experienced seizures, had an oxygen saturation level of 35%, turned blue, and had to be resuscitated. The Board finds that these adjudicative facts constitute "serious patient harm" as used in its Disciplinary Matrix and rules. Therefore, the Board modifies and adopts Finding of Fact Number 8 as follows:

Modified and Adopted Finding of Fact Number 8

Respondent's actions did result in serious patient harm.

Conclusion of Law Number 7

The ALJ also did not properly apply or interpret applicable law in this matter when he included his recommended sanction as a conclusion of law. A recommendation for a sanction is not a proper conclusion of law. An agency is the final decision maker regarding the imposition of sanctions. Once it has been determined that a violation of the law has occurred, the sanction is a matter for the agency's discretion. The choice of penalty is vested in the agency, not in the courts. The agency is charged by law with discretion to fix the penalty when it determines that the statute has been violated. Thus, the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact and conclusions of law. Further, the mere labeling of a recommended sanction as a conclusion of law or as a finding of fact does not change the effect of the ALJ's recommendation...[T]he Board, not the ALJ, is the decision maker concerning sanctions. See *Texas State Board of Dental Examiners vs. Brown*, 281 S.W. 3d 692 (Tex. App. - Corpus Christi 2009, pet. filed); *Sears vs. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751 (Tex.App.-Austin 1988, no pet); *Firemen's & Policemen's Civil Serv. Comm'n vs. Brinkmeyer*, 662 S.W.2d 953, 956 (Tex.1984); *Granek vs. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 781 (Tex.App.-Austin 2005, pet. denied).

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

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

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

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

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

Entered this 28th day of April, 2011.

TEXAS BOARD OF NURSING



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

Attachment: Proposal for Decision; Docket No. 507-10-3554 (December 23, 2010).

State Office of Administrative Hearings



Cathleen Parsley
Chief Administrative Law Judge

December 23, 2010

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

VIA INTER-AGENCY

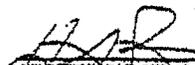
RE: Docket No. 507-10-3554; In the Matter of Permanent Certificate
Number 690642 Issued to Marshall Inno-Chyke Fintan

Dear Ms. Thomas:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 TEX. ADMIN. CODE § 155.507(c), a SOAH rule which may be found at www.soah.state.tx.us.

Sincerely,


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

Hb/slc
Enclosures

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

DOCKET NO. 507-10-3554

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

PROPOSAL FOR DECISION

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

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

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

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

¹ TEX. OCC. CODE ch. 301.

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

II. DISCUSSION

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

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

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

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

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

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

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

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

⁴ Staff Ex. 5.

⁵ Staff Ex. 5 at 5.

III. THE ALJ'S ANALYSIS AND RECOMMENDATION

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

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

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

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

A. Respondent's actions constituted only a "second tier" violation of Section 301.452(b)(10)

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

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

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

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

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

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

- 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;

⁶ Emphasis added.

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

Each of these factors will be discussed in turn.

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

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

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

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

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

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

- Evidence of practice history

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

- Evidence of present fitness to practice

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

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

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

- The length of time the licensee has practiced

Respondent has been a licensed nurse since at least September 20, 2002.⁷

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

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

⁷ Staff Ex. 1.

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

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

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

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

-- **Any mitigating or aggravating circumstances**

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

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

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

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

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

-- **The seriousness of the violation**

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

-- **The threat to public safety**

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

-- **Evidence of good professional character**

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

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

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

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

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

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

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

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

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

III. FINDINGS OF FACT

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

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

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

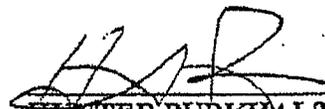
IV. CONCLUSIONS OF LAW

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

7. Based on the above Findings of Fact and Conclusions of Law, and based upon the factors listed in 22 TEX. ADMIN. CODE § 213.33, including the Board's Disciplinary Matrix, the Board should issue an order:

- Suspending Respondent's license for a period of one year; and
- Fining Respondent \$500.

SIGNED December 23, 2010.



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