BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse	§
License Number 753677	§
issued to MICHAEL EVERETTE TANNER	§

ORDER OF THE BOARD

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Registered Nurse License Number 753677, issued to MICHAEL EVERETTE TANNER, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

Respondent waived representation by counsel, informal proceedings, notice and hearing.

The Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Respondent's license to practice professional nursing in the State of Texas is currently in MSR Invalid status.

2. Respondent waived representation by counsel, informal proceedings, notice and hearing.

3. Respondent received an Associate Degree in Nursing from Gulf Coast Community College, Jackson County, Gautier, Mississippi on May 10, 1988. Respondent was licensed to practice professional nursing in the State of Texas on May 1, 2008.

4. Respondent's complete professional nursing employment history is unknown.

5. On or about September 18, 2009, while holding a license as a Registered Nurse (MSR License-Texas Invalid) in the State of Texas and practicing nursing under Respondent's Registered Nursing License Number 523108 issued by the State of California, Respondent received a Decision of the Administrative Law Judge in Case No. 2009-51, which was adopted by the Board of Registered Nursing, Department Of Consumer Affairs, State Of California, in which Respondent's license to practice professional nursing in the State Of California was Revoked due to Incompetence, Sexual Misconduct and Unprofessional Conduct. Decision and Order from the Board of Registered Nursing, Department Of Consumer Affairs, State Of California is attached and incorporated herein by reference as part of this Order.

6. On July 16, 2010 Respondent submitted a notarized statement to the Board voluntarily surrendering the right to practice professional nursing in Texas. A copy of Respondent's notarized statement, dated July 16, 2010, is attached and incorporated herein by reference as part of this Order.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation of Section 301.452(b)(8), Texas Occupations Code.

4. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

5. Under Section 301.453(d), Texas Occupations Code, the Board may impose conditions for reinstatement of licensure.

6. Any subsequent reinstatement of this license will be controlled by Section 301.452 (b), Texas Occupations Code, and 22 TAC§§213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

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ORDER

NOW, THEREFORE, IT IS ORDERED that the voluntary surrender of Registered Nurse License Number 753677, heretofore issued to MICHAEL EVERETTE TANNER, to practice professional nursing in the State of Texas, is accepted by the Executive Director on behalf of the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice professional nursing, use the title of registered nurse or the abbreviation RN or wear any insignia identifying himself as a registered nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a registered nurse during the period in which the license is surrendered.

2. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order.

4. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

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

Effective this 17th day of July, 2010.

TEXAS BOARD OF NURSING

By: _____

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

Michael Everett Tanner
4114 E. Union Hills Drive #1175
Phoenix, Arizona 85050
Texas RN License #753677

Voluntary Surrender Statement

June 23, 2010

Dear Texas Board of Nursing:

I no longer desire to be licensed as a professional nurse. Accordingly, I voluntarily surrender my license/licenses to practice in Texas. I waive representation by counsel and consent to the entry of an Order which outlines requirements for reinstatement of my license. I understand that I will be required to comply with the Board's Rules and Regulations in effect at the time I submit any petition for reinstatement.

Signature Michael E. Tanner

Date 7-16-10

Texas Nursing License Number/s 753677

The State of Texas

Before me, the undersigned authority, on this date personally appeared Michael Everett Tanner who, being duly sworn by me, stated that he executed the above for the purpose therein contained and that he understood same.

Sworn to before me the 27th day of July, 2010.

SEAL

Notary Public in and for the State of Arizona

VERONICA STAUDINGER HUGHES
NOTARY PUBLIC - ARIZONA
MARICOPA COUNTY
My Commission Expires
June 25, 2013

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHAEL EVERETTE TANNER** **Registered Nursing License No. 523108** Respondent.	Case No. 2009-51 OAH No. 2008100482

DECISION

The attached proposed decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on **September 18, 2009.**

IT IS SO ORDERED this **18th** day of **August 2009**.

Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2009-51
MICHAEL EVERETTE TANNER	OAH No. 2008100482
Registered Nursing License No. 523108,	
Respondent.	

PROPOSED DECISION

Administrative Law Judge Melissa G. Crowell, State of California, Office of Administrative Hearings, heard this matter on May 13 and 14, 2009, in Oakland, California.

Deputy Attorney General Char Sachson represented complainant Ruth Ann Terry, M.P.H., R.N., Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

Stanley G. Hilton, Attorney at Law, represented respondent Michael Everette Tanner, who was present.

The record was left open for complainant to submit a certified Certification of Costs of Investigation and Enforcement. The certification was filed on May 21, 2009, and admitted in evidence as Exhibit C. The record was closed and the matter was submitted for decision on May 21, 2009.

FACTUAL FINDINGS

1. On July 2, 1996, the Board of Registered Nursing issued Registered Nursing License number 523108 to respondent Michael Everette Tanner. The license was in full force and effect at all times relevant to this proceeding and will expire on September 30, 2009, unless renewed. Board records show that in addition to California, respondent holds nursing licenses in Alabama, Louisiana, Mississippi, Texas, and Florida.

Background

2. In 1980, respondent completed schooling in Alabama to become a licensed practical nurse. Thereafter he attended Mississippi Gulf Coast Community College in Gulf Coast, Mississippi, where he obtained an associate degree in nursing in May 1988.

3. Respondent's nursing practice is critical care nursing – he works either in emergency rooms or in critical care units.

4. In 2003 respondent worked in California as a registry nurse. For three months of that year he worked in the Emergency Department of O'Conner Hospital in San Jose.

5. Respondent returned to O'Connor Hospital in October 2005 as a per diem staff nurse on the night shift (7:00 p.m. to 7:30 a.m.) On November 2, 2005, respondent was still orienting at O'Conner, and as an orienting nurse, he was assigned a preceptor nurse for each shift. Leonida H. Gravidez, R.N., was respondent's preceptor nurse on November 2, 2005.

Patient DD

6. During the evening of November 2, 2005, patient DD[1], a 30-year-old male, was admitted to the Emergency Department of O'Connor Hospital for right knee pain. DD was accompanied by his sister, Diana Manibusan. Manibusan was a medical assistant for seven years, and a surgical coordinator for one-half year, so she has some familiarity with medical procedures.

7. Stephen E. Germany, D.O., was the emergency room physician who examined DD. Dr. Germany diagnosed an infected prepatellar bursa in the right knee, and cellulitis in the right lower leg. DD had been undergoing treatment for his knee and leg conditions prior to coming to the emergency room but the conditions had not improved. After consulting with an orthopedist, Bruce Huffer, M.D., Dr. Germany decided to admit DD to the hospital for further treatment for the infected bursa. Dr. Germany ordered blood tests, a blood culture, urinalysis, an intravenous saline lock, and pain medications.

Dr. Germany's physical findings pertained exclusively to DD's right knee and leg conditions. DD was hemodynamically stable and without gastrointestinal complaints. DD had no complaints which would have led Dr. Germany to order a rectal exam or a test for occult blood.

8. DD was one of the emergency room patients assigned to respondent and his preceptor nurse Gravidez. Respondent was the primary nurse to carry out Dr. Germany's orders for DD. Respondent's conduct as set forth in the Findings 9 and 12 below

[1] Initials are used to identify the patient in order to protect patient privacy.

witnessed by DD and by his sister, who was present in the room during their commission, but not Gravidez or any other medical staff at O'Connell.

9. During the course of his treatment of DD, Respondent entered DD's treatment room carrying supplies and holding in his mouth a syringe full of pain medication (Dilaudid). Respondent put down the supplies and syringe and left the room, leaving the pain medication unattended.

10. Respondent denies that he carried the syringe in his mouth and denies that he left medication unattended in the patient's treatment room. Respondent testified that he would never do such things. Respondent's testimony in this regard was not persuasive.

11. The undisputed expert testimony, provided by board consultant Diane Elizabeth King, R.N., PHN, BSN, CEN, established that respondent's act of walking into the patient room with a loaded syringe in his mouth and then leaving the medication unattended in the patient's room evidences the failure to exercise that degree of learning, skill, care and experience normally possessed and exercised by a competent registered nurse.

12. At some point after he had started the intravenous fluid, and had given DD pain medication, respondent returned to the room, saying something to the effect of: "As fast as I can put you in wonderland, I can bring you back." Respondent instructed DD to roll on his side and he placed his finger in DD's rectum two times. Respondent did not explain the procedure to DD prior to performing it. Respondent did not document the procedure, or its results, in the patient's chart or on the electronic patient record.

13. DD had difficulty sleeping after the incident and had questions regarding whether the rectal procedure performed by respondent was one that his physician had ordered. He discussed the matter with his close friend and neighbor, Pamela Brotherton-Sedano, a registered nurse who is the Senior Director of Patient Safety at O'Conner. Brotherton-Sedano questioned the appropriateness of respondent's conduct and commenced an investigation, which was conducted by Senior Director of Emergency and Critical Care Services Betty M. Hull, R.N.

Hull interviewed respondent on November 28, 2005. Respondent initially denied performing a rectal procedure of any kind. Respondent then stated that he might have done such a procedure and that there was an order for the procedure by Dr. Germany. Two days later, respondent contacted Hull expressing concern that he might lose his job with the hospital. At that time, respondent suggested that Gravidez might have instructed him to perform the procedure on the wrong patient, and that Gravidez had come into the room to assist him with the procedure.

Hull interviewed a number of people including Gravidez and Dr. Germany. Gravidez denied telling respondent that there was a physician order to check for occult blood, and she was adamant that she would never instruct a nurse to do a rectal procedure as it was not within the scope of her authorized nursing practice. Dr. Germany stated that he had not

ordered a rectal examination, and that there was no medical reason to order a rectal examination on DD.

Hull ultimately determined that respondent had performed a rectal procedure on DD that was not ordered by a physician. Respondent was terminated from the hospital because of that conduct.

14. Respondent admitted at hearing that he placed his finger in DD's rectum but claimed he did so only one time and solely for the purpose of obtaining a fecal specimen for a Hemoccult[2] test. Respondent testified Gravidez told him Dr. Germany had ordered the test and that had instructed him to obtain a fecal sample from DD's rectum for the test. Respondent admits that he did not confirm the existence of a physician's order for the procedure, but feels that he was "set up" by Gravidez, whom he perceives to have a bias against his sexual orientation.

Respondent's testimony regarding the alleged conduct of Gravidez was not persuasive. Gravidez testified at hearing in a manner consistent with what she told Hull during the investigation: she did not tell respondent that Dr. Germany had ordered a rectal or Hemoccult exam on DD; and she did not instruct respondent to obtain a fecal sample from DD's rectum. Because respondent is a seasoned nurse, Gravidez would not have ordered him to do anything. Gravidez has been a nurse at O'Conner Hospital since 2002. She is well respected and trusted by her superiors, and he has a reputation for being truthful. Gravidez is found to be a credible witness.

15. Respondent testified that he thought it was odd that a Hemoccult test had been ordered for DD in light of DD's condition. Respondent also testified that he expressed this to DD at the time he inserted his finger into DD's rectum. This testimony was contradicted by the testimony of DD and his sister. They each testified that respondent said no such thing in their presence. And, if in fact respondent had thought the procedure was not appropriate for DD's condition, it was incumbent upon him to advocate for his patient up the chain of command regarding the procedure before performing it. Respondent did not do this.

16. There was no medical justification for respondent to perform a rectal examination on DD. There was nothing in DD's condition that would have warranted a rectal examination, and there was no physician order for such a procedure. In addition, it is beyond the scope of practice for a registered nurse to conduct a rectal examination; only physicians may perform such an invasive procedure.

17. There was no medical justification for respondent to insert his finger into DD's rectum in order to obtain a fecal sample for a Hemoccult test. There was nothing in DD's

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[2] A Hemoccult is a test for the presence of blood in the stool. The test is performed by applying a chemical solution to a stool smear placed on a test card. Among the reasons the test is performed is to determine if the patient has internal bleeding.

condition that would warrant a Hemoccult test, and there was not a physician's order for such a test. With respect to performing the test generally, it is beyond the scope of practice of a registered nurse for a nurse to insert a finger into a patient's rectum to obtain a fecal sample for a Hemoccult test; only a physician may perform such an invasive procedure.

18. The testimony of the board's expert, which was corroborated by a number of nurse witnesses, established by clear and convincing evidence that respondent's conduct in inserting his finger into DD's rectum constituted a substantial departure from the standard of care which would ordinarily have been exercised by a competent registered nurse. Respondent failed to provide appropriate care in a situation in which he knew, or should have known, might have jeopardized DD's health.

19. The testimony of the board's expert, which was corroborated by a number of nurse witnesses, established by clear and convincing evidence that respondent's conduct in performing the invasive procedure without a physician's order justifying such a procedure, and failing to indicate the procedure or the result of the procedure in the patient's chart constituted general unprofessional conduct.

20. The testimony of the board's expert established by clear and convincing evidence that respondent's conduct in performing the invasive procedure evidenced a failure to exercise that degree of learning, skill, care and experience normally possessed and exercised by a competent registered nurse.

21. The testimony of the board's expert established by clear and convincing evidence that because of the invasive nature of the unauthorized procedure, respondent's conduct constituted sexual misconduct.

22. The testimony of the board's expert established by clear and convincing evidence that respondent's conduct in failing to explain the procedure to DD prior to performing it evidenced the failure to exercise that degree of learning, skill, care and experience normally possessed and exercised by a competent registered nurse.

23. The testimony of the board's expert established by clear and convincing evidence that respondent's conduct in failing to advocate for DD and inquire up the chain of command regarding a procedure that appeared inconsistent with a patient's condition evidenced the failure to exercise that degree of learning, skill, care and experience normally possessed and exercised by a competent registered nurse.

24. Respondent argued, but did not establish, that Jan Bravo, M.D., another physician in the emergency room at O'Connell Hospital, had a common practice in October 2005 of directing emergency room nurses to obtain a fecal specimen for a Hemoccult test by any means necessary, including using a finger in the rectum. Dr. Bravo's testimony that she did not order nurses to obtain fecal specimens from patient's rectums was found persuasive.

25. Respondent also argued that an emergency room billing sheet for DD, which included a charge for an occult blood test, somehow corroborated his testimony. It was not established, however, which nurse completed the billing sheet. Respondent says he did not complete it, and none of the witnesses from O'Conner was able to identify the handwriting on the document. It is not known whether the insurance company was ever charged for such a procedure. But even it were, it does not provide credible support of respondent's testimony regarding his conduct.

Costs

26. The board has incurred expenses totaling $16,073 in the investigation and enforcement of this matter. This amount includes $7,912.50 in investigative costs, $300 in expert costs, and $7,860.50 in deputy attorney general costs, which represents 49.75 hours of attorney work. Respondent does not challenge the reasonableness of these costs. The costs are found to be reasonable.

Other Matters

27. After the incident, DD felt violated by what had happened to him. He thought about the incident through out the day, and he had trouble sleeping. He found himself crying when in the shower, and had difficultly being with people, even those with whom he was closest. DD testified that it was not until a few months ago that he finally felt better. DD did not, however, seek any professional help for his condition.

28. At the time of the incident with DD, respondent also held a nursing position with Kaiser Permanente Santa Theresa. After respondent was terminated from O'Conner he continued to work for a time with Kaiser Permanente but ultimately lost that position as well. As a result of losing his employment, respondent became unable to make his mortgage payments and he lost his home.

29. This is the board's first disciplinary action against respondent.

30. This is the first case in which a patient has complained about respondent's conduct as a nurse.

31. Respondent presented no evidence from past or current employers regarding his competence as a nurse.

LEGAL CONCLUSIONS

1. The standard of proof applied in this proceeding is clear and convincing evidence.

First Cause for Discipline (Gross Negligence)

2. Findings 12, 16 to 18: Cause for license discipline exists pursuant to Business and Professions Code section 2761, subdivision (a)(1), for gross negligence, as defined in California Code of Regulations, title 16, section 1442. Respondent's conduct constituted a substantial departure from the standard of care which would ordinarily have been exercised by a competent registered nurse.

Second Cause for Discipline (Incompetence)

3. Findings 12, 16, 17, 22 to 24: Cause for license discipline exists pursuant to Business and Professions Code section 2761, subdivision (a)(1), for incompetence, as defined in California Code of Regulations, title 16, section 1443. Respondent's conduct evidenced the failure to exercise that degree of learning, skill, care and experience normally possessed and exercised by a competent registered nurse when he did the following: (1) failed to confirm the existence of a physician order for a procedure and performed a procedure without an existing physician order; (2) left pain medication unattended in a patient room; (3) failed to explain a procedure to a patient prior to performing the procedure; and, (4) failed to advocate for a patient.

Third Cause for Discipline (Sexual Misconduct)

4. Findings 12, 16, 17, & 21: Cause for license discipline exists pursuant to Business and Professions Code section 2761, subdivision (a), in connection with Business and Professions Code section 726, in that respondent's invasive conduct constituted sexual misconduct with a patient.

Fourth Cause for Discipline (Unprofessional Conduct)

5. Findings 12, 16, 17, & 19: Cause for license discipline exists under Business and Professions Code section 2761, subdivision (a), for unprofessional conduct, by reason of respondent's conduct of inserting his finger into a patient's rectum without a physician's order, and failing to indicate the procedure or the result of the procedure in the patient's chart.

Costs

6. Finding 26: Business and Professions Code section 125.3 provides that a licentiate found to have violated the licensing law may be ordered to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. Pursuant to that section, cause exists to order respondent to reimburse the board the sum of $16,073.

Level of Discipline

7. The board's criteria of rehabilitation (Cal. Code Regs., tit. 16, § 2522) and its disciplinary guidelines (Cal. Code Regs., tit. 16, § 2524) have been considered in determining the appropriate discipline in this matter. The relevant criteria of rehabilitation are: the nature and severity of the act; actual or potential harm to the patient; overall disciplinary record; number and variety of violations; mitigation evidence; time passed since the act occurred; cooperation with board; and other evidence of rehabilitation. Respondent's Nursing Act violations cross a spectrum, and the violations include an act of sexual misconduct with a patient, which caused psychological harm to the patient. Respondent was a seasoned nurse at the time of the event and he should have known better. Respondent has given varying accounts of his conduct, rendering each of them suspect. Respondent was not truthful with his superiors at O'Connell Hospital regarding his conduct. Respondent's testimony at hearing was not fully candid and lacked credibility in many aspects. Respondent accepts very little responsibility for his actions, and continues to blame his preceptor nurse. There is no evidence in mitigation, and minimal evidence of rehabilitation. There is no evidence from current or past employers regarding respondent's competence as a nurse. The highest priority of the board is protection of the public. (Bus. & Prof. Code, § 2841.1.) Absent stronger evidence of rehabilitation, the only discipline which is sufficient to protect the public is license revocation.

ORDER

1. Registered Nurse License Number 523108 issued to respondent Michael Everette Tanner is revoked.

2. If and when respondent's license is reinstated, he shall pay to the board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $16,073. Respondent shall be permitted to pay these costs in a payment plan approved by the board. Nothing in this provision shall be construed to prohibit the board from reducing the amount of cost recovery upon reinstatement of the license.

DATED: June 12, 2009

Melissa Crowell

MELISSA G. CROWELL
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MICHAEL EVERETTE TANNER 349 Briar Ridge Road San Jose, CA 95123 Registered Nursing License No. 523108 Respondent.	Case No. 2009-51 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 2, 1996, the Board of Registered Nursing issued Registered Nursing License Number 523108 to Michael Everette Tanner (Respondent). The Registered Nursing License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2009, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section

references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

7. Section 726 of the Code states:

"The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division, under any initiative act referred to in this division and under Chapter 17 (commencing with Section 9000) of Division 3.

"This section shall not apply to sexual contact between a physician and surgeon and his or her spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship."

8. Section 125.3 of the Code provides, in pertinent part, that the Board may

request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

9. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

10. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

11. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the

subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

FACTUAL BACKGROUND

12. On or about November 2, 2005, Respondent was working as a registered nurse in the Emergency Department at O'Connor Hospital in San Jose, California. Patient D.D., a 33 year old male, was admitted to the Emergency Department at O'Connor Hospital for knee pain. The Emergency Department physician diagnosed D.D. with an infected prepatellar bursitis in the right knee, and right lower extremity cellulitus, and ordered: a blood culture, urinalysis, further blood tests, an IV saline lock, and pain medications.

13. On or about November 2, 2005, Respondent was assigned to care for D.D. in the O'Connor Emergency Department. Respondent came into D.D.'s room with a syringe in his mouth and pain medications. Respondent put the syringe and medications down, and left the room. When he returned, he instructed D.D. to roll over onto his side. Respondent told D.D. "As fast as I can put you in wonderland, I can bring you back." Respondent then inserted his finger into D.D.'s rectum, twice. There was no order for a rectal exam, or for a fecal occult blood test, or Hemoccult (a test for blood in the stool). Further, there was no record of a rectal exam, or the results of the rectal exam in D.D.'s chart.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

14. Respondent is subject to disciplinary action under section 2761(a)(1) in

that he was grossly negligent when he performed a rectal exam on patient D.D. on November 2, 2005 at O'Connor Hospital in San Jose, California, as described above in paragraphs 12 and 13.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

15. Respondent is subject to disciplinary action under section 2761(a)(1) in that he was incompetent when he performed a rectal exam on patient D.D. on November 2, 2005 at O'Connor Hospital in San Jose, California, as described above in paragraphs 12 and 13.

16. Respondent is further subject to disciplinary action under section 2761(a)(1) in that he was incompetent when he left patient D.D.'s room with pain medication and a syringe unattended, as described above in paragraphs 12 and 13.

17. Respondent is further subject to disciplinary action under section 2761(a)(1) in that he was incompetent when he failed to explain to patient D.D. that he was going to perform a rectal exam, as described above in paragraphs 12 and 13.

18. Respondent is further subject to disciplinary action under section 2761(a)(1) in that he was incompetent when he failed to advocate for the patient and inquire with the physician as to why a rectal exam would have been ordered on a healthy adult male with knee and leg pain, as described above in paragraphs 12 and 13.

THIRD CAUSE FOR DISCIPLINE

(Sexual Misconduct)

19. Respondent is subject to disciplinary action under section 2761(a) and/or section 726 in that he committed sexual misconduct when he performed a rectal exam on patient D.D. on November 2, 2005 at O'Connor Hospital in San Jose, California, as described above in paragraphs 12 and 13.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

20. Respondent is subject to disciplinary action under section 2761(a) in that he committed unprofessional conduct when he performed a rectal exam on patient D.D. on November 2, 2005 at O'Connor Hospital in San Jose, California, as described above in

paragraphs 12 and 13.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nursing License Number 523108, issued to Michael Everette Tanner.

2. Ordering Michael Everette Tanner to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/8/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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