



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.
Katherine A. Thomas
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse § AGREED
License Number 772845, and §
Vocational Nurse §
License Number 194317 §
issued to MARTIN LYNN SMITH § ORDER

An investigation by the Texas Board of Nursing, hereinafter referred to as the Board, produced evidence indicating that MARTIN LYNN SMITH, hereinafter referred to as Respondent, Registered Nurse License Number 772845, and Vocational Nurse License Number 194317, may have violated Section 301.452(b)(10)&(13), Texas Occupations Code.

An informal conference was held on January 26, 2010, at the office of the Texas Board of Nursing, in accordance with Section 301.464 of the Texas Occupations Code.

Respondent appeared in person. Respondent was notified of his right to be represented by legal counsel and elected to waive representation by counsel. In attendance were Katherine A. Thomas, MN, RN, Executive Director; John F. Legris, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; Toni Frizell, RN, Investigator; Kathy Duncan, RN, Investigator, and Nancy Krause, RN, Investigator.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license.
2. Respondent waived representation by counsel, notice and hearing, and consented to the entry of this Order.
3. Respondent holds a license to practice professional nursing and a license to practice vocational nursing in the State of Texas.

4. Respondent received a Certificate in Vocational Nursing from Howard College, San Angelo, Texas on June 3, 2004. Respondent was licensed to practice vocational nursing in the State of Texas on August 10, 2004. Respondent received an Associate Degree in Nursing from Angelo State University, San Angelo, Texas on May 16, 2009. Respondent was licensed to practice professional nursing in the State of Texas on July 14, 2009.
5. Respondent's nursing employment history includes:

5/2004 - 1/2007	Staff Nurse	Shannon Medical Center San Angelo, Texas
8/2004 - 12/2005	Float Nurse	Shannon Clinic San Angelo, Texas
4/2005 - 1/2006	Staff Nurse	San Angelo Adult Development Center San Angelo, Texas
8/2006 - 2008	Staff Nurse Agency	Critical Health Connection San Angelo, Texas
4/2007 - 1/2009	Float Nurse	Shannon Clinic San Angelo, Texas
1/2009 - 6/2009	Employed outside of Nursing	
6/2009 - 11/2009	Charge Nurse	Sterling County Nursing Home Sterling City, Texas
11/2009 - Present	Staff Nurse Medical/Telemetry	San Angelo Community Medical Center San Angelo, Texas

6. At the time of the incidents in Findings of Fact Numbers Seven (7) and Nine (9), Respondent was employed as a Staff Nurse with Shannon Medical Center, San Angelo, Texas and had been in this position for two (2) years and eight (8) months.

7. On or about January 3, 2007, while employed as a Staff Nurse with Shannon Medical Center, San Angelo, Texas, Respondent inappropriately allowed Patient AR to use the bathroom without providing supplemental oxygen or report to the LVN relieving him that Patient AR was on 35% ventimask. Respondent assisted Patient AR to the bathroom, then left the room to obtain oxygen extension tubing from the respiratory department supply area. Additionally, Respondent proceeded to the cafeteria to obtain a beverage before returning to the floor with the oxygen tubing, and failed to return to the floor in a timely manner with the necessary supplies to provide oxygen to the patient. Subsequently, Patient AR became short of breath with a decreased oxygen saturation level requiring intubation and transfer to ICU. Respondent's may have resulted in Patient AR's inability to maintain his oxygen saturation within normal limits, becoming hypoxic, and exhibiting signs and symptoms of respiratory failure.
8. In response to the incident in Finding of Fact Number Seven (7), Respondent states that the patient had removed the supplemental oxygen device he was using to eat breakfast and was using it intermittently without signs or symptoms of being short of breath. There was no oxygen extension tubing present in the patient's room to reach to the bathroom when he discovered the patient attempting to walk to the bathroom without assistance. The patient did not exhibit any signs of being short of breath once settled in the bathroom and Respondent states that he requested the nurse's aide to change the bed sheets and assist the patient back to bed when he was through in the bathroom. Respondent admits that he assumed that the LVN on the unit with him knew the patient was on oxygen because they had been in report together and received the same information at shift change. Respondent states he did not realize the seriousness of the patient's condition because the patients on that floor were Intermediate Care, only requiring a patient check every two (2) hours. Additionally, Respondent asserts that he had not received training or education in regard as to why a patient would require a ventimask rather than regular oxygen.
9. On or about January 3, 2007, while employed as a Staff Nurse with Shannon Medical Center, San Angelo, Texas, Respondent failed to accurately document in Patient AR's medical record, in that he misdated the nurses notes to indicate January 4, 2007, instead of January 3, 2007. Respondent's conduct resulted in an inaccurate medical record and was likely to injure the patient in that subsequent care givers would not have accurate information on which to base their care decisions.

10. In response to the incident in Finding of Fact Number Nine (9), Respondent states that he opened his notes as usual that morning. He was sent home two (2) hours after the incident occurred and he did not return to the facility. Respondent admits that he misdated the notes and although he wrote January 4, 2007, they were written January 3, 2007 before he left the facility. Respondent also admits the duties assigned to him were beyond his training and experience.
11. After the incident in Findings of Fact Numbers Seven (7) and Nine (9), Respondent successfully completed supervised physical assessment, documentation and medication administration courses and clinicals while attending Angelo State University, Licensed Vocational Nurse to Registered Nurse Transition Education curriculum on May 5, 2009; and Respondent successfully completed the Texas Board of Nursing Jurisprudence Examination on May 5, 2009, which would have been a requirement of this order.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.455, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(B),(1)(C),(1)(D), (1)(G), (1)(H) &(1)(T) and 217.12(1)(B), (1)(E)&(4).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 772845, and Vocational Nurse License Number 194317, heretofore issued to MARTIN LYNN SMITH, including revocation of Respondent's license to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a WARNING WITH STIPULATIONS, 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 AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate licensure privilege, if any, to practice nursing in compact states.

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

IT IS FURTHER AGREED that:

(1) 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>.*

Texas Board of Nursing within ten (10) days of the date of this Order.

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS

HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE A REGISTERED NURSE (RN) OR VOCATIONAL NURSE (LVN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD.

(2) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(3) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(4) RESPONDENT SHALL CAUSE each employer to immediately submit any and all incident, counseling, variance, unusual occurrence, and medication or other error reports involving RESPONDENT, as well as documentation of any internal investigations regarding action by RESPONDENT, to the attention of Monitoring at the Board's office.

(5) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT's capability to practice

nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) 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 RESPONDENT's license and RESPONDENT shall be eligible for multistate licensure privileges, if any, to practice nursing in the State of Texas.

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RESPONDENT'S CERTIFICATION

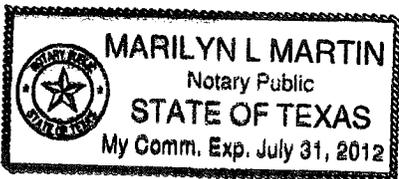
I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. 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 understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice professional and vocational nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 8th day of March, 2010.
Martin Lynn Smith
MARTIN LYNN SMITH, Respondent

Sworn to and subscribed before me this 8th day of March, 2010.

SEAL

Marilyn L Martin
Notary Public in and for the State of Texas



WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 8th day of March, 2010, by MATIN LYNN SMITH, Registered Nurse License Number 772845, and Vocational Nurse License Number 194317, and said Order is final.

Effective this 22nd day of April, 2010.




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