



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.
Patricia A. Morales
Executive Director of the Board

DOCKET NUMBER 507-09-0618

**IN THE MATTER OF
PERMANENT CERTIFICATE
NUMBER 125410
ISSUED TO
JUAN A. MORALES**

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**BEFORE THE STATE OFFICE
OF
ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: JUAN A. MORALES
2711 WATER STREET
LAREDO, TX 78040

ROY G. SCUDDAY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
SUITE 502
AUSTIN, TEXAS 78711-3025

At the regularly scheduled public meeting on January 22 - 23, 2009, the Board considered the following items: (1) The Proposal for Decision (PFD) regarding the above cited matter; and (2) Staff's recommendations that the Board adopt the PFD regarding the Vocational Nursing license of Juan A. Morales without changes.

The Board of Nursing 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.

The Board of Nursing, after review and due consideration of the PFD and Staff's recommendations 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. Further, all proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are

hereby denied.

IT IS, THEREFORE, ORDERED THAT Permanent Certificate Number 125410, previously issued to JUAN A. MORALES, to practice vocational nursing in the State of Texas be, and the same is hereby, REVOKED.

IT IS FURTHER ORDERED that, before the Board will consider the reinstatement of Respondent's license to practice vocational nursing in Texas, one year must have elapsed from this order of revocation and Respondent must satisfy all then existing requirements for licensure and demonstrate that he has undergone sufficient counseling to ensure that Respondent's misconduct will not be repeated.

IT IS FURTHER ORDERED that Permanent Certificate Number 125410, previously issued to JUAN A. MORALES, upon receipt of this Order, be immediately delivered to the office of the Texas Board of Nursing for the State of Texas.

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

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multistate licensure privilege, if any, to practice professional nursing in compact states.

THE TEXAS BOARD OF NURSING

Entered and effective this 23rd day of January, 2009.

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

Attachment: Proposal for Decision; Docket No. 507-09-0618 (December 19, 2008).

IN THE MATTER OF PERMANENT
CERTIFICATE NO. 125410
ISSUED TO

JUAN A. MORALES

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BEFORE THE STATE OFFICE

OF

ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff of the Texas Board of Nursing (Staff/Board) brought action against Juan A. Morales (Respondent) for violating TEX. OCC. CODE ANN. (Code) § 301.452 and 22 TEX. ADMIN. CODE (TAC) §§ 217.11 and 217.12 by engaging in sexual inappropriateness with patients. Staff sought to revoke Respondent's license and sought to impose on Respondent administrative costs of the proceeding pursuant to Code § 301.461. The Administrative Law Judge (ALJ) recommends that Respondent's license be revoked, and that administrative costs not be imposed on Respondent.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The hearing convened December 3, 2008, before ALJ Roy G. Scudday in the William P. Clements Building, 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by James W. Johnston, Assistant General Counsel. Respondent appeared on his own behalf. The record closed at the conclusion of the hearing on that day.

Matters concerning notice and jurisdiction were undisputed. Those matters are set out in the Findings of Fact and Conclusions of Law.

II. REASONS FOR DECISION

A. Background

Respondent is licensed as a vocational nurse. On August 11, 2006, Staff sent Respondent notice that it had filed Formal Charges against Respondent. On August 29, 2008, Staff sent

Respondent its First Amended Formal Charges. On October 14, 2008, Staff sent Respondent its Notice of Hearing.

B. Staff's Charges

Staff alleged six charges against Respondent as follows:

- 1) On March 20, 2004, Respondent engaged in sexual inappropriateness and contact by fondling and touching the genitals of a patients without his consent, in violation of Code § 301.452(b)(10) & (13) as well the Board rules at 22 TAC §§ 217.11(1)(B) & (J), and 217.12(6)(C), (D), & (E).
- 2) On March 20, 2004, Respondent engaged in sexual inappropriateness and contact by fondling and touching the genitals of a patients without his consent, in violation of Code § 301.452(b)(10) & (13) as well the Board rules at 22 TAC §§ 217.11(1)(B) & (J), and 217.12(6)(C), (D), & (E).
- 3) On June 28, 2004, Respondent engaged in sexual inappropriateness and contact by fondling and stroking the genitals of and performing oral sex on a patient, in violation of Code § 301.452(b)(10) & (13) and 22 TAC §§ 217.11(1)(B) & (J), and 217.12(6)(C), (D), & (E).
- 4) On June 28, 2004, Respondent performed a triage assessment of a patient for which he was not educationally prepared to perform, in violation of Code § 301.452(b)(10) & (13) and 22 TAC § 217.12(1)(E) & (4).
- 5) On April 21, 2006, Respondent engaged in sexual inappropriateness and contact by fondling and stroking the genitals of a patient, in violation of Code § 301.452(b)(10) & (13) and 22 TAC §§ 217.11(1)(B) & (J), and 217.12(6)(C), (D), & (E).
- 6) On August 2, 2006, Respondent provided false, deceptive, and/or misleading information on his license renewal by answering no to the question of whether there were any pending criminal charges against him, in violation of Code § 301.452(b)(2) & (10) and 22 TAC § 217.12(6)(I).

C. Evidence

Staff submitted multiple exhibits and provided testimony of Respondent, patients R.T. and G.H.; Alfonso Holguin, and Carol Marshall, Nursing Practice Consultant for the Board. Respondent testified on his own behalf.

1. Undisputed Facts

Respondent has been a licensed vocational nurse (LVN) since 1989. Respondent was employed as a LVN at Doctors Hospital of Laredo from July 31, 2001, through June 29, 2005. Respondent was employed as a LVN at the Buena Salud unit of the Association for the Advancement of Mexican Americans from December 20, 2003, through October 29, 2004. Respondent was employed as a LVN at Dilley Community Hospital from November 1, 2004, through April 21, 2006.

On March 20, 2004, while working as a LVN at the Buena Salud rehabilitation unit, Respondent treated S.P., a resident of the unit, who complained of abdominal pain, diarrhea, and cramping. Respondent closed the door of the nursing station and, using a stethoscope, listened to S.P.'s abdomen for bowel sounds. Respondent also touched S.P.'s abdomen to determine if any tenderness existed. Although S.P. alleged that Respondent had touched his genitals, no criminal charge or disciplinary action was instituted.

On March 20, 2004, while working as a LVN at the Buena Salud rehabilitation unit, Respondent treated R.T., a resident of the unit, who also complained of abdominal pain, diarrhea, and cramping. Respondent closed the door of the nursing station and, using a stethoscope, listened to R.T.'s abdomen for bowel sounds. Respondent also touched R.T.'s abdomen to determine if any tenderness existed. Although R.T. alleged that Respondent had touched his genitals, no criminal charge or disciplinary action was instituted.

On June 28, 2004, while working as a LVN in the emergency room of the Doctors Hospital of Laredo, Respondent treated G.H., who complained of an allergic rash and trouble

swallowing. Respondent directed G.H. to an examining room and instructed him to take off his clothes and put on a gown. G. H. removed his outer clothing but kept his undershorts on. G.H. was examined by a doctor who prescribed Benadryl and another medication, which Respondent gave to G.H. G.H. was subsequently discharged from the emergency room. Respondent signed the Emergency Department Record in the space labeled "Triage Nurse".

On June 1, 2005, Respondent was indicted for the offense of sexual assault for knowingly causing the sexual organ of G.H., without G.H.'s consent, to contact Respondent's mouth. A jury trial was subsequently held in the 406th District Court of Webb County, Texas, in which trial Respondent was acquitted.

On April 21, 2006, while working as a LVN at Dilley Community Hospital, Respondent attended L.M., flushing out his IV and giving him medication, including placing prescribed valium in L.M.'s applesauce to help him consume the medicine. L.M. phoned his mother who proceeded to the hospital, talked to her son, and then demanded that the police be called, complaining that Respondent had touched her son's genitals. According to the Employee Warning Notice, Respondent was suspended pending the outcome of an investigation. No charges were filed in the incident.

On August 2, 2006, Respondent renewed his license electronically. He answered the following question "NO":

Have you ever been arrested, convicted, placed on community supervision whether or not adjudicated guilty, sentenced to serve jail or prison time or granted pre-trial diversion, or plead guilty, no contest or nolo contendere to any crime in any state, territory or country, or received a court order whether or not a sentence was imposed, including any pending criminal charges or unresolved arrests whether or not appealed (excluding minor Class C traffic violations)? This includes expunged offenses and deferred adjudications with or without a finding of guilty. Please note that DUIs, DWIs, and PIs must be reported and are not considered minor traffic violations. One time minor in possession [MIP] or minor in consumption [MIC] does not need to be disclosed; therefore, you may answer "No." If you have two or more MIPs or MICs, you must answer "Yes." You may answer "No" if you have previously disclosed a criminal matter otherwise responsive to this question in a renewal and/or license form.

At the time Respondent renewed his license online, the Webb County indictment for sexual assault was still pending.

2. R.T.'s Testimony

R.T. was a resident at the Buena Salud rehabilitation unit. He testified that while Respondent was touching his abdomen to determine if any tenderness existed, Respondent reached inside R.T.'s undershorts and touched his genitals. R.T. testified that he had not complained of any pain regarding his genitals, and Respondent agreed that there was no reason for him to have touched R.T.'s genitals, and insisted that he did not do so.

3. G.H.'s Testimony

While on a family outing at Garner State Park, G.H. developed a severe rash on his body. He went to the emergency room of Doctor's Hospital of Laredo. G.H. testified that, while he was in the examining room, Respondent touched his genitals, explaining that he needed to do so to examine the extent of the rash. After the physician examined him, G.H. stated that Respondent brought him four pills, which he took and then blacked out. When G.H. regained consciousness he felt a pain in his penis, found that he was lying on the examining table, his undershorts were on the floor, and Respondent had his mouth on G.H.'s penis. G.H. pushed Respondent away, gathered his clothes and left the examining room. G.H. stated that he did not remember signing the discharge paper, nor what he did before returning to his home. After talking to his father the next day, G.H. proceeded to report the incident to the police. G.H. testified that he suffered considerable anger and embarrassment as a result of the incident.

4. Respondent's Testimony

While Respondent admitted to treating S.P. and R.T. at Buena Salud and G.H. at Doctor's Hospital, Respondent denied having touched the patients' genitals, or having had contact with G.H.'s

penis. He pointed out that he had been acquitted of the charges regarding the G.H. accusation, and asserted that all he had done in each case was to provide the best medical treatment to them.

Respondent admitted that he had been accused of touching the genitals of patient L.M. while working at Dilley Community General Hospital on April 21, 2006. According to Respondent, he had been helping L.M. go from the bathroom to the bed, but denied touching the patient's genitals. Respondent stated that he was told to take time off because of an unrelated administrative issue, but that he did not consider that he had been suspended for the L.M. incident.

In regard to the signing of the Doctor's Hospital form as a triage nurse, Respondent stated that he was not acting as a triage nurse, merely a receiving nurse, and had only examined G.H.'s rash because the emergency room was short-handed, and he wanted to determine if there was a need for emergency attention. As for the answering of the question regarding pending charges on his renewal form, Respondent testified that he was confused by the question and thought he only needed to disclose prior convictions, of which he had none.

5. Carol Marshall's Testimony

Ms. Marshall has been a Registered Nurse for 28 years with experience in diverse areas including critical care, outpatient/observation, surgery, long-term acute care, nurse aide testing, and regulation. As a Nurse Practicing Consultant for the Board since 2000, Ms. Marshall assists the Enforcement and Legal Divisions with case reviews and testifies as an expert witness in SOAH hearings.

Ms. Marshall testified that because sexual misconduct toward patients necessarily violates the trust of the patient, the Board has established the consideration of the appropriate sanctions for such conduct. She pointed out that sexual misconduct toward patients is never acceptable, that subsequent conduct of a similar nature indicates a pattern that supports license revocation, and that the four documented incidents support such a revocation in this case and the requirement for counseling.

With regard to the triage nurse allegation, Ms. Marshall noted that Board policy defines triage as the sorting of patients and prioritizing of care based on the degree or urgency and complexity of patient conditions, and she testified that such duties are beyond the scope of practice for LVNs because they are not educationally prepared to perform triage assessments. For that reason, the duties performed by Respondent in the Doctor's Hospital emergency room were outside Respondent's scope of practice.

Finally, regarding the erroneous answer on the renewal form, Ms. Marshall testified the Board's Disciplinary Sanctions for Lying and Falsification states that such a falsification raises concern about the person's propensity to lie, and the likelihood that such conduct will continue in the practice of nursing. Ms. Marshall stated that she felt the question on the form was clearly stated and that Respondent had no basis on which to be confused, particularly because an applicant for license renewal should understand the questions and importance of answering them honestly.

D. Analysis and Recommendation

1. Legal Standards

Code Chapter 301 is the Nursing Practice Act (the Act) that regulates professional and vocational nurses. The Board may suspend a nurse's license if the person is guilty of "fraud or deceit in procuring or attempting to procure a license" to practice vocational nursing;¹ engaged in "unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public,"² or failed to "conform to the minimum standards of acceptable nursing practice in a manner that, in the board's opinion, exposes a patient or other person unnecessarily to risk of harm."³

¹ Code § 301.452(b)(2).

² Code § 301.452(b)(10).

³ Code § 301.452(b)(13).

The Board rules provide that a LVN must “know and conform to the Texas Nursing Practice Act and the board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;”⁴ “implement measures to promote a safe environment for clients and others;”⁵ “know, recognize, and maintain professional boundaries of the nurse-client relationship;”⁶ “accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability;”⁷ and the LVN shall “utilize a systematic approach to provide individualized, goal-directed nursing care” by implementing appropriate aspects of care within the LVN's scope of practice.⁸

The definition of unprofessional conduct includes the unsafe practice of “accepting the assignment of nursing functions or a prescribed health function when the acceptance of the assignment could be reasonably expected to result in unsafe or ineffective client care;”⁹ and “careless or repetitive conduct that may endanger a client's life, health, or safety.”¹⁰ The definition of unprofessional conduct also includes conduct “causing or permitting physical, emotional or verbal abuse or injury or neglect to the client or the public, or failing to report same to the employer, appropriate legal authority and/or licensing board;”¹¹ “violating professional boundaries of the nurse/client relationship including but not limited to physical, sexual, emotional or financial exploitation of the client or the client's significant other(s);”¹² and “engaging in sexual conduct with a client, touching a client in a sexual manner, requesting or offering sexual favors, or language or behavior suggestive of the same.”¹³

⁴ 22 TAC § 217.11(1)(A).

⁵ 22 TAC § 217.11(1)(B).

⁶ 22 TAC § 217.11(1)(J).

⁷ 22 TAC § 217.11(1)(T).

⁸ 22 TAC § 217.11(2)(A)(iv).

⁹ 22 TAC § 217.12(1)(E).

¹⁰ 22 TAC § 217.12(4).

¹¹ 22 TAC § 217.12(6)(C).

¹² 22 TAC § 217.12(6)(D).

¹³ 22 TAC § 217.12(6)(E).

2. Specific Charges

Staff's first, second, third, and fifth charges are that Respondent touched the genitals of four patients in violation of Code § 301.452(b)(10) & (13) and the Board rules at §§ 217.11(1)(B) & (J), and 217.12(6)(C), (D), & (E). The testimony of R.T. and G.H. sufficiently established that Respondent did touch their genitals. Even without the documentation in support of the similar allegations regarding S.P. and L.M., Staff has shown by a preponderance of the evidence that these two incidents are violations of the statute and rules.

Staff's fourth charge is that Respondent acted as a triage nurse without the proper educational background in violation of Code § 301.452(b)(10) & (13) and of the rule at 22 TAC § 217.12(1)(E) & (4). It is clear from the evidence that Respondent was performing as a triage nurse when he attended G.H., and that such practice was not within his educational qualifications. Accordingly, Staff has shown by a preponderance of the evidence that this incident was a violation of the statute and rule.

Staff's fifth charge is that Respondent gave a false answer to a question on his online renewal application in violation of Code § 301.452(b)(2) & (10) and 22 TAC § 217.12(6)(I). While the question is not as clear as it could be, Respondent knew that there were charges pending in Webb County, and he should have known that a negative answer to the question was misleading. As a result, Staff has shown by a preponderance of the evidence that this was a violation of the statute and rule.

3. Recommended Sanctions

Staff argues that the only appropriate sanction for Respondent's violations is revocation of his license for a period of one year and a requirement of counseling before reinstatement.

The Board rule at 22 TAC § 213.33 provides factors to be considered for imposition of sanctions including the following:

- 1) evidence of actual or potential harm to patients, clients, or the public;
- 2) evidence of a lack of truthfulness or trustworthiness;
- 3) evidence of misrepresentation(s) of knowledge, education, experience, credentials, or skills which would lead a member of the public, an employer, a member of the health-care team, or a patient to rely on the fact(s) misrepresented where such reliance could be unsafe;
- 4) evidence of practice history;
- 5) evidence of present fitness to practice;
- 6) 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; and
- 13) any other matter that justice may require.

Ms. Marshall asserted that Respondent's sexual misconduct exhibited evidence of potential harm to patients; a history of misconduct; a question of his fitness of to practice; the length of time he has been licensed during which the misconduct occurred; the emotional damage resulting from the misconduct; the apparent failure of Respondent to attempt to correct or stop the misconduct; and the aggravated circumstances of the misconduct. She also pointed out that Respondent's failure to answer the renewal form question truthfully is evidence of his lack of truthfulness. For these reasons, Ms. Marshall asserted that a one-year revocation was the only available sanction, and that it would be inherent on Respondent to show that he had corrected his behavior before his license could be reinstated.

After reviewing the evidence and arguments of the parties, the ALJ recommends that Respondent's license be revoked for a period of one year, after which Respondent should demonstrate to the Board that he has undergone sufficient counseling to ensure that his misconduct would not be repeated before being reinstated.

Staff also sought the administrative costs of this proceeding pursuant to Code § 301.461. However, Staff offered no evidence in support of that pleading, and, as a result, no costs can be imposed.

III. FINDINGS OF FACT

1. Juan A. Morales, LVN (Respondent), holds License Number 125410 issued by the Texas Board of Nursing (Board/Staff).
2. On August 11, 2006, Staff sent Respondent notice that it had filed Formal Charges against Respondent. On August 29, 2008, Staff sent Respondent its First Amended Formal Charges. On October 14, 2008, Staff sent Respondent its Notice of Hearing.
3. The notice of hearing 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.
4. The hearing on the merits was held on December 3, 2008, in the William P. Clements Building, 300 West 15th Street, Austin, Texas. All parties appeared and participated in the hearing. The record closed at the conclusion of the hearing on that date.
5. Respondent has been a licensed vocational nurse (LVN) since 1989. Respondent was employed as a LVN at Doctors Hospital of Laredo from July 31, 2001, through June 29, 2005. Respondent was employed as a LVN at the Buena Salud unit of the Association for the Advancement of Mexican Americans from December 20, 2003, through October 29, 2004. Respondent was employed as a LVN at Dilley Community Hospital from November 1, 2004, through April 21, 2006.
6. On March 20, 2004, while working as a LVN at the Buena Salud rehabilitation unit, Respondent treated R.T., a resident of the unit, who also complained of abdominal pain, diarrhea, and cramping. Respondent closed the door of the nursing station and using a stethoscope, listened to R.T.'s abdomen for bowel sounds. Respondent also touched R.T.'s abdomen to determine if any tenderness existed. Respondent reached inside R.T.'s undershorts and touched his genitals, although R.T. had not complained of any pain regarding his genitals. There was no medical reason for Respondent to have touched R.T.'s genitals.
7. On June 28, 2004, while working as a LVN in the emergency room of the Doctors Hospital of Laredo, Respondent treated G.H. who complained of an allergic rash and trouble swallowing. Respondent directed G.H. to an examining room and instructed him to take off his clothes and put on a gown. G. H. removed his outer clothing but kept his undershorts on. G.H. was

examined by a doctor who prescribed Benadryl and another medication, which Respondent gave to G.H, who then blacked out. G.H. regained consciousness when he felt a pain in his penis, found that he was lying on the examining table, his undershorts were on the floor, and Respondent had his mouth on G.H.'s penis. G.H. pushed Respondent away, gathered his clothes and left the examining room. G.H. was subsequently discharged from the emergency room, although he did not remember signing the discharge paper, nor what he did before returning to his home.

8. After talking to his father the next day, G.H. proceeded to report the incident to the police. On June 1, 2005, Respondent was indicted for the offense of sexual assault for knowingly causing the sexual organ of G.H., without G.H.'s consent, to contact Respondent's mouth. A jury trial was subsequently held in the 406th District Court of Webb County, Texas, in which trial Respondent was acquitted. G.H. suffered considerable anger and embarrassment as a result of the incident.
9. On March 20, 2004, while working as a LVN at the Buena Salud rehabilitation unit, Respondent treated S.P., a resident of the unit, who complained of abdominal pain, diarrhea, and cramping. Respondent closed the door of the nursing station and using a stethoscope, listened to S.P.'s abdomen for bowel sounds. Respondent also touched S.P.'s abdomen to determine if any tenderness existed. Although S.P. alleged that Respondent had touched his genitals, no criminal charges or disciplinary action was instituted.
10. On April 21, 2006, while working as a LVN at Dilley Community Hospital, Respondent attended L.M., flushing out his IV and giving him medication, including placing prescribed valium in L.M.'s applesauce to help him consume the medicine. L.M. phoned his mother who proceeded to the hospital, talked to her son, and then demanded that the police be called, complaining that Respondent had touched her son's genitals. Respondent was suspended pending the outcome of an investigation. No criminal charges were filed in the incident.
11. The Emergency Department Record for the treatment of G.H. at Doctors Hospital of Laredo showed that Respondent had signed the record in the space labeled "Triage Nurse." On June 21, 2004, Respondent was performing the duties of a triage nurse, sorting patients and prioritizing of care based on the degree of urgency and complexity of patient conditions. The duties of a triage nurse are beyond the scope of practice for LVNs.
12. On August 2, 2006, Respondent renewed his license electronically. He answered the following question "NO":

Have you ever been arrested, convicted, placed on community supervision whether or not adjudicated guilty, sentenced to serve jail or prison time or granted pre-trial diversion, or plead guilty, no contest or nolo contendere to any crime in any state, territory or country, or received a court order whether or not a sentence was imposed, including any pending criminal charges or unresolved arrests whether or not appealed (excluding minor Class C traffic violations)? This includes expunged offenses and

deferred adjudications with or without a finding of guilty. Please note that DUIs, DWIs, and PIs must be reported and are not considered minor traffic violations. One time minor in possession [MIP] or minor in consumption [MIC] does not need to be disclosed; therefore, you may answer "No." If you have two or more MIPs or MICs, you must answer "Yes." You may answer "No" if you have previously disclosed a criminal matter otherwise responsive to this question in a renewal and/or license form.

At the time Respondent renewed his license online, the Webb County indictment for sexual assault was still pending.

13. Staff offered no evidence in support of the imposition on Respondent of the administrative costs of this proceeding pursuant to Code § 301.461.

IV. CONCLUSIONS OF LAW

1. The Texas Board of Nursing (Board) has jurisdiction over this matter pursuant to TEX. OCC. CODE ANN. (Code) ch. 301.
2. The State Office of Administrative Hearings has jurisdiction over the hearing in this proceeding, including the authority to issue a proposal for decision with proposed findings of fact and conclusions of law, pursuant to TEX. GOV'T CODE ANN. ch. 2003.
3. Notice of the formal charges and of the hearing on the merits was provided as required by Code § 301.454 and by the Administrative Procedure Act, TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.
4. Staff had the burden of proving the case by a preponderance of the evidence.
5. Based on Findings of Fact Nos. 6 and 7, Respondent did violate Code § 301.452(b)(10) & (13) and 22 TEX. ADMIN. CODE (TAC) §§ 217.11(1)(B) & (J), and 217.12(6)(C), (D), & (E).
6. Based on Finding of Fact No. 11, Respondent did violate Code § 301.452(b)(10) & (13) and 22 TAC § 217.12(1)(E) & (4).
7. Based on Finding of Fact No. 12, Respondent did violate Code § 301.452(b)(2) & (10) and 22 TAC § 217.12(6)(I).
8. Based upon Findings of Fact Nos. 6-12, Conclusions of Law Nos. 6 and 7, and the factors for consideration of sanctions set forth in 22 TAC § 213.33, the Board should revoke Respondent's license for a period of one year, after which Respondent should demonstrate to the Board that he has undergone sufficient counseling to ensure that his misconduct would not be repeated before being reinstated.

9. Based upon Finding of Fact No. 13, administrative costs of this proceeding should not be imposed on Respondent.

SIGNED December 19, 2008.



**ROY G. SCUDDAY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS**