DOCKET NUMBER 507-24-22303

IN THE MATTER OF	**§**	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	**§**	
NUMBER LVN 348047,	**§**	**OF**
ISSUED TO	**§**	
LATEEF AKINOLA OWOKONIRAN	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: LATEEF AKINOLA OWOKONIRAN
6743 CATARINA CIRCLE
HOUSTON, TX 77084

SUSAN RODRIGUEZ
ADMINISTRATIVE LAW JUDGE
PO BOX 13025
AUSTIN, TX 78711-3025

At the regularly scheduled public meeting on July 17, 2025, the Texas Board of Nursing (Board) considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; Staff's recommendation to the Board regarding the PFD and order; and 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. The ALJ issued an Exception Letter which found no exceptions were timely filed.

The Board, after review and due consideration of the PFD; Staff's recommendations; and the recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

Pursuant to Tex. Occ. Code. §301.459 (a-1), an Administrative Law Judge may make a recommendation regarding an appropriate action or sanction. The Board, however, has the sole authority and discretion to determine the appropriate action or sanction.

Respondent was a doctor in Nigeria for six years before moving to the United States and attempting unsuccessfully to obtain medical licenses in both North Carolina

and Texas.[1] Respondent contacted the Texas Board of Nursing in 2015 and asked whether he could obtain a nursing degree without nursing education because of his medical background in Nigeria.[2] When the Board declined, Respondent enrolled in the College of Healthcare Professionals (CHP) to obtain a certificate which would allow him to sit for the NCLEX examination for Licensed Vocational Nurses (LVNs), and attended both didactic and clinical courses, but withdrew after several months due to financial issues. Respondent then researched online nursing programs and found Sunshine Academy (Sunshine) in Florida. The Florida Board had only approved this program for a twelve-month in-person delivery including 675 hours of clinical experience in a healthcare setting.[3]

Respondent's testimony indicated he took courses for a few months online, never attending courses in-person, completed only one or two of the courses listed in his transcript, and received no hands-on clinical training.[4] Sunshine acted outside its authority when it issued Respondent a diploma and Respondent thus worked as a LVN in Texas under a diploma that was issued unlawfully in violation of the Nursing Practice Act (NPA).[5] Furthermore, the education he received at Sunshine was not substantially equivalent to a Texas education because it was online, he did not complete most of the required didactic courses and he received no clinical instruction. The Board cannot consider his nursing work at CHP because he was not awarded a diploma and none of his credits transferred to Sunshine.[6]

Respondent submitted an application to the Texas Board for license as a LVN by examination claimed to have attended "Sunrise Academy" from April 2017 to April 2018, where his affidavit of graduation from Sunshine shows his attendance was from June 2016 to June 2017.[7] His transcript reflections completion of the Sunshine approved hours of instructions and clinicals with no credits transferred from his time at CHP. Respondent signed the application, sat for the NCLEX on March 23, 2019, and was issued an LVN license on March 26, 2019. Respondent's conduct constituted fraud because he had completed three post-secondary degree programs in Nigeria, he knew he was required to have a nursing education to take the NCLEX,[8] enrolled at a legitimate program of nursing (CHP) to which he didn't complete or list on his application,[9] did not complete most courses on his Sunshine transcript, he understood an acceptable nursing education includes both didactic and clinical experiences, attested he attended the program for a year on his application but testified to attending for only six months,[10] he believed his medical degree qualified him for licensure as a nurse, he did not think he needed to take nursing classes to sit for the NCLEX, the Board's refusal to let him challenge the examination was unfair, his only goal in attending Sunshine was to be able to take the NCLEX, he was paying $10,000 to Sunshine only (a fraction of the cost of CHP), and he

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[1] PFD at p. 8.
[2] *Id.*
[3] PFD at p. 9.
[4] PFD at p. 29.
[5] PFD at p. 30.
[6] PFD at p. 31.
[7] PFD at p. 10.
[8] PFD at p. 32.
[9] PFD at p. 33.
[10] PFD at p. 34.

testified that he completed all nursing concepts at CHP and had completed all clinical learning experiences prior to his enrollment at Sunshine despite withdrawing early. Since obtaining his Texas license, Respondent has practiced as an LVN in Texas[11] in violation of Texas Occupations Code §301.451(3)(A) and is subject to discipline under Texas Occupations Code §301.452(b)(1).[12] If the Respondent continued to practice under his current credentials, he would continue to violate Tex. Occ. Code § 301.451(3)(B),[13] and by extension, Tex. Occ. Code § 301.452(b)(1).

Respondent began working as an LVN in the state of Texas in April 2019. From January 2020 through May 2022, Respondent worked at the Scott Jester IV Unit (Jester IV) as an LVN in a correctional setting. Jester IV is a psychiatric unit divided into an "A" side, "B" side, "D" side, and "E" side and further divided into three pods where inmates are housed.[14] Jester IV had standing delegation orders (SDO) written by a physician for specific scenarios that a nurse is expected to complete. These included an SDO for head injury or trauma that required the nurse to administer oxygen, apply a C-collar, place the patient on a backboard before moving the patient, take vital signs every fifteen minutes until redirected by a provider or transferred, establish an intravenous line (IV) and notify the provider of findings.[15]

On November 3, 2022, Respondent was working on the "D" and "E" side of Jester IV and responded to a call regarding a patient fall. Respondent documented that the patient had swelling on the left side of his forehead, was fully conscious and alert, and had weak lower limbs.[16] The medical record did not indicate that Respondent notified the provider. Around 11:30 p.m. on the same date, security found the patient in his pod choking on his food, gasping for breath, and ultimately becoming unresponsive. Ultimately, cardiopulmonary resuscitation (CPR) was initiated, and emergency medical services (EMS) took the patient, unresponsive to a local emergency department.[17] Respondent' initial assessment of the patient and intervention was inadequate in numerous ways: "Respondent did not check the patient's blood sugar, there was no assessment of Patient's cognitive functioning even though he observed swelling on Patient's forehead after a fall, Respondent did not grade Patient's muscle strength despite noting he had weak lower limbs, and he did not try to find out why or how Patient fell,"[18] he also "did not take Patient's vital signs every fifteen minute, which would have alerted him if Patient's condition began to decline; he moved Patient from the floor to the bed without a C-collar and a backboard, despite evidence that Patient suffered a head injury; and Respondent did not properly collaborate with other providers about Patient's care."[19]

Despite Respondent's argument that it was not within his scope of practice to start an IV, the ALJ found "the duties in the SFO are within an LVN's scope of practice."[20]

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[11] PFD at p. 14, Conclusion of Law No. 10.
[12] PFD at p. 32.
[13] PFD at p. 21.
[14] PFD at p. 11.
[15] *Id.*
[16] PFD at p. 12.
[17] PFD at p. 13.
[18] PFD at p. 36.
[19] *Id.*
[20] PFD at p. 37.

Respondent argued that directives in an SDO could not have been completed during night shift. However, the fall in question occurred at 1:20 p.m. during a day shift scheduled from 5:45 a.m. to 6"10 p.m. Respondent argued that he could not speak to a physician without going through a secretary, even in an emergency.[21] However, other facility nurses testifying at hearing indicated this was not the case and the ALJ found that argument "irrelevant" because "this perceived inconvenience is not a legitimate reason to ignore the SDO."[22] Respondent's conduct at Jester IV was found to be unprofessional conduct that failed to meet the minimum standard of nursing care.

The ALJ found the following aggravating factors in this case: actual or potential harm to patients, clients, or the public; lack of truthfulness or trustworthiness; misrepresentation of education which led a member of the public, an employer, a member of the health-care team, or a patient to rely on the misrepresentation where such reliance could be unsafe; absence of attempts by the licensee to correct or stop the violation; the seriousness of the violation; the threat to public safety; and multiple offenses under Charge I.[23] For Charge II, the ALJ found "Respondent's conduct in responding to Patient's fall was careless ... resulting in serious risk to Patient" due to his "failure to perform a proper initial evaluation, his substandard documentation, and his failure to properly collaborate with other providers."[24] For these reasons, the Board agrees with the ALJ's recommended sanction of revocation.

IT IS, THEREFORE, ORDERED THAT Licensed Vocational Nurse License Number 348047, previously issued to LATEEF AKINOLA OWOKONIRAN, to practice nursing in the State of Texas be, and the same are hereby, REVOKED.

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

Entered this 17th day of July, 2025.

TEXAS BOARD OF NURSING

Kristin K. Benton, DNP, RN

KRISTIN K. BENTON, DNP, RN
EXECUTIVE DIRECTOR FOR THE BOARD

Attachments: Proposal for Decision; Docket No. 507-24-22303 (April 25, 2025), Exceptions Letter issued May 15, 2025.

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[21] PFD at p. 38.
[22] *Id.*
[23] PFD at p. 40.
[24] PFD at p. 41.

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

April 25, 2025

JoAnna Starr
Attorney, Texas Board of Nursing

VIA EFILE TEXAS

Lateef Akinola Owokoniran
6743 Catarina Circle
Houston, Tx 77084

VIA EFILE TEXAS and VIA REGULAR MAIL

RE: SOAH Docket No. 507-24-22303;
Texas Board of Nursing v. Lateef Akinola Owokoniran

Dear Parties:

Please find attached a Proposal for Decision in this case.

Exceptions and replies may be filed by any party in accordance with 1 Texas Administrative Code section 155.507(b), a SOAH rule which may be found at www.soah.texas.gov.

CC: Service List

SOAH Docket No. 507-24-22303 Suffix: TBN

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS BOARD OF NURSING,
PETITIONER
V.
LATEEF AKINOLA OWOKONIRAN,
RESPONDENT

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BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS BOARD OF NURSING,
PETITIONER
v.
LATEEF AKINOLA OWOKONIRAN,
RESPONDENT

PROPOSAL FOR DECISION

Staff (staff) of the Texas Board of Nursing (Board) seeks to revoke the permanent vocational nursing license of Lateef Akinola Owokoniran (Respondent), contending that Respondent obtained his license or diploma through fraud, has practiced under an unlawfully issued diploma, and lacks the requisite education to hold a Texas nursing license. Staff also alleges that while working as a licensed vocational nurse (LVN) at the Scott Jester IV Unit in the Texas Department of Criminal Justice, Respondent failed to intervene when one patient suffered an injury and subsequently failed to consult with other providers and follow standing delegation orders for head injury or trauma. The Administrative Law Judge (ALJ)

finds that Staff proved its allegations by a preponderance of the evidence and recommends that Respondent's LVN license be revoked.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

Matters of notice and jurisdiction were undisputed and are set out in the findings of fact and conclusions of law.

On January 16, 2025, ALJ Susan Rodriguez of the State Office of Administrative Hearings (SOAH) convened the hearing on the merits. Attorney JoAnna Starr represented Staff. Respondent appeared and represented himself. The record closed on February 28, 2025, after the parties had the opportunity to file written closing arguments.

II. APPLICABLE LAW

Pursuant to the Texas Nursing Practice Act (Act), the Board is responsible for licensing and regulating nurses.[1] A person may not practice nursing in Texas without a Board-issued license.[2]

Education and Licensure Requirements. Each applicant for a vocational nursing license must submit to the Board a sworn application that demonstrates the applicant's qualifications. The applicant must attest that the information contained

[1] Tex. Occ. Code (Code) ch. 301.

[2] Code § 301.251(a).

in, or referenced by, the application is complete and accurate, and is not false or misleading.[3] The application must be accompanied by evidence that the applicant has, among other things, successfully completed an approved vocational nursing program.[4] An approved nursing program is a school of nursing or educational program that: (1) is approved by the Board; (2) is accredited by a national nursing accreditation agency determined by the Board to have acceptable standards; or (3) is approved by a state board of nursing of another state and the Board.[5]

The Board may recognize and accept as approved an out-of-state nursing program if the other state's standards are substantially equivalent to the Board's standards for approving Texas programs.[6] By rule, the Board has identified the standards that an out-of-state program must meet to be "substantially equivalent" to a Texas program.[7] For LVN programs, an education program may be determined to be substantially equivalent if:

> (i) the program is approved by a state board of nursing or other governmental entity to offer a pre-licensure vocational/practical nursing program of study that awards a vocational/practical nursing certificate, diploma, or degree upon completion;

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[3] 22 Tex. Admin. Code § 217.2(a)(1). The Board's rules are found at 22 Texas Administrative Code chapters 211 to 228 and are referred to herein as "Rule ___." Unless otherwise specified, this proposal for decision cites to the substantive law in effect at the time of the alleged misconduct: December 2018 for Charge I, and November 2022 for Charge II.

[4] Code § 301.252(a)(2).

[5] Code § 301.157(d).

[6] Code § 301.157(d-4).

[7] Rule 217.2(a)(4)(B). Non-substantive amendments to Rule 217.2, adopted effective May 24, 2020, and October 13, 2022, do not impact the issues in this case. 45 Tex. Reg. 3295; 47 Tex. Reg. 6581.

(ii) the program's nursing courses include didactic and supervised clinical learning experiences in medical-surgical, maternal/child health, pediatrics, geriatrics, and mental health nursing that teach students to use a systematic approach to clinical decision-making and safe patient care across the life span; and

(iii) the program includes support courses providing a sound foundation for nursing education for the level of preparation.[8]

If the Board determines that an applicant meets these qualifications, the applicant may sit for the National Council Licensure Examination (NCLEX). If the applicant successfully passes the NCLEX, the Board must issue the license.[9]

Grounds for Disciplinary Action. Generally, the Board is authorized to take disciplinary action against a nurse for a violation of the Act or a Board rule.[10] A person may not "sell, fraudulently obtain, or fraudulently furnish a nursing diploma, license, renewal license, or record," or practice nursing under a diploma, license, or record that was: (A) obtained unlawfully or fraudulently; or (B) signed or issued unlawfully or under false representation.[11] A nurse may be disciplined for engaging in fraud or

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[8] Rule 217.2(a)(4)(B).

[9] Code § 301.256.

[10] Code § 301.452(b)(1).

[11] Code § 301.451(1), (3). In its Second Amended Formal Charges—the live pleading in this case—Staff alleged generally that Respondent violated Code section 301.451. Code section 301.451(2) provides that a person may not assist another person in selling, fraudulently obtaining, or fraudulently furnishing a nursing diploma, license, renewal license, or record. Staff did not address this allegation at the hearing or in its closing argument. Any claim that Respondent is subject to disciplinary action under this provision is therefore considered waived and will not be addressed further. *See* 1 Tex. Admin. Code § 155.425(c).

deceit in procuring or attempting to procure a license to practice professional nursing or vocational nursing.[12]

The Board may also take disciplinary action against a person who commits unprofessional conduct in the practice of nursing that is likely to deceive, defraud, or injure a patient or the public.[13] Relevant to this case, Rule 217.12 defines unprofessional conduct to include the following:[14]

- (1)(A): carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Rule 217.11;
- (1)(B): failing to conform to generally accepted nursing standards in applicable practice settings;
- (4): conduct that may endanger a client's life, health, or safety;
- (6)(H): providing information which was false, deceptive, or misleading in connection with the practice of nursing; and
- (6)(I): failing to answer specific questions or providing false or misleading answers in a licensure or employment matter that could reasonably affect the decision to license, employ, certify, or otherwise utilize a nurse.

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[12] Code § 301.452(b)(2). In its closing argument, Staff argued that Respondent should also be subject to disciplinary action under Code section 301.452(b)(5) for use of a nursing license, diploma, or permit, or the transcript of such a document, that has been fraudulently purchased, issued, counterfeited, or materially altered. This provision, however, was not included in any of Staff's Formal Charges and therefore is not considered a basis for disciplinary action in this proceeding. *See* 1 Tex. Admin. Code § 155.425(c).

[13] Code § 301.452(b)(10).

[14] Amendments to Rule 217.12, adopted effective October 17, 2019, do not impact the issues in this case. 44 Tex. Reg. 5914 (Oct. 11, 2019).

A nurse's failure to care adequately for a patient or to conform to minimum standards of acceptable nursing practice that exposes a patient unnecessarily to risk of harm is an additional sanctionable offense.[15] Rule 217.11 addresses minimum standards of nursing practice, the following of which are relevant to this case:

- (1)(A): know and conform to the Act and Board rules as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;
- (1)(B): implement measures to promote a safe environment for clients and others;
- (1)(D): accurately and completely report and document required matters, including client status, nursing care rendered, physician orders, and administration of medications and treatments; and
- (1)(M): institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.

Sanctions. When a nurse violates the Act or Board rules, the Board is required to impose a disciplinary sanction, which can range from remedial education to license revocation.[16] The Board has adopted a matrix (Matrix) to be used in determining the appropriate disciplinary action.[17] The Matrix categorizes violations into tiers and sanction levels based on the seriousness of the offense and risk of harm to patients or the public.[18] When deciding the degree of sanction to be imposed within the

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[15] Code § 301.452(b)(14).

[16] Code § 301.453; Rule 213.33(e).

[17] Rule 213.33(b).

[18] Rule 213.33(b).

authorized range, the Board and SOAH shall consider: (1) whether the person is being disciplined for multiple violations or has previously been the subject of disciplinary action by the Board and has previously complied with applicable law; (2) the seriousness of the violation; (3) the threat to public safety; and (4) any other aggravating or mitigating factors in the Matrix and Board rules.[19]

Burden of Proof. Staff has the burden of proving its allegations, and Respondent has the burden of proving any mitigating factors.[20] The standard of proof is a preponderance of the evidence.[21]

III. EVIDENCE

At the hearing, Staff presented testimony from Brenda York, Mary Paningbatan, Virginia Ayers, Timothy Sherman, and Respondent, and had eighteen exhibits admitted.[22] Following the hearing, Staff submitted page/line designations from the transcript of Respondent's deposition. Respondent did not file his own page/line designations, nor did he file objections to Staff's page/line designations. Accordingly, Staff's page/line designations are **ADMITTED** as Staff Exhibit 18. Respondent did not offer any documentary evidence but testified on his own behalf.

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[19] Code § 301.4531(b); Rule 213.33(b), (c).

[20] 1 Tex. Admin. Code § 155.427.

[21] *Granek v. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 777 (Tex. App.—Austin 2005, no pet.).

[22] Staff exhibits 1, 2, 2a, 3, 3a, 3b, 5, 5a, 6, 7, 9-12, and 14-17 were admitted at the hearing.

A. BACKGROUND, DOCUMENTARY EVIDENCE, AND STAFF'S CHARGES

1. Respondent's Licensure

Respondent attended medical school in Nigeria for six years.[23] He holds bachelor's degrees in medicine and surgery from the University of Ibadan, and a master's degree in public health from the University of Lagos.[24] After he moved to the United States, Respondent unsuccessfully attempted to obtain medical licenses in North Carolina and Texas.

In 2015, Respondent contacted the Board and asked if he could sit for the NCLEX without first obtaining a nursing education because he had a medical degree and was registered with the Education Commission for Foreign Medical Graduates.[25] After the Board told him that he could not obtain a nursing license in Texas without a nursing education, Respondent enrolled in the vocational nursing program at the College of Healthcare Professionals (CHP) in Houston.[26] He took courses for several months including two weeks of clinicals in a nursing home.[27] Before completing the program, Respondent withdrew, citing financial difficulties.[28] Respondent's

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[23] Staff Ex. 18 at 13.

[24] Staff Ex. 5 at 6.

[25] Staff Ex. 5 at 1, 4.

[26] Staff Ex. 5 at 1.

[27] Staff Ex. 5 at 1, 10-39.

[28] Staff Ex. 5 at 1.

transcript from CHP shows that he was enrolled from April to August 2016 and completed courses in vocational nursing concepts, anatomy and physiology, dosage calculations, basic nursing skills, nutrition, medical terminology, and pharmacology.[29]

Respondent wanted to complete his nursing education so he researched online programs and found Sunshine Academy (Sunshine or Sunshine Academy) in Florida.[30] Sunshine was approved by the Florida Commission for Independent Education (FCIE) and the Florida Board of Nursing (Florida Board) to provide a twelve-month in-person nursing education program at its Florida campus.[31] The program was approved to provide 1,350 hours of instruction, including 675 hours of clinical experience in a healthcare setting.[32] Sunshine was not approved to conduct online instruction.[33] Respondent enrolled and began taking classes.

In December 2018, Respondent submitted an application to the Board for a Texas LVN license by examination.[34] On his application, Respondent said that he

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[29] Staff Ex. 14 at 19. Respondent testified that he completed other courses but could not remember which ones. Staff Ex. 18 at 46.

[30] Staff Ex. 5 at 1-2.

[31] Staff Exs. 12 at 1, 15 at 5-6.

[32] Staff Exs. 12 at 6, 15 at 5.

[33] Staff Ex. 15 at 2.

[34] Staff Ex. 16 at 2.

attended "Sunrise Academy" from April 2017 to April 2018.[35] According to other documents provided to the Board, Respondent was enrolled at Sunshine Academy from June 2016 to June 2017.[36] His transcript reflects that he completed 1,350 hours of instruction, including 768 hours of clinicals and labs, and that no credits transferred from CHP.[37] Sunshine provided an affidavit of graduation to the Board, certifying that Respondent attended Sunshine from June 2016 to June 2017 and that he received a diploma or certificate in nursing.[38] Respondent signed the application, attesting that he met all requirements for an LVN license.[39] He took and passed the NCLEX on March 23, 2019, and the Board issued his license on March 26, 2019.[40] Respondent began working as an LVN for a home health care company in April 2019.[41] He also worked in correctional managed care from January 2020 through May 2022.[42] He worked at the Scott Jester IV Unit (Jester IV), where he

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[35] Staff Ex. 16 at 2. Respondent reported that he attended "Sunrise College" or "Sunrise Academy" in Boynton Beach, Florida, when he applied for his Texas license and in his responses to the Board regarding its investigation. Staff Exs. 5 at 1, 16 at 2. According to the affidavit of the school's owner, Johanah Napoleon, the school is called Quisqueya School of Nursing, LLC, d/b/a Sunshine Academy. Staff Ex. 12 at 1. There is no dispute that Sunshine is the only Florida nursing program involved in this case.

[36] Staff Ex. 16 at 5-6.

[37] Staff Ex. 16 at 6.

[38] Staff Ex. 16 at 5.

[39] Staff Ex. 16 at 4.

[40] Staff Ex. 1 at 1.

[41] Staff Ex. 5a at 3.

[42] Saff Ex. 5a at 3.

was employed by the University of Texas Medical Branch (UTMB) to work in a correctional setting within the Texas Department of Criminal Justice.[43]

2. Incident at Jester IV

Jester IV is a psychiatric unit that is divided into an A and B side, and a D and E side. Each side is further divided into three pods where inmates are housed. The pods are staffed by LVNs and registered nurses (RNs). For certain situations, LVNs and RNs are subject to standing delegation orders (SDO). An SDO is an order written by a physician for a specific scenario that a nurse is expected to complete.[44] While Respondent was employed at Jester IV, an SDO was in place that provided standing orders for nurses to follow if an inmate suffered a heady injury or trauma. Among other things, the SDO required the nurse to administer oxygen, apply a C-collar for known or suspected head or neck injury, and place the patient on a backboard before moving the patient; take vital signs every fifteen minutes until redirected by a provider or the patient is transferred; establish an intravenous line (IV); and notify the provider of findings.[45]

On November 2, 2022, an inmate in Jester IV (Patient) rolled off a bench in the unit's day room and fell to the floor.[46] Patient, who had known medical conditions

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[43] Staff Exs. 5a at 3, 11 at 1.

[44] Staff Ex. 18 at 97.

[45] Staff Ex. 11 at 5-6.

[46] Staff Ex. 6 at 23.

including diabetes, chronic obstructive pulmonary disease, and major vascular neurocognitive disorder, was initially treated in the dayroom by the LVN on duty before he was taken to the medical unit. There, his care was transferred to an RN and physician on duty.[47]

On November 3, 2022, Respondent was working on the D and E side of Jester IV and responded when a call went out that Patient had fallen.[48] Respondent documented that Patient "fell in his room this afternoon at about [1:20 p.m.]" and was found on the floor.[49] Respondent documented Patient's vital signs and noted that Patient had "4x5 swelling on the left side" of his forehead, was fully conscious and alert, and had weak lower limbs.[50] He helped Patient back into bed. Respondent's plan was noted as "for provider review."[51] There is no indication in the record that Respondent notified the provider. Later in the day, around 11:30 p.m., security found Patient in his pod choking on his food.[52] Patient was gasping for breath and became unresponsive.[53] He was transferred out of his cell in unstable condition and

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[47] Staff Ex. 6 at 10, 23.

[48] Staff Exs. 10 at 3, 6 at 17.

[49] Staff Ex. 6 at 17.

[50] Staff Ex. 6 at 17.

[51] Staff Ex. 6 at 17.

[52] Staff Ex. 6 at 6.

[53] Staff Ex. 6 at 6.

cardiopulmonary resuscitation (CPR) was initiated.[54] Emergency Medical Services took Patient, still unresponsive, to a local emergency department.[55]

3. Staff's Charges

In 2023, the Board began investigating Respondent for his possible involvement in a fraudulent diploma scheme discovered after an investigation by the Federal Bureau of Investigation (FBI) and the Department of Health and Human Services Commission Office of Inspector General (HHS-OIG). The investigation, known as Operation Nightingale, implicated several nursing programs in Florida, including Sunshine.[56] Respondent was identified as a potential recipient of an illegitimate nursing diploma, and the Board informed him that he was also under investigation for using that illegitimate diploma to fraudulently obtain his nursing license.[57] When the results of the Operation Nightingale investigation were made public, Staff issued Formal Charges against Respondent, seeking discipline against his Texas LVN license for his involvement with the fraudulent diploma scheme.[58]

On or about July 23, 2024, the Board filed first amended charges against Respondent, which included additional allegations that Respondent failed to meet

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[54] Staff Ex. 6 at 6.

[55] Staff Ex. 6 at 6.

[56] Staff Ex. 2.

[57] Staff Exs. 2, 12.

[58] Staff Ex. 2.

minimum standards of nursing practice with respect to his care of Patient. Staff alleged that Respondent failed to intervene when Patient suffered a head injury, failed to consult with or report to the RN and physician about the fall, and failed to follow SDOs for treating patients with a head injury or trauma, in violation of the Act and Board rules.[59] Staff alleged that Patient was exposed to risk of harm that actually manifested ten hours later when Patient was found choking on food, became unresponsive, required CPR, and was transferred to the emergency room.

According to Staff, Respondent's LVN license should be revoked as a result of the violations alleged in the two formal charges filed against Respondent.

B. TESTIMONY OF BRENDA YORK, LVN

Ms. York has held a Texas LVN license for thirty-seven years. She has worked as an LVN in nursing homes, rehabilitation facilities, home health care, and psychiatric facilities. She has worked in the prison system for about twenty-three years. At Jester IV, she primarily works the day shift but has worked parts of some night shifts, and she has worked with Respondent.

Ms. York talked about the protocol a nurse must follow if an inmate falls. If there is an incident announced over the loudspeaker in her pod, she is required to respond. The responding nurse must immediately check the inmate and assess their cognitive functioning, look for injuries, check their mobility, take vital signs, and get

[59] Staff Ex. 3a.

additional help if needed. There is also an SDO for a patient with a head injury or trauma.[60] Among other things, the SDOs for head injury and trauma require the nurse to take vital signs every fifteen minutes, notify the provider of findings, and document the care and treatment provided in the patient's care record. According to Ms. York, these procedures and SDOs should be followed whether an incident occurs during day shift or night shift, and regardless of where or how the inmate suffered the head injury or trauma. Ms. York testified that she does not need permission from an RN or a physician to perform the tasks required by the SDOs, and said a nurse can only stop following the SDOs once the care of the patient is transferred to another provider, or if the nurse is ordered to stop.

On November 2, 2022, Ms. York was working the day shift and was assigned to D1 and D2, where Patient was being held. Ms. Paningbatan was the RN on duty during this shift and she was staffing D3 and E3. Ms. York said that if she needed an RN for any reason during her shift, she would have called Ms. Paningbatan. Ms. York said she responded to a call that Patient had fallen in the day room. He had rolled off a bench and was lying on the floor. Ms. York took multiple sets of Patient's vitals, checked his cognitive functioning, and did an assessment.[61] Patient was alert and talking, and reported that he hit his head but had no pain. Dr. Thomas arrived and advised Ms. York that Patient should be taken to the medical unit, but Ms. York completed her assessment first and then called the medical unit to let them know she

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[60] Staff Ex. 11 at 5-6.

[61] Staff Ex. 6 at 22-23.

was coming with Patient. Once at the medical unit, Ms. York transferred the care of Patient to the RN and physician on duty. Once she transferred Patient, Ms. York had no further contact with him.

C. TESTIMONY OF MARY PANINGBATAN, RN

Ms. Paningbatan has been a RN since 2016 and has worked in the prison since 2018. Ms. Paningbatan also testified about the SDOs and said that they should be followed by both RNs and LVNs, and the nurse can only stop following the SDO when the patient is transferred to the medical unit or if a physician issues another order. If an inmate suffers a head injury, the responding nurse is expected to contact the provider immediately.

Ms. Paningbatan testified that on November 3, 2022, she was the RN working on the same side of Jester IV as Respondent. She was assigned to D3 and E3, and Respondent was assigned to D1 and D2.[62] If something was outside Respondent's scope of practice, she said, he should have reached out to her, then the infirmary nurse, or, as a last resort, the charge nurse.

Ms. Paningbatan testified that Respondent did not contact her regarding Patient's fall on November 3, 2022, either to ask for help or to inform her of what happened. If she been involved in Patient's care, she would have assessed him and documented her assessment. She testified that she would expect a nurse who is

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[62] Staff Ex. 10 at 3.

assessing a patient with a head injury to contact the provider, whether that nurse was an RN or an LVN.

D. TESTIMONY OF RESPONDENT[63]

1. Education

Respondent described his education in Nigeria, testifying that when he pursued his degrees, he attended classes on campus and his coursework required labs and clinical experiences in different subjects like pediatrics, obstetrics, pathology, and surgery.[64] The clinicals involved real patients and were supervised by licensed instructors. He had to demonstrate his skills, pass tests, complete classroom studies, and complete homework. His classes had different syllabi and were taught by different professors who were available for consultation with students.[65]

In 2003, Respondent came to the United States and tried unsuccessfully to obtain his medical license in North Carolina.[66] Respondent then moved to Houston, Texas, where he and his wife have family, and tried to obtain his Texas

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[63] Respondent testified at the hearing and portions of his deposition have been admitted as Staff Exhibit 18. Unless otherwise noted, this section summarizes testimony given by Respondent at the hearing on the merits.

[64] Staff Ex. 18 at 16.

[65] Staff Ex. 18 at 41.

[66] Staff Ex. 18 at 18.

medical license.[67] He passed parts 1 and 2 of the United States Medical Licensing Examination but has not taken part 3 due to his financial situation.[68]

Respondent then contacted the Board to see if he could "challenge" the NCLEX, or take it without attending nursing school. When the Board informed him that he must attend nursing school before taking the NCLEX, Respondent took an entrance examination and enrolled in a twelve-month LVN program at CHP.[69] Tuition was $45,000 and he received $10,000 in aid. Respondent testified that he attended courses at CHP in person, had textbooks, and had a syllabus and a different professor for each course. The facility had two skills labs with equipment including dummies or mannequins the students could work on, syringes, needles, gowns, and face masks.[70] Respondent completed several courses at CHP that included classroom content. He had two or three weeks of hands-on clinical experiences in a nursing home, where he cared for patients and demonstrated his skills for the instructor.[71] He also had clinicals for the mental health unit of instruction, but he did not complete that unit of study. Respondent said he attended CHP for six or eight months but then had to withdraw because of financial difficulties.

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[67] Staff Ex. 18 at 18-20.

[68] Staff Ex. 18 at 20.

[69] Staff Ex. 18 at 21-22.

[70] Staff Ex. 18 at 24.

[71] Staff Ex. 18 at 47.

After withdrawing from CHP, Respondent searched online for another nursing program and found Sunshine Academy. Tuition was more affordable—$10,000—and payable in installments. Respondent said that although Sunshine was based in Florida, he did not have to move there because he was able to take all his courses online. Respondent testified that he was not aware Sunshine was approved only to provide on-campus, in-person instruction and was not approved to provide online instruction.[72] He said he was advised by someone at Sunshine that he needed to complete four or five courses to complete the program, and that it would take six months. Respondent could not remember the courses he took at Sunshine but said everything, including simulations and tests, was done online. Respondent received reading materials and questions via email, along with videos and multiple-choice tests. Respondent could not remember the content of any of the materials he received from Sunshine or what he was tested on. Respondent testified that he never spoke to an instructor at all during his time at Sunshine.[73]

Respondent understood that a typical nursing education requires both classroom and clinical instruction but did not know that the Board requires more than the nursing home clinical experiences he had at CHP. He was not aware that he also needed clinicals in medical/surgical, pediatrics, geriatrics, or maternal/child health. While enrolled at Sunshine, Respondent never participated in a skills lab. Clinical experiences were not required, he said, because he completed "all nursing concepts"

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[72] Staff Ex. 18 at 55.

[73] Staff Ex. 18 at 40.

at CHP, prior to enrolling at Sunshine Academy.[74] Skills were taught by video, but no one at Sunshine ever verified Respondent's ability to complete the skills.[75]

Respondent testified that his goal in enrolling at Sunshine was to be able to take the NCLEX. He thought that for $10,000, the school would send his information to the Board so he could take the NCLEX in Texas, and he said it was not fair that no one would let him take the test without first taking classes.[76]

Respondent said that he received a diploma from Sunshine but could not locate it.[77] He applied to the Board for an LVN license. Sunshine sent the Board his transcript, and he testified that he did not take or complete all the courses listed on Sunshine's transcript. Of the courses listed on his Sunshine transcript, Respondent testified that he only took a course—but no lab—in geriatric nursing theory. He did not take courses in medical/surgical, maternal/child health, pediatric, mental health, or human growth and development because he took them at CHP.[78]

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[74] Staff Ex. 18 at 56.

[75] Staff Ex. 18 at 58.

[76] Staff Ex. 18 at 55.

[77] Staff Ex. 18 at 59.

[78] Staff Ex. 18 at 65.

2. Care of Patient

Respondent said he worked at Jester IV for one year. He was familiar with the SDO regarding head injuries and trauma, and said they were implemented by UTMB and written by a physician. He said nurses are required to follow the SDO, when applicable, and SDO must be followed until an RN or physician tells him to stop.

Respondent reviewed the shift schedules and assignments for November 3, 2022, and while he agreed that those documents show he worked the day shift from 5:45 a.m. to 6:10 p.m., he denied ever working the day shift at Jester IV. He testified that he always worked the night shift and could not recall ever working the day shift. Respondent agreed that the medical record he created regarding his care of Patient showed that Patient fell at 1:20 p.m., but Respondent did not agree that Patient fell at that time, and said that it may have been the time he added his documentation in the medical record.[79]

Respondent testified that he did not receive the initial call that Patient had fallen because he was in the restroom. When he arrived at Patient's cell, he said, an RN was already there. Respondent testified that it was a male RN who always worked the night shift, which is why he, Respondent, was sure that this incident occurred during the night shift. Although Respondent could not remember the RN's name, he said that he was not listed on the day shift assignment record for November 3, 2022.

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[79] Staff Ex. 6 at 17.

Respondent said he assessed Patient and took vital signs, including blood sugar and temperature, and helped Patient back into bed. Respondent said he took a second set of vital signs but did not document it. Respondent testified that Patient had no physical injuries but agreed that he documented that Patient had "4x5 swelling" on the left side of his forehead, an injury that would require him to follow the SDO regarding head injury and trauma, as well as weak lower limbs.

According to Respondent, he called the provider at the RN's instruction and reported Patient's vital signs. The provider, whose name Respondent could not remember, told him to give Patient acetaminophen and send Patient to the clinic in the morning to see the morning provider. Respondent estimated this was at 3:00-4:00 a.m., but he could not be sure because he did not document that he contacted the provider. He did not document giving Patient acetaminophen and, after further consideration, testified that he could not remember if the provider told him to give acetaminophen or some other pain medication. Respondent then testified that he may have left the provider a voicemail message, and then said he may not have spoken with her at all. Finally, Respondent said that he can give a patient pain medication without an order from a provider, if it is pain medication that will work immediately.

According to Respondent, he had not treated Patient prior to the fall on November 3, 2022. He did not review Patient's medical records when he took the shift assignment or before or after responding to the fall. He was unaware Patient was diabetic and had vascular dementia, and did not know he had fallen the day before.

Respondent stressed that caring for patients in a prison setting is different than other settings. When Patient fell, he said, there were officers surrounding him. Because so many people are around, and because officers discourage medical staff from staying in the room too long, he, as an LVN, is limited in what he can do. Respondent said nursing activities are subject to limitation, and permission is required to do most things including setting an IV drip. He also said that if he wants to contact a physician provider, he must first go through a secretary, even in an emergency, and that sometimes providers do not want to speak to an LVN.

E. TESTIMONY OF VIRGINIA AYERS, ED.D., MS, RN, CNE

Dr. Ayers has extensive qualifications in nursing education and curriculum. She has been licensed as an RN since 1970 and has worked in several practice settings. Dr. Ayers has a master's degree in nursing education, a doctorate in education, and holds national certification as a nursing educator. She has worked for the Board since 2002, first as an investigator and, since 2006 or so, in the education department. She is familiar with the laws and regulations regarding nursing education and licensure for Texas. Dr. Ayers reviewed the formal charges and the admitted evidence and listened to the testimony presented at the hearing before giving her own testimony.

Dr. Ayers testified that a nursing license applicant who attended an out-of-state nursing school must have obtained a substantially equivalent nursing education that includes didactic courses in five areas: medical/surgical (also called nursing care of adults), geriatrics, pediatrics, mother/baby, and mental health. The

out-of-state program must also include clinical learning experiences in medical/surgical, geriatrics, pediatrics, and mother/baby. These nursing study areas are vital to a nurse's education because an LVN could be hired to work in any setting to care for any type of patient, making it critical that the nurse can handle all types of patients.

Dr. Ayers testified that Sunshine was not a Board-approved nursing program; therefore, Respondent could qualify for licensure only if he received a substantially equivalent education at Sunshine. Dr. Ayers said that on paper, Sunshine's program appears to meet the Board's requirements for substantial equivalence. However, the Board would reject any of the courses Respondent may have completed at Sunshine because they were all taken online, and Sunshine was not approved by the Florida Board to operate as an online program. Therefore, because Sunshine did not operate as it was approved by the Florida Board, the Board would not have accepted Respondent's Sunshine Academy education as substantially equivalent.[80]

Dr. Ayers next considered whether Respondent's coursework at CHP could qualify him for licensure. She testified that CHP is a twelve-month, Board-approved program. Respondent attended CHP for only six to eight months, so he did not complete the program as it was approved by the Board to operate, and CHP did not issue him a diploma. Additionally, Dr. Ayers testified that Respondent's Sunshine transcript shows that no credits from CHP transferred to Sunshine. Respondent's

[80] *See* Code § 301.157(d-4).

transcript from CHP showed that he may have completed two classes that could count toward his required nursing education—vocational nursing concepts and basic nursing skills—but it was not clear that they related to any of the five required nursing study areas. Accordingly, the Board would not consider any coursework at CHP in determining whether Respondent received a nursing education that would qualify him for licensure.

Dr. Ayers testified that Respondent does not have the requisite education to be licensed in Texas because he lacks both didactic and clinical learning experiences in the required nursing study areas. Finally, she testified that Respondent's medical school education could not make up for the shortcomings in his nursing education. Nursing, she said, is very different from the practice of medicine and involves a different set of skills.

F. TESTIMONY OF TIMOTHY SHERMAN, MSN, APRN, FNP-C

Mr. Sherman is licensed as an advanced practice RN, has a master's degree in nursing, and has worked at the Board since 2020 as a consultant regarding nursing practice. His duties include providing education on nursing jurisprudence and ethics, reviewing and revising continuing education offerings, and serving as an expert witness in legal proceedings. He has worked in an ambulatory surgery center, in pre- and post-operative settings, and was on the adjunct faculty for continuing education at Austin Community College. He has never been to Jester IV but knew that it was a lockdown unit. Mr. Sherman reviewed the formal charges and the

admitted evidence and listened to the testimony presented at the hearing before giving his own testimony.

With respect to Charge II, Mr. Sherman testified that Respondent's conduct on November 3, 2022, would be grounds for discipline as both unprofessional conduct and failure to conform to minimum standards of nursing practice. Mr. Sherman said Respondent fell below the minimum standards of nursing practice when he failed to familiarize himself with Patient before accepting the shift assignment. Thus, Respondent failed to promote a safe environment for Patient as contemplated by Rule 217.11(1)(B) because he was not aware that Patient was diabetic, that he suffered from vascular dementia, or that he had fallen the day before and was given a bolus of IV fluids, all of which would have helped Respondent determine how and when to assess and reassess Patient after the fall.

Next, Mr. Sherman opined that the Patient's assessment Respondent performed was inadequate. He explained that nurses are trained to do certain things when assessing a patient because the initial assessment helps inform subsequent decisions about care, treatment, and a patient's nursing plan. Here, there is no documentation that Respondent took a full set of vital signs, took repeat vital signs, or that he assessed Patient's cognitive functioning. Although Respondent reported Patient had weak lower limbs, he did not note Patient's muscular strength. The documentation does not reflect that Respondent tried to determine why Patient fell, which would have alerted other caregivers about what complications to watch for later, and how to prevent future falls. There is no documentation of Patient's blood

sugar, which concerned Mr. Sherman since Patient was diabetic. Finally, Respondent did not document his response using an emergent care record, which would have prompted him to document specific information relevant to the ongoing care of a patient with a possible head injury. Mr. Sherman concluded that Respondent failed to accurately and completely document the information required by Rule 217.11(1)(D).

Mr. Sherman next pointed out that Respondent failed to implement several of the protocols set out in the SDO, which was active and applicable in this situation. Respondent moved Patient without using a C-collar and backboard, failed to repeat vital signs until redirected, failed to establish an IV, and failed to administer oxygen. Importantly, Respondent never reassessed Patient, which Mr. Sherman said was crucial to understanding whether Patient's condition was declining. These actions were required under the SDO, and Respondent's failure to implement this protocol violated Rule 217.11(1)(M).

Mr. Sherman also expressed concern that the records do not show that Respondent notified Ms. Paningbatan or any other RN or physician about what happened to Patient, something Respondent is required to do under the SDO. Although Respondent testified that he talked to the RN who was already in the pod as well as a provider who told him to give Patient acetaminophen and take him to the clinic in the morning, Mr. Sherman questioned whether this happened because the records do not say who Respondent spoke to, when, or what medication was ordered—information that must be documented—or that Respondent ever took

Patient to the clinic. If Respondent did speak to a supervising provider, Mr. Sherman wondered whether he could have provided an adequate picture of Patient's situation since so little pertinent information was documented, and Respondent was unfamiliar with Patient and his medical history. Vocational nursing involves a directed scope of practice so when a patient has an event, Mr. Sherman said, it is the LVN's responsibility to provide a full and accurate report to the supervisor so modifications to the patient's plan of care can be made. This led Mr. Sherman to conclude that Respondent failed to collaborate with his supervisors when Patient fell on November 3, 2022, as required by Rule 217.11(1)(A).

Mr. Sherman testified that Respondent's conduct was careless and did not conform to accepted nursing standards for the setting. Many of the concerns Mr. Sherman had stemmed from Respondent's noncompliance with vocational nursing processes that LVNs are trained to follow. He was also critical that Respondent claimed that he was unable to provide required care because he was working in a prison and needed permission to carry out duties that are within the LVN scope of practice, and that he thinks he can administer some medications without an order. Mr. Sherman noted that Respondent's conduct placed Patient at risk for harm. Patient was a vulnerable person because of his pre-existing medical conditions and incarceration, so he was unable to freely choose when and from whom he received healthcare. Patient was entirely dependent on Respondent to respond appropriately, identify his needs, and help prevent complications and future falls. Because of this, Mr. Sherman said, Respondent committed unprofessional conduct as defined by Rule 217.12(1)(A), (1)(B), and (4).

Regarding sanctions, Mr. Sherman determined that several aggravating factors apply: patient vulnerability, lack of truthfulness and trustworthiness, potential harm, misrepresentation of education, no attempts to remediate lack of education, and threat to public safety. He opined that for the violations under Code section 301.452(b)(10), discipline pursuant to Tier 2, Sanction Level II was appropriate. He further testified that the violations under Code section 301.452(b)(14) were Tier 3 and should result in revocation.

IV. ANALYSIS

A. CHARGE I

1. Practicing Nursing Under an Unlawfully Issued Diploma

Staff met its burden of showing that Sunshine unlawfully issued Respondent's diploma. The evidence establishes that Sunshine was approved by the FCIE and the Florida Board to offer a twelve-month nursing education program that required in-person education at its campus in Florida. The program was to provide 1,350 total educational hours, including hands-on clinical education in various healthcare settings. Although Respondent was enrolled in that program, he only took courses for a few months; he never attended courses in-person at Sunshine's campus as his courses were exclusively online; he completed only one or two of the courses listed on his Sunshine transcript; and he received no hands-on clinical training while enrolled at Sunshine. Although Sunshine was authorized to issue diplomas when Respondent graduated, Respondent did not complete the requirements of the nursing program Sunshine was approved by the FCIE and the Florida Board to

provide; therefore, Sunshine acted outside its authority when it issued Respondent a diploma. Additionally, Respondent has worked in Texas as an LVN. Staff, therefore, has shown by a preponderance of the evidence that Respondent has been practicing nursing under a diploma that was issued unlawfully, in violation of Code section 301.451(3)(B). For this violation, Respondent may be subject to discipline pursuant to Code section 301.452(b)(1).

2. Substantial Equivalence

Licensure in Texas requires that an applicant show he graduated from an approved nursing education program. Sunshine was not approved by the Board, so as an out-of-state program, it needed to provide an education substantially equivalent to a Texas-approved program in order for Respondent's degree to qualify him for Texas licensure. Texas standards require LVN programs to include didactic and supervised clinical learning experiences in medical-surgical, maternal/child health, pediatrics, geriatrics, and mental health nursing.[81] On paper, Sunshine seems to meet these criteria. However, the education Respondent received at Sunshine was not the same education as was approved by the Florida Board. Respondent's entire Sunshine program took place online, and Sunshine was not approved to provide online classes. Moreover, he admitted that he did not complete most of the didactic courses listed on his Sunshine transcript, and he did not receive any clinical instruction while enrolled at Sunshine. Thus, any courses Respondent ostensibly took at Sunshine

[81] Rule 217.2(4)(B)(ii). Dr. Ayers testified that clinical experiences in mental health are optional.

cannot be considered in evaluating whether he received a substantially equivalent education.

With respect to Respondent's assertion that the Board should consider and accept his CHP coursework, Respondent did not complete the nursing program at CHP and was not awarded a diploma from CHP, and none of his credits transferred to Sunshine. For those reasons, the Board would not consider any of his CHP courses when considering whether his nursing education qualifies him for licensure.

The Board has established that Respondent did not successfully complete any nursing education program; therefore, he did not obtain a substantially equivalent education that would qualify him for an LVN license.

3. Fraud in Procuring a License

Staff argues that Respondent committed fraud in obtaining his LVN license. Neither the Act nor Board rules appear to define fraud, so it is appropriate to apply the common law definition.[82] In this case, the pertinent element of common law

[82] Common law fraud requires that (1) a speaker made a representation; (2) the representation was material; (3) the representation was false; (4) when the representation was made, the speaker (A) knew the representation was false or (B) made the representation recklessly, as a positive assertion, and without knowledge of its truth; (5) the speaker made the representation intending that another act on it; (6) the other person relied on the representation; and (7) the representation caused the other person injury. *See "Fraud,"* O'Connor's Texas Causes of Action Ch. 12-A § 1 (2023 ed.) (collecting cases). The parties did not dispute that Respondent (1) made a representation to the Board that he was qualified. The representation was (2) material to the license being approved and (3) is presumed false for purposes of this discussion. Respondent (5) made the representation with the intent that the Board rely on it and grant him a license. The Board (6) relied on the representation, and (7) alleges it suffered injury to its goal of protecting the public by only licensing qualified nurses.

fraud is that a speaker, when making a representation, knew that the representation was false or was reckless in making the representation without knowledge of its truth.

As an initial matter, Respondent's first contact with the Board involved his request to take the NCLEX without first obtaining a nursing education. The Board told him that he would not be permitted to sit for the exam without first getting a nursing education. There is no dispute that Respondent knew he was required to have a nursing education to take the NCLEX.

Respondent then enrolled at CHP, but did not complete his course of study; then enrolled at Sunshine and listed Sunshine as his completed nursing program on his application. Staff presented compelling evidence that Respondent knew, or willfully disregarded, that Sunshine was not a legitimate nursing program, and that he knew he did not obtain a legitimate nursing education from Sunshine. Most obvious is Respondent's admission that he did not complete most of the courses listed on his Sunshine transcript. In fact, his testimony seems to indicate that he completed just one course—geriatric nursing—at Sunshine. Also significant is Respondent's admission that he understood that an acceptable nursing education includes both classroom and clinical learning experiences. Despite this, Respondent attested to the Board that his education at Sunshine— where he completed just one class and had no clinical experiences—qualified him for a license.

In addition, prior to enrolling at Sunshine, Respondent completed three post-secondary degree programs in Nigeria, obtaining a medical degree and a degree

in surgery, and attended several months of a legitimate vocational nursing program in the United States. In all three programs, Respondent had in-person didactic learning and hands-on clinical instruction in healthcare settings with real patients. His professors and instructors supervised his clinical learning experiences, and he was expected to demonstrate mastery of the skills he was learning. Instructors were available to students if they had questions. Based on these experiences and the similarities among these programs, Respondent knew some indicators of a legitimate educational program: higher tuition costs; on-campus attendance; required labs and clinical work with real patients; demonstration of mastery of skills; and classes taught by different professors with known credentials who were available to students when they had questions. Sunshine Academy did not have any of these attributes.

Indeed, Respondent did not dispute that Sunshine lacked the typical components of a legitimate educational program. Instead, he continued to advance his theory that the classes he took at CHP should count as his nursing education. However, he admitted that he did not complete the CHP LVN program, did not graduate, did not get a diploma, and had clinical experience only in geriatrics. And, he did not mention his CHP education in his application to the Board, leading the ALJ to believe that he did not truly think his CHP education qualified him for licensure.

A review of Respondent's Texas application lends further support to a finding that Respondent knew he did not have a legitimate nursing education and needed to present false information to get a license. Respondent wrote on his application that

he attended Sunrise Academy—not Sunshine Academy—for one year from April 2017 through April 2018, his certification of graduation states that he attended Sunshine from June 2016 to 2017, and he testified that he only attended Sunshine for six months. The ALJ finds it more likely than not that Respondent misreported his dates of attendance to mislead the Board. If he had accurately reported that he only attended Sunshine Academy for six months, it would have alerted the Board that he had not been enrolled long enough to complete a vocational nursing program, inviting further scrutiny of his educational qualifications.

Respondent gave other testimony that supports the conclusion that he understood his education at Sunshine was inadequate and that he misled the Board. He claimed that his medical degree qualified him for licensure as a nurse. He said he did not think he needed to take nursing classes to sit for the NCLEX, and that the Board's refusal to let him take the test without a nursing education was unfair. He testified that his only goal in attending Sunshine was to be able to take the NCLEX, and he thought he was paying Sunshine $10,000—a fraction of the cost of CHP—for the school to register him to take the exam in Texas. Although he testified that he did not know Sunshine was not authorized to provide an online nursing education, he admitted that he knew clinical learning experiences were required as part of a typical nursing program. He said he was not required to complete clinical learning experiences at Sunshine because he completed those prior to enrolling. He also said that he completed all "nursing concepts" at CHP, while at the same time admitting that he withdrew early and did not complete the CHP program.

Accordingly, Staff established that Respondent engaged in fraud in procuring his license and is subject to discipline under Code section 301.452(b)(2). He also committed unprofessional conduct and is subject to disciplinary action pursuant to Code section 301.452(b)(10) because he provided information which was false, deceptive, or misleading in connection with the practice of nursing and he provided false or misleading answers in a licensure matter that could reasonably affect the decision to license a nurse.[83] Finally, the ALJ finds that Respondent fraudulently obtained his licensed, and practiced nursing under a fraudulently obtained license, in violation of Code section 301.451(1) and (3)(A), and is subject to disciplinary action under Code section 301.452(b)(1).

B. CHARGE II

Staff asserts that Respondent violated minimum nursing standards and engaged in unprofessional conduct by failing to properly intervene when Patient fell, failing to collaborate with other providers about Patient's care, and failing to follow the SDO. Respondent argues that the protocols and requirements testified to by Ms. York, Ms. Paningbatan, and Mr. Sherman, including the SDO, did not apply because he cared for Patient after a fall that occurred during the night shift, not the day shift. He also testified, to a certain extent, that he did complete some of the duties and responsibilities required.

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[83] Rules 217.12(6)(H), (6)(I).

The requirements of the nurse's initial assessment of a patient in any situation were not controverted, and the records show that Respondent's intervention and initial assessment of Patient was inadequate in numerous ways: Respondent did not check Patient's blood sugar, there was no assessment of Patient's cognitive functioning even though he observed swelling on Patient's forehead after a fall, Respondent did not grade Patient's muscle strength despite noting he had weak lower limbs, and he did not try to find out why or how Patient fell.

Other aspects of Respondent's response to Patient's fall were problematic as well. He did not take Patient's vital signs every fifteen minutes, which would have alerted him if Patient's condition began to decline; he moved Patient from the floor to the bed without a C-collar and a backboard, despite evidence that Patient suffered a head injury; and Respondent did not properly collaborate with other providers about Patient's care. Although Respondent said he spoke to the male RN who was already in Patient's pod when he arrived, he could not identify that person, and he did not document this conversation or that anyone else was in the pod when he was treating Patient. According to the schedule and shift assignments, the RN on Respondent's side of Jester IV at 1:20 p.m. on November 3, 2022, was Ms. Paningbatan. Respondent did not tell her about Patient, and she did not evaluate Patient or otherwise assist.

Next, Respondent's testimony made it unclear whether he informed a physician about Patient's fall. He first said that he talked to a doctor who told him to give Patient acetaminophen and take him to the clinic in the morning. He also

testified that perhaps he called the physician but had to leave a voicemail message, but then said that maybe he never called the physician at all. Giving Respondent the benefit of the doubt that he did speak to the physician, he did not document this discussion, or the order for acetaminophen, or whether he gave it to Patient. Medication orders, including dosage, frequency, and route, must be documented in the records.

Turning to Respondent's noncompliance with the SDO, Respondent testified that there are aspects to caring for a patient in a correctional setting that an LVN cannot perform without permission, including starting an IV. But the SDO is just that—an order requiring a nurse to carry out certain duties in a specific situation without further instructions. The duties in the SDO are within an LVN's scope of practice and Respondent gave no credible reason for why he needed additional authorization to perform tasks within his scope of practice in this setting.

Respondent then testified that some of the directives in the SDO could not be performed during the night shift, and since he only worked the night shift the fall must have happened at night, precluding him from completing some of the directives in the SDO. But Respondent reported in Patient's chart that he responded to Patient's fall at 1:20 p.m. on November 3, 2022, and the shift schedule and pod assignment records show that Respondent worked the day shift that day from 5:45 a.m. to 6:10 p.m. Additionally, Ms. York and Ms. Paningbatan testified that the SDO does not provide that the treatment regimen should vary depending on what time of day a patient suffers a head injury or trauma. Respondent also said that he

cannot speak to a physician without going through a secretary, even when there is an emergency. But whether Respondent had to first speak to a secretary to reach a physician is irrelevant. According to Respondent, he did not try to contact a physician, or, if he did, he either left a voicemail message or spoke to the doctor and was ordered to administer medication; no secretary was involved. Even if he did have to talk to a secretary first, this perceived inconvenience is not a legitimate reason to ignore the SDO.

The evidence establishes that Respondent failed to meet minimum nursing standards and committed unprofessional conduct in violation of Code section 301.452(b)(10) and (b)(14), and Rules 217.11(1)(A), (1)(B), (1)(D), and (1)(M); as well as Rules 217.12(1)(A), (1)(B), and (4).

V. SANCTIONS ANALYSIS

A. CHARGE I

Staff established that Respondent committed violations under Code section 301.451(1), (3)(A), and (3)(B), making him subject to discipline under Code section 301.452(b)(1). Staff also met its burden of proving violations under Code section 301.452(b)(2) and (b)(10). Staff asserts that Respondent's license should be revoked.

For a violation of Code section 301.452(b)(1), Tier 1 contemplates non-substantive violations of a Board order. Therefore, the ALJ determines that Respondent's violations fit Tier 2 more closely because Respondent committed a

substantive violation when he provided fraudulent or false information regarding his educational qualifications for licensure. In addition, his failure to meet the educational requirements for the license he holds posed a serious risk of harm to patients and the public. Sanction Level I calls for the licensee to complete the terms of the original Board order; since there is no Board order here, Sanction Level II, which calls for denial of licensure, suspension, revocation, or voluntary surrender, is appropriate.

With respect to Respondent's violation of Code section 301.452(b)(2), the ALJ finds this to be a Tier 2 violation because Respondent's conduct involved intentional misrepresentation of his previous nursing education and because his license was issued based on a fraudulent diploma and educational transcript. A Tier 2 offense under either sanction level can result in revocation.

As for Respondent's violation of Code section 301.452(b)(10), this was not an isolated failure to comply with a Board rule as contemplated by Tier 1. Instead, it is more appropriate to categorize Respondent's conduct as a substantive violation that posed a serious risk to patient or public safety, as described in Tier 2. Sanction Level I calls for a warning or reprimand with stipulations that can include remedial education and supervised practice, while Sanction Level II calls for suspension, probated suspension or revocation.

The Board must consider aggravating and mitigating factors in determining what sanction to impose. Staff proved the following aggravating factors apply in this case:

- actual or potential harm to patients, clients, or the public;
- lack of truthfulness or trustworthiness;
- misrepresentation of education which led a member of the public, an employer, a member of the health-care team, or a patient to rely on the misrepresentation where such reliance could be unsafe;
- absence of attempts by the licensee to correct or stop the violation;
- the seriousness of the violation; and
- the threat to public safety.[84]

Additional aggravating factors listed in the Matrix apply. There are multiple offenses under Charge I; the hidden information was serious; and the hidden information, if known, would have prevented licensure.[85] Respondent did not establish any mitigating factors. Accordingly, the ALJ determines that the violations of Code section 301.452(b)(1), (b)(2), and (b)(10), should all be classified as Tier 2, Sanction Level II, and recommends the Board revoke Respondent's license.

B. CHARGE II

With respect to Respondent's violation of Code section 301.452(b)(10), this was not an isolated failure to comply with a Board rule as contemplated by Tier 1.

[84] Rule 213.33(c)(1)-(3), (10), (14)-(15).

[85] Rule 213.33(b).

The ALJ agrees with Staff that Tier 2 applies in this case, because, as discussed above, Respondent's conduct in responding to Patient's fall was careless and did not conform to accepted nursing standards for the practice setting, resulting in serious risk to Patient. Though the ALJ agrees that the risk to Patient was serious, the ALJ does not believe Staff proved that Respondent's conduct caused Patient to choke on his food later that day and recognizes that Patient had other comorbidities that could have contributed to the choking incident. Tier 2 permits the Board to require a warning or reprimand with stipulations that include remedial education and supervised practice under Sanction Level I or suspension, probated suspension, or revocation under Sanction Level II.

Respondent's violation of Code section 301.452(b)(14) does not fit Tier 1, which applies when risk of harm is low, and was more serious than Tier 2 contemplates. Here, Respondent's actions resulted in serious risk of harm because of his failure to perform a proper initial evaluation, his substandard documentation, and his failure to properly collaborate with other providers about Patient's care. This created a serious risk that Patient could experience further injuries or that injuries undiscovered by Respondent would go untreated. Tier 3 is appropriate and can result in revocation under either sanction level.

No mitigating factors were established. Staff proved the following aggravating factors apply in this case:

- patient vulnerability;
- actual or potential harm to patients, clients, or the public;

- absence of attempts by the licensee to correct or stop the violation;
- the seriousness of the violation; and
- the threat to public safety.[86]

Based on these aggravating factors, the ALJ finds that Respondent's violations under Code section 301.452(b)(10) should be categorized as Tier 2, Sanction Level II. Under Code section 301.452(b)(14), Respondent's violations should be considered Tier 3, Sanction Level II. Respondent's license should be revoked.

VI. FINDINGS OF FACT

1. Lateef Akinola Owokoniran (Respondent) holds Texas Licensed Vocational Nursing (LVN) license no. 348047, originally issued by the Texas Board of Nursing (Board) on March 26, 2019.

2. Prior to obtaining his Texas LVN license, Respondent completed three post-secondary education programs in Nigeria, earning a bachelor's degree in medicine, a bachelor's degree in surgery, and a master's degree in public health.

3. In 2003, Respondent moved to the United States and unsuccessfully tried to obtain his medical licenses in North Carolina and Texas.

4. Respondent contacted the Board to see if he could sit for the National Council Licensure Examination (NCLEX) without going to nursing school. He was told that a nursing education is required before taking the NCLEX.

5. Respondent enrolled in the twelve-month vocational nursing program at the College of Healthcare Professionals (CHP) in Houston, Texas. He attended

[86] Rule 213.33(b), (c)(1)-(3), (10), (14)-(15).

classes there for several months before withdrawing due to financial difficulties. Respondent did not graduate or get a diploma from CHP.

6. After withdrawing from CHP, Respondent found a less expensive nursing program at Quisqueya School of Nursing, LLC d/b/a Sunshine Academy (Sunshine) in Florida.

7. Sunshine was approved by the Florida Commission on Independent Education (FCIE) and the Florida Board of Nursing (Florida Board) to provide a twelve-month in-person nursing education program. Sunshine was never approved to offer any part of its nursing program online.

8. Respondent attended Sunshine for six months and took classes online while he resided in Texas. He never traveled to Florida for in-person instruction of any kind at Sunshine.

9. Respondent did not purchase any textbooks for his classes at Sunshine, he received no clinical instruction, and he did not complete most of the courses listed on his Sunshine transcript.

10. Respondent's education at Sunshine did not include any hands-on clinical learning experiences.

11. Respondent's coursework at CHP did not transfer for credit at Sunshine.

12. Respondent did not complete the educational requirements set forth in Sunshine's program outline and approved by the FCIE and the Florida Board.

13. Sunshine issued Respondent a diploma and certified that he graduated with a diploma/certificate in nursing after attending Sunshine from June 2016 to June 2017 and that he completed eleven theory courses and ten clinical/lab courses.

14. In December 2018, Respondent submitted an application for an LVN license by examination to the Board.

15. Respondent's Sunshine transcript and certification of graduation were also included with his application.

16. Respondent did not include that he attended CHP in his application.

17. Respondent made the following false statements on his application for an LVN license: that he attended "Sunrise Academy" from April 2017 to April 2018; and that he met all requirements for licensure, including that he successfully completed a program of professional or vocational nursing education approved under Texas Occupations Code section 301.157(d).

18. Respondent knew that he had not successfully completed a program of vocational nursing.

19. Respondent made that false statement to mislead the Board regarding his educational qualifications.

20. Based on Respondent's application, he was allowed to take the NCLEX. Respondent passed the NCLEX and the Board issued his LVN license on March 26, 2019.

21. Had the Board been aware that Respondent did not meet the educational requirements for licensure, it would not have issued a license to Respondent.

22. By knowingly providing false information on his application, Respondent engaged in fraud or deceit in procuring/obtaining a license.

23. Sunshine's issuance of Respondent's diploma was unlawful.

24. Upon receiving his license, Respondent began working as an LVN.

25. In January 2023, federal authorities announced Operation Nightingale, an investigation of a fraudulent nursing diploma scheme involving several nursing programs in Florida. Sunshine was one of the schools implicated in the investigation, and Respondent was identified as a person who may have received an illegitimate or fraudulent diploma from the school.

26. In November 2022, Respondent was employed by the University of Texas Medical Branch (UTMB) as an LVN in the Scott Jester IV Unit (Jester IV), which is a psychiatric unit in the Texas Department of Criminal Justice.

27. UTMB had a standing delegation order (SDO) which prescribed a set of directives for nurses to follow when a patient suffered a head injury or trauma. Among other things, the SDO required nurses to administer oxygen; apply a C-collar and use a backboard prior to moving the patient; take vital signs every fifteen minutes until redirected or the patient is transferred; establish an intravenous line (IV); and notify the provider of findings.

28. On November 3, 2022, Respondent worked the day shift at Jester IV from 5:45 a.m. to 6:10 p.m.

29. Respondent documented that, on November 3, 2022, at about 1:20 p.m., he responded to an inmate in Jester IV (Patient) after he was notified that Patient had fallen.

30. When Respondent arrived at Patient's pod, he saw that Patient had fallen from his bed onto the floor, and that Patient had "4x5 swelling" of the forehead, indicative of a possible head injury, and weak lower limbs.

31. Respondent moved Patient back to bed but did not apply a C-collar or use a backboard.

32. Respondent failed to perform and/or failed to document a complete assessment of Patient. Respondent documented that he took some vital signs but did not repeat the vital signs every fifteen minutes. Respondent did not perform a cognitive assessment, evaluate Patient's muscular strength, or try to determine how Patient fell.

33. Respondent failed to notify the registered nurse on duty of Patient's fall.

34. Respondent failed to collaborate with other providers about Patient's care and did not document when a physician ordered him to give Patient acetaminophen, or whether he gave that medication to Patient.

35. Later the same day, Patient was found in his pod choking on his food. He became unresponsive, required cardiopulmonary resuscitation, and had to be transferred to a local emergency department.

36. Respondent was not familiar with Patient and did not review his medical chart before or after responding to Patient's pod.

37. Patient was a vulnerable person because he had serious pre-existing medical conditions including diabetes, vascular dementia, and he had fallen the day before.

38. Respondent's failure to familiarize himself with Patient and his failure to properly assess Patient when he responded to the fall created a risk of harm to Patient.

39. Respondent failed to follow the SDO regarding patients with head injury or trauma by failing to take multiple rounds of vital signs, failing to establish an IV, failing to contact the provider, and failing to use a C-collar and follow other precautions before moving Patient.

40. Upon learning of Operation Nightingale, staff (Staff) of the Board began investigating Respondent and filed formal charges proposing to revoke his LVN license.

41. Respondent timely requested a hearing, and the matter was referred to the State Office of Administrative Hearings (SOAH).

42. On November 15, 2024, Staff filed a Notice of Hearing and Second Amended Formal Charges. Together, those documents 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 either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

43. On January 16, 2025, SOAH Administrative Law Judge Susan Rodriguez convened the hearing on the merits. Attorney JoAnna Starr represented Staff. Respondent appeared and represented himself. The record closed on February 28, 2025.

44. Aggravating factors related to Respondent's conduct include patient vulnerability, potential harm, lack of trustworthiness, misrepresentation of education, lack of efforts to correct or remediate the violation, seriousness of the violation; and threat to public safety.

45. There are no mitigating factors.

VII. CONCLUSIONS OF LAW

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. Code chs. 301, 304.

2. SOAH has jurisdiction over contested cases referred by the Board, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.

3. Respondent received adequate and proper notice of the hearing on the merits. Tex. Gov't Code §§ 2001.051-.052.

4. Staff had the burden of proving that disciplinary action against Respondent's license was warranted, and Respondent had the burden of proving mitigating factors. 1 Tex. Admin. Code § 155.427.

5. The standard of proof in this case is a preponderance of the evidence. *Granek v. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 777 (Tex. App.—Austin 2005, no pet.).

6. Respondent did not complete, and cannot be certified as a graduate of, Sunshine's approved nursing program because he did not complete the school's prescribed course of study, including clinical training. Tex. Occ. Code § 301.157(d); *see* Tex. Occ. Code § 301.252(a)(2).

7. Respondent's nursing program through Sunshine was not an approved Texas program, and it was not substantially equivalent to Texas standards for LVN programs. Tex. Occ. Code § 301.157(d), (d-4); 22 Tex. Admin. Code § 217.2(a)(4)(B).

8. Respondent is subject to sanction because he fraudulently obtained a nursing license and then practiced nursing under a diploma that was fraudulently obtained and issued unlawfully. Tex. Occ. Code §§ 301.451(1), (3)(A), (3)(B), .452(b)(1), (b)(2).

9. Respondent is subject to sanction because he provided information which was false, deceptive, or misleading in connection with the practice of nursing and he provided false or misleading answers in a licensure matter that could reasonably affect the decision to license a nurse. Tex. Occ. Code section 301.452(b)(10); 22 Tex. Admin. Code § 217.12(6)(H), (6)(I).

10. Respondent is subject to sanction because he failed to conform to accepted nursing standards for providing care and was noncompliant with vocational nursing processes. His conduct was careless and placed Patient at risk. Tex. Occ. Code § 301.452(b)(10); 22 Tex. Admin. Code § 217.12(1)(A), (1)(B), (4).

11. Respondent is subject to sanction because he failed to: adequately assess Patient and intervene when responding to Patient's fall; document fully and accurately Patient's status, physician orders, administration of medications, and contact with other health care members; and institute appropriate nursing interventions in compliance with the standing delegation order. Tex. Occ. Code § 301.452(b)(14); 22 Tex. Admin. Code § 217.11(1)(A), (1)(B), (1)(D), (1)(M).

12. The Board may impose a disciplinary sanction, which can range from remedial education to revocation, and which may include assessment of a fine. Tex. Occ. Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

13. To determine the appropriate disciplinary sanction to be imposed in this case, the Board considers the factors set forth in 22 Texas Administrative Code section 213.33(c) and the Board's Disciplinary Matrix. 22 Tex. Admin. Code § 213.33(b).

14. The Board may consider any aggravating and mitigating factors set forth in the findings of fact above. 22 Tex. Admin. Code § 213.33.

VIII. RECOMMENDATION

The Board should revoke Respondent's LVN license.

SIGNED APRIL 25, 2025

Susan Rodriguez
Presiding Administrative Law Judge

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State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

May 15, 2025

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Lateef Akinola Owokoniran **VIA EFILE TEXAS**
Respondent

RE: SOAH Docket Number 507-24-22303;
Texas Board of Nursing v. Lateef Akinola Owokoniran

Dear Parties:

Please be advised that the time period to file exceptions to the Proposal for Decision (PFD) issued in the above-referenced hearing has expired and neither party filed exceptions. Therefore, the Administrative Law Judge recommends that the PFD be adopted as written. Because SOAH has concluded its involvement in the matter, the case is being returned to the **Texas Board of Nursing**.

CC: Service List