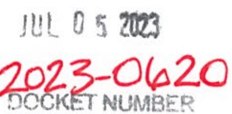
PROFESSIONAL LICENSING BOARDS

BEFORE THE GEORGIA BOARD OF NURSING

STATE OF GEORGIA



IN THE MATTER OF:	)	
	)	OSAH DOCKET NO.: 2313244
ANNALEEN JONES VISSER,	)	2313244-OSAH-PLBD-RN-28-Walker
License No. RN137224,	)	
	)	BOARD DOCKET NO.:
Respondent.	)	

FINAL DECISION

An evidentiary hearing was held in the above-captioned matter on April 10, 2023 at the Office of State Administrative Hearings. The Respondent was present at the hearing and represented by counsel. An Initial Decision was docketed by the Office of State Administrative Hearings in the above-captioned matter on May 22, 2023. On June 1, 2023, Respondent's counsel was successfully served with the Initial Decision via counsel's agent. In the absence of an application to the agency for review of said Initial Decision, or an order by the Board to review said Initial Decision on its own motion, said Initial Decision becomes the Final Decision of the Board by operation of law, pursuant to O.C.G.A. § 50-13-17(a).

FINDINGS OF FACT

The Findings of Fact entered by the Administrative Law Judge in the Initial Decision are hereby adopted and incorporated by reference herein.

CONCLUSIONS OF LAW

The Conclusions of Law entered by the Administrative Law Judge in the Initial Decision are hereby adopted and incorporated by reference herein.

ORDER

The decision of the Administrative Law Judge that Respondent's license to practice as a registered nurse in Georgia be **PLACED ON PROBATION FOR ONE YEAR** as set forth in the Initial Decision, including all terms setting forth the conditions of said probation, is adopted and incorporated by reference and, having become final on **July 3, 2023**, is hereby made the Final Decision of the Board, effective **July 3, 2023**.

GEORGIA BOARD OF NURSING

TAMMY BRYANT, MSN, BSN, RN
President

ATTEST: signed by Expressed Permission

GABRIEL STERLING
Interim Division Director
Professional Licensing Boards Division

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA BOARD OF NURSING, **Petitioner,** **v.** **ANNALEEN VISSER,** **Respondent.**	**Docket No.: 2313244** **2313244-OSAH-PLBD-RN-28-Walker** **Agency Reference No.: RN137224**

INITIAL DECISION

I. Summary of Proceedings

The Petitioner, the Georgia Board of Nursing ("Board"), brought this action seeking to sanction the Respondent's license to practice as a registered professional nurse ("RN") based on alleged violations of the laws and rules governing nursing practice in Georgia. The evidentiary hearing took place on April 10, 2023,[1] before the undersigned administrative law judge. The Board was represented by Assistant Attorneys General Griffin Ingraham and Sandra Bailey. Jacquelyn Clarke, Esq. and Michael V. Profit, Esq. appeared for the Respondent, Annaleen Visser.

II. Findings of Fact

1.

The Respondent holds a license to practice as an RN in the State of Georgia and has held such license at all times relating to the issues presented for hearing. The Respondent's license is active. (Exhibit P-1).

2.

The Respondent has been employed by the Cobb County Adult Detention Center (also the "Cobb County Jail" or "jail") since 1998. In September 2019 she was working as a charge nurse

[1] The record in this matter closed on April 19, 2023, following the submission of post-hearing briefing.

for the jail. A charge nurse supervises the jail's medical staff and is responsible for the jail's infirmary and inmate health care. (Testimony of Respondent; Testimony of Sandra Tilton.)

3.

Providing health care services to the jail's inmates poses unique challenges. The inmate population tends to be less healthy than the general population and they may not provide accurate medical histories to providers. Additionally, Cobb County Sheriff's Deputies ("Deputy" or "Deputies") must accompany nurses when they provide medical treatment to inmates. Although nurses can request that a Deputy open a jail cell, they have no authority to open the door themselves. Despite these challenges, nurses practicing at the Cobb County Jail still must meet the minimal standards of acceptable and prevailing nursing practice. (Testimony of Jennifer Goldsberry; Testimony of Kim Pearson; Testimony of Sandra Tilton.)

4.

On September 19, 2019, two inmates attacked a Deputy and the Cobb County Jail went into lockdown status. When the jail is locked down, inmate movement is restricted. (Testimony of Sandra Tilton.)

5.

As a result of the lockdown, inmates were anxious to leave their cells. They frequently sought medical treatment or asked to go to the emergency room because a hospital typically provides inmates with better food and more comfortable accommodations. (Testimony of Kimberly Pearson; Testimony of Sandra Tilton.)

6.

The Cobb County Jail has 2000 inmates and an infirmary that provides inmates with health care services. Even when the jail is not locked down, the infirmary usually is "packed." Sandra

Tilton, the Respondent's supervisor, noted that the Respondent always has worked hard to care for the inmates in the infirmary. (Testimony of Tiana Davis; Testimony of the Respondent; Testimony of Sandra Tilton; Exhibits P-10, P-11.)

7.

There are fourteen cells in the infirmary; each cell can hold up to four patients. In addition to health care providers and staff, at least one Deputy is assigned to secure the infirmary. The cells have glass front walls that allow anyone working in the infirmary to see inside of the cell. While on duty, the Respondent sits at a desk positioned so that she can monitor the activity taking place within the infirmary. (Testimony of Tiana Davis; Testimony of the Respondent; Testimony of Sandra Tilton; Exhibits P-10, P-11.)

8.

On September 23, 2019, K.W. was arrested and taken to the Cobb County Jail. A Preliminary Health Screening Assessment indicated that he had ingested cocaine within the past seventy-two hours. (Exhibit P-13.)

9.

After K.W. completed the Preliminary Health Screening Assessment, the Respondent administered an Infirmary Physical Assessment. She asked K.W. about the type and quantity of drugs he had ingested. According to the Respondent, K.W. did not disclose any medical issues other than those related to withdrawing, or detoxing, from heroin. (Testimony of the Respondent; Exhibit P-13.)

10.

Although the Preliminary Health Screening Assessment specified that K.W. had ingested cocaine, the jail's medical records indicate that he underwent an opioid detox protocol for heroin.

Depending on the type of drug and the quantity ingested, patients who are detoxing can exhibit many symptoms including: goosebumps, sweating, a runny nose, vomiting, agitation, altered mental status, sleeping issues, pain, fear, seizures, body aches, muscle and bone pain, and dilated pupils. While detoxing, an individual may not eat or may sleep a lot of the time. These symptoms also can be indicative of other health conditions. (Testimony of the Respondent; Testimony of Kim Pearson; Testimony of Sandra Tilton; Exhibit P-13.)

11.

Over the next three days, K.W. remained at the infirmary. He received medication to alleviate his withdrawal symptoms and daily assessments by a physician. On September 27, 2019, the jail's physician determined that K.W. could be discharged, and he was transferred from the infirmary to the jail's general population. (Testimony of the Respondent; Exhibit P-13.)

12.

On September 28, 2019, shortly before midnight, K.W. was readmitted to the infirmary. Medical records indicate that he complained of abdominal discomfort and include findings of nausea and vomiting. According to the medical records, K.W. also stated "I'm still detoxing. I swear I'm never going to use drugs again." (Testimony of the Respondent; Exhibit P-13.)

13.

On September 29, 2019, both the Respondent and Tiana Davis, a unit secretary at the infirmary, were working the 6 a.m. to 6 p.m. shift. The Respondent arrived at the infirmary at 5:45 a.m. and was told by the night nurse that the Respondent had eaten breakfast and also had requested to go to the hospital. His vitals had been taken during the night and were normal. (Testimony of Tiana Davis; Testimony of the Respondent; Exhibits P-10, P-11.)

14.

On September 29, 2019, Tiana Davis had been employed by the Cobb County jail as a unit secretary for four months. Ms. Davis does not have a medical background or medical training. The unit secretary's job duties included answering and transferring calls. If a patient in the infirmary needed assistance, the patient was able to contact Ms. Davis. She would answer the call and alert the charge nurse on duty. (Testimony of Tiana Davis.)

15.

On September 29, 2019, Patient K.W. was in cell eight. Ms. Davis's desk sits directly in front of cell eight and she was able to observe K.W. through the glass wall. (Testimony of Tiana Davis.)

16.

At approximately 6:15 a.m., K.W. rang the call bell and told Ms. Davis that he could not breathe. Ms. Davis notified the Respondent, and the Respondent directed her to tell K.W. to lie down. (Testimony of Tiana Davis.)

17.

K.W. rang the call bell a few more times, again stating he could not breathe. The Respondent repeated her instructions to Ms. Davis that K.W. should lie down. After observing K.W., Ms. Davis became concerned and told Tiffany Womack, a lab technician who was in the infirmary, that K.W. appeared to be in distress. Ms. Davis asked Ms. Womack to check on him. (Testimony of Tiana Davis; Testimony of Tiffany Womack.)

18.

In addition to being a lab technician, Ms. Womack is a certified nursing assistant and has been trained as an EMT. She was responsible for checking a patient's vital signs and drawing

blood. She had worked at the jail since 2017. (Testimony of Tiffany Womack.)

19.

K.W. began to knock at the cell door, shouting that he could not breathe and asking for help. According to Ms. Womack, K.W. was sweating and "visibly sick." After she saw him fall to the ground, she approached the Respondent to voice her concern and offered to take his vital signs. The Respondent rejected Ms. Womack's offer, stating that she believed that K.W. was "drug seeking" and attempting to be transferred to a hospital. She also told Ms. Womack that someone would take his vital signs when he stopped shouting and calmed down. (Testimony of Respondent; Testimony of Tiffany Womack.)

20.

The Respondent maintains that no one informed her that K.W. had said that he could not breathe. Even if she had been told about his complaints, K.W. was shouting and would have had to have been breathing. (Testimony of the Respondent.)

21.

Ms. Womack believed that K.W. was quite ill. She asked a Deputy to open K.W.'s cell so that she could take his vital signs, but the Deputy told Ms. Womack that she could only open the cell door if the charge nurse instructed her to do so. (Testimony of Tiffany Womack.)

22.

At approximately 6:24 a.m., the Respondent walked towards K.W.'s cell and looked inside for about twenty seconds. According to the Respondent, she was checking for signs of sweating, tremors, nausea, vomiting, or pain, but did not see anything that concerned her. She believed that K.W.'s symptoms demonstrated that he was still detoxing. She also testified that K.W.'s cellmate was unhappy with his agitated behavior and the situation was volatile. Accordingly, she told K.W.

to move away from another inmate's bed, and he complied with her directions. Later, the second inmate was removed from the cell. (Testimony of the Respondent; Exhibits P-10, Exhibit P-11.)

23.

The infirmary staff typically checks patients' vital signs around 7:15 a.m. During this process, the Deputies remove patients from their cells one at a time. According to the Respondent, K.W. was too agitated to have his vital signs taken and she did not detect a medical emergency. (Testimony of the Respondent.)

24.

In Ms. Womack's opinion, K.W. was not combative because he was too weak; "he could not have acted out [because] he was very sick." (Testimony of Tiffany Womack.)

25.

Video footage taken in the infirmary on the morning of September 29, 2019, does not include audio. However, per the video's timestamp, the Deputies removed K.W. from his cell at approximately 7:30 a.m. K.W. did not appear agitated and the Deputies did not put him in handcuffs. After exiting his cell, K.W. sat and/or lied down on the floor outside of the cell. (Exhibits P-10, P-11.)

26.

Approximately ten minutes after he left his cell, a Deputy moved K.W. from the floor to a chair. K.W. repeatedly slumped down and had to be pulled back up by a Deputy. A Deputy remained near K.W. from the moment he was taken out of his cell until he left the infirmary. (Exhibits P-10, P-11.)

27.

While K.W. was outside of his cell, the Respondent sat at her desk. She claimed that she

did not assess K.W. while he was outside of his cell because he was acting out, and, additionally, it would not have been appropriate to approach the area if a Deputy was busy with an inmate. (Testimony of the Respondent.)

28.

Ultimately, the Respondent testified that she directed that K.W. be moved to a single cell in the jail annex so that he could calm down. The annex is outside of the infirmary. After the deputies moved K.W. to the annex, it would be impossible for the Respondent to visually monitor his condition. She noted that a Deputy checked cells in the annex every fifteen minutes and would alert her if there was a problem. (Testimony of the Respondent.)

29.

After being placed in handcuffs, K.W. left the infirmary on foot. Several Deputies provided him assistance. Later footage shows that Deputies had placed K.W. in a wheelchair for transport to the annex. (Exhibits P-10, P-11.)

30.

Video footage taken at the annex shows that later that morning a jail employee found K.W. in his cell lying on the ground and unresponsive. Although jail staff attempted to revive him, at 9:51 a.m. he was pronounced deceased. The cause of death was a perforated stomach ulcer. (Testimony of the Respondent; Testimony of Jennifer Goldsberry; Exhibits P-11, P-13.)

31.

Kimberly Pearson has been an RN for thirty-nine years. She has worked in correctional institutions as a health care provider and consults with jails and prisons to help them develop appropriate policies and procedures. (Testimony of Kimberly Pearson.)

32.

In Ms. Pearson's view, the Respondent met the standard of care for a nurse practicing in a correctional setting. The Respondent was aware that K.W. had been sent to the infirmary because he was vomiting. Vomiting is a common symptom when a patient is detoxing, and his vomiting ceased once he was brought to the infirmary. She had not been informed of any unusual circumstances by the night nurse, and his vital signs taken before her shift began were stable. Ms. Pearson maintained that K.W.'s symptoms were consistent with heroin withdrawal and saw no indication that K.W. needed more than a focused visual assessment, a tool nurses regularly use to assess a patient's wellbeing. (Testimony of Kimberly Pearson.)

33.

Dr. Jennifer Goldsberry is a Family Nurse Practitioner and an Advanced Practice Nurse. She holds a Doctorate in Nursing Practice and teaches nursing at Georgia College and State University. Although Dr. Goldsberry has not practiced nursing in a jail or prison, she has taken care of inmates undergoing detox protocols in a hospital setting. (Testimony of Jennifer Goldsberry.)

34.

Dr. Goldsberry has completed approximately fifty peer reviews for the Board and conducted a peer review regarding the Respondent's treatment of K.W.[2] After reviewing video footage from the jail, medical records, and documentation of interviews conducted during an investigation,[3] she concluded that the Respondent's treatment of K.B. fell below the minimal standard of care.

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[2] Dr. Goldsberry testified that she was paid $150.00 to conduct the peer review.
[3] No information was provided as to which entity performed the investigation.

35.

A patient can detox for up to ten days; typically, symptoms peak in the first few days and will improve. After three days of detoxing, a physician determined that K.W. had improved enough to be released to the general population. K.W. returned to the infirmary one day later because he was vomiting and complaining of stomach pain. (Testimony of Jennifer Goldsberry; Testimony of the Respondent; Exhibit P-13.)

36.

When a patient is in drug withdrawal, symptoms usually improve over time. Although some of K.W.'s symptoms are consistent with detoxing, he appeared to be getting worse, not better. According to Dr. Goldsberry, K.W.'s falling, "writhing" in pain, and lying on the ground, coupled with his repeated statements that he was unable to breathe, warranted a full assessment. Patients in many settings may have cause to exaggerate their symptoms, but a nurse still has the obligation to ensure that the patient is not seriously ill. While nursing is not an exact science, the Respondent's inaction did not meet minimal standards of care. [4] (Testimony of Jennifer Goldsberry.)

37.

At the absolute minimum, the Respondent should have evaluated K.W.'s mental status, heart, lungs, stomach, and vital signs and palpated his stomach. However, instead of performing an appropriate assessment, the Respondent directed that K.W. be removed from the infirmary and taken to the annex, where she would be unable to assess his condition - even visually. (Testimony

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[4] Some of Dr. Goldsberry's conclusions were based on inaccurate assumptions and the undersigned does not find her testimony relating to these assumptions to be persuasive. For example, according to Dr. Goldsberry, when K.W. was readmitted to the infirmary he complained of a stomach ulcer. The records submitted by the Board do not indicate that K.W. ever disclosed to jail staff that he had a stomach ulcer. See Exhibit P-13.

of Jennifer Goldsberry.)

III. Conclusions of Law

1.

The Board bears the burden of proof in this matter. Ga. Comp. R. & Regs. 616-1-2-.07(1). The standard of proof is a preponderance of evidence. Ga. Comp. R. & Regs. 616-1-2-.21(4).

2.

When a contested case is referred to the Office of State Administrative Hearings, the administrative law judge assigned to the case has "all the powers of the ultimate decision maker in the agency . . . ." O.C.G.A. § 50-13-41(b). The evidentiary hearing is *de novo*, and the administrative law judge "shall make an independent determination on the basis of the competent evidence presented at the hearing." Ga. Comp. R. & Regs. 616-1-2-.21(1).

3.

The Board is the entity responsible for licensing nurses in Georgia and establishing standards for the nursing profession. The Board is authorized to sanction an RN who has violated the statutes and rules governing the profession as set forth in the Georgia Registered Professional Nurses Practice Act, O.C.G.A. §§ 43-26-1 to -13; the rules of the Georgia Board of Nursing, Ga. Comp. R. & Regs. 410-1-.01 to 410-14-.01; and the general statutory provisions regarding disciplinary actions by professional licensing boards, found at O.C.G.A. § 43-1-19.[5] The sanctions available to the Board are set forth in O.C.G.A. § 43-1-19(d), as follows:

(1) Refuse to grant or renew a license to an applicant;

(2) Administer a public or private reprimand, but a private reprimand shall not be disclosed to any person except the licensee;

[5] Chapter 1 of Title 43 is expressly adopted and incorporated by reference into Chapter 26 of Title 43. O.C.G.A. § 43-26-5(c).

(3) Suspend any license for a definite period or for an indefinite period in connection with any condition which may be attached to the restoration of such license;

(4) Limit or restrict any license as the board deems necessary for the protection of the public;

(5) Revoke any license;

(6) Condition the penalty upon, or withhold formal disposition pending, the applicant's or licensee's submission to such care, counseling, or treatment as the board may direct;

(7) Impose a fine not to exceed $500.00 for each violation of a law, rule, or regulation relating to the licensed business or profession; or

(8) Impose on a licensee or applicant fees or charges in an amount necessary to reimburse the professional licensing board for the administrative and legal costs incurred by the board in conducting an investigative or disciplinary proceeding.

O.C.G.A. § 43-1-19(d).

4.

The Board has the authority to discipline a licensee upon a finding that the licensee has done the following:

(6) Engaged in any unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice harmful to the public that materially affects the fitness of the licensee . . . to practice a business or profession licensed under this title or is of a nature likely to jeopardize the interest of the public; such conduct or practice need not have resulted in actual injury to any person or be directly related to the practice of the licensed business or profession but shows that the licensee or applicant has committed any act or omission which is indicative of bad moral character or untrustworthiness. Such conduct or practice shall also include any departure from, or the failure to conform to, the minimal reasonable standards of acceptable and prevailing practice of the business or profession licensed under this title; [...]

O.C.G.A. § 43-1-19(a)(6).

5.

Nursing conduct failing to meet the minimal standards of acceptable and prevailing nursing

practice, which could jeopardize the health, safety, and welfare of the public, constitutes unprofessional conduct. Ga. Comp. R. & Regs. 410-10-.03(1). Unprofessional conduct includes:

> (e) Abandoning or knowingly neglecting patients/clients requiring nursing care; […]
>
> (g) Failing to take appropriate action to safeguard a patient's welfare; [….]

Ga. Comp. R. & Regs. 410-10-.03(2)(e),(g).

6.

The Respondent argues that she neither neglected K.W., nor did she fail to take appropriate action to safeguard his welfare. In her judgment, K.W.'s symptoms were consistent with a patient detoxing from heroin use, and, given what she knew about K.W.'s medical history and past treatment, additional assessment was unwarranted.

7.

Although the Respondent maintains that no one informed her that K.W. had said he could not breathe, Ms. Davis's and Ms. Womack's testimony that they told the Respondent that K.W. had complained that he could not breathe is credible. The undersigned relies on Dr. Goldsberry's testimony that the severity and timing of K.W.'s symptoms, in conjunction with his repeated statements that he could not breathe, required that the Respondent perform more than a visual assessment to meet minimal standards of acceptable and prevailing nursing practice. When K.W. was removed from his cell, he appeared to be almost incapacitated – unable to sit or stand unsupported. Instead of performing an assessment, the Respondent directed that K.W. be moved to the jail annex where she no longer would be able to observe his condition.

8.

Ms. Pearson testified that the Respondent's conduct should be considered in light of the unique challenges faced by nurses providing medical care to inmates in a correctional facility

during a lockdown. In this vein, the Respondent suggests both that security constraints prevented her from performing an additional assessment and that she had cause to believe that K.W. was exaggerating his symptoms.

9.

These arguments are unavailing. Security constraints did not prevent the Respondent from treating K.W. Unlike Ms. Womack, the Respondent was not told that a Deputy would not or could not open K.W.'s cell. Having been alerted by at least two individuals that he appeared to be in distress, the Respondent indicated that she would take K.W.'s vitals once he had calmed down. When he was removed from his cell, K.W. was neither agitated nor unruly. In fact, the Deputies did not put him in handcuffs until transferring him to the annex. At all relevant times a Deputy was in close proximity to K.W.; however, the Respondent never asked for – and thus was never refused – the opportunity to examine him. To the contrary, she ordered him to be removed to another location where he would receive less frequent monitoring.

10.

The Respondent also argues that K.W. had reason to lie about the severity of his condition so that he could be transferred to a hospital with all of its attendant privileges. Although patients, even those who are not incarcerated, may feign illness in the attempt to obtain some type of benefit, as Dr. Goldsberry testified, a nurse cannot simply ignore a patient in distress because she thinks he may have reason to exaggerate his symptoms.

IV. Decision[6]

Based on the evidence presented at the hearing, the undersigned finds that the Respondent's care of K.W. on September 29, 2019, fell below minimal standards of acceptable and prevailing nursing practice, in violation of O.C.G.A. § 43-1-19(a)(6) and Ga. Comp. R. & Regs. 410-10-.03(1), Ga. Comp. R. & Regs. 410-10-.03(2)(e),(g). In formulating a sanction, the undersigned considers that the Respondent's supervisor praised her work ethic and that she is an experienced RN with no prior disciplinary history. In accordance with the foregoing Findings of Fact and Conclusions of Law, the undersigned recommends that the Respondent's license to practice as an RN be placed on probation for one year. As a condition of probation, she shall complete any continuing education courses designated by the Board, pay a fine of $250.00 and the Board's investigative costs of $150.00, the amount paid to Dr. Goldsberry. Payments should be forwarded to 237 Coliseum Drive, Macon, GA 31217-3858, in care of the Legal/Disciplinary Nurse Consultant.

SO ORDERED, this 22nd day of May, 2023.

Ronit Walker
Administrative Law Judge

[6] This Court's decision constitutes an "Initial Decision." This Initial Decision will become the "Final Decision" of the Board in thirty days, unless either party makes a timely application for the Board to review the Initial Decision. If either party seeks timely review of the Initial Decision, the result of that review by the Board will constitute the Final Decision. See O.C.G.A. §§ 50-13-17(a), 50-13-41(d); Ga. Comp. R &. Regs. 616-1-2-.27.

NOTICE OF INITIAL DECISION

Attached is the Initial Decision of the administrative law judge. A party who disagrees with the Initial Decision may file a motion with the administrative law judge and/or an application for agency review.

Filing a Motion with the Administrative Law Judge

A party who wishes to file a motion to vacate a default, a motion for reconsideration, or a motion for rehearing must do so within 10 days of the entry of the Initial Decision. Ga. Comp. R. & Regs. 616-1-2-.28, -.30(4). All motions must be made in writing and filed with the judge's assistant, with copies served simultaneously upon all parties of record. Ga. Comp. R. & Regs. 616-1-2-.04, -.11, -.16. The judge's assistant is Devin Hamilton - 404-657-3337; Email: devinh@osah.ga.gov; Fax: 404-657-3337; 225 Peachtree Street NE, Suite 400, South Tower, Atlanta, Georgia 30303.

Filing an Application for Agency Review

A party who seeks review by the referring agency must file an application for agency review within 30 days after service of the Initial Decision. O.C.G.A. §§ 50-13-17(a), -41. **In nearly all cases, agency review is a prerequisite for judicial review.** O.C.G.A. § 50-13-19(a).

The application for agency review must be filed with: **Georgia Board of Nursing, Professional Licensing Board Division, Secretary of State, 237 Coliseum Drive, Macon, GA 31217-3858**. Copies of the application for agency review must be served upon all parties of record and filed simultaneously with the OSAH Chief Clerk at 225 Peachtree Street NE, Suite 400, South Tower, Atlanta, Georgia 30303. If a timely application for agency review is not filed and the referring agency does not review the Initial Decision on its own motion, the Initial Decision will become the Final Decision of the referring agency by operation of law. O.C.G.A. §§ 50-13-17(a), -41.

Docket No.: 2313244-OSAH-PLBD-RN-28-Walker

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA BOARD OF NURSING, Petitioner,	))	OSAH DOCKET NO.
vs.	)))	
ANNALEEN JONES VISSER, License No. RN137224,	)))	
Respondent.	)	

MATTERS ASSERTED AND
STAUTES AND RULES INVOLVED

Pursuant to O.C.G.A. 50-13-13 and 50-13-41, and under the authority of O.G.G.A. § 43-26-5, the Georgia Board of Nursing (the "Georgia Board") hereby provides the Respondent with the Matters Asserted which, if correct, constitute sufficient grounds for the sanctioning of Respondent's license to practice as a licensed practical nurse in the State of Georgia, including **revocation, indefinite suspension**, **the imposition of costs in an amount necessary to reimburse the Board for the administrative and legal costs incurred by the Board in conducting an investigative or disciplinary proceeding**, and the Statutes and Rules which Respondent is alleged to have violated.

MATTERS ASSERTED

1.

The Respondent is licensed to practice nursing as a registered professional nurse in the State of Georgia and was so licensed at all times relevant to the matters asserted herein.

2.

On or about September 29, 2019, Respondent knowingly neglected patient K.W. when K.W. required nursing care. Respondent was asked repeatedly to assess and/or provide care to

K.W. by at least two people. Specifically, two witnesses observed K.W; and both found K.W. to be very sick and heard him saying "I can't breathe." Both witnesses alerted Respondent and implored her to provide care to K.W. and Respondent refused.

3.

Respondent's failure to provide nursing care to K.W. constitutes unprofessional conduct.

4.

Pursuant to O.C.G.A. § 43-1-19(d)(8), the Board requests that the costs of this legal proceeding that are necessary to reimburse the Board for this legal, disciplinary proceeding, including the costs of the court reporter and the Office of State Administrative Hearings, be incorporated as a Finding of Fact.

5.

In addition to assessing the costs of this legal proceeding to Respondent, pursuant to O.C.G.A. § 43-1-19(d)(8), the Board also requests that its investigative costs and peer review costs be incorporated as a Finding of Fact, and that Respondent be ordered to pay the Board its investigative costs and peer review costs in this case of $150.00.

6.

To the extent that Respondent's address has changed and Respondent failed to notify the Board and/or provide a current address, Respondent has violated Ga. Comp. R. & Regs. 410-1-.03(2).

STATUTES AND RULES INVOLVED

Disciplinary action against the Respondent's license is sought pursuant to the statutory provisions related to professional licensing boards, O.C.G.A. § 43-1-1, et seq.; the Georgia Nurse

Practice Act, O.C.G.A. § 43-26-1, et seq.; and the rules of the Georgia Board of Nursing, found at Ga. Comp. R. & Regs.., Ch. 410; including, but not limited to, the following provisions:

1.

O.C.G.A. § 43-26-5(c) provides that Chapter 1 of Title 43 is expressly adopted and incorporated by reference into Chapter 26 as if all the provisions of Chapter 1 were included in Chapter 26.

2.

O.C.G.A. § 43-1-19(a) provides that a professional licensing board shall have the authority to refuse to grant a license to an applicant, to revoke the license of a person or to discipline a person licensed by a board, upon a finding by a majority of the entire board that the licensee has:

> (6) Engaged in any unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice materially affects the fitness of the licensee or applicant to practice a business or profession licensed under this title, or of a nature likely to jeopardize the interest of the public, which conduct or practice need not have resulted in actual injury or be directly related to the practice of the licensed business or profession but shows that the licensee or applicant has committed any act or omission which is indicative of bad moral character or untrustworthiness. Unprofessional conduct shall also include any departure from, or failure to conform to, the minimal reasonable standards of acceptable and prevailing practice of the business or profession licensed under this title [.]

3.

Pursuant to Ga. Comp. R. & Regs. 410-10-.03(1), nursing conduct failing to meet the minimal standards of acceptable and prevailing nursing practice, which could jeopardize the health, safety, and welfare of the public, shall constitute unprofessional conduct. This conduct shall include, but not be limited to, the following:

2(e) Abandoning or knowingly neglecting patients/clients requiring nursing care; […]

2(g) Failing to take appropriate action to safeguard a patient's welfare; [.]

4.

In addition, O.C.G.A. § 43-1-19 (d) provides that when a professional licensing board finds that any person should be disciplined pursuant to subsection (a) of this Code section or the laws, rules, or regulations relating to the business or profession licensed by the board, the board may take any one or more of the following actions:

> (1) Refuse to grant or renew a license to an applicant;
>
> (2) Administer a public or private reprimand, but a private reprimand shall not be disclosed to any person except the licensee;
>
> (3) Suspend any license for a definite period or for an indefinite period in connection with any condition which may be attached to the restoration of said license;
>
> (4) Limit or restrict any license as the board deems necessary for the protection of the public;
>
> (5) Revoke any license;
>
> (6) Condition the penalty upon, or withhold formal disposition pending, the applicant's or licensee's submission to such care, counseling, or treatment as the board may direct;
>
> (7) Impose a fine not to exceed $500.00 for each violation of a law, rule, or regulation relating to the licensed business or profession; or
>
> (8) Impose on a licensee or applicant fees or charges in an amount necessary to reimburse the professional licensing board for the administrative and legal costs incurred by the board in conducting an investigative or disciplinary proceeding.

Additionally, O.C.G.A. § 43-1-19 (e) provides that, in addition to and in conjunction with the actions described in subsection (d) of this Code section, a professional licensing board may make a finding adverse to the licensee or applicant but withhold imposition of judgment

and penalty; or it may impose the judgment and penalty but suspend enforcement thereof and place the licensee on probation, which probation may be vacated upon noncompliance with such reasonable terms as the board may impose.

5.

Pursuant to Ga. Comp. R. & Regs. r. 410-1-.03(2): A licensee shall notify the Board in writing within thirty (30) days of any mailing, physical or email address changes. Address changes should be made by the licensee through the Board's website.

6.

Pursuant to O.C.G.A. § 43-1-19(k): If any licensee or applicant after reasonable notice fails to appear at any hearing of the professional licensing board for that licensee or applicant, the board may proceed to hear the evidence against such licensee or applicant and take action as if such licensee or applicant had been present. A notice of hearing, initial or recommended decision, or final decision of the board in a disciplinary proceeding shall be served personally upon the licensee or applicant or served by certified mail or statutory overnight delivery, return receipt requested, to the last known address of record with the board. If such material is served by certified mail or statutory overnight delivery and is returned marked "unclaimed" or "refused" or is otherwise undeliverable and if the licensee or applicant cannot, after diligent effort, be located, the division director, or his or her designee, shall be deemed to be the agent for service for such licensee or applicant for purposes of this Code section, and service upon that director, or that director's designee, shall be deemed to be service upon the licensee or applicant.

GEORGIA BOARD OF NURSING

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