BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 777389 and	§	
Vocational Nurse License	§	
Number 161889 issued to	§	
MELODY MCREYNOLDS-PEREZ	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the l considered the matter of MELODY MCREYNOLDS-PEREZ, Registered Nurse License Number 777389 and Vocational Nurse License Number 161889, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(9),(10),(12)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on August 25, 2010, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.

3. Respondent is currently licensed to practice professional and vocational nursing in the State of Texas.

4. Respondent received a Certificate in Vocational Nursing from San Jacinto College North, Houston, Texas, on December 13, 1996. Respondent was licensed to practice vocational nursing in the State of Texas on March 5, 1997. Respondent received an Associate Degree in Nursing from Alvin Community College, Alvin, Texas, on July 14, 2009. Respondent was licensed to practice professional nursing in the State of Texas on November 10, 2009.

TEXAS BOARD OF NURSING
I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

5. Respondent's professional and vocational nursing employment history includes:

03/97 - 05/00	Unknown	
06/00 - 09/00	LVN	A+ Medical Staffing Manchester, Tennessee
09/00 - 09/03	LVN	NurseFinders Wichita Falls, Texas
05/01 - 07/03	LVN	Triumph Hospital Houston, Texas
05/03 - Unknown	LVN	HCA All About Staffing Houston, Texas
10/03 - Unknown	LVN	Advantage Nursing Houston, Texas
10/04 - 04/05	LVN	American Hospice Houston, Texas
04/05 - 08/05	LVN	East Houston Regional Medical Ctr Houston, Texas
08/05 - Unknown	LVN	Park Manor of Westchase Houston, Texas
Present	Unknown	

6. At the time of the initial incident, Respondent was employed as an agency nurse with HCA All About Staffing, Houston, Texas, and assigned to Bayshore Medical Center, Pasadena, Texas, and had been in this position for five (5) years and four (4) months.

7. On or about September 13, 2008 and September 19, 2008, while employed with All About Staffing Gulf Coast Division, Houston, Texas, and assigned to Bayshore Medical Center, Pasadena, Texas, Respondent lacked fitness to practice nursing in that she was observed to be exhibiting impaired behavior, including but not limited to: overly concerned with patients' pain medications and disappearing off the unit several times. Respondent's condition could have affected her ability to recognize subtle signs, symptoms, or changes in the patients' conditions and could have affected her ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patients in potential danger; and leaving a nursing assignment could have resulted in the patients not getting the care that they needed.

8. In response to Finding of Fact Number Seven (7), Respondent states:

"I did not exhibit impaired behavior nor was I overly concerned with patients' pain medications nor did I disappear off the unit several times. With my patient load there is no way I could have disappeared off of the unit nor would I have a reason to disappear off of the unit. In fact I didn't even leave the unit to eat lunch. I know we had inservices about patients' calling administration complaining about being left in pain after asking several times for something for relief. I know at that time I incorporated asking my patients if they needed anything for pain as I was told to do. We were told to treat pain as the fifth vital sign. I checked on my patients after they received anything for pain and they had relief from pain."

9. On or about September 19, 2008, while employed with All About Staffing Gulf Coast Division, Houston, Texas, and assigned to Bayshore Medical Center, Pasadena, Texas, Respondent engaged in the intemperate use of alprazolam and cocaine in that she produced a specimen for a reasonable suspicion/cause urine drug screen which resulted positive for alprazolam and cocaine. Possession of alprazolam and cocaine is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of alprazolam and cocaine by a nurse, while subject to call or duty, could impair the nurse's ability to recognize subtle signs, symptoms or changes in the patients' condition, and could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patients in potential danger.

10. In response to Finding of Fact Number Nine (9), Respondent states:

"I did not engage in the intemperate use of alprazolam and cocaine. Hurricane Ike had just been through the Houston area at that time. When I gave a urine specimen Bayshore hospital lab could not test it because it was still closed from flooding. All About Staffing HR told me the specimen was sent to two places, the first one not operational, the second one out of state. I told my Dr. of the results. He said the test was erroneous and to have them give me another test. I did another urine test which came back negative. At that time All About Staffing HR director told me if the second test came back negative it would prove the first one to be a mistake because the levels of drug were so high in the first urine test which was not mine."

11. On or about December 5, 2008, while employed with Advantage Nursing Services, Inc., Metaire, Louisiana, and assigned to Park Plaza Hospital, Houston, Texas, Respondent removed Dilaudid 2mg from the medication dispensing system for Patient Medical Record Number 8594160 without a valid physician's order. Respondent's conduct may have injured the patient in that the administration of Dilaudid without a physician's order could result in the patient suffering from adverse reactions.

12. In response to Finding of Fact Number Eleven (11), Respondent states:

"I did not remove Dilaudid 2mg from the medication dispensing system for Patient Medical Record Number 8594160 without a valid physician's order. When a physician writes an order for any medication it is sent to the pharmacy. The pharmacist or technician, I think, has to put the medication order in the medication machine on the profile of the patient before the medicine can be removed. I would have no reason to pull a medication from the machine unless it was on the patient profile and the patient asked for it if it was PRN med. If the medication is scheduled, I would pull it to give as scheduled. The only way a medication can be on a profile is from a physician's order, therefore there is no way I could have pulled Dilaudid without a physician's order. I would not take it upon myself to prescribe a medication and give it."

13. On or about December 5, 2008, while employed with Advantage Nursing Services, Inc., Metaire, Louisiana, and assigned to Park Plaza Hospital, Houston, Texas, Respondent removed Toradol 30mg from the medication dispensing system for Patient Medical Record Number 8594160 after the medication had been discontinued. Respondent's conduct was likely to injure the patient in that the administration of Toradol without a physician's order could result in the patient suffering from adverse reactions.

14. In response to Finding of Fact number Thirteen (13), Respondent states:

"I did not remove Torodol 30mg from the medication dispensing system for Patient Medical Record Number 8594160 after the medication had been discontinued. All active medications are listed on the profile of the patient in the medication dispensing system. If the medication is ordered PRN I would give it to the patient if they ask for it. If the medication is scheduled, I would give is as scheduled. The only way to pull a medication from the dispensing machine is for that medicine to be active on the patient profile. So if I was able to pull Torodol for that patient, it was active, not discontinued at the time it was given. The machine will not show any medication that is not ordered or not active on the patient profile. I would have no reason to pull any medication that is not active or that the patient did not ask for. Therefore, this charge is not correct."

15. On or about December 8, 2008, while employed with Advantage Nursing Services, Inc., Metairie, Louisiana, and assigned to Plaza Specialty Hospital, Houston, Texas, Respondent removed medications from the medication dispensing system for patients, but failed to document the administration, including signs symptoms and responses to the medications, in the patients' medication administration record and/or nurse's notes, as follows:

Date	Patient Acct #	Physician's Order	Medication Dispensing System Record Time and Quantity	Medication Administration Record	Nurses Notes
12-8-08	8605941 [S.O.]	Zofran 4mg/2ml soln IV q6h prn	Ondansetron Hcl 4mg/2ml inj 0910 (1)	No Entry	No Entry
12-8-08	8605941 [S.O.]	Morphine 1mg/0.5ml soln IV q6h prn	Morphine 2mg/ml 1ml inj 0911 (1)	No Entry	No Entry
12-8-08	8583064 [A.L.]	Hydrocodone-Acetaminophen 5-500mg 2 tab F-Tube q6h prn	Hydrocodone-Acetaminophen 5-500mg tab 1005 (1)	0850	No Entry
12-8-08	8583064 [A.L.]	Promethazine 25mg/1ml soln 1ml IV q6h prn nausea	Promethazine 2mg/ml 1ml inj 1005 (1)	No Entry	No Entry
12-8-08	8583064 [A.L.]	Provigil 100mg/1tab F-Tube q am @ 0700	Modafinil 200mg tab 1009 (1)	No Entry	No Entry
12-8-08	8605941 [S.O.]	Morphine 1mg/0.5ml soln IV q6h prn	Morphine 2mg/ml 1ml inj 1151 (1)	No Entry	No Entry
12-8-08	8583064 [A.L.]	Hydrocodone-Acetaminophen 5-500mg 2 tab F-Tube q6h prn	Hydrocodone-Acetaminophen 5-500mg tab 1453 (1)	No Entry	No Entry
12-8-08	8583064 [A.L.]	Promethazine 25mg/1ml soln 1ml IV q6h prn nausea	Promethazine 2mg/ml 1ml inj 1454 (1)	No Entry	No Entry
12-8-08	8605941 [S.O.]	Morphine 1mg/0.5ml soln IV q6h prn	Morphine 2mg/ml 1ml inj 1629 (1)	No Entry	No Entry
12-8-08	8583064 [A.L.]	Promethazine 25mg/1ml soln 1ml IV q6h prn nausea	Promethazine 2mg/ml 1ml inj 1648 (1)	No Entry	No Entry
12-8-08	8583064 [A.L.]	Hydrocodone-Acetaminophen 5-500mg 2 tab F-Tube q6h prn	Hydrocodone-Acetaminophen 5-500mg tab 1743 (1)	No Entry	No Entry
12-8-08	8583064 [A.L.]	No Order	Codeine-Guafen 10-100mg/5ml 1743 (1)	No Entry	No Entry

Respondent's conduct was likely to injure the patients in that subsequent care givers would rely on her documentation to further medicate the patients which could result in an overdose.

16. On or about December 8, 2008, while employed with Advantage Nursing Services, Inc., Metairie, Louisiana, and assigned to Plaza Specialty Hospital, Houston, Texas, Respondent removed medications from the medication dispensing system for patients, but failed to follow the facility's policy and procedure for wastage of the unused portions of the medications, as follows:

Date	Patient Visit #	Physician's Order	Medication Dispensing System Record Time and Quantity	Medication Administration Record	Nurses Notes	Wastage
12-8-08	8605941 [S.O.]	Zofran 4mg/2ml soln IV q6h prn	Ondansetron Hcl 4mg/2ml inj 0910 (1)	No Entry	No Entry	Not Documented
12-8-08	8605941 [S.O.]	Morphine 1mg/0.5ml soln IV q6h prn	Morphine 2mg/ml 1ml inj 0911 (1)	No Entry	No Entry	Not Documented
12-8-08	8583064 [A.L.]	Hydrocodone-Acetaminophen 5-500mg 2 tab F-Tube q6h prn	Hydrocodone-Acetaminophen 5-500mg tab 1005 (1)	0850	No Entry	Not Documented
12-8-08	8583064 [A.L.]	Promethazine 25mg/1ml soln 1ml IV q6h prn nausea	Promethazine 2mg/ml 1ml inj 1005 (1)	No Entry	No Entry	Not Documented
12-8-08	8583064 [A.L.]	Provigil 100mg/1tab F-Tube q am @ 0700	Modafinil 200mg tab 1009 (1)	No Entry	No Entry	Not Documented
12-8-08	8605941 [S.O.]	Morphine 1mg/0.5ml soln IV q6h prn	Morphine 2mg/ml 1ml inj 1151 (1)	No Entry	No Entry	0936 G: 1mg W: 1mg
12-8-08	8583064 [A.L.]	Hydrocodone-Acetaminophen 5-500mg 2 tab F-Tube q6h prn	Hydrocodone-Acetaminophen 5-500mg tab 1453 (1)	No Entry	No Entry	Not Documented
12-8-08	8583064 [A.L.]	Promethazine 25mg/1ml soln 1ml IV q6h prn nausea	Promethazine 2mg/ml 1ml inj 1454 (1)	No Entry	No Entry	Not Documented
12-8-08	8605941 [S.O.]	Morphine 1mg/0.5ml soln IV q6h prn	Morphine 2mg/ml 1ml inj 1629 (1)	No Entry	No Entry	Not Documented
12-8-08	8583064 [A.L.]	Promethazine 25mg/1ml soln 1ml IV q6h prn nausea	Promethazine 2mg/ml 1ml inj 1648 (1)	No Entry	No Entry	Not Documented
12-8-08	8583064 [A.L.]	Hydrocodone-Acetaminophen 5-500mg 2 tab F-Tube q6h prn	Hydrocodone-Acetaminophen 5-500mg tab 1743 (1)	No Entry	No Entry	Not Documented
12-8-08	8583064 [A.L.]	No Order	Codeine-Guafen 10-100mg/5ml 1743 (1)	No Entry	No Entry	Not Documented

Respondent's conduct was likely to deceive the hospital pharmacy and placed them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).

17. In response to Findings of Fact Numbers Fifteen (15) and Sixteen (16), Respondent states:

"When I removed medication from the medication dispensing system I followed the directions on the patient MAR given to me by the Charge Nurse and directions on the patient profile as listed in the dispensing system. My routine to ensure safety and patients 5 rights is: get the medications ready, take them and the MAR with me to the patient, check the armband on the patient, talk to the patient to verify identity and explain what I am doing and what medications are ordered for him/her, check each medication against the MAR before I open it, check the proper indication and initial on the MAR, open the medication after each initial, place/put the medication in the proper container (med cup, etc.) and give the medications to the patient. I did this same routine with all patients assigned to me with the MARs the Charge Nurse gave me. When I removed any medication from the dispensing system that needed partial dose wasted I called for another nurse to witness waste with me and we both had to document it in the dispensing system at that time. I followed instructions given to me from the Charge Nurse. Anytime a partial dose has to be wasted, the dispensing system automatically shows the screen for waste and the information has to be documented at that time."

18. On or about December 7, 2008 to December 8, 2008, while employed with Advantage Nursing Services, Inc., Metairie, Louisiana, and assigned to Plaza Specialty Hospital, Houston, Texas, Respondent lacked fitness to practice nursing in the State of Texas in that she was observed exhibiting impaired behavior, including but not limited to: acting jittery, unable to concentrate, having pinpoint pupils and acting hyper. Respondent's condition could have affected her ability to recognize subtle signs, symptoms or changes in the patients' conditions, and could have affected her ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patients in potential danger.

19. In response to Finding of Fact Number Eighteen (18), Respondent states:

"If they at Plaza Specialty Hospital, Houston, Texas, observed this alleged behavior, why did the nursing supervisor, charge nurse and all other nursing staff allow me to continue to work and complete my assigned duty of 12 hour shifts for 2 full days? Why didn't they pull me off the floor and screen me for drugs and question me? In December 2008 I was still under a physician's care from MD Anderson Cancer Center. My doctors there prescribed a non-narcotic medication for me because I told them I'm a nurse and cannot work drowsy or impaired in any way. I subsequently suffered a seizure related to the medication prescribed to me. I stopped working when this happened and I realized I needed to stay off from work for a longer amount of time. I continued in school in the LVN - RN nursing program, which resumed January 2009 and I was able to go back at that time. I did miss the Fall 2008 semester due to cancer."

20. On or about December 8, 2008, while employed with Advantage Nursing Services, Inc., Metairie, Louisiana, and assigned to Plaza Specialty Hospital, Houston, Texas, Respondent removed Robitussen AC from the medication dispensing system for Patient Account #8583064 [A.L.], without a valid physician's order. Respondent's conduct was likely to injure the patient in that the administration of medications without a valid physician's order could result in the patient suffering from adverse reactions.

21. In response to Finding of Fact Number Twenty (20), Respondent states:

"I did not remove Robitussin AC from the medication dispensing system for AL without a valid physician's order. I followed the medication directions on the patients MAR and on the patients profile in the medication dispensing system. The order, the MAR and the profile all had to match for that medication to be available for the patient in the medication dispensing system. I would not have been able to remove Robitussen AC from the medication dispensing system unless it was on the patient profile. Robitussen AC would not have been on the MAR and on the profile in the medication dispensing system without a valid physician's order. Pharmacy cannot add a medication to the profile without a valid physician's order. I cannot prescribe medication nor would I."

22. On or about May 5, 2009, June 25, 2009 and April 19, 2010, Respondent underwent a Psychological Evaluation with Rion Hart, Ph.D., wherein Dr. Hart advised the following:

"Given the difficulty I had pinning her down on the types of medications she has taken and currently takes, and the variety that she has been prescribed for her various physical difficulties, it was not possible to obtain a clear picture of how much she may rely on the medication or misuse it at times. Her reporting is also complicated by her testing results which did not provide a valid source of information regarding her psychological functioning, personality characteristics, or drug dependency patterns...From the records and Ms. Perez's acknowledgment, in December of 2008 she experienced significant impairment while at work which she attributes to a reaction to prescribed medication. This certainly could be the case, but previous drug testing in September had detected alprazolam which she stated she had been prescribed, and it remains possible that she was intemperate in her use of medications. Given her reported emotional strains related to her son, the diagnosis and surgery for cancer, and pain due to back and gastrointestinal ailments it could be that she simply had come to rely too heavily on medication and mixing the narcotics and psychotropics at times resulted in impaired functioning. Of course, it is always possible that she had developed a drug problem and indeed misappropriated controlled substance from patients for her own use, but the records do not indicate any clear and convincing evidence of this...On the other hand, the test data could not confirm the absence of a drug problem and if she is permitted to practice it would be prudent to randomly drug test her on a frequent basis to ensure that she does not report to work with drugs on board that could in any way compromise her performance. If feasible, it would also be a good idea to monitor the prescriptions that she is receiving from various physicians that have a potential to impair

functioning in order to limit the possibility of misuse. Her psychiatrist should be apprised of all of the medication she is taking so that he can advise her on their use, monitor them and counsel her relative to their possible misuse."

23. The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or chemical dependency.

24. Formal Charges were filed on April 5, 2010.

25. Formal Charges were mailed to Respondent on April 6, 2010.

CONCLUSIONS OF LAW

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

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation of Section 301.452(b)(9),(10),(12) &(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A),(B),(C)&(D) and 217.12(1)(A),(1)(B),(4),(5),(10)(A),(10)(B),(10)(D)&(11)(B).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 777389 and Vocational Nurse License Number 161889, heretofore issued to MELODY MCREYNOLDS-PEREZ, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a REPRIMAND WITH STIPULATIONS AND A FINE, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

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

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

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address:*

http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary.*

(5) RESPONDENT SHALL pay a monetary fine in the amount of five hundred dollars ($500). RESPONDENT SHALL pay this fine within forty-five (45) days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEAR(S) OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR VOCATIONAL NURSE (LVN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

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

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

(8) For the first year of employment as a Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse. Direct supervision requires another professional nurse to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(9) For the remainder of the stipulation period, RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(10) RESPONDENT SHALL CAUSE each employer to submit, on forms provided

to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for two (2) year(s) of employment as a nurse.

(11) RESPONDENT SHALL abstain from the consumption of alcohol, Nubain, Stadol, Dalgan, Ultram, or other synthetic opiates, and/or the use of controlled substances, except as prescribed by a licensed practitioner for a legitimate purpose. If prescribed, RESPONDENT SHALL CAUSE the licensed practitioner to submit a written report identifying the medication, dosage and the date the medication was prescribed. The report shall be submitted directly to the office of the Board by the prescribing practitioner, within ten (10) days of the date of the prescription. **In the event that prescriptions for controlled substances are required for periods of two (2) weeks or longer, the Board may require and RESPONDENT SHALL submit to an evaluation by a Board approved physician specializing in Pain Management or Psychiatry. The performing evaluator will submit a written report to the Board's office, including results of the evaluation, clinical indications for the prescriptions, and recommendations for on-going treatment within thirty (30) days from the Board's request.**

(12) RESPONDENT SHALL submit to random periodic screens for controlled substances, tramadol hydrochloride (Ultram), and alcohol. For the first three (3) month period, random screens shall be performed at least once per week. For the next three (3) month period, random screens shall be performed at least twice per month. For the next six (6) month period, random screens shall be performed at least once per month. For the remainder of the stipulation, random screens shall be performed at least once every three (3) months. All random screens SHALL BE conducted through urinalysis. Screens obtained through urinalysis are the sole method accepted by the Board.

Specimens shall be screened for at least the following substances:

Amphetamines	Meperidine
Barbiturates	Methadone
Benzodiazepines	Methaqualone
Cannabinoids	Opiates
Cocaine	Phencyclidine
Ethanol	Propoxyphene
tramadol hydrochloride (Ultram)	

A Board representative may appear at the RESPONDENT'S place of employment at any time during the stipulation period and require RESPONDENT to produce a specimen for screening.

All screens shall be properly monitored and produced in accordance with the Board's policy on Random Drug Testing. A complete chain of custody shall be maintained for each specimen obtained and analyzed. RESPONDENT SHALL be responsible for the costs of all random drug screening during the stipulation period.

Any positive result for which the nurse does not have a valid prescription or failure to report for a drug screen, which may be considered the same as a positive result, will be regarded as non-compliance with the terms of this Order and may subject the nurse to further disciplinary action including EMERGENCY SUSPENSION pursuant to Section 301.4551, Texas Occupations Code, or REVOCATION of Respondent's license(s) and nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

(13) RESPONDENT SHALL participate in therapy with a "professional counselor" possessing credentials approved by the Board. RESPONDENT SHALL CAUSE the therapist to submit written reports, on forms provided by the Board, as to the RESPONDENT'S progress in therapy, rehabilitation and capability to safely practice nursing. The report must indicate whether or not the RESPONDENT'S stability is sufficient to provide direct patient care safely. Such reports are to be furnished each and every month for three (3) months. If therapy is recommended for beyond three (3) months, the reports shall then be required at the end of each three (3) month period for the duration of the stipulation period, or until RESPONDENT is dismissed from therapy.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

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RESPONDENT'S CERTIFICATION

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

Signed this 24 day of September, 2010.

MELODY MCREYNOLDS-PEREZ, Respondent

Sworn to and subscribed before me this 24th day of September, 2010.

SEAL

LUCIANA THEODORE
Notary Public
STATE OF TEXAS
My Comm. Exp. 09-03-13

Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 24th day of September, 20 10, by MELODY MCREYNOLDS-PEREZ, Registered Nurse License Number 777389 and Vocational Nurse License Number 161889, and said Order is final.

Effective this 9th day of November, 20 10.

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