

Respondent's complete professional nursing employment history continued:

02/1999 - 09/2002	RN	Advanced Temporaries Tyler, Texas
01/2002 - 05/2002	RN	Valley Baptist Medical Center Harlingen, Texas
06/2002 - 10/2003	RN	Good Shepherd Hospital Longview, Texas
11/2003 - 11/2004	RN	University of Texas Health Center at Tyler Tyler, Texas
12/2004 - 05/2005	RN	Birmingham Health Care Center Rusk, Texas
12/2004 - 05/2005	RN	Rusk State Hospital Rusk, Texas
05/2005 - 05/2006	RN	American Traveler Staffing Boca Raton, Florida
07/2006 - 12/2006	RN	Trinity Mother Francis Health System Jacksonville, Texas
01/2007 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a Staff RN with Trinity Mother of Francis Health System, Jacksonville, Texas, and had been in this position for five (5) months.
7. On or about December 21, 2006, while employed as a Registered Nurse with Trinity Mother Francis Health System, Jacksonville, Texas, Respondent lacked fitness to practice nursing in that she exhibited impaired behavior while on duty, including but not limited to: walking strangely, being light headed, and not feeling like herself. Respondent's condition resulted from an adverse reaction to a prescribed sample of Ultram ER. Respondent's condition could have affected her ability to recognize subtle signs, symptoms or changes in 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.
8. On or about December 21, 2006, the same day as the events described in finding of fact number seven, and while employed as a Registered Nurse with Trinity Mother Francis Health System, Jacksonville, Texas, Respondent failed to inform the physician that Patient Medical

Record Number 98039872, with a "closed head injury", was vomiting. Respondent's conduct was likely to injure the patient in that she failed to institute appropriate nursing interventions to stabilize the patient's condition and exposed the patient unnecessarily to a risk of harm.

9. On or about December 21, 2006, the same day as the events described in finding of fact number seven, and while employed as a Registered Nurse with Trinity Mother Francis Health System, Jacksonville, Texas, Respondent withdrew various medications from the medication dispensing system but failed to completely and accurately document the administration of the medication in the patient's Medication Administration Record and/or Nurse's Notes as follows:

<u>Date</u>	<u>Patient</u>	<u>Time Pulled</u>	<u>Medication</u>	<u>Time on MAR</u>	<u>Waste</u>	<u>Orders</u>
12/21/06	98039872	1043	Clopidogrel Bisulf 75mg Tab (1)	None	None	Plavix 75mg PO Daily
12/21/06	98039872	1044	Atenolol 25mg Tab (1)	None	None	Atenolol 12.5mg PO Daily
12/21/06	98039872	1046	Escitalopram 10mg Tab (1)	None	None	Lexapro 20mg PO Daily
12/21/06	98106863	1317	Pregbalin 25mg Capsule (2)	None	None	Lyrica 50mg 1 tab po 3 times daily

Respondent's conduct placed patient safety at risk in that subsequent care givers may have relied on her documentation to further medicate the patient which could result in an overdose.

10. On or about December 21, 2006, the same day as the events described in finding of fact number seven, and while employed as a Registered Nurse with Trinity Mother Francis Health System, Jacksonville, Texas, Respondent falsely documented the administration of Morphine 2mg in the Medication Administration Record (MAR) of Patient #97053197 in that she did not actually administer the Morphine as follows:

<u>Date</u>	<u>Patient</u>	<u>Time Pulled</u>	<u>Time on MAR</u>	<u>Orders</u>
12/21/06	97053197	None	0820	Morphine 2g IV q 1.5 hrs prn pain

Respondent's conduct was likely to injure the patient in that subsequent care givers would not have accurate information on which to base their decisions to administer further which could have caused a delay in the patient getting the care needed.

11. In Response to Finding of Facts Number through Seven (7) through Eleven (11), Respondent states that she saw her pain management physician on the morning of December 20, 2006, and that she told him that she was an RN and that she needed a medication that was non-narcotic that would help her through the work day. Respondent states that he offered her a prescription of Ultram ER and she requested a sample before she purchased the medication. Additionally, at 6am on December 21, 2006, Respondent took an Ultram ER pill and went to work where at approximately 0955, she started to feel strange, a little light headed, and was walking funny. Respondent then states that she notified nursing management, who did not relieve her of duty at that time. Respondent says she thought that the medication would wear off, but did ask for a break, which was refused due to coming admits. Respondent states that the nursing management's decision not to relieve her of her nursing duties resulted in several documentation errors. At 0145 Respondent states that she went to the administrative part of the facility and was approached by the case manager and the Director of Administration stating they wanted to see her. They asked if Respondent felt impaired, and Respondent responded by telling them about the new medication that she had taken and that she wasn't feeling herself. Management called the prescribing physician and verified, Respondent then requested a drug screen. The Director of Administration was adamant that a drug screen was not necessary, and stated that Respondent could not work in her condition and that they just needed a few days to investigate this.
12. The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to the Respondent's continuing with her nursing assignment when she became aware that she was having a medication reaction, thereby compromising her ability to practice safely.

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 violations of Section 301.452(b)(10),(12)&(13) Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(B),(D),(M) & (T), and 22 TEX. ADMIN. CODE §217.12(1)(A),(4)&(5) and (10)(A)&(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 653847, heretofore issued to CATHERINE CORBIN, including revocation of Respondent's license to practice professional nursing in the State of Texas.

ORDER

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

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

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

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL deliver the wallet-sized license issued to CATHERINE CORBIN, to the office of the Texas Board of Nursing within ten (10) days from the date of ratification of this Order.

(2) 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) contact 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>.

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 ONE YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(3) 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.

(4) 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.

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

(6) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT's capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for one (1) year of employment as a nurse.

(7) 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.

(8) RESPONDENT SHALL submit to random periodic screens for controlled substances, tramadol hydrochloride (Ultram), and alcohol. For the duration of the stipulation period, random screens shall be performed at least once per month, for a total of 12 drug screens within the one-year stipulation period. All random screens SHALL BE conducted through urinalysis. Screens obtained through urinalysis is 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 will be regarded as non-compliance with the terms of this Order and may subject the nurse to further disciplinary action by this Board. Failure to report for a drug screen may be considered the same as a positive result and may result in further disciplinary action by this Board.

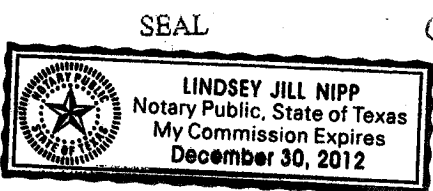
IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT's license and RESPONDENT shall be eligible for multistate licensure privileges, if any, to practice nursing in the State of Texas.

RESPONDENT'S CERTIFICATION

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

Signed this 8 day of July, 20 10.
Catherine Corbin
CATHERINE CORBIN, Respondent

Sworn to and subscribed before me this 8th day of July, 20 10.



[Signature]
Notary Public in and for the State of TEXAS

Approved as to form and substance

[Signature]
ELIZABETH L. HIGGINBOTHAM, Attorney for Respondent

Signed this 6th day of July, 20 10.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 8th day of July, 2010, by CATHERINE CORBIN, Registered Nurse License Number 653847, and said Order is final.

Effective this 17th day of August, 2010.

Katherine A. Thomas

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

