BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Vocational Nurse License Number 53848 §
issued to JEAN B. MEALS §

ORDER OF THE BOARD

On this day, the Texas Board of Nursing, hereinafter referred to as the Boa accepted the voluntary surrender of Vocational Nurse License Number 53848, issued to JEAN B. MEALS, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

Respondent waived representation by counsel, informal proceedings, notice and hearing.

The Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Respondent's license to practice vocational nursing in the State of Texas is currently in Delinquent status.

2. Respondent waived representation by counsel, informal proceedings, notice and hearing.

3. Respondent received a Certificate in Vocational Nursing from Grayson County College, Denison, Texas, on September 6, 1972. Respondent was licensed to practice vocational nursing in the State of Texas on October 18, 1972.

4. Respondent's vocational nursing employment history includes:

11/72 - 08/94	Unknown	
09/94 - 01/96	LVN	Gainesville Convalescent Center Gainesville, TX

01/96 - 09/96	LVN	Rern Manor Nursing Home Pilot Point, TX
10/96 - 06/07	LVN	Wilson N. Jones Medical Center Sherman, TX
07/07 - Present	Unknown	

5. On or about June 9, 2007, through June 10, 2007,while employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas, Respondent withdrew Promethazine from the medication dispensing system (Omnicell) for Patient Medical Record Number 137319, but failed to document, or accurately document, including the signs, symptoms and responses to the medication administered in the medical records, as follows:

Date	Patient Medical Record Number	Physicians Orders	Medication Dispensing System (Omnicell) Records	Medication Administration Record (MAR)	Nursing Notes
06/09/07	137319	Phenergan 12.5mg IV Q 6 hrs PRN nausea (if not allergic)	(1) Amp Promethazine 25mg/1ml @ 22:59	Documented as administered @ 22:51	Not documented as administered
06/10/07	137319	Phenergan 12.5mg IV Q 6 hrs PRN nausea (if not allergic)	(1) Amp Promethazine 25mg/1ml @ 02:04	Documented as administered @ 03:15	Not documented as administered

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

6. On or about June 9, 2007, through June 10, 2007, while employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas Respondent withdrew Promethazine from the Medication Dispensing System (Omnicell) for Patient Medical Record Number 137319 and administered the medications in excess of physicians' orders, as follows:

Date	Patient Medical Record Number	Physicians Orders	Medication Dispensing System (Omnicell) Records	Medication Administration Record (MAR)	Nursing Notes
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Respondent's conduct was likely to injure the patient in that the administration of narcotics in excess of, or without physicians' orders, could result in the patient suffering from adverse reactions.

7. On or about June 11, 2007, while employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas, Respondent falsified the medical records of Patient Medical Record Number 137319 in that she altered the 24 Hour Record and failed to appropriately label the entries as "late entries". Respondent's conduct was likely to injure the patient in that subsequent care givers did not have accurate information on which to base their decisions for further care.

8. On or about June 11, 2007, while employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas, Respondent lacked fitness to practice vocational nursing in that she was drooling and had slurred speech. 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.

9. On or about June 11, 2007, while employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas, Respondent engaged in the intemperate use of Propoxyphene in that she submitted a specimen for a reasonable suspicion/cause drug screen which resulted positive for Propoxyphene. Possession of Propoxyphene without a lawful prescription is prohibited by Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act). The use of Propoxyphene by a Licensed Vocational Nurse, while subject to call or duty, could impair the nurse's ability to recognize subtle signs, symptoms or changes in the patient's condition, and could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgements, and decisions regarding patient care, thereby placing the patient in potential danger.

10. Formal Charges were filed on January 22, 2010. A copy of the Formal Charges is attached and incorporated by reference as part of this Order.

11. Formal Charges were mailed to Respondent on January 26, 2010.

12. On March 23, 2010, Respondent returned Vocational Nurse License Number 53848 and submitted a notarized statement to the Board voluntarily surrendering the right to practice vocational nursing in Texas. A copy of Respondent's notarized statement, dated March 1, 2010, is attached and incorporated herein by reference as part of this Order.

13. The Board policy implementing Rule 213.29 in effect on the date of this Agreed Order provides discretion by the Executive Director for consideration of conditional reinstatement after proof of twelve (12) consecutive months of abstinence from alcohol and drugs followed by licensure limitations/stipulations and/or peer assistance program participation.

14. 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.

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 22 TEX. ADMIN. CODE §217.12(1)(A),(4),(5), (6)(A)&(H),(10)(A),(B)&(D)&(11)(B).

4. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

5. Under Section 301.453(d), Texas Occupations Code, the Board may impose conditions for reinstatement of licensure.

6. Any subsequent reinstatement of this license will be controlled by Section 301.452 (b), Texas Occupations Code, and 22 TAC§§213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

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ORDER

NOW, THEREFORE, IT IS ORDERED that the voluntary surrender of Vocational Nurse License Number 53848, heretofore issued to JEAN B. MEALS, to practice vocational nursing in the State of Texas, is accepted by the Executive Director on behalf of the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice vocational nursing, use the title of Licensed Vocational Nurse or the abbreviation "LVN" or wear any insignia identifying herself as a Licensed Vocational Nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a Licensed Vocational Nurse during the period in which the license is surrendered.

2. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order; and, RESPONDENT has obtained objective, verifiable proof of twelve (12) consecutive months of sobriety immediately preceding the petition.

3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

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

Effective this _____ day of March 30, 2010.

TEXAS BOARD OF NURSING

By: _____

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

In the Matter of Permanent License	§	**BEFORE THE TEXAS**
Number 53848, Issued to	§	
JEAN B. MEALS, Respondent	§	**BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, JEAN B. MEALS, is a Vocational Nurse holding license number 53848, which is in current status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about June 9, 2007, through June 10, 2007,while employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas, Respondent withdrew Promethazine from the medication dispensing system (Omnicell) for Patient Medical Record Number 137319, but failed to document, or accurately document, including the signs, symptoms and responses to the medication administered in the medical records, as follows:

Date	Patient Medical Record Number	Physicians Orders	Medication Dispensing System (Omnicell) Records	Medication Administration Record (MAR)	Nursing Notes
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06/10/07	137319	Phenergan 12.5mg IV Q 6 hrs PRN nausea (if not allergic)	(1) Amp Promethazine 25mg/1ml @ 02:04	Documented as administered @ 03:15	Not documented as administered

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

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(10)&(13), Texas Occupations Code, 22 TEX. ADMIN. CODE §217.11(1)(A), (B)&(D)(iv), and 22 TEX. ADMIN. CODE §217.12(1)(A)&(4).

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CHARGE II.

On or about June 9, 2007, through June 10, 2007, while employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas Respondent withdrew Promethazine from the Medication Dispensing System (Omnicell) for Patient Medical Record Number 137319 and administered the medications in excess of physicians' orders, as follows:

Date	Patient Medical Record Number	Physicians Orders	Medication Dispensing System (Omnicell) Records	Medication Administration Record (MAR)	Nursing Notes
06/09/07	137319	Phenergan 12.5mg IV Q 6 hrs PRN nausea (if not allergic)	(1) Amp Promethazine 25mg/1ml @ 22:59	Documented as administered @ 22:51	Not documented as administered
06/10/07	137319	Phenergan 12.5mg IV Q 6 hrs PRN nausea (if not allergic)	(1) Amp Promethazine 25mg/1ml @ 02:04	Documented as administered @ 03:15	Not documented as administered

Respondent's conduct was likely to injure the patient in that the administration of narcotics in excess of, or without physicians' orders, could result in the patient suffering from adverse reactions.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(10)&(13), Texas Occupations Code, 22 TEX. ADMIN. CODE §217.11(1)(A)&(C), and 22 TEX. ADMIN. CODE §217.12(1)(A)&(4).

CHARGE III.

On or about June 11, 2007, while employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas, Respondent falsified the medical records of Patient Medical Record Number 137319 in that she altered the 24 Hour Record and failed to appropriately label the entries as "late entries". Respondent's conduct was likely to injure the patient in that subsequent care givers did not have accurate information on which to base their decisions for further care.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(10)&(13), Texas Occupations Code, 22 TEX. ADMIN. CODE §217.11(1)(A), (B)&(D), and 22 TEX. ADMIN. CODE §217.12(1)(A),(4)&(6)(A)&(H)&(10)(B).

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CHARGE IV.

On or about June 11, 2007, while employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas, Respondent lacked fitness to practice vocational nursing in that she was drooling and had slurred speech. 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.

The above action constitutes grounds for disciplinary action in accordance with 301.452(b)(10)&(12), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(4)&(5).

CHARGE V.

On or about June 11, 2007, while employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas, Respondent engaged in the intemperate use of Propoxyphene in that she submitted a specimen for a reasonable suspicion/cause drug screen which resulted positive for Propoxyphene. Possession of Propoxyphene without a lawful prescription is prohibited by Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act). The use of Propoxyphene by a Licensed Vocational Nurse, while subject to call or duty, could impair the nurse's ability to recognize subtle signs, symptoms or changes in the patient's condition, and could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgements, and decisions regarding patient care, thereby placing the patient in potential danger.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(9)&(10),Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(5),(10)(A)&(D)&(11)(B).

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NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to revocation of Respondent's license to practice nursing in the State of Texas pursuant to the Board's rules, 22 TEX. ADMIN. CODE §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to § 301.461, TEX. OCC. CODE ANN. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1,200.00).

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.state.tx.us.

NOTICE IS GIVEN that to the extent applicable, based on the Formal Charges, the Board will rely on Adopted Disciplinary Guidelines for Criminal Conduct and on Adopted Disciplinary Sanction Policies for Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder, for Lying and Falsification, and for Fraud, Theft & Deception, which can be found at the Board's website, www.bon.state.tx.us.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.state.tx.us/disciplinaryaction/discp-matrix.html.

Filed this 22nd day of January, 2010.

TEXAS BOARD OF NURSING

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
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Jena Renee Koslan Abel, Assistant General Counsel
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0999/D

JEAN B. MEALS
1039 HWY 377 North
Whitesboro, TX 76273
Texas LVN License #53848

Voluntary Surrender Statement

March 1, 2010

Dear Texas Board of Nursing:

I no longer desire to be licensed as a vocational nurse. Accordingly, I voluntarily surrender my license to practice in Texas. I waive representation by counsel and consent to the entry of an Order which outlines requirements for reinstatement of my license. I understand that I will be required to comply with the Board's Rules and Regulations in effect at the time I submit any petition for reinstatement.

Signature Jean B Meals

Date 3/18/10

Texas Nursing License Number # 53848

The State of Texas

Before me, the undersigned authority, on this date personally appeared JEAN B. MEALS who, being duly sworn by me, stated that she executed the above for the purpose therein contained and that she understood same.

Sworn to before me the 18 day of March, 2010.

SEAL

AIMEE MCADOO
Notary Public
STATE OF TEXAS
My Comm. Exp. 02-25-2014

Aimee McAdoo

Notary Public in and for the State of _____

Dear Mr Freemyer:

I want to inform you. I do not wish to Continue to work as a LVN no longer. I am being treated for breast Cancer with Chemotherapy + soon radiation--

I have been pre occupied with my treatments, why I have not responded sooner.

Thank-you

Jean Meeks

Feb 24, 2010
Kevin G Freemyer

September 6, 2007
Jason Bressie
Investigator B.N.E.

Dear Mr. Bressie:

I am responding to the errounous allegations against me brought by former employer W.N.J. Hospital, Sherman, Texas
It is true that I failed to document the Phenergan 12.5 mg. that I gave to patient number 137315. there were a lot of
circumstances that brought about this error in charting.I realize that I should have documented the medication as soon
as I gave it. but durning that course I had many distractions at that particular time. I was assigned 6 high acuity patlients.
all but one had dementia. They were climbing out of bed, pulling out their IV's. I had to address the problem of patient
safety before I could sit down to chart. I made myself notes of medication that I had to chart.at a later time. I put the
safety of my patlients first. I would like to mention that I work 12 hours shift, on this particular weekend, I was unable to
take a 5 minute break or take a supper break for two nights this can be verified by my co-workers and my floor charge nurse
Shonna Anderson R.N. I reported continually that I was over-whelmed,but no relief came to let me have a break.
One of my patients had C-diff and I was needed to give incontient came hourly to make sure that the patient was
clean, dry and comfortable.One of the doctors, who was making rounds, for himself and 3 other doctors had put his things
on top of my notes and I was not able to get to things that I needed. This was 8:30 a.m. I was exhausted at that time from
not being able to take atleast a 5 minute break all night. I truly thought I had a window of time to come back and chart
I did report to the on coming nurse what I had given and what time I gave it.

Betty Witford R.N. was the nurse that I reported off to. I would like to give you some history concerning this nurse,
that can be verified by other staff members about her demeaner. Ms Witford had tried to get me in trouble numerous
times, not only me but other nurses because were LVN's and she was a R.N. I had reported her to my Supervisor
Nancy Horton R.N. numerous times about her, being a bully and making snide remarks concerning LVNs but nothing
was never done. On June 10, 2007 Betty had been pulled from another floor. The staff could tell that she was very
angry, to the point that she would not even answer Carolyn Greenwood LVN who tried to make her welcome to the
floor. She thought that she would be in charge,but instead she had to take patients. My group which was a heavy
acuity load. I had spent most of my shift with patient 137315, because he was combative, hitting with his fist,pinching
and kicking. He had a safety monitor on because he would get out of his bed.his room was at the end of the hall
and you could not hear him if he got out of bed which he did anyway so I had to keep a close eye on him all night.
I had wrapped his Iv site with kerlix to keep him from pulling out the IV's. At 0700 June 10,2007 I assisted lab

tech Linda Billmirer to hold his hand while she drew his lab so that he would not hit her in the face in which he
tried. the patient had been awake all night and at 0730 his family came in and the patient I37315 was asleep.
I made a special trip to his room to let his family know that I gave him nubain and phenergan durning the night
for pain and nausea. They asked me about the bandage on his hand and I told him that it was to keep him from
pulling out his IV. Betty Witford was in the room. I could tell something was not right the family would not
even make eye contact with me. Betty had already started her good/bad nurse routine and it was well noted
I clocked out and went home.
4pm. The floor nurse Wilma Johnson R.N. called me and ask me if I gave the patient 137315 any phenergan durning
the night, I told her yes, she stated that I had not charted any phenergan. I stated that I had just forgot.
Betty had reported to Dr. Watson that I did not chart phenergan. The doctor did not know that the patient had his nights
and days mixed up. He thought that he was over sedated which case he was not. I wished a million times that I took
the time to chart that I gave him the phenergan.I did not know that Betty made a varience report until the next day.
which dose not make any difference I should have charted the med.
I thought that I could make a late entry or a clarification of the events of the night activity. I made one I asked my
floor charge nurse if I should make one she told me that it would be a good idea. I let her read what I had wrote
and she told me everything looked okay.Shonna Anderson R.N. did not know either, that it was wrong to do this
now both of us know for sure. I did not feel like this was falsification.
June 11,20007 0715 am Supervisor Carol Hagenswold R.N. called me to come to her office in 15 minutes I told her
that I was in report and that I would bring Shonna Anderson with me because I have learned that you need to have
someone with you when you go and talk to her. She did not waste anytime she came to the floor with the House supervisor
Paula McDaniels R.N. I asked her what this was about , was it about my slurred speech, which was a event that
happen a week before. I had just had extended dental work done and I had new dentures which did not fit properly
on that occassion I had glued my tongue to my teeth on accident. I was trying to get my tongue free and I guess
I did have slurred speech if you did not know me and what trouble I was having with my teeth. The house supervisor
had known me for years and knew that I was having problems with my new dentures. I had went to the dentist
about a week before this all had happen. Paula McDaniels had sent another nurse, Mary Kay Courtney R.N.
to assess me and I did not Know this at the time they thought that I must had been having a stroke.
On the way to work-med I told Carol Hagenswold that I had taken a darvocet on Sunday morning approx 0900 am
because I was having severe pain in my gums due to the alignment of my dentures had cause lascerations on
my gums. On the way to the work-med I was council by Carol Hagenswold with her back to me walking approx
6 feet in front of me, telling me of allegations of compliants from other co-workers against

me. She told this
to me with on lookers in the hallway which cause me to become embarrassed. WNJ has a fair treatment policy
but I never had the opportunity to respond to the alligations against me. I ask how long would the drug screen
take. I was told that it would be approx 3-4 days It took 2 weeks They were screening for nubain and phernergan.

Number 2 alligation:
I did administer the phenergan in a timely manner. I did take the pherengan out the said time from the omi cel
I went and rechecked the time because it showed up on the omi cel. The patient `137315 has a drawer in a med
cart in a locked medication room. I placed the med in the drawer until I could administer the medication.
I was not given the opportunity to explain this to my supervisors, only to my floor charge nurse Shonna Anderson R.N.
who I have worked with for years. and she knows me very well as do many co-wkorkers
This leads to Number 3 errounous alligation
I made many mistakes but I do not lie. I give good care to my patients even until this very day I have people thanking me
for caring for them or a family member.
I can give you many characters reverences from Doctors and staff thanking me for giving good care to their patients
I would like to tell you that Betty Wiftord R.N. was terminated August 22, 2007 for her behavior toward another
staff member,

Jean Meals
1039 Hwy 377 North
Whitesboro, Texas 76273
903-564-5050