

DOCKET NUMBER 507-07-1447

IN THE MATTER OF
PERMANENT CERTIFICATE
NUMBER 583207
ISSUED TO
JACQUELINE LOUISE KUBENA

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BEFORE THE STATE OFFICE
OF
ADMINISTRATIVE HEARINGS



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.
Patricia A. Thomas
Executive Director of the Board

ORDER OF THE BOARD

TO: Jacqueline Louise Kubena
PO Box 591
Hallettsville, Texas 77964

During open meeting held in Austin, Texas, the Board of Nurse Examiners finds that after proper and timely notice was given, the above-styled case was heard by an Administrative Law Judge who made and filed a proposal for decision containing the Administrative Law Judge's findings of fact and conclusions of law. The proposal for decision was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein.

The Board of Nurse Examiners, after review and due consideration of the proposal for decision, and exceptions and replies filed, if any, adopts the findings of fact and conclusions of law of the Administrative Law Judge as if fully set out and separately stated herein. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Certificate Number 583207, previously issued to JACQUELINE LOUISE KUBENA, to practice professional nursing in the State of Texas be, and the same is hereby, REVOKED.

IT IS FURTHER ORDERED that Permanent Certificate Number 583207, previously issued to JACQUELINE LOUISE KUBENA, upon receipt of this Order, be immediately delivered to the office of the Board of Nurse Examiners for the State of Texas.

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

Entered this 19th day of July, 2007.

BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS

BY: 
KATHERINE A. THOMAS, MN, RN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

SOAH DOCKET NO. 507-07-1447

IN THE MATTER OF
PERMANENT LICENSE
NUMBER 583207 ISSUED TO
JACQUELINE LOUISE KUBENA

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BEFORE THE STATE OFFICE

OF
ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff of the Texas State Board of Nurse Examiners (Staff/ Board) brought this case for disciplinary action against Jacqueline L. Kubena (Respondent) for violating the Nursing Practice Act¹ and the Board's Rules.² Staff recommends revocation of Respondent's license, with possible reinstatement after one year upon a showing that Respondent has received treatment for chemical dependency or verification of sobriety or abstinence from mood altering substances for at least one year. The Administrative Law Judge (ALJ) finds that Staff proved by a preponderance of the evidence that the alleged violations occurred, and recommends that Respondent's license be revoked as requested.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

There are no contested issues of notice or jurisdiction. Those matters are set out in the findings of fact and conclusions of law without further discussion here.

A hearing on the merits was convened on April 26, 2007, at the State Office of Administrative Hearings (SOAH), 300 West 15th Street, Fourth Floor, Austin, Texas, before ALJ Alvin Stoll. The Board was represented by Assistant General Counsel Victoria Cox. Respondent appeared and represented herself. The record closed on the same day.

¹ TEX. OCC. CODE ANN. §§ 301.001 *et seq.*

² 22 ADMIN. CODE §§ 217.11 and 217.12.

II. ALLEGATIONS AND APPLICABLE LAW

Staff alleges that Respondent, a registered nurse who currently holds Registered Nurse License No. 583207, violated the Nursing Practice Act and the Board's rules and policies. For that reason, the Board seeks to revoke Respondent's license.

Staff sets forth four charges against Respondent in the Amended Formal Charges of April 14, 2007.³ Staff alleges in Charge I that, from July through November of 2004, while employed at the Hallettsville Rehabilitation and Nursing Center (Center), Respondent failed to administer Hydrocodone to patients as ordered by physicians. Specifically, Staff alleges that Respondent admitted to administering Hydrocodone to patients to help them sleep, when the medications had only been ordered as treatment for pain as needed.

Staff states that Respondent's failure to administer the medications as ordered is grounds for disciplinary action as unprofessional or dishonorable conduct that is likely to deceive, defraud, or injure a patient or the public,⁴ and that it constitutes a failure to adequately care for a patient or to conform to the minimum standards of acceptable nursing practice, and in a manner that exposes a patient or other person unnecessarily to risk of harm.⁵ Staff states that the actions violate the Board's rules, which provide that a registered nurse shall implement measures to promote a safe environment for clients and others,⁶ and that registered nurses shall know the rationale for and effects of medications and treatments and shall correctly administer them.⁷

The next three charges relate to events that occurred from December 1 through December 6, 2004, regarding six units of Hydrocodone/APAP 10-325 signed out for Patient

³ Petitioner's Exhibit 4a.

⁴ TEX. OCC. CODE ANN. § 301.452(b)(10).

⁵ TEX. OCC. CODE ANN. § 301.452(b)(13).

⁶ 22 ADMIN. CODE § 217.11(1)(B).

⁷ 22 ADMIN. CODE § 217.11(1)(C).

No. 04-0089-01. Staff alleges in Charge II that Respondent signed out Hydrocodone for that patient on three different occasions, but failed to document on the patient's records that the medication was administered. Specifically, Staff alleges that Respondent signed out two units of Hydrocodone on December 1, 2004 at 12:30 a.m., two units on December 4, 2004 at 11:00 p.m., and two units at an unspecified time on December 6, 2004, and that Respondent failed to document administering the drugs on that patient's medical records. Staff alleges in Charge III that Respondent failed to follow the required procedure for recording the wasting of the six units of Hydrocodone/APAP 10-325. Finally, in Charge IV, Staff alleges that Respondent did not in fact administer the six units of Hydrocodone/APAP 10-325, as proved by a urine specimen collected from the patient, which tested negative for the presence of hydrocodone. Staff alleges that Respondent misappropriated the drugs.

Staff states that Respondent's actions regarding the six units of Hydrocodone/APAP 10-325 constitutes unprofessional or dishonorable conduct that is likely to deceive, defraud, or injure a patient or the public,⁸ and a failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that exposes a patient or other person to unnecessary risk of harm.⁹ Additionally, Staff states that Respondent's conduct violated the Board's rules, which provide that registered nurses shall: (1) implement measures to promote a safe environment for clients and others;¹⁰ (2) accurately and completely report and document the client's status, including signs and symptoms, nursing care rendered, physician orders, administration of medications and treatments, client responses, and contacts with other health care team members concerning significant events regarding the client's status;¹¹ (3) not engage in careless or repetitive conduct that may endanger a client's life, health, or safety;¹² (4) not engage in falsification of or

⁸ TEX. OCC. CODE ANN. § 301.452(b)(10).

⁹ TEX. OCC. CODE ANN. § 301.452(b)(13).

¹⁰ 22 ADMIN. CODE § 217.11(1)(B).

¹¹ 22 ADMIN. CODE § 217.11(1)(D).

¹² 22 ADMIN. CODE § 217.12(4).

making incorrect, inconsistent, or unintelligible entries in any agency, client, or other record pertaining to drugs or controlled substances;¹³ and (5) shall know the rationale for and effects of medications and treatments and shall correctly administer them.¹⁴

III. SUMMARY OF EVIDENCE PRESENTED

A. Staff's Evidence

1. Documentary Evidence

Staff submitted twelve exhibits, including the formal charges, correspondence from Respondent, medical records, and summaries of testimony.

2. Evidence and Testimony Regarding Violations

Staff called five witnesses who were employed as nursing professionals at the Center and who testified regarding the events set forth in the formal charges. The Center is a 100-bed nursing and rehabilitative facility in Hallettsville, Texas. Almost all of the residents are elderly, most are frail or in poor health, and many suffer from Alzheimer's Disease or other cognitive disorders. The facility was staffed at a level that only met minimum state standards. From July 2004 through December 2004, Respondent worked as one of two charge nurses on the night shift.¹⁵

Judith Lawrence was Director of Nursing at the Center from July 3, 2004 through August 4, 2004. Ms. Lawrence testified that during this period she observed that, according to the patient records, Hydrocodone was being administered every night to four residents at the Center when Respondent was on duty as the charge nurse. During the same period, when Respondent was not on

¹³ 22 ADMIN. CODE § 217.12(10)(B).

¹⁴ 22 ADMIN. CODE § 217.12(10)(C).

¹⁵ Testimony of Donna Howell, RN.

duty, the four residents were not given Hydrocodone by the other nurses. Respondent also administered medication to residents that were under the care of another nurse, without communicating with that nurse. Ms. Lawrence discussed these instances with an assigned regional nurse, who agreed that they appeared suspicious. On July 20, 2004, Ms. Lawrence discussed the matter with Respondent, who stated that she gave the medication to the residents to help them sleep better. Respondent told Ms. Lawrence that she had her own supply of Hydrocodone, and thus would have no reason to appropriate medication that was prescribed for residents.¹⁶

Dona Howell, RN, was Director of Nursing at the Center during October and November of 2004. Ms. Howell testified that she received reports from nurses and other employees at the Center regarding medication records for controlled drugs that contained Hydrocodone. The employees reported that Respondent had administered Hydrocodone-containing medications in excessive quantities and under suspicious circumstances. Ms. Howell reviewed the files of the approximately 90 residents at the Center. She found that many doses of Hydrocodone were checked out of inventory under Respondent's name or initials.¹⁷ She further found that the medications had been recorded as having been administered to 12 different residents at night, usually at 11:00 p.m. and at 3:00 a.m. She noted that the residents involved had common characteristics: they suffered from dementia or otherwise had difficulty speaking for themselves. The records indicated that the Hydrocodone had been administered by Respondent.

Ms. Howell testified that she met with Respondent on November 3, 2004. At the meeting, she confronted Respondent with the sign-out sheets and medication records. Respondent acknowledged that she gave the medication to the residents. The stated reason was that it helped the residents sleep better. Ms. Howell then reminded Respondent of the correct methods for administering pain medication. The residents in question had physician prescriptions for Hydrocodone, but it was to be administered only as needed for pain. The medicine was to be given only after a determination was made that a resident was in pain. For residents with a limited ability

¹⁶ See also Petitioner's Exhibit No. 6, pp. 27-28.

¹⁷ See also Petitioner's Exhibit No. 6, pp. 95-96.

to communicate, that determination can be made from such signs as furrowed brows, moans, or other indications of pain. Once it is determined that the requisite level of pain is present, correct medical practices require that non-narcotic drugs such as Tylenol or Advil be given first. If those drugs did not alleviate the pain, then other drugs, including those containing Hydrocodone, may be given. Ms. Howell testified that she told Respondent that administering Hydrocodone to help residents sleep was contrary to physicians' orders and was improper. If residents had trouble sleeping, the problem should be reported so that appropriate medication could be prescribed.¹⁸

Staff also introduced evidence regarding administration of Oxycontin, a similar narcotic.¹⁹ On October 19, 2009 Respondent signed out an Oxycontin 80mg tab and noted the administration time as 9:00 a.m. Respondent had worked the night shift and had left by 6:00 a.m. that morning. Respondent was not at the center at the stated administration time, and neither Respondent nor any other personnel recorded administering the medication on the patient records.²⁰

Staff witnesses testified that on November 1, 2004, Respondent indicated on controlled substance inventory records that an Oxycontin 80mg tab had been "popped by mistake." Any drug that is removed from inventory and not administered must be recorded as having been wasted, and must have corroborating initials or signature of another qualified person. On this occasion, the patient records showed the initials of Loretta Smolik, LVN, a nurse at the Center, as the person who witnessed the wastage.²¹ Ms. Smolik testified, however, that she did not witness the wastage, that she did not enter her initials, and that the initials were not in her handwriting.

Staff presented detailed testimony and documentary evidence regarding medication that Respondent signed out for Patient No. 04-0008-01, an 84-year old resident at the Center who

¹⁸ Petitioner's Exhibit No. 6, p. 41; testimony of Donna Howell, RN.

¹⁹ The Amended Formal Charges contain no charges regarding mishandling of Oxycontin; all the charges relate to Hydrocodone. The two drugs are related narcotic analgesics classified as Schedule II controlled substances. Respondent did not object to the testimony regarding incidents involving Oxycontin.

²⁰ Petitioner's Exhibit No. 6, pp. 91-92; testimony of Donna Howell, RN.

²¹ Petitioner's Exhibit 6, pp. 91-92; testimony of Loretta Smolik, LVN.

weighed 71.2 pounds and was administered fluids by catheter. Her mental state was described as confused and disoriented. Staff presented evidence that Respondent signed out two units of Hydrocodone for this resident on December 1, 2004, at 12:30 a.m., two units on December 4, 2004, at 11:00 p.m., and two units at an unspecified time on December 6, 2004. Respondent did not document that she administered the medications on that patient's records.²²

Under the Center's procedures, once medications are signed out for a specific patient, the medication must either be recorded as administered to that patient or as wasted. Medication is wasted when it is refused, spoiled, or otherwise not administered. Staff presented evidence that Respondent did not record the Hydrocodone signed out for Patient No. 04-0008-01 as either administered or wasted.

During the time when these events occurred, from December 1 through December 6, 2004, a Board investigator was at the Center.²³ The nursing staff told the investigator that Patient No. 04-0008-01 did not display drowsiness or any other signs that would be expected from an elderly, frail patient receiving Hydrocodone in the quantity that Respondent had signed out. The investigator suggested that a urine analysis be performed on the patient. The investigator gave directions regarding time lines to be followed, to insure that the test was reasonably close in time to when the drugs were signed out for the patient.²⁴ A urine specimen was obtained on December 7, 2004, at 11:55 a.m. The specimen was taken to a lab. The lab results indicated that the patient tested negative for the drugs containing Hydrocodone.²⁵

Donna Howell, the Director of Nursing, testified that she obtained permission from the physician and family members of Patient No. 04-0089-01 to administer Hydrocodone to the patient. One unit of the drug was administered. In a subsequent urine analysis, the patient tested positive for

²² Petitioner's Exhibit No. 6, pp. 51-53.

²³ Petitioner's Exhibit 6, p. 66.

²⁴ Testimony of Donna Howell, RN, and Nancy Brenek, LVN

²⁵ Petitioner's Exhibit 6, pp. 68-73.

the drug. The test was repeated for control purposes, and again the patient tested positive. In each case, the time lines were the same as those in the original urine analysis that tested negative.²⁶

On December 8, 2004, Respondent was told of the urine analysis and investigation regarding Patient No. 04-0008-01. She resigned from her position at the Center on the same day.²⁷

3. Evidence and Testimony Regarding Sanctions

Staff called Carol A. Marshall, MSN, RN, as an expert witness regarding appropriate sanctions. Ms. Marshall is the Board's Lead Nursing Consultant for Practice. She has extensive career experience in testing, evaluation, and qualifications for the nursing profession, and conducts workshops on legal and practice issues throughout Texas.²⁸ She reviews files and work history of nursing professionals to determine if there are signs of substance addiction or chemical dependency. She stated that, in her opinion, the facts this case present numerous grounds for suspecting that substance addiction or chemical dependency may be present. Specifically, she noted that Respondent admitted to having had a prescription for Hydrocodone and that she used the drug. Additionally, during 2001 and 2002, Respondent was late to work on many different dates, resulting in her receiving verbal counseling.²⁹ She noted that the volume of drugs containing Hydrocodone that Respondent signed out, while employed at the center from July through November of 2004, exceeded that of other nurses employed at the center, and that Respondent had a pattern of recording these drugs as being administered to elderly residents of the center who had limited communications skills. She noted the evidence that Respondent administered medication to residents that were under the care of another nurse, without communicating with that nurse; that Respondent did not always record the administration of the drugs or follow the policies regarding wastage; and that

²⁶ Testimony of Eileen Prasek, LVN; Petitioner's Exhibit 6, pp. 68-73.

²⁷ Testimony of Donna Howell, RN.

²⁸ Petitioner's Exhibit 10.

²⁹ See also Petitioner's Exhibit 10, pp. 15-26.

Respondent's documentation regarding wastage of medication included the initials of a co-worker who denied having witnessed the wastage. Ms. Marshall also noted the evidence that Respondent did not in fact administer the Hydrocodone that she checked out for a specific resident. Ms. Marshall stated that, in her opinion, even though there is no direct proof that Respondent consumed the improperly documented narcotics, the facts and circumstances taken together are sufficient to place the Board on notice that there may be substance addiction or chemical dependency that requires attention. Ms. Marshall also stated that if Respondent sold the medication, rather than consuming it, that would also require the Board's attention.

Ms. Marshall testified that any chemical dependency on the part of a nursing professional, including addiction to pain pills such as Hydrocodone, presents a danger to patients and to the public. Even though a person may develop tolerance to a drug, habitual use of mind or mood altering medications affects the mental and physical acuity necessary to provide skilled nursing care, particularly to residents at the Center, most of whom are frail and elderly, or suffering from dementia. She stated that Hydrocodone is a depressant that reduces cognitive functions, critical thinking skills, operational skills, and the careful observation required for effective care of patients. Nurses who are addicted may develop impulses and personality traits that result in giving their own needs priority over the needs of the patients.

Ms. Marshall referred to policies regarding disciplinary sanctions that the Board has adopted for nurses who have a diagnosis of chemical dependency, or who abuse drugs or demonstrate a pattern of substance abuse.³⁰ Under those policies, the Board recognizes a responsibility to the public and the nurse when information about use of addictive substances by a nurse that may impact public safety comes to the Board's attention. The Board recognizes a responsibility for swift action to remove a nurse from performing duties involving direct patient care until the nurse is deemed safe to return to those duties. The Board's policy contains a particular reference to those who are especially vulnerable, including the elderly, the mentally ill, sedated and anesthetized patients, and patients whose mental or cognitive abilities are compromised.

³⁰ The Board's policy is entitled Disciplinary Sanctions for Nurses with Chemical Dependency and was entered into evidence at the hearing.

The Board's policy also addresses nurses who obtain medications through theft from a facility. Theft or diversion of drugs raises the question of substance abuse and possible patient harm and must be investigated. Nurses implicated in such acts may be required to complete a Texas Peer Assistance for Nurses (TPAN) program and obtain a chemical dependency evaluation. A nurse who is not willing or able to attend and complete treatment will be offered the opportunity voluntarily surrender his or her licence. If the license is not surrendered, the nurse will be served with formal charges, and the Board will seek license revocation.

Ms. Marshall stated her opinion that revocation of Respondent's license was an appropriate sanction. The repeated instances in which Respondent's actions regarding controlled substances did not conform to the standards of nursing practice, and the unprofessional conduct of misappropriating and diverting controlled substances, are factors associated with substance abuse, misuse, and chemical dependency, and put the Board on notice that Respondent may be chemically dependent. The Board asked that Respondent obtain an chemical dependency evaluation, but respondent refused. Respondent was requested to complete a TPAN program, but that she declined to do so. Ms. Marshall testified that, given those circumstances, the appropriate sanction under the Board's policy is revocation. Ms. Marshall stated that under the Board's rules, Respondent could apply for reinstatement. The criteria for reinstatement would include proof of at least 12 consecutive months of sobriety.

B. Respondent's Evidence

Respondent's prior written responses were placed into evidence by Staff.³¹ Respondent testified briefly on her own behalf, stating that she did not misappropriate or consume Hydrocodone or other controlled substances belonging to the Center. Respondent also cross examined Staff's witnesses at length. Respondent's theory of the case is that the corporate owners of the Center needed a scape goat to divert attention from severe under staffing and mismanagement at the Center. Consequently, when reports surfaced regarding handling of controlled substances, scrutiny was

³¹ Petitioner's Exhibit 5.

focused on Respondent to the exclusion of all others. In particular, Respondent suggests that another nurse, who was discharged for substance abuse during the following year, may have been responsible for some of the incidents. Respondent defended her administration of controlled medication on the grounds that she believed the medications were beneficial and helped the residents to sleep. Respondent stated that she administered drugs to patients under the care of other nurses in order to assist the other nurses with their workloads. She said that she declined to enter chemical dependency treatment programs because she does not have an addiction problem.

Respondent presented the testimony of Frances Berckenhoff, a certified nurses' assistant worked with Respondent during the relevant periods. She testified to Respondent's skill and diligence in coping with adverse conditions at the Center, when there were insufficient personnel to cope with severely ill and disabled residents. On cross examination, Staff's witnesses also agreed that Respondent had good abilities as a nurse and performed many duties competently.³²

IV. ANALYSIS

A. Proof of Violations

Staff established by a preponderance of the evidence that Respondent engaged in the conduct set forth in the formal charges, and accordingly is subject to disciplinary action under TEX. OCC. CODE ANN. § 301.452(b)(10), which specifies unprofessional or dishonorable conduct that in the board's opinion is likely to deceive, defraud, or injure a patient or the public as grounds for discipline. Staff's evidence establishes that Respondent signed out medications containing Hydrocodone for a specific resident at the center, but did not document the administration or wastage of the medication. Moreover, Staff established that Respondent did not in fact administer the medication to that patient. This evidence is sufficient to show that Respondent herself consumed the medication or otherwise disposed of it in an unauthorized manner. Staff's evidence also showed that Respondent recorded the wastage of Oxycontin 80mg tabs as having been witnessed by a person

³² E.g. Testimony of Donna Howell, RN and Nancy Brenek, LVN

who in fact did not witness the wastage and did not sign as a witness. These acts violate 22 ADMIN. CODE § 217.12(10)(B), which provides that a nurse shall not falsify or making incorrect entries in a client record pertaining to drugs or controlled substances.

Staff established by a preponderance of the evidence that Respondent engaged in conduct that makes her subject to disciplinary action under TEX. OCC. CODE ANN. § 301.452(b)(13), which specifies failure to care adequately for a patient, or to conform to the minimum standards of acceptable nursing practice that exposes a patient or other person unnecessarily to risk of harm. Staff's evidence established that Respondent had a pattern of recording the administration of Hydrocodone to residents of the Center who were elderly, in poor health, and who suffered from cognitive disorders that limited their ability to communicate. Respondent recorded administering Hydrocodone to patients who were not administered such drugs by other nurses at the Center, and to patients who were not assigned to her. These actions were recurring and were observed by two Directors of Nursing and other personnel at the Center from July through December 2004.

Respondent's self-reported practice of giving Hydrocodone as a sleep medication failed to conform to the minimum standards of acceptable nursing practice in a manner that exposed a patient unnecessarily to risk of harm. Hydrocodone is a narcotic that can cause injury or addiction, and should only be administered as needed for pain according to a physician's prescription. This is particularly so for the frail and elderly residents at the Center. Respondent's practice violated 22 ADMIN. CODE § 217.12(10)(C), which provides that a nurse shall know the rationale for and effects of medications and treatments and shall correctly administer them.

Staff's evidence and witnesses are credible and sufficient to establish the facts alleged. Respondent's cross examination of the witnesses, while tenacious and thorough, did not undermine any of the essential facts. Respondent believes that she was selected for special scrutiny. However, Staff's evidence directly implicates Respondent with regard to numerous controlled substance violations at the Center. Respondent's theory that some other nurse could have been responsible is disproved by Respondent's signature, exclusive presence at the scene, or other evidence connecting her to the incidents.

B. Appropriate Sanction

Staff seeks to revoke Respondent's license. Under TEX. OCC. CODE ANN. § 301.453, if the Board determines that a person has committed an act listed in TEX. OCC. CODE ANN. Section 301.452(b), the board shall enter a disciplinary order. That order may consist of a written warning, a public reprimand, limitation or restriction of a license, suspension of a license not to exceed five years, or revocation of a license. If the board suspends or revokes a license, the board may impose conditions for reinstatement that the person must satisfy before reinstatement. Persons who wish to retain a license to practice professional nursing are required to provide evidence of current sobriety and fitness pursuant to 22 ADMIN. CODE § 213.29(a). Subsection (c) of that rule provides that in any matter before the Board that involves an allegation of chemical dependency, or misuse or abuse of drugs or alcohol, at a minimum the person involved must obtain for the Board a chemical dependency evaluation performed by a licensed chemical dependency evaluator.

The evidence in this case shows multiple instances of improper actions regarding narcotics that are classified as Schedule II controlled substances, including diversion of drugs. The testimony of the expert witness that the facts of this case present a pattern that is consistent with substance abuse or chemical dependency is also persuasive. In view of those circumstances, Staff acted properly, pursuant to TEX. OCC. CODE ANN. § 301.453(b)(2), in requesting that Respondent either undergo treatment or present proof of sobriety. As Respondent chose not to do so, license revocation is an appropriate sanction under the Board's policy on disciplinary sanctions and under TEX. OCC. CODE ANN. § 301.453(a)(6).

V. FINDINGS OF FACT

1. Jacqueline L. Kubena (Respondent) holds Registered Nurse License No. 583297.
2. Respondent was employed at the Hallettsville Rehabilitation and Nursing Center (the Center) from July through December of 2004. Respondent was a charge nurse during the night shift.
3. During July through November of 2004, Respondent administered Hydrocodone to residents. Respondent stated that she administered Hydrocodone to residents to help them sleep. Hydrocodone is a controlled substance or medication to be used only for pain control.

4. Respondent's reported administration of Hydrocodone was contrary to physician's orders that it was to be administered only for pain as needed. Respondent's administration of the drug without first administering lesser pain medications violated nursing standards.
5. During the same period, Respondent checked out Hydrocodone to numerous residents at the Center who suffered from dementia or other communications impairments.
6. Respondent signed out or recorded administering Hydrocodone to residents at the Center at a much greater frequency than other nurses caring for the same residents.
7. Respondent frequently signed out or recorded administering Hydrocodone to residents who suffered from dementia and could not speak for themselves.
8. On October 19, 2007, Respondent signed out an Oxycontin 80mg tab and stated the administration time as 9:00 a.m. Respondent had worked the night shift on that date and had left by 6:00 a.m. Respondent was not at the center at the stated administration time, and the medication was not recorded as administered on the patient records.
9. On November 1, 2004, Respondent documented on controlled medication inventory records that an Oxycontin 80mg tab had been "popped by mistake." Respondent's wastage records for the medication contained the initials of Loretta Smolik, LVN, a nurse at the Center, as a person witnessing the wastage of the medication. Ms. Smolik did not enter her initials or witness the wastage.
10. During December 1 through December 6, 2004, Respondent signed out Hydrocodone for Patient No. 04-0008-01 at the Center, but did not record administering the medication on the patient records and did not record wastage of the medication.
11. A urine analysis was performed on Patient No. 04-0008-01 after Respondent recorded administering Hydrocodone to the patient. The urine analysis indicated that the patient did not receive the Hydrocodone.
12. Respondent stated that she used Hydrocodone.
13. Respondent's conduct as set forth in facts 4 through 11 are recognized within the nursing profession as factors associated with substance abuse, misuse, and chemical dependency.
14. Staff of the Texas State Board of Nurse Examiners (the Board) requested that Respondent take certain steps, such as entering a Texas Peer Assistance for Nurses program, undergoing a forensic evaluation by a psychologist or psychiatrist to rule out chemical dependency or other concerns regarding fitness to practice, or by agreeing to a period of drug monitoring and testing. Respondent did not agree to take any of those actions.

V. CONCLUSIONS OF LAW

1. The Board has jurisdiction over matters related to this hearing pursuant to TEX. OCC. CODE ANN. §§ 301.452 and 301.453.
2. The State Office of Administrative Hearings has jurisdiction over this hearing, including the authority to issue a proposal for decision with findings of fact and conclusions of law, pursuant to TEX. GOV'T CODE ANN. ch. 2003 and § 301.454.
3. Proper and timely notice was given to Respondent pursuant to TEX. GOV'T CODE ANN. ch. 2001 and 22 ADMIN. CODE §§ 213.22.
4. Respondent violated statutes and rules regarding the practice of nursing, including TEX. OCC. CODE ANN. § 301.452(b)(10) and (b)(13) and 22 ADMIN. CODE §§ 217.11(1)(D) and 217.12(10)(B).
5. The Board is authorized to take disciplinary action against Respondent, including revocation, pursuant to TEX. OCC. CODE ANN. § 301.453.
6. Based on the foregoing Findings of Fact, revocation of Respondent's license is an appropriate sanction under the Board's disciplinary policy for nurses for whom there is information regarding misuse or abuse of drugs.
7. Pursuant to TEX. OCC. CODE ANN. § 301.453, Respondent's license to practice nursing in the State of Texas should be revoked.

SIGNED June 13, 2007



**ALVIN STOLL
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS**