



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.
Katherine A. Thomas
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse §
License Number 700824 and Vocational § AGREED
Nurse Licence Number 136739 §
issued to LORENZO LEWIS GREER § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board considered the matter of LORENZO LEWIS GREER, Registered Nurse License Number 700824 and Vocational Nurse License Number 136739, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal conference, notice and hearing, and agreed to the entry of this Order offered on September 18, 2008, 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.
2. Respondent waived representation by counsel, informal conference, notice and hearing, and agreed to the entry of this Order.
3. Respondent is currently licensed to practice professional nursing in the State of Texas. Respondent's license to practice vocational nursing in the State of Texas is in "delinquent" status.
4. Respondent received a Certificate in Vocational Nursing from McClennan Community College, Waco, Texas, on January 10, 1992, and received an Associate Degree in Nursing from Temple College, Temple, Texas, on May 9, 2003. Respondent was licensed to practice vocational nursing in the State of Texas on May 27, 1992, and was licensed to practice professional nursing in the State of Texas on October 7, 2003.

5. Respondent's nursing employment history includes:

1992 - 05/2000	Unknown	
06/2000 - 05/2002	Staff Relief	Medical Staff Network Waco, Texas
08/2001 - 05/2002	Part-Time Charge Nurse	Coryell Hospital System Gatesville, Texas
05/2002 - Unknown	Part-Time Charge Nurse	Elmwood Nursing Home Marlin, Texas
2002 - 2004	Staff Relief	Care Pros Staffing Agency Temple, Texas
12/2004 - 04/2005	Shift RN Supervisor	Central Texas Veterans Hospital Temple, Texas
05/2005 - 07/2005	Unknown	
08/2005 - 05/2006	Part-Time Charge Nurse	Central Texas Hospital Cameron, Texas
05/2006 - Unknown	Charge Nurse	Bellmead Rehabilitation Center Bellmead, Texas
10/2006	Staff Nurse	Falls Community Hospital Marlin, Texas
11/2006 - Present	Unknown	

6. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Charge Nurse with Central Texas Hospital, Cameron, Texas, and had been in this position for nine (9) months.

7. On or about May 7, 2006, while employed as a Charge Nurse with Central Texas Hospital, Cameron, Texas, Respondent failed to immediately report a narcotic discrepancy discovered at the change of shift to the Director of Nursing (DON), as required, and instead, walked outside to the back of the hospital. A Staff Nurse reported the discrepancy to the DON, who instructed all nurses with access to narcotics to submit a urine sample for drug testing. Although Respondent was directly instructed by the DON to submit a urine sample before leaving the facility, he refused and left anyway. Respondent's conduct resulted in an incomplete investigation by the facility, which had a responsibility to investigate the missing narcotics.

8. On or about May 13, 2006, while employed as a Charge Nurse with Central Texas Hospital, Cameron, Texas, Respondent left the facility without notification to and/or authorization from a supervisor approximately two and a half hours (2.5 hours) after clocking in and assuming care of patients. The day before, the DON left multiple phone messages for Respondent requesting that he report for counseling regarding concerns about medication errors and the aforementioned narcotics discrepancy before he reported for his shift. The DON scheduled another nurse for Respondent's scheduled shift when she had no contact from him, assuming that he might not come to work. When Respondent clocked in at 0648 hours, he told the other nurse to leave, and assumed care of her assigned patients. When the DON was notified that Respondent had shown up for work, she came to the facility to speak with him. She did not see Respondent at the Nurse's Station when she arrived and assumed that he was on the floor caring for his patients since his name was written with assigned patients on the board, but was told by a Staff Nurse that he was no longer at the facility. The DON assumed care of the patients that Respondent abandoned until another nurse arrived. Respondent's conduct was likely to injure patients by creating an unsafe clinical environment and could have resulted in Respondent's assigned patients not receiving needed care.
9. On or about October 11, 2006, and October 17, 2006, while employed as a Staff Nurse with Falls Community Hospital and Clinic, Marlin, Texas, Respondent twice failed to notify appropriate staff, including his supervisor, when leaving his nursing assignment, as follows:
- On October 11, 2006, Respondent was in his third day of orientation was to work with another RN who was doing patient care; however, Respondent could not be located on several instances, including two instances in which his supervisor was not able to "locate his whereabouts" for 30-40 minutes, and he did not answer his pages; and
 - On October 17, 2006, Respondent was to assume charge nurse duties with the actual Charge Nurse checking behind him. Respondent did not perform as instructed and "disappeared for long periods."
- Respondent's conduct was likely to injure patients in that leaving nursing assignments could have resulted in Respondent's assigned patients not receiving needed care.
10. On or about October 18, 2006, while employed as a Staff Nurse with Falls Community Hospital and Clinic, Marlin, Texas, Respondent erroneously administered medications ordered for another patient, including Augmentin, a Penicillin based antibiotic, to Patient Number 052571, who had a known allergy to Penicillin. Additionally, Respondent administered another antibiotic, Zithromax, to the patient three (3) hours earlier than ordered by the physician. Consequently, Patient Number 052571 experienced adverse reactions that required medical intervention, including the administration of three intravenous medications. Respondent's conduct unnecessarily placed the patient at risk for side effects, including anaphylaxis and/or possible demise.
11. On or about October 18, 2006, while employed as a Staff Nurse with Falls Community Hospital and Clinic, Marlin, Texas, Respondent failed to transcribe an admission order for Atrovent and Albuterol per nebulizer into the Medication Administration Record of Patient

Number 119955, who had been admitted in the afternoon for treatment of pneumonia and asthma. Consequently, the patient did not receive a nebulizer treatment until the next morning. Respondent's conduct was likely to injure the patient in that failure to transcribe ordered medications could have resulted in non-efficacious treatment and/or could have resulted in further complications from untreated disease processes.

12. On or about August 9, 2006, Respondent submitted fraudulent and forged correspondence dated May 13, 2006, to the Board which indicated that his services at Central Texas Hospital, Cameron, Texas, were simply no longer needed. On May 13, 2006, Respondent's employment with Central Texas Hospital, Cameron, Texas, was terminated "for patient abandonment and refusal to provide a urinalysis for narcotic discrepancy" and having refused counseling. Respondent's conduct was deceptive.
13. In response to the incidents in Findings of Fact Numbers Seven (7) through Twelve (12), Respondent states that he phoned the DON regarding the narcotic discrepancy and was only instructed to fill out an incident report, not to submit a urine sample for a drug screen. Further, he had already tested negatively for drugs several times previously, including his initial employment drug screen both for Central Texas Hospital, Cameron, Texas, and for other organizations. Respondent asserts that when he arrived to work on May 13, 2006, his name was crossed out on the schedule, he was not assigned patients, did not receive report, and did not "receive any keys" or count narcotics. According to Respondent, the DON and another supervisory nurse were standing next to the Nurse's Station when he arrived at work and after standing at the Nurse's Station for over forty-five (45) minutes with no one speaking to him, he called the DON from the Nurse's Station, resigned his employment, clocked out and left the facility. Respondent claims that he is a "black African-American, Protestant, family man," yet has "been dogged by discrimination" because he is "a minority male in a so called women's profession." Regarding Finding of Fact Number Ten (10), Respondent states that he was in orientation and worked the same hours as the person orienting him; on his first day he was orientating in the afternoon with the Unit Clerk, who left at different times of the day, so it is possible that he did not answer the overhead page because he was not in the building. According to Respondent, he was instructed to gather his supplies and leave the building after he had given report to the oncoming nurse and had clocked out. Regarding Patient Number 052571, Respondent explains that he was not prepared and felt rushed to complete his medication pass. Respondent further attributes the medication error to the Medication Administration Record, which "was unorganized and difficult to follow," to the patient having been transferred to a room much farther away from the medication room, and to the medication cart being kept in the medication room and his having to "go back and forth patient after patient" to gather medications. Regarding his failure to transcribe an admission order for Patient Number 119955, Respondent states that he worked the 7am - 7pm shift and "each nurse on 7pm - 7am shift was to make a twelve (12) hour chart check to catch anything that might have been missed."

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)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§ 217.11(1)(A),(1)(B),(1)(C), (1)(D)&(1)(I) and 217.12(1)(A),(1)(B),(4),(6)(G),(6)(H)&(12).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered License Number 700824 and Vocational Nurse License Number 136739, heretofore issued to LORENZO LEWIS GREER, including revocation of Respondent's licenses 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 Registered License Number 700824 and Vocational Nurse License Number 136739, previously issued to LORENZO LEWIS GREER, to practice nursing in Texas is hereby SUSPENDED for a period of two (2) years with the suspension STAYED and Respondent is hereby placed on PROBATION for (2) years with the following agreed terms of probation:

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

IT IS FURTHER AGREED and ORDERED that while Respondent's licenses are 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.

(1) 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.

(2) RESPONDENT SHALL deliver the wallet-sized licenses issued to LORENZO LEWIS GREER, to the office of the Texas Board of Nursing within ten (10) days of the date of this Order.

(3) 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 Chemical Dependency, 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. *Information regarding Board-approved courses in Texas Nursing Jurisprudence 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 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>

(5) 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>.*

(6) 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://www.learningext.com/products/generalce/critical/ctabout.asp>.*

(7) RESPONDENT SHALL pay a monetary fine in the amount of five hundred dollars (\$500.00). 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 PROBATION CONDITIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE PROBATIONARY 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 PROBATIONARY PERIOD:

(8) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the probation conditions on RESPONDENT's licenses. 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 probation conditions on RESPONDENT's licenses. 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.

(9) 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.

(10) 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.

(11) For the remainder of the probation 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.

(12) 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) years of employment as a nurse.

IT IS FURTHER AGREED and ORDERED that if during the period of probation, an additional allegation, accusation, or petition is reported or filed against the Respondent's licenses, the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order,
RESPONDENT SHALL be issued unencumbered licenses and multistate licensure privileges, if any,
to practice nursing in the State of Texas.

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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 licenses to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 17 day of November, 2008.

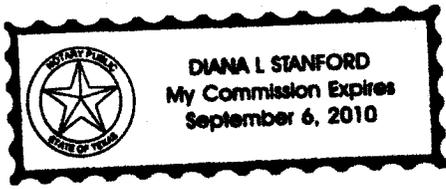
Lorenzo L Greer
LORENZO LEWIS GREER, Respondent

Sworn to and subscribed before me this 17 day of November, 2008.

SEAL

Diana L Stanford

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 17th day of November, 2008, by LORENZO LEWIS GREER, Registered License Number 700824 and Vocational Nurse License Number 136739, and said Order is final.

Effective this 9th day of December, 2008.



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