DOCKET NUMBER 507-01-3044

IN THE MATTER OF	§	BEFORE THE STATE OFFICE
PERMANENT CERTIFICATE	§	
NUMBER 651532	§	OF
ISSUED TO	§	
TAMMY COX	§	ADMINISTRATIVE HEARINGS

ORDER OF THE BOARD

TO: Tammy Cox
c/o Bonner Smith
Attorney at Law
5220 80th Street
Lubbock, TX 79424

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.

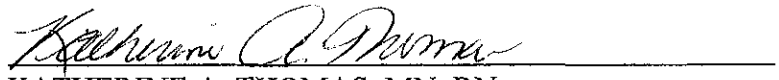
NOW, THEREFORE, IT IS ORDERED that Permanent Certificate Number 651532, previously issued to TAMMY COX, to practice professional nursing in the State of Texas be, and the same is hereby, REVOKED.

IT IS FURTHER ORDERED that Permanent Certificate Number 651532, previously issued to TAMMY COX, 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 11th day of October, 2001.

BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS

BY: 

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

SOAH DOCKET NOS.
507-01-2957, 507-01-2958, 507-01-2960, 507-01-2961, 507-01-2962, 507-01-2963, 507-01-2964, 507-01-2965, 507-01-2966, 507-01-2968, 507-01-2969, 507-01-2970, 507-01-2971, 507-01-2973, 507-01-2974, 507-01-2975, 507-01-2976, 507-01-2977, 507-01-2978, 507-01-3044, 507-01-3045 and 507-01-3097

TEXAS STATE BOARD OF NURSE EXAMINERS,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
CERTAIN LICENSEES OF THE BOARD,	§	
	§	
Respondents	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff of the Texas State Board of Nurse Examiners (Board) seeks discipline against several of the Board's licensees (Respondents) for violating various provisions of the Nursing Practice Act (Act), TEX. OCC. CODE ANN. ch. 301, and the Board's rules. Despite being sent proper notice, none of the Respondents appeared or were represented at the hearing. Based on the Respondents' failure to appear, Staff's allegations were accepted as true, establishing the asserted violations. The Administrative Law Judge agreed with Staff's recommendation that Respondents' nursing licenses be revoked.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The Board has jurisdiction to discipline its licensees for violations of the Act or its rules pursuant to § 301.453 of the Act. The State Office of Administrative Hearings (SOAH) has jurisdiction to hear the Board's disciplinary cases and issue proposals for decisions pursuant to TEX. GOV'T CODE ANN. ch. 2003 and § 301.454 of the Act.

On May 22, 25, and 31, 2001, Staff sent notices of hearing to the last known address in the Board's records for each Respondent listed on the Attachment. The notice of hearing stated the date, time, and location of the hearing, referenced the applicable rules and statutes, and contained a short, plain statement of the factual basis for the allegations.

On June 25, 2001, the hearing in this matter convened before SOAH Administrative Law Judge (ALJ) Mike Rogan in the SOAH Hearings Facility, 1700 N. Congress, Suite 1100, Austin, Texas. Staff was represented by Assistant General Counsel Phong Phan. The Respondents did not appear and were not represented at the hearing. After introducing evidence sufficient to establish jurisdiction and notice, Staff moved for a default pursuant to 1 TEX. ADMIN. CODE § 155.55. Based on the Respondents' failure to appear, the ALJ granted the default and deemed all Staff's factual allegations true.

II. RECOMMENDATION

The ALJ recommends a default be entered against all the Respondents listed on the Attachment, and that those Respondents' nursing licenses be revoked based on the deemed facts as set forth in the Findings of Fact and Conclusions of Law presented below.

III. FINDINGS OF FACT

1. The persons listed on the Attachment hereto (Respondents) hold licenses to practice professional nursing issued by the Texas State Board of Nurse Examiners (Board).

2. By notices of hearing sent May 22, 25, and 31, 2001, the Board's Staff (Staff) notified the Respondents that formal charges had been filed and a disciplinary hearing had been scheduled in this matter. The notices of hearing were sent by first class mail and by certified mail, return receipt requested, to each Respondent's last known address as contained in the Board's records.

3. The notices of hearing informed each Respondent of the allegations, the right to appear and be represented by counsel, the time and place of the hearing, the statutes and rules involved, and the factual basis for the allegations. The notice further provided in boldface type: "FAILURE TO APPEAR AT THE HEARING IN PERSON OR BY LEGAL REPRESENTATIVE, REGARDLESS OF WHETHER AN APPEARANCE HAS BEEN ENTERED, WILL RESULT IN THE ALLEGATIONS CONTAINED IN THE FORMAL CHARGES BEING ADMITTED AS TRUE AND THE PROPOSED RECOMMENDATION OF STAFF SHALL BE GRANTED BY DEFAULT."

4. The Respondents did not appear and were not represented at the hearing held June 25, 2001.

5. Based on the Respondents' failure to appear at the hearing, Staff moved for default as authorized by 1 TEX. ADMIN. CODE § 155.55.

6. Staff's motion for default was granted and its allegations against each Respondent were deemed true.

7. Each Respondent violated certain provisions of the Act and the Board's rules as listed in the Attachment hereto.

8. Staff recommended each Respondent's license be revoked.

IV. CONCLUSIONS OF LAW

1. The Texas State Board of Nurse Examiners (Board) has jurisdiction over this matter pursuant to the Nursing Practice Act (the Act), TEX. OCC. CODE ANN. § 301.453 (Vernon 2000).

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this matter, 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 (Vernon 2000) and § 301.454 of the Act.

3. Based on Findings of Fact Nos. 2 and 3, each Respondent listed on the Attachment hereto received proper and timely notice of the intention to institute disciplinary action and of the hearing, pursuant to TEX. GOV'T. CODE ANN. §§ 2001.051 and 2001.054(c) (Vernon 2000).

4. Based on Finding of Fact No. 7, each Respondent violated certain provisions of the Act and the Board's rules as set out in the Attachment hereto.

5. Based on the Findings of Fact Nos. 2 - 4 and Conclusion of Law No. 3, a default should be entered against each Respondent pursuant to 1 TEX. ADMIN. CODE § 155.55 (2001).

6. Based on Conclusions of Law Nos. 4 and 5, the license to practice professional nursing of each Respondent should be revoked, pursuant to § 301.453 of the Act.

SIGNED this 9th day of July, 2001.

Mike Rogan

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS STATE BOARD OF NURSE EXAMINERS, *Petitioner*	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
CERTAIN LICENSEES OF THE BOARD, *Respondents*	§	**ADMINISTRATIVE HEARINGS**

ATTACHMENT

Hearing held on June 25, 2001, before Administrative Law Judge Mike Rogan.

CHART STARTS ON NEXT PAGE

SOAH DOCKET No. RESPONDENT and *PERMANENT CERTIFICATE No.*	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2957 JIMMIE MACK BELL Certificate No. 666356	CHARGE I. On or about October 27/28, 2000, while employed as a Registered Nurse with Elite Nursing Services, Temple, Texas, and working in on the Telemetry Unit at St. David's Medical Center, Austin, Texas, Respondent failed to document the condition and medications administered to patients in his care as evidenced by the following: Medical Record #L0007613[illegible] – No nursing narrative notes, no vital signs documented for the entire shift. Has marked checks in both Foley catheter and Voided columns. No intake and output entries documented. Failed to document that medications to be administered at 2100 were given. Medical Record # L000851864 -- No date on record but signed by Respondent. Has marked checks in both *Foley catheter and Voided columns*.. The patient was a dialysis patient. The column for wound assessment has only "(?)SC". Medical Record #L000898220 -- Narrative note has entry timed at 2350 (beginning of night shift) "pt quiet for most of shift." Narrative entry at 0630 "you know were (sic) I live." There are no vital signs documented for the night shift. There are no intake and output entries documented for the night shift. *Medical Record #L000945701 -- Only narrative entry is at 0405-* "Players are starting. . .." (the rest of the entry is unintelligible). Medications including Proventil, Apresoline, Heparin flush, and Cardizem are not documented as given. CHARGE II. On or about October 28, 2000, while employed as a Registered Nurse with Elite Nursing Services, Temple, Texas, and working in on the Telemetry Unit at St. David's Medical Center, Austin, Texas, Respondent was unable to give coherent reports on his patients to the oncoming shift. Nurses who were trying to obtain reports from Respondent notified their supervisor that Respondent appeared to be in an impaired state. Respondent's pupils were dilated, he had difficulty making eye contact, and had trouble focusing. Respondent's conduct impaired the nurse's ability 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. OCC. CODE ANN. §§ 301.452(b)(12) and (13) and 22 TEX. ADMIN. CODE §§ 217.11(4) and 217.12(12).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2958 FRANCES A. F. DAIGLE Certificate No. 213936	CHARGE I. On or about October 28, 2000, while employed with Wilson N. Jones Medical Center, Sherman, Texas, Respondent failed to initiate cardiopulmonary resuscitation (CPR) on Medical Record #89388 when he was found with an absence of respirations and other vital signs. The patient did not have a 'Do Not Resuscitate' order. Respondent was working as the house supervisor and was the first registered nurse to assess the patient after the Licensed Vocational Nurse assigned to the patient discovered him not breathing. Respondent made the decision not to call a code and advised the charge nurse not to call a code.	TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE § 217.12(2).	Revocation
507-01-2960 BARBARA FARLEY DEAN Certificate No. 451021	CHARGE I. Respondent, on or about May 26, 2000, was convicted of misdemeanor theft by the Harris County Criminal Court at Law No. 3, Houston, Texas, cause number 1002237. CHARGE II. Respondent, on or about February 9, 2000, while employed with The Care Group of Texas, Houston, Texas, made false entries in the medical record of patient A.M. Respondent documented care given to patient A.M. at 7:00 a.m. when in fact she did not begin caring for the patient until 9:00 a.m. Respondent's conduct was likely to deceived subsequent care givers who would rely on this information to further care for the patient.	TEX. OCC. CODE ANN. §§ 301.452(b)(3) and (10) and 22 TEX. ADMIN. CODE §§ 217.12(1) and (20).	Revocation
507-01-2961 GREG GILBERT Certificate No. 658148	CHARGE I. Respondent, on or about November 4, 1998, while employed with Baptist St. Anthony Health System, Amarillo, Texas, engaged in the intemperate use of Barbiturates in that Respondent produced a specimen for a drug screen which resulted positive for Barbiturates. Possession of Barbiturates is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Barbiturates by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. REV. CIV. STAT. ANN. arts. 4525(b)(8)&(9) and 22 TEX. ADMIN. CODE § 217.13(1).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2962 TINA C. HARRINGTON Certificate No. 525561	CHARGE I. On or about June 19, 1997, Respondent's license to practice professional nursing in the State of Louisiana was placed on probation for two (2) years by the Louisiana State Board of Nursing, Metairie, Louisiana.	TEX. REV. CIV. STAT. ANN. art. 4525(b)(7).	Revocation
507-01-2963 KAREN E. HIGMAN Certificate No. 623365	CHARGE I. On or about July 2/3, 1999, while employed as a Registered Nurse with Lake Granbury Medical Center, Granbury, Texas, Respondent withdrew Demerol 50mg in excess of physician's orders for Patient Account #856019. The physician had ordered the medication to be given every 3-4 hours as needed. CHARGE II. On or about July 3, 1999, while employed with Lake Granbury Medical Center, Granbury, Texas, Respondent engaged in the intemperate use of Demerol in that Respondent produced a specimen for a drug screen which resulted positive for Demerol. Possession of Demerol is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Demerol by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. REV. CIV. STAT. ANN. art. 4525(b)(8), (9) & (12) and 22 TEX. ADMIN. CODE §§ 217.11 (6) and 217.13(3).	Revocation
507-01-2964 DIANE L. KEESEE Certificate No. 561449	CHARGE I. Respondent, on or about January 1998, provided false information on her employment application submitted to Memorial Hermann The Woodlands Hospital, The Woodlands, Texas. Respondent failed to include her employment with Park Plaza Hospital, Houston, Texas from July 2, 1990 through January 5, 1992. Respondent's conduct was likely to deceive the public. CHARGE II. On or about April 10, 2000 through May 2, 2000, while employed at Memorial Hermann The Woodlands Hospital, The Woodlands, Texas, Respondent withdrew controlled substances from the Pyxis Medication System but failed to document the administration of the medication in the patient's Medication Administration Record.	TEX. REV. CIV. STAT. ANN. art. 4525(b)(9) and TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE §§ 217.12(1)&(4) and 217.13(17).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2965 RHONDA L. LEONARD Certificate No. 583302	CHARGE I. On or about March 17, 2000, while employed with CareStaff of Dallas, Dallas, Texas and on assignment at BHC Millwood Hospital, Arlington, Texas, Respondent engaged in the intemperate use of alcohol in that Respondent had the odor of alcohol on her breath while on duty. The use of alcohol by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. OCC. CODE ANN. § 301.452(b)(9)	Revocation
507-01-2966 ANGELA E. MARTIN Certificate No. 634202	CHARGE I. Respondent failed to comply with the Agreed Order issued to her by the Board of Nurse Examiners for the State of Texas on September 12, 2000. Noncompliance is a result of the Respondent's failure to notify her present employer, Matrix Personnel Services, Houston, Texas, of the Order and the stipulations in effect therein. CHARGE II. During a period of time from September 17, 2000 through October 2000, Respondent failed to comply with the Agreed Order issued to her by the Board of Nurse Examiners for the State of Texas on September 12, 2000. Noncompliance is a result of the Respondent's employment with Matrix Personnel Services, Houston, Texas, as a professional nurse. CHARGE III. On or about September 22, 2000, Respondent failed to comply with the Agreed Order issued to her by the Board of Nurse Examiners for the State of Texas on September 12, 2000. Noncompliance is a result of the Respondent's failure to cause her employer, Matrix Personnel Services, Houston, Texas, to submit a Notification of Employment form to the office of the Board.	TEX. OCC. CODE ANN. § 301.452(b)(1).	Revocation
507-01-2968 HOLLY MEADOWS Certificate No. 638036	CHARGE I. Respondent, on or about August 17, 2000, failed to comply with the Agreed Order issued to her by the Board of Nurse Examiners for the State of Texas on March 25, 1999. Noncompliance is the result of Respondent's failure to comply with all requirements of the Texas Peer Assistance Program for Nurses (TPAPN) contract during its term.	TEX. OCC. CODE ANN. § 301.452(b)(1).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2969 ALICE E. MITCHELL Certificate No. 240765	CHARGE I. On or about March 24, 2000, while employed at Hi-Plains Hospital, Hale Center, Texas, Respondent failed to accurately document on the Narcotic Record the wastage of a 50 mg Demerol carpuject. Respondent signed out a 50 mg Demerol carpuject at 0540 for Patient Number 36514 and documented the following wastage: ".5mg used" and ".5 mg wasted." Respondent's documentation did not reflect wastage of the remaining 40 mg Demerol. Respondent's conduct was likely to deceive or defraud patients or the public. CHARGE II. On or about March 26, 2000, while employed at the aforementioned facility, Respondent signed out 10 mg Morphine Sulfate to Patient Number 36514 at 0100 without a valid physician's order. Respondent's conduct was likely to injure the patient. CHARGE III. On or about March 26, 2000, while employed at the aforementioned facility, Respondent signed out 10 mg Morphine Sulfate to Patient Number 36514 at 0100 but failed to document the administration in the Medication Administration Record or the Nurses Notes. Respondent conduct was likely to deceive or defraud patients or the public. CHARGE IV. On or about March 9, 2000, while employed at the aforementioned facility, Respondent signed out Morphine Sulfate 10mg to Patient 36514 at 0100, documented the administration of 5mg Morphine Sulfate, but failed to document the wastage of the remaining 5 mg Morphine Sulfate and failed to obtain a co-signature for the wastage on the Narcotic Record.	TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE §§ 217.12(1), (3), (4) and (18).	Revocation
507-01-2970 HUBERT W. MORROW, III Certificate No. 546610	CHARGE I. Respondent, on or about July 20, 2000, while employed with Community Medical Center Sherman, Sherman, Texas, engaged in the intemperate use of Alcohol in that Respondent produced a specimen for a drug screen which resulted positive for Ethanol. The use of Alcohol by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. OCC. CODE ANN. §§ 301.452(b)(9) and (13) and 22 TEX. ADMIN. CODE § 217.11(1).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2971 BRENDA S. O'KEEFE Certificate No. 613759	CHARGES I and II. On or about January 14 and 20, 2000, while employed at Plano Rehabilitation Hospital, Plano, Texas, Respondent engaged in the intemperate use of alcohol in that Respondent produced a specimen which tested positive for alcohol. The use of alcohol by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. OCC. CODE ANN. § 301.452(b)(9).	Revocation
507-01-2973 KAREN R. ROGERS Certificate No. 541392	CHARGES I and II. Respondent, on or about November 9, 1999, while employed with Medical Staffing Network, Staff Relief, Houston, Texas, and working at Northeast Medical Center, Houston, Texas, failed to accurately and completely document the administration of the medications she withdrew from the pyxis system for patients on the Medication Administration Record (MAR) and the 24 Hour Patient Notes. Respondent also withdrew medications from the pyxis system for patients without a physician's order. CHARGE III and IV. Respondent, during July and August of 2000, while employed with Medical Staffing Network, Staff Relief, Houston, Texas, and working at Memorial City Hospital, Houston, Texas, failed to accurately and completely document the administration of the medications she withdrew from the pyxis system for patients on the Medication Administration Record (MAR) and the 24 Hour Patient Notes. Respondent also withdrew medications from the pyxis system for patients without a physician's order. CHARGE V. Respondent, on or about February 28, 2001 and March 1, 2001, while employed with Staff Search, Houston, Texas, and working at Memorial Hermann Hospital, Houston, Texas, withdrew Morphine Sulfate from the pyxis system for patients but failed to accurately and completely document the administration of the Morphine Sulfate on the Medication Administration Record (MAR) and the 24 Hour Patient Notes.	TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE §§ 217.12(3) and (4).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2974 DIANE M. SHELLEY Certificate No. 602059	CHARGE I. Respondent, on or about August 24, 2000, while employed with Methodist Hospital, San Antonio, Texas, engaged in the intemperate use of Alcohol in that Respondent produced a specimen for a blood test which resulted positive for Alcohol. The use of Alcohol by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. OCC. CODE ANN. §§ 301.452(b)(9) and (13) and 22 TEX. ADMIN. CODE § 217.11(1).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2975 MELISSA M. SLOAN Certificate No. 602086	CHARGE I. Respondent, on or about May and June 1999, while employed with Baylor University Medical Center, Dallas, Texas, withdrew Demerol for patients in excess frequency and dosage of physician's orders and/or failed to follow the facility's policy and procedure for wastage of medications. CHARGE II. Respondent, on or about November 22, 1999, while employed with Baylor University Medical Center, Dallas, Texas, engaged in the intemperate use of Cocaine in that Respondent produced a specimen for a drug screen which resulted positive for Cocaine. Possession of Cocaine is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Cocaine by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger. CHARGE III. Respondent, during August, 2000, while employed with Baylor University Medical Center, Dallas, Texas, misappropriated Demerol by using the Pyxis code of another nurse. Possession of Demerol is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). Respondent's conduct defrauded the facility of the cost of the medication. CHARGE IV. Respondent, on or about August 15-17, 2000, while employed with Baylor University Medical Center, Dallas, Texas, was responsible for numerous discrepancies in the documentation of narcotics administration including failing to document the administration of narcotics she withdrew for patients, withdrawing narcotics for patients in excess frequency and dosage of physician's orders and/or failing to follow the facility's policy and procedure for the wastage of medications.	TEX. REV. CIV. STAT. ANN. art. 4525(b)(9) and TEX. OCC. CODE ANN. §§ 301.452(b)(9), (10) and (13) and 22 TEX. ADMIN. CODE §§ 217.11 (1) and (4), 217.12(3), (18) and (19), and 217.13(3) and (14).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2976 MATTIE B. WASHINGTON *Certificate No. 518520*	CHARGE I. On or about August 15, 2000, Respondent failed to comply with the Agreed Order issued by the Board of Nurse Examiners for the State of Texas on June 30, 2000. Noncompliance is the result of Respondent's failure to apply and be accepted into the Texas Peer Assistance Program for Nurses (TPAPN) by August 15, 2000.	TEX. OCC. CODE ANN. §§ 301.452(b)(1).	Revocation
507-01-2977 MARTHA L. WESTON Certificate No. 557435	CHARGE I. On or about December 25, 1999, while employed with American Health Care Recruiters, Inc., Metairie, Louisiana, and on assignment at University Medical Center, Lubbock, Texas, Respondent withdrew controlled substances from the Pyxis Medication System without a valid physician's order. CHARGE II. On or about December 25, 1999, while employed at the aforementioned facility, Respondent misappropriated Lortab and Morphine Sulfate from the facility and the patients thereof. Respondent's conduct was likely to defraud patients and the public.	TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE §§ 217.12 (3) and (19).	Revocation
507-01-2978 JOYCE W. WILSON Certificate No. 607256	CHARGE I. On or about May 27, 1999 through June 7, 1999, while employed at Harvest Care Center of Lumberton, Lumberton, Texas, Respondent signed out butalbital/comp/codeine #3 to Resident #0276 but failed to document the administration of this medication in the Medication Administration Record (MAR).	TEX. REV. CIV. STAT. ANN. art. 4525(b)(9) and 22 TEX. ADMIN. CODE § 217.13 (5).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-3044 TAMMY COX Certificate No. 651532	**CHARGE I.** On or about December 1999 through January 2000, while employed with Lakeridge Rehabilitation and Nursing Center, Lubbock, Texas, Respondent passed or attempted to pass unauthorized prescriptions for Hydrocodone (Lortab-10) at Walgreens Pharmacies in Lubbock, Texas. Possession of Hydrocodone through the use of unauthorized prescriptions is prohibited by Chapter 481 of the Texas Health and Safety Code (Texas Controlled Substances Act). Respondent's conduct was likely to decei e the pharmacies. **CHARGE II.** On or about March 2, 2000, while employed at White Dove Rehabilitation, Littlefield, Texas, Respondent misappropriated 1 tab of Lortab belonging to patient L.S. Respondent's conduct was likely to defraud the patient. **CHARGE III.** On or about February 2000 through May 2000, while employed with Slaton Care Center, Slaton, Texas, Respondent accessed the pyxis machine to obtain narcotics for patients without a physician's order and failed to document the administration of the narcotics on the patient's Medication Administration Record (MAR).	TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE §§ 217.12 (1), (3), (4)(D) and (E), (19) and (21).	Revocation
507-01-3045 GARY B. ETHRIDGE Certificate No. 594520	**CHARGE I.** On or about May 1, 200, Respondent failed to comply with the Agreed Order issued to him by the Board of Nurse Examiners for the State of Texas on March 15, 2000. Non-compliance is the result of Respondent's failure to apply and be accepted into the TPAPN within 45 days of entry of the Order issued March 15, 2000.	TEX. OCC. CODE ANN. § 301.452(b)(1).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-3097 JAMES S. KELLER *Certificate No. 503453*	CHARGE I. Between February 1997 and July 1998, while employed as Director of Nursing at Pine Shadow Retreat in Porter, Texas, Respondent failed to keep residents free from physical restraint imposed for purposes not required to treat the resident's medical condition. Respondent's conduct was *likely to deceive the public regarding the level of care* and supervision residents of the facility were receiving, and unnecessarily exposed the patients to the risk of harm. CHARGE II. Between February 1997 and July 1998, while employed as Director of Nursing at Pine Shadow Retreat in Porter, Texas, Respondent failed to implement measures to promote a safe environment for residents and staff when he did not enforce and evaluate a safe "Smoking Policy". As a result of Respondent's failure, on April 28, 1997, Resident # 1457 (identified by the initials E.M..) had his clothing catch on fire. The resident was transported to Hermann Hospital in Houston, Texas, where he expired. CHARGE III. *Between February* 1997 and July 1998, while employed as Director of Nursing at Pine Shadow Retreat in Porter, Texas, Respondent failed to supervise the care provided by those for whom he was administratively responsible. Respondent's conduct was likely to injure the patients, and likely led to resident E.M. being set afire in the facility.	TEX. REV. CIV. STAT. ANN. arts. 4525(b)(9) and (12) and 22 TEX. ADMIN. CODE §§ 217.11(8) and 217.13(1) and (10).	Revocation

DOCKET NUMBER 507-01-3044

IN THE MATTER OF PERMANENT CERTIFICATE NUMBER 651532	§	BEFORE THE BOARD OF
	§	
	§	NURSE EXAMINERS
ISSUED TO	§	
TAMMY COX	§	FOR THE STATE OF TEXAS

ORDER OVERRULING MOTION TO SET ASIDE DEFAULT

On September 11, 2001, during open meeting at Austin, Texas, the Eligibility and Disciplinary Committee of the Board of Nurse Examiners considered the Motion to Set Aside the Default Judgment filed by Respondent in response to the Proposal for Decision issued on July 9, 2001 in the above referenced matter. After review of the motion and due consideration of the evidence presented, the Committee believes Respondent's motion is without merit and should be denied. *See Anderson v. Railroad Commission of Texas*, 963 S.W.2d 217 (Tex.App.–Austin 1998, pet. denied).

NOW, THEREFORE, IT IS ORDERED that Respondent's Motion to Set Aside the Default Judgment is DENIED.

Entered this 11th day of September, 2001.

BOARD OF NURSE EXAMINERS
FOR THE STATE OF TEXAS

BY: Katherine A. Thomas
KATHERINE A. THOMAS, MN, RN
EXECUTIVE DIRECTOR

SOAH DOCKET NOS.
507-01-2957, 507-01-2958, 507-01-2960, 507-01-2961, 507-01-2962, 507-01-2963, 507-01-2964, 507-01-2965, 507-01-2966, 507-01-2968, 507-01-2969, 507-01-2970, 507-01-2971, 507-01-2973, 507-01-2974, 507-01-2975, 507-01-2976, 507-01-2977, 507-01-2978, 507-01-3044, 507-01-3045 and 507-01-3097

TEXAS STATE BOARD OF NURSE EXAMINERS,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
V.	§	**OF**
	§	
CERTAIN LICENSEES OF THE BOARD,	§	
	§	
Respondents	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

Staff of the Texas State Board of Nurse Examiners (Board) seeks discipline against several of the Board's licensees (Respondents) for violating various provisions of the Nursing Practice Act (Act), TEX. OCC. CODE ANN. ch. 301, and the Board's rules. Despite being sent proper notice, none of the Respondents appeared or were represented at the hearing. Based on the Respondents' failure to appear, Staff's allegations were accepted as true, establishing the asserted violations. The Administrative Law Judge agreed with Staff's recommendation that Respondents' nursing licenses be revoked.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

The Board has jurisdiction to discipline its licensees for violations of the Act or its rules pursuant to § 301.453 of the Act. The State Office of Administrative Hearings (SOAH) has jurisdiction to hear the Board's disciplinary cases and issue proposals for decisions pursuant to TEX. GOV'T CODE ANN. ch. 2003 and § 301.454 of the Act.

On May 22, 25, and 31, 2001, Staff sent notices of hearing to the last known address in the Board's records for each Respondent listed on the Attachment. The notice of hearing stated the date, time, and location of the hearing, referenced the applicable rules and statutes, and contained a short, plain statement of the factual basis for the allegations.

On June 25, 2001, the hearing in this matter convened before SOAH Administrative Law Judge (ALJ) Mike Rogan in the SOAH Hearings Facility, 1700 N. Congress, Suite 1100, Austin, Texas. Staff was represented by Assistant General Counsel Phong Phan. The Respondents did not appear and were not represented at the hearing. After introducing evidence sufficient to establish jurisdiction and notice, Staff moved for a default pursuant to 1 TEX. ADMIN. CODE § 155.55. Based on the Respondents' failure to appear, the ALJ granted the default and deemed all Staff's factual allegations true.

II. RECOMMENDATION

The ALJ recommends a default be entered against all the Respondents listed on the Attachment, and that those Respondents' nursing licenses be revoked based on the deemed facts as set forth in the Findings of Fact and Conclusions of Law presented below.

III. FINDINGS OF FACT

1. The persons listed on the Attachment hereto (Respondents) hold licenses to practice professional nursing issued by the Texas State Board of Nurse Examiners (Board).

2. By notices of hearing sent May 22, 25, and 31, 2001, the Board's Staff (Staff) notified the Respondents that formal charges had been filed and a disciplinary hearing had been scheduled in this matter. The notices of hearing were sent by first class mail and by certified mail, return receipt requested, to each Respondent's last known address as contained in the Board's records.

3. The notices of hearing informed each Respondent of the allegations, the right to appear and be represented by counsel, the time and place of the hearing, the statutes and rules involved, and the factual basis for the allegations. The notice further provided in boldface type: "FAILURE TO APPEAR AT THE HEARING IN PERSON OR BY LEGAL REPRESENTATIVE, REGARDLESS OF WHETHER AN APPEARANCE HAS BEEN ENTERED, WILL RESULT IN THE ALLEGATIONS CONTAINED IN THE FORMAL CHARGES BEING ADMITTED AS TRUE AND THE PROPOSED RECOMMENDATION OF STAFF SHALL BE GRANTED BY DEFAULT."

4. The Respondents did not appear and were not represented at the hearing held June 25, 2001.

5. Based on the Respondents' failure to appear at the hearing, Staff moved for default as authorized by 1 TEX. ADMIN. CODE §.155.55.

6. Staff's motion for default was granted and its allegations against each Respondent were deemed true.

7. Each Respondent violated certain provisions of the Act and the Board's rules as listed in the Attachment hereto.

8. Staff recommended each Respondent's license be revoked.

IV. CONCLUSIONS OF LAW

1. The Texas State Board of Nurse Examiners (Board) has jurisdiction over this matter pursuant to the Nursing Practice Act (the Act), TEX. OCC. CODE ANN. § 301.453 (Vernon 2000).

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this matter, 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 (Vernon 2000) and § 301.454 of the Act.

3. Based on Findings of Fact Nos. 2 and 3, each Respondent listed on the Attachment hereto received proper and timely notice of the intention to institute disciplinary action and of the hearing, pursuant to TEX. GOV'T. CODE ANN. §§ 2001.051 and 2001.054(c) (Vernon 2000).

4. Based on Finding of Fact No. 7, each Respondent violated certain provisions of the Act and the Board's rules as set out in the Attachment hereto.

5. Based on the Findings of Fact Nos. 2 - 4 and Conclusion of Law No. 3, a default should be entered against each Respondent pursuant to 1 TEX. ADMIN. CODE § 155.55 (2001).

6. Based on Conclusions of Law Nos. 4 and 5, the license to practice professional nursing of each Respondent should be revoked, pursuant to § 301.453 of the Act.

SIGNED this 9th day of July, 2001.

Mike Rogan

MIKE ROGAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS STATE BOARD OF NURSE EXAMINERS, *Petitioner*	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
CERTAIN LICENSEES OF THE BOARD, *Respondents*	§	**ADMINISTRATIVE HEARINGS**

ATTACHMENT

Hearing held on June 25, 2001, before Administrative Law Judge Mike Rogan.

CHART STARTS ON NEXT PAGE

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2957 JIMMIE MACK BELL Certificate No. 666356	**CHARGE I.** On or about October 27/28, 2000, while employed as a Registered Nurse with Elite Nursing Services, Temple, Texas, and working in on the Telemetry Unit at St. David's Medical Center, Austin, Texas, Respondent failed to document the condition and medications administered to patients in his care as evidenced by the following: Medical Record #L0007613[illegible] – No nursing narrative notes, no vital signs documented for the entire shift. Has marked checks in both Foley catheter and Voided columns. No intake and output entries documented. Failed to document that medications to be administered at 2100 were given. Medical Record # L000851864 -- No date on record but signed by Respondent. Has marked checks in both Foley catheter and Voided columns.. The patient was a dialysis patient. The column for wound assessment has only "(?)SC". Medical Record #L000898220 -- Narrative note has entry timed at 2350 (beginning of night shift) "pt quiet for most of shift." Narrative entry at 0630 "you know were (sic) I live." There are no vital signs documented for the night shift. There are no intake and output entries documented for the night shift. Medical Record #L000945701 -- Only narrative entry is at 0405- "*Players are starting. . ..*" (the rest of the entry is unintelligible). Medications including Proventil, Apresoline, Heparin flush, and Cardizem are not documented as given. **CHARGE II.** On or about October 28, 2000, while employed as a Registered Nurse with Elite Nursing Services, Temple, Texas, and working in on the Telemetry Unit at St. David's Medical Center, Austin, Texas, Respondent was unable to give coherent reports on his patients to the oncoming shift. Nurses who were trying to obtain reports from Respondent notified their supervisor that Respondent appeared to be in an impaired state. Respondent's pupils were dilated, he had difficulty making eye contact, and had trouble focusing. Respondent's conduct impaired the nurse's ability 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. OCC. CODE ANN. §§ 301.452(b)(12) and (13) and 22 TEX. ADMIN. CODE §§ 217.11(4) and 217.12(12).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2958 FRANCES A. F. DAIGLE Certificate No. 213936	CHARGE I. On or about October 28, 2000, while employed with Wilson N. Jones Medical Center, Sherman, Texas, Respondent failed to initiate cardiopulmonary resuscitation (CPR) on Medical Record #89388 when he was found with an absence of respirations and other vital signs. The patient did not have a 'Do Not Resuscitate' order. Respondent was working as the house supervisor and was the first registered nurse to assess the patient after the Licensed Vocational Nurse assigned to the patient discovered him not breathing. Respondent made the decision not to call a code and advised the charge nurse not to call a code.	TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE § 217.12(2).	Revocation
507-01-2960 BARBARA FARLEY DEAN Certificate No. 451021	CHARGE I. Respondent, on or about May 26, 2000, was convicted of misdemeanor theft by the Harris County Criminal Court at Law No. 3, Houston, Texas, cause number 1002237. CHARGE II. Respondent, on or about February 9, 2000, while employed with The Care Group of Texas, Houston, Texas, made false entries in the medical record of patient A.M. Respondent documented care given to patient A.M. at 7:00 a.m. when in fact she did not begin caring for the patient until 9:00 a.m. Respondent's conduct was likely to deceived subsequent care givers who would rely on this information to further care for the patient.	TEX. OCC. CODE ANN. §§ 301.452(b)(3) and (10) and 22 TEX. ADMIN. CODE §§ 217.12(1) and (20).	Revocation
507-01-2961 GREG GILBERT Certificate No. 658148	CHARGE I. Respondent, on or about November 4, 1998, while employed with Baptist St. Anthony Health System, Amarillo, Texas, engaged in the intemperate use of Barbiturates in that Respondent produced a specimen for a drug screen which resulted positive for Barbiturates. Possession of Barbiturates is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Barbiturates by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. REV. CIV. STAT. ANN. arts. 4525(b)(8)&(9) and 22 TEX. ADMIN. CODE § 217.13(1).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2962 TINA C. HARRINGTON Certificate No. 525561	CHARGE I. On or about June 19, 1997, Respondent's license to practice professional nursing in the State of Louisiana was placed on probation for two (2) years by the Louisiana State Board of Nursing, Metairie, Louisiana.	TEX. REV. CIV. STAT. ANN. art. 4525(b)(7).	Revocation
507-01-2963 KAREN E. HIGMAN Certificate No. 623365	CHARGE I. On or about July 2/3, 1999, while employed as a Registered Nurse with Lake Granbury Medical Center, Granbury, Texas, Respondent withdrew Demerol 50mg in excess of physician's orders for Patient Account #856019. The physician had ordered the medication to be given every 3-4 hours as needed. CHARGE II. On or about July 3, 1999, while employed with Lake Granbury Medical Center, Granbury, Texas, Respondent engaged in the intemperate use of Demerol in that Respondent produced a specimen for a drug screen which resulted positive for Demerol. Possession of Demerol is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Demerol by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. REV. CIV. STAT. ANN. art. 4525(b)(8), (9) & (12) and 22 TEX. ADMIN. CODE §§ 217.11 (6) and 217.13(3).	Revocation
507-01-2964 DIANE L. KEESEE Certificate No. 561449	CHARGE I. Respondent, on or about January 1998, provided false information on her employment application submitted to Memorial Hermann The Woodlands Hospital, The Woodlands, Texas. Respondent failed to include her employment with Park Plaza Hospital, Houston, Texas from July 2, 1990 through January 5, 1992. Respondent's conduct was likely to deceive the public. CHARGE II. On or about April 10, 2000 through May 2, 2000, while employed at Memorial Hermann The Woodlands Hospital, The Woodlands, Texas, Respondent withdrew controlled substances from the Pyxis Medication System but failed to document the administration of the medication in the patient's Medication Administration Record.	TEX. REV. CIV. STAT. ANN. art. 4525(b)(9) and TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE §§ 217.12(1)&(4) and 217.13(17).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2965 RHONDA L. LEONARD Certificate No. 583302	CHARGE I. On or about March 17, 2000, while employed with CareStaff of Dallas, Dallas, Texas and on assignment at BHC Millwood Hospital, Arlington, Texas, Respondent engaged in the intemperate use of alcohol in that Respondent had the odor of alcohol on her breath while on duty. The use of alcohol by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. OCC. CODE ANN. § 301.452(b)(9)	Revocation
507-01-2966 ANGELA E. MARTIN Certificate No. 634202	CHARGE I. Respondent failed to comply with the Agreed Order issued to her by the Board of Nurse Examiners for the State of Texas on September 12, 2000. Noncompliance is a result of the Respondent's failure to notify her present employer, Matrix Personnel Services, Houston, Texas, of the Order and the stipulations in effect therein. CHARGE II. During a period of time from September 17, 2000 through October 2000, Respondent failed to comply with the Agreed Order issued to her by the Board of Nurse Examiners for the State of Texas on September 12, 2000. Noncompliance is a result of the Respondent's employment with Matrix Personnel Services, Houston, Texas, as a professional nurse. CHARGE III. On or about September 22, 2000, Respondent failed to comply with the Agreed Order issued to her by the Board of Nurse Examiners for the State of Texas on September 12, 2000. Noncompliance is a result of the Respondent's failure to cause her employer, Matrix Personnel Services, Houston, Texas, to submit a Notification of Employment form to the office of the Board.	TEX. OCC. CODE ANN. § 301.452(b)(1).	Revocation
507-01-2968 HOLLY MEADOWS Certificate No. 638036	CHARGE I. Respondent, on or about August 17, 2000, failed to comply with the Agreed Order issued to her by the Board of Nurse Examiners for the State of Texas on March 25, 1999. Noncompliance is the result of Respondent's failure to comply with all requirements of the Texas Peer Assistance Program for Nurses (TPAPN) contract during its term.	TEX. OCC. CODE ANN. § 301.452(b)(1).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2969 ALICE E. MITCHELL Certificate No. 240765	**CHARGE I.** On or about March 24, 2000, while employed at Hi-Plains Hospital, Hale Center, Texas, Respondent failed to accurately document on the Narcotic Record the wastage of a 50 mg Demerol *carpuject*. Respondent signed out a 50 mg Demerol carpuject at 0540 for Patient Number 36514 and documented the following wastage: ".5mg used" and ".5 mg wasted." Respondent's documentation did not reflect wastage of the remaining 40 mg Demerol. Respondent's conduct was likely to deceive or defraud patients or the public. **CHARGE II.** On or about March 26, 2000, while employed at the aforementioned facility, Respondent signed out 10 mg Morphine Sulfate to Patient Number 36514 at 0100 without a valid physician's order. Respondent's conduct was likely to injure the patient. **CHARGE III.** On or about March 26, 2000, while employed at the aforementioned facility, Respondent signed out 10 mg Morphine Sulfate to Patient Number 36514 at 0100 but failed to document the administration in the Medication Administration Record or the Nurses Notes. Respondent conduct was likely to deceive or defraud patients or the public. **CHARGE IV.** On or about March 9, 2000, while employed at the aforementioned facility, Respondent signed out Morphine Sulfate 10mg to Patient 36514 at 0100, documented the administration of 5mg Morphine Sulfate, but failed to document the wastage of the remaining 5 mg Morphine Sulfate and failed to obtain a co-signature for the wastage on the Narcotic Record.	TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE §§ 217.12(1), (3), (4) and (18).	Revocation
507-01-2970 HUBERT W. MORROW, III Certificate No. 546610	**CHARGE I.** Respondent, on or about July 20, 2000, while employed with Community Medical Center Sherman, Sherman, Texas, engaged in the intemperate use of Alcohol in that Respondent produced a specimen for a drug screen which resulted positive for Ethanol. The use of Alcohol by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. OCC. CODE ANN. §§ 301.452(b)(9) and (13) and 22 TEX. ADMIN. CODE § 217.11(1).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2971 BRENDA S. O'KEEFE Certificate No. 613759	CHARGES I and II. On or about January 14 and 20, 2000, while employed at Plano Rehabilitation Hospital, Plano, Texas, Respondent engaged in the intemperate use of alcohol in that Respondent produced a specimen which tested positive for alcohol. The use of alcohol by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. OCC. CODE ANN. § 301.452(b)(9).	Revocation
507-01-2973 KAREN R. ROGERS Certificate No. 541392	CHARGES I and II. Respondent, on or about November 9, 1999, while employed with Medical Staffing Network, Staff Relief, Houston, Texas, and working at Northeast Medical Center, Houston, Texas, failed to accurately and completely document the administration of the medications she withdrew from the pyxis system for patients on the Medication Administration Record (MAR) and the 24 Hour Patient Notes. Respondent also withdrew medications from the pyxis system for patients without a physician's order. CHARGE III and IV. Respondent, during July and August of 2000, while employed with Medical Staffing Network, Staff Relief, Houston, Texas, and working at Memorial City Hospital, Houston, Texas, failed to accurately and completely document the administration of the medications she withdrew from the pyxis system for patients on the Medication Administration Record (MAR) and the 24 Hour Patient Notes. Respondent also withdrew medications from the pyxis system for patients without a physician's order. CHARGE V. Respondent, on or about February 28, 2001 and March 1, 2001, while employed with Staff Search, Houston, Texas, and working at Memorial Hermann Hospital, Houston, Texas, withdrew Morphine Sulfate from the pyxis system for patients but failed to accurately and completely document the administration of the Morphine Sulfate on the Medication Administration Record (MAR) and the 24 Hour Patient Notes.	TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE §§ 217.12(3) and (4).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2974 DIANE M. SHELLEY Certificate No. 602059	CHARGE I. Respondent, on or about August 24, 2000, while employed with Methodist Hospital, San Antonio, Texas, engaged in the intemperate use of Alcohol in that Respondent produced a specimen for a blood test which resulted positive for Alcohol. The use of Alcohol by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.	TEX. OCC. CODE ANN. §§ 301.452(b)(9) and (13) and 22 TEX. ADMIN. CODE § 217.11(1).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2975 MELISSA M. SLOAN Certificate No. 602086	CHARGE I. Respondent, on or about May and June 1999, while employed with Baylor University Medical Center, Dallas, Texas, withdrew Demerol for patients in excess frequency and dosage of physician's orders and/or failed to follow the facility's policy and procedure for wastage of medications. CHARGE II. Respondent, on or about November 22, 1999, while employed with Baylor University Medical Center, Dallas, Texas, engaged in the intemperate use of Cocaine in that Respondent produced a specimen for a drug screen which resulted positive for Cocaine. Possession of Cocaine is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Cocaine by a Registered 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, judgments, and decisions regarding patient care, thereby placing the patient in potential danger. CHARGE III. Respondent, during August, 2000, while employed with Baylor University Medical Center, Dallas, Texas, misappropriated Demerol by using the Pyxis code of another nurse. Possession of Demerol is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). Respondent's conduct defrauded the facility of the cost of the medication. CHARGE IV. Respondent, on or about August 15-17, 2000, while employed with Baylor University Medical Center, Dallas, Texas, was responsible for numerous discrepancies in the documentation of narcotics administration including failing to document the administration of narcotics she withdrew for patients, withdrawing narcotics for patients in excess frequency and dosage of physician's orders and/or failing to follow the facility's policy and procedure for the wastage of medications.	TEX. REV. CIV. STAT. ANN. art. 4525(b)(9) and TEX. OCC. CODE ANN. §§ 301.452(b)(9), (10) and (13) and 22 TEX. ADMIN. CODE §§ 217.11 (1) and (4), 217.12(3), (18) and (19), and 217.13(3) and (14).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-2976 MATTIE B. WASHINGTON *Certificate No. 518520*	**CHARGE I.** On or about August 15, 2000, Respondent failed to comply with the *Agreed Order* issued by the Board of Nurse Examiners for the State of Texas on June 30, 2000. Noncompliance is the result of Respondent's failure to apply and be accepted into the Texas Peer Assistance Program for Nurses (TPAPN) by August 15, 2000.	TEX. OCC. CODE ANN. §§ 301.452(b)(1).	Revocation
507-01-2977 MARTHA L. WESTON Certificate No. 557435	**CHARGE I.** On or about December 25, 1999, while employed with American Health Care Recruiters, Inc., Metairie, Louisiana, and on assignment at University Medical Center, Lubbock, Texas, Respondent withdrew controlled substances from the Pyxis Medication System without a valid physician's order. **CHARGE II.** On or about December 25, 1999, while employed at the aforementioned facility, Respondent misappropriated Lortab and Morphine Sulfate from the facility and the patients thereof. Respondent's conduct was likely to defraud patients and the public.	TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE §§ 217.12 (3) and (19).	Revocation
507-01-2978 JOYCE W. WILSON Certificate No. 607256	**CHARGE I.** On or about May 27, 1999 through June 7, 1999, while employed at Harvest Care Center of Lumberton, Lumberton, Texas, Respondent signed out butalbital/comp/codeine #3 to Resident #0276 but failed to document the administration of this medication in the Medication Administration Record (MAR).	TEX. REV. CIV. STAT. ANN. art. 4525(b)(9) and 22 TEX. ADMIN. CODE § 217.13 (5).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-3044 TAMMY COX Certificate No. 651532	**CHARGE I.** On or about December 1999 through January 2000, while employed with Lakeridge Rehabilitation and Nursing Center, Lubbock, Texas, Respondent passed or attempted to pass unauthorized prescriptions for Hydrocodone (Lortab-10) at Walgreens Pharmacies in Lubbock, Texas. Possession of Hydrocodone through the use of unauthorized prescriptions is prohibited by Chapter 481 of the Texas Health and Safety Code (Texas Controlled Substances Act). Respondent's conduct was likely to deceive the pharmacies. **CHARGE II.** On or about March 2, 2000, while employed at White Dove Rehabilitation, Littlefield, Texas, Respondent misappropriated 1 tab of Lortab belonging to patient L.S. Respondent's conduct was likely to defraud the patient. **CHARGE III.** On or about February 2000 through May 2000, while employed with Slaton Care Center, Slaton, Texas, Respondent accessed the pyxis machine to obtain narcotics for patients without a physician's order and failed to document the administration of the narcotics on the patient's Medication Administration Record (MAR).	TEX. OCC. CODE ANN. § 301.452(b)(10) and 22 TEX. ADMIN. CODE §§ 217.12 (1), (3), (4)(D) and (E), (19) and (21).	Revocation
507-01-3045 GARY B. ETHRIDGE Certificate No. 594520	**CHARGE I.** On or about May 1, 200, Respondent failed to comply with the Agreed Order issued to him by the Board of Nurse Examiners for the State of Texas on March 15, 2000. Non-compliance is the result of Respondent's failure to apply and be accepted into the TPAPN within 45 days of entry of the Order issued March 15, 2000.	TEX. OCC. CODE ANN. § 301.452(b)(1).	Revocation

SOAH DOCKET No. RESPONDENT and PERMANENT CERTIFICATE No.	SUMMARY OF VIOLATION(S)	STATUTE AND/OR RULE VIOLATED	DISCIPLINARY ACTION
507-01-3097 JAMES S. KELLER Certificate No. 503453	**CHARGE I.** Between February 1997 and July 1998, while employed as Director of Nursing at Pine Shadow Retreat in Porter, Texas, Respondent failed to keep residents free from physical restraint imposed for purposes not required to treat the resident's medical condition. Respondent's conduct was likely to deceive the public regarding the level of care and supervision residents of the facility were receiving, and unnecessarily exposed the patients to the risk of harm. **CHARGE II.** Between February 1997 and July 1998, while employed as Director of Nursing at Pine Shadow Retreat in Porter, Texas, Respondent failed to implement measures to promote a safe environment for residents and staff when he did not enforce and evaluate a safe "Smoking Policy". As a result of Respondent's failure, on April 28, 1997, Resident # 1457 (identified by the initials E.M..) had his clothing catch on fire. The resident was transported to Hermann Hospital in Houston, Texas, where he expired. **CHARGE III.** Between February 1997 and July 1998, while employed as Director of Nursing at Pine Shadow Retreat in Porter, Texas, Respondent failed to supervise the care provided by those for whom he was administratively responsible. Respondent's conduct was likely to injure the patients, and likely led to resident E.M. being set afire in the facility.	TEX. REV. CIV. STAT. ANN. arts. 4525(b)(9) and (12) and 22 TEX. ADMIN. CODE §§ 217.11(8) and 217.13(1) and (10).	Revocation