

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Vocational Nurse §  
License Number 174748 § AGREED  
issued to TERRI JAYNE BROWN-RUBE § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of TERRI JAYNE BROWN-RUBE, Vocational Nurse License Number 174748, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(9),(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 April 14, 2008, by Katherine A. Thomas, MN, RN, Executive Director.

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 vocational nursing in the State of Texas.
4. Respondent received a Certificate in Vocational Nursing from Southwest Technology Center, Altus, Oklahoma, on February 13, 1997. Respondent was licensed to practice vocational nursing in the State of Oklahoma on July 1, 1997. Respondent was licensed to practice vocational nursing in the State of Texas on December 22, 1999.
5. Respondent's vocational nursing employment history includes:  
  
12/1999 - 01/2002                      Unknown

Respondent's vocational nursing employment history continued:

02/2002 - 06/2002	Travel LVN	Medstaff Pennsylvania
06/2002 - 06/2004	Travel LVN	Richards Healthcare Houston, Texas
06/2004 - 12/2004	Charge LVN	LaDora Nursing Home Bedford, Texas
01/2005 - 05/2006	Staff LVN	Healthsouth Cityview Forth Worth, Texas
05/2006 - 10/2006	Staff LVN	The Plaza at Ridgmar Fort Worth, Texas
11/2006	Staff LVN	Westside Campus of Care White Settlement, Texas
12/2006 - 05/2007	Staff LVN	Trinity Mission Health and Rehabilitation of Granbury Granbury, Texas
06/2007 - 08/2007	Staff LVN	Benbrook Nursing and Rehabilitation Benbrook, Texas
08/2007 - 09/2007	Staff LVN	The Estates Healthcare and Rehabilitation Center Fort Worth, Texas
09/2007 - 10/2007	Staff LVN	Trinity Mission Health and Rehabilitation of Burleson Burleson, Texas
11/2007 - 12/2007	Unknown	
01/2008 - 02/2008	Agency LVN	One to One Staffing Haslet, Texas
03/2008 - present	Staff LVN	Trail Lake Nursing and Rehabilitation Center Fort Worth, Texas

6. At the time of the initial incidents, Respondent was employed as a Licensed Vocational Nurse with The Plaza at Ridgmar, Fort Worth, Texas, and had been in this position for approximately three (3) months.
7. On or about August 2006, while employed with The Plaza at Ridgmar, Fort Worth, Texas, Respondent misappropriated Vicodin, or failed to take the necessary precautions to prevent the misappropriation of Vicodin, belonging to the facility and patients thereof. Respondent's conduct was likely to defraud the facility and patients of the cost of the medications.
8. On or about August 2006, while employed with The Plaza at Ridgmar, Fort Worth, Texas, Respondent withdrew Vicodin, from the medication dispensing system for patients without and/or in excess of a valid physician's order. Respondent's conduct was likely to injure the patient in that the administration of Vicodin in excess frequency and/or dosage of the physician's order could result in the patient suffering from adverse reactions.
9. On or about August 2006, while employed with The Plaza at Ridgmar, Fort Worth, Texas, Respondent withdrew Vicodin, from the medication dispensing system for patients, but failed to completely and accurately document the administration of the medications in the patients' Medication Administration Records (MARs), Nurses Notes, or both. Respondent's conduct was likely to injure the patients in that subsequent care givers would rely on her documentation to further medicate the patient which could result in an overdose.
10. On or about August 2006, while employed with The Plaza at Ridgmar, Fort Worth, Texas, Respondent withdrew Vicodin, from the medication dispensing system for patients, but failed to follow the policy and procedure for the wastage of the medications. Respondent's conduct was likely to deceive the hospital pharmacy and placed them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).
11. On or about September 30, 2006, while employed with The Plaza at Ridgmar, Fort Worth, Texas, Respondent engaged in the intemperate use of Hydrocodone in that Respondent produced a specimen for a drug screen which resulted positive for Hydrocodone. Possession of Hydrocodone without a lawful prescription is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Hydrocodone by a 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.
12. On or about November 2006, while employed with Westside Campus of Care, White Settlement, Texas, Respondent withdrew Hydrocodone, from the medication dispensing system for patients, but failed to completely and accurately document the administration of the medication in the patients' Medication Administration Records (MARs), Nurses Notes, or both. Respondent's conduct was likely to injure the patients in that subsequent care givers would rely on her documentation to further medicate the patient which could result in an overdose.

13. On or about November 2006, while employed with Westside Campus of Care, White Settlement, Texas, Respondent withdrew Hydrocodone, from the medication dispensing system for patients in excess frequency and/or dosage of the physician's order. Respondent's conduct was likely to injure the patient in that the administration of Hydrocodone in excess frequency and/or dosage of the physician's order could result in the patient suffering from adverse reactions.
14. On or about November 2006, while employed with Westside Campus of Care, White Settlement, Texas, Respondent withdrew Hydrocodone, from the medication dispensing system for patients, but failed to follow the policy and procedure for the wastage of the medication. Respondent's conduct was likely to deceive the hospital pharmacy and placed them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).
15. On or about November 2006, while employed with Westside Campus of Care, White Settlement, Texas, Respondent misappropriated Hydrocodone or failed to take the necessary precautions to prevent the misappropriation of Hydrocodone, belonging to the facility and patients there of. Respondent's conduct was likely to defraud the facility and patients of the cost of the medications.
16. On or about March 25, 2007 through April 2, 2007, while employed with Trinity Mission Health and Rehabilitation of Granbury, Granbury, Texas, Respondent engaged in the intemperate use of Oxazepam in that Respondent produced a specimen for a drug screen which resulted positive for Oxazepam. Possession of Oxazepam without a lawful prescription is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Oxazepam by a 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.
17. On or about March 25, 2007 through April 2, 2007, while employed with Trinity Mission Health and Rehabilitation of Granbury, Granbury, Texas, Respondent withdrew narcotics from the medication dispensing system for patients, but failed to completely and accurately document the administration of the medications in the patients' Medication Administration Records (MARs), Nurses Notes, or both. Respondent's conduct was likely to injure the patients in that subsequent care givers would rely on her documentation to further medicate the patient which could result in an overdose.
18. On or about March 25, 2007, through April 2, 2007, while employed with Trinity Mission Health and Rehabilitation of Granbury, Granbury, Texas, Respondent misappropriated Hydrocodone, or failed to take the necessary precautions to prevent the misappropriation of Hydrocodone belonging to the facility and patients thereof. Respondent's conduct was likely to defraud the facility and patients of the cost of the medications.

19. On or about March 25, 2007, through April 2, 2007, while employed with Trinity Mission Health and Rehabilitation of Granbury, Granbury, Texas, Respondent withdrew Hydrocodone, from the medication dispensing system for patients, but failed to follow the policy and procedure for the wastage of the medications, in that you admitted to your employer you flushed the pills down the toilet. Respondent's conduct was likely to deceive the hospital pharmacy and placed them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).
20. On or about September 22, 2007, through September 25, 2007, while employed with The Estates Healthcare and Rehabilitation Center, Fort Worth, Texas, Respondent misappropriated Hydrocodone from the facility and patients thereof, in that Respondent admitted to her employer that she cut the Hydrocodone pills from the blister packs and replaced the pills with Tylenol, and she signed out Hydrocodone pills on the Narcotic Control Sheet for a patient that was not in the facility, and in the hospital at the time. Respondent's conduct was likely to defraud the facility and patients of the cost of the medications.
21. On or about October 4, 2007, through October 10, 2007, while employed with Trinity Mission of Burleson, Burleson, Texas, Respondent withdrew Hydrocodone, from the medication dispensing system for patients, but failed to completely and accurately document the administration of the medication in the patients' Medication Administration Records (MARs), Nurses Notes, or both. Respondent's conduct was likely to injure the patients in that subsequent care givers would rely on her documentation to further medicate the patient which could result in an overdose.
22. On or about October 4, 2007, through October 10, 2007, while employed with Trinity Mission of Burleson, Burleson, Texas, Respondent gave the wrong medication to the wrong patient. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in nonefficacious treatment.
23. On or about October 4, 2007, through October 10, 2007, while employed with Trinity Mission of Burleson, Burleson, Texas, Respondent misappropriated Hydrocodone from the facility and patients thereof, in that she signed out Hydrocodone pills on the Narcotic Control Sheet for patients that were not in the facility, and in the hospital at the time. Respondent's conduct was likely to defraud the facility and patients of the cost of the medications.
24. On or about October 4, 2007, through October 10, 2007, while employed with Trinity Mission of Burleson, Burleson, Texas, Respondent engaged in the intemperate use of Hydrocodone in that Respondent produced a specimen for a drug screen which resulted positive for Hydrocodone. Possession of Hydrocodone without a lawful prescription is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Hydrocodone by a 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.

25. On or about February 18, 2008, while employed with One to One Staffing, Haslet, Texas, Respondent withdrew Methadone from the medication dispensing system for patients in excess of the physician's order and you administered the Methadone to Patient Medical Record Number 2459 in excess of the physician's order. Respondent's conduct was likely to injure the patient in that the administration of Methadone in excess frequency and/or dosage of the physician's order could result in the patient suffering from adverse reactions.
26. On or about February 18, 2008, while employed with One to One Staffing, Haslet, Texas, Respondent failed to administer Roxanol to Patient Medical Record Number 2459 as ordered by the physician, in that Respondent administered Methadone to the patient for breakthrough pain instead of Roxanol. Respondent's conduct was likely to injure the patient in that failure to administer medications as ordered by the physician could have resulted in nonefficacious treatment.
27. On or about February 18, 2008, while employed with One to One Staffing, Haslet, Texas, Respondent misappropriated Methadone tablets from the facility and patients thereof, or failed to take the necessary precautions to prevent the misappropriation of the Methadone tablets. Respondent's conduct was likely to defraud the facility and patients of the cost of the medications.
28. On or about February 18, 2008, while employed with One to One Staffing, Haslet, Texas, Respondent engaged in the intemperate use of Methadone and Opiates in that Respondent produced a specimen for a drug screen which resulted positive for Methadone and Opiates. Possession of Methadone and Opiates without a lawful prescription is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Methadone and Opiates by a 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.
29. On or about April 13, 2008, while employed with Trail Lake Nursing and Rehabilitation Center, Fort Worth, Texas, Respondent misappropriated Vicodin belonging to the facility and patients thereof, in that Respondent admitted to misappropriating the Vicodin pills to the Fort Worth Police Department, Fort Worth, Texas. Respondent's conduct was likely to defraud the facility and patients of the cost of the medications.
30. On or about April 13, 2008, while employed with Trail Lake Nursing and Rehabilitation Center, Fort Worth, Texas, Respondent engaged in the intemperate use of Vicodin in that Respondent admitted to consuming the Vicodin, and that she had been dealing with an "addiction problem" for the past twelve (12) years. Possession of Vicodin without a lawful prescription is prohibited by Chapter 481 of the Texas Health & Safety Code (Controlled Substances Act). The use of Vicodin by a 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.

31. The Respondent's conduct described in the preceding Findings of Fact was reportable under the provisions of Sections 301.401-301.419, Texas Occupations Code.
32. The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or chemical dependency.
33. Respondent's conduct described in Findings of Fact Numbers Seven (7) through Thirty (30) resulted from Respondent's dependency on chemicals.
34. Respondent's compliance with the terms of a Board approved peer assistance program should be sufficient to protect patients and the public.

#### CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.455, 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)(9)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(A)(C)(D) and 22 TEX. ADMIN. CODE §217.12(4),(5),(6)(G),(8),(10)(A)(C)(D)(E)&(11(B).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number 174748, heretofore issued to TERRI JAYNE BROWN-RUBE, including revocation of Respondent's license to practice vocational nursing in the State of Texas.
5. The Board may, in its discretion, order a nurse to participate in a peer assistance program approved by the Board if the nurse would otherwise have been eligible for referral to peer assistance pursuant to Section 301.410, Texas Occupations Code.

#### ORDER

IT IS THEREFORE AGREED and ORDERED that RESPONDENT, in lieu of the sanction of Revocation under Section 301.453, Texas Occupations Code, SHALL comply with the following conditions for such a time as is required for RESPONDENT to successfully complete the Texas Peer Assistance Program for Nurses (TPAPN):

RESPONDENT SHALL deliver the wallet-sized license issued to TERRI JAYNE

BROWN-RUBE, to the office of the Texas Board of Nursing within ten (10) days from the date of ratification of this Order for appropriate notation.

(1) RESPONDENT SHALL, within forty-five (45) days following the date of entry of this final Order, apply to TPAPN and SHALL, within ninety (90) days following the date of entry of this final Order, sign and execute the TPAPN participation agreement, which SHALL include payment of a non-refundable participation fee in the amount of three hundred fifty dollars (\$350) payable to TPAPN.

(2) Upon acceptance into the TPAPN, RESPONDENT SHALL waive confidentiality and provide a copy of the executed TPAPN participation agreement to the Texas Board of Nursing.

(3) RESPONDENT SHALL comply with all requirements of the TPAPN participation agreement during its term and SHALL keep her license to practice nursing in the State of Texas current.

(4) RESPONDENT SHALL CAUSE the TPAPN to notify the Texas Board of Nursing of any violation of the TPAPN participation agreement.

IT IS FURTHER AGREED and ORDERED, RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas as amended, Texas Occupations Code, Section §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.01 *et seq.* and this Order.

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

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

Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED, SHOULD RESPONDENT fail to comply with this Order or the terms of the participation agreement with the TPAPN, such noncompliance will result in further disciplinary action including revocation of Respondent's license 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. I do acknowledge possessing a diagnosis that deems me eligible to participate in the Texas Peer Assistance Program for Nurses. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, and Conditions One (1) through Four (4) of this Order to obtain disposition of the allegations through peer assistance and to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes effective upon acceptance by the Executive Director on behalf of the Texas Board of Nursing, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice vocational nursing in the State of Texas, as a consequence of my noncompliance.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
TERRI JAYNE BROWN-RUBE, Respondent

Sworn to and subscribed before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

SEAL

\_\_\_\_\_  
Notary Public in and for the State of \_\_\_\_\_

WHEREFORE PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby accept and enter the Agreed Order that was signed on the \_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by TERRI JAYNE BROWN-RUBE, Vocational Nurse License Number 174748, and said Order is final.

Entered and effective this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

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

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. I do acknowledge possessing a diagnosis that deems me eligible to participate in the Texas Peer Assistance Program for Nurses. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, and Conditions One (1) through Four (4) of this Order to obtain disposition of the allegations through peer assistance and to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes effective upon acceptance by the Executive Director on behalf of the Texas Board of Nursing, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice vocational nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 22 day of Apr., 2008.

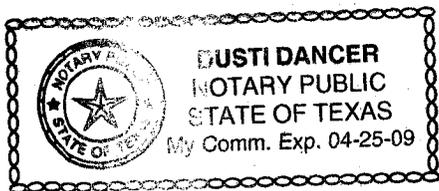
TERRI JAYNE BROWN-RUBE  
TERRI JAYNE BROWN-RUBE, Respondent

Sworn to and subscribed before me this 22<sup>nd</sup> day of APRIL, 2008.

SEAL

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Notary Public in and for the State of TEXAS



WHEREFORE PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby accept and enter the Agreed Order that was signed on the 22nd day of April, 20 08, by TERRI JAYNE BROWN-RUBE, Vocational Nurse License Number 174748, and said Order is final.

Entered and effective this 24th day of April, 20 08.



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