



I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Patricia A. Thomas
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse License §
Number 544606 and Vocational Nurse § AGREED
License Number 114086, issued to §
CATHERINE D. MCAHON § ORDER

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Registered Nurse License Number 544606 and Vocational Nurse License Number 114086, issued to CATHERINE D. MCAHON, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c) of the Texas Occupations Code.

Respondent waived representation by counsel, informal conference and hearing, and agreed to the entry of this Order.

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

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was provided to 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, notice and hearing, and agreed to the entry of this Order.
3. Respondent holds licenses to practice professional and vocational nursing in the State of Texas which are currently on inactive status.
4. Respondent received a Certificate in Vocational Nursing from Odessa College, Odessa, Texas, on May 10, 1985 and received a Diploma in Nursing from Odessa College, Odessa, Texas, in May 1987. Respondent was licensed to practice vocational nursing in the State of Texas on May 22, 1986 and was licensed to practice professional nursing in the State of Texas on March 29, 1988.

5. Respondent's professional and vocational nursing employment history includes:

07/85 - 03/01	GVN/LVN/RN	Medical Center Hospital Odessa, Texas
12/01 - 04/04	Field Supervisor	Nurses Unlimited Abilene, Texas
04/04 - 02/06	Staff Nurse	Hendrick Medical Center Abilene, Texas
03/06 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a Staff Nurse with Hendrick Medical Center, Abilene, Texas, and had been in this position for one (1) year.
7. On or about April 1, 2005, while employed with Hendrick Medical Center, Abilene, Texas, Respondent failed to administer Diflucan IV at 0200 to patient medical record number 542525, as ordered by the physician. The medication was found in the patient's room by the on-coming staff at 1200 a.m. Respondent's conduct was likely to expose the patient unnecessarily to a risk of harm in that missing a dose of Diflucan predisposes the patient to continued infection.
8. On or about April 11, 2005, and April 12, 2005, while employed with Hendrick Medical Center, Abilene, Texas, Respondent was observed by the supervisor to be sleeping while on duty. Respondent's conduct could have affected her ability to recognize subtle signs, symptoms or changes in the patient's condition, and could have affected her ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.
9. On or about August 24, 2005, while employed with Hendrick Medical Center, Abilene, Texas, Respondent administered Cardura and Lortab to Patient Medical Record Number 943278 who was hypotensive, which resulted in the patient's blood pressure reading of 74/30. Respondent's conduct was likely to expose the patient unnecessarily to a risk of harm from medical complications including development of arrhythmia and chest pain.
10. On or about August 25, 2005, while employed with Hendrick Medical Center, Abilene, Texas, Respondent failed to administer Primaxin to Patient Medical Record Number 840682, as ordered by the physician. The Normal Saline was infused; however, the medication vial was not broken or mixed. Respondent's conduct was likely to expose the patient unnecessarily to a risk of harm in that missing a dose of Primaxin predisposes the patient to continued infection.

11. On or about December 19, 2005, while employed with Hendrick Medical Center, Abilene, Texas, Respondent failed to administer Sandostatin at 2100 to Patient Medical Record Number 879306, as ordered by the physician. The medication was found in the refrigerator by the on-coming staff the morning of December 20, 2005. Respondent's conduct was likely to expose the patient unnecessarily to a risk of harm in that it delayed treatment of her disease process.
12. On or about February 2, 2006, while employed with Hendrick Medical Center, Abilene, Texas, Respondent administered Morphine 8mg, Dilaudid 1mg, and Phenergan 25mg IM to patient medical record number 405117 at 0109. The patient became combative and started hallucinating and per Respondent's nursing notes an order for Narcan was received. Respondent failed to document the order for Narcan in the Physician Order Sheet; and she failed to administer the Narcan. Instead, Respondent documented that she administered a placebo of Normal Saline 1cc IM, without a physician's order. Respondent's conduct was likely to expose the patient unnecessarily to a risk of harm from a delay in treatment of her disease process and was likely to deceive subsequent care givers would did not have the benefit of the documented information upon which to base their medical care.
13. Respondent states that she had been physically ill for a long time and her Manager, her co-workers and employee health knew about her condition. She states that after she left her employment at Hendrick Medical Center she was hospitalized with MRSA Pneumonia and she does not remember some of the errors. "As a nurse, I tried to fix any small errors I found. If a medication was due at 7:00 pm and I found it at 7:45pm I would hang it and adjust the time accordingly. I have always tried to do my best in this profession I love. I will also say that I am medically retired at this time, and not anticipating a return to work in a hospital, or area where medication will be given."
14. Respondent, by her signature to this Order, expresses her desire to voluntarily surrender her license to practice nursing in the State of Texas.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violation of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(C)&(1)(D) and 217.12(5).
4. The evidence received is sufficient cause pursuant to Section 301.453(d), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 544806 and Vocational Nurse License Number 114086, heretofore issued to CATHERINE D. MCAHON, including revocation of Respondent's license to practice nursing in the State of Texas.

5. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.
6. Under Section 301.453(d), Texas Occupations Code, as amended, the Board may impose conditions for reinstatement of licensure.
7. Any subsequent reinstatement of this license will be controlled by Section 301.453(d), Texas Occupations Code, and 22 TEX. ADMIN. CODE §213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

ORDER

NOW, THEREFORE, IT IS AGREED and ORDERED that the VOLUNTARY SURRENDER of Registered Nurse License Number 544606 and Vocational Nurse License Number 114086, heretofore issued to CATHERINE D. MCAHON, to practice nursing in the State of Texas, is accepted by the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL immediately deliver the wallet-sized licenses, heretofore issued to CATHERINE D.MCAHON, to the office of the Texas Board of Nursing.
2. RESPONDENT SHALL NOT practice professional or vocational nursing, use the titles "registered nurse and vocational nurse" or the abbreviations "RN" or "LVN" or wear any insignia identifying herself as a registered nurse or a vocational nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a registered nurse or a vocational nurse during the period in which the license is surrendered.
3. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order.
4. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

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

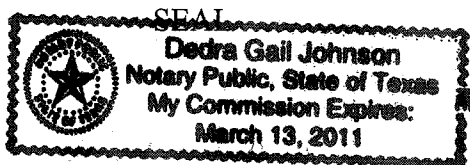
RESPONDENT'S CERTIFICATION

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 becomes final when accepted by the Executive Director at which time the terms of this Order become effective and a copy will be mailed to me.

Signed this 16th day of July, 2008.

Catherine D. McAhon
CATHERINE D. MCAHON, Respondent

Sworn to and subscribed before me this 16th day of July, 2008.



Dedra Gail Johnson
Notary Public in and for the State of 3-13-2011

WHEREFORE, PREMISES CONSIDERED, the Executive Director on behalf of the Texas Board of Nursing does hereby accept the voluntary surrender of Registered Nurse License Number 544606 and Vocational Nurse License Number 114086, previously issued to CATHERINE D. MCAHON.

Effective this 22nd day of July, 2008.



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