BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse	§	AGREED
License Number 699503	§	
issued to NKEMJIKA OBI OFFOR	§	ORDER

TEXAS BOARD OF NURSING
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.
Executive Director of the Board

On this day the Texas Board of Nursing, hereinafter referred to as the Boa considered the matter of NKEMJIKA OBI OFFOR, Registered Nurse License Number 699503, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on March 12, 2011, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license.

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

3. Respondent is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from Austin Community College, Austin, Texas, on May 8, 2003. Respondent was licensed to practice professional nursing in the State of Texas on August 5, 2003.

5. Respondent's nursing employment history includes:

08/2003 - 11/2005	Staff Nurse	St. David's Medical Center Austin, Texas
06/2004 - 10/2004	Staff Nurse	Brackenridge Hospital Austin, Texas

Respondent's nursing employment history continued:

10/2004 - 05/2007	Staff Nurse	Texas Neuro Austin, Texas
08/2006 - 05/2007	Director of Nursing	Regency Village Care Center Austin, Texas
06/2007 - 10/2007	Unknown	
11/2007 - 01/2009	Staff Nurse	Seton Medical Center Austin, Texas
02/2009 - Present	Unknown	

6. On January 22, 2009, Respondent was issued the sanction of Remedial Education through an Agreed Order by the Texas Board of Nursing. A copy of the January 22, 2009 Agreed Order, Findings of Fact, and Conclusions of Law is attached and incorporated, by reference, as part of this Order.

7. At the time of the initial incident in Finding of Fact Number Seven (7), Respondent was employed as a Staff Nurse with Seton Medical Center, Austin, Texas, and had been in this position for six (6) months.

8. On or about May 31, 2008, while employed as a Staff Nurse with Seton Medical Center, Austin, Texas, Respondent failed to transcribe and implement admission orders for Patient Number 873770, who was admitted at 0100 hours, for weakness and shortness of breath, which included the transfusion of two units of PRBCs (packed red blood cells) and lab work. Additionally, Respondent failed to adequately assess and/or document an admission assessment in the patient's medical record. Consequently, Respondent's conduct delayed treatment for Patient Number 873770 until 0400 and resulted in an incomplete medical record on which subsequent caregivers would rely to base ongoing medical care.

9. On or about May 31, 2008, while employed as a Staff Nurse with Seton Medical Center, Austin, Texas, Respondent failed to restart an IV for Patient Number 5236977, after the Charge Nurse discovered that the patient, who was confused, pulled out the IV and instructed Respondent of the need to restart the patient's IV at approximately 0130 hours. At 0630 hours, the oncoming nursing staff discovered that the IV had still not been started. Additionally, although the patient was admitted with symptoms of a stroke, Respondent failed to document a neurological assessment, except to note the patient's level of alertness. Respondent's conduct resulted in a delay of treatment to the patient and created an incomplete medical record on which subsequent caregivers would rely to base their care decisions.

10. On or about June 6, 2008, while employed as a Staff Nurse with Seton Medical Center, Austin, Texas, Respondent failed to timely obtain admission orders for Patient Number 5328228, who was admitted at 2050 hours for treatment of an infected wound. Although the physician's orders were not written until 0130 hours on June 7, 2008, Respondent did not transcribe the orders until 0330 hours, resulting in the patient not receiving medications, including antibiotic medication, until the day shift. Respondent's conduct delayed treatment and was likely to harm the patient from from non-efficacious treatment.

11. On or about June 27, 2008, while employed as a Staff Nurse with Seton Medical Center, Austin, Texas, Respondent erroneously administered Ultram 100mg (Tramadol Hydrocholride) to Patient Number 39763 instead of the ordered dose of Ultram 75mg. Respondent's conduct may have harmed the patient from over-sedation.

12. On or about December 30, 2008, while employed as a Staff Nurse with Seton Medical Center, Austin, Texas, Respondent erroneously administered Morphine 10mg intravenously to Patient Number 383410, when the ordered route was intramuscular (IM). Additionally, Respondent failed to assess the patient's neurovascular status, which was ordered by the physician. Respondent's conduct may have harmed the patient from over-sedation by Morphine, and was likely to harm the patient from the undetected progression of clinical complications of lumbar surgery, including neurovascular deterioration.

13 On or about January 5, 2009, while employed as a Staff Nurse with Seton Medical Center, Austin, Texas, Respondent failed to timely assess and notify the Charge Nurse or Critical Response team when the condition of Patient Number 5267429 continued to deteriorate. Patient Number 5267429 experienced critically low blood pressure, increased respirations, diminished urinary output, and the patient was diaphoretic. Despite the patient's critical and worsening condition, Respondent failed to assess or document an assessment in the patient's medical record after midnight and failed to document the patient's intake or output throughout his shift. At 0636 hours, the Rapid Response Team was called when the Charge Nurse noted that the patient was diaphoretic, had gasping respirations and a rapid heart rate, had zero blood pressure, and a critically low oxygen saturation level. The patient was transferred to the ICU and was pronounced deceased later that day. Respondent's conduct resulted in an inaccurate, incomplete medical record, and may have contributed to the patient's demise.

14. In response to the incidents in Findings of Fact Numbers Eight (8) through Thirteen (13), Respondent states that he was very busy during this shift and expected the Charge Nurse, who usually helped with admissions by transcribing and implementing admission orders, to assist with the admission of Patient Number 873770, however she did not. Respondent explains that when he was instructed by the Charge Nurse to restart the peripheral IV of Patient Number 5236977, he was unsuccessful because the patient's veins were extremely difficult to locate. Respondent adds that he informed the Charge Nurse and both the Charge Nurse and a nurse from the IV Team were also unable to restart the patient's IV. According to Respondent, when Patient Number 5328228 arrived without admission orders he informed the physician of the situation, however, the physician told him that she was busy in the

Emergency Department. Respondent reports that when the physician eventually arrived and wrote orders, they were immediately copied and sent to the pharmacy, which generates a Medication Administration Record (MAR); however, the MAR was not generated and the pharmacy's explanation was that the orders must have gotten lost during shift change. Respondent admits that he erroneously administered too much Ultram to Patient Number 39763 and explains that he was temporarily distracted by a patient who had fallen. Respondent asserts that he administered Morphine IM, as ordered, into the right thigh of Patient Number 383410. Regarding Patient Number 5267429, Respondent states that he was informed in shift report that the patient was dying. According to Respondent, at about 0130 hours, he expressed concern to the Charge Nurse about his patient load and the appropriateness of Patient Number 5267429 being assigned to their floor. Respondent contends that he checked on the patient hourly because she was non-verbal and appeared to be sleeping most of the night. Respondent adds that the patient's prognosis was very poor, but her vital signs were steady, her breath sounds were even and unlabored, her heart sounds were regular, and her urinary output was more than 30 ml per hour. Respondent states that at around 0630 hours, he asked the Charge Nurse for assistance with the patient and she found the patient hyperventilating, a code was called, and the patient was revived and transferred to the Intensive Care Unit (ICU). Respondent concludes that in hindsight, he should have been a stronger patient advocate and insisted that, because of the patient's illness and poor prognosis, she be transferred to the ICU, a unit better equipped for her situation, and asserts that he will now be a better patient advocate than he was for this patient.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A),(1)(B)&(1)(C),(1)(D),(1)(M),(1)(P)&(3)(A) and 217.12(1)(A),(1)(B)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 699503, heretofore issued to NKEMJIKA OBI OFFOR, including revocation of Respondent's license(s) to practice professional nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a REPRIMAND WITH STIPULATIONS, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act,

Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER AGREED and ORDERED that, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a nurse licensure compact 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 that:

(1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding Sexual Misconduct, Fraud, Theft and Deception, Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder, and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses

stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Information regarding Board-approved courses in Texas Nursing Jurisprudence may be found at the Board's website Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be*

found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in physical assessment. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. RESPONDENT SHALL perform physical assessments on live patients in a clinical setting for a minimum of twenty-four (24) hours. The clinical component SHALL focus on tasks of physical assessment only and shall be provided by the same Registered Nurse who provides the didactic portion of this course. To be approved, the course shall cover all systems of the body. Performing assessments on mock patients or mannequins WILL NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home

study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Nurses. The course shall include content on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(5) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Information regarding this workshop may be found at the following web address: http://learningext.com/hives/a0f6f3e8a0/summary.*

IT IS FURTHER AGREED, SHOULD RESPONDENT PRACTICE AS A NURSE IN THE STATE OF TEXAS, RESPONDENT WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING AND

RESPONDENT MUST WORK IN SUCH SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING STIPULATIONS FOR TWO (2) YEARS OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWENTY-FOUR (24) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) LICENSE WILL NOT APPLY TO THIS STIPULATION PERIOD:

(6) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the stipulations on RESPONDENT'S license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(7) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within five (5) days of employment as a nurse.

(8) For the first year of employment as a Registered Nurse under this Order, RESPONDENT SHALL be directly supervised by a Registered Nurse. Direct supervision requires another professional nurse to be working on the same unit as RESPONDENT and immediately

available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). The RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(9) For the remainder of the stipulation period, RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(10) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for two (2) years of employment as a nurse.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of License Number 699503	§	AGREED
issued to NKEMJIKA OBI OFFOR	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of NKEMJIKA OBI OFFOR, Registered Nurse License Number 699503, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on November 11, 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 proceedings, notice and hearing, and agreed to the entry of this Order.

3. Respondent is currently licensed to practice professional nursing in the State of Texas.

4. Respondent received an Associate Degree in Nursing from Austin Community College, Austin, Texas, in May 2003. Respondent was licensed to practice professional nursing in the State of Texas on August 5, 2003.

5. Respondent's professional nursing employment history includes:

08/03 - 11/05	Staff Nurse	St. David's Hospital Austin, Texas
10/04 - 08/06	Staff Nurse	Texas NeuroRehab Center - Blue Bonnet Austin, Texas

Respondent's professional nursing employment history continued:

08/06 - 05/07	Director of Nursing	Regency Village Care Center Austin, Texas
06/07 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as Director of Nursing with Regency Village Care Center, Austin, Texas, and had been in this position for one (1) year and one (1) month.

7. On or about March 2007, while employed with Regency Village Care Center, Austin, Texas, Respondent failed to follow the policy and procedure in effect at the facility for the wastage of drugs, including controlled substances. Respondent destroyed medications without a witness which resulted in a failure to have the wastage co-signed. Respondent's conduct was likely to deceive the facility and it's consultant pharmacist and placed them in violation of Chapters 481 and 483 of the Texas Health and Safety Code (Controlled Substances Act and Dangerous Drug Act).

8. Respondent states that during his interview he was told by the Regional Manager that he would be going to a sister facility, Regency Village Care Center, Waco, Texas for two weeks to give him a bird's eye view of how things were done since it was all new to him. "I was as green as they come". After he was hired the plan changed and he was left to figure everything out on his own and fend for himself. He was employed as the Director of Nursing (DON) from February 2006 to May 2007. During his employment there was very limited storage space available for drugs that were to be destroyed. He talked to the pharmacist about destroying medications once a month. Sometime in March 2007, a clean-cut, well-groomed white woman walked into his office and inquired if they had any drugs for destruction. He told her yes, they had a lot of them. The Assistant DON was in the office they shared and he stated "We have been waiting for you". The woman then began to back out of the doorway and told us "Why don't you two go ahead and I'll be right back." "With the help of Mr. Cotton I destroyed the drugs. About a week or two later the chief pharmacist was in my office and asked about the boxes still there and I told him. He reported to the administrator that, according to him, he could not sign off on the destruction of the drugs because there was no pharmacist present at the time of destruction. I was reported to the state, who conducted an investigation. I was absolved of any wrongdoing in that investigation."

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 a violation of Section 301.452(b)(10), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.12(10)(C).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 699503, heretofore issued to NKEMJIKA OBI OFFOR, including revocation of Respondent's license to practice professional nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of REMEDIAL EDUCATION, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code §§301.001 *et seq.*, the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq.* and this Order.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate licensure privilege, if any, to practice professional 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 State of Texas and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL deliver the wallet-sized license issued to NKEMJIKA OBI OFFOR to the office of the Texas Board of Nursing within ten (10) days of the date of ratification of this Order.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is not being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) contact hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in "Regulatory Requirements for Drug Therapy in The Nursing Facility," a 6.25 contact hour workshop presented in various locations by the Texas Department of Aging and Disability Services. In order to receive credit for completion of this workshop, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this workshop to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure.

Information regarding this workshop may be found at the following website: http://www.dads.state.tx.us/providers/training/jointtraining.cfm or by contacting (512) 438-2201.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, RESPONDENT SHALL be issued an unencumbered license and multistate licensure privileges, if any, to practice professional 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 violation 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 when this Order becomes final and the terms of this Order become effective, 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 professional nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 15 day of January, 2009.

NKEMJIKA OBLOFFOR, Respondent

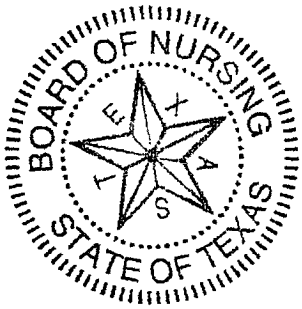
Sworn to and subscribed before me this 15th day of January, 2009.

SEAL

Notary Public in and for the State of Texas

Elizabeth Louise Lawrence
Notary Public, State of Texas
My Commission Expires:
May 2, 2010

WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby ratify and adopt the Agreed Order that was signed on the 15th day of January, 2009, by NKEMJIKA OBI OFFOR, Registered Nurse License Number 699503, and said Order is final.



Effective this 22nd day of **January**, **2009**.

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. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice professional nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 28 day of March, 2011.

NKEMJIKA OBI OFFOR, Respondent

Sworn to and subscribed before me this 28th day of March, 2011.

ASHLEY M JONES
My Commission Expires
December 17, 2011

Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 28th day of March, 2011, by NKEMJIKA OBI OFFOR, Registered Nurse License Number 699503, and said Order is final.

Effective this 10th day of May, 2011.

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