



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

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse § AGREED
License Number 724665 §
issued to KEVIN BADON § ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of KEVIN BADON, Registered Nurse License Number 724665, 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 informal proceedings, notice and hearing, and agreed to the entry of this Order offered on November 16, 2010, 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(s).
2. Respondent waived 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 a Baccalaureate Degree in Nursing from Dillard University, New Orleans, Louisiana, on May 11, 1998. Respondent was licensed to practice professional nursing in the State of Texas on February 13, 2006.
5. Respondent's nursing employment history includes:

1998 - 2000 Staff Nurse Children's Hospital
New Orleans, Louisiana

1998 - 2001 Staff Nurse/ED Memorial Medical Center
New Orleans, Louisiana

Respondent's nursing employment history continued:

1999 - 2000	Staff Nurse/ER	Medical Center of Louisiana New Orleans, Louisiana
2000 - 2003	Staff Nurse	Lakeland Medical Center New Orleans, Louisiana
10/01 - 04/03	Nurse Manager Emergency Department	Children's Hospital New Orleans, Louisiana
04/03 - 06/03	Nurse Manager Emergency Department	St. Charles General Hospital New Orleans, Louisiana
06/03 - 12/04	Director of Specialty Care Departments	St. Charles General Hospital New Orleans, Louisiana
2003 - 12/04	Staff Nurse	Lakeside Hospital Metairie, Louisiana
01/04 - 01/05	Adjunct Professor	Dillard University New Orleans, Louisiana
01/05 - 08/05	Staff Nurse Emergency Department	Veterans Administration Medical Center New Orleans, Louisiana
09/05 - 01/06	Clinical Nurse	Michael E DeBakey VA Medical Center Houston, Texas
01/06 - 11/07	Charge Nurse	Memorial Hermann Northwest Hospital Houston, Texas
2008 - Present	Clinical Educator	Michael E DeBakey VA Medical Center Houston, Texas

6. At the time of the initial incident, Respondent was employed as a Staff Nurse with Memorial Hermann Northwest, Houston, Texas, and had been in this position for two (2) months.
7. On or about March 20, 2006 through May 8, 2006, while employed with Memorial Hermann Northwest, Houston, Texas, Respondent withdrew Xanax from the medication dispensing system (Pyxis) for patients without valid physician's order, as follows:

Date	Patient	Physician's Order	Pyxis Records	Emergency Room Records (Dispensed Medications)
03-20-06	966078	No Order	Xanax TAB 0.25mg 0516 (1)	Not Documented as Given
04-02-06	706091	No Order	Xanax TAB 0.25mg 0533 (1)	0543 Entry: Care Complete, Discharge Ordered
04-06-06	836096	No Order	Xanax TAB 0.25mg 0421 (1)	Not Documented as Given
04-07-06	786097	No Order	Xanax TAB 0.25mg 0525 (1)	Not Documented as Given
04-16-06	286106	No Order	Xanax TAB 0.25mg 0255 (2)	Not Documented as Given
05-03-06	936123	No Order	Xanax TAB 0.25mg 1955 (2)	1956 Entry: Documented 0.5mg Given
05-03-06	086123	No Order	Xanax TAB 0.25mg 2218 (2)	Not Documented as Given
05-06-06	486125	No Order	Xanax TAB 0.25mg 0044 (2)	Not Documented as Given
05-08-06	036127	No Order	Xanax TAB 0.25mg 0257 (2)	Not Documented as Given
05-08-06	926135	No Order	Xanax TAB 0.25mg 0304 (2)	Not Documented as Given

Respondent's conduct was likely to injure the patient, in that the administration of Xanax without a valid physician's order could result in the patient suffering adverse effects.

8. On or about March 20, 2006 through May 8, 2006, while employed with Memorial Hermann Northwest, Houston, Texas, Respondent withdrew Xanax from the medication dispensing system (Pyxis), for patients, but failed to document, or accurately document the administration of the medication in the patient's Emergency Department Record, as follows:

Date	Patient	Physician's Order	Pyxis Record	Emergency Department Record (Dispensed Medications)
03-20-06	966078	No Order	Xanax TAB 0.25mg 0516 (1)	Not Documented as Given
04-02-06	706091	No Order	Xanax TAB 0.25mg 0533 (1)	0543 Entry: Care Complete, Discharge Ordered
04-06-06	836096	No Order	Xanax TAB 0.25mg 0421 (1)	Not Documented as Given
04-07-06	786097	No Order	Xanax TAB 0.25mg 0525 (1)	Not Documented as Given

04-16-06	286106	No Order	Xanax TAB 0.25mg 0255 (2)	Not Documented as Given
05-03-06	936123	No Order	Xanax TAB 0.25mg 1955 (2)	1956 Entry: Documented 0.5mg Given
05-03-06	086123	No Order	Xanax TAB 0.25mg 2218 (2)	Not Documented as Given
05-06-06	486125	No Order	Xanax TAB 0.25mg 0044 (2)	Not Documented as Given
05-08-06	036127	No Order	Xanax TAB 0.25mg 0257 (2)	Not Documented as Given
05-08-06	926135	No Order	Xanax TAB 0.25mg 0304 (2)	Not Documented as Given

Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on his documentation to further medicate the patient which could result in an overdose.

9. On or about March 20, 2006 through May 8, 2006, while employed with Memorial Hermann Northwest, Houston, Texas, Respondent withdrew Xanax from the medication dispensing system (Pyxis) for patients, but failed to follow the facility's policy and procedure for wastage of any of the unused portions of the medications, as follows:

Date	Patient	Physician's Order	Pyxis Record	Emergency Department Record (Dispensed Medications)	Wastage
03/20/06	966078	No Order	Xanax TAB 0.25mg 0516 (1)	Not Documented as Given	Not Documented
04/02/06	706091	No Order	Xanax TAB 0.25mg 0533 (1)	0543 Entry: Care Complete, Discharge Ordered	Not Documented
04/06/06	836096	No Order	Xanax TAB 0.25mg 0421 (1)	Not Documented as Given	Not Documented
04/07/06	786097	No Order	Xanax TAB 0.25mg 0525 (1)	Not Documented as Given	Not Documented
04/16/06	286106	No Order	Xanax TAB 0.25mg 0255 (2)	Not Documented as Given	Not Documented
05/03/06	936123	No Order	Xanax TAB 0.25mg 1955 (2)	1956 Entry: Documented 0.5mg Given	Not Documented
05/03/06	086123	No Order	Xanax TAB 0.25mg 2218 (2)	Not Documented as Given	Not Documented
05/06/06	486125	No Order	Xanax TAB 0.25mg 0044 (2)	Not Documented as Given	Not Documented
05/08/06	036127	No Order	Xanax TAB 0.25mg 0257 (2)	Not Documented as Given	Not Documented
05/08/06	926135	No Order	Xanax TAB 0.25mg 0304 (2)	Not Documented as Given	Not Documented

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).

10. During September 2, 2007 through October 27, 2007, while employed with Memorial Hermann Northwest, Houston, Texas, Respondent withdrew Diphenhydramine from the medication dispensing system (Pyxis) for patients without a physician's order, as follows:

Date	Patient	Physician's Order	Pyxis Record	Emergency Department Records (Dispensed Medications)
09/02/07	67245	No Order	0334 (1) Diphenhydramine	Not Documented
09/03/07	57245	No Order	0340 (2) Diphenhydramine	0344 Entry: Patient left ED
09/05/07	77247	No Order	0158 (1) Diphenhydramine	Not Documented
09/05/07	07248	No Order	0437 (2) Diphenhydramine	Not Documented
09/14/07	577257	No Order	0555 (1) Diphenhydramine	Not Documented
09/15/07	17258	No Order	0529 (1) Diphenhydramine	Not Documented
09/16/07	977259	No Order	0510 (1) Diphenhydramine	Not Documented
09/16/07	977259	No Order	0629 (1) Diphenhydramine	Not Documented
09/22/07	77265	No Order	0612 (2) Diphenhydramine	0453 Entry: Patient left ED
09/28/07	47270	No Order	0456 (2) Diphenhydramine	0320 Entry: Patient left ED
10/08/07	57280	No Order	0118 (2) Diphenhydramine	Not Documented
10/15/07	67288	No Order	0122 (1) Diphenhydramine	Not Documented
10/17/07	07289	No Order	0544 (2) Diphenhydramine	Not Documented
10/22/07	17294	No Order	0451 (1) Diphenhydramine	0435 Entry: Patient left ER
10/27/07	27300	No Order	0328 (1) Diphenhydramine	Not Documented

Respondent's conduct was likely to injure the patient, in that the administration of Diphenhydramine without a valid physician's order could result in the patient suffering adverse effects.

11. On or about September 2, 2007 through October 27, 2007, while employed with Memorial Hermann Northwest, Houston, Texas, Respondent withdrew Diphenhydramine and Morphine from the medication dispensing system (Pyxis) for patients, but failed to accurately and completely document the administration of the medications in the patient's Emergency Department Record, as follows:

Date	Patient	Physician's Order	Pyxis Record	Emergency Department Records (Dispensed Medications)
09/02/07	67245	No Order	0334 (1) Diphenhydramine	Not Documented
09/03/07	57245	No Order	0340 (2) Diphenhydramine	0344 Entry: Patient left ED
09/05/07	77247	No Order	0158 (1) Diphenhydramine	Not Documented
09/05/07	07248	No Order	0437 (2) Diphenhydramine	Not Documented
09/14/07	577257	No Order	0555 (1) Diphenhydramine	Not Documented
09/15/07	17258	No Order	0529 (1) Diphenhydramine	Not Documented
09/16/07	977259	No Order	0510 (1) Diphenhydramine	Not Documented
09/16/07	977259	No Order	0629 (1) Diphenhydramine	Not Documented
09/22/07	77265	No Order	0612 (2) Diphenhydramine	0453 Entry: Patient left ED
09/28/07	47270	No Order	0456 (2) Diphenhydramine	0320 Entry: Patient left ED
10/08/07	57280	No Order	0118 (2) Diphenhydramine	Not Documented
10/15/07	67288	No Order	0122 (1) Diphenhydramine	Not Documented
10/15/07	27289	Morphine 2-4mg IV q2-4h PRN	0129 (1) Morphine 2mg	0129 Entry: Given by [p] Primary Nurse
10/15/07	27289	Morphine 2-4mg IV q2-4h PRN	0130 (1) Morphine 2mg	Not Documented
10/17/07	07289	No Order	0544 (2) Diphenhydramine	Not Documented
10/22/07	17294	No Order	0451 (1) Diphenhydramine	0435 Entry: Patient left ER
10/27/07	27300	Not Order	0328 (1) Diphenhydramine	Not Documented

Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation to further medicate the patient which could result in an overdose.

12. On or about September 2, 2007 through October 27, 2007, while employed with Memorial Hermann Northwest, Houston, Texas, Respondent withdrew Diphenhydramine and Morphine from the medication dispensing system (Pyxis), but failed to follow the policy and procedure for wastage of the unused portion of the medications, as follows:

Date	Patient	Physician's Order	Pyxis Record	Emergency Department Record (Dispensed Medications)	Wastage
09/02/07	67245	No Order	0334 (1) Diphenhydramine	Not Documented	None Documented
09/03/07	57245	No Order	0340 (2) Diphenhydramine	0344 Entry: Patient left ED	None Documented
09/05/07	77247	No Order	0158 (1) Diphenhydramine	Not Documented	None Documented

09/05/07	07248	No Order	0437 (2) Diphenhydramine	Not Documented	None Documented
09/14/07	77257	Morphine 2mg IV	0445 (1) Morphine 8mg	0452 Entry: 2mg given	None Documented
09/14/07	577257	No Order	0555 (1) Diphenhydramine	Not Documented	None Documented
09/15/07	17257	Morphine 8mg IV	0147 (1) Morphine 8mg	0147 Entry: 2mg given	None Documented
09/15/07	17258	No Order	0529 (1) Diphenhydramine	Not Documented	None Documented
09/16/07	977259	No Order	0510 (1) Diphenhydramine	Not Documented	None Documented
09/16/07	977259	No Order	0629 (1) Diphenhydramine	Not Documented	None Documented
09/22/07	77265	No Order	0612 (2) Diphenhydramine	0453 Entry: Patient left ED	None Documented
09/28/07	47270	No Order	0456 (2) Diphenhydramine	0320 Entry: Patient left ED	None Documented
09/28/07	47271	Morphine 2mg IV	2243 (1) Morphine 8mg	No Records	None Documented
10/08/07	57280	No Order	0118 (2) Diphenhydramine	Not Documented	None Documented
10/15/07	67288	No Order	0122 (1) Diphenhydramine	Not Documented	None Documented
10/15/07	27289	Morphine 2-4mg IV q2-4h PRN	0129 (1) Morphine 2mg	0129 Entry: Given by Ip1 (Primary Nurse)	None Documented
10/15/07	27289	Morphine 2-4mg IV q2-4h PRN	0130 (1) Morphine 2mg	Not Documented	None Documented
10/17/07	07289	No Order	0544 (2) Diphenhydramine	Not Documented	None Documented
10/22/07	17294	No Order	0451 (1) Diphenhydramine	0435 Entry: Patient left ER	None Documented
10/27/07	27300	No Order	0328 (1) Diphenhydramine	Not Documented	None Documented

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).

13. In response to Findings of Fact Numbers Seven (7) through Twelve (12), Respondent states that any Pyxis, dispensing, wastage, documentation and other errors which may have occurred took place without his knowledge or participation. As the charge nurse, he was responsible for precepting nurses new to the emergency unit at Memorial Hermann Northwest. Incoming nurses were supposed to be assigned their own Pyxis ID by the pharmacy department, however, a delay in this process could lead to new nurses working their first shifts under a preceptor without yet being assigned an ID. In such an event, the new nurse would remove medications from the Pyxis using their preceptor's Pyxis code. As a result of this practice many of the staff nurses in the Memorial Hermann ER were aware of the his Pyxis code. He believes that, if true, the above noted discrepancies occurred due to another nurse using his Pyxis ID to remove medications without his knowledge. The Pyxis machines at the Memorial Hermann ER were also known to experience malfunctions where nurses withdrawing medications could inadvertently do so under the ID of the last person to use the machine. This also could have contributed to any errors. Finally, Respondent states that he voluntarily submitted a drug screen in reference to the 2006 allegations which was negative. When confronted with the 2007 allegations, he offered another drug screen. Memorial Hermann did not follow through on this offer as his supervisors did not believe he was diverting or misappropriating any medications.
14. Charges were filed on January 15, 2009.
15. Charges were mailed to Respondent on January 16, 2009.

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),(C)&(D) and 217.12 (4),(6)(G),(8),(10)(B)&(C)&(11)(B).
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 724665, heretofore issued to KEVIN BADON, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a WARNING 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 this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, 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. *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 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>.*

(3) 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>

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 ONE (1) YEAR

OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) 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:

(4) RESPONDENT SHALL CAUSE each employer to immediately submit any and all incident, counseling, variance, unusual occurrence, and medication or other error reports involving RESPONDENT, as well as documentation of any internal investigations regarding action by RESPONDENT, to the attention of Monitoring at the Board's office.

(5) RESPONDENT SHALL abstain from the consumption of alcohol, Nubain, Stadol, Dalgan, Ultram, or other synthetic opiates, and/or the use of controlled substances, except as prescribed by a licensed practitioner for a legitimate purpose. If prescribed, RESPONDENT SHALL CAUSE the licensed practitioner to submit a written report identifying the medication, dosage and the date the medication was prescribed. The report shall be submitted directly to the office of the Board by the prescribing practitioner, within ten (10) days of the date of the prescription. **In the event that prescriptions for controlled substances are required for periods of two (2) weeks or longer, the Board may require and RESPONDENT SHALL submit to an evaluation by a Board approved physician specializing in Pain Management or Psychiatry. The performing evaluator will submit a written report to the Board's office, including results of the evaluation, clinical indications for the prescriptions, and recommendations for on-going treatment within thirty (30) days from the Board's request.**

(6) RESPONDENT SHALL submit to random periodic screens for controlled substances, tramadol hydrochloride (Ultram), and alcohol. For the duration of the stipulation period, random screens shall be performed at least once per month. All random screens SHALL BE conducted through urinalysis. Screens obtained through urinalysis are the sole method accepted by the Board.

Specimens shall be screened for at least the following substances:

Amphetamines	Meperidine
Barbiturates	Methadone
Benzodiazepines	Methaqualone
Cannabinoids	Opiates
Cocaine	Phencyclidine
Ethanol	Propoxyphene
tramadol hydrochloride (Ultram)	

A Board representative may appear at the RESPONDENT'S place of employment at any time during the stipulation period and require RESPONDENT to produce a specimen for screening.

All screens shall be properly monitored and produced in accordance with the Board's policy on Random Drug Testing. A complete chain of custody shall be maintained for each specimen obtained and analyzed. RESPONDENT SHALL be responsible for the costs of all random drug screening during the stipulation period.

Any positive result for which the nurse does not have a valid prescription or failure to report for a drug screen, which may be considered the same as a positive result, will be regarded as non-compliance with the terms of this Order and may subject the nurse to further disciplinary action including EMERGENCY SUSPENSION pursuant to Section 301.4551, Texas Occupations Code, or REVOCATION of Respondent's license(s) and nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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.

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RESPONDENT'S CERTIFICATION

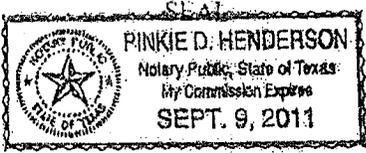
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid 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(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 16 day of NOV, 2010


KEVIN BADON, Respondent

Sworn to and subscribed before me this 16th day of November, 2010





Notary Public in and for the State of TEXAS

Approved as to form and substance.


Dan Lye, Attorney for Respondent

Signed this 16 day of November, 2010.

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 16th day of November, 2010, by KEVIN BADON, Registered Nurse License Number 724665, and said Order is final.

Effective this 8th day of March, 2011.



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

