

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of Registered Nurse § AGREED
License Number 709316 §
issued to SONYA RENEE STERLING § ORDER



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 P. Thomas
Executive Director of the Board

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Registered Nurse License Number 709316, issued to SONYA RENEE STERLING, 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 proceedings, notice 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, 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 McClennan County Community College, Waco, Texas, on May 6, 2004. Respondent was licensed to practice professional nursing in the State of Texas on August 26, 2004.
5. Respondent's professional nursing employment history includes:

08/2004 - 08/2009	RN	Providence Hospital Waco, Texas
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Respondent's professional nursing employment history continued:

08/2009 - 09/2009	RN	Goodall - Witcher Hospital Clifton, Texas
10/2009 - 12/2009	RN	Scott & White Memorial Hospital Temple, Texas
01/2010 - 04/2010	RN	Lighthouse Nursing Agency Killeen, Texas
05/2010 - Present	RN	City of Waco-Health Department Waco, Texas

6. At the time of the initial incident, Respondent was employed as a Registered Nurse with Providence Health Center, Waco, Texas and had been in this position for four (4) years and nine (9) months.
7. On or about June 11, 2009, while employed as a Registered Nurse with Providence Health Center, Waco, Texas, Respondent withdrew Morphine from the Medication Dispensing System (Omniceil) for Patient Medical Record Number 600203 without a valid physician's order. Respondent's conduct was likely to injure the patient, in that the administration of Morphine, without a valid physician's order, could result in the patient suffering from adverse reactions.
8. On or about June 11, 2009, while employed as a Registered Nurse with Providence Health Center, Waco, Texas, Respondent withdrew Morphine from the Medication Dispensing System (Omniceil) for Patient Medical Record Number 600203 but failed to document, or accurately document the administration of the medication in the patient's Medication Administration Records and/or nurse's notes. 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.
9. On or about June 11, 2009, while employed as a Registered Nurse with Providence Health Center, Waco, Texas, Respondent withdrew Morphine from the Medication Dispensing System (Omniceil) for Patient Medical Record Number 600203 but failed to follow the facility's policy and procedure for wastage of any of the unused portions 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).
10. On or about June 11, 2009, while employed as a Registered Nurse with Providence Health Center, Waco, Texas, Respondent misappropriated Morphine from the facility and patients thereof, or failed to take precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients of the cost of medications.

11. In response to Findings of Fact Numbers Seven (7) through Ten (10), Respondent states: "I have no memory of this incident happening. I can say that during the past year, Providence Emergency Room has seen an influx of patients and I had voluntarily been working six days a week. My only explanation for this incident is that I received a verbal order from the doctor, and instead of immediately documenting the order and having the chart in hand when I gave the medication, I walked off, medicated the patient and dropped the medication in the sharps container in the room. When I left the room, I must have forgotten to chart the order, medication, and waste. I admit that this is poor nursing practice and I am making every effort possible to avoid verbal orders. I ask the doctors to come and chart any medication himself/herself and I carry that chart with me when giving all medications. I also make sure to have a licensed nurse witness all medication wastes. I no longer waste medications in a room."
12. On or about July 12, 2009, while employed as a Registered Nurse with Providence Health Center, Waco, Texas, Respondent withdrew Morphine from the Medication Dispensing System (Omniceil) for Patient Medical Record Number 505830 but failed to document, or accurately document the administration of the medication in the patient's Medication Administration Records and/or nurse's notes. 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.
13. On or about July 12, 2009, while employed as a Registered Nurse with Providence Health Center, Waco, Texas, Respondent withdrew Morphine from the Medication Dispensing System (Omniceil) for Patient Medical Record Number 505830 but failed to follow the facility's policy and procedure for wastage of any of the unused portions 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).
14. On or about July 12, 2009, while employed as a Registered Nurse with Providence Health Center, Waco, Texas, Respondent misappropriated Morphine from the facility and patients thereof, or failed to take precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients of the cost of medications.
15. In response to Findings of Fact Numbers Twelve (12) through Fourteen (14), Respondent states: "As to July 12, 2009, I believe that once again I used poor nursing practice and that the explanation in allegation number one is the same as this."
16. On or about August 11, 2009, while employed as a Registered Nurse with Providence Health Center, Waco, Texas, but not on duty, Respondent accessed the medication room and withdrew Morphine 10mg from the Medication Dispensing System (Omniceil) for her son, Patient Medical Record Number 727193. Additionally, Respondent admitted that she signed out the medication under her son's name. Respondent's conduct was likely to injure the patient, in that the administration of Morphine, without a valid physician's order, could result in the patient experiencing adverse reactions.

17. In response to Finding of Fact Number Sixteen (16), Respondent states: "I made extremely poor choices on this day. I brought my son to the ER and he was being treated for a severe headache. The doctor had given him 2mg of Morphine IVP. I waited for 45 minutes with my crying son and called for the nurse a couple of times. No one came to the room. I then took it upon myself to go and withdraw the Morphine from the Omnicell and went into the room to administer it myself. Upon returning to the room, a nurse was in the room giving him Lortab Elixir, PO. I walked over and dropped the medication in the sharps container and intended on wasting it. The doctor came in and spoke with me about the discharge and I honestly forgot. When questioned about it, I admitted I withdrew the medication and was fired."
18. On or about September 4, 2009, while employed as a Registered Nurse with Goodall-Witcher Hospital, Clifton, Texas Respondent withdrew Morphine and Demerol from the Medication Dispensing System for Patient Medical Record Number 064110 in excess dosage of physician's orders. Respondent's conduct was likely to injure the patients, in that the administration of Morphine and Demerol in excess dosage of the physician's order could result in the patients experiencing adverse reactions.
19. On or about September 4, 2009, while employed as a Registered Nurse with Goodall-Witcher Hospital, Clifton, Texas Respondent withdrew Morphine and Demerol from the Medication Dispensing System for Patient Medical Record Number 064110, but failed to document, or accurately document the administration of the medication in the patients Medication Administration Records and/or nurse's notes. 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.
20. On or about September 4, 2009, while employed as a Registered Nurse with Goodall-Witcher Hospital, Clifton, Texas Respondent withdrew Morphine and Demerol from the Medication Dispensing System for Patient Medical Record Number 064110, but failed to follow the facility's policy and procedures for wastage of any of the unused portions 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).
21. On or about September 4, 2009, while employed as a Registered Nurse with Goodall-Witcher Hospital, Clifton, Texas Respondent misappropriated Morphine and Demerol belonging to the facility and patients thereof, or failed to take precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients of the cost of medications.
22. On or about September 4, 2009, while employed as a Registered Nurse with Goodall-Witcher Hospital, Clifton, Texas, Respondent engaged in the intemperate use of Morphine, in that Respondent produced a specimen for a drug screen that resulted positive for Morphine. Possession of Morphine, without a valid prescription, is prohibited by Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act). The use of Morphine by a Registered Nurse, while subject to call or duty, could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgements, and decisions regarding patient care, thereby placing the patient in potential danger.

23. In response to Findings of Fact Numbers Eighteen (18) through Twenty-two (22), Respondent states: "I went to the nurse practitioner numerous times and verbalized that this patient was receiving too much medication without any relief and we needed to look at what else could be wrong with her. I was trained by an agency nurse as to the process of withdrawing, documenting, and wasting medication. On this day it was brought to my attention that this was not the procedure per hospital policy. This was the first I had heard that I was not doing it according to policy and immediately corrected my actions. When I was given the drug screen, I notified the person taking the urine that I had received Morphine 3 days prior in that facility's ER. There was no documentation made at that time. I informed them again when I was terminated for the drug screen, that I had been seen by their facility and given Morphine and would be willing to provide a UA every shift to prove I did not abuse drugs."
24. On or about November 13, 2009 through December 28, 2009, while employed as a Registered Nurse with Scott and White Memorial Hospital, Temple, Texas, Respondent withdrew Dilaudid from the Medication Dispensing System (Pyxis) for Patient Medical Record Number 4964294 and Patient Medical Record Number 4202330, who were not under her care and the patients denied receiving the medication. Respondent's conduct was likely to defraud the patients of the cost of the medication.
25. On or about November 13, 2009 through December 28, 2009, while employed as a Registered Nurse with Scott and White Memorial Hospital, Temple, Texas, Respondent withdrew Dilaudid from the Medication Dispensing System (Pyxis) for Patient Medical Record Number 4964294 and Patient Medical Record Number 4202330, but failed to follow the facility's policy and procedure for the wastage of the unused portion 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).
26. On or about November 13, 2009 through December 28, 2009, while employed as a Registered Nurse with Scott and White Memorial Hospital, Temple, Texas, Respondent misappropriated Dilaudid from the facility and patients thereof, or failed to take the precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients of the cost of medications.
27. On or about December 28, 2009, while employed as a Registered Nurse with Scott and White Memorial Hospital, Temple, Texas, Respondent engaged in the intemperate use of Hydromorphone (Dilaudid), in that she produced a specimen for a drug screen that resulted positive for Hydromorphone. Possession of Hydromorphone, without a valid prescription, is prohibited by Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act). The use of Hydromorphone by a Registered Nurse, while subject to call or duty, could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgements, and decisions regarding patient care, thereby placing the patient in potential danger.

28. On or about April 11, 2010, while employed as a Registered Nurse with Lighthouse Nursing Agency, Killeen, Texas, and on assignment at Scott and White Continuing Care Hospital, Temple, Texas, Respondent withdrew Ativan from the Medication Dispensing System for Patient Medical Record Number 5346727, but failed to document, or accurately document the administration of the medication in the patient's Medication Administration Record and/or nurse's notes. 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.
29. On or about April 11, 2010, while employed as a Registered Nurse with Lighthouse Nursing Agency, Killeen, Texas, and on assignment at Scott and White Continuing Care Hospital, Temple, Texas, Respondent withdrew Ativan from the Medication Dispensing System for Patient Medical Record Number 5346727, but failed to follow the facility's policy and procedures for the wastage of any of the unused portions 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).
30. On or about April 11, 2010, while employed as a Registered Nurse with Lighthouse Nursing Agency, Killeen, Texas, and on assignment at Scott and White Continuing Care Hospital, Temple, Texas, Respondent misappropriated Ativan belonging to the facility and patients thereof, or failed to take the precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients of the cost of medications.
31. In response to Findings of Fact Numbers Twenty-eight (28) through Thirty (30), Respondent states: "I made every effort to make sure that I charted and wasted every medication that I used while employed at Scott and White Continuing Care Hospital. I can only say that maybe I missed a dose of Ativan and Dilaudid. I understand that his is no excuse and I have made every effort to avoid this happening again.
32. On or about April 15, 2010, while employed as a Registered Nurse with Lighthouse Nursing Agency, Killeen, Texas, and on assignment at Scott and White Continuing Care Hospital, Temple, Texas, Respondent withdrew Dilaudid from the Medication Dispensing System for Patient Medical Record Number 5382941, using another nurses name. Respondent's conduct was likely to defraud the facility and patients of the cost of medications.
33. On or about April 15, 2010, while employed as a Registered Nurse with Lighthouse Nursing Agency, Killeen, Texas, and on assignment at Scott and White Continuing Care Hospital, Temple, Texas, Respondent withdrew Dilaudid from the Medication Dispensing System for Patient Medical Record Number 5382941, but failed to document, or accurately document the administration of the medication in the patient's Medication Administration Record and/or nurse's notes. 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.

34. On or about April 15, 2010, while employed as a Registered Nurse with Lighthouse Nursing Agency, Killeen, Texas, and on assignment at Scott and White Continuing Care Hospital, Temple, Texas, Respondent withdrew Dilaudid from the Medication Dispensing System for Patient Medical Record Number 5382941, but failed to follow the facility's policy and procedures for the wastage of any of the unused portions 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).
35. On or about April 15, 2010, while employed as a Registered Nurse with Lighthouse Nursing Agency, Killeen, Texas, and on assignment at Scott and White Continuing Care Hospital, Temple, Texas, Respondent misappropriated Dilaudid belonging to the facility and patients thereof, or failed to take the precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients of the cost of medications.
36. In response to Findings of Fact Numbers Thirty-two (32) through Thirty-five (35), Respondent states: "Some of this is correct. The other nurse and I were both in the medication room and talking about another patient and life in general. I did not realize, nor did she, that she had not signed out of the medication system. I pulled the medication out and went to administer to the patient. When I scanned the medication it informed me that it was not time to administer the medication. I went and wasted that medication with another nurse. The medication was wasted according to policy and procedure. When we realized that it was a problem, the other nurse and myself immediately went to the pharmacist and explained what had happened. We showed her where the med was pulled under the wrong nurse and where I had wasted the medication. She looked at the printout and said it looked like an honest mistake but that everything looked to be in order. Later in the shift, the nurse manager came to investigate and I stayed to answer questions and be available for a drug screen. I was told that I could go home. Upon getting home, Lighthouse Nursing called and said that I would not be needed to return and suggested that I do a drug screen ASAP. The following morning I tested negative for all drugs.
37. On December 6, 2010, Respondent completed a chemical dependency evaluation performed by Dr. Matthew Ferrara. Dr. Ferrara concludes that Respondent provided unreliable responses throughout the assessment process. Dr. Ferrara concludes that there is not enough reliable information to recommend that the Respondent be licensed to practice as a nurse. Dr. Ferrara proposes that if the Respondent wants to participate in another evaluation with this examiner and provide reliable information, this examiner would agree to re-evaluate Respondent. However, Respondent would have to agree to undergo a polygraph exam as part of the re-evaluation.
38. Respondent, by her signature to this Order, expresses her desire to voluntarily surrender her license to practice nursing in the State of Texas.

39. The Board policy implementing Rule 213.29 in effect on the date of this Agreed Order provides discretion by the Executive Director for consideration of conditional reinstatement after proof of twelve (12) consecutive months of abstinence from alcohol and drugs followed by licensure limitations/stipulations and/or peer assistance program participation.
40. 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.

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)(9),(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A),(B),(C),(D)&(T) and 217.12(1)(E),(4),(5),(6)(G),(8),(10)(A),(C),(E)&(11)(B).
4. The evidence received is sufficient cause pursuant to Section 301.453(a), Texas Occupations Code, to take disciplinary action against Registered License Number 709316, heretofore issued to SONYA RENEE STERLING, 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 709316, heretofore issued to SONYA RENEE STERLING, 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 license, heretofore issued to SONYA RENEE STERLING, to the office of the Texas Board of Nursing.
2. RESPONDENT SHALL NOT practice professional nursing, use the title "registered nurse" or the abbreviation "RN" or wear any insignia identifying herself as a registered nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a registered 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; and, RESPONDENT has obtained objective, verifiable proof of twelve (12) consecutive months of sobriety immediately preceding the petition.
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 nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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RESPONDENT'S CERTIFICATION

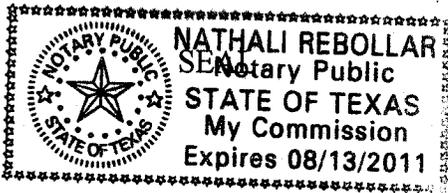
I understand that I have the right to legal counsel prior to signing this Agreed Order.

I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. 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 21 day of January, 2011.

Sonya Renee Sterling
SONYA RENE E STERLING, Respondent

Sworn to and subscribed before me this 21st day of January, 2011.

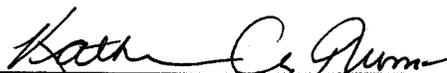


Nathali Rebollar
Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Executive Director on behalf of the Texas Board of Nursing does hereby accept the voluntary surrender of Registered Nurse License Number 709316, previously issued to SONYA RENEE STERLING.

Effective this 21st day of January, 2011.




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