



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

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

On this day came to be considered by the Texas Board of Nursing, hereinafter referred as the Board, the Petition for Reinstatement of Registered Nurse License Number 709316, held by SONIA RENEE STERLING, hereinafter referred to as Petitioner.

An informal conference was held on July 23, 2013, at the office of the Texas Board of Nursing, in accordance with Section 301.464, Texas Occupations Code.

Petitioner appeared in person. Petitioner was notified of her right to be represented by legal counsel and elected to waive representation by counsel. In attendance were Katherine A. Thomas, MN, RN, FAAN, Executive Director; Kristin Benton, MSN, RN, Director of Nursing; John R. Griffith, Assistant General Counsel; Anthony L. Diggs, MSCJ, Director, Enforcement Division; Gisselle Gonzales, Investigator; and Diane E. Burell, Investigator.

FINDINGS OF FACT

1. Prior to institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Petitioner and Petitioner was given an opportunity to show compliance with all requirements of the law for retention of the license(s).
2. Petitioner waived representation by counsel, notice and hearing, and consented to the entry of this Order.
3. Petitioner received an Associate Degree in Nursing from McLennan Community College, Waco, Texas, on May 6, 2004. Petitioner was licensed as a professional nurse in the State of Texas on August 26, 2004.
4. Petitioner's professional nursing employment history includes:

8/04 - 8/09	Staff Nurse	Providence Hospital Waco, Texas
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Petitioner's professional nursing employment history continued:

8/09 - 9/09	Staff Nurse	Goodall-Witcher Memorial Hospital Temple, Texas
10/09 - 12/09	Staff Nurse	Scott & White Memorial Hospital Temple, Texas
1/10 - 4/10	Agency Nurse	Lighthouse Nursing Agency Killeen, Texas
5/10 - 1/11	Staff Nurse	City of Waco Health Department Waco, Texas
2/11 - present	Not employed in nursing	

5. On January 21, 2011, the Board accepted the voluntary surrender of Petitioner's license(s) to practice professional nursing in the State of Texas. A copy of the January 21, 2011, Agreed Order, Findings of Fact, and Conclusions of Law, is attached and incorporated, by reference, as a part of this Order.
6. On or about April 17, 2013, Petitioner submitted a Petition for Reinstatement of License to practice professional nursing in the State of Texas.
7. Petitioner presented the following in support of her petition:
  - 7.1. Letter, dated April 10, 2012, from Teran Yaklin, LCSW, Crossroads to Recovery Program Coordinator, Providence Healthcare Network DePaul Center, Waco, Texas, stating on April 5, 2012, Petitioner was assessed for the Chemical Dependency Outpatient program at the DePaul Center. Given the information that Petitioner provided, she does not meet the diagnostic criteria for an intensive outpatient program. The recommendation made to Petitioner was to attend Narcotics Anonymous meetings along with individual therapy.
  - 7.2. Letter from Thomas A. Harris, EdD, ADC III, Psychologist, Waco Psychological Associates, Waco, Texas, stating Petitioner was seen initially on May 23, 2012, to address issues related to maintaining long term sobriety. She was also hopeful of eventually being allowed to regain her nursing license. In the course of her treatment, Petitioner developed strategies to diffuse triggers for drug use, reduce stress, increase positive communication, and set effective boundaries to manage resentments. Petitioner has been open to treatment recommendations and comes across as highly motivated to avoid situations that might prove challenging to her recovery. It is felt that Petitioner has progressed sufficiently in her recovery program that she could function well in a health delivery situation as long as she was not directly responsible for administering opiate medication. Petitioner has been very forthcoming in identifying nursing positions she could handle with confidence and those that might be problematic. This awareness is viewed as consistent with Petitioner's commitment to her recovery. Petitioner continues to be seen in therapy in order to increase the quality of her recovery.

- 7.3. Letter of support from Amanda B. stating that she is an active member of Narcotics Anonymous and has had the pleasure of sponsoring many different women. Ms. B. is currently Petitioner's sponsor and has been for almost a year now. Petitioner has shared her story, she works her steps, attends meetings, and keeps in touch with Ms. B. Petitioner has come a long way and has made great progress.
- 7.4. Documentation of eleven (11) random drug screens collected from April 26, 2012, through March 1, 2013.
- 7.5. Documentation of support group meetings dating from May 9, 2012, through April 5, 2013.
- 7.6. Documentation of the minimum requirement of Continuing Education contact hours.
8. Petitioner gives April 21, 2010, as her date of sobriety.

#### CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or chemical dependency.
3. Pursuant to Section 301.467, Texas Occupations Code, the Board may refuse to issue or renew a license, and may set a reasonable period that must lapse before reapplication. Pursuant to 22 TEX. ADMIN. CODE §213.26, the Board may impose reasonable conditions that a Petitioner must satisfy before reissuance of an unrestricted license.

#### ORDER

IT IS THEREFORE AGREED, subject to ratification by the Texas Board of Nursing, that the petition of SONYA RENEE STERLING, Registered Nurse License Number 709316, to practice nursing in the state of Texas, be and the same is hereby GRANTED, AND SUBJECT TO THE FOLLOWING STIPULATIONS SO LONG AS THE PETITIONER complies 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 the stipulations contained in 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 Petitioner to practice nursing in the State of Texas.

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

IT IS FURTHER AGREED and ORDERED that while Petitioner's license(s) is/are encumbered by this Order, Petitioner may not work outside the State of Texas pursuant to a nurse licensure compact privilege without the written permission of the State of Texas and the Board of Nursing in the party state where Petitioner wishes to work.

(1) PETITIONER SHALL pay all re-registration fees and be issued a license to practice nursing in the State of Texas, which shall bear the appropriate notation. Said licenses issued to SONYA RENEE STERLING, shall be subject to the following agreed post-licensure stipulations:

(2) PETITIONER SHALL pay a monitoring fee in the amount of five hundred (\$500.00) dollars. PETITIONER SHALL pay this fine within forty-five (45) days of relicensure. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

(3) PETITIONER SHALL, within one (1) year of relicensure, successfully complete a course in Texas nursing jurisprudence and ethics. PETITIONER 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. PETITIONER 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 PETITIONER'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.texas.gov/disciplinaryaction/stipscourses.html>

(4) PETITIONER SHALL, within one (1) year of relicensure, 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, PETITIONER SHALL SUBMIT the continuing education certificate of completion for this program 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. *Board-approved courses may be found at the following Board website address:*  
<http://www.bon.texas.gov/disciplinaryaction/stipscourses.html>

**IT IS FURTHER AGREED, SHOULD PETITIONER CHOOSE TO WORK AS A NURSE IN TEXAS, PETITIONER WILL PROVIDE DIRECT PATIENT CARE AND PRACTICE IN A HOSPITAL, NURSING HOME, OR OTHER CLINICAL SETTING A MINIMUM OF SIXTY-FOUR (64) HOURS PER MONTH UNDER THE FOLLOWING PROBATION CONDITIONS FOR THREE (3) YEARS OF EMPLOYMENT. THE LENGTH OF THE PROBATION PERIOD WILL BE EXTENDED UNTIL SUCH THIRTY-SIX (36) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A**

**REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:**

(5) PETITIONER SHALL notify all future employers in nursing of this Order of the Board and the stipulations on PETITIONER'S license(s). PETITIONER 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.

(6) PETITIONER SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the PETITIONER by the Board, to the Board's office within five (5) days of employment as a nurse.

(7) For the first year of employment as a Nurse under this Order, PETITIONER SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as PETITIONER and immediately available to provide assistance and intervention. PETITIONER SHALL work only on regularly assigned, identified and predetermined unit(s). The PETITIONER SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. PETITIONER SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(8) For the remainder of the stipulation period, PETITIONER SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, who is on the premises. The supervising nurse is not required to be on the same unit or ward as PETITIONER, 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 PETITIONER is currently

working. PETITIONER SHALL work only regularly assigned, identified and predetermined unit(s). PETITIONER SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. PETITIONER SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

(9) PETITIONER SHALL NOT practice as a nurse on the night shift, rotate shifts, work overtime, accept on-call assignments, or be used for coverage on any unit other than the identified, predetermined unit(s) to which PETITIONER is regularly assigned for one (1) year of employment as a nurse.

(10) PETITIONER SHALL NOT practice as a nurse in any critical care area for one (1) year of employment as a nurse. Critical care areas include, but are not limited to, intensive care units, emergency rooms, operating rooms, telemetry units, recovery rooms, and labor and delivery units.

(11) PETITIONER SHALL NOT administer or have any contact with controlled substances, Nubain, Stadol, Dalgan, Ultram, Propofol, or other synthetic opiates for one (1) year of employment as a nurse.

(12) PETITIONER SHALL CAUSE each employer to submit, on forms provided to the PETITIONER by the Board, periodic reports as to PETITIONER'S capability to practice nursing. These reports shall be completed by the nurse who supervises the PETITIONER. 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 three (3) year(s) of employment as a nurse.

(13) PETITIONER 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, PETITIONER 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 PETITIONER SHALL submit to a pain management and/or chemical dependency evaluation by a Board approved evaluator. The performing evaluator must submit a written report meeting the Board's requirements to the Board's office within thirty (30) days from the Board's request.**

(14) PETITIONER SHALL submit to random periodic screens for controlled substances, tramadol hydrochloride (Ultram), and alcohol. For the first three (3) month period, random screens shall be performed at least once per week. For the next three (3) month period, random screens shall be performed at least twice per month. For the next six (6) month period, random screens shall be performed at least once per month. For the remainder of the stipulation period, random screens shall be performed at least once every three (3) months. 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 and their metabolites:

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

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

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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. PETITIONER 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 refusal to submit to a drug or alcohol screen may subject the nurse to further disciplinary action, including EMERGENCY SUSPENSION pursuant to Section 301.4551, Texas Occupations Code, or REVOCATION of PETITIONER's license(s) and nurse licensure compact privileges, if any, to practice nursing in the State of Texas. Further, failure to report for a drug screen, excessive dilute specimens, or failure to call in for a drug screen may be considered the same as a positive result or refusal to submit to a drug or alcohol screen.

(15) PETITIONER SHALL participate in therapy with a "professional counselor" possessing credentials approved by the Board. PETITIONER SHALL CAUSE the therapist to submit written reports, on forms provided by the Board, as to the PETITIONER'S progress in therapy, rehabilitation and capability to safely practice nursing. The report must indicate whether or not the PETITIONER'S stability is sufficient to provide direct patient care safely. Such reports are to be furnished each and every month for three (3) months. If therapy is recommended beyond the initial three (3) months, the reports shall then be required at the end of each three (3) month period for the remainder of the stipulation period, or until PETITIONER is dismissed from therapy.

(16) PETITIONER SHALL attend at least two (2) support group meetings each week, one of which must be for substance abuse and provided by Alcoholics Anonymous, Narcotics Anonymous, or another comparable recovery program that has been pre-approved by the Board. PETITIONER SHALL provide acceptable evidence of attendance. Acceptable evidence shall consist of a written record of at least: the date of each meeting; the name of each group attended; and the signature and printed name of the chairperson of each group attended by PETITIONER. PETITIONER SHALL submit the required evidence on the forms provided by the Board at the end of every three (3) month period. No duplications, copies, third party signatures, or any other substitutions will be accepted as evidence.

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

PETITIONER'S CERTIFICATION

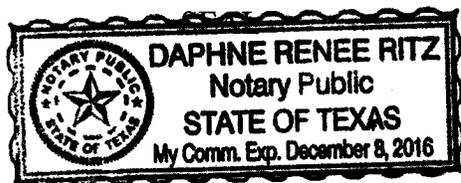
I understand that I have the right to legal counsel prior to signing this Reinstatement Agreed Order. I waive representation by counsel. I certify that my past behavior, except as disclosed in my Petition for Reinstatement of Licensure, has been in conformity with the Board's professional character rule. I have provided the Board with complete and accurate documentation of my past behavior in violation of the penal law of any jurisdiction which was disposed of through any procedure short of convictions, such as: conditional discharge, deferred adjudication or dismissal. I have no criminal prosecution pending in any jurisdiction.

I have reviewed this Order. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order. 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 agree to inform the Board of any other fact or event that could constitute a ground for denial of licensure prior to reinstating my license to practice professional nursing in the state of Texas. I understand that if I fail to comply with all terms and conditions of this Order, my license(s) to practice nursing in the State of Texas will be revoked, as a consequence of my noncompliance.

Signed this 12 day of August, 2013.

Sonya Renee Sterling  
SONYA RENEE STERLING, Petitioner

Sworn to and subscribed before me this 12 day of August, 2013.



Daphne Ritz  
Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Reinstatement Agreed Order that was signed on the 12th day of August, 2013, by SONYA RENEE STERLING, Registered Nurse License Number 709316, and said Order is final.

Effective this 10th day of September, 2013.



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



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.  
*[Signature]*  
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

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

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 this 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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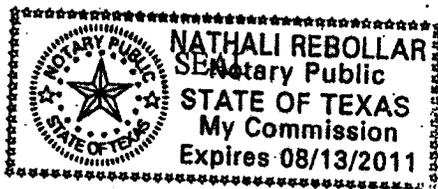
RESPONDENT'S CERTIFICATION

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 RENEE 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 21<sup>st</sup> day of January, 2011.



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