

Respondent's vocational nursing employment history continued:

4/2009 - Present Unknown

6. At the time of the initial incident, Respondent was employed as a Licensed Vocational Nurse with Wilson N. Jones Medical Center, Sherman, Texas, and had been in this position for two (2) years and four (4) months.
7. During December 11, 2008, through February 27, 2009, while employed with Wilson N. Jones Medical Center, Sherman, Texas, Respondent removed Tramadol, Hydrocodone and Oxazepam from the Omnicell Medication Dispensing System for patients but failed to accurately and/or completely document the administration of said medications on the patients' Medication Administration Records (MAR), as follows:

Omicell Date/Time	Patient Account #	Omicell Record	Physician's Orders	MAR	Wastage
12/11/08 @ 5:44 PM	0025007895	Tramadol 50 MG Tab(1)	Tramadol 50 MG Tab (1) Q4HPRN	No Documentation	None
12/11/08 @ 5:44 PM	0025007895	Hydrocodone/ APAP 5/325 Tab (2)	Norco 5/325 MG 2 Tabs Q4H PRN	No Documentation	None
12/21/08 @ 4:44 PM	0025012712	Hydrocodone/ APAP 5/325 TAB (1)	Norco 5/325 MG TAB (1) Q6H PRN	No Documentation	None
12/30/08 @ 12:17 PM	0025013745	Hydrocodone/ APAP 5/325Tab (2)	No Order	No Documentation	None
12/30/08 @ 5:31 PM	0025013745	Hydrocodone/ APAP 5/325 Tab (2)	No Order	No Documentation	None
1/3/09 @ 11:34 AM	0025014225	Hydrocodone/ APAP 5/325 Tab (1)	Norco 5/325 MG TAB (1) Q4H	No Documentation	None
1/4/09 @ 6:06 PM	0025014225	Oxazepam 10 MG Cap	Oxazepam 10 MG Q6H	No Documentation	None
2/27/09 @ 5:43 PM	0025025990	Hydrocodone/ APAP 5/325 Tab (1)	Norco 5/325 MG Tab (1) PRN As Directed	No Documentation	None

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

8. During December 11, 2008, through February 27, 2009, while employed with Wilson N. Jones Medical Center, Sherman, Texas, Respondent withdrew Tramadol, Hydrocodone and Oxazepam from the Omnicell Medication Dispensing System for patients but failed to follow facility policy and procedure in place for the proper wastage of the unused portions of the medications, as follows:

Omnicell Date/Time	Patient Account #	Omnicell Record	Physician's Orders	MAR	Wastage
12/11/08 @ 5:44 PM	0025007895	Tramadol 50mg Tab (1)	Tramadol 50 MG Tab (1) Q4H PRN	No Documentation	None
12/11/08 @ 5:44 PM	0025007895	Hydrocodone/ APAP 5/325 Tab (2)	Norco 5/325 MG 2 Tabs Q4H PRN	No Documentation	None
12/21/08 @ 4:44 PM	0025012712	Hydrocodone/ APAP 5/325 TAB (1)	Norco 5/325 MG TAB (1) Q6H PRN	No Documentation	None
12/30/08 @ 12:17 PM	0025013745	Hydrocodone/ APAP 5/325 Tab (2)	No Order	No Documentation	None
12/30/08 @ 5:31 PM	0025013745	Hydrocodone/ APAP 5/325 Tab (2)	No Order	No Documentation	None
1/3/09 @ 11:34 AM	0025014225	Hydrocodone/ APAP 5/325 Tab (1)	Norco 5/325 MG TAB (1) Q4H	No Documentation	None
1/4/09 @ 6:06 PM	0025014225	Oxazepam 10mg Cap	Oxazepam 10 MG Q6H	No Documentation	None
2/27/09 @ 5:43 PM	0025025990	Hydrocodone/ APAP 5/325 Tab (1)	Norco 5/325 MG Tab (1) PRN As Directed	No Documentation	None

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).

9. During December 11, 2008, through February 27, 2009, while employed with Wilson N. Jones Medical Center, Sherman, Texas, Respondent misappropriated Tramadol, Hydrocodone and Oxazepam 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 the medications.
10. On or about December 21, 2008, while employed with Wilson N. Jones Medical Center, Sherman, Texas, Respondent withdrew one (1) tab Hydrocodone/APAP 5/325 from the Omnicell Medication Dispensing System at 9:06 a.m., 2:01 p.m. and 4:44 p.m., for Patient Account Number 0025012712 which was in excess of the physician's order of one (1) tab Norco 5/325 MG Q6H PRN (every six hours as needed). Respondent's conduct was likely to injure the patient in that the administration of Hydrocodone in excess frequency and/or dosage of the physician's order could result in the patient suffering from adverse reactions.
11. On or about December 30, 2008, while employed with Wilson N. Jones Medical Center, Sherman, Texas, Respondent withdrew two (2) tabs Hydrocodone/APAP 5/325 from the Omnicell Medication Dispensing System at 12:17 p.m. and 5:31 p.m., for Patient Account Number 0025013745 without a valid physician's order. Respondent's conduct was likely to injure the patient in that the administration of Hydrocodone without a valid physician's order could result in the patient suffering from adverse reactions.

12. On or about March 31, 2009, while employed with Wilson N. Jones Medical Center, Sherman, Texas, Respondent engaged in the intemperate use of Darvocet and Xanax in that she provided a specimen for a drug screen which resulted positive for Darvocet and Xanax. Possession of Darvocet and Xanax, without a valid prescription, is prohibited. The use of Darvocet and Xanax by a Licensed Vocational Nurse, while subject to call or duty, could impair the nurse's ability to recognize subtle signs, symptoms or changes in the patient's condition, and could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.
13. In response to the conduct outlined in Finding of Fact Number Seven (7), Respondent states that the facility changed the MARs and switched to computerized charting, which required the nurses to chart in three different areas. She had a very hard time adjusting to the change, which was partially due to being trained two to three months prior to the change. Respondent states that she had I.T. help her on numerous occasions for fear of mis-documentation or the appearance of misappropriations. Respondent adds that she never intentionally documented anything wrong and tried to get help when she was having trouble. In response to the conduct outlined in Finding of Fact Number Eight (8), Respondent states that a witness must enter their password and watch the waste occur. Since she was the only LVN on the floor, the supervisor or RN witnessed the wastage on most occasions. In response to the conduct outlined in Finding of Fact Number Nine (9), Respondent states that she has never and would never intentionally misappropriate any medication from a patient. In response to the conduct outlined in Finding of Fact Number Ten (10), Respondent states that some doctor's orders are hard to read and she had trouble with the Omnicell and MARs. She adds that she always asked a superior before giving any medication that did not have an order put into the Omnicell or that she had any questions about. Respondent states that she always used the three check and sometimes more when dispensing medications. In response to the conduct outlined in Finding of Fact Number Twelve (12), Respondent states that she just had knee surgery and had a doctor's prescription for both medications. She adds that she had not worked the weekend prior to, the day before, or the day of the testing. She further adds that she did not take the medications while working or when scheduled to work.
14. Formal Charges were filed on April 7, 2010.
15. Formal Charges were mailed to Respondent on April 12, 2010.

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)(9),(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(B),(1)(C)&(1)(D) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B),(4),(5),(6)(G),(10)(A),(10)(B),(10)(C), (10)(D)&(11)(B).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number , heretofore issued to SHARON LYNETTE GRIFFITT, 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 Vocational Nurse License Number 205369, previously issued to SHARON LYNETTE GRIFFITT, to practice nursing in Texas is hereby SUSPENDED and said suspension is ENFORCED INDEFINITELY. In connection with this SUSPENSION, the Board imposes the following conditions:

- (1) RESPONDENT SHALL NOT practice vocational nursing, use the title "vocational nurse" or the abbreviation "LVN" or wear any insignia identifying herself as a vocational nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a vocational nurse during the period in which the license is suspended.
- (2) RESPONDENT SHALL NOT petition for stay or probation of the SUSPENSION until one (1) year has elapsed from the date of this Order.
- (3) RESPONDENT SHALL, prior to seeking to petition for a stay or probation of the SUSPENSION, submit to a psychological evaluation with a chemical dependency component by a Board approved evaluator who specializes in forensic evaluations.

The performing evaluator, prior to the evaluation, must be provided a copy of the Board's file regarding RESPONDENT. The evaluator is to send a report of the evaluation to the Board's office. The report shall include a description of the instruments used for evaluation with the results of the evaluation and recommendations, if applicable.

In addition, the report must include a statement regarding the probability RESPONDENT would be able to consistently behave in accordance with the requirements of Rules 213.27- 213.29 at 22 Texas Administrative Code, as well as the minimum standards set by the Board's Rules 217.11 at 22 TAC and generally accepted nursing standards. The evaluation must include a statement that RESPONDENT would or would not consistently avoid behaviors identified by the Board as constituting unprofessional conduct.

- (4) Upon petitioning for stay or probation of the SUSPENSION, RESPONDENT SHALL satisfy all then existing requirements for practice.
- (5) RESPONDENT SHALL be entitled to submission of her petition for stay or probation of the SUSPENSION before the Eligibility and Disciplinary Committee of the Board.
- (6) RESPONDENT SHALL be entitled to a hearing conducted by the State Office of Administrative Hearings if the Board proposes to refuse to lift the enforcement of the suspension after the one (1) year of enforcement has elapsed.

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

the State of Texas.

IT IS FURTHER AGREED and ORDERED that 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 the 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 and ORDERED that if during the period of probation, an additional allegation, accusation, or petition is reported or filed against the Respondent's license(s), the probationary period shall not expire and shall automatically be extended until the allegation, accusation, or petition has been acted upon by the Board.

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 waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 22 day of November, 2011.

Sharon L. Griffith
SHARON LYNETTE GRIFFITH, Respondent

Sworn to and subscribed before me this _____ day of _____, 20____.

SEAL

Notary Public in and for the State of _____

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 22nd day of November, 2011, by SHARON LYNETTE GRIFFITT, Vocational Nurse License Number 205369, and said Order is final.

Effective this 19th day of January, 2012.



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