In the Matter of Permanent License	§	**BEFORE THE TEXAS**
Number 200382, Issued to	§	
CHRISTINA LYNN GONZALEZ, Respondent	§	**BOARD OF NURSING**

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

Executive Director of the Board

ORDER OF TEMPORARY SUSPENSION

TO: Christina Lynn Gonzalez
317 Ellen Drive
Deer Park, TX 77536

A public meeting of the Texas Board of Nursing was held on April 12, 2012, at 333 Guadalupe, Room 2-225, Austin, Texas, in which the Temporary Suspension of Permanent Vocational Nurse License Number 200382, issued to CHRISTINA LYNN GONZALEZ was considered pursuant to Section 301.4551, TEXAS OCCUPATIONS CODE. Staff of the Texas Board of Nursing appeared and presented evidence and information concerning the conduct of CHRISTINA LYNN GONZALEZ and whether her continued practice as a nurse would constitute a continuing and imminent threat to the public welfare.

After review and due consideration of the evidence and information presented, the Board finds that the following charges are substantiated:

On or about December 28, 2011, Respondent failed to comply with the Agreed Order issued to her on October 5, 2011, by the Texas Board of Nursing. Respondent's non-compliance is the result of her failure to comply with all requirements of the Texas Peer Assistance Program for Nurses (TPAPN). Stipulation Number Three (3) of the Agreed Order dated October 5, 2011, reads, in pertinent part:

(3) RESPONDENT SHALL comply with all requirements of the TPAPN participation agreement during its term.

The Texas Board of Nursing further finds that, given the nature of the charges concerning her fitness to practice, the continued practice of nursing by CHRISTINA LYNN GONZALEZ constitutes a continuing and imminent threat to public welfare and that the temporary suspension of Vocational Nurse License No. 200382 is justified pursuant to Section 301.4551, TEXAS OCCUPATIONS CODE.

NOW, THEREFORE, IT IS ORDERED that Permanent Certificate Number 200382, issued to CHRISTINA LYNN GONZALEZ, to practice nursing in the State of Texas be, and the same is hereby, SUSPENDED IMMEDIATELY in accordance with Section 301.4551, TEXAS OCCUPATIONS CODE.

IT IS FURTHER ORDERED that a probable cause hearing be conducted in accordance with Section 301.455(c) not later than seventeen (17) days following the date of the entry of this order, and a final hearing on the matter be conducted in accordance with 301.455(d) not later than the 61st day following the date of the entry of this order.

Entered this 12th day of April, 2012.

TEXAS BOARD OF NURSING

BY: _____

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR

In the Matter of Permanent License	§	**BEFORE THE TEXAS**
Number 200382, Issued to	§	
CHRISTINA LYNN GONZALEZ, Respondent	§	**BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, CHRISTINA LYNN GONZALEZ, is a Vocational Nurse holding license number 200382, which is in current status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about December 28, 2011, Respondent failed to comply with the Agreed Order issued to her on October 5, 2011, by the Texas Board of Nursing. Respondent's non-compliance is the result of her failure to comply with all requirements of the Texas Peer Assistance Program for Nurses (TPAPN). Stipulation Number Three (3) of the Agreed Order dated October 5, 2011, reads, in pertinent part:

> (3) RESPONDENT SHALL comply with all requirements of the TPAPN participation agreement during its term.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1)&(10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(9)&(11)(B).

BALANCE OF PAGE LEFT BLANK INTENTIONALLY

CONTINUED ON NEXT PAGE

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 Tex. Admin. Code §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1,200.00).

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that to the extent applicable, based on the Formal Charges, the Board will rely on Adopted Disciplinary Sanction Policies for Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder, which can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.texas.gov/disciplinaryaction/discp-matrix.html.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Orders which ise attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Agreed Board Order, dated October 5, 2011.

Filed this 12th day of April, 2012.

TEXAS BOARD OF NURSING

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Assistant General Counsel
State Bar No. 24036103
Lance R. Brenton, Assistant General Counsel
State Bar No. 24066924
John R. Griffith, Assistant General Counsel
State Bar No. 24079751
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
Nikki Hopkins, Assistant General Counsel
State Bar No. 24052269
John F. Legris, Assistant General Counsel
State Bar No. 00785533
TEXAS BOARD OF NURSING
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6824
F: (512) 305-8101 or (512)305-7401

Attachments: Agreed Board Order, dated October 5, 2011

D/2012.03.07

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Vocational Nurse License Number 200382	§	AGREED
issued to CHRISTINA LYNN GONZALEZ	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of CHRISTINA LYNN GONZALEZ, Vocational Nurse License Number 200382, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(9),(10)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on July 15, 2011, by Katherine A. Thomas, MN, RN, Executive Director.

FINDINGS OF FACT

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

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

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

4. Respondent received a Certificate in Vocational Nursing from San Jacinto College South, Houston, Texas, on August 12, 2005. Respondent was licensed to practice vocational nursing in the State of Texas on September 27, 2005.

5. Respondent's vocational nursing employment history includes:

10/05 - 01/06	LVN	Clear Lake Pediatrics Webster, TX
01/06 - 04/08	LVN	Bayshore Medical Center Pasadena, TX

Respondent's vocational nursing employment history (continued):

09/07 - 04/09	LVN	Patients Medical Center Pasadena, TX
04/09 - 01/10	LVN	Clear Lake Regional Medical Center Webster, TX
03/10 - 08/10	LVN	Memorial Hermann Southeast Hospital Houston, TX
Unknown - 12/10	LVN	Cornerstone Hospital of Clear Lake, Webster, TX
Unknown - 04/11	LVN	Triumph Hospital Clear Lake Webster, TX
Unknown - 06/11	LVN	Supplemental Health Care Houston , TX
07/11 - Current	Unknown	

6. On or about February 28, 2009, through March 28, 2009 while employed as a Licensed Vocational Nurse at Patients Medical Center, Pasadena, Texas, Respondent withdrew narcotics from the medication dispensing system (PYXIS) for patients in excess of, or without valid physicians' orders. Respondent's conduct was likely to injure the patient in that the administration of narcotics in excess of, or without physicians' orders, could result in the patient suffering from adverse reactions.

7. On or about February 28, 2009, through March 28, 2009 while employed as a Licensed Vocational Nurse at Patients Medical Center, Pasadena, Texas, Respondent withdrew narcotics from the medication dispensing system (PYXIS) for patients, but failed to document, or accurately document the administration, including the signs, symptoms and responses to the narcotics in the patients' Medication Administration Record (MAR) or Nurses Notes. Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation to further medicate the patients which could result in an overdose.

8. On or about February 28, 2009, through March 28, 2009 while employed as a Licensed Vocational Nurse at Patients Medical Center, Pasadena, Texas, Respondent withdrew narcotics from the medication dispensing system (PYXIS) for patients, but failed to properly waste unused portions, if any, 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).

9. On or about February 28, 2009, through March 28, 2009 while employed as a Licensed Vocational Nurse at Patients Medical Center, Pasadena, Texas, Respondent misappropriated, or failed to take precautions to prevent such misappropriation, of medication. Respondent's conduct was likely to defraud the facility and patients of the cost of the medication.

10. On or about March 28, 2009, while employed as a Licensed Vocational Nurse at Patients Medical Center, Pasadena, Texas, Respondent engaged in the intemperate use of Opiates (Codeine/Morphine) in that she submitted a specimen for a for-cause drug screen which resulted positive for Opiates (Codeine/Morphine). Possession of Opiates without a lawful prescription is prohibited by Chapter 481 of the Texas Health and Safety Code (Controlled Substance Act). The use of Opiates 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, judgements, and decisions regarding patient care, thereby placing the patient in potential danger.

11. In response to Findings of Fact Numbers Six (6) through Ten (10), Respondent states that she may have withdrawn medications prior to the patient being released from the Emergency Room. Regarding not having a valid physician's order, Respondent states that the medication would sometimes be discontinued by the Emergency Room before the time she received the patient. Respondent states that the patient load was high and there was minimal time for documentation. Additionally, Respondent states that a fellow nurse was not always around to witness a medication waste. Regarding the drug screen, Respondent states that she submitted a copy of her medication profile to her employer and should have had a prescription for everything she tested positive for.

12. On or about December 1, 2009, through December 26, 2009, while employed as a Licensed Vocational Nurse with Clear Lake Regional Medical Center, Webster, Texas, Respondent withdrew narcotics from the medication dispensing system for patients in excess of, or without valid physicians' orders. Respondent's conduct was likely to injure the patient in that the administration of narcotics in excess of, or without physicians' orders, could result in the patient suffering from adverse reactions.

13. On or about December 1, 2009, through December 26, 2009, while employed as a Licensed Vocational Nurse with Clear Lake Regional Medical Center, Webster, Texas, Respondent withdrew narcotics from the medication dispensing system for patients, but failed to document, or accurately document the administration, including the signs, symptoms and responses to the narcotics in the patients' Medication Administration Record (MAR) or Nurses Notes. . Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation to further medicate the patients which could result in an overdose.

14. On or about December 1, 2009, through December 26, 2009, while employed as a Licensed Vocational Nurse with Clear Lake Regional Medical Center, Webster, Texas, Respondent withdrew narcotics from the medication dispensing system for patients, but failed to properly waste unused portions, if any, 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).

15. On or about December 1, 2009, through December 26, 2009, while employed as a Licensed Vocational Nurse with Clear Lake Regional Medical Center, Webster, Texas, Respondent misappropriated, or failed to take precautions to prevent such misappropriation, of medication. Respondent's conduct was likely to defraud the facility and patients of the cost of the medication.

16. On or about August 13, 2010, through August 26, 2010, while employed as a Licensed Vocational Nurse with Memorial Hermann Southeast Hospital, Houston, Texas, Respondent withdrew Hydromorphone, Fentanyl, Lorazepam, and Meperidine from the Medication Dispensing System (Pyxis) for patients, but failed to document, or accurately document the administration of the medications in the patients' Medication Administration Records (MAR) 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 patients which could result in an overdose.

17. On or about August 13, 2010, through August 26, 2010, while employed as a Licensed Vocational Nurse with Memorial Hermann Southeast Hospital, Houston, Texas, Respondent withdrew Hydromorphone, Fentanyl, Lorazepam, and Meperidine from the Medication Dispensing System (Pyxis) for patients, but failed to follow that 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).

18. On or about August 13, 2010, through August 26, 2010, while employed as a Licensed Vocational Nurse with Memorial Hermann Southeast Hospital, Houston, Texas, Respondent misappropriated Hydromorphone, Fentanyl, Lorazepam, and Meperidine 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 the medication.

19. In response to Finding of Fact Numbers Sixteen (17) through Eighteen (18), Respondent states that her role at Memorial Hermann was very different than anything she has done in that past because her position required her to "task" for the floor nurses or RNs. Respondent states that as a LVN, she was not allowed to chart under certain areas in the patients' files. Respondent states that she had to rely on the RN for documentation and waste.

20. On or about November 14, 2010, through December 29, 2010, while employed as a Licensed Vocational Nurse with Cornerstone Hospital of Clear Lake, Webster, Texas, Respondent withdrew narcotics from the medication dispensing system for patients in excess of, or without a valid physician's order. Respondent's conduct was likely to injure the patient in that the administration of narcotics in excess of, or without physicians' orders, could result in the patient suffering from adverse reactions.

21. On or about November 14, 2010, through December 29, 2010, while employed as a Licensed Vocational Nurse with Cornerstone Hospital of Clear Lake, Webster, Texas, Respondent withdrew narcotics from the medication dispensing system for patients, but failed to document the administration, including signs, symptoms and responses, in the patients' Medication Administration Record (MAR) or Nurses Notes. Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation to further medicate the patients which could result in an overdose.

22. On or about November 14, 2010, through December 29, 2010, while employed as a Licensed Vocational Nurse with Cornerstone Hospital of Clear Lake, Webster, Texas, Respondent withdrew narcotics from the medication dispensing system for patients, but failed to properly waste unused portions, if any, 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).

23. On or about November 14, 2010, through December 29, 2010, while employed as a Licensed Vocational Nurse with Cornerstone Hospital of Clear Lake, Webster, Texas, Respondent misappropriated, or failed to take precautions to prevent such misappropriation, of the medications. Respondent's conduct was likely to defraud the facility and patients of the cost of the medication.

24. On or about April 2, 2011, while employed as a Licensed Vocational Nurse with Triumph Hospital Clear Lake, Webster, Texas, Respondent withdrew narcotics from the medication dispensing system for patients in excess of, or without a valid physician's order. Respondent's conduct was likely to injure the patient in that the administration of narcotics in excess of, or without physicians' orders, could result in the patient suffering from adverse reactions.

25. On or about April 2, 2011, while employed as a Licensed Vocational Nurse with Triumph Hospital Clear Lake, Webster, Texas, Respondent withdrew narcotics from the medication dispensing system for patients, but failed to document the administration, including signs, symptoms and response, in the patients' Medication Administration Record (MAR) or Nurses Notes. Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation to further medicate the patients which could result in an overdose.

26. On or about April 2, 2011, while employed as a Licensed Vocational Nurse with Triumph Hospital Clear Lake, Webster, Texas, Respondent withdrew narcotics from the medication dispensing system for patients, but failed to properly waste unused portions, if any, 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).

27. On or about April 2, 2011, while employed as a Licensed Vocational Nurse with Triumph Hospital Clear Lake, Webster, Texas, Respondent misappropriated, or failed to take precautions to prevent such misappropriation, of the medications. Respondent's conduct was likely to defraud the facility and patients of the cost of the medication.

28. On or about June 22, 2011, while employed as a Licensed Vocational Nurse with Supplemental Health Care, Houston, Texas, and assigned to Harris County Sheriff's Office, Houston, Texas, Respondent misappropriated medications belonging to the facility and patients thereof. Respondent's conduct was likely to defraud the facility and patients of the cost of the medication.

29. On or about June 22, 2011, Respondent was arrested by the Harris County Sheriff's Office, Houston, Texas, for POSSESSION OF A CONTROLLED SUBSTANCE - PENALTY GROUP 3 < 28 GRAMS (a Class A Misdemeanor offense committed on June 22, 2011).

30. The Respondent's conduct described in the preceding Finding of Fact was reportable under the provisions of Sections 301.401-301.419, Texas Occupations Code.

31. 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.

32. Respondent's compliance with the terms of a Board approved peer assistance program should be sufficient to protect patients and the public.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.455, 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, 22 TEX. ADMIN. CODE §217.11(1)(A),(B),(C)&(D)(iv), and 22 TEX. ADMIN. CODE §217.12(1)(A)&(B),(4),(6)(G),(8),(10)(B),(C)&(D),(11)(B)&(13).

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 200382, heretofore issued to CHRISTINA LYNN GONZALEZ, including revocation of Respondent's license to practice nursing in the State of Texas.

5. The Board may, in its discretion, order a nurse to participate in a peer assistance program approved by the Board if the nurse would otherwise have been eligible for referral to peer assistance pursuant to Section 301.410, Texas Occupations Code.

ORDER

IT IS THEREFORE AGREED and ORDERED that RESPONDENT, in lieu of the sanction of Revocation under Section 301.453, Texas Occupations Code, SHALL comply with the following conditions for such a time as is required for RESPONDENT to successfully complete the Texas Peer Assistance Program for Nurses (TPAPN):

(1) RESPONDENT SHALL, within forty-five (45) days following the date of entry of this final Order, apply to TPAPN and SHALL, within ninety (90) days following the date of entry of this final Order, sign and execute the TPAPN participation agreement, which SHALL include payment of a non-refundable participation fee in the amount of three hundred fifty dollars ($350.00) payable to TPAPN.

(2) Upon acceptance into the TPAPN, RESPONDENT SHALL waive confidentiality and provide a copy of the executed TPAPN participation agreement to the Texas Board of Nursing.

(3) RESPONDENT SHALL comply with all requirements of the TPAPN participation agreement during its term and SHALL keep her license to practice nursing in the State of Texas current.

(4) RESPONDENT SHALL CAUSE the TPAPN to notify the Texas Board of Nursing of any violation of the TPAPN participation agreement.

IT IS FURTHER AGREED, SHOULD RESPONDENT have her probation amended for the offense outlined in Finding of Fact Number Twenty-Nine (29), if applicable, said judicial action will result in further disciplinary action including Revocation of Respondent's license to practice vocational nursing in the State of Texas. Early termination of community supervision shall not constitute a violation of this order.

IT IS FURTHER AGREED and ORDERED, RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, Section §§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 is encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a multistate licensure privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED, SHOULD RESPONDENT fail to comply with this Order or the terms of the participation agreement with the TPAPN, such noncompliance will result in further disciplinary action including EMERGENCY SUSPENSION pursuant to Section 301.4551, Texas Occupations Code, or REVOCATION of Respondent's license and nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

BALANCE OF PAGE INTENTIONALLY LEFT BLANK.

CONTINUED ON NEXT PAGE.

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. I do acknowledge possessing a diagnosis that deems me eligible to participate in the Texas Peer Assistance Program for Nurses. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, and Conditions One (1) through Four (4) of this Order to obtain disposition of the allegations through peer assistance and to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes effective upon acceptance by the Executive Director on behalf of the Texas Board of Nursing, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order. I will be subject to investigation and disciplinary sanction, including revocation of my license to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 28 day of September, 2011.

CHRISTINA LYNN GONZALEZ, Respondent

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

SEAL

TIMOTHY L. McCOY
NOTARY PUBLIC
STATE OF TEXAS
My Commission Expires
July 06, 2015

Notary Public in and for the State of TX

WHEREFORE PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby accept and enter the Agreed Order that was signed on the 28th day of September, 20 11, by CHRISTINA LYNN GONZALEZ, Vocational Nurse License Number 200382, and said Order is final.

Entered and effective this 5 day of October, 20 11.

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