



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

BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of Registered Nurse           §     AGREED  
License Number 429907, issue to           §  
RACHEL N. IMO NWAOBASI                 §     ORDER

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Registered Nurse License Number 429907, issued to RACHEL N. IMO NWAOBASI, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c), 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(s).
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 a Baccalaureate Degree in Nursing from Adventist Mission, Ile-Ife, Nigeria on June 20, 1967. Respondent was licensed to practice professional nursing in the State of Texas on April 1, 1974.
5. Respondent's nursing employment history includes:

1973 to 1974	Graduate Nurse	Riverside General Hospital Houston, Texas
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Respondent's nursing employment history continued:

1974 to 1982	Staff Nurse/ Supervisor	St. Anthony Center Houston, Texas
1983 to 1987	Agency Nurse/PRN	Logos Medical Personnel Services Houston, Texas
1988 to 1992	Staff Nurse	Ben Taub Hospital Houston, Texas
1992 to 1994	Assistant Manager Total Patient Care	LBJ Hospital Houston, Texas
1994 to 12/2001	Staff Nurse/Assistant Nurse Manager	Ben Taub Hospital Houston, Texas
2002 to 10/2003	Supervisor	Seven Acres Jewish Senior Care Houston, Texas
11/2003 to 04/2010	Staff Nurse	The Woman's Hospital of Texas Houston, Texas
05/2010 to Present	Unknown	

6. On February 11, 2003, Respondent's license to practice professional nursing was issued the sanction of Remedial Education by the Board of Nurse Examiners for the State of Texas. A copy of the Findings of Fact, Conclusions of Law and Agreed Order dated February 11, 2003, is attached and incorporated by reference as part of this Order.
7. At the time of the initial incident, Respondent was employed as a Staff Nurse with The Woman's Hospital of Texas, Houston, Texas, and had been in this position for approximately six (6) years and two (2) months.
8. On or about January 14, 2010, while employed with The Woman's Hospital of Texas, Houston, Texas, Respondent failed to notify the physician for Patient Medical Record Number F000473252 that the hospitalist had not examined the patient, as he ordered at 2230, after the patient complained of redness and swelling above her C-section incision. Respondent's conduct was likely to deceive the physician who needed complete information on which to base her care.

9. On or about January 14-15, 2010, while employed with The Woman's Hospital of Texas, Houston, Texas, Respondent failed to obtain a catheterized urine specimen for testing for Patient Medical Record Number F000473252 as ordered by the physician. At the end of Respondent's shift, she reported that she was unsuccessful and the procedure was performed by a co-worker and the charge nurse with no difficulty. Respondent's conduct exposed the patient unnecessarily to a risk of harm from complications due to a delay of treatment of her disease process.
10. On or about February 15, 2010, while employed with The Woman's Hospital of Texas, Houston, Texas, Respondent failed to administer Vicodin as requested by the patient and ordered by the physician for Patient Medical Record Number F000552961. Respondent's conduct exposed the patient unnecessarily to a risk of harm from a delay of treatment of her disease process.
11. On or about February 15, 2010, while employed with The Woman's Hospital of Texas, Houston, Texas, Respondent failed to assist Patient Medical Record Number F000552961 to the restroom. The patient requested assistance to the restroom several times and Respondent told the patient "it is too early." The patient reported that after several ignored attempts to get assistance to the restroom, she had her husband help her up. Respondent's conduct exposed the patient unnecessarily to a risk of harm from injury due to assistance by the husband who did not have proper training to provide nursing care.
12. In response to Findings of Fact Numbers Eight (8) and Nine (9), Respondent states that she received report at 1900. One of her patients had an area above the abdominal site that was marked with a circle by the previous nurse. The area inside the circle was red, but the redness was still inside the circle. The patient was concerned about it and wanted her doctor to come and see it. At 2000 after completing her assessments she called the patient's physician and requested a return call. When he did not call she made a 2<sup>nd</sup> call. Later the physician returned her call and gave an order which she documented. One of the orders was to have the in-house hospitalist evaluate the patient. She called the in-house doctor and he requested that she retrieve the patient's vital signs for the 3 days and report to him. She reported to the patient that the in-house doctor would come and see her. She returned to the patient's room later and the doctor had not seen her. She called the in-house doctor again, but could not get him. She called the house supervisor and she gave her three numbers to call, but still did not get in touch with him. The charge nurse called a number that was determined to be a pager and he called back. He told her that he had forgotten to come and see the patient. He arrived shortly after that conversation and ordered a straight cath for a urine sample, at 0638. Respondent states that she works 7a-7p and the order was given at 0638. She went to get the patient's urine sample, but when she was trying to get the cath inserted the patient was closing her legs up tight. She discarded the contaminated catheter and went to get a fresh one and to get another nurse to assist her. On her way out of the room she ran into a nurse who offered assistance. The nurse offered to perform the cath so that she could finish her documentation and give report. She denies that she reported at the end of

her shift that she was unsuccessful, that information is not in her report. The orders were carried out before she left.

In response to Finding of Fact Number Ten (10), Respondent states that she gave the patient the Vicodin ordered, but there was some delay because she noticed the Vicodin Order was not in the medication dispensing device (Omnnicell). The medications profiled in the Omnicell were for a patient that had a c-section, not a vaginal delivery. She immediately called the pharmacist and reported the error and they corrected it immediately. She notified the patient that there would be a delay. She administered two Vicodin PO and denies refusing to carry out the order.

In response to Finding of Fact Number Eleven (11), Respondent states that she gave the patient admitting education which included that a nurse/staff must be called the first time the patient is out of bed to bathroom to void. Her phone number was written on the board. She responded when she got the first call and she was assisting the patient for her first time void when the charge nurse called her. "I do not recall several ignored attempts to get assistance to the bathroom" or having told the patient that "it's too early." Respondent states that they carry mobile phones on the floor so the patients can call them and the patient can also call the nursing station. She denies receiving a call. With her help the patient voided, the urine was measured and pericare and perimed as well as ice-pack applied. The patient was assisted back to bed and made comfortable.

13. Respondent, by her signature to this Order, expresses her desire to voluntarily surrender her license(s) to practice nursing in the State of Texas.

#### CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.
2. Notice was served in accordance with law.
3. The evidence received is sufficient to prove violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(C),(1)(D),(1)(M)&(1)(P) and 217.12(1)(A),(1)(B),(4).
4. The evidence received is sufficient cause pursuant to Section 301.453(a), Texas Occupations Code, to take disciplinary action against Registered License Number 429907, heretofore issued to RACHEL N. IMO NWAOBASI, including revocation of Respondent's license(s) 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 429907, heretofore issued to RACHEL N. IMO NWAOBASI, 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 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.
2. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order.
3. 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

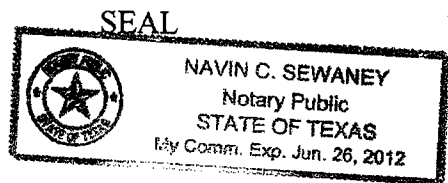
I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and 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 26<sup>th</sup> day of March, 2012.

R N Waoobasi

RACHEL N. IMO NWAOBASI, Respondent

Sworn to and subscribed before me this 26<sup>th</sup> day of MARCH, 2012.



Navin C. Sewaney  
Notary Public in and for the State of TX  
COUNTY OF HARRIS.

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 429907, previously issued to RACHEL N. IMO NWAOBASI.



Effective this 29<sup>th</sup> day of March, 2012.

*Katherine A. Thomas*

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

BEFORE THE BOARD OF NURSE EXAMINERS  
FOR THE STATE OF TEXAS

**ORIGINAL**

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In the Matter of License Number 429907                                 §     AGREED  
issued to RACHEL N. IMO NWAOBASI                                    §     ORDER

On this day the Board of Nurse Examiners for the State of Texas, hereinafter referred to as the Board, considered the matter of RACHEL N. IMO NWAOBASI, License Number 429907, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(13), Texas Occupations Code. Respondent waived informal conference, notice and hearing, and agreed to the entry of this Order offered on November 22, 2002, 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 informal conference, notice and hearing, and agreed to the entry of this Order.
3. Respondent is currently licensed to practice professional nursing in the State of Texas.
4. Respondent received a Diploma from Adventist Mission School of Nursing, Ife Ife, Nigeria, in 1970. Respondent was licensed to practice professional nursing in the State of Texas in April 1974.
5. Respondent's professional employment history includes:

1985 to 1988	Staff Nurse	Logos Medical Personnel Services
	Acute Care/Private	Houston, Texas
	Hospital/Home	



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Respondent's professional employment history continued:

1988 to 1992	Staff Nurse IMU/Telemetry/ Medical/Surgical/ CCU-EKG codes	Ben Taub Hospital Houston, Texas
1992 to 1994	Assistant Manager Total Patient Care	LBJ Hospital Houston, Texas
1994 to 12/2001	RN Assistant Manager/Unit Coordinator	Ben Taub Hospital Houston, Texas
12/2001 to Present	Retired from Ben Taub/Working PRN	

6. At the time of the incident, Respondent was employed as a RN Assistant Manager in the Geriatric Unit with Ben Taub Hospital, Houston, Texas, and had been in this position for seven (7) years.
7. On or about December 2, 2001, while employed with Ben Taub Hospital, Houston, Texas, Respondent failed to completely assess, document and intervene in the care of Medical Record #038880701332. The patient complained of "not feeling well" at 1900. No assessments, including vital signs, were performed or documented. At 2030, the patient experienced weakness, color was pale, pulse was hard to palpate, and the patient collapsed. A code blue was called at 2100. Resuscitation was attempted without success. Respondent's failure to completely assess the patient may have deprived the patient of needed medical intervention to stabilize the condition, and may have exposed the patient to unnecessary risk of harm.
8. On or about December 2, 2001, while employed with Ben Taub Hospital, Houston, Texas, Respondent failed to respond to a call for help from Medical Record #038880701332. Respondent was the direct care provider for this patient. The patient had complained of "not feeling well" at 1900. No documentation of the patient's status was completed. The patient was found on the floor by non-direct care staff. The patient was discovered with breathing problems, pale in color, with a pulse hard to palpate. Respondent's failure to care for the patient could have deprived the patient of needed medical intervention to stabilize the condition. This could have exposed the patient to unnecessary risk of harm.

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9. On or about December 2, 2001, while employed with Ben Taub Hospital, Houston, Texas, Respondent failed to collaborate with the attending physician regarding the status of Medical Record #03888071332. The patient complained of "not feeling well" at 1900. The physician was in the unit at 1945, but Respondent did not communicate the patient's complaint to the physician. No assessments, including vital signs and patient status, were documented in the medical record. The physician on-call was paged at 2100 after the patient had collapsed. Resuscitation was attempted without success, and the patient subsequently died. Respondent's failure to collaborate with the physician may have deprived the physician of necessary information to implement necessary medical interventions, and may have exposed the patient to unnecessary risk of harm.

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)(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(2),(4), & (21).
4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against License Number 429907, heretofore issued to RACHEL N. IMO NWAOBASI, including revocation of Respondent's professional license to practice nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Board of Nurse Examiners, that RESPONDENT SHALL receive the sanction of REMEDIAL EDUCATION, and RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Revised Civil Statutes of Texas as amended, Texas Occupations Code, Section §§301.001 *et seq.*, the Rules and Regulations Relating to Professional Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.01 *et seq.* and this Order.

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IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate licensure privilege, if any, to practice professional 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 State of Texas and the Board of Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL deliver the wallet-size license issued to RACHEL N. IMO NWAOBASI to the office of the Board of Nurse Examiners within three weeks of the date of ratification of this Order for appropriate notation.

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing jurisprudence. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Registered Nurses. It shall be a minimum of six (6) contact hours in length. The course's content shall include the Nursing Practice Act, standards of practice, and documentation of care. Courses focusing on malpractice issues will not be accepted. RESPONDENT SHALL CAUSE the sponsoring institution to submit a Verification of Course Completion form, provided by the Board, to the Office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure.

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(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in physical assessment. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include Registered Nurses. The didactic portion of this course shall be a minimum of six (6) hours in length. RESPONDENT SHALL perform physical assessments on live patients in a clinical setting for a minimum of twenty-four (24) hours which shall be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of physical assessment only. To be approved, the course shall cover all systems of the body. Performing assessments on mock patients or mannequins WILL NOT be accepted. The course description shall indicate goals and objectives for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure.

(4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation. RESPONDENT SHALL obtain Board approval of the course prior to enrollment. Home study courses and video programs will not be approved. The course shall be a minimum of six (6) hours in length of classroom time. In order for the course to be approved, the target audience shall include Registered Nurses. The course shall include content

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on the following: nursing standards related to accurate and complete documentation; legal guidelines for recording; methods and processes of recording; methods of alternative record-keeping; and computerized documentation. RESPONDENT SHALL cause the instructor to submit a Verification of Course Completion form, provided by the Board, to the Board's office to verify RESPONDENT's successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, RESPONDENT SHALL be issued an unencumbered license and multistate licensure privileges, if any, to practice professional nursing in the State of Texas.

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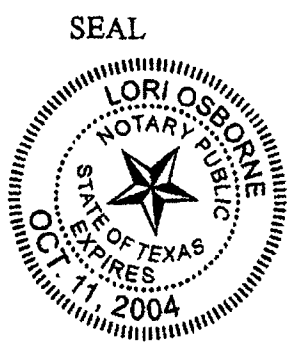
**ORIGINAL**

RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violation 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 when this Order becomes final and the terms of this Order become effective, 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 professional nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 28<sup>th</sup> day of January, 2003.  
R Nwaobasi  
RACHEL N. IMO NWAOBASI, Respondent

Sworn to and subscribed before me this 28<sup>th</sup> day of January, 2003.



Lori Osborne  
Notary Public in and for the State of TX

Approved as to form and substance.  
Andrea D. Arceneaux  
Andrea D. Arceneaux, Attorney for Respondent

Signed this 28<sup>th</sup> day of January, 2003.

WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Board of Nurse Examiners for the State of Texas, does hereby ratify and adopt the Agreed Order that was signed on the 28th day of January, 2003, by RACHEL N. IMO NWAOBASI, License Number 429907, and said Order is final.

Effective this 11th day of February, 2003.



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