BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse	§
License Number 792661	§
issued to WESLEY ROLEN ROSS	§

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 THE BOARD

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Registered Nurse License Number 792661, issued to WESLEY ROLEN ROSS, 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.

The Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Respondent is currently licensed to practice professional nursing in the State of Texas.

2. Respondent waived representation by counsel, informal proceedings, notice and hearing.

3. Respondent received an Associate Degree in Nursing from Indian River Community College, Fort Pierce, Florida on May 3, 2003. Respondent was licensed to practice professional nursing in the State of Texas on October 13, 2010.

4. Respondent's complete professional nursing employment history is unknown.

5. On or about January 19, 2011, Respondent was issued an Order of Emergency Suspension of License by the State of Florida Department of Health wherein Respondent's Florida Registered Nursing License was suspended for engaging or attempting to engage in the possession, sale, or distribution of controlled substances and unprofessional conduct. Furthermore on or about June 16, 2011, Respondent was issued a Final Order by the Florida Board of Nursing wherein Respondent's Florida Registered Nursing license was censured.

Specifically, Respondent's license was suspended on or about June 20, 2011, and Respondent was issued a fine of $250.00 and costs in the amount of $8,511.47. On or about August 2, 2011, the suspension was stayed and Respondent's license was placed under stipulations or obligations by the Florida Board of Nursing. A copy of the Order of Emergency Suspension of License issued by the State of Florida Department of Health dated January 19, 2011 and Final Order issued by the Florida Board of Nursing dated June 16, 2011 are attached and incorporated by reference as a part of this charge.

6. Formal Charges were filed on September 11, 2011. A copy of the Formal Charges is attached and incorporated by reference as part of this Order.

7. Formal Charges were mailed to Respondent on September 6, 2011.

8. On January 19, 2012, the Board received a notarized statement from Respondent voluntarily surrendering the right to practice nursing in Texas. A copy of Respondent's notarized statement, dated January 17, 2012, is attached and incorporated herein by reference as part of this Order.

9. 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.

10. 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.

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)(8), Texas Occupations Code.

4. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

5. Under Section 301.453(d), Texas Occupations Code, the Board may impose conditions for reinstatement of licensure.

6. Any subsequent reinstatement of this license will be controlled by Section 301.452 (b), Texas Occupations Code, and 22 TAC§§213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

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ORDER

NOW, THEREFORE, IT IS ORDERED that the voluntary surrender of Registered Nurse License Number 792661, heretofore issued to WESLEY ROLEN ROSS, to practice professional nursing in the State of Texas, is accepted by the Executive Director on behalf of 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 of registered nurse or the abbreviation RN or wear any insignia identifying himself 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; and, RESPONDENT has obtained objective, verifiable proof of twelve (12) consecutive months of sobriety immediately preceding the petition.

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 professional nursing in the State of Texas.

Effective this 27th day of January, 2012.

TEXAS BOARD OF NURSING

By: _____

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

Wesley Rolen Ross
13632 SW 16th Drive
Okeechobee, Florida 34974
Texas RN License #792661

Voluntary Surrender Statement

December 9, 2011

Dear Texas Board of Nursing:

I no longer desire to be licensed as a professional nurse. Accordingly, I voluntarily surrender my license/licenses to practice in Texas. I waive representation by counsel and consent to the entry of an Order which outlines requirements for reinstatement of my license. I understand that I will be required to comply with the Board's Rules and Regulations in effect at the time I submit any petition for reinstatement.

Signature _____

Date 1-17-2012

Texas Nursing License Number/s 792661

The State of Florida

Before me, the undersigned authority, on this date personally appeared WESLEY ROLEN ROSS who, being duly sworn by me, stated that he executed the above for the purpose therein contained and that he understood same.

Sworn to before me the 17th day of Jan, 2012.

SEAL

MARCUS A. HANIMAN
Commission # EE 033524
Expires October 15, 2014
Bonded Thru Troy Fain Insurance 800-385-7019

Marcus A Haniman, Notary

Notary Public in and for the State of Florida

FLORIDA DEPARTMENT OF HEALTH

Rick Scott
Governor

H. Frank Farmer, Jr., M.D., Ph.D.
State Surgeon General

CERTIFICATION

I, **Melisa Nobles**, Deputy Agency Clerk and Custodian of Records, HEREBY certify the following to be true and correct as on file with the Department of Health.

Attached is a true and correct copy of the Final Order from Case Number **2010-06118 & 2010-19846** as maintained by the Department of Health. The attached is a regularly received and retained record of the **Board of Nursing** vs. **Wesley Rolen Ross RN9232486** and is received and retained in the ordinary course of business of the Department of Health.

Melisa Nobles
Deputy Agency Clerk

Personally appeared before me, the undersigned authority, **Melisa Nobles**, Deputy Agency Clerk, Department of Health, Division of Medical Quality Assurance, who being sworn, says that this is a true and correct copy from the official file of the Department of Health.

Melisa Nobles
Deputy Agency Clerk

STATE OF FLORIDA
COUNTY OF LEON

Before me, personally appeared Melisa Nobles whose identity is personally known to me as Deputy Agency Clerk, and who, acknowledges that his/her signature appears above.

Sworn and subscribed to, before me, this **28th** day of **July 2011.**

Notary Public-State of Florida

RENADA CONLEY
Commission DD 818579
Expires November 9, 2012
Bonded Thru Troy Fain Insurance 800-385-7019

Type or Print Name

Final Order No. DOH-11-1446-S -MQA
FILED DATE - 6.20-11
Department of Health
By: Cindy L. Carraway
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF NURSING

DEPARTMENT OF HEALTH,

Petitioner,

vs.

Case No.: 2010-06118
2010-19846
License No.: RN 9232486

WESLEY ROLEN ROSS,

Respondent.
_____/

FINAL ORDER

THIS CAUSE came before the BOARD OF NURSING (Board) pursuant to Sections 120.569 and 120.57(4), Florida Statutes, on June 2, 2011, in Jacksonville, Florida, for the purpose of considering a settlement agreement (attached hereto as Exhibit A) entered into between the parties in this cause. Upon consideration of the settlement agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise fully advised in the premises, it is hereby

ORDERED AND ADJUDGED that the settlement agreement as submitted be and is hereby approved and adopted in toto and incorporated herein by reference. The costs are $8,511.47. Accordingly, the parties shall adhere to and abide by all the terms and conditions of the settlement agreement.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 16 day of June, 2011.

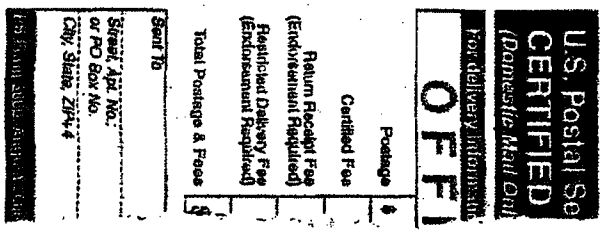
BOARD OF NURSING

William E. Spooner

JOE R. BAKER, JR.
Executive Director for
Jessie Colin, RN, PhD
Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to WESLEY ROLEN ROSS, 13632 SW 16th Drive, Okeechobee, FL 33974 and Jean D'Aprix, IPN, P.O. Box 49130, Jacksonville FL 32240; and by interoffice delivery to and by interoffice delivery to Lee Ann Gustafson, Senior Assistant Attorney General, Department of Legal Affairs, PL-01 The Capitol, Tallahassee FL 32399-1050, Jodi-Ann Johnson, Assistant General Counsel, Department of Health, 4052 Bald Cypress Way, Bin C-65, Tallahassee, Florida 32399-3265 this 20 day of June, 2011.



Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. CASE NO. 2010-06118

WESLEY ROLEN ROSS, R.N.

RESPONDENT.

_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Nursing against Respondent, Wesley Rolen Ross, R.N., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of nursing pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 464, Florida Statutes.

2. At all times material to this Complaint, Respondent was a registered nurse (R.N.) within the state of Florida, having been issued license number RN 9232486.

3. Respondent's address of record is 10458 N.W. 1st Avenue, Okeechobee, Florida 34972.

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4. At all times material to this Complaint, Respondent was employed by Medstaff Healthcare Solutions, a nurse staffing company, and was working as a R.N. at Wellington Regional Medical Center (WRMC) located in Wellington, Florida.

5. On or about March 5, 2010, Respondent was scheduled to work the 7:00 p.m. to 7:00 a.m. shift at WRMC.

6. During Respondent's shift beginning on or about March 5, 2010, Respondent was assigned to provide care to Patient P.R.

7. On or about March 5, 2010, at approximately 8:00 p.m. Respondent documented that Patient P.R. denied experiencing any pain.

8. On or about March 5, 2010, at approximately 8:30 p.m. Respondent wrote a telephone order for Patient P.R. to receive 2 milligrams (mg) Dilaudid by IV push every three hours as needed for pain.

9. Dilaudid is the brand name for hydromorphone and is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, hydromorphone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States.

10. On or about March 5, 2010, Respondent indicated that the aforementioned telephone order was authorized by Dr. Prettelt; Respondent sent the order to the pharmacy.

11. Dr. Prettelt denies authorizing the aforementioned telephone order.

12. On or about March 5, 2010, Respondent did not place the telephone order in Patient P.R.'s medical record.

13. On or about March 5, 2010, Respondent did not transcribe the telephone order on Patient P.R.'s medication administration record (MAR).

14. During Respondent's shift on or about March 5, 2010, Respondent was an agency nurse and not an employee of WRMC. As such, Respondent did not have direct access to controlled substances in the medication dispensing system.

15. WRMC utilized an automated medication dispensing system (Pyxis). Pyxis is a locked cart that contains controlled substances and is accessed through the use of a computer. Each time a nurse removes a controlled substance from the Pyxis cart, he or she must indicate which patient the medication is intended for. If the dose available in the Pyxis cart is greater than the dose ordered by the physician, the nurse must

discard the excess in the presence of a witness and document doing so in the Pyxis computer. This is done in order to accurately account for controlled substances removed and to assure proper patient billing for nursing care provided. In order to accurately record care rendered to the patient, all medications administered must be documented in the patient's record.

16. Each time a nurse removes a medication from Pyxis, the medication, date, time, patient for whom the drug is intended, and nurse removing the drug is recorded in the Pyxis computer. Reports showing what medications were removed from Pyxis for specific patients can be generated from Pyxis.

17. Since Respondent did not have access to controlled substances at WRMC, Respondent needed a WRMC staff nurse to procure these substances from Pyxis.

18. During Respondent's shift beginning on or about March 5, 2010, five 2 mg vials of Dilaudid were removed from Pyxis for Patient P.R. by five different nurses.

19. During Respondent's shift beginning on or about March 5, 2010, Respondent did not document administering Dilaudid to Patient P.R.

20. Patient P.R.'s MAR does not indicate any administration of Dilaudid during Respondent's shift beginning on or about March 5, 2010.

21. Patient P.R. denies experiencing any pain on or about March 5, or 6, 2010, and denies receiving any pain medication on or about March 5, or 6, 2010.

22. On or about March 6, 2010, at the end of Respondent's shift, Respondent gave a report to the on-coming nurse and indicated that there were no new orders for any of his patients.

COUNT ONE

23. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

24. Section 464.018(1)(l), Florida Statutes (2009), provides that engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in chapter 893, for any other than legitimate purposes authorized by this part, constitutes grounds for discipline of a licensee by the Board of Nursing.

25. As set forth above, Respondent engaged or attempted to engage in the possession of Dilaudid, a drug set forth in Chapter 893, for any other than legitimate purposes authorized by this part.

26. Based on the foregoing, Respondent violated Section 464.018(1)(l), Florida Statutes (2009), by engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in chapter 893, for any other than legitimate purposes authorized by this part.

COUNT TWO

27. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

28. Section 464.018(1)(h), Florida Statutes (2009), provides that unprofessional conduct, as defined by board rule, constitutes grounds for disciplinary action by the Board of Nursing.

29. Rule 64B9-8.005(1), Florida Administrative Code, provides that unprofessional conduct includes inaccurate recording.

30. Respondent engaged in inaccurate recording by:

a) failing to document that Patient P.R. was experiencing pain or other symptoms that would support the need for a physician's order for 2 mg Dilaudid by IV push every three hours; and/or

b) failing to transcribe the telephone order for Dilaudid on Patient P.R.'s MAR; and/or

c) failing to document the administration and/or waste of any of the five 2 mg vials of Dilaudid removed on or about March 5, 2010, for Patient P.R.

31. Based on the foregoing, Respondent violated Section 464.018(1)(h), Florida Statutes (2009), by engaging in unprofessional conduct, as defined by Rule 64B9-8.005(1), Florida Administrative Code, to include inaccurate recording.

COUNT THREE

32. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

33. Section 464.018(1)(h), Florida Statutes (2009), provides that unprofessional conduct, as defined by board rule, constitutes grounds for disciplinary action by the Board of Nursing.

34. Rule 64B9-8.005(6), Florida Administrative Code, provides that unprofessional conduct includes falsifying or altering of patient records or nursing progress records, employment applications or time records.

35. Respondent falsified or altered patient records by:

a) transcribing the aforementioned telephone order for Patient P.R. without physician approval; and/or

b) failing to place the telephone order for Dilaudid in Patient P.R.'s chart.

36. Based on the foregoing, Respondent violated Section 464.018(1)(h), Florida Statutes (2009), by engaging in unprofessional conduct, as defined by Rule 64B9-8.005(6), Florida Administrative Code, to include falsifying or altering of patient records or nursing progress records, employment applications or time records.

WHEREFORE, Petitioner respectfully requests that the Board of Nursing enter an Order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 12th **day of** October, **2010.**

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angela Barton
DATE 10/13/2010

Carla A. Schell
Assistant General Counsel
DOH Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265
Florida Bar Number 0042155
(850) 245 – 4640 Telephone
(850) 245 – 4683 Facsimile

PCP: 10/12/2010
PCP Members: L. Kirkpatrick & D. Mobley
/CS

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2010-19846**

WESLEY ROLEN ROSS, R.N.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Nursing against Respondent, Wesley Rolen Ross, R.N., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of nursing pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 464, Florida Statutes.

2. At all times material to this Administrative Complaint, Respondent was a registered nurse (R.N.) within the state of Florida, having been issued license number 9232486.

54324

3. Respondent's address of record is 10458 NW 1st Avenue, Okeechobee, Florida 34972.

4. At all times material to this Administrative Complaint, Respondent worked as a registered nurse at staffing agencies including All About Staffing and Medstaff Healthcare Solutions. Respondent provided services as a registered nurse at various facilities on a temporary basis.

5. From on or about March 5, 2010, at or about 7:00 p.m., to on or about March 6, 2010, at or about 7:00 a.m., Respondent was assigned to work a night shift at Wellington Regional Medical Center (Wellington Regional) through Medstaff Healthcare Solutions.

6. Wellington Regional utilized the Pyxis automated medication dispensing system. Pyxis consists of locked medication carts that secure and control access to controlled substances through a computer system. Each cart has a computer terminal on top of the cart that is linked to the pharmacy. Nurses can access Pyxis with either an individual password or through a fingerprint scan. The nurse selects the medication needed and the patient for whom the medication is intended and the specific drawer that contains that medication unlocks and opens. Activity reports can be generated from Pyxis that show all medications removed from the Pyxis

cart by a specific nurse. The activity reports indicate the medication, dose, date, time, patient for whom the medication is intended, and nurse removing the medication.

7. In order to accurately record patient care, and to accurately account for controlled substances, Wellington Regional required nurses to document the time each medication was administered to the patient on the patient's medical record. If a dose or partial dose of a controlled substance was removed from Pyxis, but not administered to the patient, the nurse was required to discard the controlled substance in the presence of another licensed nurse. The nurse discarding the controlled substance, and the nurse witness, both entered their names into the Pyxis computer to document that the controlled substance was discarded. The discard of a controlled substance is referred to in Pyxis as a "waste."

8. Nurses can only give medications, including controlled substances, to patients if the medication is ordered by the patient's physician. At Wellington Regional, once a physician order for medication was written, a copy of the order was provided to the pharmacy department. A pharmacy staff member entered the order into the Pyxis computer.

9. On or about March 5, 2010, at or about 7:00 p.m., Respondent arrived at Wellington Regional to work in the intensive care unit. He was assigned to care for patient P.R.

10. At or about 8:00 p.m., Respondent documented an assessment of P.R. and recorded that P.R. denied she was having pain.

11. At or about 8:30 p.m., Respondent documented a physician's order for P.R. to receive hydromorphone 2 milligrams (mg) by intravenous injection every three hours as needed for pain. Respondent documented that the order was received by telephone from P.R.'s physician. Respondent provided a copy of the order to the pharmacy, but did not place the order in P.R.'s medical record.

12. Hydromorphone is commonly prescribed to treat pain. According to Section 893.03(2), Florida Statutes, hydromorphone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of hydromorphone may lead to severe psychological or physical dependence.

13. P.R.'s physician did not authorize the order for P.R. to receive hydromorphone.

14. During the night shift from 7:00 p.m. on March 5, 2010 to 7:00 a.m. on March 6, 2010, Respondent obtained vials of hydromorphone from Pyxis, ostensibly for P.R., but failed to document that he administered the hydromorphone to P.R.

15. In the morning of on or about March 6, 2010, Respondent reported to the oncoming day nurse about the condition of his patients, including P.R. Respondent did not report anything about receiving an order for P.R. to receive hydromorphone for pain.

16. After receiving Respondent' report, the day nurse observed that P.R. had an order for hydromorphone entered into Pyxis, but that there was no order in P.R.'s medical record. The day nurse contacted the pharmacy, which provided her with a copy of the order that had been written by Respondent. The day nurse notified the Nursing Supervisor.

17. The Nursing Supervisor initiated an investigation and observed that P.R. had not complained of pain for three days. The Nursing Supervisor questioned P.R.'s physician who denied that he authorized the order for P.R. to receive hydromorphone.

18. On or about March 29, 2010, Wellington Regional notified the Department alleging that Respondent falsified a physician order for

hydromorphone in order to obtain vials of hydromorphone without authorization.

19. On or about July 15, 2010, Respondent was assigned to work at Lawnwood Regional Medical Center through All About Staffing.

20. Lawnwood Regional Medical Center had a similar medication dispensing system as did Wellington Regional. Nurses at Lawnwood were required to accurately record patient care and accurately account for controlled substances by documenting each medication administered to a patient on the patient's medical record. Any unused portions of controlled substances that had been removed for patients, but not administered to them, were required to be discarded, or wasted, in the presence of another licensed nurse.

21. On or about July 15, 2010, an audit conducted at Lawnwood Regional Medical Center revealed that on six occasions, Respondent had removed a vial of hydromorphone from the locked medication cart and administered a portion to a patient, but failed to properly discard, with a witness, the remaining unused portion of 1.5 mg of hydromorphone. A supervisor confronted Respondent about his failure to document that he wasted, or discarded, the unused portion of the hydromorphone he

removed, ostensibly for patients. Respondent stated he did discard the unused portion of the drug, but failed to do so in the presence of a witness.

22. On or about July 16, 2010, Lawnwood Regional Medical Center contacted All About Staffing and advised that Lawnwood Regional Medical Center would not be using Respondent' services as a registered nurse in the future due to his failure to properly waste controlled substances.

23. On or about July 22, 2010, All About Staffing assigned Respondent to work at Northwest Medical Center (NWMC). Respondent was assigned to work in the emergency department (ED) for approximately 13 weeks.

24. NWMC utilized the Acudose automated medication dispensing system. Acudose consists of locked medication carts that secure and control access to controlled substances through a computer system. Each cart has a computer terminal on top of the cart that is linked to the pharmacy. Nurses can access Acudose with either an individual password or through a fingerprint scan. The nurse selects the medication needed and the patient for whom the medication is intended and the specific drawer that contains that medication unlocks and opens. Activity reports

can be generated from Acudose that show all medications removed from the Acudose cart by a specific nurse. The activity reports indicate the medication, dose, date, time, patient for whom the medication is intended, and nurse removing the medication.

25. In order to accurately record patient care, and to accurately account for controlled substances, NWMC required nurses to document the time each medication was administered to the patient on the patient's medical record. If a dose or partial dose of a controlled substance was removed from Acudose, but not administered to the patient, the nurse was required to discard the controlled substance in the presence of another licensed nurse. The nurse discarding the controlled substance, and the nurse witness, both entered their names into the Acudose computer to document that the controlled substance was discarded, or wasted.

26. At NWMC, when a medication is ordered by a physician, a copy of the order is sent to the pharmacy department. A pharmacy staff member entered the order into the Acudose computer allowing nurses to remove the ordered medication from Acudose.

27. If a physician's order for a medication is not entered into Acudose, nurses can still remove the medication from Acudose, but can

only do so by using the override function. The override function is available so that nurses can administer newly ordered medications without having to wait for the pharmacy staff to enter the order into the computer.

28. NWMC routinely conducted audits of controlled substance usage by nurses. The audits compared the doses of a specific medication removed by a nurse to the average, or mean, doses of that medication removed by nurses in the same area. The audits alerted supervisors to nurses whose medication removal rates were several standard deviations above the average. Nurses with high removal rates of controlled substances were often investigated further to determine if a nurse was engaged in diversion of controlled substances.

29. On or about August 17, 2010, M.N., a 38 year old female patient, presented to the ED at NWMC due to an assault. M.N. was treated and discharged on or about August 17, 2010, at or about 4:40 p.m.

30. On or about August 17, 2010, A.D.M., a 25 year old female patient, presented to the ED at NWMC due to a sore throat. A.D.M. was treated and discharged on or about August 17, 2010, at or about 6:22 p.m.

31. On or about August 17, 2010, R.M., a 60 year old male patient, presented to the ED at NWMC after a motor vehicle accident. R.M. was treated and discharged on or about August 17, 2010, at or about 6:45 p.m.

32. On or about August 18, 2010, using the override function in Acudose, Respondent removed several 2 mg vials of hydromorphone from Acudose, ostensibly for N.M., A.D.M., and R.M., when those patients had been discharged the previous day and were no longer present in the ED. The following table summarizes the hydromorphone that Respondent removed from Acudose for N.M., A.D.M., and R.M.

Patient	Medication Removed from Acudose	Date and Time Removed	Waste	Physician Order	Date and time patient left the ED
A.D.M.	Two hydromorphone 2 mg vials	8/18/10 8:49 a.m.	None	No order for hydromorphone	8/17/10 at 6:22 p.m.
R.M.	Two hydromorphone 2 mg vials	8/18/10 8:57 a.m.	None	No order for hydromorphone	8/17/10 at 11:10 p.m.
M.N.	Two hydromorphone 2 mg vials	8/18/10 8:58 a.m.	None	No order for hydromorphone	8/17/10 at 9:49 p.m.

33. On or about August 21, 2010, at or about 3:19 p.m., S.B., a 64 year old female patient, presented to the ED at NWMC with complaints of fever and a cough. S.B. was treated and discharged on or about August 21, 2010, at or about 7:20 p.m.

34. On or about August 22, 2010, at or about 3:30 a.m., E.N., a 7 month old female patient, was brought to the ED at NWMC with a cough and congestion. E.N. was treated and discharged on or about August 22, 2010, at or about 5:00 a.m.

35. On or about August 22, 2010, at or about 10:30 a.m., S.A., a 43 year old male patient, presented to the ED at NWMC with complaints of right ear noise. S.A. was treated and discharged on or about August 22, 2010, at or about 11:30 a.m.

36. On or about August 22, 2010, at or about 7:32 p.m., S.S., a 79 year old female patient presented to the ED at NWMC with complaints of a laceration after a fall. S.S. was treated and discharged on or about August 22, 2010, at or about 10:40 p.m.

37. On or about August 23, 2010, using the override function in Acudose, Respondent removed several 2 mg vials of hydromorphone from Acudose, ostensibly for S.B., E.N., S.A., and S.S., when those patients had

been discharged and were no longer present in the emergency room. The following table summarizes the hydromorphone that Respondent removed for S.B., E.N., S.A., and S.S.

Patient	Medication Removed from Acudose	Date and Time Removed	Waste	Physician Order	Date and time patient left the ED
S.B.	Two hydromorphone 2 mg vials	8/23/10 7:22 a.m.	None	No order for hydromorphone	8/21/10 at 7:20 p.m.
S.A.	Two hydromorphone 2 mg vials	8/23/10 7:35 a.m.	None	No order for hydromorphone	8/22/10 at 11:30 a.m.
S.S.	Two hydromorphone 2 mg vials	8/23/10 7:54 a.m.	None	No order for hydromorphone	8/22/10 at 10:40 p.m.
E.N.	Two hydromorphone 2 mg vials	8/23/10 8:05 a.m.	None	No order for hydromorphone	8/22/10 at 5:00 a.m.

38. In or about August and September, 2010, Respondent continued this pattern of removing vials of hydromorphone using the override function for patients who had previously been discharged and were no longer present in the NWMC ED. The following table provides a

sample of some, but not all, incidents where Respondent removed hydromorphone for patients no longer present at the NWMC ED.

Patient	Medication Removed from Acudose	Date and Time Removed	Waste	Physician Order	Date and time patient left the ED
P.A.	Two hydromorphone 2 mg vials	8/24/10 7:49 a.m.	None	No order for hydromorphone	8/23/10 at 11:45 a.m.
Ma.A.	Two hydromorphone 2 mg vials	8/28/10 7:32 a.m.	None	No order for hydromorphone	8/27/10 at 12:55 p.m.
Mi.A	Two hydromorphone 2 mg vials	8/28/10 7:34 a.m.	None	No order for hydromorphone	8/27/10 at 11:10 p.m.
T.D.	Two hydromorphone 2 mg vials	8/28/10 7:44 a.m.	None	No order for hydromorphone	8/27/10 at 7:29 p.m.
A.T.	Two hydromorphone 2 mg vials	8/28/10 8:13 a.m.	None	No order for hydromorphone	8/27/10 at 9:45 p.m.
M.Al.	Two hydromorphone 2 mg vials	8/30/10 7:38 a.m.	None	No order for hydromorphone	8/29/10 at 7:54 p.m.
M.Ba. (3 year old)	Two hydromorphone 2 mg vials	8/30/10 10:30 a.m.	None	No order for hydromorphone	8/29/10 at 9:49 p.m.

C.B.	Two hydromorphone 2 mg vials	8/30/10 10:37 a.m.	None	No order for hydromorphone	8/30/10 at 1:15 a.m.
M.Ba. (3 year old)	Two hydromorphone 2 mg vials	8/31/10 11:19 a.m.	None	No order for hydromorphone	8/29/10 at 9:49 p.m.
W.B.	Two hydromorphone 2 mg vials	9/22/10 9:30 a.m.	None	No order for hydromorphone	9/22/10 at 3:30 a.m.
M.Bo.	Two hydromorphone 2 mg vials	9/22/10 9:31 a.m.	None	No order for hydromorphone	9/21/10 at 5:43 a.m.

39. In or about September of 2010, an audit of controlled substance usage by specific nurses was conducted. The audit revealed that in or about August of 2010, Respondent removed significantly more hydromorphone when compared to other nurses and also used the override function to remove medications more often than other nurses. Respondent was over five standard deviations above the mean for removing hydromorphone when compared to the amount of hydromorphone removed by other nurses.

40. On or about September 24, 2010, the Chief Nursing Officer and Emergency Department Director for NWMC contacted All About Staffing and reported that Respondent was suspected of drug diversion.

41. On or about September 25, 2010, the ED Director from NWMC directed Respondent to submit to a drug test due to the large amount of hydromorphone he was removing from Pyxis using the override function for patients who were no longer present in the ED. Respondent refused to submit to the drug test.

42. On or about September 25, 2010, Respondent was terminated from his staffing assignment at NWMC and All About Staffing was notified that Respondent had been removing large amounts of hydromorphone from Acudose, for patients who were no longer present in the ED.

43. On or about September 28, 2010, a Human Resources representative from All About Staffing sent Respondent a certified letter directing him to contact the Intervention Project for Nurses (IPN).

44. IPN is the impaired practitioner program for the Board of Nursing, pursuant to Section 456.076, Florida Statutes. IPN is a program that monitors the evaluation, care and treatment of impaired nurses. IPN oversees random drug screens and provides for the exchange of information between treatment providers, evaluators and the Department for the protection of the public.

45. On or about September 30, 2010, NWMC contacted the Margate Police Department and notified them that Respondent was suspected of stealing numerous vials of hydromorphone. A Margate Police Officer met with the Emergency Room Director who reported that Respondent was removing an excessive amount of hydromorphone. The Director reported that an investigation was conducted and it was discovered that many of the patients for whom Respondent was removing hydromorphone had already been discharged from the ED.

46. On or about October 7, 2010, the ED Director contacted a Margate Police Officer again and advised that the investigation into Respondent' diversion had been completed and it was discovered that Respondent had removed 278 vials of hydromorphone without authorization.

47. On or about October 13, 2010, as a result of the complaint filed by Wellington Regional in or about March of 2010, the Department filed an Administrative Complaint in DOH case number 2010-06118. The complaint charges Respondent with engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in Chapter 893, for any other than legitimate purposes authorized by Chapter

464, Part I, Florida Statutes in violation of Section 464.018(1)(i), Florida Statutes; and charges Respondent with unprofessional conduct, as defined by Rule of the Board of Nursing in violation of Section 464.018(1)(h), Florida Statutes. As of the date of this Emergency Suspension Order, case number 2010-06118 is still pending.

48. On or about January 7, 2011, the Department contacted IPN to determine if Respondent had engaged in any treatment or entered into an IPN monitoring contract. IPN reported that Respondent was reported to IPN by his employer, but Respondent did not contact IPN.

COUNT ONE

49. Petitioner re-alleges and incorporates paragraphs one (1) through forty-eight (48) as if fully set forth herein.

49. Section 464.018(1)(i), Florida Statutes (2010), subjects a licensee to discipline, including suspension, for engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in Chapter 893, Florida Statutes, for any other than legitimate purposes authorized by Part I of Chapter 464, Florida Statutes.

50. Respondent repeatedly engaged or attempted to engage in the possession of hydromorphone, a drug set forth in Chapter 893, Florida

Statutes, by removing multiple vials of the drug from Acudose without a physician's order and for patients who were already discharged and no longer present in the emergency department at NWMC.

51. Respondent violated Section 464.018(1)(i), Florida Statutes (2010), by engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in Chapter 893, Florida Statutes, for any other than legitimate purposes as authorized by this Part I of Chapter 464, Florida Statutes.

COUNT TWO

52. Petitioner realleges and incorporates paragraphs one (1) through forty-eight (48) as if fully set forth herein.

53. Section 464.018(1)(h), Florida Statutes (2010), subjects a licensee to discipline, including suspension, for unprofessional conduct, as defined by rule of the Board of Nursing.

54. Rule 64B9-8.005(1), Florida Administrative Code, defines unprofessional conduct to include inaccurate recording.

55. Respondent removed multiple doses of hydromorphone from Acudose and indicated in Acudose that the hydromorphone was intended to be administered to patients that had previously been in the NWMC ED.

The patients were no longer present in the ED and the hydromorphone was not administered to those patients. Respondent failed to account for what was done with approximately 278 vials of hydromorphone.

56. Respondent violated Section 464.018(1)(h), Florida Statutes (2010), by unprofessional conduct, as defined by Rule 64B9-8.005(1), Florida Administrative Code, to include inaccurate recording.

WHEREFORE, the Petitioner respectfully requests that the Board of Nursing enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 8th **day of** February, **20** 11.

State Surgeon General

P. J. Monte

Philip Monte
Assistant General Counsel
DOH Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265
Florida Bar Number 580406
(850) 245 - 4640 Telephone
(850) 245 - 4683 Facsimile

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE FEB 09 2011

PCP: 02/08/2011
PCP members: L. Kirkpatrick & D. Mobley

IPM

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v.

CASE NO.: 2010-06118
2010-19846

WESLEY ROLEN ROSS, R.N.,

Respondent.

SETTLEMENT AGREEMENT

Pursuant to Section 120.57(4), Florida Statutes, the above named parties hereby offer this Agreement to the Board of Nursing as disposition of the Administrative Complaint, attached hereto as Exhibit "A", in lieu of any other administrative proceedings. The terms herein become effective only if and when a Final Order accepting this Agreement is issued by the Board and filed. In considering this Agreement, the Board may review all investigative materials regarding this case. If this Agreement is rejected, it, and its presentation to the Board, shall not be used against either party.

STIPULATED FACTS

1. Respondent is a **REGISTERED NURSE** in the State of Florida holding license number **RN 9232486.**

2. The Respondent is charged by an Administrative Complaint filed by the Department and properly served upon Respondent with violations of Chapters 456

and/or 464, Florida Statutes. A true and correct copy of the Administrative Complaint is attached hereto and incorporated by reference as Exhibit A.

3. Respondent neither admits nor denies the factual allegations contained in the Administrative Complaint.

STIPULATED LAW

1. Respondent admits that he/she is subject to the provisions of Chapters 456 and 464, Florida Statutes, and the jurisdiction of the Department and the Board.

2. Respondent admits that the stipulated facts, if proven true, constitute violations of laws as alleged in the Administrative Complaint.

3. Respondent admits that the Agreement is a fair, appropriate and reasonable resolution to this pending matter.

PROPOSED DISPOSITION

1. The Board of Nursing shall reprimand the license of the Respondent.

2. The Respondent must pay an administrative fine in the amount of **two hundred fifty dollars ($250.00)** and investigative costs not to exceed **eight thousand, nine hundred nineteen dollars, and four cents ($8,919.04)** within eight (8) years from the date of entry of the Final Order. If the Respondent is placed on probation, the payment is due **prior** to the completion of the probationary period. The Respondent has the responsibility to document financial hardship **prior** to the due date of the payment. Payment must be by money order. Partial payments shall be accepted. Payment shall be made to the Board of

Nursing and mailed to, Compliance Management Unit, Bin C76, P.O. Box 6320, Tallahassee, Florida 32314-6320, Attention: Nursing Compliance Officer.

3. The Respondent shall enroll in and successfully complete courses in **Medication Administration, and Documentation (4 to 6 credits)**. This shall be in addition to other normally required continuing education courses. Verification of course content and course completion must be submitted to the Nursing Compliance Officer within six (6) months from the date of this Order. The Board will retain jurisdiction for the purpose of enforcing continuing education requirements.

4. The license of **WESLEY ROLEN ROSS, R.N.**, is suspended until the Respondent undergoes an evaluation coordinated by the Intervention Project for Nurses (IPN), and complies with any and all terms and conditions imposed by IPN as a result of said evaluation. At such time the suspension shall be stayed and remain stayed as long as the Respondent participates in the IPN. It is the duty of the Respondent to contact the IPN at P.O. Box 49130, Jacksonville Beach, Florida 32249-9130, (904) 270-1620 within 30 days from the date of entry of the Final Order. If the Respondent is in need of monitoring or treatment, he/she will comply with all conditions of the IPN Advocacy Contract or he/she will be in violation of the Final Order. Violation of the IPN Advocacy Contract shall result in the immediate lifting of the stay of suspension. Reinstatement will require compliance with all terms and conditions set forth in any previous Board Order, and the Respondent's appearance before the Board to demonstrate his/her present ability to engage in the safe practice of nursing, which shall include a demonstration of two (2) years of documented continuous sobriety. The

Board reserves the right to impose reasonable conditions of reinstatement at the time of appearance before the Board to demonstrate present ability to engage in the safe practice of nursing.

5. If the Respondent is not in need of monitoring or treatment and the IPN is not suitable, upon notification by the IPN to the Board office, then the Respondent is placed on probation for 2 year(s) subject to the following conditions:

a. The Respondent shall not violate Chapter 456 or 464, Florida Statutes, the rules promulgated pursuant thereto, any other state or federal law, rule, or regulation relating to the practice or the ability to practice nursing. Violation of an order from another state/jurisdiction shall constitute grounds for violation of the Board Order adopting this Agreement.

b. The Respondent must report any change in his/her address, telephone number, employment, employer's address or telephone number, or any arrests [or violations of probation or whatever impediment which may be on the license from another jurisdiction], in writing by certified mail within ten (10) working days to the Nursing Compliance Officer at the Department of Health, Client Services Unit, HMQAMS, BIN # C01, 4052 Bald Cypress Way, Tallahassee, Florida 32399-3251.

c. Whether employed as a nurse or not, the Respondent shall submit written reports to the Nursing Compliance Officer at the address provided in the previous paragraph, which contain the Respondent's name; license number; current address; current telephone number; the name, address, and telephone number of each current employer, whether employed as a nurse or not; and a statement by the Respondent describing his/her employment. This report shall be submitted to the Nursing Compliance Officer every three (3) months in a manner as directed by the Nursing Compliance Officer.

d. All current and future settings in which the Respondent practices nursing shall be promptly informed of the Respondent's probationary status. Within five (5) days of

the receipt of the Order adopting this Agreement, the Respondent shall furnish a copy to his/her nursing supervisor or supervisors, if there are multiple employers. The supervisor(s) must acknowledge this probation to the Board compliance officer in writing on employer letterhead within ten (10) days. Should the Respondent change employers, he/she must supply a copy of the Order adopting this Agreement to his/her supervisor within five (5) days. The new employer shall acknowledge the probation in writing on employer letterhead to the Board compliance officer within ten (10) days. The Respondent shall be responsible for assuring reports from the nursing supervisors will be furnished to the Nursing Compliance Officer every three (3) months. That report shall describe the Respondent's work assignment, workload, level of performance, and any problems that have occurred during that quarter. Any report indicating an unprofessional level of performance shall constitute a violation of this probation.

e. If the Respondent leaves Florida for thirty (30) days or more or ceases to practice nursing in Florida, the term of probation shall be tolled until the Respondent returns to active practice of nursing in Florida. Then the probationary period will resume. Unless the Final Order adopting this Settlement Agreement expressly states otherwise, any and all fines and costs imposed, or continuing education required, are not tolled by this provision, and must be paid or completed within the time specified and are not tolled by this provision. Employer reports are not required during the time probation is tolled. Working in nursing without notification to the Board is a violation of this Order.

f. The Respondent must work in a setting under direct supervision and only on a regularly assigned unit. Direct supervision requires another nurse to be working on the same unit as the Respondent and readily available to provide assistance and intervention. The Respondent cannot be employed by a nurse registry, temporary nurse employment agency or home health agency. Multiple employers are prohibited. The Respondent cannot be self-employed as a nurse.

6. The Respondent shall not violate Chapter 456 or 464, Florida Statutes, the rules promulgated pursuant thereto, any other state or federal law, rule, or regulation relating to the practice or the ability to practice nursing. Violation of an order from another state/jurisdiction shall constitute grounds for violation of the Board Order adopting this Agreement.

7. It is expressly understood that this Agreement is subject to the approval of the Board and Department and has no force and effect until an Order is entered adopting the Agreement.

8. This Agreement is executed by the Respondent for the purpose of avoiding further administrative action by the Board of Nursing regarding the acts or omissions specifically set forth in the Administrative Complaint attached hereto. In this regard, Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent prior to, or in conjunction with, consideration of the Agreement. Furthermore, should this joint Agreement not be accepted by the Board, it is agreed that presentation to, and consideration of, this Agreement and other documents and matters by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation, consideration or resolution of these proceedings. Respondent shall offer no evidence, testimony or argument that disputes or contravenes any stipulated fact or conclusion of law.

9. Respondent and the Department fully understand that this joint Agreement and subsequent Final Order incorporating same will in no way preclude additional proceedings by the Board and/or Department against the Respondent for

acts or omissions not specifically set forth in the Administrative Complaint attached hereto. This Agreement relates solely to the current disciplinary proceedings arising from the above-mentioned Administrative Complaint and does not preclude further action by other divisions, departments, and/or sections of the Department, including but not limited to the Agency for Health Care Administration's Medicaid Program Integrity Office.

10. The Respondent waives the right to seek any attorney's fees or costs from the Department in connection with this disciplinary proceeding.

11. Respondent waives all rights to appeal and further review of this Agreement and these proceedings.

WHEREFORE, the parties hereto request the Board to enter a Final Order accepting and implementing the terms contained herein.

SIGNED this 22nd day of March 2011.

WESLEY ROLEN ROSS, R.N.

Before me personally appeared Wesley R. Ross, whose identity is known to be by personally known (type of identification), and who under oath, acknowledges that his/her signature appears above.
Sworn to and subscribed by Respondent before me this 22nd day of March 2011.

Notary Public
My Commission Expires: Sept 4, 2011.

JANINE MIMS
Commission DD 707205
Expires September 4, 2011

APPROVED this ____ day of _____, 201_.

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

Counsel for Petitioner:
Phillip Monte
Assistant General Counsel
FBN: 0580406
Department of Health
Prosecution Services Unit
4052 Bald Cypress Way, BIN #C-65
Tallahassee, Florida 32399-3265

54356

TO: Cassandra G. Pasley, BSN, JD, Chief
Bureau of Health Care Practitioner Regulation

FROM: Joe Baker, Jr., Executive Director
Florida Board of Nursing

DATE: June 10, 2011

RE: Delegation of Authority

During my absence on Monday, June 13, 2011, through Wednesday, June 22, 2011, the following managers are delegated authority for the board office:

June 13-14	Robert Johnson	Program Ops Administrator
June 15-16	William Spooner	Program Ops Administrator
June 17-20	Mr. Johnson	
June 21-22	Mr. Spooner	

I will be on leave and then attending the NCSBN Executive Officer Leadership Summit.

Thank you.

JBjr/ms

In the Matter of Permanent License	§	**BEFORE THE TEXAS**
Number 792661, Issued to	§	
WESLEY ROLEN ROSS, Respondent	§	**BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, WESLEY ROLEN ROSS, is a Registered Nurse holding license number 792661, 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 January 19, 2011, Respondent was issued an Order of Emergency Suspension of License by the State of Florida Department of Health wherein Respondent's Florida Registered Nursing License was suspended for engaging or attempting to engage in the possession, sale, or distribution of controlled substances and unprofessional conduct. Furthermore on or about June 16, 2011, Respondent was issued a Final Order by the Florida Board of Nursing wherein Respondent's Florida Registered Nursing license was censured. Specifically, Respondent's license was suspended on or about June 20, 2011, and Respondent was issued a fine of $250.00 and costs in the amount of $8,511.47. On or about August 2, 2011, the suspension was stayed and Respondent's license was placed under stipulations or obligations by the Florida Board of Nursing. A copy of the Order of Emergency Suspension of License issued by the State of Florida Department of Health dated January 19, 2011 and Final Order issued by the Florida Board of Nursing dated June 16, 2011 are attached and incorporated by reference as a part of this charge.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to 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 ($1200.00).

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.state.tx.us.

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

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Orders which are attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Order of Emergency Suspension of License issued by the Florida Board of Nursing dated January 19, 2011 and Final Order issued by the State of Florida Department of Health dated June 16, 2011.

Filed this 2nd day of September, 20 11.

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 Robert Brenton, Assistant General Counsel
State Bar No. 24066924
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
Nikki Hopkins, Assistant General Counsel
State Bar No. 24052269
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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: Order of Emergency Suspension of License issued by the State of Florida Department of Health dated January 19, 2011 and Final Order issued by the Florida Board of Nursing dated June 16, 2011.

D/2010.12.28