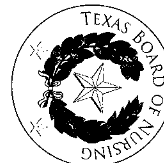

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse	§	
License Number 706508	§	AGREED
issued to AMANDA LYNN BELL	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Boa considered the matter of AMANDA LYNN BELL, Registered Nurse License Number 7065, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)(12)&(13), Texas Occupations Code. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order offered on February 11, 2009, by Katherine A. Thomas, MN, RN, Executive Director, subject to ratification by the Board.

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's license to practice professional nursing in the State of Texas is currently in delinquent status.

4. Respondent received a Diploma in Nursing from the Covenant School of Nursing, Lubbock, Texas, on May 28, 2004. Respondent was licensed to practice professional nursing in the State of Texas on July 6, 2004.

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

6. On or about August 7, 2007, while employed with Nursefinders, and on assignment at Snyder Oaks Care Center, Snyder, Texas, Respondent lacked fitness to practice professional nursing, in that she was found sitting on the floor next to the med cart, unable to turn the pages of the narcotic book during a count of the narcotics drawer, and she appeared distracted. Additionally, several controlled substances and syringes were found in her vehicle. Respondent's condition could have affected her ability to recognize subtle signs, symptoms or changes in patients' conditions, and could have affected her ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patients in potential danger.

7. On or about August 6, 2007, and August 7, 2007, while employed with Nursefinders, and on assignment at Snyder Oaks Care Center, Snyder, Texas, Respondent signed out Hydrocodone, Oxycodone, and Morphine for residents in excess frequency/dosage of physicians' orders, as follows:

Date	MR#	Physician's Order	Controlled Substance Record of Administration	Medication Record	Comments
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs @ "11pm"	Not Available	Previous dose given at 8pm by previous shift. 2 tabs as ordered. Pt was not due for another dose until 12 mn, and it only should have been 1 tab
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.

8/6/07	3050	Morphine 30mg 1 cap BID	Morphine 30mg 1 Cap @ "11pm"	Not Documented	Dose due at 8A & 8P. 8P dose already given. RN copied previous line on CSRA, #s don't make sense
8/6/07	4346	Hydrocodone 5/500 / 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 1 Tab @ "11pm"	Not Documented	Previous dose given at 8P. Too early for another dose.
8/6/07	4346	Hydrocodone 5/500 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 2 Tabs @ "0151"	Not Documented	Not allowed 2 at a time. Too early from previous dose. Amount on hand wrong. Copied previous line. Crossed out #s and rewrote w/o initialing
8/6/07	4346	Hydrocodone 5/500 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 2 Tabs (Time Signed Out Illegible)	Not Documented	Not allowed 2 at a time. Time given unintelligible.
8/6/07	4243	Hydrocodone 5/500 1 PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "1030"	Not Documented	Only allowed 1 tab at a time. Initially wrote 30 on hand, withdrew 2, zero remaining. Scratched out zero, wrote 28.
8/6/07	3050	Hydrocodone 5/500 2 PO Q4 hrs PRN	Hydrocodone 5/500 2 Tabs @ "10:3A" (sic)	Not Documented	Copied previous line on CSRA. Wasn't there at 1030A.
8/6/07	4386	Hydrocodone 10/500 1 Q4hrs PRN	Hydrocodone 10/500 2 Tabs @ "5pm"	Not Documented	Only allowed 1 tab at a time. Excess dosage. Copied previous line on CSRA. #s don't make sense.
8/6/07 or 8/7/07	4434	Oxycodone 5mg 1 TID	Oxycodone 5mg 2 Tabs (Date and Time Signed Out Illegible)	Not Documented	No doses should have been given on overnight shift. Wrote amount on hand as previous amount on hand instead of amount remaining from previous dose. Last dose given at 8pm on 8/6/07.
8/6/07 or 8/7/07	4381	Hydrocodone 5/500 1 PO TID	Hydrocodone 5/500 2 Tabs @ "1100" Date written: "8/8/07"	Not Documented	None due on her shift. Pt did have a PRN Rx for pain med, 2 tabs, but none was doc'd being given. The CSRA written on was for the scheduled dose. Date written was in the future.
8/6/07 or 8/7/07	3050	Hydrocodone 5/500 2 PO Q4 hrs PRN	Hydrocodone 5/500 2 Tabs @ "10:30" (Date Signed Out Illegible)	Not Documented	Unintelligible #s for amounts on hand and remaining

8/7/07	4253	Hydrocodone 5/500 1 tab PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "0100"	Not Documented	Excess dosage
8/7/07	4253	Hydrocodone 5/500 1 tab PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "0100" or "0700"	Not Documented	Excess dosage/frequency. Copied #s from previous line on CSRA. #s don't make sense.
8/7/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered. Count was zero available to pull, RN scribbled out #s and re-wrote them to try to show 2 more pills available.

Respondent's conduct was likely to injure patients in that the administration of Hydrocodone, Oxycodone, and Morphine in excess frequency and/or dosage of the physician's order could result in patients suffering from adverse reactions, including respiratory depression, and is in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).

8. On or about August 6, 2007 and August 7, 2007, while employed with Nursefinders, and on assignment at Snyder Oaks Care Center, Snyder, Texas, Respondent signed out Hydrocodone, Oxycodone, Morphine, and Xanax for residents, but failed to document, or accurately document the administration of the medications in the patient's Medication Records, as follows:

Date	MR#	Physician's Order	Controlled Substance Record of Administration	Medication Record	Comments
8/6/07	3050	Morphine 30mg 1 cap BID	Morphine 30mg 1 Cap @ "11pm"	Not Documented	Dose due at 8A & 8P. 8P dose already given. RN copied previous line on CSRA, #s don't make sense
8/6/07	4346	Hydrocodone 5/500 / 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 1 Tab @ "11pm"	Not Documented	Previous dose given at 8P. Too early for another dose.
8/6/07	4346	Hydrocodone 5/500 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 2 Tabs @ "0151"	Not Documented	Not allowed 2 at a time. Too early from previous dose. Amount on hand wrong. Copied previous line. Crossed out #s and rewrote w/o initialing

8/6/07	4346	Hydrocodone 5/500 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 2 Tabs (Time Signed Out Illegible)	Not Documented	Not allowed 2 at a time. Time given unintelligible.
8/6/07	4243	Hydrocodone 5/500 1 PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "1030"	Not Documented	Only allowed 1 tab at a time. Initially wrote 30 on hand, withdrew 2, zero remaining. Scratched out zero, wrote 28
8/6/07	4386	Hydrocodone 10/500 1 Q4hrs PRN	Hydrocodone 10/500 2 Tabs @ "5pm"	Not Documented	Only allowed 1 tab at a time. Excess dosage. Copied previous line on CSRA. #s don't make sense.
8/6/07	3050	Hydrocodone 5/500 2 PO Q4 hrs PRN	Hydrocodone 5/500 2 Tabs @ "10:3A" (sic)	Not Documented	Copied previous line on CSRA. Wasn't there at 1030A.
8/6/07 or 8/7/07	4434	Oxycodone 5mg 1 TID	Oxycodone 5mg 2 Tabs (Date and Time Signed Out Illegible)	Not Documented	No doses should have been given on overnight shift. Wrote amount on hand as previous amount on hand instead of amount remaining from previous dose. Last dose given at 8pm on 8/6/07.
8/6/07 or 8/7/07	4381	Hydrocodone 5/500 1 PO TID	Hydrocodone 5/500 2 Tabs @ "1100" Date written: "8/8/07"	Not Documented	None due on her shift. Pt did have a PRN Rx for pain med, 2 tabs, but none was doc'd being given. The CSRA written on was for the scheduled dose. Date written was in the future.
8/6/07 or 8/7/07	3050	Hydrocodone 5/500 2 PO Q4 hrs PRN	Hydrocodone 5/500 2 Tabs @ "10:30" (Date Signed Out Illegible)	Not Documented	Unintelligible #s for amounts on hand and remaining
8/7/07	4253	Hydrocodone 5/500 1 tab PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "0100"	Not Documented	Excess dosage
8/7/07	4253	Hydrocodone 5/500 1 tab PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "0100" or "0700"	Not Documented	Excess dosage/frequency. Copied #s from previous line on CSRA. #s don't make sense.
8/7/07	4259	Xanax 0.25mg 1 tab PO TID PRN	Xanax 0.25mg 1 Tab (Time Signed Out Illegible)	Not Documented	Wrote date twice instead of time Resident states no meds given

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

and is in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).

9. On or about August 6, 2007, and August 7, 2007, while employed with Nursefinders, and on assignment at Snyder Oaks Care Center, Snyder, Texas, Respondent made incorrect, inconsistent, and/or unintelligible entries onto the Controlled Substance Record of Administration for residents, as follows:

Date	MR#	Physician's Order	Controlled Substance Record of Administration	Medication Record	Comments
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.
8/6/07	3050	Morphine 30mg 1 cap BID	Morphine 30mg 1 Cap @ "11pm"	Not Documented	Dose due at 8A & 8P. 8P dose already given. RN copied previous line on CSRA, #s don't make sense
8/6/07	4346	Hydrocodone 5/500 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 2 Tabs @ "0151"	Not Documented	Not allowed 2 at a time. Too early from previous dose. Amount on hand wrong. Copied previous line. Crossed out #s and rewrote w/o initialing
8/6/07	4346	Hydrocodone 5/500 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 2 Tabs (Time Signed Out Illegible)	Not Documented	Not allowed 2 at a time. Time given unintelligible.

8/6/07	4386	Hydrocodone 10/500 1 Q4hrs PRN	Hydrocodone 10/500 2 Tabs @ "5pm"	Not Documented	Only allowed 1 tab at a time. Excess dosage. Copied previous line on CSRA. #s don't make sense.
8/6/07	4243	Hydrocodone 5/500 1 PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "1030"	Not Documented	Only allowed 1 tab at a time. Initially wrote 30 on hand, withdrew 2, zero remaining. Scratched out zero, wrote 28
8/6/07	3050	Hydrocodone 5/500 2 PO Q4 hrs PRN	Hydrocodone 5/500 2 Tabs @ "10:3A" (sic)	Not Documented	Copied previous line on CSRA. Wasn't there at 1030A.
8/6/07 or 8/7/07	4434	Oxycodone 5mg 1 TID	Oxycodone 5mg 2 Tabs (Date and Time Signed Out Illegible)	Not Documented	No doses should have been given on overnight shift. Wrote amount on hand as previous amount on hand instead of amount remaining from previous dose. Last dose given at 8pm on 8/6/07.
8/6/07 or 8/7/07	4381	Hydrocodone 5/500 1 PO TID	Hydrocodone 5/500 2 Tabs @ "1100" Date written: "8/8/07"	Not Documented	None due on her shift. Pt did have a PRN Rx for pain med, 2 tabs, but none was doc'd being given. The CSRA written on was for the scheduled dose. Date written was in the future.
8/6/07 or 8/7/07	3050	Hydrocodone 5/500 2 PO Q4 hrs PRN	Hydrocodone 5/500 2 Tabs @ "10:30" (Date Signed Out Illegible)	Not Documented	Unintelligible #s for amounts on hand and remaining
8/7/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered. Count was zero available to pull, RN scribbled out #s and re-wrote them to try to show 2 more pills available.
8/7/07	4253	Hydrocodone 5/500 1 tab PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "0100" or "0700"	Not Documented	Excess dosage & frequency. Copied #s from previous line on CSRA. #s don't make sense.
8/7/07	4259	Xanax 0.25mg 1 tab PO TID PRN	Xanax 0.25mg 1 Tab (Time Signed Out Illegible)	Not Documented	Wrote date twice instead of time Resident states no meds given

Respondent's conduct above was likely to injure the patients in that subsequent care givers would rely on her documentation to further medicate the patient which could result in an overdose or result in non-efficacious treatments and is in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).

10. On or about August 6, 2007 and August 7, 2007, while employed with Nursefinders, and on assignment at Snyder Oaks Care Center, Snyder, Texas, Respondent signed out Hydrocodone, Oxycodone, Morphine, and Xanax for residents, but failed to follow the facility's policy and procedure regarding wastage of any of the unused portions of the medications, as follows:

Date	MR#	Physician's Order	Controlled Substance Record of Administration	Medication Record	Comments	Waste
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs @ "11pm"	Not Available	Previous dose given at 8pm by previous shift. 2 tabs as ordered. Pt was not due for another dose until 12 mn, and it only should have been 1 tab	None
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.	None
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.	None
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.	None
8/6/07	4285	Hydrocodone 10/325 2PO BID & 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered.	None
8/6/07	3050	Morphine 30mg 1 cap BID	Morphine 30mg 1 Cap @ "11pm"	Not Documented	Dose due at 8A & 8P. 8P dose already given. RN copied previous line on CSRA, #s don't make sense	None

8/6/07	4346	Hydrocodone 5/500 / 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 1 Tab @ "11pm"	Not Documented	Previous dose given at 8P. Too early for another dose.	None
8/6/07	4346	Hydrocodone 5/500 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 2 Tabs @ "0151"	Not Documented	Not allowed 2 at a time. Too early from previous dose. Amount on hand wrong. Copied previous line. Crossed out #s and rewrote w/o initialing	None
8/6/07	4346	Hydrocodone 5/500 1 PO Q4-6 PRN/ QHS	Hydrocodone 5/500 2 Tabs (Time Signed Out Illegible)	Not Documented	Not allowed 2 at a time. Time given unintelligible.	None
8/6/07	3050	Hydrocodone 5/500 2 PO Q4 hrs PRN	Hydrocodone 5/500 2 Tabs @ "10:3A" (sic)	Not Documented	Copied previous line on CSRA. Wasn't there at 1030A.	None
8/6/07	4243	Hydrocodone 5/500 1 PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "1030"	Not Documented	Only allowed 1 tab at a time. Initially wrote 30 on hand, withdrew 2, zero remaining. Scratched out zero, wrote 28	None
8/6/07	4386	Hydrocodone 10/500 1 Q4hrs PRN	Hydrocodone 10/500 2 Tabs @ "5pm"	Not Documented	Only allowed 1 tab at a time. Excess dosage. Copied previous line on CSRA. #s don't make sense.	None
8/6/07 or 8/7/07	4434	Oxycodone 5mg 1 TID	Oxycodone 5mg 2 Tabs (Date and Time Signed Out Illegible)	Not Documented	No doses should have been given on overnight shift. Wrote amount on hand as previous amount on hand instead of amount remaining from previous dose. Last dose given at 8pm on 8/6/07.	None
8/6/07 or 8/7/07	4381	Hydrocodone 5/500 1 PO TID	Hydrocodone 5/500 2 Tabs @ "1100" Date written: "8/8/07"	Not Documented	None due on her shift. Pt did have a PRN Rx for pain med, 2 tabs, but none was doc'd being given. The CSRA written on was for the scheduled dose. Date written was in the future.	None
8/6/07 or 8/7/07	3050	Hydrocodone 5/500 2 PO Q4 hrs PRN	Hydrocodone 5/500 2 Tabs @ "10:30" (Date Signed Out Illegible)	Not Documented	Unintelligible #s for amounts on hand and remaining	None

8/7/07	4285	Hydrocodone 10/325 2PO BID / 1 Q4hrs PRN / max 8/day	Hydrocodone 10/325 2 Tabs (Time Signed Out Illegible)	Not Available	Writing gets more and more unintelligible. Can't decipher time. Only allowed 1 tab, RN pulled 2 each time. More often than ordered. Count was zero available to pull, RN scribbled out #s and re-wrote them to try to show 2 more pills available.	None
8/7/07	4253	Hydrocodone 5/500 1 tab PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "0100"	Not Documented	Excess dosage	None
8/7/07	4253	Hydrocodone 5/500 1 tab PO Q4hrs PRN	Hydrocodone 5/500 2 Tabs @ "0100" or "0700"	Not Documented	Excess dosage/frequency. Copied #s from previous line on CSRA. #s don't make sense.	None
8/7/07	4259	Xanax 0.25mg 1 tab PO TID PRN	Xanax 0.25mg 1 Tab (Time Signed Out Illegible)	Not Documented	Wrote date twice instead of time Resident states no meds given	None

Respondent's conduct was likely to deceive the hospital pharmacy and placed them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).

11. On or about August 6, 2007 and August 7, 2007, while employed with Nursefinders, and on assignment at Snyder Oaks Care Center, Snyder, Texas, Respondent misappropriated Hydrocodone, Oxycodone, Morphine, and Xanax belonging to the facility and patients thereof, or failed to take precautions to prevent such misappropriation. Respondent's conduct defrauded the facility and the patients thereof of the cost of the medications and is in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substances Act).

12. On or about August 7, 2007, Respondent was arrested by the Snyder Police Department, Snyder, Texas, for "Possession of a Controlled Substance, Greater Than Four (4) Grams, But Less Than Two Hundred (200) Grams," a 2nd Degree Felony.

13. On or about October 3, 2007, Respondent successfully completed an Intensive Residential Treatment Program through Managed Care Center for Addictive/Other Disorders, Lubbock, Texas.

14. Respondent admits to having become addicted to hydrocodone after being in a car accident.

15. 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.

16. Formal Charges were filed on October 17, 2008.

17. Formal Charges were mailed to Respondent on October 21, 2008.

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)(12)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(B)(C)(D)&(T) and 22 TEX. ADMIN. CODE §217.12(1)(A)(C)(E),(4),(5),(6)(A)(G)(H),(10)(B)(C),(11)(B)&(13).

4. The evidence received is sufficient cause pursuant to Section 301.452(b), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 706508, heretofore issued to AMANDA LYNN BELL, including revocation of Respondent's license to practice professional nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that Registered Nurse License Number 706508, previously issued to AMANDA LYNN BELL, to practice professional nursing in Texas is hereby SUSPENDED for a period of three (3) years with the suspension STAYED and Respondent is hereby placed on PROBATION for three (3) years with the following agreed terms of probation:

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate privilege, 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 the 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.

(1) RESPONDENT SHALL comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq*., the Rules and Regulations Relating to Nurse Education, Licensure and Practice, 22 TEX. ADMIN. CODE §211.1 *et seq*. and this Order.

(2) RESPONDENT SHALL pay a monetary fine in the amount of five hundred dollars ($500). RESPONDENT SHALL pay this fine within forty-five (45) days of entry of this Order. Payment is to be made directly to the Texas Board of Nursing in the form of cashier's check or U.S. money order. Partial payments will not be accepted.

(3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics. RESPONDENT SHALL obtain Board approval of the course prior to enrollment only if the course is <u>not</u> being offered by a pre-approved provider. Home study courses and video programs will not be approved. In order for the course to be approved, the target audience shall include nurses. It shall be a minimum of six (6) contact hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. 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. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(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 only if the course is not being offered by a pre-approved provider. 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 Nurses. The course shall include content 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. *Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

(5) IT IS FURTHER AGREED, SHOULD RESPONDENT be convicted of or receive a deferred order for the offense(s) as outlined in Finding of Fact Number TWELVE (12), said judicial action will result in further disciplinary action including Revocation of Respondent's license to practice professional nursing in the State of Texas.

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

(6) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the probation conditions on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each present employer within five (5) days of receipt of this Order. RESPONDENT SHALL notify all future employers in nursing of this Order of the Board and the probation conditions on RESPONDENT's license. RESPONDENT SHALL present a complete copy of this Order and all Proposals for Decision issued by the Administrative Law Judge, if any, to each future employer prior to accepting an offer of employment.

(7) RESPONDENT SHALL CAUSE each present employer in nursing to submit the Notification of Employment form, which is provided to the Respondent by the Board, to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Notification of Employment form, which is provided to the Respondent by

the Board, to the Board's office within five (5) days of employment as a nurse.

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

(9) For the remainder of the probation period, RESPONDENT SHALL be supervised by a Registered Nurse who is on the premises. The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years experience in the same or similar practice setting to which the Respondent is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

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

(11) RESPONDENT SHALL NOT practice as a nurse in any critical care area for

one (1) year of employment as a nurse. Critical care areas include, but are not limited to, intensive care units, emergency rooms, operating rooms, telemetry units, recovery rooms, and labor and delivery units.

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

(13) RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the Respondent by the Board, periodic reports as to RESPONDENT's capability to practice nursing. These reports shall be completed by the Registered Nurse who supervises the RESPONDENT. These reports shall be submitted by the supervising nurse to the office of the Board at the end of each three (3) month period for three (3) years of employment as a nurse.

(14) RESPONDENT SHALL abstain from the consumption of alcohol, Nubain, Stadol, Dalgan, Ultram, or other synthetic opiates, and/or the use of controlled substances, except as prescribed by a licensed practitioner for a legitimate purpose. If prescribed, RESPONDENT SHALL CAUSE the licensed practitioner to submit a written report identifying the medication, dosage and the date the medication was prescribed. The report shall be submitted directly to the office of the Board by the prescribing practitioner, within ten (10) days of the date of the prescription. **In the event that prescriptions for controlled substances are required for periods of two (2) weeks or longer, the Board may require and RESPONDENT SHALL submit to an evaluation by a Board approved physician specializing in Pain Management or Psychiatry. The performing evaluator will submit a written report to the Board's office, including results of the evaluation, clinical indications for the prescriptions, and recommendations for on-going**

treatment within thirty (30) days from the Board's request.

(15) RESPONDENT SHALL submit to random periodic screens for controlled substances, tramadol hydrochloride (Ultram), and alcohol. For the first three (3) month period, random screens shall be performed at least once per week. For the next three (3) month period, random screens shall be performed at least twice per month. For the next six (6) month period, random screens shall be performed at least once per month. For the remainder of the probation period, random screens shall be performed at least once every three (3) months. All random screens SHALL BE conducted through urinalysis. Screens obtained through urinalysis is the sole method accepted by the Board.

Specimens shall be screened for at least the following substances:

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

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

All screens shall be properly monitored and produced in accordance with the Board's policy on Random Drug Testing. A complete chain of custody shall be maintained for each specimen obtained and analyzed. RESPONDENT SHALL be responsible for the costs of all random drug screening during the probation period.

Any positive result for which the nurse does not have a valid prescription will be regarded as non-compliance with the terms of this Order and may subject the nurse to further

disciplinary action by this Board. Failure to report for a drug screen may be considered the same as a positive result and may result in further disciplinary action by this Board.

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

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

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT's license and RESPONDENT shall be eligible for multistate licensure 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 is subject to ratification by the Board. When this Order is ratified, the terms of this Order become effective, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice professional nursing in the State of Texas, as a consequence of my noncompliance.

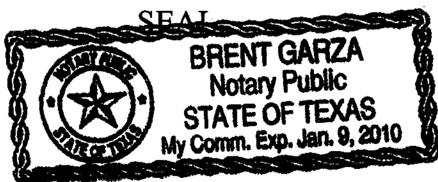
Signed this 9th day of March, 2009.

Amanda Lynn Bell

AMANDA LYNN BELL, Respondent

Sworn to and subscribed before me this 9th day of March, 2009.

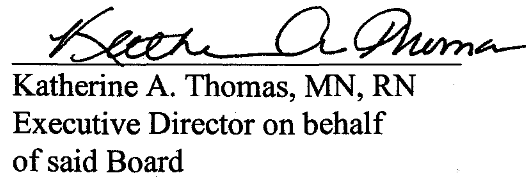
SEAL



Notary Public in and for the State of Texas

WHEREFORE, PREMISES CONSIDERED, the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 9th day of March, 2009, by AMANDA LYNN BELL, Registered Nurse License Number 706508, and said Order is final.

Effective this 23rd day of April, 2009.



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