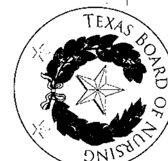

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

DOCKET NUMBER 507-13-0300

IN THE MATTER OF	§	**BEFORE THE STATE OFFICE**
PERMANENT CERTIFICATE	§	
NUMBERS 172054 & 669397	§	**OF**
ISSUED TO	§	
STEPHANI RAQUEL PELOQUIN	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: STEPHANI RAQUEL PELOQUIN
1200 CR 152 #25
GEORGETOWN, TX 78626

SHANNON KILGORE
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on January 17-18, 2013, the Texas Board of Nursing (Board) considered the following items: (1) Order Number 3, *Dismissing Case,* issued by the ALJ in the above cited matter; (2) Staff's recommendation that the Board revoke the Respondent's registered and vocational nursing licenses by default; and (3) Respondent's recommendation to the Board regarding the above cited matter, if any.

On November 8, 2012, the ALJ convened a hearing on the merits in this matter. Staff of the Board was present for the hearing. However, the Respondent was not present at the hearing, and no one appeared on her behalf. During the hearing on November 8, 2012, Staff introduced evidence into the record demonstrating that Respondent had been sent a Notice of Hearing by first class certified mail return receipt requested to her last known address of record maintained by the Board in accordance with 22 Tex. Admin. Code §213.10(a). The ALJ found that Staff's notice was adequate and issued Order No. 3, granting Staff's Motion for Default and dismissing the case from the docket of SOAH and remanding it to the Board for informal disposition on a default basis in accordance with the Government Code §2001.056.

The Board, after review and due consideration of Order Number 3, *Dismissing Case,* issued by the ALJ in the above cited matter, finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with the Government Code §2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Occupations Code Chapter 301 (Nursing Practice Act) for retention of Respondent's licenses to practice professional and vocational nursing in the State of Texas. The Board further finds that the Formal Charges were properly initiated and filed in accordance with the Occupations Code §301.458. The Board further finds that proper and timely notice regarding the violations alleged in the Formal Charges was given to Respondent in accordance with the requirements of the Government Code §2001.051 and §2001.052 and 1 Tex. Admin. Code §155.501. The Board further finds that the Respondent failed to appear in accordance with 22 Tex. Admin. Code Chapter 213 and 1 Tex. Admin. Code §155.501. As a result of the Respondent's failure to

appear, the Board has determined that the factual allegations listed in the Formal Charges are to be deemed admitted by default and the Board is authorized to enter a default order against the Respondent pursuant to the Government Code §2001.056 and 22 Tex. Admin. Code §213.16. Further, the Board has determined that it is entitled to revoke the Respondent's registered and vocational nursing licenses pursuant to 22 Tex. Admin. Code §213.33(m).

Therefore, the Board hereby adopts the factual allegations, which have been deemed admitted, and the conclusions of law contained in the Formal Charges, which are attached hereto and incorporated herein by reference for all purposes, and Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing in accordance with the Government Code Chapter 2001 and 22 Tex. Admin.Code §213.16(j). All parties have a right to judicial review of this Order. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

IT IS, THEREFORE, ORDERED THAT Permanent Certificate Numbers 669397 and 172054, previously issued to STEPHANI RAQUEL PELOQUIN, to practice nursing in the State of Texas be, and the same are hereby, REVOKED.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multi-state privileges, if any, to practice nursing in the State of Texas.

FURTHER, pursuant to the Occupations Code §301.467, RESPONDENT is not eligible to petition for reinstatement of licensure until at least one (1) year has elapsed from the date of this Order. Further, upon petitioning for reinstatement, RESPONDENT must satisfy all then existing requirements for relicensure.

Entered this 18th day of January, 2013.

TEXAS BOARD OF NURSING

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR FOR THE BOARD

Attachment: Formal Charges

In the Matter of	§	BEFORE THE TEXAS
Permanent Registered Nurse	§	
License Number 669397 &	§	
Permanent Vocational Nurse	§	
License Number 172054	§	
Issued to STEPHANI RAQUEL PELOQUIN,	§	
Respondent	§	BOARD OF NURSING

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, STEPHANI RAQUEL PELOQUIN, is a Registered Nurse holding License Number 669397 which is in current status at the time of this pleading, and is a Vocational Nurse holding License Number 172054, which is in delinquent 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 August 24, 2012, Respondent became non-compliant with the Agreed Order issued to her by the Texas Board of Nursing on June 6, 2012. Non-compliance is the result of Respondent's failure to pay the board ordered participation fee to the Texas Peer Assistance Program for Nurses (TPAPN). Stipulation number one (1) of the Agreed Order dated June 6, 2012 states:

"RESPONDENT SHALL, within forty-five (45) days following the date of entry of this final Order, apply to TPAPN and SHALL, within ninety (90) days following the date of entry of this final Order, sign and execute the TPAPN participation agreement, which SHALL include payment of a non-refundable participation fee in the amount of five hundred dollars ($500.00) payable to TPAPN."

On or about August 24, 2012, Respondent was dismissed from the Texas Peer Assistance Program for Nurses (TPAPN).

A copy of the Findings of Fact, Conclusions of Law, and Agreed Order dated June 6, 2012, is attached and incorporated, by reference, as part of this pleading.

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

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NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license/s 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.texas.gov.

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

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

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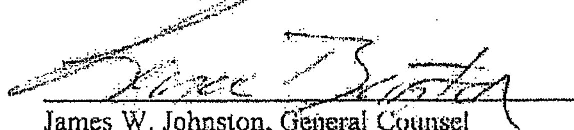
NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order(s) which is/are attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Order dated June 6, 2012; Order dated January 5, 2010.

Filed this 25th day of September, 2012.

TEXAS BOARD OF NURSING



James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Assistant General Counsel
State Bar No. 24036103
Lance Robert Brenton, Assistant General Counsel
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State Bar No. 24079751
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
Nikki Hopkins, Assistant General Counsel
State Bar No. 24052269
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TEXAS BOARD OF NURSING
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6811
F: (512) 305-8101 or (512)305-7401

Attachments: Order of the Board dated June 6, 2012
Order of the Board dated January 5, 2010

D/2012.06.19

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	§	AGREED
License Number 669397 and Vocational	§	
Nurse License Number 172054	§	
issued to STEPHANI RAQUEL PELOQUIN	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of STEPHANI RAQUEL PELOQUIN, Registered Nurse License Number 669397 and Vocational Nurse License Number 172054, 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 April 19, 2012, by Katherine A. Thomas, MN, RN, FAAN, Executive Director.

FINDINGS OF FACT

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

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

3. Respondent is currently licensed to practice professional nursing in the State of Texas. Respondent holds a license to practice vocational nursing in the State of Texas which is in delinquent status.

4. Respondent received a Certificate in Vocational Nursing from Temple Junior College, Temple, Texas, on May 11, 1999. Respondent was licensed to practice vocational nursing in the State of Texas on June 16, 1999. Respondent received an Associate Degree in Nursing from Temple College, Temple, Texas, on May 1, 2000. Respondent was licensed to practice professional nursing in the State of Texas on June 27, 2000.

5. Respondent's nursing employment history includes:

06/99 - 12/99	Unknown	
01/00 - 06/00	LVN	Heartland Nursing Home Temple, Texas
06/00 - 05/07	RN	Scott & White Hospital Temple, Texas
07/07 - 11/10	RN	VA Hospital Temple, Texas
12/10 - Present	Unknown	

6. On or about January 5, 2010, Respondent's licenses to practice professional and vocational nursing in the State of Texas were issued REMEDIAL EDUCATION by the Texas Board of Nursing. A copy of the Findings of Fact, Conclusions of Law, and Agreed Order, dated January 5, 2010, is attached and incorporated, by reference, as part of the order.

7. At the time of the initial incident, Respondent was employed as a registered nurse with Central Texas Veterans Health System, Temple, Texas, and had been in this position for two (2) years and six (6) months.

8. On or about January 6, 2010 to January 12, 2010, while employed with Central Texas Veterans Health System, Temple, Texas, Respondent administered hydrocodone to Patient ID number H988982 in excess frequency and/or dosage of the physician's order, as follows:

Date	Patient ID#	Physician's Order	Medication Dispensing System Record Time and Quantity	Medication Administration Record
1-6-10	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0810 (1)	0810
1-6-10	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 1209 (1)	1207
1-6-10	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 1545 (1)	1545
1-7-10	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0818 (1)	0853
1-7-10	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 1135 (1)	1134

1-8-10	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0809 (1)	0810
1-8-10	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 1225 (1)	1227
1-8-10	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 1659 (1)	1700
1-11-11	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0114 (1)	0115
1-11-11	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0506 (1)	0548
1-12-11	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0027 (1)	0027
1-12-11	H988982	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0431 (1)	0441

Respondent's conduct was likely to injure the patient in that the administration of hydrocodone in excess frequency and/or dosage of the physician's order could result in the patient suffering from adverse reactions.

9. In response to Finding of Fact Number Eight (8), Respondent states:

"On January 6, I mistakenly administered a pain medication to a patient after four hours, rather than six hours, as the order was written. This was partially due to over-reliance on my part on the protection afforded by this safety measure, the lockout. Also contributing was under-staffing, exhaustion due to caring for my mother all hours when not at work, issues with my teenage children, which I had to deal with completely on my own."

10. On or about January 29, 2010 through January 30, 2010, and April 4, 2010, while employed with Central Texas Veterans Health System, Temple, Texas, Respondent removed medications from the pyxis medication dispensing system for patients, but failed to accurately and/or completely document its administration in the patients' medication administration record and/or nurses notes, as follows:

Date	Patient ID#	Physician's Order	Medication Dispensing System Record Time and Quantity	Medication Administration Record	Nurses Notes
1-29-10	T777622	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0130 (2)	No Entry	No Entry
1-29-10	T777622	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0615 (2)	No Entry	No Entry

1-30-10	L482827	Hydrocodone 5/ Apap 500mg tab 1 q4h prn pain	Hydrocodone/Acet 500mg/5mg tab 0513 (1)	No Entry	No Entry
4-4-10	K447404	Morphine Sulfate IR 15mg 1 tab q8h prn	Morphine IR 15mg 0709 (1)	No Entry	No Entry

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

11. In response to Finding of Fact Number Ten (10), Respondent states:

"All the medications I gave were administered to the patients properly, but because PRNs do not show up on the "missed meds" list, I was not aware that they had not scanned the first time. Every night, from 0200 to 0300, the system would shut down and the medication would be required to be written into what was called a "contingency report". This would be sent to pharmacy, who, at that point, would enter it into the electronic MAR. Obviously, this did not occur several times. I saw one of my patient's IV antibiotic entered in at 0220, with a note stating "reason for administration - pain 6/10". This is just one example of how easily the contingency reports could be entered incorrectly or not entered at all."

12. On or about January 29, 2010 through January 30, 2010, and April 4, 2010, while employed with Central Texas Veterans Health System, Temple, Texas, Respondent removed medications from the pyxis medication dispensing system for patients, but failed to follow the facility policy and procedure for wastage of the unused portions of the medications, as follows:

Date	Patient ID#	Physician's Order	Medication Dispensing System Record Time and Quantity	Medication Administration Record	Nurses Notes	Wastage
1-29-10	T777622	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0130 (2)	No Entry	No Entry	Not Documented
1-29-10	T777622	Hydrocodone 10/ Apap 500mg tab, UD, Give 1 tab po q6h prn pain	Hydrocodone/Acet. 500mg UD 10mg tab 0615 (2)	No Entry	No Entry	Not Documented
1-30-10	L482827	Hydrocodone 5/ Apap 500mg tab 1 q4h prn pain	Hydrocodone/Acet 500mg/5mg tab 0513 (1)	No Entry	No Entry	Not Documented
4-4-10	K447404	Morphine Sulfate IR 15mg 1 tab q8h prn	Morphine IR 15mg 0709 (1)	No Entry	No Entry	Not Documented

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 Substance Act).

13. In response to Finding of Fact Number Twelve (12), Respondent states:

"Wastage was not an issue on any of the reports I saw regarding myself, but I did see several other nurses to whom this happened."

14. On or about May 7, 2010 and May 12, 2010, while employed with Central Texas Veterans Health System, Temple, Texas, Respondent lacked fitness to practice nursing in the State of Texas in that she was observed exhibiting impaired behavior including, but not limited to: feeling dizzy, unable to concentrate, having an unsteady gait and making numerous medication errors. 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.

15. In response to the incident in Finding of Fact Number Fourteen (14), Respondent states:

"I have sent in copies of medical records reflecting that on the night of May 8 - May 9, I was suffering from a severe ear infection as well as exhaustion and a bad reaction to antidepressants I had started taking. I attempted to call in sick for that shift, but my job was threatened, so I forced myself to come in and try to "muddle through" the shift. I was left in charge by Georgia Ohe, who stated that I was not fit to take over, yet she left me in charge anyway. There is a letter from Kenneth Hansen, PA, detailing all the medical conditions and the actions which should have been taken regarding a medically or chemically impaired nurse. I was allow/forced to work while I was obviously not fit to do so. Only after allowing me to provide direct patient care for two shifts, while observing my mistakes and altered behavior, was I finally taken for a UA, which came back negative. I was sick, not drunk or on illicit drugs."

16. On or about May 2010, while employed with Central Texas Veterans Health System, Temple, Texas, Respondent lacked fitness to practice nursing in the State of Texas in that she reported having suicidal thoughts to her nurse manager. 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.

17. In response to Finding of Fact Number Sixteen (16), Respondent states:

"I never expressed that I was "suicidal" to my supervisor. I did tell her I was overwhelmed, exhausted and frustrated. I asked her to help me by making my schedule more reasonable. She stated that "since you are never here anyway, it does not matter." She did not refer me to the Employee Assistance program, which is part of the handbook for supervisors, and her duty as a supervisor. She offered me no help at all."

18. On or about January 27, 2012, Respondent underwent a Chemical Dependency Evaluation with Matthew L. Ferrera, Ph.D., wherein Dr. Ferrara advised the following:

"Based upon this evaluation, it appears that Ms. Peloquin has some risk factors that suggest that she would have some difficulty conforming her behavior to the Nursing Practice Act, Board rules and regulations, and generally accepted standards of nursing practice. On the other hand, Ms. Peloquin also has some protective factors and good work history, other than the Board allegations.

Given the results of the assessments, it is recommended that Ms. Peloquin be considered for licensure, if some safeguards in place. Ms. Peloquin should be required to have her practice supervised and she should be required to participate in a program of random drug/alcohol screens for a period of time for the purpose of ensuring that she is not engaging in a pattern of substance abuse behavior."

19. On or about March 12, 2012 to March 30, 2012, while employed with St. David's North Austin Medical Center, Austin, Texas, Respondent withdrew pain medications from the medication dispensing system for patients, but failed to accurately and/or completely document the administration in the patients' electronic medication administration records (eMars) and/or nurse's notes. Respondent's conduct was likely to injure the patients in that subsequent care givers would rely on her documentation to further medicate the patients which could result in an overdose.

20. On or about March 12, 2012 to March 30, 2012, while employed with St. David's North Austin Medical Center, Austin, Texas, Respondent withdrew pain medications from the medication dispensing system for patients, but failed to follow the facility's policy and procedure for wastage of the unused portions of the medications. Respondent's conduct was likely to deceive the hospital pharmacy and placed them in violation of Chapter 481 of the Texas Health and Safety Code (Controlled Substance Act).

21. On or about April 19, 2012, Respondent contacted the Texas Board of Nursing regarding Findings of Fact Numbers Nineteen (19) and Twenty (20) and requested that she be allowed to participate in the Texas Peer Assistance Program for Nurses (TPAPN).

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

23. 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.

24. Respondent's conduct described in Findings of Fact Numbers Eight (8) to Seventeen (17) was significantly influenced by Respondent's impairment by dependency on chemicals and mental illness.

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

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.455, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation of Section 301.452(b)(10),(12)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §§217.11(1)(A),(B),(C)&(D) and 217.12(1)(A),(4),(5),(10)(B),(10)(C)&(11)(B).

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 669397 and Vocational Nurse License Number 172054, heretofore issued to STEPHANI RAQUEL PELOQUIN, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

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

ORDER

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

(1) RESPONDENT SHALL, within forty-five (45) days following the date of entry of this final Order, apply to TPAPN and SHALL, within ninety (90) days following the date of entry of this final Order, sign and execute the TPAPN participation agreement, which SHALL include payment of a non-refundable participation fee in the amount of five hundred dollars ($500.00) payable to TPAPN.

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

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

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

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

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

IT IS FURTHER AGREED and ORDERED that while Respondent's license(s) is/are encumbered by this Order, Respondent may not work outside the State of Texas pursuant to a multistate licensure privilege without the written permission of the Texas Board of Nursing and the Board of Nursing in the party state where Respondent wishes to work.

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

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violations alleged herein. I do acknowledge possessing a diagnosis that deems me eligible to participate in the Texas Peer Assistance Program for Nurses. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, and Conditions One (1) through Four (4) of this Order to obtain disposition of the allegations through peer assistance and to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes effective upon acceptance by the Executive Director on behalf of the Texas Board of Nursing, and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

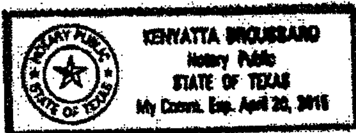
Signed this 30 day of May, 2012.

Stephani Raquel Peloquin

STEPHANI RAQUEL PELOQUIN, Respondent

Sworn to and subscribed before me this 30 day of MAY, 2012.

SEAL



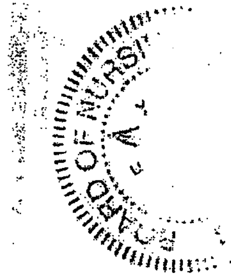
Kenyatta Broussard

Notary Public in and for the State of TEXAS

WHEREFORE PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby accept and enter the Agreed Order that was signed on the 30th day of May, 2012, by STEPHANI RAQUEL PELOQUIN, Registered Nurse License Number 669397 and Vocational Nurse License Number 172054, and said Order is final.

Entered and effective this 6th day of June, 2012.

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



BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse	§	AGREED
License Number 669397 and Vocational	§	
Nurse License Number 172054 issued to	§	ORDER
STEPHANI RAQUEL CRENSHAW PELOQUIN	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of STEPHANI RAQUEL CRENSHAW PELOQUIN, Registered Nurse License Number 669397, and Vocational Nurse License Number 172054, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may have violated Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived informal proceedings, notice and hearing, and agreed to the entry of this Order offered on October 14, 2009, by Katherine A. Thomas, MN, RN, Executive Director.

FINDINGS OF FACT

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

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

3. Respondent is currently licensed to practice professional nursing in the State of Texas, and Respondent's State of Texas vocational nursing license is in delinquent status at this time.

4. Respondent received an Associate Degree in Nursing from Temple College, Temple, Texas on May 1, 2000. Respondent was licensed to practice professional nursing in the State of Texas on June 27, 2000. Respondent received a Certificate in Vocational Nursing from Temple Junior College, Temple, Texas, on May 11, 1999. Respondent was licensed to practice vocational nursing in the State of Texas on June 16, 1999.

5. Respondent's professional and vocational nursing employment history includes:

6/1999 - 1/2000	Staff LVN	Heartland Healthcare Temple, Texas
1/2000 - 5/2007	Staff Nurse	Scott & White Memorial Hospital Temple, Texas
6/2007 - Present	Unknown	

6. At the time of the incidents in Findings of Fact Numbers Seven (7)and Nine (9), Respondent was employed as a Staff Nurse with Scott and White Memorial Hospital, Temple, Texas, and had been in this position for seven (7) years and four (4) months.

7. On or about May 11, 2007, while employed as a Staff Nurse at Scott and White Memorial Hospital, Temple, Texas, Respondent incorrectly documented she had administered a narcotic when it was administered by another nurse. Respondent's conduct resulted in an inaccurate medical record and was deceptive in regard to who administered the medication.

8. In response to the incident in Finding of Fact Number Seven (7), Respondent states she documented the administration of the medications that were given by another nurse, but it was not in at attempt to deceive. Respondent states that, "Because of serious under staffing, the nurse that administered the medication failed to find the time to document the administration and there was the potential for another health care provider to give the medication again if it is not documented. The Medication Administration Record computer documentation was a point and click system which did not lend itself to easily making notations.

9. On or about May 11, 2007, while employed as a Staff Nurse at Scott and White Memorial Hospital, Temple, Texas, Respondent administered and/or documented that she administered a narcotic that was not ordered by the physician. Respondent's conduct was likely to injure the patient in that subsequent care givers would rely on her documentation in order to provide further patient care.

10. In response to Finding of Fact Number Nine (9), Respondent states she documented on the wrong chart, and states she had just finished a delivery and was getting the recovery process underway when another nurse came in and told her she had a new admission. Respondent states the other nurse pulled the medications and Respondent saw her give them. Respondent went to check on her third patient and then went to start charting, and she documented the medication administration for the newly delivered patient on the new admission patient's chart. Respondent states the correct patient received the correct medication.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violations of Section 301.452(b)(10)&(13), Texas Occupations Code, and 22 TEX. ADMIN. CODE §217.11(1)(B),(1)(C)&(1)(D), 22 TEX. ADMIN. CODE §217.12(1)(B)&(4).

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 669397, and Vocational Nurse License Number 172054, heretofore issued to STEPHANI RAQUEL CRENSHAW PELOQUIN, including revocation of Respondent's license to practice professional and vocational nursing in the State of Texas.

ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of REMEDIAL EDUCATION, and 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.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's multistate licensure 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, Respondent may not work outside the State of Texas pursuant to a multistate licensure privilege without the written permission of the State of Texas and the Board of

Nursing in the party state where Respondent wishes to work.

IT IS FURTHER AGREED that:

(1) RESPONDENT SHALL deliver the wallet-sized license issued to STEPHANI RAQUEL CRENSHAW PELOQUIN to the office of the Texas Board of Nursing within ten (10) days of the date of ratification of this Order.

(2) 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 not 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) 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.*

(3) 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.*

(4) RESPONDENT SHALL, within one (1) year of entry of this Order successfully complete the course "Sharpening Critical Thinking Skills," a 3.6 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) Learning Extension. In order to receive credit for completion of this program, RESPONDENT SHALL SUBMIT the continuing education certificate of completion for this program to the Board's office, to the attention of Monitoring. This course is to be taken in addition to any continuing education requirements the Board may have for relicensure. *Information regarding this workshop may be found at the following web address: http://ncsbn.hivelive.com/hives/a0f6f3e8a0/summary.*

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

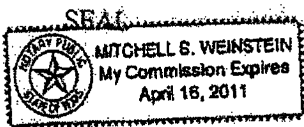
I understand that I have the right to legal counsel prior to signing this Agreed Order. I have reviewed this Order. I neither admit nor deny the violations alleged herein. By my signature on this Order, I agree to the Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that when this Order becomes final and the terms of this Order become effective, a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including revocation of my license to practice professional and vocational nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 29 day of December, 2009.

STEPHANI RAQUEL CRENSHAW PELOQUIN, Respondent

Sworn to and subscribed before me this 29 day of December, 2009

SEAL



Notary Public in and for the State of TEXAS

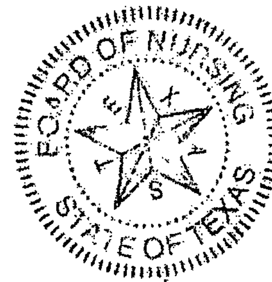
Approved as to form and substance.

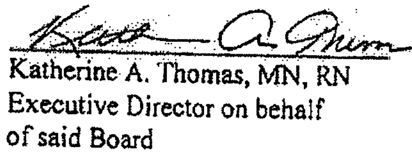
Taralynn Mackay, Attorney for Respondent

Signed this 12th day of December, 2009.

WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing, does hereby ratify and adopt the Agreed Order that was signed on the 29th day of December, 2009, by STEPHANI RAQUEL CRENSHAW PELOQUIN, Registered Nurse License Number 669397, and Vocational Nurse License Number 172054, and said Order is final.

Effective this 5th day of January, 2010.





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

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