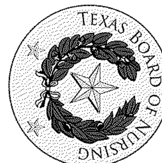


I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§	AGREED
Vocational Nurse License Number 136921	§	
issued to TONYA LYNN FREED	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of TONYA LYNN FREED, Vocational Nurse License Number 136921, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

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

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

FINDINGS OF FACT

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

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

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

4. Respondent received a Certificate in Vocational Nursing from the Army Practical Nurse Course, Fort Sam Houston, Texas, on February 20, 1992. Respondent was licensed to practice vocational nursing in the State of Texas on May 27, 1992.

5. Respondent's employment history includes:

02/92 - 04/94	LVN	United States Army
04/94 - 05/96	Nursing Supervisor	Nova Health Systems Utica, New York
05/96 - 10/96	LVN	Team Texas Home Health Universal City, Texas

Respondent's employment history continued:

01/97 - 04/99	LVN	Institute of Pain Management Midland, Texas
05/99 - 01/00	LVN	Arthritis and Osteoporosis Center Midland, Texas
01/00 - 02/04	LVN	Carl D'Agostino, MD, LTD Midland, Texas
02/04 - 03/05	LVN	Rockwood Manor Midland, Texas
03/05 - 04/08	LVN	Terrace West Nursing Center Midland, Texas
05/08 - 02/12	LVN	MARC, Inc. Midland, Texas
02/12 - 08/12	LVN On-Call Pilot	MARC, Inc. Midland, Texas
09/12 - Present	Unknown	

6. At the time of the initial incident, Respondent was employed as a LVN On-Call with MARC, Inc., Midland, Texas, and had been in this position for four (4) months.

7. On or about June 6, 2012, while employed with MARC, Inc., Midland, Texas, and assigned as the LVN On-Call, Respondent failed to assess and evaluate the status of Patient S.S. at 3:15 am, or ensure that another appropriate healthcare provider evaluated the patient, after she was notified by telephone that the patient was experiencing heavy breathing, dry coughing and some congestion type sounds. Instead, Respondent assigned an unlicensed group home staff member to take the patient's vital signs. Respondent's conduct exposed the patient unnecessarily to a risk of harm from complications due to undiagnosed and, consequently, untreated disease processes which may have contributed to his demise.

8. On or about June 6, 2012, while employed with MARC, Inc., Midland, Texas, and assigned as the LVN On-Call, Respondent again failed to assess and evaluate the status of Patient S.S. at 3:32 am, or ensure that another appropriate healthcare provider evaluated the patient, after she was notified by telephone that the patient's condition was getting worse, he was foaming at the mouth and had thick drainage from his nose. At 4:07 am the patient became unresponsive and 911 was called. The patient was transferred to the hospital where he was pronounced dead. Respondent's conduct exposed the patient unnecessarily to a risk of harm from complications due to undiagnosed and, consequently, untreated disease processes which may have contributed to his demise.

9. On or about June 6, 2012, while employed with MARC, Inc., Midland, Texas, and assigned as the LVN On-Call, Respondent failed to notify the Registered Nurse On-Call or a physician of the status of Patient SS after she was notified by telephone that the patient's condition was getting worse, he was foaming at the mouth and had thick drainage from his nose. At 4:07 am the patient became unresponsive and 911 was called. The patient was transferred to the hospital where he was pronounced dead. Respondent's conduct was likely to deceive subsequent care givers who relied on the information to institute timely interventions to stabilize the patient, thereby placing the patient at risk of complications.

10. In response to Findings of Fact Number Seven (7) and Eight (8), Respondent states that the patient chronically had watery eyes, runny nose, excessive saliva and was a mouth breather. On June 6, 2012, he had participated in a picnic and also had a doctor's appointment which resulted in no concerns by the physician. Sometime around 3:00am she received a call from the Administrator on Call (AOC) who told her that the patient had heavy breathing and was coughing. She asked if vital signs had been taken and the AOC told her she would have the staff take vitals and call her with the results. When they reported the vital signs they were within normal except for an elevated pulse. She instructed AOC to have staff place the patient on the recliner and give him some water. The next call she received was to report that after drinking water the patient coughed up thick white foam and some came out of his nose. She instructed AOC to have staff continue to monitor. She received a third call from the AOC stating that staff had called 911, and she went to the home and arrived when the EMS arrived. She found the patient sitting in the recliner, she checked for a pulse and found non. The paramedics entered the house and initiated CPR and then transferred the patient to the hospital. In response to Finding of Fact Number Nine (9), Respondent states that the RN On-Call was on bed rest due to pregnancy issues and she notified her about the patient's transfer to the hospital the next day.

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

CONCLUSIONS OF LAW

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

2. Notice was served in accordance with law.

3. The evidence received is sufficient to prove violation(s) of 22 TEX. ADMIN. CODE §217.11(1)(A),(1)(D),(1)(M),(1)(P)&(2)(A) and 22 TEX. ADMIN. CODE §217.12(1)(A), (1)(B)&(4).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Vocational Nurse License Number 136921, heretofore issued to TONYA LYNN FREED, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

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

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

7. Any subsequent reinstatement of this license will be controlled by Section 301.453(d), Texas Occupations Code, and 22 TEX. ADMIN. CODE §213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

ORDER

NOW, THEREFORE, IT IS AGREED and ORDERED that the VOLUNTARY SURRENDER of Vocational Nurse License Number 136921, heretofore issued to TONYA LYNN FREED, to practice nursing in the State of Texas, is accepted by the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice vocational nursing, use the title "vocational nurse" or the abbreviation "LVN" or wear any insignia identifying as a vocational nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a vocational nurse during the period in which the license is surrendered.

2. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order.

3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

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

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 violation(s) alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes final when accepted by the Executive Director at which time the terms of this Order become effective and a copy will be mailed to me.

Signed this 8 day of May, 2013.

TONYA LYNN FREED, Respondent

Sworn to and subscribed before me this 8 day of May, 2013

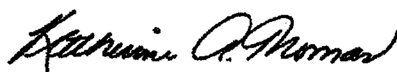
SEAL

MARIBEL J. BEGGS
Notary Public
St. Mary's County
Maryland
My Commission Expires Dec. 17, 2016

Notary Public in and for the State of Maryland

WHEREFORE, PREMISES CONSIDERED, the Executive Director on behalf of the Texas Board of Nursing does hereby accept the voluntary surrender of Vocational Nurse License Number 136921, previously issued to TONYA LYNN FREED.

Effective this __10th__ day of __May__, 2013.



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