IN THE MATTER OF PERMANENT REGISTERED NURSE LICENSE NUMBER 760060	§ § §	BEFORE THE TEXAS BOARD OF NURSING
ISSUED TO GILBERT ARRIAGA	§ §	ELIGIBILITY AND DISCIPLINARY COMMITTEE

TEXAS BOARD OF NURSING
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

TO: GILBERT ARRIAGA
1725 N LAKE BRAZOS DR, 3503
WACO, TX 76704

During open meeting held in Austin, Texas, on **February 11, 2014**, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, Chapter 301 of the Texas Occupations Code, for retention of Respondent's license(s) to practice nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by reference for all purposes and the 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 [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.

NOW, THEREFORE, IT IS ORDERED that Permanent Registered Nurse License Number 760060, previously issued to GILBERT ARRIAGA, to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

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

Entered this **11th day of February, 2014**.

TEXAS BOARD OF NURSING

BY: 

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Attachment: Formal Charge filed November 1, 2013.

CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of February, 2014, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested
GILBERT ARRIAGA
1725 N LAKE BRAZOS DR, 3503
WACO, TX 76704

BY: Katherine A. Thomas
KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

In the Matter of	§	**BEFORE THE TEXAS**
Permanent Registered Nurse	§	
License Number 760060	§	
Issued to GILBERT ARRIAGA,	§	
Respondent	§	**BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, GILBERT ARRIAGA, is a Registered Nurse holding License Number 760060 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 November 9, 2012, Respondent failed to comply with the Agreed Order issued to him on November 8, 2011, by the Texas Board of Nursing. Noncompliance is the result of his failure to comply with Stipulation Number One (1) of the Agreed Order which states, in pertinent part:

> (1) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in Texas nursing jurisprudence and ethics....

A copy of the November 8, 2011, Agreed Order, Findings of Fact, and Conclusions of Law 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) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

CHARGE II.

On or about November 9, 2012, Respondent failed to comply with the Agreed Order issued to him on November 8, 2011, by the Texas Board of Nursing. Noncompliance is the result of his failure to comply with Stipulation Number Two (2) of the Agreed Order which states, in pertinent part:

> (2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

CHARGE III.

On or about November 9, 2012, Respondent failed to comply with the Agreed Order issued to him on November 8, 2011, by the Texas Board of Nursing. Noncompliance is the result of his failure to comply with Stipulation Number Three (3) of the Agreed Order which states, in pertinent part:

> (3) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in nursing documentation....

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

CHARGE IV.

On or about November 9, 2012, Respondent failed to comply with the Agreed Order issued to him on November 8, 2011, by the Texas Board of Nursing. Noncompliance is the result of his failure to comply with Stipulation Number Four (4) of the Agreed Order which states, in pertinent part:

> (4) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete the course "Sharpening Critical Thinking Skills,"...

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(1) and (10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(11)(B).

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, 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.

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: Agreed Order dated November 8, 2011.

Issued this 1st day of November, 2013.

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
John R. Griffith, Assistant General Counsel
State Bar No. 24079751
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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: Agreed Order dated November 8, 2011.

D/2012.06.19

BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Registered Nurse	§	AGREED
License Number 760060	§	
issued to GILBERT ARRIAGA	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Boa considered the matter of GILBERT ARRIAGA, Registered Nurse License Number 7600 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 September 2, 2011, 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(s).

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

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

4. Respondent received an Associate Degree in Nursing from McLennan Community College, Waco, Texas, on December 13, 2007. Respondent was licensed to practice professional nursing in the State of Texas on August 19, 2008.

5. Respondent's nursing employment history includes:

08/08 - 06/09	Staff Nurse Med/Surg	Providence Health Center Waco, Texas
07/09 - Present	Unknown	

TEXAS BOARD OF NURSING
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

6. At the time of the initial incident, Respondent was employed as a Staff Nurse with Providence Health Center, Waco, Texas, and had been in this position for seven (7) months.

7. On or about March 30, 2009, while employed with Providence Health Center, Waco, Texas, Respondent lacked fitness to practice professional nursing in that while on duty Respondent was observed by staff to be lethargic and then verbally aggressive, talking loud, whistling for long periods. Respondent was referred for a reasonable suspicion/for cause drug screen which resulted positive for prescription medications including Clonazepam, Oxazepam, and Tramadol at a level of 25345ng/ml. Respondent's conduct could have affected his ability to recognize subtle signs, symptoms or changes in the patient's condition, and could have affected his ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.

8. During March 2009, while employed with Providence Health Center, Waco, Texas, Respondent lacked fitness to practice professional nursing in that while on duty Respondent was observed by staff to be so groggy that he fell against a locker and staff drove him to his physician's office. On another occasion Respondent was extremely aggressive than a short time later Respondent had slurred speech. Respondent's conduct could have affected his ability to recognize subtle signs, symptoms or changes in the patient's condition, and could have affected his ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.

9. On or about April 6, 2009, while employed with Providence Health Center, Waco, Texas, Respondent lacked fitness to practice professional nursing in that while on duty Respondent was observed to be verbally aggressive, then later lethargic, "out of it" with slurred speech, barely able to keep her eyes open, leaning on some equipment for support, and unable to type his patient assessments. Respondent's conduct could have affected his ability to recognize subtle signs, symptoms or changes in the patient's condition, and could have affected his ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patient in potential danger.

10. On or about June 7, 2009, while employed with Providence Health Center, Waco, Texas, Respondent withdrew Norco from the Medication Dispensing System (Omnicell) for a patient without a physician's order. Respondent's conduct was likely to injure the patient in that the administration of Norco without a valid physician's order could result in the patient suffering from adverse reactions.

11. On or about June 7, 2009, while employed with Providence Health Center, Waco, Texas, Respondent withdrew Norco from the Medication Dispensing System (Omnicell) for a patient but failed to follow the policy and procedure for the wastage. 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).

12. In response to Finding of Fact Number Seven (7), Respondent states that he was tired that morning as was the case on many mornings because he was not sleeping as well as he would have liked. He was not incapacitated in any manner nor was his ability to function. His supervisor came to him and asked him if he was OK. He stated "yeah" she always asked people this question typically to see if they needed anything. He asked a co-worker if they noticed a concern in the supervisor's question and they told him that she thought he was on drugs. He went to the supervisor about the statement and volunteered for a drug screen. She escorted him to the HR office to wait for the drug screen. While he was waiting he made a phone call and the HR person came out and yelled at him to get off the phone. As for the whistling, he whistles particularly to a Hindi song he learned that had a pleasing melody. His physician had switched him from clonazepam to oxazepam because he told the doctor he was developing a tolerance to the clonazepam. As for the Tramadol he was prescribed a dose of 1-2 tabs QID. He had taken 2 tabs four times daily along with Tylenol for a synergistic effect and mobic just to maintain minimal relief. He was in pain all day at work and immobile on his days off. He never took any medication that was not prescribed.

13. In response to Finding of Fact Number Eight (8), Respondent states that this allegation preceded allegation one. For approximately one month or more prior to being driven to Dr. Coleman's office by a friend, he had been experiencing severe insomnia. On two occasions the week prior to the event he tried to call in to work explaining that he was experiencing severe sleeping problems and had gotten little to no sleep and that he did not feel he could provide the best of care, that he feared making mistakes. On both occasions after lengthy persuasions and pressure to come to work he did so against his better judgement, fearing repercussions. He didn't want to let the team down or the patients. This was the same case when he had to come in to work after being even more sleep deprived and this time he was so tired that while receiving report outside the patient's room he was leaning against the wall, and yes his eyes and body showed his exhaustion. They finally recognized that he had given all he had already and that he need the day off to sleep. When Patrice offered to take him to Dr. Coleman, he was grateful, relieved, finally the insomnia was going to be addressed and he was going to get back to 100%. Dr. Coleman prescribed Trazidone for the insomnia and also anxiety medication, in addition he was taking Tramadol for his knee pain. That night he took the medication at 10:00pm and the next morning he woke up groggier and slower than usual. When he got to work his supervisor told him that he looked like he could barely keep his eyes open and he told her that he had taken the medication and didn't know he would have aftereffects. She told him to go home and sleep a few more hours and then come back for the 11a-11p. "At no point did I find myself to be so mentally charged as to be aggressive and then become slurred. There were times that I proclaimed my irritation and aggravation about their timing of drug testing me." I took prescribed anxiolytics but never at work. The only times I may have been slurred were during those times early in the AM from sleep deprivation.

13. In response to Finding of Fact Number Nine (9), Respondent states that "as far as slurred speech, again my tone, southern drawl, and speed of speech may throw some off but I was never slurred. . .as far as aggressive, again I do feel that there were times when a nurse must be aggressive. Not in the sense of threatening, but in trying to get things done promptly and as ordered..."

14. In response to Findings of Fact Numbers Ten (10) and Eleven (11), Respondent states that he was terminated as a result of this incident, he was never given the opportunity to determine how he may have made the mistake. He was not allowed to review the MAR or Orders. The only scenario where he can see this occurring is if the physician wrote the order for Lortab and he overrode the OMNICARE system for a Norco which is the exact same thing. He had no access to determine what he did wrong. They had just adopted the CARROT system which required them to scan themselves, the patient, the medication and then themselves again to complete the process of the medication being populated as given in only one of the two systems that would show this or any med as being given. If you missed a scan anywhere in that process the scanner would time out and the information be lost. Sometimes the scanner would freeze up and the process of documenting would not be completed. "If I did anything wrong it was in making a documentation error."

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

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 760060, heretofore issued to GILBERT ARRIAGA, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

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ORDER

IT IS THEREFORE AGREED and ORDERED, subject to ratification by the Texas Board of Nursing, that RESPONDENT SHALL receive the sanction of a WARNING WITH STIPULATIONS, 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, while under the terms of this Order, this Order SHALL apply to any and all future licenses issued to Respondent to practice nursing in the State of Texas.

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 nurse licensure compact 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 that:

(1) 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) 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.*

(2) RESPONDENT SHALL, within one (1) year of entry of this Order, successfully complete a course in medication administration. 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. The didactic portion of this course shall be a minimum of six (6) hours in length. The course shall contain a minimum twenty-four (24) hour clinical component which is to be provided by the same Registered Nurse who provides the didactic portion of this course. The clinical component SHALL focus on tasks of medication administration only. In order for the course to be approved, the course's content shall include: a review of proper administration procedures for all standard routes; computation of drug dosages; the five (5) rights of medication administration; factors influencing the choice of route; and possible adverse effects resulting from improper administration. The course description shall indicate goals and objectives

for the course, resources to be utilized, and the methods to be used to determine successful completion of the course. RESPONDENT SHALL successfully complete both the didactic and clinical portions of the course to satisfy this stipulation. RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form, provided by the Board, to the office of the Board to verify RESPONDENT'S successful completion of the course. This course shall be taken in addition to any other courses stipulated in this Order, if any, and in addition to any continuing education requirements the Board has for relicensure. *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 Board-approved courses may be found at the following Board website address: http://www.bon.state.tx.us/disciplinaryaction/stipscourses.html.*

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 STIPULATIONS FOR ONE (1) YEAR OF EMPLOYMENT. THE LENGTH OF THE STIPULATION PERIOD WILL BE EXTENDED UNTIL SUCH TWELVE (12) MONTHS HAVE ELAPSED. PERIODS OF UNEMPLOYMENT OR OF EMPLOYMENT THAT DO NOT REQUIRE THE USE OF A REGISTERED NURSE (RN) OR A VOCATIONAL NURSE (LVN) LICENSE, AS APPROPRIATE, WILL NOT APPLY TO THIS STIPULATION PERIOD:

(5) RESPONDENT SHALL notify each present employer in nursing of this Order of the Board and the stipulations on RESPONDENT'S license(s). 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 stipulations on RESPONDENT'S license(s). 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.

(6) 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.

(7) For the duration of the stipulation period, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational 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.

(8) 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 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 one (1) year of employment as a nurse.

(9) 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.

(10) 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. All random screens SHALL BE

conducted through urinalysis. Screens obtained through urinalysis are 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 stipulation 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 stipulation period.

Any positive result for which the nurse does not have a valid prescription or failure to report for a drug screen, which may be considered the same as a positive result, will be regarded as non-compliance with the terms of this Order and may subject the nurse to 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.

IT IS FURTHER AGREED, that upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and RESPONDENT shall be eligible for nurse licensure compact privileges, if any.

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(s) to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 12 day of October, 2011.

GILBERT ARRIAGA, Respondent

Sworn to and subscribed before me this 12 day of October, 2011.

SEAL
RAQUEL VIVIENNE ESTELLE
MY COMMISSION EXPIRES
June 8, 2015

Raquel Vivienne Estelle

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 12th day of October, 2011, by GILBERT ARRIAGA, Registered Nurse License Number 760060, and said Order is final.

Effective this 8th day of November, 2011.

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