



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.
Patricia Johnson
Executive Director of the Board

BEFORE THE TEXAS BOARD OF NURSING

In the Matter of §
Vocational Nurse License Number 332683 §
issued to SHANNON MARIE RANGEL §

ORDER OF THE BOARD

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of SHANNON MARIE RANGEL, Vocational Nurse License Number 332683, hereinafter referred to as Respondent.

This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

Respondent waived 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. Respondent's license to practice as a vocational nurse in the State of Texas is in Suspended status.
2. Respondent waived notice and hearing, and agreed to the entry of this Order.
3. Respondent received a Certificate in Vocational Nursing from Summit Career College, Colton, California, on July 8, 2005. Respondent was licensed to practice vocational nursing in the State of Texas on July 25, 2016.
4. Respondent's nursing employment history includes:

10/15 - 03/16	LVN	Lubbock Hospitality Nursing and Rehab Lubbock, Texas
10/15 - 1/17	LVN	Epic Healthcare Services Lubbock, Texas

4. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.
5. Under Section 301.453(d), Texas Occupations Code, as amended, the Board may impose conditions for reinstatement of licensure.
6. 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.

TERMS OF ORDER

NOW, THEREFORE, IT IS ORDERED that the **VOLUNTARY SURRENDER** of Vocational Nurse License Number 332683, heretofore issued to SHANNON MARIE RANGEL, to practice nursing in the State of Texas, is accepted by the Executive Director on behalf of the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice vocational nursing, use the title "vocational nurse" or the abbreviation "LVN" or wear any insignia identifying herself/himself 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:
 - A. At least one (1) year has elapsed from the date of this Order; and,
 - B. RESPONDENT has obtained objective, verifiable proof of twelve (12) consecutive months of sobriety immediately preceding the petition.
3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

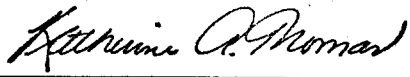
IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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Effective this 18th day of October, 2017.

TEXAS BOARD OF NURSING

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

SHANNON MARIE RANGEL
4505 N CR 1500, Shallowater, TX 79363
LVN LICENSE NUMBER 332683

Voluntary Surrender Statement

Dear Texas Board of Nursing:

I no longer desire to be licensed as a nurse. Accordingly, I voluntarily surrender my license(s) to practice nursing in the State of Texas. I waive representation by counsel and consent to the entry of an Order which outlines requirements for reinstatement of my license. I understand that I may not petition for reinstatement until one (1) year from the effective date of the Order. I understand that I will be required to comply with the Board's Rules and Regulations in effect at the time I submit any petition for reinstatement.

Signature: Shannon Rangel

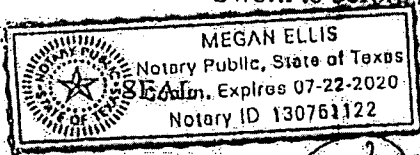
Date: Oct. 18, 2017

LVN LICENSE NUMBER 332683

The State of Texas

Before me, the undersigned authority, on this date personally appeared SHANNON MARIE RANGEL who, being duly sworn by me, stated that he or she executed the above for the purpose therein contained and that he or she understood same.

Sworn to before me the 18th day of October, 2017.



Megan Ellis
Notary Public in and for the State of TEXAS

1 ARIZONA STATE BOARD OF NURSING
2 4747 N. 7TH STREET, SUITE 200
3 PHOENIX ARIZONA 85014-3655
4 602 771-7800

5 IN THE MATTER OF PRACTICAL NURSE
6 LICENSE NO. LP041945
7 ISSUED TO:

8 SHANNON M RANGEL,
9 Aka: Salinas, Shannon Marie; Walker, Shannon
10 Marie; Courson, Shannon Marie; Salinas, Shannon
11 M

12 RESPONDENT

13 **FINDINGS OF PUBLIC
14 EMERGENCY AND ORDER OF
15 SUMMARY SUSPENSION**

16 **CASE NO. 1301020**

17 On January 26, 2017, the Arizona State Board of Nursing ("Board") met at 4747 North
18 7th Street, Ste. 200, Phoenix, Arizona 85014-3655, to consider a complaint filed against
19 Shannon M. Rangel ("Respondent"), practical nurse license no. LP041945. Information was
20 presented to the Board and, as a result, the Board made the following Preliminary Findings of
21 Fact, Conclusions of Law and Order.

22 **PRELIMINARY FINDINGS OF FACT**

23 1. On August 22, 2012 while on duty at Banner Behavioral Health in Scottsdale,
24 Arizona, Respondent was witnessed/observed by coworkers and patients using a loud voice,
25 appearing angry and using inappropriate language (profanity) directed towards a patients.

26 2. On or about November 11, 2012, while on duty at Banner Behavioral Health,
Respondent became tearful and was unable to complete her duties. On November 12, 2012,
Respondent met with her supervisor and reported severe depression, resulting in her inability to
continue to work. On November 18th, Respondent returned to work and again left early, unable
to complete her duties. On November 19th, Respondent reported further depression, left work
at prior to the end of her shift. At approximately 2200, Respondent called a co-worker and

1 reported she had taken a lot of pills. Respondent admitted she was distraught and unable to
2 complete her duties during this time.

3 3. On or about March 29, 2015, while on duty at Winslow Campus of Care in
4 Winslow, Arizona, Respondent was observed by multiple staff to be falling asleep including
5 while standing at medication cart drawing up insulin and while conversing with others.
6 Coworkers observed Respondent's affect and behavior to fluctuate from tearful, speaking in a
7 low voice to defensive, louder voice and Respondent appeared to be confused. Respondent told
8 a coworker that she took several medications, including Lunesta, a controlled medication
9 commonly prescribed for insomnia after midnight and attributed her symptoms to lack of sleep.
10 Respondent asked another coworker for Xanax and previously asked same coworker for
11 numbers to "outpatient rehab" for assistance in getting off of OxyContin.
12

13 4. On or about April 1, 2015, Respondent was terminated from Winslow Campus of
14 Care. According to the Termination Report "Employee has had several instances where health
15 is concerned. Falls asleep at times when talking to staff or family members. Takes multiple
16 medications that cause self to be drowsy, and alters mental status. Incident March 29, 2015
17 where Respondent was falling asleep at medication cart, residents were not given medications
18 as prescribed. CNAs and other nurses that were working that day concerned for Respondent
19 and resident safety. Stated to another nurse that she took several medications after midnight to
20 help her sleep and that she never went to sleep. Facility has had to send Respondent to the
21 emergency room to seek medical attention several times. At this point, resident safety is a
22 concern and for this reason Respondent is being let go for health reasons."
23
24

25 5. On June 27, 2015 while on duty at Maravilla Care Center in Phoenix, Arizona,
26 Respondent was observed to be sleeping and difficult to arouse. When aroused, Respondent's

1 speech was slurred, she dropped a pen and had difficulty picking it back up. Respondent again
2 closed her eyes and her voice drifted off. Respondent stood up, walked to the medication cart
3 where she was observed to fall asleep while standing. Respondent was assessed by nursing
4 coworkers to be confused, disoriented and unable to safely practice. Respondent was unable to
5 provide or receive report on patients. Respondent was observed brushing the shoulders of a
6 coworker and when asked, claimed incorrectly that there were spiders on the coworker.
7 Another co-worker observed Respondent "taking numerous pills" and Respondent told her
8 coworker she would "feel better once her meds kicked in."
9

10 6. On or about July 8, 2015, Respondent submitted an application for employment
11 to Good Samaritan Society in Prescott Valley, Arizona. Respondent failed to disclose her
12 employment and termination from Maravilla Care Center despite the instructions asking for
13 continued record of employment, beginning with your most recent position over the past five
14 years.
15

16 7. On September 17 and 19, 2015, while employed at Good Samaritan Society,
17 Respondent was observed swearing numerous times where staff, patients and visitors could
18 hear.
19

20 8. On September 22 2015, while employed at Good Samaritan Society, Respondent
21 underwent a random urine drug test and tested positive for butalbital, a controlled substance.
22 Respondent drug test results were confirmed positive by a medical review officer.
23

24 9. On September 25, 2015, Respondent was terminated from Good Samaritan
25 Society According to the termination report, Respondent had received multiple verbal
26 counselings related to bringing her adult son to work, providing her son with access to
employee entry security code and permitting her son to be in areas where confidential patient

1 information was available.

2 10. Respondent submitted an application for endorsement of licensure to Texas
3 Board of Nursing (TXBN) on June 28, 2015. Respondent failed to disclose the current
4 complaint investigation against her Arizona nursing license and falsely claimed her address of
5 record to be in California. At the time of submitting the application Respondent was a resident
6 of Arizona and had been since on or about March 2010. Respondent is not known to have had
7 a California address or license during this time.
8

9 11. In or about July 2015, Respondent moved/relocated to Texas. Respondent failed
10 to notify the Board in writing within 30 days or ever of her address change.

11 12. From on or about October 7, 2015 to March 25, 2016, Respondent was employed
12 at Lubbock Hospitality House Nursing and Rehab in Lubbock TX. Respondent was terminated
13 for inappropriate behavior which consisted of sleeping on duty; speaking disrespectfully to
14 residents, family members and co-workers; using the "N" word in reference to a CNA while
15 speaking with a resident; and not supervising CNAs. Several employees reported to the
16 supervisor they had observed Respondent taking unknown medications while on duty.
17

18 13. From on or about February 2016 – May 15, 2016, Respondent was employed at
19 Littlefield Hospitality in Texas. There were three occasions where Respondent was on duty and
20 needed to be urgently relieved of her duties and transported by ambulance to a hospital. The
21 symptoms displayed by Respondent included fluctuations from being "hyper to lethargic and
22 passed out" while on duty. Respondent's former supervisor described Respondent as being
23 "unstable" and the episodes of Respondent's mood and demeanor fluctuations from hyper to
24 lethargic progressed rapidly and became more consistent to the point when Respondent was on
25 duty, there was another nurse on call and ready to relieve Respondent if needed.
26

1 The conduct and circumstances described in the Preliminary Findings of Fact constitutes
2 unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. 32-1663 and
3 32-1664, and violates the following statutes and rules:

4 **A.R.S. § 32-1663(D) as defined in and currently cited (August 6, 2016) as A.R.S. § 32-1601**
5 **(24)**

6 24. "Unprofessional conduct" includes the following whether occurring in this state or
7 elsewhere:

8 (a) Committing fraud or deceit in obtaining, attempting to obtain or renewing a license or a
9 certificate issued pursuant to this chapter.

10 (d) Any conduct or practice that is or might be harmful or dangerous to the health of a patient
11 or the public.

12 (e) Being mentally incompetent or physically unsafe to a degree that is or might be harmful
13 or dangerous to the health of a patient or the public.

14 (g) Willfully or repeatedly violating a provision of this chapter or a rule adopted pursuant to
15 this chapter.

16 (h) Committing an act that deceives, defrauds or harms the public.

17 (j) Violating this chapter or a rule that is adopted by the board pursuant to this chapter.

18 **A.A.C. § R4-19-403 (currently cited January 31, 2009) For purposes of A.R.S. § 32-**
19 **1601(24)(d), any conduct or practice that is or might be harmful or dangerous to the health**
20 **of a patient or the public includes one or more of the following:**

21 1. A pattern of failure to maintain minimum standards of acceptable and prevailing nursing
22 practice;

23 2. Intentionally or negligently causing physical or emotional injury;

24 9. Failing to take appropriate action to safeguard a patient's welfare or follow policies and
25 procedures of the nurse's employer designed to safeguard the patient;
26

1 17. A pattern of using or being under the influence of alcohol, drugs, or a similar substance to
2 the extent that judgment may be impaired and nursing practice detrimentally affected, or while
3 on duty in any health care facility, school, institution, or other work location;

4 18. Obtaining, possessing, administering, or using any narcotic, controlled substance, or
5 illegal drug in violation of any federal or state criminal law, or in violation of the policy of any
6 health care facility, school, institution, or other work location at which the nurse practices;
7

8 27. Making a false or misleading statement on a nursing or health care related employment or
9 credential application concerning previous employment, employment experience, education, or
10 credentials;

11 31. Practicing in any other manner that gives the Board reasonable cause to believe the health
12 of a patient or the public may be harmed.

13 A.A.C. R4-19-308 (B) A licensee or applicant shall notify the Board in writing or electronically
14 through the Board website of any change in mailing address within 30 days.
15

16
17 **FINDING OF PUBLIC EMERGENCY AND ORDER**

18 Based upon the facts and circumstances set forth in the Preliminary Findings of Fact and
19 Preliminary Conclusions of Law, the Board finds that the public health safety and welfare
20 imperatively requires emergency action.

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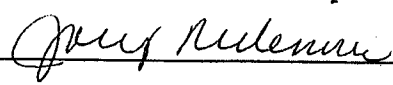
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IT IS THEREFORE ORDERED, pursuant to A.R.S. § 41-1092.11(B) and effective immediately, that Shannon M. Rangel (“Respondent”), the holder of number is practical nurse license number LP041945 is **SUMMARILY SUSPENDED** pending proceedings for revocation and other action by the Board. A hearing in this matter shall be promptly instituted and determined.

Dated this 26th day of January, 2017

SEAL



Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

1 COPIES HAND-DELIVERED in the Board office this 26th day of January, 2017 to:

2 Charity Clark

3
4 ~~COPY mailed this _____ day of January, 2017, by Certified Mail Receipt No. _____ to:~~

5
6 Charity Clark Law, PLLC
7 505 West Ray Road, Suite 4
8 Chandler, AZ 85225
9 Attorney for Respondent

8 COPY mailed this 26th day of January, 2017, by First Class Mail to:

9 Shannon M. Rangel



11
12 COPY hand- delivered this 26th day of January, 2017, to:

13 Elizabeth Campbell
14 Assistant Attorney General
15 1275 W Washington LES Section
16 Phoenix AZ 85007

17 By: TRINA SMITH
18 Hearing Department Staff

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