BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of	§	AGREED ORDER
Registered Nurse License Number 908238	§	
issued to AMANDA JOAN MARIE FARRAR	§	
	§	

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of AMANDA JOAN MARIE FARRAR, Registered Nurse License Number 908238, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(9),(10),(12)&(13), Texas Occupations Code. Respondent waived notice and hearing and agreed to the entry of this Agreed Order approved by Katherine A. Thomas, MN, RN, FAAN, Executive Director, on November 30, 2018.

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 notice and hearing, and agreed to the entry of this Agreed Order.

3. Respondent's license to practice as a professional nurse in the State of Texas is in current status.

4. Respondent received an Associate Degree in Nursing from Marion Technical College, Marion, Ohio, on May 1, 2013. Respondent was licensed to practice professional nursing in the State of Ohio on July 9, 2013, was licensed to practice professional nursing in the State of Texas on September 13, 2016.

5. Respondent's nursing employment history includes:

07/2013 - 10/2015	Registered Nurse	Fairhaven Upper Sandusky, Ohio

Respondent's nursing employment history continued:

08/2014 - 10/2016	Registered Nurse	Bucyrus Community Hospital Bucyrus, Ohio
09/2015 - 10/2016	Registered Nurse	Sojourn at Seneca Tiffin Seneca Tiffin, Ohio
11/2016 - 04/2017	Unknown	
05/2017 - 08/2017	Registered Nurse	Baptist Medical Center San Antonio, Texas
08/2017 - 11/2017	Registered Nurse	Seton Medical Center Austin, Texas
12/2017 - 07/2018	Unknown	
08/2018 - 09/2018	Registered Nurse	Southwest General Hospital San Antonio, Texas
10/2018	Registered Nurse	South Texas Spine and Surgical Hospital San Antonio, Texas
11/2018 - Present	Unknown	

6. At the time of the initial incidents, Respondent was employed as a Registered Nurse with Baptist Medical Center, San Antonio, Texas, and had been in that position for approximately one (1) month.

7. On or about June 13, 2017, through July 8, 2017, while employed as a Registered Nurse with Baptist Medical Center, San Antonio, Texas, Respondent withdrew Hydromorphone from the Omnicell medication dispensing system for patients, but failed to document and/or accurately and completely document the administration of the Hydromorphone in the patients' Medication Administration Record (MAR) and/or Nurses' Notes. Respondent's conduct was likely to injure the patients, in that subsequent caregivers would rely on her documentation to further medicate the patients, which could result in an overdose. Additionally, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

8. On or about June 5, 2017, through July 8, 2017, while employed as a Registered Nurse with Baptist Medical Center, San Antonio, Texas, Respondent withdrew Hydromorphone from the Omnicell medication dispensing system for Patient Number 1716400668, but failed to follow the facility's policy and procedure for wastage of the unused portions of the medications. Respondent's conduct left medications unaccounted for, was likely to

deceive the hospital pharmacy, and placed the pharmacy in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

9. On or about June 7, 2017, while employed as a Registered Nurse with Baptist Medical Center, San Antonio, Texas, Respondent administered Hydromorphone to Patient Number 1714600824 in excess dosage of a physician's order. Respondent's conduct was likely to injure the patient in that the administration of medication in excess frequency and/or dosage of the physicians' orders could result in the patient suffering from adverse reactions. Additionally, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

10. On or about June 19, 2017, while employed as a Registered Nurse with Baptist Medical Center, San Antonio, Texas, Respondent misappropriated Hydromorphone belonging to the facility and patients thereof, or failed to take precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients thereof of the cost of the medications.

11. On or about October 16, 2017, through November 5, 2017, while employed as a Registered Nurse with Seton Medical Center, Austin, Texas, Respondent withdrew Hydromorphone, Hydrocodone, Lorazepam, and Morphine from the Omnicell medication dispensing system for patients, but failed to document and/or accurately and completely document the administration of the Hydromorphone, Hydrocodone, Lorazepam, and Morphine in the patients' Medication Administration Record (MAR) and/or Nurses' Notes. Additionally, Respondent documented administering medications before they were pulled. Respondent's conduct was likely to injure the patients, in that subsequent caregivers would rely on her documentation to further medicate the patients, which could result in an overdose. Additionally, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

12. On or about October 26, 2017, while employed as a Registered Nurse with Seton Medical Center, Austin, Texas, Respondent withdrew Lorazepam from the Omnicell medication dispensing system for Patient Number 7392637, but failed to follow the facility's policy and procedure for wastage of the unused portions of the medications. Respondent's conduct left medications unaccounted for, was likely to deceive the hospital pharmacy, and placed the pharmacy in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

13. On or about October 26, 2017, through October 30, 2017, while employed as a Registered Nurse with Seton Medical Center, Austin, Texas, Respondent misappropriated Hydromorphone, Lorazepam, and Morphine belonging to the facility and patients thereof, or failed to take precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients thereof of the cost of the medications.

14. On or about November 5, 2017, while employed as a Registered Nurse with Seton Medical Center, Austin, Texas, Respondent withdrew and administered Hydrocodone, to patients in excess frequency and/or dosage of physician's orders. Respondent's conduct was likely

to injure the patient in that the administration of medication in excess frequency and/or dosage of the physicians' orders could result in the patient suffering from adverse reactions. Additionally, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

15. On or about August 2018 through September 3, 2018, while employed as a Registered Nurse with Southwest General Hospital, San Antonio, Texas, Respondent withdrew medication from the medication dispensing system for patients, but failed to document and/or accurately and completely document the administration of the medication in the patients' Medication Administration Record (MAR) and/or Nurses' Notes. Respondent's conduct was likely to injure the patients, in that subsequent caregivers would rely on her documentation to further medicate the patients, which could result in an overdose. Additionally, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

16. On or about August 2018 through September 3, 2018, while employed as a Registered Nurse with Southwest General Hospital, San Antonio, Texas, Respondent withdrew medication 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 left medications unaccounted for, was likely to deceive the hospital pharmacy, and placed the pharmacy in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

17. On or about August 2018 through September 3, 2018, while employed as a Registered Nurse with Southwest General Hospital, San Antonio, Texas, Respondent misappropriated medications belonging to the facility and patients thereof, or failed to take precautions to prevent such misappropriation. Respondent's conduct was likely to defraud the facility and patients thereof of the cost of the medications.

18. On or about August 2018 through September 3, 2018, while employed as a Registered Nurse with Southwest General Hospital, San Antonio, Texas, Respondent withdrew medication from the medication dispensing system for patients and/or administered in excess frequency and/or dosage of the physician's orders. Respondent's conduct was likely to injure the patient in that the administration of medication in excess frequency and/or dosage of the physicians' orders could result in the patient suffering from adverse reactions. Additionally, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

19. On or about September 3, 2018, while employed as a Registered Nurse with Southwest General Hospital, San Antonio, Texas, Respondent engaged in the intemperate use of Opiates in that she produced a for-cause drug screen that resulted positive for Opiates. The use of Opiates by a Nurse, while subject to call or duty, could impair the nurse's ability to recognize subtle signs, symptoms, or changes in a patient's condition, and could impair the nurse's ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing a patient in potential danger.

20. On or about October 16, 2018 through October 23, 2018, while employed as a Registered Nurse with South Texas Spine and Surgical Hospital, San Antonio, Texas, Respondent withdrew Demerol, Promethazine, and Diphenhydramine from the Pyxis medication dispensing system for patients, but failed to document and/or accurately and completely document the administration of the Demerol, Promethazine, and Diphenhydramine in the patients' Medication Administration Record (MAR) and/or Nurses Notes. Respondent's conduct was likely to injure the patients, in that subsequent caregivers would rely on her documentation to further medicate the patients, which could result in an overdose. Additionally, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

21. On or about October 16, 2018 through October 23, 2018, while employed as a Registered Nurse with South Texas Spine and Surgical Hospital, San Antonio, Texas, Respondent withdrew Demerol, Promethazine, and Diphenhydramine from the Pyxis 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 left medications unaccounted for, was likely to deceive the hospital pharmacy, and placed the pharmacy in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

22. On or about October 16, 2018 through October 23, 2018, while employed as a Registered Nurse with South Texas Spine and Surgical Hospital, San Antonio, Texas, Respondent misappropriated Demerol, Promethazine, and Diphenhydramine belonging to the facility and patients thereof, or failed to take precautions to prevent such misappropriation. Furthermore, two (2) vials of Promethazine, two (2) vials of Diphenhydramine, one (1) tablet of OxyContin, a needle, and a syringe were found in her home. In addition, the lot numbers on the vials of Promethazine and Diphenhydramine were matched to the facility. Respondent's conduct was likely to defraud the facility and patients thereof of the cost of the medications and supplies.

23. On or about October 17, 2018, while employed as a Registered Nurse with South Texas Spine and Surgical Hospital, San Antonio, Texas, Respondent administered Percocet to Patient Number HS in excess dosage and/or frequency of a physician's order. Respondent's conduct was likely to injure the patient in that the administration of medication in excess frequency and/or dosage of the physicians' orders could result in the patient suffering from adverse reactions. Additionally, Respondent's conduct placed the hospital in violation of Chapter 481 (Controlled Substances Act) of the Texas Health and Safety Code.

24. On or about October 23, 2018, while employed as a Registered Nurse with South Texas Spine and Surgical Hospital, San Antonio, Texas, Respondent lacked fitness to practice nursing in that she was found in her home with a needle stuck in her arm and a vial of Promethazine (Phenergan) lying next to her. Subsequently, Respondent was taken to Northeast Methodist Hospital, San Antonio, Texas, for a possible drug overdose and/or attempted suicide, and on or about October 25, 2018, Respondent was transferred to San Antonio's Health and Behavioral Center, San Antonio, Texas. 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.

25. In response to the incidents in Findings of Fact Numbers Seven (7), through Fourteen (14), Respondent states that she failed both at Baptist and at Seton. Respondent states that at both facilities, she had a heavy load of patients that were on as-needed medications and she spoke to management about it. Respondent states that she does not have a diverting problem; instead, she has a time management and charting problem. Respondent states that she has inaccurate documentation. Respondent states that her administration times were incorrectly documented due to writing the times on her report sheet then later documenting related to her poor time management. Respondent states that she never meant to delude or intentionally falsify her documentation. Respondent states that she has given up the fast pace hospital setting.

26. Formal Charges were filed on October 3, 2018.

27. 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 301.451-301.555, 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)(B),(1)(C),(1)(D),(1)(T)&(3) and 22 TEX. ADMIN. CODE §217.12 (1)(A),(1)(B),(1)(C),(1)(E),(4),(5),(6)(G),(8),(10)(C),(10)(D),(10)(E)&(11)(B).

4. The evidence received is sufficient cause pursuant to Section 301.452(b)(9),(10), (12)&(13), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 908238, heretofore issued to AMANDA JOAN MARIE FARRAR.

5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

6. 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.

TERMS OF ORDER

I. SANCTION AND APPLICABILITY

IT IS THEREFORE AGREED and ORDERED that Registered Nurse License Number 908238, previously issued to AMANDA JOAN MARIE FARRAR, to practice nursing in the State of Texas is/are hereby **SUSPENDED** and said suspension is **ENFORCED** until RESPONDENT:

A. **Applies to, is accepted into, and completes enrollment in the Texas Peer Assistance Program for Nurses (TPAPN), including payment of a non-refundable participation fee to TPAPN in the amount of five hundred dollars ($500.00), if licensed as a registered nurse, or in the amount of three hundred fifty dollars ($350.00), if licensed as a vocational nurse;**

B. Is **cleared to safely practice as a nurse** based on a fitness evaluation, as may be required by TPAPN; and

C. **Waives confidentiality and provides a copy of the fully executed TPAPN participation agreement to the Board**.

IT IS FURTHER AGREED, upon verification of successful completion of the above requirements, the Suspension will be **STAYED**, and RESPONDENT will be placed on **PROBATION** for such time as is required for RESPONDENT to successfully complete the TPAPN **AND** until RESPONDENT fulfills the additional requirements of this Order.

D. RESPONDENT SHALL pay all re-registration fees, if applicable, and RESPONDENT'S licensure status in the State of Texas will be updated to reflect the applicable conditions outlined herein.

E. RESPONDENT SHALL **comply with all requirements of the TPAPN participation agreement** during its term and SHALL keep all applicable licenses to practice nursing in the State of Texas in current status.

F. RESPONDENT SHALL CAUSE the TPAPN to **notify the Texas Board of Nursing of any violation of the TPAPN participation agreement**.

G. This Order SHALL apply to any and all future licenses issued to RESPONDENT to practice nursing in the State of Texas.

H. This Order SHALL be applicable to RESPONDENT'S nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

I. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state.

II. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT agrees to comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nursing Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 *et seq.*, and this Agreed Order.

III. REMEDIAL EDUCATION COURSE(S)

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the suspension being stayed, unless otherwise specifically indicated**:

> **A Board-approved course in Texas nursing jurisprudence and ethics** that 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. Home study and video programs will not be approved.

In order to receive credit for completion of this/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider.

Information about Board-approved courses and Verification of Course Completion forms are available from the Board at www.bon.texas.gov/compliance.

IV. EFFECT OF NONCOMPLIANCE

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 TEMPORARY 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.

V. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Agreed Order, all encumbrances will be removed from RESPONDENT'S license(s) to practice nursing in the State of Texas and, subject to meeting all existing eligibility requirements in Texas Occupations Code Chapter 304, Article III, RESPONDENT may be eligible for nurse licensure compact privileges, if any.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violation(s) 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 entry of this Order and all conditions of said 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 possible revocation of my license(s) and/or privileges to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 10 day of December 20 18

AMANDA JOAN MARIE FARRAR, Respondent

Sworn to and subscribed before me this 10th day of December 20 18

SEAL

J ACEVEDO
Notary Public
STATE OF TEXAS
My Comm. Exp. 07/13/2019

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 ratify and adopt the Agreed Order that was signed on the 10th day of December, 2018, by AMANDA JOAN MARIE FARRAR, Registered Nurse License Number 908238, and said Agreed Order is final.

Effective this 11th day of December, 2018.

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