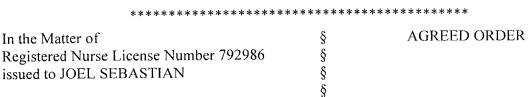
BEFORE THE TEXAS BOARD OF NURSING





On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of JOEL SEBASTIAN, Registered Nurse License Number 792986, 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 January 16, 2020.

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 Vance-Granville Community College, Henderson, North Carolina, on May 14, 2010. Respondent was licensed to practice professional nursing in the State of Texas on October 21, 2010.
- 5. Respondent's nursing employment history includes:

10/2010 – 10/2011 RN Regency Village Webster, Texas

Respondent's nursing employment history continued:

11/2011 – 1/2012	Unknown	
2/2012 – 7/2018	RN	Houston Methodist Sugar Land Sugar Land, Texas
8/2018 - 11/2018	Unknown	
12/2018 - 8/2019	RN	CHI St. Luke's - Baylor St. Luke's Medical Center Houston, Texas
9/2019 – Present	Unknown	

- 6. At the time of the initial incident, Respondent was employed as a Registered Nurse with Houston Methodist Sugar Land, Sugar Land, Texas, and had been in that position for six (6) years and five (5) months.
- 7. On or about July 26, 2018, through July 27, 2018, while employed as a Registered Nurse with Houston Methodist Sugar Land Hospital, Sugar Land, Texas, Respondent lacked fitness to practice nursing in that he exhibited signs of impaired behavior while on duty, including, but not limited to: red eyes, stuttered when he spoke, and was confused. Furthermore, Respondent had a fresh needle stick with blood on his forearm. Additionally, Respondent's first urine sample was cold and smelled like the soft drink he carried into the restroom and his second urine sample appeared to be water. Respondent subsequently admitted he used intravenous drugs. Respondent's condition could have affected his ability to recognize subtle signs, symptoms or changes in patients' conditions, and could have affected his ability to make rational, accurate, and appropriate assessments, judgments, and decisions regarding patient care, thereby placing the patients in potential danger.
- 8. On or about July 26, 2018, while employed as a Registered Nurse with Houston Methodist Sugar Land Hospital, Sugar Land, Texas, Respondent withdrew three (3) vials of Hydromorphone 2mg and one (1) vial of Fentanyl 100mcg from the medication dispensing system for Patient Medical Record Number 013478565 but failed to administer and/or 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 patient, in that subsequent care givers would rely on his documentation to further medicate the patient, 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.
- 9. On or about July 26, 2018, while employed as a Registered Nurse with Houston Methodist Sugar Land Hospital, Sugar Land, Texas, Respondent withdrew Fentanyl 100mcg from the medication dispensing system for Patient Medical Record Number 013478565 and failed

- to document the pain assessment in the patient's medical records. Respondent's conduct was likely to injure the patient from clinical care decisions formulated based upon incomplete assessment information.
- 10. On or about July 26, 2018, while employed as a Registered Nurse with Houston Methodist Sugar Land Hospital, Sugar Land, Texas, Respondent withdrew three (3) vials of Hydromorphone 2mg and one (1) vial of Fentanyl 100mcg from the medication dispensing system for Patient Medical Record Number 013478565 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.
- 11. On or about July 26, 2018, while employed as a Registered Nurse with Houston Methodist Sugar Land Hospital, Sugar Land, Texas, Respondent misappropriated three (3) vials of Hydromorphone 2mg and Fentanyl 25mcg 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.
- 12. On or about July 27, 2018, while employed as a Registered Nurse with Houston Methodist Sugar Land Hospital, Sugar Land, Texas, Respondent withdrew Morphine 4mg/ml from the medication dispensing system for Patient Medical Record Number 034877266 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 patient, in that subsequent care givers would rely on his documentation to further medicate the patient, 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.
- 13. On or about July 27, 2018, while employed as a Registered Nurse with Houston Methodist Sugar Land Hospital, Sugar Land, Texas, Respondent withdrew Morphine 4mg/ml from the medication dispensing system for Patient Medical Record Number 034877266 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.
- 14. On or about July 27, 2018, while employed as a Registered Nurse with Houston Methodist Sugar Land Hospital, Sugar Land, Texas, Respondent misappropriated Morphine 4mg/ml 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.
- 15. On or about August 14, 2019, through August 15, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent

withdrew thirteen (13) Morphine Inj. 2mg from the medication dispensing system for Patient 02503326 but failed to document and/or accurately and completely document the administration of the medication in the patient's Medication Administration Record (MAR) and/or Nurses' Notes. Respondent's conduct was likely to injure the patient, in that subsequent care givers would rely on his documentation to further medicate the patient, 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 14, 2019, through August 15, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew thirteen (13) Morphine Inj. 2mg from the medication dispensing system for Patient 02503326 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 14, 2019, through August 15, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent misappropriated thirteen (13) Morphine Inj. 2mg 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 15, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew four (4) Hydromorphone Inj. 0.5mg from the medication dispensing system for Patient 05585837 but failed to document and/or accurately and completely document the administration of the medication in the patient's Medication Administration Record (MAR) and/or Nurses' Notes. Respondent's conduct was likely to injure the patient, in that subsequent care givers would rely on his documentation to further medicate the patient, 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.
- 19. On or about August 15, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew four (4) Hydromorphone Inj. 0.5mg from the medication dispensing system for Patient 05585837 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.
- 20. On or about August 15, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent misappropriated four (4) Hydromorphone Inj. 0.5mg 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.
- 21. On or about August 15, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew two (2) Hydromorphone 0.5mg tablets from the medication dispensing system for Patient 03149673 but failed to document and/or accurately and completely document the administration of the medication in the patient's Medication Administration Record (MAR) and/or Nurses' Notes. Respondent's conduct was likely to injure the patient, in that subsequent care givers would rely on his documentation to further medicate the patient, 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.
- 22. On or about August 15, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew two (2) Hydromorphone Inj. 0.5mg from the medication dispensing system for Patient 03149673 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.
- 23. On or about August 15, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent misappropriated two (2) Hydromorphone Inj. 0.5mg 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.
- 24. On or about August 17, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew seven (7) Morphine Inj. 4mg from the medication dispensing system for Patient 02542864 but failed to document and/or accurately and completely document the administration of the medication in the patient's Medication Administration Record (MAR) and/or Nurses' Notes. Respondent's conduct was likely to injure the patient, in that subsequent care givers would rely on his documentation to further medicate the patient, 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.
- 25. On or about August 17, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew seven (7) Morphine Inj. 4mg from the medication dispensing system for Patient 02542864 but failed to follow the facility's policy and procedure for wastage of the unused portions of the medication. 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.

- 26. On or about August 17, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent misappropriated seven (7) Morphine Inj. 4mg 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.
- 27. On or about August 22, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew four (4) Morphine Inj. 2mg from the medication dispensing system for Patient 02333577 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.
- 28. On or about August 22, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew four (4) Morphine Inj. 2mg from the medication dispensing system for Patient 01234115 but failed to document and/or accurately and completely document the administration of the medication in the patient's Medication Administration Record (MAR) and/or Nurses' Notes. Respondent's conduct was likely to injure the patient, in that subsequent care givers would rely on his documentation to further medicate the patient, 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.
- 29. On or about August 22, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew four (4) Morphine Inj. 2mg from the medication dispensing system for Patient 01234115 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.
- 30. On or about August 22, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent misappropriated four (4) Morphine Inj. 2mg 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.
- 31. On or about August 22, 2019, through August 23, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew three (3) Hydromorphone Inj. 0.5mg from the medication dispensing system for Patient 05231854 but failed to document and/or accurately and completely document the administration of the medication in the patient's Medication Administration Record (MAR) and/or Nurses' Notes. Respondent's conduct was likely to injure the patient, in

that subsequent care givers would rely on his documentation to further medicate the patient, 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.

- 32. On or about August 22, 2019, through August 23, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent withdrew three (3) Hydromorphone Inj. 0.5mg from the medication dispensing system for Patient 05231854 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.
- 33. On or about August 22, 2019, through August 23, 2019, while employed as a Registered Nurse with CHI St. Luke's Baylor St. Luke's Medical Center, Houston, Texas, Respondent misappropriated three (3) Hydromorphone Inj. 0.5mg 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.
- 34. In response to Findings of Fact Numbers Eight (8) through Eleven (11), Respondent states he was psychologically and emotionally drained and gave himself Hydromorphone intravenously. Respondent relates he took two (2) vials of Hydromorphone from Patient Medical Record Number 013478565 and administering them to himself, but denies taking a third vial of Hydromorphone or the Fentanyl. In response to Findings of Fact Numbers Twelve (12) through Fourteen (14), Respondent states his orientee properly wasted the Morphine 4mg due to patient refusal.
- 35. Formal Charges were filed on March 22, 2019.
- 36. 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)&(3) and 22 TEX. ADMIN. CODE §217.12(1)(A),(1)(B), (1)(C),(1)(E),(4),(5),(6)(G),(8),(10)(C),(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 792986, heretofore issued to JOEL SEBASTIAN.
- 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 792986, previously issued to JOEL SEBASTIAN, 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 <u>cleared to safely practice as a nurse</u> 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 <u>comply with all requirements of the TPAPN</u> <u>participation agreement</u> 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 <u>notify the Texas Board of Nursing of any violation of the TPAPN participation agreement</u>.
- 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 <u>not</u> being offered by a pre-approved provider. Information about Board-approved courses and Verification of Course Completion forms are available from the Board at <u>www.bon.texas.gov/compliance</u>.

IV. SUBSEQUENT CRIMINAL PROCEEDINGS

IT IS FURTHER AGREED, should the RESPONDENT'S conduct, as outlined in the findings of fact of this Agreed Order, result in subsequent judicial action, including a deferred disposition, RESPONDENT may be subject to further disciplinary action, up to, and including, revocation of RESPONDENT'S license(s) to practice nursing in the State of Texas.

V. 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.

VI. 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) and/or privilege(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 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 TEMPORARY SUSPENSION pursuant to Section 301.4551, Texas Occupations Code, and/or possible revocation of my license(s) and/or privileges to practice nursing in the State of Texas, as a consequence of my noncompliance.

	J. Sel	ostian	anuany, 20,20.
	JOEL SEBAST	IAN, KESP	ONDENI
Sworn to and subscribed before me	this <u>23</u> day o	f January	_, 20 <u>20</u> .
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JOHN ABRAHAM			***************************************
Notary Public, State of Paxas Comm. Expires 07-02-2023	Notary Public i	n and for the	State of TX
Notary ID 132074574			
William Hotel,	Approved as to	form and su	bstance.
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			01/23/2020
	Signed this	day of	, 20 .

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Signed this ____ day of __

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 23rd day of January, 2020, by JOEL SEBASTIAN, Registered Nurse License Number 792986, and said Agreed Order is final.

Effective this 24th day of January, 2020.

Katherine A. Thomas, MN, RN, FAAN

Executive Director on behalf

of said Board