STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING,	)	
Petitioner,	)	
vs.	)	Case No. 97-4083
CECIL HAROLD FLOYD,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was conducted in this case on July 9, 1999, in Largo, Florida, before Carolyn S. Holifield, a duly-designated Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Howard M. Bernstein, Esquire
Agency for Health Care Administration
Allied Health - Medical Quality Assistance
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308-5403

For Respondent: No Appearance

STATEMENT OF THE ISSUES

Whether Respondent engaged in unprofessional conduct and, if so, what penalty should be imposed on his nursing license.

PRELIMINARY STATEMENT

In a three-count Administrative Complaint dated June 26, 1997, the Department of Health, Board of Nursing (Department), charged Respondent, Cecil Harold Floyd (Respondent), with

engaging in unprofessional conduct within the meaning of specified statutes and rules governing the regulation of nursing. Count I alleged that Respondent engaged in conduct that failed to conform to the minimal acceptable standards of prevailing nursing practice and, thus, is subject to disciplinary action pursuant to Section 464.018(1)(h), Florida Statutes. Count II of the Administrative Complaint alleged that Respondent administered medications or treatment in a negligent manner and is subject to disciplinary action pursuant to Rule 64B9-8.005(1)(e)2., Florida Administrative Code. Finally, Count III alleged that Respondent committed acts of negligence or gross negligence by omission or commission and, therefore, is subject to disciplinary action pursuant to Rule 64B9-8.005(1)(e)12., Florida Administrative Code.

The Administrative Complaint claimed that the act which constitutes the basis for the alleged violations was Respondent's recording observations in the nurse’s notes about Patient M.F., but noting only that the patient should be monitored. Also, it was alleged that the patient’s roommate had indicated that she believed M.F. had suffered a stroke due to the fact that she could not swallow and her speech was slurred.

Respondent challenged the allegations and timely requested a formal hearing. The matter was forwarded to the Division of Administrative Hearings for assignment of an Administrative Law Judge to conduct the hearing.

Pursuant to an Order issued May 22, 1998, Admissions 1-8 of the Department's Request for Admissions were deemed admitted by Respondent and, thus, required no proof of hearing.

At hearing, the Department called four witnesses: Katie Appelgate; Mary Edwards; Donna Gondak; and Conchita McClory. The Department offered and had four exhibits received into evidence. Respondent failed to appear at hearing and no evidence or testimony was presented on his behalf.

At the conclusion of the hearing, Petitioner requested that the record remain open until July 29, 1999, to allow Petitioner to take the deposition testimony of Patient E.M. and Diane Nora, the Department's expert witness, and to late-file those depositions and the Department's Exhibits 1, 2, 3 and 5. Thereafter, the Department requested and was granted an additional extension of time in which to file its late-filed exhibits and proposed recommended order. The Department's Exhibits 2 and 3 were filed on September 28, 1999, and the Department's Exhibit 5 was filed on September 30, 1999. The aforementioned depositions and the Department's Exhibit 1 were not filed with the Division of Administrative Hearings, and, therefore, are not a part of the record in this case.

A Transcript of the proceeding was filed on July 27, 1999. Petitioner filed a Proposed Recommended Order which has been considered in preparation of this Recommended Order. Respondent did not file proposed findings of facts and conclusions of law.

FINDINGS OF FACT

1. The Department of Health is the state agency charged with regulating the practice of nursing pursuant to Chapter 464, Florida Statutes.

2. Respondent, Cecil Harold Floyd, was at all times material hereto a licensed practical nurse in the State of Florida, having been issued a license numbered PN 0960631.

3. At all times material hereto, Respondent was employed as a licensed practical nurse by the North Shore Senior Adult Community in St. Petersburg, Florida.

4. At all times material hereto, Respondent was assigned to care for Patient M.F., a patient in the skilled nursing section of the North Shore Senior Adult Community.

5. On February 26-27, 1996, Respondent worked as the charge nurse on the 11:00 p.m. to 7:00 a.m. shift. On February 27, 1996, at approximately 6:00 a.m., Respondent wrote in the nurse's notes that Patient M.F. was lethargic and having difficulty swallowing; that the patient's bottom dentures were out; and that the patient's tongue was over to the right side. In this entry, Respondent also noted "will continue to monitor."

6. After Respondent completed his shift on February 27, 1996, Conchita McClory, LPN, was the charge nurse in the skilled nursing facility at North Shore Senior Adult Community. At about 8:10 a.m., Nurse McClory was called by the CNA who was attempting to wake up Patient M.F. Upon Nurse McClory's entering Patient

M.F.'s room, she observed that the patient was sleeping, incontinent, and restless and that the right side of the patient's face was dropping. Based on these observations, Nurse McClory believed that Patient M.F. may have suffered a stroke and she immediately called 911. Following the 911 call, Patent M.F. was taken to Saint Anthony's Hospital in Saint Petersburg, Florida.

7. Prior to coming to this country, Conchita McClory had been trained and worked as a registered nurse in the Philippines. However, Ms. McClory is not licensed as a registered nurse in the State of Florida.

8. Saint Anthony's Hospital's records regarding Patient M.F. indicate that the patient had a history of multiple strokes beginning in 1986.

9. The Department's Administrative Complaint against Respondent included the following factual allegations, all of which were alleged to have occurred on February 27, 1996:

> a. At approximately 6:00 a.m., Respondent recorded in the nurse's notes that Patient M.F. was lethargic and having difficulty swallowing; the patient's bottom dentures were out; and the patient's tongue was over to the right side. Respondent also noted in the nurses' notes that Patient M.F. should continue to be monitored.
>
> b. Patient M.F.'s roommate told Respondent that she believed that M.F. had suffered a stroke because she could not swallow and her speech was slurred.
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> c. At about 8:00 a.m., Patient M.F.'s roommate went to the nurses' station and

> requested that a certified nurse's assistant check on M.F. Patient M.F. was found paralyzed on her left side, soaked in urine and unable to speak.

10. There was no evidence presented to support the factual allegations referenced in paragraph 9b and 9c above and included in the Administrative Complaint.

CONCLUSIONS OF LAW

11. The Division of Administrative Hearings has jurisdiction over the subject matter of and the parties to this proceeding. Section 120.569 and 120.57(1), Florida Statutes.

12. Section 464.018(2), Florida Statutes, empowers the Board of Nursing to revoke, suspend, or otherwise discipline the license of a nurse who is found guilty of any one of the acts enumerated in Section 464.018(1), Florida Statutes.

13. Count I of the Administrative Complaint alleges that Respondent engaged in conduct that failed to conform to the minimal acceptable standard of prevailing nursing practice and, therefore, is subject to disciplinary action pursuant to Section 464.018(1)(h), Florida Statutes. That section states:

> (1) The following acts shall be grounds for disciplinary action set forth in this section:
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> * * *
>
> (h) Unprofessional conduct, which shall include, but not be limited to, any departure from, or the failure to conform to the minimal standards of acceptable and prevailing nursing practice, in which actual injury need not be established.

14. Count II of the Administrative Complaint alleges that Respondent administered medication or treatments in a negligent manner and that, as a result thereof, he is subject to disciplinary action pursuant to Rule 59S-8.005(1)(e)2., Florida Administrative Code (1997). That rule has subsequently been renumbered as Rule 64B9-8.005(1)(e)2., Florida Administrative Code.

15. Count III of the Administrative Complaint alleges that Respondent committed acts of negligence or gross negligence by omission or commission and is, therefore, subject to discipline pursuant to Rule 59S-8.005(1)(e)12., Florida Administrative Code. As noted in paragraph 14, that rule has been renumbered as Rule 64B9-8.005(1)(e)12., Florida Administrative Code.

16. The relevant provisions of Rule 64B9-8.005(1)(e), Florida Administrative Code, provide the following:

> (1) The Board of Nursing shall impose disciplinary penalties upon a determination that a license:
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> * * *
>
> (e) Is guilty of unprofessional conduct which shall include, but not be limited to:
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> * * *
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> 2. Administering medications or treatments in a negligent manner; or
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> * * *
>
> 12. Acts of negligence, gross negligence, either by omission or commission;

17. In a license disciplinary proceeding such as this, the burden is on the regulatory agency to establish the facts upon which its allegations are based by clear and convincing evidence. Ferris v. Turlington, 510 So. 2d 392 (Fla. 1987).

18. In this case, the Department has failed to meet its burden of proof.

19. The evidence established that near the end of Respondent's shift, he checked on Patient M.F. and recorded in the nurse's notes that the patient was lethargic and having difficulty swallowing; that her bottom dentures were out; that her tongue was over to the right side; and that the patient should continue to be monitored.

20. No evidence was presented to establish Patient M.F.'s roommate told Respondent that she believed that Patient M.F. had suffered a stroke because she could not swallow and her speech was slurred. Furthermore, there was no evidence that when Patient M.F. was checked at approximately 8:00 a.m. on February 27, 1999, she was found paralyzed on her left side, soaked in urine, and unable to speak. The record lacks any evidence that Respondent's conduct as described in paragraph 5 above, without more, constitutes unprofessional conduct. Accordingly, the Department has failed to prove by clear and convincing evidence that Respondent is guilty of the alleged violations contained in the Administrative Complaint.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Department of Health, Board of Nursing, enter a final order dismissing the Administrative Complaint against Respondent.

DONE AND ENTERED this 6th day of October, 1999, in Tallahassee, Leon County, Florida.

CAROLYN S. HOLIFIELD
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 6th day of October, 1999.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.