STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING,

Petitioner,

vs. Case No. 99-3604

ERMA ONITA WEBSTER SOLOMON,

Respondent.

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its duly-designated Administrative Law Judge, William J. Kendrick, held a formal hearing in the above-styled case on November 12, 1999, by video teleconference, with sites in Tallahassee and Miami, Florida.

APPEARANCES

For Petitioner: Diane K. Kiesling, Esquire
Agency for Health Care Administration
Building 3, Room 3231A
2727 Mahan Drive
Tallahassee, Florida 32308

For Respondent: No appearance at hearing

STATEMENT OF THE ISSUE

At issue in this proceeding is whether Respondent committed the offenses set forth in the Administrative Complaint and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

On June 29, 1999, Petitioner filed an Administrative Complaint against Respondent, a licensed registered nurse, which charged that Respondent violated the provisions of Section 464.018(1)(h), Florida Statutes, by failing to conform to the minimal standards of acceptable and prevailing nursing practice. The gravamen of such charge was Petitioner's contention that in 1994, Respondent prepared the wrong patient for chemotherapy and failed to appropriately check the Red Cart used for cardiopulmonary resuscitation; in 1995, Respondent administered the wrong chemotherapy to a patient; and on or about March 14, 1997, and March 27, 1997, Respondent failed to properly dispose of finished chemotherapy bags.

Respondent filed an election-of-rights wherein she disputed the allegations of fact contained in the Administrative Complaint and requested a formal hearing. Consequently, Petitioner referred the matter to the Division of Administrative Hearings for the assignment of an administrative law judge to conduct a formal hearing pursuant to Sections 120.569, 120.57(1), and 120.60(5), Florida Statutes.

At hearing, Petitioner called Jane Welt, Mireya Guzman, Myrtle Perdue, Wyrlane Williams, Shirley Chandler, Lavette Tookes, Esmie Bonitto, James Keith Buehner, Nancy Harvey, and David Rosenberg as witnesses, and Petitioner's Exhibits numbered 1-8 were received into evidence.[1] Neither Respondent

nor anyone on her behalf appeared at hearing, and no evidence was otherwise offered on her behalf.

The hearing transcript was filed December 16, 1999, and the parties were accorded ten days from that date to file proposed recommended orders. Petitioner elected to file such a proposal and it has been duly-considered.

FINDINGS OF FACT

1. Respondent, Erma Onita Webster Solomon, is, and was at all times material hereto, a licensed registered nurse (RN) in the State of Florida, having been issued license number RN 0984482, and was employed by the Public Health Trust, Jackson Memorial Hospital (JMH), 1611 Northwest 12th Avenue, Miami, Florida, as a Nurse II, in the Special Immunology Clinic, Ambulatory Services Division.

2. Here, the proof demonstrated, as alleged in the Administrative Complaint that in 1994, Respondent (while employed at JMH) failed to appropriately check the Red Cart used for cardiopulmonary resuscitation and prepared the wrong patient for chemotherapy. More particularly, the proof demonstrated that for the week of March 21, 1994, through March 25, 1994, Respondent was responsible for assuring that all emergency equipment on the Red Cart used for cardiopulmonary resuscitation was current. Respondent failed in such duty in that an audit on March 24, 1994, revealed that a pediatric ventilation tray had expired on March 20, 1994. Dated (noncurrent) equipment could jeopardize

patient care and, consequently, Respondent's conduct (in failing to assure the presence of current emergency equipment) was unprofessional and constituted a departure from, or failure to conform to, the minimal standards of acceptable and prevailing nursing practice. With regard to the contention that Respondent prepared the wrong patient for chemotherapy treatment the proof demonstrated that on July 20, 1994, Respondent initiated an intravenous for administration of chemotherapy and brought a bag of chemotherapy to administer; however, it was not administered, when the patient recognized the chemotherapy was not hers. By failing to appropriately identify the patient against standard identification, Respondent failed to utilize appropriate nursing protocols essential to minimize patient risk and, consequently, her failure constituted a departure from, or failure to conform to, the minimal standards of acceptable and prevailing nursing practice.

3. The proof further demonstrated, consistent with the allegations of the Administrative Complaint, that in 1995 Respondent administered the wrong chemotherapy to a patient. More particularly, the proof demonstrated that on October 5, 1995, Respondent administered the wrong chemotherapy to her patient because she failed to appropriately identify (correlate) the patient with the patient number and dosage on the bag of chemotherapy she administered. More specifically, Respondent administered a bag of Doxil 32 mg to her patient (#2201315), that

had been ordered for another patient (#520384). Consequently, an additional order for Doxil 10 mg was required for Respondent's patient (#2201315) to receive the correct dosage prescribed, and a new bag of Doxil 32 mg had to be prepared for the other patient (#520384). While there were no apparent side effects, Respondent's failure to appropriately identify the patient against standard identification represented a failure to utilize appropriate nursing protocols essential to minimize patient risk and, consequently, Respondent's conduct constituted a departure from, or failure to conform to, the minimal standards of acceptable and prevailing nursing practice.

4. Finally, the proof demonstrated, consistent with the allegations of the Administrative Complaint, that on March 14, 1997, and again on March 25, 1997, Respondent failed to properly dispose of finished chemotherapy bags. More particularly, the proof demonstrated that on March 14, 1997, after having administered a chemotherapy treatment to a patient, Respondent, contrary to accepted protocol which required immediate double bagging of the chemotherapy waste materials to avoid contamination (since such agents aerosolize easily and pose a significant health risk to others), left the Doxil, with the tubing hanging in a downward position and the tip uncapped and open to the air. Again, on March 25, 1997, Respondent failed to immediately remove or double bag the chemotherapy waste after administration of the chemotherapeutic agent. Rather, again,

Respondent left a spent chemotherapy bag (Doxil) and attached IV tubing hanging from an IV pole, with the tip uncapped and dripping the chemotherapy agent into a waste basket. Respondent's failure to appropriately dispose of chemotherapy waste violated appropriate nursing protocols essential to minimize public health risk, and constituted a departure from, or failure to conform to, the minimal standards of acceptable and prevailing nursing practice.

CONCLUSIONS OF LAW

5. The Division of Administrative Hearings has jurisdiction over the parties to, and the subject matter of, these proceedings. Section 120.569, 120.57(1), and 120.60(5), Florida Statutes.

6. Where, as here, the Department proposes to take punitive action against a licensee, it must establish grounds for disciplinary action by clear and convincing evidence. Section 120.57(1)(h), Florida Statutes (1997), and Department of Banking and Finance v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996). That standard requires that "the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to

be established." Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

7. Regardless of the disciplinary action sought to be taken, it may be based only upon the offenses specifically alleged in the administrative complaint. See Kinney v. Department of State, 501 So. 2d 129 (Fla. 5th DCA 1987); Sternberg v. Department of Professional Regulation, Board of Medical Examiners, 465 So. 2d 1324 (Fla. 1st DCA 1985); and Hunter v. Department of Professional Regulation, 458 So. 2d 844 (Fla. 2d DCA 1984). Moreover, in determining whether Respondent violated the provisions of Section 464.018, as alleged in the Amended Administrative Complaint, one "must bear in mind that it is, in effect, a penal statute. . . . This being true, the statute must be strictly construed and no conduct is to be regarded as included within it that is not reasonably proscribed by it." Lester v. Department of Professional and Occupational Regulations, 348 So. 2d 923, 925 (Fla. 1st DCA 1977).

8. Pertinent to this case, Section 464.018, Florida Statutes, provides:

> (1) The following acts shall be grounds for disciplinary action set forth in this section:
>
> * * *
>
> (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 case actual injury need not be established.

Also pertinent to this case, Rule 64B9-8.005, Florida Administrative Code, defines "unprofessional conduct" to include:

> (2) Administering medications or treatments in negligent manner; or
>
> * * *
>
> (12) Acts of negligence, gross negligence, either by omission or commission; or
> (13) Failure to conform to the minimal standards of acceptable prevailing nursing practice, regardless of whether or not actual injury to a patient was sustained. . . .

9. Here, as observed in the Findings of Fact, Petitioner demonstrated with the requisite degree of certainty that Respondent committed multiple violations of Section 464.018(1)(h), Florida Statutes, as alleged in the Administrative Complaint. Consequently, it remains to resolve the appropriate penalty that should be imposed.

10. As a penalty for Respondent's violations, Petitioner suggests that an administrative fine be imposed in the amount of $1,000; that Respondent's license be suspended until such time as the Board of Nursing (Board) is satisfied that she is capable of safely engaging in the practice of nursing; and that upon reinstatement Respondent be placed on a term of probation for a period of time and subject to such reasonable conditions as the Board may specify. Such proposal is consistent with the provisions of Section 464.018(2) and (3), Florida Statutes, and the Board's penalty guidelines (Rule 64B9-8.006, Florida Administrative Code). Consequently, there being no apparent

reason to deviate from Petitioner's recommendation, its proposed penalty is accepted as appropriate. Walker v. Department of Business and Professional Regulation, 23 Fla. L. Weekly D292 (Fla. 5th DCA 1998)(Penalty imposed was within Florida Real Estate Commission's statutory authority and would not be disturbed.)

RECOMMENDATION

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

RECOMMENDED that a final order be entered which finds Respondent guilty of the multiple violations of Section 464.018(1)(h), Florida Statutes, as alleged in the Administrative Complaint and that, as a penalty for such violations, imposes an administrative fine in the amount of $1,000; suspends Respondent's license until such time as the Board is satisfied that she is capable of safely engaging in the practice of nursing; and upon reinstatement places Respondent on a term of probation for a period of time and subject to such reasonable conditions as the Board may specify.

DONE AND ENTERED this 14th day of January, 2000, in Tallahassee, Leon County, Florida.

WILLIAM J. KENDRICK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 14th day of January, 2000.

ENDNOTE

1/ Also, Petitioner's request that, by virtue of Respondent's failure to respond, the matters set forth in Petitioner's Request for Admissions served October 1, 1999, be deemed admitted was granted.

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.