

STATE OF FLORIDA  
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,	)	
BOARD OF NURSING,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 00-1931
	)	
RACHELLE CHIARO VASLOWSKI, R.N.,	)	
	)	
Respondent.	)	
_____	)	

RECOMMENDED ORDER

A hearing was held pursuant to notice, on February 20, 2001, in Daytona Beach, Florida, by Stephen F. Dean, assigned Administrative Law Judge of the Division of Administrative Hearings, in Tallahassee, Florida.

APPEARANCES

For Petitioner: Michael E. Duclos, Esquire  
Agency for Health Care Administration  
2727 Mahan Drive  
Tallahassee, Florida 32308

For Respondent: No appearance

STATEMENT OF THE ISSUE

The issue in this proceeding is whether Respondent committed the offences set forth in the Administrative Complaint and, if so, whether Respondent's nursing license should be disciplined accordingly.

PRELIMINARY STATEMENT

On October 28, 1998, Petitioner issued an Administrative Complaint which alleged that Respondent violated the provisions of Section 464.018(1)(h), Florida Statutes, by having engaged in unprofessional conduct on or about January 6, 1998.

Respondent, through her attorney of record, filed an Answer to the Administrative Complaint and an Election of Rights form contesting the allegations and requesting a formal hearing. Petitioner referred the matter to the Division of Administrative Hearings on May 8, 2000. On May 11, 2000, the Division of Administrative Hearings issued an Initial Order. The parties filed a joint Response to Initial Order. In accordance with the dates provided in the Response to Initial Order, a Notice of Hearing was issued for February 20, 2001.

In compliance with the Order of Prehearing Instructions, Petitioner filed a Unilateral Prehearing Stipulation. Respondent's attorney filed a motion to withdraw because of a lack of client cooperation, which the assigned Judge granted.

At the hearing, Petitioner presented the testimony of Barbara Geyer, R.N., and Katherine Johnson, R.N. Petitioner's Exhibits numbered 1 through 5 were admitted into evidence.

Respondent did not appear at the hearing, although she was duly noticed.

Petitioner timely filed its Proposed Recommended Order on March 16, 2001, which was read and considered.

#### FINDINGS OF FACT

1. The Agency for health Care Administration is the agency charged with the regulatory and prosecutorial duties related to nursing practice in the State of Florida.

2. Respondent, Rachelle Chiaro Vaslowski, holds a nursing license number RN 2913542.

3. Respondent's last known address is 240 Brookline Avenue, Daytona Beach, Florida 32118.

4. Respondent was employed by the Coquina Center (the Center) from February 12, 1997, until her termination on January 7, 1998.

5. On January 6 and 7, 1998, Respondent was working a day shift at the Center as a registered nurse, at 170 North Center Street, Ormond Beach, Florida.

6. Respondent was under the supervision of Barbara Geyer, R.N., Unit Manager for the sub-acute care section of the nursing home. Respondent was assigned to care for patients which included the administration of their scheduled medications.

7. Ms. Geyer testified regarding Respondent's performance of her duties. On Respondent's shift, patients, whom Respondent was caring for, had not received the medication that they were prescribed. Ms. Geyer also observed twenty to thirty cc' s of clear fluid on Respondent's medication cart when this was brought to her attention by Respondent.

8. Respondent told Ms. Geyer, "I've just spilled a bottle of Roxanol, should I take the plunger and suck it back up again." Roxanol is a strong mixture of pain medication, consisting of Morphine and Demerol, used to medicate the terminally ill. Ms. Geyer advised Respondent that the medication had to be appropriately discarded and the correct documents completed regarding its wastage.

9. Ms. Geyer, who has been an R.N. for many years, observed that Respondent had a very confused look on her face.

10. Ms. Geyer went to her Director of Nursing, Kathy Johnson and advised her of the situation. Both women interviewed Respondent regarding the spilling of the narcotic.

11. A hasty inventory also was conducted of Respondent's medication cart. Respondent was the only person on duty with a key to the cart. There were medications for which Respondent had received which were unaccounted for. Two and a half vials of Morphine and 14 Ambien were missing.

12. They also found two vials marked as containing Roxanol. Since this was the medication that was supposed to have been spilled, Ms. Geyer questioned Respondent about it. Respondent replied, "What do you want, there is more than you need?"

13. Ms. Geyer and Ms. Johnson both stuck their fingers in the supposed vials containing Roxanol. Both women testified that one had a bitter taste and the other had no taste at all.

14. Ms. Geyer observed that, in addition to having a dazed look in her eyes, Respondent gave totally inappropriate responses to the questions she was asked when interviewed.

15. Ms. Johnson, the head nurse, testified that she observed Respondent's nursing skills had declined. Respondent forgot to chart medications she administered. This became a pattern. Ms. Johnson identified Petitioner's Exhibit No. 5 as the complaint she had filed with the State against Respondent on February 20, 1998.

16. Ms. Johnson was qualified as a nursing expert based on her education, training, and experience. She observed that Respondent, when interviewed following the spilling incident, was confused and dazed. Questions had to be repeated several times to her. Respondent appeared not to understand the questions.

17. Ms. Johnson described that when Respondent was informed that they were going to do a narcotics count on Respondent's medication cart, Respondent grabbed her belongings and left the facility in haste. She did not clock out. She did not tell anybody she was leaving. She left the keys on the cart and she was out the door. Ms. Johnson opined that this was very unprofessional behavior.

18. The Center's pharmacy policies and procedures were identified by Ms. Geyer. Ms. Geyer explained the policies and procedures regarding controlled substances. Respondent failed to follow the policy and procedure for disposing of controlled substances.

19. As supervising nurse, Ms. Geyer, filled out a narcotics "wasting" report on Respondent spilling of Roxanol. The medication error report was signed by Barbara Geyer.

20. Ms. Johnson also testified that it is a violation of nursing procedures to not account for narcotics properly when you administer or "waste" them. Further, she opined it was unprofessional conduct to work under the influence of narcotics, to take medications that are intended for patients, and not properly chart medications.

#### CONCLUSIONS OF LAW

21. The Division of Administrative Hearings has jurisdiction over the parties and subject matter in this case.

Sections 120.569 and 120.57(1), Florida Statutes.

22. Section 464.018(1)(h), Florida Statutes, makes it a violation of the Nurse Practice Act for a licensee to engage in:

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 . . . "

23. Rule 64B9-8.005, Florida Administrative Code, defines unprofessional conduct to include:

(1) Inaccurate recording, falsifying or altering of patient records . . . ;

(2) Administering medications or treatments in a negligent manner;

(3) Misappropriating supplies, equipment or drugs; or

(4) Leaving a nursing assignment before properly advising appropriate personnel

\* \* \*

(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.

24. Petitioner has the burden of proving by clear and convincing evidence that Respondent failed to practice nursing in accordance with the Florida Statutes, and the Rules.

25. The evidence shows Respondent failed to conform to minimal acceptable standards of nursing practice by diverting

drugs meant for patients by using the drugs on duty; by failing to follow policies and procedures for disposing of controlled substances; and by leaving her nursing assignment before being properly relieved.

26. The observations of two experienced registered nurses indicate that Respondent was under the influence of drugs while she was on duty. The evidence indicates the drugs she had taken were diverted from patients. Her actions are below the minimum acceptable prevailing standards for nursing practice according to the expert witness. Further, by diverting the drugs to her own use, she was in possession of controlled substances unlawfully. Respondent's conduct is a violation of Section 464.018(1)(h), Florida Statutes.

27. Rule 64B9-8.006(3)(i), provides penalty guidelines for unprofessional conduct in delivery of nursing services as follows: \$250-\$1000 fine and up to suspension until Respondent proves she practice safety followed by probation.

28. Rule 64B9-8.006(3)(j), provides penalty guidelines for unlawful possession of controlled substances as follows: \$250-\$1000 fine and up to 5 years suspension followed by probation.

29. Rule 64B9-8.006(3)(k), provides penalty guidelines for impairment as follows: \$100-\$1000 plus referral to IPN and stayed suspension under IPN or probation with conditions.



30. What Respondent did was the result of her impairment. The appropriate disposition of this case is to prohibit Respondent from practicing until she has proven she is no longer impaired and can practice safely and professionally. Therefore, she should be suspended until she completes satisfactorily the IPN program, demonstrates she has the knowledge and ability to practice professionally, and, thereafter, her practice should be followed for a sufficient period to insure she continues to practice safely. A fine is inappropriate in this case, but if one must be rendered, the minimum of \$100 should be levied.

#### RECOMMENDATION

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

#### RECOMMENDED:

That the Board of Nursing enter a final order suspending the license of Respondent to practice until she has satisfactorily completed the IPN program, and, thereafter, place her on a five-year probation to follow her practice.

DONE AND ENTERED this 6th day of April, 2001, in  
Tallahassee, Leon County, Florida.

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STEPHEN F. DEAN  
Administrative Law Judge  
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Filed with the Clerk of the  
Division of Administrative Hearings  
this 6th day of April, 2001.

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.