STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING	)	
Petitioner,	)	
vs.	)	Case No. 00-2944PL
CYNTHIA CHANCE,	)	
Respondent.	)	

RECOMMENDED ORDER

A formal hearing was held pursuant to notice on November 15, 2000, in Jacksonville, Florida, before Barbara J. Staros, assigned Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Diane K. Kiesling, Esquire
Agency for Health Care Administration
Building 3, Room 3231A
2727 Mahan Drive
Tallahassee, Florida 32308-5403

For Respondent: Walter Bell, Esquire
1482 East 25th Street
Jacksonville, Florida 32206

STATEMENT OF THE ISSUE

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

PRELIMINARY STATEMENT

Petitioner, Department of Health, issued an Administrative Complaint on August 13, 1999, alleging one count of professional violation against Respondent, a licensed practical nurse. The Administrative Complaint was amended on January 10, 2000, by adding an additional count.

Respondent disputed the allegations in the Amended Complaint and petitioned for a formal hearing involving disputed issues of material fact. The case was referred to the Division of Administrative Hearings on or about July 18, 2000. A formal hearing was set for November 15, 2000. On October 10, 2000, Petitioner filed a Motion for Leave to Amend Administrative Complaint. The motion was granted to proceed pursuant to Petitioner's Second Amended Administrative Complaint.

The parties filed a Joint Pre-hearing Stipulation. At hearing, Petitioner presented the testimony of Lu Apostol, Fely Cunanan, Pamela Schiesser, Barbara Kelley, Kim Harrell, Amy Hill, Susan Ranson, Anne Hollander, Erlinda Serna, and Carol Lee. Lu Apostol and Fely Cunanan were each accepted as an expert in nursing and standards of nursing practice. Petitioner's Exhibits 1-5 and 7 were admitted into evidence. Petitioner requested official recognition of Chapter 464, Florida Statutes, and Chapter 64B9, Florida Administrative Code (these statutes and rules had been pre-marked as Petitioner's Exhibit 6). No opposition was stated to that request and the request was

granted. Respondent presented the testimony of Tresa Della Calfee and Respondent. Respondent's Exhibit 1 was admitted into evidence.

A Transcript, consisting of one volume, was filed on December 1, 2000. On December 11, 2000, Petitioner timely filed its Proposed Recommended Order, which has been considered in the preparation of this Recommended Order. Respondent has not filed any post-hearing submission.

FINDINGS OF FACT

Stipulated Facts

1. The Petitioner is the State Agency charged with the regulation of the practice of nursing pursuant to Chapters 20,456 (formerly Chapter 455, Part II; see Chapter 2000-160, Laws of Florida) and 464, Florida Statutes. Pursuant to the authority of Section 20.43(3)(g), Florida Statutes, the Petitioner has contracted with the Agency for Health Care Administration to provide consumer complaint, investigative and prosecutorial services required by the Division of Medical Quality Assurance, councils or boards, as appropriate, including the issuance of emergency orders of suspension or restriction.

2. Respondent is Cynthia Chance. Respondent is a Licensed Practical Nurse in the State of Florida, having been issued license No. PN 0855441.

3. On or between March 1997-May 1997, Respondent was employed by Health Force, a nurse-staffing agency.

4. In or about March 1997, Respondent was assigned to work various shifts at Baptist Medical Center-Beaches. In or about March 1997, Respondent submitted time slips to Health Force alleging that she had worked an eight-hour shift on March 18, 1997. In or about March 1997, Respondent submitted time-slips to Health Force alleging that she had worked an eight-hour shift on March 21, 1997.

Findings of fact based on the evidence of record

Missing Drugs

5. On May 13, 1997, Health Force received a "late call" from Cathedral Gerontology Center (Cathedral) needing a "stat" nurse because one of their nurses had not come to work. Tresa Streeter (now Calfee), administrator for Health Force, called Respondent who reported to Cathedral at 6:50 p.m. Kim Harrell, R.N., a supervisor at Cathedral, was the nurse who stayed until Respondent arrived.

6. Also at 6:50 p.m. on May 13, 1997, Barbara Kelley, R.N., received and signed for a delivery of medications for residents from American Pharmaceutical Services. Included in that delivery was an order of Alprazolam (Xanax) and an order of Diazepam (Valium) for two residents on the floor where Respondent was working that evening. The delivery came with a separate medication or narcotics card for each medication.

7. There were two floors of residents at Cathedral. Each floor had its own medication cart and its own nurse assigned to

the floor. Controlled medications have a separate box in the medication cart with a separate key. The nurse on each floor had a key to her own medication cart but did not have a key to the medication cart of the other floor. The Director of Nursing (DON) also had a key to both medication carts in the event of an emergency such as a lost key.

8. After receiving and signing for these drugs, Nurse Kelley locked the medications that belonged to her medication cart in it and inserted the narcotic cards for those medications into the notebook that corresponded to her cart. She then gave the medications and control sheets that belonged to Respondent's medication cart to Respondent, placing them in Respondent's hand. Nurse Kelley told Respondent that these were controlled drugs and instructed Respondent to lock up the medications in Respondent's medicine cart.

9. There is conflicting testimony as to what happened next. Respondent admits to receiving the medications and the control cards. However, Respondent maintains that she placed the medications in the locked drawer of the medication cart and inserted the cards into the notebook in front of Nurse Kelley, whereas Nurse Kelley maintains that she walked away immediately after giving the drugs and cards to Respondent and did not see her place the drugs in the controlled drug lock box or the cards in the notebook.

10. It was a policy at Cathedral for the out-going nurse to count controlled drugs with the on-coming nurse. When Respondent arrived on the night in question, she counted the controlled medications with Nurse Harrell. The narcotics count for both narcotics cards and actual doses was 16. At the end of her shift, Respondent counted the controlled medications with the on-coming nurse, Pamela Schiesser. The number of narcotics cards and tablets or doses was 16, the same as when Respondent came on duty.

11. Nurse Schiesser was scheduled to work a double shift, 11 to 7 and 7 to 3. During the 11 to 7 shift, Nurse Schiesser was the only nurse for both floors of residents and she, therefore, had the key to both medication carts.

12. Sometime during the 7 to 3 shift on May 14, 1997, Nurse Schiesser called the pharmacy to find out about a medication order she had placed for two residents so they would not run out. She was informed by the pharmacy that the drugs had been delivered the evening before and that they had been signed for by Nurse Kelley. She checked the delivery sheets and confirmed that Nurse Kelley had signed for the medications. After determining that there were no cards for the missing drugs and the drugs were not in the cart, she then reported to her supervisor, Kim Harrell, that the medication had been delivered but could not be located.

13. Nurse Schiesser and Nurse Harrell checked the entire medication cart, the medication cart for the other floor and the medication room but did not find the missing medications. Nurse Harrell then notified the Assistant Director of Nursing (ADON), Lu Apostol, and the Director of Nursing (DON), Fely Cunanan, regarding the missing medications.

14. The ADON began an investigation and secured written statements from all of the nurses on her staff who had access to the drugs: Nurses Kelley, Harrell, and Schiesser. She called Nurse Kelley to confirm that she had received the medications from the pharmacy and confirmed that the two missing medications, Alprazolam (Xanax) and Diazepam (Valium), were given by Nurse Kelley to Respondent. The ADON also called Tresa Streeter (now Calfee), the administrator of Health Force for whom Respondent worked to notify her of the missing medications.

15. On May 14, 1997, Ms. Streeter (Calfee) called Respondent and informed her about the missing drugs.

16. On May 15,2000, Ms. Streeter and Respondent went to Cathedral for a meeting. They were informed that the two missing drugs had not been located and they were shown the written statements of the other nurses. Respondent admitted that the drugs had been given to her the night before by Nurse Kelley, but stated that she had locked the drugs in her cart. She denied any further knowledge about the drugs.

17. At Ms. Streeter's suggestion, Respondent took a blood test on May 15, 2000.[1] The drug test result was negative thus indicating that the drugs were not in her blood at the time of the test, which was two days after the drugs were missing. No competent evidence was presented as to how long it takes for these drugs to leave the bloodstream.

18. Cathedral had a policy that required that all controlled substances be properly accounted for and secured by each nurse responsible for the drugs. This policy was verbally communicated from the off-going nurse to the oncoming nurse. When Nurse Kelley gave the drugs and drug cards in question to Respondent, she specifically instructed Respondent to lock up the drugs in the narcotics drawer.

19. Respondent maintains that other people had keys to her medication cart and could have taken the drugs after she put them in the locked narcotics box. This testimony is not persuasive. Every witness from Cathedral testified unequivocally that there was only one key in the facility for each medication cart and that key was in the possession of the nurse assigned to that cart. The only other key, which was in the possession of the Director of Nursing, was not requested or given to anyone at anytime material to these events.

20. The persuasive testimony is that Respondent was the only person during her shift with a key to her medication cart. That key was passed to Nurse Schiesser who discovered that the

drugs and narcotics cards were not in the medication cart or notebook.

21. The count of the drugs and the cards on hand did not show that anything was missing at the change of shift from Respondent to Nurse Schiesser as the count was 16, the same as when Respondent came on the shift. If Respondent had put the drugs and corresponding cards in the medication cart, the count should have been 18. The only logical inference is that Respondent did not put the drugs or cards in the cart.

22. In the opinion of the two witnesses accepted as experts in nursing and nursing standards, Respondent's failure to properly secure the narcotics and to document the receipt of these controlled drugs constitutes practice below the minimal acceptable standards of nursing practice.

Time-Slips

23. While employed by Health Force as an agency nurse, Respondent was assigned at various times to work at Baptist Medical Center-Beaches (Beaches). Respondent submitted time cards or slips for each shift she worked to Health Force so that she would be paid for the work. Respondent submitted time-slips for working at Beaches on March 18 and 21, 1997.

24. When Health Force billed Beaches for these two dates, Anne Hollander, the Executive Director of Patient Services, the person responsible for all operations at Beaches since 1989, determined that Respondent had not worked on either March 18 or

21, 1997. Ms. Hollander faxed the time-slips back to Health Force for verification. She advised Health Force that Respondent was not on the schedule as having worked on either of those dates. She also advised Health Force that the supervisor's signatures on the two time-slips did not match anyone who worked at Beaches. Ms. Hollander is intimately familiar with the signatures of all the supervisors who are authorized to sign time-slips at Beaches and none of them have a signature like the signatures on the two time-slips.

25. Health Force did an investigation and ended up paying Respondent for the two days, but did not further invoice Beaches. Health Force was never able to determine whose signatures were on the time-slips. Health Force did have Respondent scheduled to work at Beaches on March 21, 1997, but not on March 18, 1997.

26. Beaches keeps a staffing sheet for every day and every shift. The supervisors are responsible for completion of the staffing schedules to ensure that the necessary staff is scheduled to work on each shift. These staffing sheets are used for both scheduling and doing the payroll. According to Ms. Hollander, it is not possible that Respondent's name was just left off the staffing sheets. The staffing sheets are the working sheets. If a person works who is not originally on the staffing sheet, the supervisor writes that person's name into the correct column at the time they come to work. Ms. Hollander has been familiar with these staffing sheets for 12 years and does

not recall any time when someone's name has been left off the staffing sheet when he or she had worked.

27. The two supervisors who testified, Erlinda Serna and Carol Lee, are equally clear that in their many years of experience as supervisors at Beaches, no one has worked and not been on the staff schedules. Anybody who worked would show up on the schedule. Every shift and every day should be on the staffing schedules. Ms. Serna is unaware of any time in her 10 years at Beaches that someone's name was left completely off the schedules, but that person actually worked.

28. Respondent's name was on the staffing schedule for March 21, 1997, but it was crossed out and marked as cancelled. When agency nurses are scheduled at Beaches, but are not needed, they are cancelled with the agency. If the agency fails to timely notify the nurse and the nurse shows up for work, the agency must pay her for two hours. If the hospital fails to notify the agency timely and the nurse shows up for work, then the hospital must pay the nurse for two hours. In no event is a nurse who is cancelled paid for more than two hours.

29. There are times when a nurse is cancelled and shows up for work, but the hospital has a need for the nurse either as a nurse or in another capacity such as a Certified Nursing Assistant (CNA). If that happens, the nurse's name is again written into the nursing unit staffing schedule.

30. For March 18, 1997, Respondent's name is not on the schedule for Beaches. She did not work in any capacity on March 18, 1997. For March 21, 1997, Respondent's name was on the schedule, but she was cancelled. Even if she had not been timely notified that she was cancelled and she showed up for work, the most she could have billed for was two hours. If she had stayed and worked in a different capacity, her name would have been rewritten into the staffing schedule. Beaches is very strict and follows a specific protocol. No one except the supervisors is allowed to sign time cards. The signatures on these two time cards do not belong to any supervisor at Beaches. Therefore, it can only be concluded that Respondent did not work on March 18 or 21, 1997, at Beaches and that she submitted false time-slips for work she did not do on March 18 and 21, 1997.

31. In June 1997, Respondent was also working as an agency nurse for Maxim Healthcare Services (Maxim). On June 8, 1997, Respondent submitted a time ticket to Maxim and to Beaches indicating that she had worked eight-hour shifts at Beaches on June 2, 3, 4, and 5, 1997. All four days were on the same time ticket and purported to bear the initials and signature of Carol Lee. This time ticket was brought to Ms. Hollander's attention because Beaches had a strict policy that only one shift could appear on each time slip. Even if a nurse worked a double shift, she would have to complete two separate time tickets, one for each shift. Under Beaches policy, no time ticket would ever have

more than one shift on it. The time tickets are submitted to Ms. Hollander's office daily with the staffing schedules that correspond. Therefore, a time ticket for a person who is not on the staffing schedule would immediately stand out.

32. When Ms. Hollander was given the time ticket for June 2-5, 1997, she investigated and reviewed the staffing sheets for those days. Respondent was not listed on any of the staffing schedules. Ms. Hollander then showed the time ticket to Erlinda Serna, who was the nursing supervisor on the 3 to 11 shift. Nurse Serna verified that Respondent had not worked on the shift any of those days.

33. Ms. Hollander then showed the time-slip to Carol Lee, the 11 to 7 nursing supervisor. Carol Lee verified that she had not initialed or signed the time ticket and that the initials and signature were a forgery. Nurse Lee would not have signed a time ticket with more than one shift per time ticket because she was well aware of the policy prohibiting more than one shift per time ticket. Nurse Lee verified that Respondent had not been scheduled to work any of those days and that Respondent had not worked on June 3, 4, or 5, 1997.

34. These inquiries to Nurse Serna and Nurse Lee took place within a few days after the dates for which Respondent had submitted this time ticket. Therefore, the matter was fresh in the minds of both nursing supervisors. Both are certain that

Respondent was neither scheduled nor worked on June 2-5, 1997. Only nursing supervisors at Beaches are authorized to sign time tickets.

35. Maxim Healthcare has a policy of never working a nurse in excess of 40 hours in one week. The same policy was in effect in 1997. Susan Ranson, the records custodian who also staffs for Maxim on the weekends and assists in their billing, indicated that Respondent was paid by Maxim for working at another facility the same week as June 2-5, 1997. June 2-5, 1997, are a Monday through Thursday. Specifically, Respondent submitted a time ticket to Maxim for another facility showing that she worked 12 hours on Saturday, June 7, 1997, and 13 hours on Sunday, June 8, 1997. Maxim pays from Monday through Sunday. If Respondent had worked 32 hours at Beaches on Monday through Thursday and then 25 hours at another facility on Saturday and Sunday, she would have worked more than 40 hours in one week, which would have violated their policy and would have required Maxim to pay overtime. When Maxim gets a request for a nurse and has no one to send who would not exceed 40 hours in one week, rather than exceed 40 hours, the agency does not staff the job.

36. In the disciplinary document from Health Force dated June 18, 1997, Health Force advised Respondent that it would not be scheduling her based on the complaints they received regarding false billing, the missing drugs at Cathedral, and another incident at Beaches that occurred during this same time.

37. Taken in its totality, the testimony of Respondent is not credible.

38. Respondent's explanation of the discrepancy in the count of drugs and corresponding cards is that during her shift "there was [sic] one or two cards that only had one or two pills on them, so you just throw them away. And that's what made it back to 16." This explanation is unpersuasive. If there had been any pills left in the drawer from cards that Respondent threw away, the count would have been off at the change of shift. Moreover, several witnesses testified as to the care that is taken to carefully account for all narcotics. Respondent's assertion that narcotic pills were simply thrown away is not credible. Nurse Schiesser clearly remembered that there were no cards for the medications in question and there were no medications from this delivery in the medication cart.

39. Respondent has been previously disciplined by the Board of Nursing in the Board's case No. 98-20122.

CONCLUSIONS OF LAW

40. The Division of Administrative Hearings has jurisdiction over the parties and subject matter in this case pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

41. Petitioner has the burden of proving by clear and convincing evidence the specific allegations of the Second Amended Administrative Complaint. See Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

42. Section 464.018(1)(h), Florida Statutes (1997), 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 . . ."

43. Rule 64B9-8.005(1), Florida Administrative Code, defines unprofessional conduct to include:

> Inaccurate recording, falsifying or altering of patient records or nursing progress records, employment applications or time records. . .

44. In this case, the persuasive evidence indicates that Respondent received the Xanax and Valium from Ms. Kelley and thereafter, the drugs could not be located. If Respondent had secured the drugs in her locked narcotics box as she should have, the drugs would not have disappeared. The only plausible explanation is that Respondent failed to secure the drugs as she should have. These two drugs are controlled substances pursuant to Section 893.03(4), Florida Statutes, and the handling of controlled substances is controlled by the standards of nursing practice. The experts were unequivocal that Respondent failed to conform to the minimal acceptable standards of nursing practice by failing to account for the whereabouts of these drugs. Respondent's failure to secure and document the receipt of these controlled substances constitutes practice below the minimal acceptable standards of nursing practice. Petitioner has carried

its burden of proving this violation of Section 464.018(1)(h), Florida Statutes, by clear and convincing evidence.

45. As to the second Count in the Administrative Complaint, the evidence is equally clear that Respondent falsified her time cards to Health Force for March 18 and 21, 1997, and to Maxim for June 2-5, 1997, for work she allegedly performed at Beaches. The clear and convincing evidence is that the signatures and the initials on these time tickets are forgeries. No supervisor from Beaches signed these time cards. Respondent's submission of these false time cards in an attempt to receive compensation constitutes falsification of employment and time records in violation of Section 464.018(1)(h), Florida Statutes, and as further defined in Rule 64B9-8.005(1), Florida Administrative Code. Petitioner has carried its burden of proving these allegations by clear and convincing evidence.

46. It is concluded that Respondent's testimony to the contrary is implausible and unpersuasive. It was in direct conflict with the testimony of almost every other witness. These conflicts are resolved against Respondent and Respondent's testimony is rejected.

47. Respondent is guilty of both counts of unprofessional conduct and violating the rules defining unprofessional conduct. Rule 64B9-8.006, Florida Administrative Code, details the disciplinary guidelines of the Board of Nursing, together with the range of penalties and the aggravating and mitigating

circumstances. Rule 64B9-8.006(3)(i), Florida Administrative Code, specifies the penalty for unprofessional conduct in the delivery of nursing services to be a fine from $250 to $1000 plus from one-year probation to suspension until proof of safety to practice, followed by probation with conditions. Rule 64B9-8.006(2), Florida Administrative Code, further states that the disciplinary guidelines are based on a single count violation of each provision listed; however, "[m]ultiple counts of violations of the same provision of Chapter 464, or the rules promulgated thereto, or other unrelated violations will be grounds for enhancement of penalties."

48. Furthermore, all aggravating or mitigating circumstances are subject to proof at the formal hearing by clear and convincing evidence. Rule 64B9-8.006(4)(a), Florida Administrative Code. In this case, Petitioner has shown that Respondent has a prior and recent disciplinary history with the Board. Additionally, the offense of falsifying time cards is an offense that has been repeated in the instant case. These are both serious aggravating factors that must be considered.

49. In arriving at an appropriate penalty in the instant case, consideration has been given to the disciplinary guidelines set forth in Rule 64B9-8.006, Florida Administrative Code, above.

RECOMMENDATION

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

RECOMMENDED:

That the Respondent be found guilty of one count of violating Section 464.018(1)(h), Florida Statutes, by failing to secure and document receipt of the drugs at Cathedral Gerontology Center;

That the Respondent be found guilty of one count of violating Section 464.018(1)(h), Florida Statutes, and of violating Rule 64B9-8.005(1), Florida Administrative Code, by falsifying employment and time records on multiple occasions; and

That a penalty be imposed consisting of a fine of $1000 and payment of costs associated with probation, together with a reprimand and a three-year suspension of license to be followed by a two-year probation with conditions as deemed appropriate by the Board of Nursing. Reinstatement of Respondent's license after the term of the suspension shall require compliance with all terms and conditions of the previous Board Order and her appearance before the Board to demonstrate her present ability to engage in the safe practice of nursing, which shall include a demonstration of at least three years of documented compliance with the Intervention Project for Nurses.

DONE AND ENTERED this 29th day of December, 2000, in Tallahassee, Leon County, Florida.

BARBARA J. STAROS
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 29th day of December, 2000.

ENDNOTE

[1]/ There was conflicting evidence as to whether the drug test was performed on the 14th or 15th. The weight of the evidence, including the written lab result, shows that the test was conducted on May 15, 2000.

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.