STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING,	)	
Petitioner,	)	
vs.	)	Case No. 02-2293PL
RICHARD CARLTON FLEET,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a hearing was held in this case in accordance with Section 120.57(1), Florida Statutes, on August 23, 2002, by video teleconference at sites in Fort Lauderdale and Tallahassee, Florida, before Stuart M. Lerner, a duly-designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Amy M. Pietrodangelo, Esquire
Rosanna Catalano, Esquire
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265

For Respondent: Mary S. Lingerfeldt, Esquire
Bunnell, Woulfe, Kirschbaum, Keller, McIntyre & Gregory, P.A.
888 East Las Olas Boulevard
Fort Lauderdale, Florida 33301

STATEMENT OF THE ISSUE

Whether Respondent committed the violations alleged in the Amended Administrative Complaint, and, if so, what disciplinary action should be taken against him.

PRELIMINARY STATEMENT

On or about January 31, 2002, Petitioner issued a three-count Administrative Complaint against Respondent, a Florida-licensed registered nurse. Through the submission of a completed Election of Rights form, Respondent denied the allegations of wrongdoing made in the Administrative Complaint and requested "a hearing involving disputed issues of material fact, pursuant to Section 120.569, Florida Statutes, and Section 120.57(1), Florida Statutes, before an Administrative Law Judge appointed by the Division of Administrative Hearings." On June 10, 2002, the matter was referred to the Division of Administrative Hearings for the assignment of an Administrative Law Judge to conduct the hearing Respondent had requested.

On June 26, 2002, Respondent filed a Motion to Strike paragraphs 11 and 13 of the Administrative Complaint. On July 11, 2002, an Order was issued granting the motion "with leave for Petitioner to file an Amended Administrative Complaint with amended paragraphs 11 and 13 . . . ."

On July 23, 2002, Petitioner filed a Motion for Leave to File an Amended Administrative Complaint. The motion was granted by Order issued July 29, 2002.

The Amended Administrative Complaint filed by Petitioner alleges that, based upon the following facts, Respondent is "subject to discipline pursuant to [S]ection 464.018(1)(h), Florida Statutes, for unprofessional conduct by failing to conform to the minimal acceptable standards of prevailing nursing practice as defined in Rule 64B9-8.005(13), Florida Administrative Code" (Count One); "for unprofessional conduct by administration of treatments or medications in a negligent manner, as defined in Rule 64B9-8.005, Florida Administrative Code" (Count Two); and "for unprofessional conduct by practicing beyond the scope of the licensee's license, educational preparation or nursing experience as defined in Rule 64B9-8.005(15), Florida Administrative Code" (Count Three):

> 1. Petitioner is the state agency charged with regulating the practice of nursing pursuant to Chapters 20, 456, and 464, Florida Statutes.
>
> 2. Respondent is and has been at all times material hereto, a licensed registered nurse in the State of Florida, having been issued license number 3109442.
>
> 3. Respondent's last known address is . . . .
>
> 4. On or between September 11, 2000 and March 28, 2001, the Respondent was employed

by Imperial Point Medical Center, Fort Lauderdale, Florida. Imperial Point Medical Center is a hospital in the North Broward Hospital District.

5. On or about March 18, 2001, Patient F. L., 17-year-old male overdose patient, was admitted to the emergency department for treatment of a drug overdose.

6. On or about March 18, 2001, Respondent disrobed F. L. and did not clothe him in a hospital gown.

7. On or about March 18, 2001, the Respondent became violent with patient F. L. while F. L. was confined in four point restraints. The Respondent climbed onto the stretcher with F. L., placed his knee on . . . F. L.'s neck and placed his open left hand on the patient's face.

8. The Respondent continued to use excessive force in the patient F. L.'s care by grabbing and twisting the patient's penis and scrotum.

9. The Respondent's aggressive behavior continued when he choked patient F. L. until F. L. turned blue.

10. Patient F. L. became upset and asked for his mother.

11. The Respondent retorted with inappropriate comments about F. L.'s mother, and told him, "I've got your mother here."

12. The Respondent requested a urine sample from F. L., but the patient refused.

13. After F. L. refused to submit a urine sample to the Respondent, the Respondent hit F. L. with a Foley catheter before inserting it in a very aggressive manner.

14. The Respondent inserted the Foley catheter [i]n patient F. L. without physician[']s[] orders.

15. During the course of the attack, the Respondent verbally harassed and insulted the patient.

16. The Respondent exhibited aggressive and physical behavior toward male patient F. L.

17. On or about February 23, 2001, K. N. was admitted to the emergency room at Imperial Point Medical Center with acute intoxication.

18. Respondent disrobed K. N., an unconscious female patient, and made derogatory statements about the patient's body.

19. Respondent stated, "Look at the tits on this one," and "Wouldn't you like to get some of that?" to another North Broward Hospital District male employee about patient K. N.

20. The Respondent was given a hospital gown to cover K. N., but chose not to cover her and continued to make offensive comments about unclothed K. N.

21. The Respondent failed to respect the privacy and dignity of female patient K. N.

22. The incidents involving male patient F. L. and female patient K. N. are demonstrative of the Respondent's number of repetitions of offenses involving aggression and disrespect toward patients.

Respondent filed an Answer to Amended Administrative Complaint, in which he admitted that he "is a licensed registered nurse in the State of Florida" and "was employed by

Imperial Point Medical Center in 2001" and denied the remaining allegations made in the Amended Administrative Complaint.

As noted above, the final hearing in this case was held on August 23, 2002, as scheduled. Ten witnesses testified at the final hearing: J. L., Robert Russo, Beverly Gilberti, Deborah Fialk, Christie Jackson, Catherine Moses, Karlene Williams, Dr. Michael Estep, Dr. Luis Maciera-Rodriguez, and Respondent. In addition to the testimony of these ten witnesses, seven exhibits (Petitioner's Exhibits 1 through 7) were offered and received into evidence.

At Petitioner's request, and without objection, the evidentiary record was left open for 21 days to allow Petitioner the opportunity to take the deposition of George Austin and to provide the undersigned with the transcript of Mr. Austin's deposition for consideration in lieu of Mr. Austin's live testimony.

At the conclusion of the evidentiary portion of the hearing on August 23, 2002, the undersigned established a deadline (30 days after the date of the undersigned's receipt of the complete hearing transcript or 30 days from the date of the undersigned's receipt of the transcript of Mr. Austin's deposition, whichever was later) for the filing of proposed recommended orders.

The undersigned received the transcript of Mr. Austin's deposition on September 9, 2002. The complete hearing

transcript consists of two volumes. The undersigned received one of these two volumes on September 3, 2002, and the other on September 30, 2002.

Petitioner and Respondent both filed their Proposed Recommended Orders on October 30, 2002. The undersigned has carefully considered these post-hearing submittals.

FINDINGS OF FACT

Based upon the evidence adduced at the final hearing and the record as a whole, the following findings of fact are made:

1. Respondent is now, and has been since October 17, 1996, a Florida-licensed registered nurse. He holds license number 3109442.

2. From September 11, 2000, to March 28, 2001, Respondent was employed as a registered nurse by the North Broward Hospital District and assigned to the emergency room at Imperial Point Medical Center (IPMC) in Broward County, Florida.

3. IPMC is a division of the North Broward Hospital District.

4. It serves as a designated Baker Act receiving facility where persons are "brought involuntary[ily] for psychiatric evaluation" and referral.

5. Some of these persons are "dangerous and violent" and have "cause[ed] injuries to the staff of the emergency room."

6. In early 2001, Respondent was involved in two separate incidents in which he mistreated a patient in the emergency room at IPMC.

7. The first incident occurred on or about February 23, 2001.

8. On that day, K. N., a 21-year-old female, was admitted to the emergency room suffering from "acute intoxication."

9. Pursuant to emergency room policy, upon her admittance to the emergency room, K. N. was "completely undressed . . . to make sure that [she was] not hiding any drugs, contraband, weapons, [or other] things of that nature."

10. K. N. was lying, "passed out" and completely naked, on a stretcher in an examining room with Respondent by her side, when one of the hospital's emergency room technicians, Robert Russo, walked into the room to assist Respondent.

11. Respondent greeted Mr. Russo by making the following comments about K. N.: "Look at those tits. Wouldn't you like to get a piece of that?"

12. Mr. Russo left the room to get a hospital gown for Respondent to put on K. N., as Respondent was required to do, in accordance with hospital policy, so as "to preserve [K. N.'s] dignity."

13. Mr. Russo returned with a gown and gave it to Respondent, but Respondent did not put it on K. N. or otherwise use it to try to cover K. N.

14. Respondent, though, did continue making comments about K. N.'s body. Referring to K. N.'s genitals, he remarked to Mr. Russo, "That's sweet," or words to that effect.

15. Feeling "uncomfortable," Mr. Russo left the room.

16. By allowing K. N. to remain completely naked and by making the remarks he did to Mr. Russo about K. N.'s body, Respondent failed to conform to the minimal acceptable standards of prevailing nursing practice.

17. The following month, Respondent was involved in another incident in which he acted inappropriately toward an IPMC emergency room patient.

18. This second incident occurred on March 18, 2001.

19. The patient Respondent mistreated on this day was F. L., a 17-year-old male with a history of drug abuse.

20. F. L. was brought to the IPMC emergency room by the City of Pompano Beach Fire/Rescue at the request of F. L.'s mother, J. L., who accompanied him to the emergency room and remained there for the duration of F. L.'s stay.

21. J. L. had "called 911" after F. L. had come home from a night of drinking and, in her presence, had had a seizure.

22. By the time fire/rescue arrived at their home, F. L. was conscious, and he remained conscious during the ambulance ride to IPMC.

23. J. L. wanted F. L. to be involuntarily committed under the Baker Act. She did not think she would be able to handle his coming back home because he "was on drugs at the time" and she thought that he would "go crazy" if he did not receive treatment.

24. F. L. was aware of his mother's desire. In the past, he had attempted to "fight" (verbally, but not physically) efforts to have him "Baker Acted."

25. F. L. was admitted to the IPMC emergency room at 3:49 a.m. on March 18, 2001.

26. At the time of his admittance, F. L. was conscious, "somewhat calm," and able to stand up and walk "with a wobble" and to speak coherently (although his speech was slurred).

27. He was asked to give a urine sample for a "urine screen," and with the help of his mother, who accompanied him to bathroom "[s]o he wouldn't fall or miss the cup," he complied.

28. F. L. soon became upset and "verbally abusive to the staff" on duty, including Respondent.

29. Respondent decided that F. L. needed to be restrained.

30. With the help of others, including Mr. Russo, Respondent restrained F. L. "with Velcro restraints on the wrists and the ankles."

31. Respondent then requested that F. L. give another urine sample. F. L., in turn, "asked for a urine bottle." Respondent refused F. L.'s request. Instead, he took out a Foley catheter.

32. A Foley catheter is a thin, flexible rubber tube that is threaded through the urethra and into the bladder. It is used to drain urine from the bladder. It should be sterile and lubricated when inserted.

33. F. L. went "totally beserk" when he saw the catheter, letting it be known in no uncertain terms that he did not want to be catherized and again requesting that he be given a "urine bottle."

34. Respondent responded, inappropriately, by "hit[ting] [F. L.] in the face with the catheter numerous times," while telling F. L. two or three times, "I'm going to shove this hose down your dick."

35. This caused F. L., understandably, to become even more loud and boisterous.

36. Respondent enlisted the assistance of three or four others, including Mr. Russo and George Austin, a Wackenhut security officer on patrol at the hospital, to place F. L. in

four-point leather restraints (one for each ankle and wrist) on a stretcher in Room 6. 1/

37. F. L. resisted, but was eventually subdued and restrained on the stretcher.

38. Given F. L.'s out-of-control behavior, placing him in four-point restraints was warranted.

39. After F. L. was restrained on the stretcher, Respondent, against F. L.'s will, inserted the Foley catheter (that he had used to hit F. L. and that was therefore not sterile) in F. L. 2/ Respondent did so in a rough and negligent manner, without using lubricating jelly or any other type of lubrication.

40. Subsequently, while F. L. was still in four-point restraints on the stretcher, he became "more upset, more verbally abusive," and "tried to sit up." Respondent responded, inappropriately, by "grabb[ing] [F. L.] by the neck," "slapp[ing] him back down onto the stretcher," and "choking [F. L.] until [F. L.] was almost blue." Respondent "let go" of F. L. only after an observer intervened.

41. After Respondent stopped choking him, F. L. "asked for his mother." 3/ Respondent responded, again inappropriately, by telling F. L. three times, "I got your mother right here," as he "grabbed his own testicles." 4/

42. As could be expected, this "further upset" F. L., and he again tried to sit up. Respondent's response was, again, an inappropriate one. He "climbed up on the stretcher," "put his right knee on [F. L.'s] chest," "cover[ed] F. L.'s face" with his left hand, and with his right hand "grabbed" F. L.'s penis and scrotum and "squeeze[d] and twist[ed]."

43. Respondent, without any justification, "squeeze[d] and twist[ed]" F. L.'s penis and scrotum "two or three times" while F. L. was in four-point restraints on the stretcher. On one of these occasions, he told F. L. (as he was "squeeze[ing] and twist[ing]") "something like," "What are you going to do now?"

44. During his encounter with F. L. on March 18, 2001, Respondent used more force against F. L. than was reasonably necessary to properly discharge his nursing duties and to protect himself and those around him. 5/

45. By physically, and also verbally, abusing F. L., Respondent failed to conform to the minimal acceptable standards of prevailing nursing practice. 6/

46. When J. L. was finally reunited with her son, she noticed that he had red marks on his face and "bruise[s]" on his extremities.

47. The IPMC emergency room physician who evaluated F. L. determined that there was reason to believe that F. L. was "mentally ill as defined in Section 394.455(18), Florida

Statutes" (based upon an "initial diagnosis" of "acute agitation"), and that F. L. otherwise met the "criteria for involuntary examination" under the Baker Act.

48. At approximately 2:45 p.m. on March 18, 2001, F. L. was discharged from IPMC and transferred to Florida Medical Center.

49. Sometime after the March 18, 2001, incident involving F. L., a security officer and nurse working at IPMC expressed to Beverly Gilberti, the nurse/manger of IPMC's emergency room, their "concerns" regarding Respondent's "practice."

50. On March 26, 2001, Ms. Gilberti contacted Gayle Adams, IPMC's human resources specialist, and told her about the security officer's and nurse's "concerns."

51. Ms. Adams began an investigation into the matter.

52. Ms. Gilberti telephoned Respondent and advised him that he was being suspended pending the outcome of an investigation into alleged wrongdoing on his part.

53. Respondent was given "very little information as to what type of complaint[s]" were being investigated.

54. On March 28, 2001, before the investigation had been completed, Respondent telephoned Ms. Adams and "verbally resigned over the phone."

CONCLUSIONS OF LAW

55. The Board of Nursing (Board) is now, and has been at all times material to the instant case, statutorily empowered to take punitive action against a Florida-licensed registered nurse based upon any of the grounds enumerated in Subsection (1) of Section 464.018, Florida Statutes.

56. The penalties that the Board was statutorily authorized to impose at the time of the alleged violations in the instant case were found in Subsection (2) of Section 464.018, Florida Statutes (2000), which provided as follows:

> When the board finds any person guilty of any grounds set forth in subsection (1), it may enter an order imposing one or more of the following penalties:
>
> (a) Refusal to certify to the department an applicant for licensure.
>
> (b) Revocation or suspension of a license with reinstatement subject to the provisions of subsection (3).[7/]
>
> (c) Permanent revocation of a license.
>
> (d) Restriction of practice.
>
> (e) Imposition of an administrative fine not to exceed $1,000 for each count or separate offense.
>
> (f) Issuance of a reprimand.
>
> (g) Placement of the nurse on probation for a period of time and subject to such conditions as the board may specify, including requiring the nurse to submit to treatment, to attend continuing education

> courses, to take an examination, or to work under the supervision of another nurse.

See Childers v. Department of Environmental Protection 696 So. 2d 962, 964 (Fla. 1st DCA 1997)("The version of a statute in effect at the time grounds for disciplinary action arise controls."); and Willner v. Department of Professional Regulation, Board of Medicine, 563 So. 2d 805, 806 ("The 1986 amendment increased the maximum fine from $1,000 per violation to $5,000 per violation. Since all the violations for which appellant was found guilty occurred prior to the effective date of the 1986 amendment, the maximum fine which could lawfully be imposed by appellee was $1,000 per violation.").

57. The Board may take punitive action against a licensee only after the licensee has been given reasonable written notice of the charges and an adequate opportunity to request a proceeding pursuant to Sections 120.569 and 120.57, Florida Statutes.

58. An evidentiary hearing must be held, if requested by the licensee, when there are disputed issues of material fact. Sections 120.569(1) and 120.57(1), Florida Statutes.

59. At the hearing, Petitioner bears the burden of proving that the licensee engaged in the conduct, and thereby committed the violations, alleged in the charging instrument.

60. Proof greater than a mere preponderance of the evidence must be presented. Clear and convincing evidence of the licensee's guilt is required. See Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Company, 670 So. 2d 932, 935 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292, 294 (Fla. 1987); Pou v. Department of Insurance and Treasurer, 707 So. 2d 941 (Fla. 3d DCA 1998); and Section 120.57(1)(j), Florida Statutes ("Findings of fact shall be based upon a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute . . . .").

61. Clear and convincing evidence "requires more proof than a 'preponderance of the evidence' but less than 'beyond and to the exclusion of a reasonable doubt.'" In re Graziano, 696 So. 2d 744, 753 (Fla. 1997). It is an "intermediate standard." Id. For proof to be considered "'clear and convincing' . . . 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." In re Davey, 645 So. 2d 398, 404 (Fla. 1994), quoting, with approval,

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

62. In determining whether Petitioner has met its burden of proof, it is necessary to evaluate Petitioner's evidentiary presentation in light of the specific factual allegations made in the charging instrument. Due process prohibits an agency from taking disciplinary action against a licensee based upon conduct not specifically alleged in the charging instrument. See Hamilton v. Department of Business and Professional Regulation, 764 So. 2d 778 (Fla. 1st DCA 2000); Lusskin v. Agency for Health Care Administration, 731 So. 2d 67, 69 (Fla. 4th DCA 1999); and Cottrill v. Department of Insurance, 685 So. 2d 1371, 1372 (Fla. 1st DCA 1996).

63. Furthermore, "the conduct proved must legally fall within the statute or rule claimed [in the charging instrument] to have been violated." Delk v. Department of Professional Regulation, 595 So. 2d 966, 967 (Fla. 5th DCA 1992). In deciding whether "the statute or rule claimed to have been violated" was in fact violated, as alleged by Petitioner, if there is any reasonable doubt, that doubt must be resolved in favor of the licensee. See Whitaker v. Department of Insurance and Treasurer, 680 So. 2d 528, 531 (Fla. 1st DCA 1996); Elmariah v. Department of Professional Regulation, Board of Medicine, 574 So. 2d 164, 165 (Fla. 1st DCA 1990); and Lester v. Department of

Professional and Occupational Regulations, 348 So. 2d 923, 925 (Fla. 1st DCA 1977).

64. In those cases where the proof is sufficient to establish that the licensee committed the violation(s) alleged in the charging instrument and that therefore disciplinary action is warranted, it is necessary, in determining what disciplinary action should be taken against the licensee, to consult the Board's "disciplinary guidelines," as they existed at the time of the violation(s). See Parrot Heads, Inc. v. Department of Business and Professional Regulation, 741 So. 2d 1231, 1233 (Fla. 5th DCA 1999)("An administrative agency is bound by its own rules . . . creat[ing] guidelines for disciplinary penalties."); and Orasan v. Agency for Health Care Administration, Board of Medicine, 668 So. 2d 1062, 1063 (Fla. 1st DCA 1996)("[T]he case was properly decided under the disciplinary guidelines in effect at the time of the alleged violations."); see also State v. Jenkins, 469 So. 2d 733, 734 (Fla. 1985)("[A]gency rules and regulations, duly promulgated under the authority of law, have the effect of law."); Buffa v. Singletary, 652 So. 2d 885, 886 (Fla. 1st DCA 1995)("An agency must comply with its own rules."); and Williams v. Department of Transportation, 531 So. 2d 994, 996 (Fla. 1st DCA 1988)(agency is required to comply with its disciplinary guidelines in taking disciplinary action against its employees).

65. At the time of the alleged violations in the instant case, the Board's "disciplinary guidelines" were found in Rule 64B9-8.006, Florida Administrative Code, which then provided, in pertinent part, as follows:

> (1) The legislature created the Board to assure protection of the public from nurses who do not meet minimum requirements for safe practice or who pose a danger to the public. . . .
>
> (2) The Board sets forth below a range of disciplinary guidelines from which disciplinary penalties will be imposed upon practitioners . . . guilty of violating Chapter 464, F.S. The purpose of the disciplinary guidelines is to give notice to licensees . . . of the range of penalties which will normally be imposed [for] violations of particular provisions of Chapter 464. The disciplinary guidelines are based upon a single count violation of each provisions listed. Multiple 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. All penalties at the upper range of the sanctions set forth in the guidelines (e.g. suspension, revocation) include lesser penalties, i.e., fine, reprimand or probation, which may be included in the final penalty at the Board's discretion.
>
> (3) The following disciplinary guidelines shall be followed by the Board in imposing disciplinary penalties upon licensees for violation of the noted statutes and rules:
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> * * *
>
> (i) Unprofessional conduct (464.018(h) . . . . , F.S.)

-In delivery of nursing services: Fine from $250-$1,000 plus from one year probation with conditions and appropriate CE courses to suspension[8/] until proof of safety to practice,[9/] followed by probation with conditions.[10/] . . .

(4)(a) The Board shall be entitled to deviate from the foregoing guidelines upon a showing of aggravating or mitigating circumstances by clear and convincing evidence, presented to the Board prior to the imposition of a final penalty at informal hearing. If a formal hearing is held, any aggravating or mitigating factors must be submitted to the hearing officer at formal hearing. At the final hearing following a formal hearing, the Board will not hear additional aggravating or mitigating evidence.

(b) Circumstances which may be considered for purposes of mitigation or aggravation of penalty shall include, but are not limited to, the following:

1. The severity of the offense.

2. The danger to the public.

3. The number of repetitions of offenses.

4. Previous disciplinary action against the licensee in this or any other jurisdiction.

5. The length of time the licensee has practiced.

6. The actual damage, physical or otherwise, caused by the violation.

7. The deterrent effect of the penalty imposed.

8. Any efforts at rehabilitation.

9. Attempts by the licensee to correct or stop violations, or refusal by the licensee to correct or stop violations.

10. Cost of treatment.

11. Financial hardship.

12. Cost of disciplinary proceedings.

66. The Amended Administrative Complaint issued in the instant case alleges that Respondent violated Subsection (1)(h) of Section 464.018, Florida Statutes, in that, in connection with his "delivery of nursing services" at IPMC in or around February and March of 2001, he engaged in "unprofessional conduct" by "failing to conform to the minimal acceptable standards of prevailing nursing practice as defined in Rule 64B9-8.005(13), Florida Administrative Code" (Count One); by "administ[ering] . . . treatments or medications in a negligent manner, as defined in Rule 64B9-8.005, Florida Administrative Code" (Count Two); and by "practicing beyond the scope of the licensee's license, educational preparation or nursing experience as defined in Rule 64B9-8.005(15), Florida Administrative Code" (Count Three).

67. In February and March of 2001, Subsection (1)(h) of Section 464.018, Florida Statutes (2000), authorized the Board to take disciplinary action against a Florida-licensed registered nurse for "[u]nprofessional conduct, . . . include[ing], 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." 11/

68. At that time, "unprofessional conduct," as used in subsection (1)(h) of Section 464.018, Florida Statutes (2000), was defined by Board rule as follows:

> Unprofessional conduct shall include:
>
> (1) Inaccurate recording, falsifying or altering of patient records or nursing progress records, employment applications or time records; or
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> (2) Administering medications or treatments in negligent manner; or
>
> (3) Misappropriating supplies, equipment or drugs; or
>
> (4) Leaving a nursing assignment before properly advising appropriate personnel; or
>
> (5) Violating the confidentiality of information or knowledge concerning a patient; or
>
> (6) Discrimination on the basis of race, creed, religion, sex, age or national origin, in the rendering of nursing services as it relates to human rights and dignity of the individuals; or
>
> (7) Engaging in fraud, misrepresentation, or deceit in taking the licensing examination; or
>
> (8) Aiding and abetting the practice of registered nursing or practical nursing by any person not licensed as a registered nurse or a licensed practical nurse; or

(9) Practicing registered nursing or practical nursing in the State of Florida without a current license or time limited permission by the Board to be employed; or

(10) Impersonating any applicant or acting as proxy for the applicant in any examination required for the issuance of a license; or

(11) Impersonating another licensed practitioner, or permitting another person to use his certificate for the purpose of nursing for compensation; 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; or

(14) Exercising influence on a patient in such a manner as to exploit the patient for financial gain of the licensee or a third party; or

(15) Practicing beyond the scope of the licensee’s license, educational preparation or nursing experience; or

(16) Submitting the attestation of 24 hours of continuing education and one hour continuing education on domestic violence for licensure renewal under Rule 64B9-3.013, F.A.C., when the licensee has not attended or completed all such hours in the biennium; or

(17) Failure of an ARNP dispensing practitioner to comply with the registration and compliance requirements of Rule 64B9-4.011, F.A.C.; or

(18) Testing positive for any drugs under Chapter 893, F.S., on any drug screen when

the nurse does not have a prescription and legitimate medical reason for using such drug; or

(19) Violation of a Board order entered in a licensure proceeding;

(20) Providing false or incorrect information to the employer regarding the status of the license.

69. Petitioner proved by clear and convincing evidence that Respondent "fail[ed] to conform to the minimal standards of acceptable prevailing nursing practice" in connection with his "delivery of nursing services" to K. N. on February 23, 2001, and to F. L. on March 18, 2001, and that Respondent therefore is guilty of having engaged in "unprofessional conduct," as described in Subsection (13) of the version of Rule 64B9-8.005, Florida Administrative Code, that was in effect on those dates, as Petitioner alleged in Count One of the Amended Administrative Complaint.

70. Petitioner proved by clear and convincing evidence that Respondent inserted a Foley Catheter in F. L. on March 18, 2001, in a negligent manner and that Respondent therefore is guilty of having engaged in "unprofessional conduct," as described in Subsection (2) of the version of Rule 64B9-8.005, Florida Administrative Code, that was in effect on that date, as Petitioner alleged in Count Two of the Amended Administrative Complaint. 12/

71. Petitioner failed to prove by clear and convincing that the Foley catheter was inserted "without physician[']s[] orders." Accordingly, Petitioner's proof is insufficient to establish that Respondent is guilty of having engaged in "unprofessional conduct," as described in Subsection (15) of the version of Rule 64B9-8.005, Florida Administrative Code, that was in effect on March 18, 2001, as Petitioner alleged in Count Three of the Amended Administrative Complaint. This count of the Amended Administrative Complaint should therefore be dismissed.

72. The Board is authorized to impose upon Respondent, for his having committed the violations alleged in Counts One and Two of the Amended Administrative Complaint, "one or more of the . . . penalties" that were specified in Subsection (2) of Section 464.018, Florida Statutes (2000), provided the Board acts in accordance with its "disciplinary guidelines," as they existed at the time of the violations.

73. Having carefully considered the facts of the instant case in light of these "disciplinary guidelines," and further recognizing that the Board is now, and has been at all times material to the instant case, statutorily authorized to "assess costs related to the investigation and prosecution" of those disciplinary cases it decides, 13/ the undersigned concludes that, for his having committed the "[m]ultiple counts of

violations" described in Counts One and Two of the Amended Administrative Complaint (which occurred on two different dates, involved two different patients, and were extremely serious breaches of acceptable behavior for a nurse toward a patient), Respondent should have his license permanently revoked and be required to pay a $1,000.00 fine, as well as the "costs related to the investigation and prosecution of the case." 14/ The harsh penalty of permanent revocation is warranted "to protect the public." Its imposition will ensure that Respondent will not commit (in this state) any future violations of a similar nature and will deter others from doing so. 15/

RECOMMENDATION

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

RECOMMENDED that the Board issue a final order in which it dismisses Count Three of the Amended Administrative Complaint, finds Respondent guilty of the violations alleged in Counts One and Two of the Amended Administrative Complaint, and, as punishment for having committed these violations, permanently revokes Respondent's license and requires him to pay a fine in the amount of $1,000.00, as well as the "costs related to the investigation and prosecution of the case." 16/

DONE AND ENTERED this 4th day of November, 2002, in Tallahassee, Leon County, Florida.

STUART M. LERNER
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 4th day of November, 2002.

ENDNOTES

1/ At the time of the incident, F. L. was approximately five feet, seven inches tall and weighed approximately 155 pounds.

2/ The evidentiary record does not clearly and convincingly establish that, as alleged in paragraph 14 of the Amended Administrative Complaint, Respondent acted "without physician[']s[] orders" when he "inserted the Foley catheter [i]n patient F. L." While IPMC's records of F. L.'s March 18, 2001, admittance (which were offered and received into evidence as Petitioner's Exhibit 2) do not reflect that any such orders were given, neither do these records reflect that F. L. was ever catherized (which, credible eyewitness testimony establishes, he was). Although a nurse should document that he or she has received verbal orders from a physician to insert a Foley catheter, according to the credible testimony of Dr. Michael Estep, an emergency room physician at IPMC, "[t]here are instances when [such orders are] not written down." Furthermore, when asked at the final hearing whether he had "any independent memory that [he] ordered a [Foley] catheter, verbally," the IPMC emergency room physician who evaluated Respondent, Dr. Luis Maciera-Rodriguez, responded, "I don't recall right offhand, but I may have, because sometimes we do that. I don't recall offhand if I did that or not."

3/ F. L.'s mother had left the room immediately after her son had gone "totally berserk" (before Respondent had hit F. L. with the Foley catheter), and she had not returned.

4/ The appropriate response would have been to "get [F. L.'s] mother," who was in the waiting room area.

5/ Registered nurses are supposed to use only "minimum force, according to what the needs are," to "restrain a combative patient."

6/ This finding is supported by expert testimony presented by Petitioner, which the undersigned has credited. Compare with Jordan v. Department of Professional Regulation, 522 So. 2d 450, 452 (Fla. 1st DCA 1988)("The Department of Professional Regulation presented expert testimony that appellant's actions represented a failure to conform to acceptable and prevailing nursing standards. We therefore affirm the guilt phase of appellant's case.").

7/ Subsection (3) of Section 464.018, Florida Statutes (2000), provided as follows:

> The board shall not reinstate the license of a nurse, or cause a license to be issued to a person it has deemed unqualified, until such time as it is satisfied that such person has complied with all the terms and conditions set forth in the final order and that such person is capable of safely engaging in the practice of nursing.

8/ Subsection (1) of Rule 64B9-8.006, Florida Administrative Code, specified that the following types of suspensions could be imposed upon licensees as disciplinary penalties:

> (a) Suspension until appearance before the Board or for a definite time period and demonstration of ability to practice safely.
>
> (b) Suspension until appearance before the board, or for a definite time period, and submission of mental or physical examinations from professionals specializing in the diagnosis or treatment of the suspected condition, completion of counseling, completion of continuing

education, demonstration of sobriety and ability to practice safely.

(c) Suspension until fees and fines paid or until proof of continuing education completion submitted.

(d) Suspension until evaluation by and treatment in the Intervention Project for Nurses. In cases involving substance abuse, chemical dependency, sexual misconduct, physical, or mental conditions which may hinder the ability to practice safely, the Board finds participation in the IPN under a stayed suspension to be the preferred and most successful discipline.

(e) Suspension stayed so long as the licensee complies with probationary conditions.

9/ Subsection (2) of Rule 64B9-8.011, Florida Administrative Code, provided (as it still does):

In order to demonstrate the present ability to engage in the safe practice of nursing, the nurse must submit evidence which may include:

(a) Completion of continuing education courses approved by the Board, particularly if the disciplinary action resulted from unsafe practice or the nurse has been out of practice for a number of years.

(b) Participation in nursing programs, including refresher courses, clinical skills courses, and any Board approved nursing education programs leading to licensure in this state, particularly if the nurse has been out of practice for a number of years.

(c) Submission of evaluations of mental or physical examinations by appropriate professionals which attest to the nurse's present ability to engage in safe practice

or conditions under which safe practice can be attained.

(d) Completion of treatment within a program designed to alleviate alcohol or other chemical dependencies, including necessary aftercare measures or a plan for continuation of such treatment as appropriate. Current sobriety must be demonstrated.

(e) Other educational achievements, employment background, references, successful completion of criminal sanctions imposed by the courts and restoration of civil rights if a convicted felon, or other factors which would demonstrate rehabilitation and present ability to engage in the safe practice of nursing.

10/ Subsections (1)(f), (g), (h) and (i) of Rule 64B9-8.006, Florida Administrative Codek, identified the following types of probations upon which a licensee could be placed:

(f) Probation with the minimum conditions of not violating laws, rules, or orders related to the ability to practice nursing safely, keeping the Board advised of the nurse's address and employment, and supplying both timely and satisfactory probation and employer/supervisor reports.

(g) Probation with specified continuing education courses in addition to the minimum conditions. In those cases involving unprofessional conduct or substandard practice, including recordkeeping, the Board finds continuing education directed to the practice deficiency to be the preferred punishment.

(h) Probation with added conditions of random drug screens, abstention from alcohol and drugs, participation in narcotics or alcoholics anonymous, psychological counseling, the prohibition on agency work, or the requirement that work must be under

direct supervision on a regularly assigned unit.

(i) Personal appearances before the Board to monitor compliance with the Board's order.

11/ Subsection (1)(h) of Section 464.018, Florida Statutes, now provides as follows:

The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

Unprofessional conduct, as defined by board rule.

"Unprofessional conduct" is presently "defined by board rule," as follows:

Unprofessional conduct shall include:

(a) Inaccurate recording; or

(b) Misappropriating supplies or equipment; or

(c) Leaving a nursing assignment without advising licensed nursing personnel; or

(d) Practicing registered nursing or practical nursing in the State of Florida with a delinquent license for no more than 90 days; or

(e) Acts of negligence either by omission or commission; or

(f) Submitting the attestation of 24 hours of continuing education and one hour continuing education on domestic violence for licensure renewal under Rule 64B9-3.013, F.A.C., when the licensee has not attended or completed all such hours in the biennium; or

(g) Failure of an ARNP dispensing practitioner to comply with the registration and compliance requirements of Rule 64B9-4.011, F.A.C.

Rule 64B9-8.005(1), Florida Administrative Code. "Failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified by training or experience" is now a separate violation (not falling within the definition of "unprofessional conduct"). It is prohibited by Subsection (1)(n) of Section 464.018, Florida Statutes, and includes, according to Subsection (2) of Rule 64B9-8.005, Florida Administrative Code, the following:

(a) Falsifying or altering of patient records or nursing progress records, employment applications or time records; or

(b) Administering medications or treatments in negligent manner; or

(c) Misappropriating drugs; or

(d) Violating the confidentiality of information or knowledge concerning a patient; or

(e) Discrimination on the basis of race, creed, religion, sex, age or national origin, in the rendering of nursing services as it relates to human rights and dignity of the individuals; or

(f) Engaging in fraud, misrepresentation, or deceit in taking the licensing examination; or

(g) Aiding and abetting the practice of registered nursing or practical nursing by any person not licensed as a registered nurse or a licensed practical nurse; or

(h) Impersonating another licensed practitioner, or permitting another person to use his certificate for the purpose of nursing for compensation; or

(i) Acts of gross negligence, either by omission or commission; or

(j) Exercising influence on a patient in such a manner as to exploit the patient for financial gain of the licensee or a third party; or

(k) Testing positive for any drugs under Chapter 893, F.S., on any drug screen when the nurse does not have a prescription and legitimate medical reason for using such drug; or

(l) Violation of a Board order entered in a licensure proceeding; or

(m) Providing false or incorrect information to the employer regarding the status of the license; or

(n) Practicing beyond the scope of the licensee's license, educational preparation or nursing experience.

12/ In finding that Respondent engaged in "unprofessional conduct," as alleged in Counts One and Two of the Amended Administrative Complaint, the undersigned has credited the inculpatory eyewitness testimony of Petitioner's key fact witnesses, Mr. Russo and Mr. Austin, who had no apparent motive or reason to testify falsely against Respondent, over the conflicting self-serving testimony given by Respondent. See Martuccio v. Department of Professional Regulation, 622 So. 2d 607, 609 (Fla. 1st DCA 1993)(Although the self-serving nature of testimony given by "[p]ersons having a pecuniary or proprietary interest in the outcome of litigation" does not render such testimony inadmissible, the interest of the person in the outcome of the case may be considered in evaluating the credibility of the testimony).

13/ See Section 456.072(4), Florida Statutes ("In addition to any other discipline imposed through final order, or citation, entered on or after July 1, 2001, pursuant to this section or discipline imposed through final order, or citation, entered on or after July 1, 2001, for a violation of any practice act, the board, or the department when there is no board, shall assess

costs related to the investigation and prosecution of the case."). The Board has had such authority "to assess costs related to the investigation and prosecution of the case" since before the violations committed by Respondent in the instant case. See Section 9 of Chapter 94-119, Laws of Florida.

14/ These are penalties that Petitioner, in its Proposed Recommended Order, has suggested that the undersigned recommend to the Board.

15/ Respondent presented no evidence indicating that he has made, or that he intends to make, any effort to rehabilitate himself. (Indeed, he did not even concede that he was in need of rehabilitation.) Moreover, there is nothing in the evidentiary record to suggest that any efforts at rehabilitation, if made by Respondent, would be successful. Cf. S.E.C. v. Householder, 2002 WL 1466812 (N. D. Ill. 2002)("[T]here is no indication that Householder has either recognized his culpability or that he has offered any assurances, sincere or otherwise, that he will not commit any future violations. It is therefore sufficiently likely that Householder will continue to engage in these violations of the law if he is not enjoined from doing so.").

16/ "In the absence of a rule setting out a procedure for establishing the appropriate amount of such costs, fundamental fairness requires that the Board . . . require [Petitioner] to submit to the Board and to the Respondent an itemized listing of the costs for which payment is requested and that the Respondent be given an opportunity to contest the accuracy and/or reasonableness of the costs before the Board determines the amount of costs the Respondent will be required to pay." Department of Health, Board of Nursing v. Matus, No. 97-1911, 1997 WL 1053326 (Fla. DOAH 1997)(Recommended Order).

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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.