STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 03-0534PL
	)	
JANE WICKHAM, L.P.N.,	)	
	)	
Respondent.	)	
	)	

RECOMMENDED ORDER

Upon due notice, a disputed-fact hearing was conducted in this case on May 6, 2003, in Bunnell, Florida, before the Division of Administrative Hearings, by its duly-assigned Administrative Law Judge, Ella Jane P. Davis.

APPEARANCES

For Petitioner: Trisha D. Bowles, Esquire
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399

For Respondent: No Appearance

STATEMENT OF THE ISSUES

Whether Respondent violated Section 464.018(1)(h), Florida Statutes (2000), covering unprofessional performance of nursing duties and failure to conform to minimal standards of nursing practice, and if so, what penalty should be imposed.

PRELIMINARY STATEMENT

On February 18, 2000, Petitioner, Department of Health, filed an Administrative Complaint against Respondent, alleging that she violated Section 464.018(1)(h), Florida Statutes (2000), as defined in Rule 64B9-8.005(14), Florida Administrative Code. Specifically, it is alleged that Respondent performed her nursing duties in an unprofessional manner and failed to conform to the minimal standards of acceptable and prevailing nursing practice by using excessive physical force and causing a patient physical and emotional harm.

Respondent requested an administrative hearing, and the case was referred to the Division of Administrative Hearings on or about February 13, 2003.

On May 6, 2003, the disputed-fact hearing was held in Bunnell, Florida. After waiting 45 minutes from the time scheduled for the hearing to commence, neither Respondent nor the court reporter had appeared. As permitted by law, the Agency provided taping equipment instead of a court reporter.

The docket was sounded throughout the courthouse and Respondent was not found. The hearing proceeded thereafter.

Petitioner had previously filed a Motion to Deem Admissions Admitted, which was granted orally at hearing.[1/] Petitioner's Motion for Official Recognition of Section 20.403, Florida

Statutes; Section 464.018, Florida Statutes; and Rule 64B9-8.005, Florida Administrative Code, was likewise granted orally. Petitioner presented the testimony of Dianne Mongelli, Evelyn Bible, Judy Kiziukiewicz, Lynn Peabody, Kimberly Horn, and Meiko Mills. Petitioner's Exhibits A, B, C, D, E, and F were admitted in evidence. Records subject to confidentiality provisions established by statute or rule have been protected and are being transmitted, under seal, to the Agency with this Recommended Order.

Respondent had not appeared by the end of Petitioner's case-in-chief, and the hearing was concluded.

A Transcript, created from the taped hearing, was filed on June 9, 2003. This Transcript was paid for by the Agency and created by a certified court reporter of the Division of Administrative Hearings. A Post-Hearing Order was entered which advised both parties of the date the Transcript was filed with the Division and of the opportunity to file Proposed Recommended Orders.

Petitioner's Proposed Recommended Order was timely filed on June 16, 2003, and has been considered. Respondent has not filed any proposal.

FINDINGS OF FACT

1. Respondent Jane Wickham is a Licensed Practical Nurse in the State of Florida, having been issued license number PM1227531.

2. Petitioner is the State Agency charged with regulation of the practice of nursing, pursuant to Chapters 20, 456, and 464, Florida Statutes (2000).

3. On June 6, 2001, Respondent was a nurse employed by and/or working at Daytona Health and Rehabilitation Center (DHRC), Daytona Beach, Florida.

4. On June 6, 2001, Respondent was assigned to provide patient care to patient M. M., an 81-year-old female patient, who suffers from Alzheimer's Dementia and/or Alzheimer's Disease and dementia. M. M. had been recently admitted to DHRC on May 23, 2001. Her records indicate she was very combative. Respondent had worked with M. M. between May 23, 2001, and June 6, 2001.

5. On June 6, 2001, Respondent attempted to administer oral medication to M. M.. M. M. said the medicine upset her stomach and refused it. She was heard repeatedly saying, "I don’t want it!" Respondent enlisted assistance from a Certified Nursing Assistant (CNA), who helped Respondent give M. M. a portion of the medicine, which M. M. then spat into Respondent's face. Some medicine struck Respondent. Respondent wiped

herself off with a towel. She then grabbed M. M. forcibly by the arm, and briskly walked her into the dayroom and sat her on the couch.

6. Lynn Peabody, Physical Therapy Assistant, observed M. M. and Respondent in the dayroom. M. M. attempted to get up from the couch and away from Respondent. M. M. and Respondent were swinging at each other, but Ms. Peabody was unable to see any "striking" by Respondent. M. M. swung the towel and knocked off Respondent's glasses.

7. At that point, Respondent one again grabbed M. M. forcibly by her arm, wrenched her up from the couch, and briskly walked her to her room. Respondent used such force that M. M.'s slipper was pulled off as she tried to resist being pulled down the hall by Respondent.

8. Respondent put patient M. M. in her room, shut the door, and held the door shut, trapping patient M. M. inside. While trapped in the room, M. M. was yelling, screaming, and trying to get out of the room. M. M. was upset and crying. Judy Kiziukiewicz, Marketing Director, was in the restroom across the hall from M. M.'s room. She heard screaming and banging from the altercation. She heard M. M. calling, "Help! help! help!" She also heard Respondent saying, "I'll kill you! I'll kill you!" Ms. Kiziukiewicz exited the restroom and went to M. M.'s aid. M. M. was shaky, tearful, frightened, and

holding her arm, which was very red. M. M. said to Ms. Kiziukiewicz, "She won't let me out."

9. Ms. Peabody testified without refutation that she observed Respondent shut M. M. in her room and hold the door closed, while M. M. shouted "Let me out!" Ms. Peabody also heard Respondent say, "I've had enough of this shit."

10. About 3:00 p.m. on June 7, 2001, Janice Ullery, Licensed Practical Nurse, documented in patient M. M.'s records that M. M.'s right thumb was swollen and noted bruising.

11. On June 8, 2001, Thomas Mistrata, an Investigator for the Department of Children and Families, interviewed patient M. M. He did not testify, but his report was admitted, pursuant to Section 120.57(1)(c), as explaining or supplementing direct evidence. His report indicates bruising to M. M.'s right hand, along the thumb extending to the wrist, and small circular bruising to M. M.'s arm, which appeared to him to be a hand print. His report also indicates observation of bruising to the top of M. M.'s left hand that was circular and approximately four centimeters wide. He took photographs of the bruises. Ms. Kiziukiewicz, who did testify, observed that these photographs did not fully show the redness of M. M.'s arm on June 6, 2001, when she observed M. M.'s injuries immediately after M. M.'s altercation with Respondent.

12. On June 9, 2001, M. M. was examined by James R. Shoemaker, D.O. Dr. Shoemaker observed and documented in M. M.'s DHRC medical records a bruise on M. M.'s right hand.

13. Upon the expert testimony of Meiko Miles, Licensed Nurse Practioner and Registered Nurse, it is found that Respondent's conduct with regard to Alzheimer's Patient, M. M., was below prevailing standards of nursing, constituted negligence, and further constituted a failure to conform to the minimal standards of acceptable and prevailing nursing practice for elderly, fragile patients or for patients refusing medications. Even though Ms. Miles was not present for all of the witnesses' testimony concerning the actual altercation between Respondent and M. M., I accept Ms. Miles' testimony based upon her review of medical records, nursing notes, and medical administration reports, and given her answers in response to questions which conformed to the facts as related by the witnesses who had observed the actual event.

14. I also accept the testimony of Ms. Miles and other witnesses to the effect that Respondent's training and experience had or should have provided her with less extreme methods upon which to rely in dealing with M. M.'s resistance and combativeness.

CONCLUSIONS OF LAW

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

16. Petitioner has the duty to go forward and the burden of proof by clear and convincing evidence of all elements of the administrative complaint. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

17. 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 in which actual injury need not be established . . . "

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

> (12) Acts of negligence, gross negligence, either by omission or by commission;
>
> (13) Failure to conform to the minimal standards of acceptable and prevailing nursing practice, regardless of whether or not actual injury to the patient was sustained.

19. The foregoing Findings of Fact have been made upon the competent evidence admitted at trial and upon the Admissions deemed admitted. However, where the "live" testimony and actual

medical records in evidence differed from the (Requests for) Admission, the undersigned has considered that to be the "best evidence" over the Requests for Admission which went unanswered by a pro se litigant.[2/] Even so, it has been clearly and convincingly proven that Respondent violated Section 464.018(1)(h), Florida Statutes. Moreover, actual injury to Patient M. M. also has been clearly and convincingly proven.

20. Respondent used unnecessary force with Patient M. M., causing physical and emotional injury to her. Respondent is guilty of violating Section 464.018(1)(h), Florida Statutes, and Rule 64B9-8.005(12) and (13), Florida Administrative Code, by failing to conduct herself professionally, in that she caused physical and emotional harm to M. M..

21. Rule 64B9-8.006, Florida Administrative Code, details the disciplinary guidelines of the Board of Nursing, together with a range of penalties and the aggravating and mitigating circumstances. Rule 64B9-8.006(3)(p), Florida Administrative Code, specifies the penalties for a first offense for unprofessional conduct, in which case actual injury has been established pursuant to Section 464.018(1)(h), Florida Statutes, as ranging from a fine of $250.00 and probation to a $500.00 fine and suspension, to be followed by a term of probation. Lesser penalties of a reprimand and/or course work may be included. The Rule also provides a wide range of types of

suspensions, restrictions of practice, and conditions of probation.

22. Rule 64B9-8.006(5)(b), Florida Administrative Code, lists ten mitigating/aggravating factors to be considered in assigning a penalty. Subsections 1, 3, 4, 5, 9, and 10 are relevant here. The evidence herein also suggests the following mitigating circumstances, not necessarily recognized by the guidelines: that M. M. was a very combative patient; that Respondent had only worked with M. M. a portion of 13 days; that Respondent tried to ameliorate a volatile situation by calling in the CNA; and that Respondent was provoked by M. M.'s spitting on her and by the visual disorientation and physical damage to Respondent's glasses caused by M. M.'s active physical resistance. Be that as it may, the testimony is clear and convincing that Respondent was never in serious physical danger from M. M. nor was she wounded by M. M. Respondent should not have allowed anger to guide her judgment and actions in place of professional standards for dealing with this type of patient.

RECOMMENDATION

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

RECOMMENDED that the Department of Health, Board of Nursing enter a final order which finds Respondent, Jane Wickham, guilty of violating Section 464.018(1)(h), Florida Statutes, and of

violating Rule 64B9-8.005 (12) and (13), Florida Administrative Code; and imposing a penalty as follows:

(1) Issues a reprimand;

(2) Assigns a fine of $300.00, plus the cost of investigation;

(3) Requires that Respondent complete a specified number of hours of continuing education course work in the subject areas of anger management and patient rights;

(4) Places Respondent on probation until such fine is paid and such course work is completed, the probation to be upon such conditions as the Board deems appropriate to protect the public health, safety and welfare; and

(5) Requires, after the fine is paid and the course work is completed, that Respondent appear before the Board to determine if she is safe to practice and to determine if any further probation is warranted, and if so, to determine the terms of that probation.

DONE AND ENTERED this 9th day of July, 2003, in Tallahassee, Leon County, Florida.

ELLA JANE P. DAVIS
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 9th day of July 2003.

ENDNOTES

[1/] In accordance with the Florida Rules of Civil Procedure, only a Notice of Filing of Requests for Admission was filed with the Division. However, a full copy of the requests themselves was submitted at the disputed-fact hearing and that copy is included with the exhibits being returned to the Agency.

[2/] Requests for Admission which are admitted or not timely answered may be considered as true, without further proof. However, where evidence which differs from the Admissions is offered at the hearing by the party relying on the Admission, it is nonsensical to rely on the Admissions.

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.