STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING, Petitioner, vs. HARVEY J. PRICE, L.P.N., Respondent.	)	Case No. 05-0072PL

RECOMMENDED ORDER

Notice was provided and on March 17, 2005, a formal hearing was held in this case. Authority for conducting the hearing is set forth in Sections 120.569 and 120.57(1), Florida Statutes (2004). The hearing location was the Alachua County Civil Courthouse, 201 East University Avenue, Gainesville, Florida. The hearing was conducted by Charles C. Adams, Administrative Law Judge.

APPEARANCES

For Petitioner: Judith A. Law, Esquire
J. Blake Hunter, Esquire
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265

For Respondent: Harvey J. Price, pro se
Post Office Box 99
High Springs, Florida 32655

STATEMENT OF THE ISSUE

Should discipline be imposed by Petitioner against Respondent's license to practice as a licensed practical nurse (L.P.N.)?

PRELIMINARY STATEMENT

On September 23, 2004, Petitioner through its Administrative Complaint in Case No. 2003-16450 charged Respondent in three counts with violations pertaining to his practice as a L.P.N. The details of the Administrative Complaint are discussed in the Conclusions of Law in this Recommended Order. Respondent was provided an opportunity to respond to the Administrative Complaint through a form referred to as an "Election of Rights." He chose option three in the election process pertaining to a formal hearing pursuant to Sections 120.569(2)(a) and 120.57(1), Florida Statutes, given his contest of the factual allegations and provisions of law set out in the Administrative Complaint.

On January 6, 2005, the case was received by the Division of Administrative Hearings (DOAH) calling for the assignment of an administrative law judge to conduct the formal hearing. The case was assigned DOAH Case No. 05-0072PL to be heard by the undersigned. Following notice, the hearing took place on the aforementioned date.

Petitioner presented Gloria Brown, L.P.N., Meiko D. Mills, R.N., M.S.N., A.R.N.P., and Alice Bostick, as it witnesses. Petitioner's Exhibits numbered one through five were admitted as evidence. Petitioner's request for admissions propounded to Respondent numbered one through eight and twelve through fifteen were admitted and form the basis for fact-finding in the Recommended Order. Respondent testified in his own behalf. Respondent did not offer exhibits.

On April 20, 2005, a hearing transcript was filed with DOAH. On April 28, 2005, Petitioner filed a proposed recommended order which has been considered in preparing the Recommended Order.

FINDINGS OF FACT

Findings Established by Request for Admissions:

1. Petitioner is the State of Florida department charged with regulating the practice of nursing pursuant to Section 20.43, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 464, Florida Statutes.

2. Respondent is and has been at all time material to the complaint a L.P.N. in the State of Florida, having been issued license number 9246217.

3. Respondent's address of record is Post Office Box 99, High Springs, Florida 32655-0099.

4. At all times material to this case, Respondent was employed as a L.P.N. by Suwannee Home Care and Medical Personnel, a staffing agency.

5. At all times material to this case, Respondent was assigned to work as a L.P.N. at Alachua Nursing and Rehabilitation in Gainesville, Florida (Alachua).

6. At all times material to this case, Alachua in Gainesville, was a licensed rehabilitation facility as defined in Section 400.021(13), Florida Statutes.

7. At all times material to this case, Patient E.D. was admitted to Alachua (having been admitted) on June 20, 2003, with a diagnosis of status post CVA (stroke).

8. On or about June 21, 2003, Respondent was assigned to care for E.D. on the 3 to 11 p.m. shift, and at the end of the shift, Respondent reported to the oncoming nurse that he assisted with the care of E.D. and that E.D. was okay and in no acute distress.

9. Respondent's nurse's notes regarding the care he provided to patient E.D. do not mention whether he suctioned the tracheostomy care being provided; and do not contain any physical assessment of the patient.

10. Respondent should have performed and documented tracheostomy care, including but not limited to frequency of suctioning, amount of color of sputum suctioned, cleaning of the

tracheostomy device, oral hygiene, and method of communication with the patient.

11. Respondent should have performed and documented a physical assessment of the patient that included respiratory rate and effort, color, pulse rate, and exertional level.

12. Respondent should have monitored and followed up on patient E.D.'s vital signs.

Additional Facts:

13. Alice Bostick, is a Medical Malpractice Investigator for Petitioner. She was involved in the investigation leading to the drafting of the Administrative Complaint. As part of the process she attempted to notify Respondent of the allegations made against him. On July 15, 2003, she sent a letter of notification to Respondent at an address obtained from a printout of license information associated with Respondent. That address was 13134 North 22nd Street, Apartment 109, Tampa, Florida 33612. The information sent to Respondent was a Uniform Complaint Form and a Nursing Home Adverse Incident Report. The information sent to Respondent was returned as undeliverable and not subject to forwarding, absent a forwarding request made from Respondent to the U.S. Postal Service.

14. Having failed to notify Respondent at the Tampa address, Ms. Bostick took advantage of access which the Petitioner has to the Florida Department of Highway Safety and

Motor Vehicles records to locate Respondent's address maintained by the other state agency. The address provided by the other agency was Post Office Box 99, High Springs, Florida 32655-0099. This was the proper address. Utilizing the new address, the same information was dispatched a second time from Petitioner to Respondent. This time it was not returned as undelivered. Instead Respondent contacted Petitioner's office in person and by his remarks made it known that he received the communication from Petitioner concerning the investigation.

15. At times relevant to this case Respondent worked for the Suwannee Valley Nursing Agency. That agency assigned him to work on a shift at Alachua, now the Manor of Gainesville.

16. On June 21, 2003, Respondent worked the 3:00 p.m., to 11:00 p.m., shift at Alachua. One of the resident's in his care at that time was E.D.

17. Resident E.D. was born on May 18, 1920. She had been released from the hospital on June 20, 2003, and transferred to Alachua. She was receiving oxygen. Physician's orders called for tracheostomy care (trach care) to be administered "Q 6 hours." She had a catheter which was last changed on the date of her release from the hospital. The order indicated that the catheter should be changed every Friday beyond that point. The resident was being fed by tube.

18. As Respondent describes it, E.D. was among 30 patients in his care on the shift. Other residents included persons with G-tubes and insulin-dependent diabetics. Respondent was very busy during his shift helping the residents.

19. Another staff member at the nursing home reminded the Respondent that he needed to suction E.D's trach. At some point in time Respondent and the other staff member suctioned the trach. When this function was performed during the shift is not established in the nursing home record pertaining to resident E.D., as that record was presented at the hearing. Therefore it was not shown an entry was made in the resident's record for care confirming the suctioning of the trach.

20. The only reference to patient E.D. made in writing by Respondent presented at hearing, was from nursing notes related to resident E.D. In the nurse's note Respondent made an entry at the end of his shift as to vital signs for the resident, pulse rate 92, respiration rate 24 and a notation that Respondent "Assisted e-care no acute distress noted."

21. Contrary to the nurse's note made by Respondent, resident E.D. was in distress as discovered by Gloria Brown, L.P.N., who came on shift to work from 11:00 p.m. June 21, 2003, until 7:00 a.m. June 22, 2003.

22. Ms. Brown was familiar with the need to suction a trach and to make appropriate entry in the nursing notes in caring for a trach patient. Notes are also made in relation to oxygen saturation for that resident if a doctor's order calls for that entry. Ms. Brown properly expected the prior shift nurse to notify her concerning the resident's condition as to the number of liters of O_2 provided the resident and if the resident had a fever. If the resident had a Foley catheter placed reference would be made to that circumstance. Generally if the resident was experiencing a problem, Ms. Brown would expect the outgoing nurse to mention that fact.

23. On June 21, 2003, at 11:45 p.m., as Ms. Brown described in the nursing notes, "On first rounds observed resident E.D. with shallow breathing, skin color grayish, O_2 on a 2 liter per trach mask. Attempt to suction, felt resistance. Sat. 24. O_2 increased to three liters. Able to palpate pulse. 911 was called. Transported to Shands at UF via 911. Respiratory distress."

24. Resident E.D. was transported to Shands Hospital at 12:00 midnight. When resident E.D. was transported to the hospital she was experiencing respiratory distress. She had a baseline level of consciousness in the alert range.

25. Petitioner presented an expert to comment on Respondent's care rendered resident E.D. in the context of the

allegations set forth in the Administrative Complaint. That expert was Meiko D. Mills, R.N., M.N.S., A.R.N.P. Ms. Mills is licensed to practice nursing in Florida. She has a business that involves the preparation for graduates of L.P.N. schools and R.N. schools to take the National Licensing Examination for those fields.

26. Ms. Mills is familiar with trach care. She has had occasion to write nursing notes pertaining to trach care. She is generally familiar with the requirements for nursing notes in the patient record concerning any form of patient care rendered by the nurse practitioner. She was recognized in this case as an expert in the field of nursing related to patient care and L.P.N.s.

27. In providing trach care, Ms. Mills refers to the need for a sterile environment and the part of the trach device that she refers to as a tube, requires a lot of cleaning because of secretions from the patient. She describes the fact that the trach device will form a crust. As a result the center portion of the device sometimes has to be taken out and soaked in sterile water to clean it. The suctioning process associated with trach care involves the use of a suctioning machine in which all the encrustations and saliva are removed. It is possible for a hard mucus plug to form if suctioning is not done appropriately, according to Ms. Mills.

28. Ms. Mills expressed her opinion concerning Respondent's care provided resident E.D., as to a reasonable degree of certainty and whether Respondent met the minimal standards for acceptable and prevailing care and treatment of E.D. She described that care as lacking. Ms. Mills comments that the nursing note that was made by Respondent at the end of his shift was inadequate in describing the kind of care provided to the resident. In particular she describes the lack of reference to the trach issue and the oxygen saturation issue. She perceives that E.D. required considerable attention and that attention is not reflected in the nursing note.

29. As a person responsible for providing care to E.D., who had a trach, Ms. Mills refers to the need for the Respondent to establish a baseline at the beginning of the shift. That baseline is constituted of vital signs and oxygen saturation, as well as a basic assessment of the resident. There was the need to compare the vital signs assessment to the shift before Respondent came on duty to gain an impression of any trends. The observations by Respondent should have been documented in nursing notes beginning with the baseline as to vital signs, oxygen saturation, reference to the condition of the trach, respiratory effort and so forth, and there was the need to go back and reassess over time.

30. As Ms. Mills explains the resident's condition was reaching an abnormal state on the shift before. Without entries concerning the resident's condition, the assumption is made by Ms. Mills, that the patient care and in particular trach care was not performed by Respondent.

31. Ms. Mills refers to a normal pulse rate as 80 to 100, but Ms. Mills cautions her students that a pulse rate close to 100 bears watching. A respiration rate approaching the highest normal demands attention. Anything above that creates concern. Higher readings tend to manifest themselves with shallower breathing by patient at more frequent intervals, given the body's attempt to compensate for a lack of oxygen. To address this condition a baseline oxygen saturation should be established at the beginning of a shift to help set a plan of care. A resident such as E.D. with a pulse rate of 97 and respiration rate of 24 is a person who needs to be closely monitored. There was no record by Respondent reflecting the establishment of monitoring to address these circumstances. The resident's progress should have been noted as to pulse rate and respiration rate several times during Respondent's shift, as Ms. Mills perceives it. Respondent should have also notified the oncoming nurse for the following shift that the patient was not doing well. This was not done.

32. Overall, Ms. Mills feels that Respondent was deficient in his documentation concerning resident E.D. through the nursing notes. The general comment by Respondent that he assisted with care is not sufficient to establish that trach care was performed in Ms. Mills opinion.

33. According to Ms. Mills, some of the vital signs reflected in the resident's record would create the possibility that they were in relation to a mucus plug in the trach.

34. When the Resident E.D. was transported from the nursing home on June 21, 2003, at 11:30 the oxygen saturation at that time was 78 percent and her pulse was 159. In Ms. Mills opinion those values represented the fact that the resident was in distress.

35. Ms. Mills believes that Respondent engaged in unprofessional conduct by acts of omission.

36. Ms. Mills compared the nursing notes made by Respondent to those made by nurses on the prior two shifts at the nursing home. The prior notes were described as good notes talking about the care, while Ms. Mills did not get the same feeling about the notes made by Respondent.

37. Ms. Mills compared the circumstances when Respondent came on shift when resident E.D. had a pulse of 100 and respiration rate of 20 and the change from the respiration of 20 to the respiration rate of 24 at the end of the shift, as

indicating that the resident had shallow compensatory respiration because of a lack of oxygen. This leads Ms. Mills to the conclusion that the vital signs look worse and the person was significantly compromised over the day. Whether this circumstance was brought about by the formation of a plug due to a lack of trach care, Ms. Mills is not certain, but the vital signs indicate that the resident was sufficiently compromised to alert a health professional to that possibility. Earlier in the day the resident had a respiration rate of 28 and a pulse of 110. The change in those values over time up through the Respondent's shift did not indicate improvement in resident's condition in Ms. Mills' opinion.

38. Ms. Mills' opinions that have been described are accepted.

39. Based upon the facts found and Ms. Mills' expert opinion, Respondent failed to meet minimal standards of acceptable and prevailing nursing practice in the care provided resident E.D.

CONCLUSIONS OF LAW

40. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceedings in accordance with Sections 120.569, 120.57(1), and 456.001(5), Florida Statutes (2004).

41. The Administrative Complaint left open the possibility that the Board of Nursing would enter a final order imposing suspension or permanent revocation as discipline against Respondent's license to practice nursing. Consequently, to prove the allegations in the Administrative Complaint, Petitioner must do so by clear and convincing evidence. See Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stearn and Company, 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

42. The meaning of clear and convincing evidence has been explained in the case In re: Davey, 645 So. 2d 398 (Fla. 1994), quoting with approval from Slomowitz v. Walker, 429 So. 2d 797 (Fla. 4th DCA 1983).

43. The material allegations in the Administrative Complaint are:

> 1. Petitioner is the state department charged with regulating the practice of nursing pursuant to Section 20.436, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 464, Florida Statutes.
>
> 2. At all times material to this Complaint, Respondent was a licensed practical nurse (L.P.N.) within the state of Florida, having been issued license number 924621.
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> 3. Respondent's current address of record is P.O. Box 99, High Springs, Florida 32655-0099.

4. At all times material to this Complaint, Respondent was employed as a L.P.N. by Suwannee Home Care and Medical Personnel, a staffing agency. On June 21, 2003, Respondent was assigned to work as a L.P.N. at Alachua Nursing and Rehabilitation in Gainesville, Florida (Alachua).

5. Patient E.D. was a then eighty-three year-old woman who had been admitted to Alachua on June 20, 2003, with a diagnosis of status post CVA (stroke) and she had a tracheostomy that required regular care and suctioning.

6. On or about June 21, 2003, Respondent was assigned to care for E.D. on the 3 to 11 p.m. shift. At the end of the shift, Respondent reported to the oncomning nurse that E.D. was okay and in no acute distress. Respondent recorded in the nurses notes at 11 p.m. that E.D. had 130/80 blood pressure, 98.1 temperature, 97 pulse rate, 24 respiratory rate. He also reported in the notes that he had assisted with care and no acute distress was noted.

7. On or about June 21, 2003, at 11:45 p.m., the nurse from the next shift made rounds and found E.D. to be in respiratory distress, with grey skin color, shallow respirations and oxygen saturation at 24% (95-100% is normal). The nurse was unable to suction the hard mucous plug from the tracheostomy tube and immediately called 911. Patient E.D. was transferred to the hospital where a hard mucous plug was finally suctioned from the tracheostomy device.

8. Respondent's nurse's notes regarding the care he provided to Patient E.D. do not mention whether he suctioned the tracheostomy device at any time during his shift; do not document any tracheostomy care being provided; and do not contain any physical assessment of the patient.

9. At a minimum, Respondent should have performed and documented tracheostomy care, including but no limited to, frequency of suctioning, amount and color of sputum suctioned, cleaning of the tracheostomy device, oral hygiene, and method of communication with the patient. Additionally, Respondent should have performed and documented a physical assessment of the patient that included respiratory rate and effort, color, pulse rate, and exertional level.

10. Respondent should have monitored and followed up on Patient E.D.'s vital signs because the patient's pulse rate was high normal as occurs in cases of compromised respirations and the rate of respiration was 24 per minute (normal is 12-18). Oxygen saturation should have been determined at the beginning of the shift and any deviation from that baseline should have been monitored, especially when the patient showed signed of hypoxia (low oxygen).

11. On or about July 15, 2003, the department attempted to contact the Respondent by mail to give Respondent notification of the pending investigation, a copy of the Uniform Complaint Form, and supporting documentation. This notification letter was sent to Respondent's then address of record. The notification letter was sent to Respondent's then address of record. This notification was returned to the department by U.S. Postal Service on July 29, 2003, marked, "no forward order on file, unable to forward."

12. On or about August 5, 2003, the department forwarded the notification letter to P.O. Box 99, High Springs, Florida, an address that was provided from the Department of Highway Safety and Motor Vehicles.

> 13. On or about October 3, 2003, the Respondent finally updated his official address of record to his correct address.

44. Count One of the Administrative Complaint accuses Respondent of violating Section 464.018(1)(n), Florida Statutes (2002), which states:

> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (n) Failing to meet minimum standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified by training or experience.

45. Count Two of the Administrative Complaint accuses Respondent of violating Section 464.018(1)(h), Florida Statutes (2002), referring to:

> Unprofessional conduct, as defined by board rule.

46. The Board rule referred to in Count Two is Florida Administrative Code Rule 64B9-8.005(1)(e) which states:

> (1) Unprofessional conduct shall include:
>
> * * *
>
> (e) Acts of negligence either by omission or commission.

47. Concerning Counts One and Two, Respondent is said to have violated the statute and rule in the following manner:

a. By failing to mention the tracheostomy in his end shift report and nurses notes;

b. By failing to provide or failing to document having provided tracheostomy care, including frequency of suctioning, amount and color of sputum suctioned, cleaning of the tracheostomy device, oral hygiene, and method of communication with the patient;

c. By failing to perform and document a physical assessment of the patient, including respiratory rate and effort, color, pulse rate, and exertional level;

d. By failing to monitor and follow up on Patient E.D.'s elevated pulse rate;

e. By failing to monitor and follow up on Patient E.D.'s elevated rate of respiration; and

f. By failing to determine a baseline for oxygen saturation for the patient at the beginning of the shift and failing to monitor the oxygen saturation when the patient showed signs of hypoxia (low oxygen).

48. Count Three accuses Respondent of violating Section 456.072(1)(k), Florida Statutes (2003), which states:

> The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
>
> * * *
>
> (k) Failing to perform any statutory or legal obligation placed on a licensee. . . .

49. The discipline that may be imposed for a violation of Section 456.072(1)(k), Florida Statutes (2003), is as set forth in Section 456.072(2), Florida Statutes (2003).

50. In relation to Count Three, Section 456.001(4), Florida Statutes, states:

> 'Health care practitioner' means any person licensed under . . . chapter 464 . . .

51. In relation to Count Three, Section 456.035, Florida Statutes (2003), states:

> (1) Each licensee of the department is solely responsible for notifying the department in writing of the licensee's current mailing address and place of practice, as defined by rule of the board or the department if there is no board. Electronic notification shall be allowed by the department; however, it shall be the responsibility of the licensee to ensure that the electronic notification was received by the department. A licensee's failure to notify the department of a change of address constitutes a violation of this section, and the licensee may be disciplined by the board or the department if there is no board.
>
> (2) Notwithstanding any other law, service by regular mail to a licensee's last known address of record with the department constitutes adequate and sufficient notice to the licensee for any official communication to the licensee by the board or the department except when other service is required under s. 456.076.

52. Based upon the statutory references quoted in relation to Count Three, Respondent is accused of the failure to notify the Petitioner in writing of his current mailing address and place of practice.

53. References in Count One through Count Three to the Florida Statutes and Florida Administrative Code concerning the text within those references have remained constant from the time that the events were alleged to have occurred until the present, notwithstanding revisions to Florida Statutes or the Florida Administrative Code.

54. Clear and convincing evidence has been presented to find Respondent in violation of Counts One and Two. Respondent failed to meet minimal standards of acceptable and prevailing nursing practice and engaged in unprofessional conduct through a negligent act of omission in carrying for Resident E.D. The facts found and the opinion testimony offered by Ms. Mills form the basis for this conclusion, when compared to the underlying allegations in the Administrative Complaint which are referenced in these conclusions of law.

55. Clear and convincing evidence has been presented to establish the violation alleged in Count Three. Respondent failed to comply with the requirements to maintain his current mailing address with Petitioner as required by Section 456.035, Florida Statutes (2003), and by this failure did not perform a statutory obligation placed upon him in violation of Section 456.072(1)(k), Florida Statutes (2003).

56. Having found the violations, discipline may be imposed pursuant to Section 456.072(2), Florida Statutes (2002), and Section 456.072(2), Florida Statutes (2003).

RECOMMENDATION

Upon consideration of the facts found and the conclusions of law reached, it is

RECOMMENDED:

That a final order be entered finding Respondent in violation of those provisions of law set forth in Counts One through Three, calling for a written reprimand for those violations, imposing an administrative fine of $500.00, and placing Respondent on probation for a period of two years.

DONE AND ENTERED this 24th day of May, 2005, in Tallahassee, Leon County, Florida.

S

CHARLES C. ADAMS
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 24th day of May, 2005.

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.