STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING, Petitioner, vs. GAIL KING DELLINGER, R.N., Respondent.	)	Case No. 05-3217PL

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on March 21 and 22, 2006, in Viera, Florida, before Susan B. Harrell, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Kathryn E. Price, Esquire
Diane Kiesling, Esquire
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Bureau of Practitioner Regulation
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For Respondent: William F. Sutton, Jr., Esquire
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STATEMENT OF THE ISSUES

Whether Respondent violated Subsections 464.018(1)(h) and 464.018(1)(n), Florida Statutes (2002);

Subsection 456.072(1)(n), Florida Statutes (2002 and 2003); and Florida Administrative Code Rules 64B9-8.005(1) and 64B9-8.005(2), and, if so, what discipline should be imposed.

PRELIMINARY STATEMENT

On January 31, 2005, Petitioner, Department of Health, Board of Medicine (Department) filed a three-count Administrative Complaint against Respondent, Gail King Dellinger, R.N. (Ms. Dellinger), alleging that she violated Subsections 464.018(1)(h) and 464.018(1)(n), Florida Statutes (2002); Subsection 456.072(1)(n), Florida Statutes (2002 and 2003); and Florida Administrative Code Rules 64B9-8.005(1) and 64B9-8.005(2). Ms. Dellinger requested an administrative hearing, and the case was forwarded to the Division of Administrative Hearings on September 6, 2005, for assignment of an administrative law judge to conduct the final hearing. The case was originally assigned to Administrative Law Judge Charles C. Adams, but was reassigned to Administrative Law Judge Susan B. Harrell, who conducted the final hearing.

The final hearing was scheduled for November 28, 2005. Ms. Dellinger requested a continuance, which was granted by an order dated November 4, 2005, rescheduling the final hearing for December 20, 2005. The parties jointly requested a continuance, which was granted, and the final hearing was rescheduled for

February 9, 2006. Ms. Dellinger again requested a continuance, and the final hearing was rescheduled for March 21 and 22, 2006.

On March 20, 2006, the Department filed Petitioner's Motion to Take Official Recognition, requesting that official recognition be taken of the following: Florida Administrative Code Rule 64B9-8.005, effective March 23, 2000, to February 16, 2002; Florida Administrative Code Rule 64B9-8.005, effective February 17, 2002, to the present; Florida Administrative Code Rule 64B9-8.006, effective May 8, 2000 to May 1, 2002; Florida Administrative Code Rule 64B9-8.006, effective May 2, 2002, to January 11, 2003; and Florida Administrative Code Rule 64B9-8.006, effective January 12, 2003, to February 21, 2004. The motion was granted, and official recognition was taken of the above-referenced rules.

At the final hearing, the Department called the following witnesses: Kyle Anderson, M.D.; Dave Madsen; Doris Spivy; Velma Pellot; Penny Dalton; Gail King Dellinger; Lija Scherer; Dr. Jay Olsson; and Harriet Brinker, R.N. Petitioner's Exhibits 1 through 3, 4B through 4D, 6, 7, 8 (testimony of Dr. Jay Olsson only), 9 through 11, and 13 were admitted in evidence. Petitioner's Exhibits 4F, 4G, 5, and 12 were proffered.

At the final hearing, Ms. Dellinger testified in her own behalf and called Christina Deal and Francis Mallamaci as her

witnesses. Respondent's Exhibits 3, 4, and 7 were admitted in evidence.

The three-volume Transcript of the final hearing was filed on April 27, 2006. The parties timely filed their proposed recommended orders, which have been considered in rendering this Recommended Order.

FINDINGS OF FACT

1. The Department is the state agency charged with regulating the practice of nursing in Florida pursuant to Section 20.43 and Chapters 456 and 464, Florida Statutes (2005).

2. At all times material to the proceeding, Ms. Dellinger was a licensed registered nurse in the State of Florida, having been issued license number RN 2837932. She currently resides in South Carolina.

3. At all times material to this proceeding, Ms. Dellinger was the owner and operator of the Gail K. Dellinger Adult Family Care Home, d/b/a King Manor, at 3515 Fell Road, Melbourne, Florida (King Manor).

4. King Manor was an adult family care home (AFCH), which is required to be operated in accordance with Chapter 400, Florida Statutes (2005), and Florida Administrative Code Chapter 58A-14. AFCHs are licensed by the Agency for Health Care Administration (AHCA).

5. During the period of April 8, 2003, up to and including May 16, 2003, an 88-year-old female, J.E., resided at King Manor.

6. On or about April 8, 2003, patient J.E. was approved to live at King Manor after being evaluated by Kyle Anderson, M.D. (Dr. Anderson), a physician who was J.E.'s primary care physician. At the time of her admission to King Manor, J.E. had medical issues and history that included myocardial infarction, coronary artery disease, hypertension, peripheral vascular disease, a low thyroid condition, Alzheimer's dementia, chronic back pain from compression fractures, a seizure disorder, and a right below-the-knee amputation.

7. At the time J.E. was admitted to King Manor, she was prescribed medications including: Imdur, NORVASC, Lopressor, Levothroid, Aricept, Miacalcin, Seroquel, Coumadin, Dilantin, and Lortab. Imdur is a nitrous preparation for coronary disease. NORVASC is an antihypertensive medication. Lopressor is a beta blocker, which decreases the heart rate and lowers the blood pressure. Levothroid is a thyroid supplement for low thyroid. Aricept is a medication for Alzheimer's dementia. Miacalcin is a nose spray used for osteoporosis. Seroquel is a mild-to-moderate antipsychotic medication, used in the elderly often times for agitation. Coumadin is a blood thinner. Lortab

is a pain medication for chronic back pain. Dilantin is an antiseizure medication.

8. Upon admission to King Manor on April 8, 2003, the Seroquel was not among J.E.'s medications. Not taking Seroquel would have increased J.E.'s agitation and confusion. Penny Dalton, the daughter of J.E., had her husband deliver the Seroquel to King Manor toward the end of the week in which J.E. was admitted to King Manor. The inventory of J.E.'s possessions conducted by the Brevard County Sheriff's Department and signed by Respondent included Seroquel. The evidence is not clear and convincing that J.E. had any Seroquel at King Manor on April 11.

9. On the afternoon of Friday, April 11, 2003, J.E. became very agitated and anxious. J.E. demanded that she be given something. Ms. Dellinger called Dr. Anderson's office and got a recorded message. Ms. Dellinger testified that the recorded message said if it was an emergency to call 911 and that any prescription refills could not be done for 72 hours.
Ms. Dellinger's testimony is not credible. Dr. Anderson is on call for his patients, and, if Ms. Dellinger wanted to speak to Dr. Anderson, all she had to do was hold the line until the answering service picked up the call. The answering service would have contacted Dr. Anderson.

10. Dr. Jay Olsson (Dr. Olsson) acted as the King Manor medical director. He had previously seen J.E. as a patient

through his medical group and had access to King Manor residents' patient files. After listening to the recorded message from Dr. Anderson's office, Ms. Dellinger called Dr. Olsson to obtain a prescription for Ativan for J.E. She followed her telephonic request with a written request to Dr. Olsson, which stated:

> Request to administer 0.5 Ativan BID/PRN in place of Seroquel 25 MG-BID. Daughter to bring Pt's meds from home. Administer only (4/13-4/14-4/15). Pt. to follow up with primary MD. Anderson on 4/17/03. Pt is anxious, and unable to sleep. Thank you, Gail. Verbal order--4/11/03.

At the bottom of the written request was typed or printed "Gail K. Dellinger, R.N."

11. Dr. Olsson verbally ordered Ativan for J.E., a prescription medication designed to relieve anxiety, on a per need basis for three days, April 13, 14, and 15, 2003, and signed the written request after the verbal order was given.

12. Ms. Dellinger told Dr. Olsson that she could not leave King Manor to get the prescription filled and that one of the residents had a supply of Ativan. Although Dr. Olsson does not recall whether he told Ms. Dellinger that she could get an Ativan from the other resident's supply until the prescription could be filled, he did not think that anything was wrong with borrowing from the other resident. Ms. Dellinger took three Ativan pills from the prescription supply of J.B., another King

Manor resident, and placed them in J.E.'s pill dispenser. Ms. Dellinger witnessed J.E. take at least one Ativan.

13. Ms. Dellinger testified that the following day, which would have been a Saturday, J.E. went to the daycare facility taking her pill dispenser with the Ativan in it. However, Ms. Dellinger also testified that J.E. only went to the daycare on Tuesdays and Fridays. According to Ms. Dellinger, J.E.'s daughter found out about the Ativan from the daycare facility and told Ms. Dellinger that she did not want her mother to take the Ativan. Ms. Dellinger testified that she called Health South and told them that the prescription would not be filled.

14. Ms. Dellinger's testimony is not credible. The request for the Ativan was made on April 11, 2003, but the written confirmation of the verbal order showed that the Ativan was to be administered only on April 13, 14, and 15. Thus, if the written order was correct, Ms. Dellinger should not have given J.E. an Ativan until Sunday. However, it is clear that Ms. Dellinger gave J.E. an Ativan from J.B.'s supply on Friday, April 11, 2003. Additionally, Ms. Dalton could not have been made aware by the day care facility on Saturday, April 12, 2003, that J.E. had the Ativan because J.E. did not go to daycare on Saturdays. Thus, she could not have told Ms. Dellinger on April 12, 2003, that she did not want her mother to take Ativan,

and Ms. Dellinger would have no reason to inform Health South that the prescription would not be filled.

15. J.E. saw Dr. Anderson on April 17, 2003. Ms. Dellinger accompanied J.E. to Dr. Anderson's office, and Ms. Dalton was also present during the visit. Dr. Anderson advised Ms. Dellinger that he was J.E.'s primary care physician and that he wanted to be contacted when there was a change of J.E.'s status. He additionally advised Ms. Dellinger that he was to be the physician prescribing medications for J.E.

16. Ms. Dellinger did not tell Dr. Anderson during the visit on April 17 that Dr. Olsson had prescribed Ativan for J.E. or that J.E. had taken an Ativan.

17. The office records of Dr. Olsson revealed that on April 15, 2003, Ms. Dellinger called Dr. Olsson's office and asked Dr. Olsson to "Please go evaluate pt [J.E.] & take over care." Ms. Dellinger also neglected to tell Dr. Anderson on April 17, 2003, that she had asked Dr. Olsson to take over the care of J.E. Dr. Olsson's records indicate that John Stacy, a physician's assistant, would go and evaluate J.E. on April 21, 2003.

18. Mr. Stacy did go and evaluate J.E. on April 21, 2003. His notes indicate that J.E. was "doing well at this time with no acute problems." Mr. Stacy also wrote the following in the summary of his evaluation:

> We are making arrangements for routine follow-up. She is going to have a PT/INR and Dilantin level each month. We are getting a urinalysis today because of her history of frequent urinary tract infections and some complaints of dysuria. We will be following her at this facility as necessary.

Dr. Olsson countersigned the initial evaluation notes made by Mr. Stacy. It is clear that Ms. Dellinger wanted Dr. Olsson to take over the care of J.E., even after Dr. Anderson had informed her that he was J.E.'s primary care physician.

19. J.E. went to her daughter's house during the last weekend in April 2003. When she returned to King Manor on the following Monday, J.E. had a pressure sore on her right stump. Ms. Dalton indicated that she had an appointment the following day to have the sore evaluated. The following day J.E. was seen by Roy McMurray at Brevard Prosthetics. According to Dr. Anderson's records, Mr. McMurray requested a prescription for a stump shrinker for J.E., which prescription Dr. Anderson signed on May 1, 2003.

20. Ms. Dellinger testified that although Ms. Dalton had relayed the method of treatment of the pressure sore that she was given by Brevard Prosthetics, she would not carry out those treatments and that she did not agree with the use of a stump shrinker. Ms. Dellinger testified that she contacted Dr. Olsson's office to come and take a look at J.E. on April 30, 2003. According to Ms. Dellinger, Mr. Stacy came out and gave

her orders for the treatment of the pressure sore. Again, Ms. Dellinger's testimony is not credible. There is no indication in the medical records that Mr. Stacy came to see J.E. on April 30, 2003, in relation to her pressure sore. The first record of Dr. Olsson which referred to the treatment of the pressure sore was a verbal order on May 6, 2003, from Dr. Olsson. Dr. Olsson's records indicate that he visited J.E. at King Manor on May 7, 2003, concerning her pressure sore.

21. On May 5, Dr. Anderson saw J.E. to evaluate the wound on her stump. Dr. Anderson prescribed clindamycin, an antibiotic and saline wet-to-dry dressing with changes twice a day. It is clear that Ms. Dellinger was not willing to follow the orders of J.E.'s primary care physician and took upon herself to get Dr. Olsson involved in the care of J.E.

22. On or about May 8, Petitioner faxed Dr. Olsson requesting J.E. be provided with a prescription for Klonipin or Ambien as a sleep aid and for anxiety. Ambien is a controlled substance used in the treatment of insomnia. Dr. Olsson prescribed Ambien for J.E. The Ambien prescription for 30 tablets was filled on May 9, 2003.

23. J.E. died on May 16, 2003. After her death, the Brevard County Sheriff's deputies compiled an inventory sheet, listing J.E.'s medications, which included 18 Ambien tablets.

24. Dr. Anderson was unaware that Dr. Olsson had been treating J.E., while she was a resident at King Manor, until after her death.

25. Respondent met M.R. when M.R. was a resident at Health South Sea Pines (Sea Pines). Respondent served as staff nurse for M.R. during her stay at Sea Pines. M.R. was discharged and entered into a nursing home. Respondent knew that M.R. was paying for her nursing home care with her own funds. Respondent visited M.R. at the nursing home and knew that M.R. did not want to go back to her own home. In February 2003, M.R. became a resident of King Manor and resided there until the facility was closed.

26. On or about June 6, 2003, AHCA placed King Manor on a resident admissions moratorium which prevented King Manor from admitting new residents. Ms. Dellinger informed the King Manor residents, including M.R., of the AHCA moratorium and its possible effects on King Manor which could include the closing of the facility.

27. Ms. Dellinger borrowed money from M.R., totaling at least $11,500. In September 2003, a check for $8,000 was issued to Ms. Dellinger from M.R.'s account, and, in November 2003, a check for $3,500 was issued to Ms. Dellinger from M.R.'s account. Ms. Dellinger orally agreed to repay the loan through

a reduction of M.R.'s monthly payment. There are no written agreements or records regarding the loan.

28. In late January or early February 2004, an arrest warrant/Notice to Appear was issued for the charge of exploitation of an elderly person regarding the loans from M.R. to Ms. Dellinger. At the time of the warrant, $1,000 had been repaid. At the time of the final hearing in the instant proceeding, all money had been repaid.

29. During the period of November 16, 2003, through December 9, 2003, Ms. Dellinger was in South Carolina and was physically absent from the State of Florida. She left John Harrison Brown (Mr. Brown), a certified nursing assistant, to care for the King Manor residents. At this time, King Manor had three residents: W.R., M.R., and L.M.R. W.R., a male resident, had a catheter and was very frail. Mr. Brown had to help W.R. with all his daily activities. The two female residents, M.R. and L.M.R., needed considerably less care and could do most of their daily activities.

30. Mr. Brown became distraught and contacted Ms. Dellinger around 2 a.m. on December 9, 2003. He told her that he was "freaking" and could not do the job anymore because of the pressure of being responsible for the residents while Ms. Dellinger was away. He told Ms. Dellinger that he was "ready to do something to himself," meaning that he was

suicidal. Ms. Dellinger could tell from the conversation that Mr. Brown had been drinking. Her response to the situation was to tell Mr. Brown to take an Ativan.

31. Mr. Brown contacted sheriff's deputies on December 9, 2003, to come and get him. He advised deputies that he drank beer in violation of probation and asked the deputies to come and take him to jail. On December 9, 2003, Mr. Brown was arrested at King Manor, taken to jail, and charged with violation of probation. Sometime during his incarceration, Mr. Brown was found dead hanging in his jail cell.

32. Harriet Brinker, R.N. (Ms. Brinker), was accepted as an expert in nursing, specializing in geriatric care. Ms. Brinker opined that Ms. Dellinger failed to meet the standards of professional conduct when she failed to inform Dr. Anderson that J.E. had been prescribed and administered Ativan and Ambien. It was Ms. Brinker's opinion that Ms. Dellinger was negligent when she requested a prescription for Ambien by name because she was placing herself at the level of a physician and determining what medication needed to be prescribed. Ms. Brinker further opined that Ms. Dellinger failed to meet the standards of professional conduct by requesting the prescription for Ambien when J.E. had not been examined by Dr. Olsson. It should be noted that Dr. Olsson had examined J.E. the day before he prescribed the Ambien.

Ms. Brinker also opined that Ms. Dellinger failed to meet the standards of professional conduct by calling a doctor who was not the primary care physician when Dr. Anderson had advised Ms. Dellinger that he was to be the physician prescribing medications for J.E. It was also Ms. Brinker's opinion that Ms. Dellinger was guilty of unprofessional conduct by leaving the three residents in Mr. Brown's care while she was in South Carolina. The care that the residents needed would have had to have been provided by a licensed practical nurse and not a certified nursing assistant.

33. Ms. Brinker opined that Ms. Dellinger practiced below the minimal standards of acceptable prevailing nursing practice and misappropriated drugs when she removed Ativan from the supply of another resident and gave the pills to J.E. It was Ms. Brinker's opinion that Ms. Dellinger failed to meet the standard of care when she requested a specific medication from Dr. Olsson, when she knew that Dr. Anderson was J.E.'s primary care physician. She was of the opinion that Ms. Dellinger negligently administered Ambien to J.E. because Respondent exposed J.E. to a higher level of risk by not knowing how Ambien would interact with the medication regimen Dr. Anderson had prescribed for J.E. Ms. Brinker opined that Ms. Dellinger put herself at the level of a physician when she requested and obtained Ambien for J.E.

CONCLUSIONS OF LAW

34. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. §§ 120.569 and 120.57, Fla. Stat. (2005).

35. The Department has the burden to establish the allegations in the Administrative Complaint by clear and convincing evidence. Department of Banking and Finance v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996). In Slomowitz v. Walker, 429 So. 2d 797 (Fla. 4th DCA 1983), the court developed a working definition of "clear and convincing evidence," which has been adopted by the Florida Supreme Court in In re Davey, 645 So. 2d 398 (Fla. 1994). The court in Slomowitz stated:

> [C]lear and convincing evidence requires that 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.

Slomowitz, 429 at 800.

36. The Department alleged that Ms. Dellinger violated Subsection 464.018(1)(h), Florida Statutes (2002), which provides that disciplinary action may be taken for

"[u]nprofessional conduct, as defined by board rule." Florida Administrative Code Rule 64B9-8.005(1)(e) provides that unprofessional conduct shall include "[a]cts of negligence either by omission or commission." The Department alleged in the Administrative Complaint that Ms. Dellinger committed unprofessional conduct in the following ways:

> a. On or about April 17, 2003, and thereafter, Respondent negligently failed to inform Patient J.E.'s primary care physician of a change in Patient J.E.'s medications, specifically that Patient J.E. had been prescribed and administered Ativan;
> b. Respondent negligently obtained a prescription for Ambien and began administering Ambien to Patient J.E. after having been advised that Patient J.E.'s primary care physician did not want sleeping pills/medication to be given to Patient J.E. because it could mask symptoms related to an infection in Patient J.E.'s stump.
> [c.] Respondent committed unprofessional conduct by negligently leaving Patients M.R., H.C., and W.R. under the care of a certified nursing assistant, Brown, who Respondent knew or had reason to know, was not qualified to provide the care and assistance required by these patients while she was absent from the state.

37. The Department has proven by clear and convincing evidence that Ms. Dellinger violated Subsection 464.018(1)(h), Florida Statutes (2002), and Florida Administrative Code Rule 64B9-8.005(1), by failing to advise Dr. Anderson that J.E. had been prescribed and taken Ativan. The Department did not establish that Dr. Anderson had told Ms. Dellinger not to

administer sleeping medications to J.E. because it would mask the symptoms of the pressure sore, but the Department did establish that Ms. Dellinger obtained the Ambien negligently by requesting the prescription from Dr. Olsson when she knew that Dr. Anderson was J.E.'s primary care physician and wanted to be the physician prescribing medications for J.E.

38. The Department did establish by clear and convincing evidence that Ms. Dellinger violated Subsection 464.018(1)(h), Florida Statutes (2002), by leaving Mr. Brown in charge of the residents at King Manor while Ms. Dellinger went to work in South Carolina for several weeks. The care needed by the residents, in particular W.R., warranted the care of at least a licensed practical nurse. Ms. Dellinger knew that Mr. Brown was a certified nursing assistant and was not trained to take care of the residents at the level of care which their conditions warranted.

39. The Department alleged in the Administrative Complaint that Ms. Dellinger violated Subsection 464.018(1)(n), Florida Statutes (2002), which provides that disciplinary action may be taken for the following act:

> (n) 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.

40. Florida Administrative Code Rule 64B9-8.005(2) provides that "[f]ailing to meet or departing from minimal standards of acceptable and prevailing nursing practice" includes the following:

> (b) Administering medications or treatments in a negligent manner; or
>
> * * *
>
> (n) Practicing beyond the scope of the licensee's license, educational preparation or nursing experience.

41. The Department alleged in the Administrative Complaint that Ms. Dellinger failed to meet or departed from the minimal standards of prevailing nursing practice by the following:

> a. Respondent misappropriated Ativan by removing and/or borrowing Ativan from the medication supply of another Patient and administering it to Patient J.E.;
> b. Respondent negligently administered Ambien to Patient J.E. despite instructions from J.E.'s primary care physician not to give Patient J.E. sleeping pills/medication because it could mask symptoms related to an infection in Patient J.E.'s stump;
> c. Respondent practiced beyond the scope of her license, educational preparation and or nursing experience, by circumventing Patient J.E.'s primary care physician and obtaining a prescription for Ambien and subsequently administering Ambien to Patient J.E., based on her professional judgment, despite instructions from Patient J.E.'s primary care physician not to give Patient J.E. sleeping pills/medication.

42. The Department has established by clear and convincing evidence that Ms. Dellinger failed to meet the minimal standards

of acceptable and prevailing nursing practice when she misappropriated three Ativan pills from J.B.'s medication supply and gave them to J.E. The Department did not establish that Dr. Anderson had told Ms. Dellinger not to give J.E. a sleeping medication because it would mask the symptoms of a pressure sore on J.E.'s stump. The Department did establish that Ms. Dellinger was trying to circumvent the care of J.E.'s primary care physician by contacting Dr. Olsson for prescriptions and medical evaluations when Dr. Anderson had told Ms. Dellinger that he was J.E.'s primary care physician and wanted to be contacted when there was a change in J.E.'s condition and that he wanted to be the physician prescribing the medications for J.E.

43. The Department alleged in the Administrative Complaint that Ms. Dellinger violated Subsection 456.072(1)(n), Florida Statutes (2002 and 2003), which provides that disciplinary action may be taken against a health care professional for "[e]xercising influence on the patient or client for the purpose of financial gain of the licensee or a third party." Specifically, the Department alleged that "Respondent exercised influence on Patient M.R. through the nurse-patient/client relationship and obtained loans in an amount exceeding $11,000 from Patient M.R. for the financial gain of the Respondent and/or a third party."

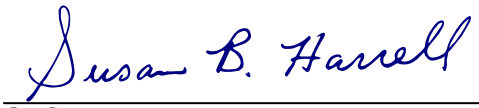
44. The Department failed to establish by clear and convincing evidence that Ms. Dellinger exercised influence on M.R. for Ms. Dellinger's financial gain. The evidence established that M.R. made a loan to Ms. Dellinger, but the evidence does not establish that Ms. Dellinger used her nurse-patient/client relationship as a way to influence M.R. to give her the loan.

RECOMMENDATION

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

RECOMMENDED that a final order be entered finding that Gail King Dellinger violated Subsections 464.018(1)(h) and 464.018(1)(n), Florida Statutes (2002), and Florida Administrative Code Rules 64B9-8.005(1) and 64B9-8.005(2), and did not violate Subsection 456.072(1)(n), Florida Statutes (2002 and 2003); imposing an administrative fine of $500; suspending her license for two years; and placing her on probation for three years after the suspension of her license on terms to be set by the Board of Nursing.

DONE AND ENTERED this 29th day of June, 2006, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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this 29th day of June, 2006.

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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.