STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING,	)	
Petitioner,	)	
vs.	)	Case No. 06-1423PL
DAVID CARPENTER, R.N.,	)	
Respondent.	)	

RECOMMENDED ORDER

Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings, conducted the final hearing in Vero Beach and Viera, Florida, on July 20 and 28, 2006.

APPEARANCES

For Petitioner: Ellen M. Simon
Assistant General Counsel
Department of Health
Prosecution Services Unit
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Tallahassee, Florida 32399-3265

For Respondent: David Carpenter, pro se
419 Sandpiper Drive
Satellite Beach, Florida 32937

STATEMENT OF THE ISSUES

The issues are whether Respondent is guilty of failing to meet the applicable standard of care with respect to acts and omissions involving two patients, in violation of Section

464.018(1)(n), Florida Statutes, and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

By Administrative Complaint dated November 30, 2004, Petitioner alleges that Respondent was a registered nurse at all material times, holding license number RN 2732432.

The Administrative Complaint alleges that Respondent was a registered nurse at Integrated Health Services in Vero Beach. He allegedly cared for R. F., who was a resident at the facility. The Administrative Complaint alleged that R. F.'s physician had ordered duo derm "dressings" for a reddened "area" on the coccyx that were to be changed every three days. The Administrative Complaint alleges that, on June 30, 2002, the dressing was scheduled to be changed, and Petitioner worked the 11:00 p.m. to 7:00 a.m. shift. The Administrative Complaint alleges that, on July 1, 2002, Respondent recorded on the wound treatment and progress record that he changed the dressing. The Administrative Complaint alleges that, on July 3, 2002, the wound nurse found that the dressing on R. F.'s coccyx wound bore a date of June 27, 2002, indicating that it had not been changed on July 1.

The Administrative Complaint alleges that J. R. was a resident on October 24, 2002. The Administrative Complaint alleges that a physician issued an order at about 3:00 p.m. for

the intravenous administration of potassium supplement. The Administrative Complaint alleges that Respondent was assigned to work the 11:00 p.m. to 7:00 a.m. shift as the shift supervisor. The Administrative Complaint alleges that the responsibilities of the shift supervisor included auditing all patient charts for new orders and ensuring that the orders are implemented. The Administrative Complaint alleges that, during the evening of October 24 and morning of October 25, Respondent did not start or attempt to start the potassium or ensure that someone else started or attempted to start the potassium.

Count One of the Administrative Complaint alleges that Section 464.018(1)(n), Florida Statutes, authorizes the Board of Nursing to impose discipline for a failure to meet the minimal standards of acceptable and prevailing nursing practice. Count One alleges that Florida Administrative Code Rule 64B9-8.005(2)(a) provides that the failure to meet the minimal standards of acceptable and prevailing nursing practice includes falsifying or altering records or nursing progress notes. Count One alleges that Respondent failed to meet the applicable standards by falsely noting in R. F.'s wound treatment and progress record that he had changed the wound dressing.

Count Two of the Administrative Complaint alleges that Florida Administrative Code Rule 64B9-8.005(2)(b) provides that the failure to meet the minimal standards of acceptable and

prevailing nursing practice includes administering medications or treatments in a negligent manner. Count Two alleges that Respondent failed to meet the applicable standards by failing to change R. F.'s wound dressing and failing to start J. R.'s intravenous potassium administration. (Count Two contains a third ground, but it applies to another resident for whom Petitioner presented no evidence.)

At the hearing, Petitioner called four witnesses and offered into evidence 12 exhibits: Petitioner Exhibits 1-10 and 12-14. Respondent called no witnesses and offered into evidence three exhibits: Respondent Exhibits 1-3. All exhibits were admitted except Petitioner Exhibit 8 and Respondent Exhibits 1 and 3, which were proffered.

The court reporter filed the transcript on August 31, 2006. Petitioner filed a proposed recommended order on September 11, 2006. Respondent filed a letter on August 31, 2006.

FINDINGS OF FACT

1. At all material times, Respondent has been a licensed registered nursing in Florida, holding license number RN 2732432. At all material times, he was employed as a registered nurse at Integrated Health Services in Vero Beach, Florida.

2. In June and July 2002, R. F. was a resident of Integrated Health Services. She had wounds to both buttocks.

On June 7, 2002, her physician ordered the application of duo derms to each wound and ordered that the dressing be changed at least every three days, or more frequently, if needed.

3. The wound treatment and progress records for both wounds are identical forms that require the nurse tending the wound to describe it, by abbreviations, in terms of drainage, general appearance, and surrounding skin and then to initial the notes. The initialing of the form signifies that the nurse also has changed the dressing, not just described the wound, as it would be impossible to view the wound without removing the old dressing. The form on which this information is recorded is divided into days, so that the date of the activity is clear on the completed form.

4. The forms in this case for the June treatments of these wounds show that licensed practical nurse Kathleen Ertle described each wound on June 7. The only difference between them was that the wound on the right buttock was dry and pink, and the wound on the left buttock was moist and red. Three days later, on June 10, Respondent changed each dressing, and described each wound appropriately--by now, both wounds were moist, red, and macerated. Two days later, Nurse Ertle changed the dressings and described the wounds as unchanged from two days earlier. The following day, June 13, Respondent changed the dressings and described the wounds as unchanged.

5. Three days later, on June 16, Respondent changed the dressings and described the wounds as unchanged. On June 18, he changed the dressings, and this time described the left wound as dry, but the right wound as moist. Three days later, on June 21, Respondent changed the dressings and described both wounds as dry and pink, not red.

6. The June 24 entry on wound treatment and progress record for both wounds is a little confusing, but the confusion does not appear to have contributed to the violations in this case. Respondent entered a description of each wound--again, dry, pink, and macerated--but overwritten on this entry are: "healed" and "ERROR." It is unclear who wrote these entries or what is identified as erroneous--Respondent's initial description or that the wounds are healed.

7. The next entry for either wound is by Nurse Ertle who, on June 27, described the left wound as macerated, red, and reddened. On June 28, Nurse Ertle made entries for both wounds, describing each as macerated, red, and reddened. There are no more entries for June.

8. The next entry is July 1 and is made by Respondent, who described the wounds as dry, pink, and macerated. On July 3, each wound bears two entries. At the top is an entry by Respondent, describing each wound as dry, pink, and macerated.

Beneath these entries are entries by Nurse Ertle, describing each wound as dry, red, and reddened.

9. The next entry for each wound is July 5, on which Respondent described each wound as unchanged from his preceding description. The last entry for each wound is July 8, at which time Respondent described each wound as still unchanged. The wound treatment and progress record for the left wound bears an additional notation to discontinue wound treatment. Neither record, though, bears additional entries as to wound care, and both wounds were subsequently treated by a special air-pressure mattress.

10. The problems as to R. F. arose when, on July 3, Nurse Ertle examined the wounds and the dressings. Nurses routinely mark the date of application on the exterior of the dressing. Instead of finding "July 1" on the dressing on the right-buttock wound, Nurse Ertle found the date, "June 28." This finding was inconsistent with the above-described entries in the records.

11. Petitioner proved that Respondent failed to change the right-buttock dressing on July 1. As evidenced by his notation on the record, Respondent had undertaken the duty to change the dressing on July 1, and the evidence is clear that he failed to do so, at least as to the right buttock.

12. Petitioner also proved that Respondent made the July 1 entry in an attempt to falsify or alter the records. Initially,

it seemed at least as likely that Respondent made the entry in advance of changing the dressing, intending to do so, and merely forgot to do so. (Even if such advance recording of nursing activity is improper, it is not an act with which Respondent is charged.) However, Petitioner's nursing expert, Katherine Johnson, pointed out that the charting could not have been an innocent mistake, such as by charting before changing the dressing, because Respondent charted the condition of the wound, which he could not have seen without removing the dressing. Although Petitioner charged Respondent with falsification of the records that he changed the dressing, not that he falsely described the wound, evidence of fraudulent intent in describing the wound tends to establish fraudulent intent in recording that he had changed the dressing.

13. However, Petitioner failed to prove that Respondent's act and omission caused significant harm to R. F. Nurse Ertle testified on direct that the wound deteriorated from Stage I to Stage II between June 28 and July 3, but later testified, on cross-examination, that the deterioration had taken place before June 27. Shortly after the introduction of the special mattresses, both wounds healed.

14. At 3:00 p.m. on October 24, 2002, an advanced registered nurse practitioner (ARNP) ordered the intravenous administration of potassium to J. R., who was a patient at

Integrated Health Services. The purpose of the order was to treat hypernatremia. This order was received by a nurse working the 3:00 p.m. to 11:00 p.m. shift. However, neither she nor any other nurse on this shift attempted to start the IV, which was only started at 6:45 a.m. on October 25.

15. Respondent arrived at Integrated Health Services at 11:00 p.m., at which time he served as the shift supervisor. The record fails to establish that any nurse on the preceding shift had documented the ARNP's order, such as in the nurse's notes, in such a way that Respondent reasonably could have found it and taken appropriate action on the order, either starting the IV or calling the ARNP and explaining what had happened and stating when the IV could be started. Furthermore, Petitioner's nursing expert, Katherine Johnson, testified that the duty of ensuring that the IV had been started or the ARNP informed of the failure fell to the nurse who took the orders and her shift supervisor, and the duty of auditing the records to ensure that orders were carried out by the preceding shift belonged to the nurse assigned to the patient. In no instance did Ms. Johnson assign the duty of auditing as belonging to the subsequent shift supervisor, Respondent.

CONCLUSIONS OF LAW

16. The Division of Administrative Hearings has jurisdiction over the subject matter. §§ 120.569 and 120.57(1), Fla. Stat. (2006).

17. Section 464.018(1)(n), Florida Statutes, authorizes the Board of Nursing to impose discipline for "[f]ailing 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."

18. Florida Administrative Code Rule 64B9-8.005(2) provides, in part:

> (2) Failing to meet or departing from minimal standards of acceptable and prevailing nursing practice shall include, but not be limited to, 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[.]

19. Petitioner must prove the material allegations by clear and convincing evidence. Department of Banking and Finance v. Osborne Stern and Company, Inc., 670 So. 2d 932 (Fla. 1996) and Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

20. Petitioner has proved by clear and convincing evidence separate violations of Florida Administrative Code Rule 64B9-8.006(2)(a) and (b) in the above-described act and omission of Respondent in the care of R. F. However, as to J. R.,

Petitioner failed to prove that Respondent had a duty to audit the records.

21. For a first offense, Florida Administrative Code Rule 64B9-8.006(3)(oo) provides a penalty range of a $250 fine to a $500 fine with suspension followed by probation for a violation of Rule 64B9-8.006(2)(a). For a first offense, Florida Administrative Code Rule 64B9-8.006(3)(pp) provides the same penalty range for a violation of Rule 64B9-8.006(2)(b).

22. According to the record, Respondent has not previously been disciplined. Petitioner failed to prove that the act and omission of which Respondent is guilty significantly impacted the patient's health, although, in general, the failure to change a dressing poses the risk of skin breakdown in the case of a vulnerable patient such as R. F. The greater aggravating factor, though, is that Respondent is guilty of the act of falsely entering in the records that he changed the dressing and the omission of failing to change the dressing. Either offense, alone, would have posed little, if any, risk to the patient, but, by combining the failure to change the dressing with a false entry that the dressing had been changed, Respondent effectively prevented others from intervening sooner to ensure that the dressing was changed when it needed to be changed.

RECOMMENDATION

It is

RECOMMENDED that the Board of Nursing enter a final order finding Respondent guilty of two violations of Florida Administrative Code Rule 64B9-8.006(2) and imposing an administrative fine of $1000.

DONE AND ENTERED this 19th day of September, 2006, in Tallahassee, Leon County, Florida.

ROBERT E. MEALE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 19th day of September, 2006.

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 must be filed with the agency that will issue the final order in this case.