STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING,

Petitioner,

vs. Case No. 19-5216PL

JANINE MARIE LEONARD, R.N.,

Respondent.
_____/

RECOMMENDED ORDER

A disputed-fact evidentiary hearing was held on December 5, 2019, before Elizabeth W. McArthur, Administrative Law Judge with the Division of Administrative Hearings (DOAH), by video teleconference at sites in Sarasota and Tallahassee, Florida.

APPEARANCES

For Petitioner: Kimberly Lauren Marshall, Esquire
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For Respondent: Sara A. Bazzigaluppi, Esquire
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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent misappropriated hydromorphone, morphine, a syringe, a needle,

and/or tubing from her employer and whether Respondent possessed or attempted to possess controlled substances for illegitimate purposes, in violation of the statutes and rule charged in the Administrative Complaint; and, if so, what penalty should be imposed.

## PRELIMINARY STATEMENT

On March 7, 2018, the Department of Health (Department or Petitioner) filed a two-count Administrative Complaint before the Board of Nursing (Board) against Janine Marie Leonard, R.N. (Respondent). The first count alleged that Respondent engaged in unprofessional conduct in violation of section 464.018(1)(h), Florida Statutes (2017),[1/] as defined in Florida Administrative Code Rule 64B9-8.005(2), by misappropriating drugs, supplies, and/or equipment. The second count alleged that Respondent violated section 464.018(1)(i) by engaging or attempting to engage in the possession, sale, or distribution of controlled substances for illegitimate purposes.

In an Election of Rights form and an Answer to the Administrative Complaint, Respondent timely disputed the allegations and requested a disputed-fact hearing. The Department transmitted the matter to DOAH on October 1, 2019, for the assignment of an administrative law judge to conduct the requested hearing.

Pursuant to the joint request of the parties, the hearing was set for December 5 and 6, 2019, by video teleconference with sites in Sarasota and Tallahassee.

Prior to the hearing, the parties filed a Joint Pre-hearing Stipulation in which they stipulated to several facts. The stipulated facts have been incorporated in the Findings of Fact below to the extent relevant.

One day before the hearing, Respondent filed a motion in limine and motion for costs. The motions were addressed at the outset of the hearing, and were denied for reasons set forth in the hearing record.

At the hearing, Petitioner presented the testimony of the following witnesses: Marlena (Joie) Monroe, R.N.; Tracey Taylor, R.N.; Mary Kay Butterfield, R.N.; Dawn Beljin, R.N.; and Joseph Pietranton, R.Ph. Petitioner's Exhibits 1, 3 through 6, 10, and 11 were admitted into evidence.[2/] Petitioner provided redacted and unredacted sets of its exhibits, with the redacted set obliterating confidential information. The unredacted set of exhibits will be placed in a sealed envelope labelled to indicate the confidential nature of the contents.

Respondent testified on her own behalf and also presented the testimony of Crystal Oliver, C.N.A. Respondent's Exhibit 2 was admitted into evidence.

The evidentiary hearing was completed in one day. At the conclusion, the parties requested 20 days from the filing of the hearing transcript to submit proposed recommended orders (PROs), which was granted.[3/] The one-volume hearing Transcript was filed December 13, 2019. The parties timely filed their PROs, which have been carefully considered in the preparation of this Recommended Order.

## FINDINGS OF FACT

1. The Department has regulatory jurisdiction over the practice of nursing pursuant to section 20.43 and chapters 456 and 464, Florida Statutes. In particular, the Department is authorized to file and prosecute an administrative complaint against a nurse after a probable cause panel (PCP) of the Board determines there is probable cause to suspect a licensee has committed a disciplinable offense, and direction is given by the PCP to the Department on the filing of an administrative complaint.

2. At all times material to the allegations in the Administrative Complaint, Respondent was licensed to practice nursing in Florida as a registered nurse, having been issued license number RN 9344420.

3. The allegations arose from an incident occurring while Respondent worked at Regional Bayfront Health, a hospital in

Venice, Florida. Respondent worked the night shift, from 7:00 p.m. to 7:00 a.m.

4. On the night shift spanning September 28, 2017, to September 29, 2017, Respondent worked as a floor nurse in "Two North," which is the orthopedic and neurological postsurgical unit.

5. The other floor nurse working the night shift with Respondent in Two North was Marlena (often referred to by her nickname, "Joie" or "Joei") Monroe, also a registered nurse.

6. The nurses' station for Two North was behind a long counter facing the elevators, so that someone getting off an elevator at Two North would be standing in front of the nurses' station counter. Nurses and the unit secretary (who only worked during the day shift) sat behind the counter when they were not moving about in the unit.

7. Directly to the left of where the nurses sat behind the nurses' station counter was the Two North "med room," where medication and medical supplies were kept. During the night shift, when the hospital's pharmacy was not open, controlled substances such as opioids could be accessed from two secure AcuDose machines, which were locked and accessible only to nurses with fingerprint and passcode input.

8. At some point during the night shift that began at 7:00 p.m. on September 28, 2017, and ended at 7:00 a.m. on

September 29, 2017, Ms. Monroe observed Respondent go into the med room with a purple pouch about the size of a pencil bag. (Respondent clarified that the purple pouch was not a pencil bag, but the carrying pouch for her blood pressure cuff that she usually had with her, among other personal items, in a large cloth tote bag that she routinely brought to and from work).

9. Ms. Monroe observed Respondent take some glass vials out of the purple pouch and put them in a sharps container. She observed Respondent get needles and syringes off of the counter and put them in the purple pouch. She then saw Respondent put glass medication vials into the purple pouch. She observed Respondent leave the med room and put the purple pouch into Respondent's tote bag.

10. Ms. Monroe's testimony was clear and credible regarding what she observed. Respondent did not directly refute any part of Ms. Monroe's eyewitness account, other than to generally deny taking drugs and putting them in her bag. Respondent did not, for example, deny that she took her purple pouch into the med room. Indeed, she admitted that, although the purple pouch was the carrying pouch for her blood pressure cuff, that night the blood pressure cuff was not in her purple pouch. She did not explain why the blood pressure cuff was removed from its carrying pouch or why she brought the purple pouch in her tote bag to work that night shift if not for carrying the blood pressure cuff.

11. Instead of directly refuting Ms. Monroe's eyewitness account, Respondent attempted to dispute whether Ms. Monroe was physically situated to see what she described. This attempt was ineffective, and largely predicated on mischaracterizations of Ms. Monroe's testimony and other evidence. The credible evidence established that Ms. Monroe was in a position to clearly observe what she attested to. The med room was directly to the left of where Ms. Monroe was sitting behind the nurses' station counter, about ten feet away. The med room was brightly lit. Ms. Monroe clearly described her direct line of sight from where she was sitting into the med room, because the door, though closed, was made of clear glass from the doorknob height up.

12. Respondent's description of the med room was quite different from Ms. Monroe's description. For example, Respondent described the med room as "probably three feet [wide] by five feet [long]." (Tr. 169). Ms. Monroe testified that the med room was five feet wide by 15 feet long. (Tr. 47). Considering everything identified in the med rooms--two AcuDose machines on the left wall, which is the far wall from where the door opens; a large locked medication bin housing bags of IV solution and other prepared medication next to the AcuDose machines; a counter against the back wall curving around to the right side of the room, with supply bins and areas for preparing medication, and a sink at the counter's end against the right wall closest to where

the door opens--Respondent's estimate could not possibly be accurate. The locked machines and large bin on the left side and counter on the right side extend out from the walls, likely taking up a minimum of two feet of the room's width, which would leave, at most, one foot between machines and counters for people to move around, using Respondent's estimate, which would be impossibly narrow. Indeed, as Respondent admitted, "I'm not very good as far as judging feet." (Tr. 168).

13. Their descriptions of the med room door were similarly disparate. Respondent described a "vertical windowpane" in the door, but was vague about the dimensions: "I don't--I don't know the dimensions. It's not very big. It's, I don't know, maybe a foot-by-a-foot window, I guess. It could be a little bit bigger. I'm not really sure." (Tr. 169). She gave that estimate after admitting she is not good at "judging feet" and right before she estimated the med room dimensions as impossibly small.

14. Considering all of the credible evidence, Ms. Monroe's clear descriptions of the med room and the nurses' station are credited. Her testimony was more credible and certain than Respondent's vague descriptions and impossible estimates of dimensions, which, to her credit, she acknowledged was not her strength.

15. More than two years after the incident, Ms. Monroe did not recall when during the night shift she observed Respondent

put glass vials, needles, and syringes in her purple pouch and then put her purple pouch in her tote bag. Ms. Monroe guessed that it was sometime after midnight. It was certainly before 6:00 to 6:30 a.m. when the day shift charge nurse, Tracey Taylor, arrived.

16. Ms. Taylor testified that when she arrived on the morning of September 29, 2017, Ms. Monroe told her what she had observed. Ms. Taylor did not remember the exact words used by Ms. Monroe, but said it was along the lines of "I saw her putting stuff into her pencil bag." (Tr. 78). Ms. Taylor's written statement dated September 29, 2017, was consistent with that recollection: "This morning at 6:30 [a.m.], prior to receiving report from the night shift nurse, it was brought to my attention that Janine Leonard, a night shift RN, was observed putting vials of medications into her bag."

17. Ms. Taylor wanted to verify for herself what Ms. Monroe told her before calling a house supervisor, so she looked in Respondent's tote bag, which was on the floor underneath the nurses' station counter/desk area or a cubbyhole to the side. The tote bag itself was open, and Respondent's personal things were visible. Ms. Taylor saw the purple pouch and opened it. The unit secretary had arrived by then and was present when Ms. Taylor opened the purple bag. Respondent was not present; she had gone down one of the patient hallways.

18. After seeing for herself that what Ms. Monroe said she saw Respondent put into her purple pouch was in the purple pouch, Ms. Taylor called the night shift house supervisor, identified only as Ronette, who reported that she was going to call the director of the unit and have her come to the floor. Shortly thereafter, Mary Kay Butterworth, who had just arrived for her first day on the job as director of the Two North unit, and Linda Munier, the day shift house supervisor, met Ms. Taylor and were briefed. They notified Ann Pasik, the risk manager. Ms. Taylor spoke with Ms. Pasik, and informed her that Respondent was still on the floor.

19. Respondent testified that Ms. Butterfield came to her and told her to go to human resources after she was done with her charting. Respondent finished her charting, got her tote bag, and went to human resources where she waited in another employee's presence for two hours. Ms. Pasik, Ms. Butterfield, and the pharmacy director, Joe Pietranton, arrived in human resources. They asked Respondent if they could search her bag, and she consented.

20. The hospital's Chief Nursing Officer, Dawn Beljin, explained that pursuant to standard hospital procedure, when there is an allegation of drug diversion by a nurse, she and the pharmacy director have to be notified. Mr. Pietranton was notified upon his arrival that morning, and then he, Ms. Pasik,

and Ms. Butterfield went to Ms. Beljin's office to inform her of the allegation. Ms. Beljin recalled that this occurred right before 7:30 a.m., as she had a 7:30 a.m. meeting that she had to attend. Ms. Beljin instructed the three others to investigate.

21. Ms. Pasik was not a witness at the hearing. The other two investigators, Ms. Butterworth and Mr. Pietranton, testified consistently that the search of Respondent's tote bag yielded the purple pouch (described by Mr. Pietranton as a purple pencil bag or cosmetic bag), among other personal items. They opened the purple pouch, and found glass vials of medications, a syringe, and two needles, all in their original unopened packaging or containers.

22. Mr. Pietranton took pictures of the contents, and then secured the contents in a tamper-proof security/evidence bag, labelled by Mr. Pietranton and locked in the pharmacy vault. The contents of the purple pouch were: three vials of morphine, four milligrams each; five ampules of hydromorphone (Dilaudid), one milligram each; two needles (a BD safety guide 23-gauge needle and a BD blunt-fill 18-gauge needle); and one BD three-milliliter syringe. Both types of narcotics found in Respondent's purple pouch are controlled substances pursuant to chapter 893, Florida Statutes.

23. Respondent did not visibly or audibly react to the discovery of the narcotics and supplies in her purple pouch.

Respondent said that she was asked by the hospital personnel how the contents got there, and she told them she did not know. She did not claim to have a valid prescription for either controlled substance, nor did she suggest she had any legitimate purpose for possessing those drugs. Respondent's explanation for having no reaction to the discovery of drugs in her purple pouch was that she was in shock. She added that she was also brought up that way: "you don't show emotions." (Tr. 164).[4/]

24. In the hearing, by way of opening statement and in argument, counsel for Respondent suggested the possibility that the drugs were planted in Respondent's tote bag, because the bag was visible and accessible to anyone in the vicinity of the nurses' station, and hinted that testimony to be offered by Respondent's character witness about the relationship between Respondent and Ms. Monroe might suggest that Ms. Monroe had a motive for having planted drugs on Respondent. Nothing ever came of this prediction. Instead, counsel for Respondent seemed surprised to elicit testimony from the character witness, Ms. White, that Respondent and Ms. Monroe were friends at work and outside of work, going out together and interacting on social media. Ms. White volunteered even more detail, saying that if Ms. Monroe needed something, Respondent would bring it in for her, and if Respondent needed something, Ms. Monroe would bring it in for Respondent. When Respondent's counsel asked Ms. White

if she ever witnessed any odd behavior between Respondent and Ms. Monroe, Ms. White not only denied that she had, but went on to volunteer that "everything was copacetic. . . . There was nothing rude or anything. Everybody was working together to get things done. So there was no grudges or any anger or anything[.]" (Tr. 155).

25. There was no evidence, by way of Ms. White's testimony or otherwise, of any ill will between Respondent and Ms. Monroe, any grudge held by Ms. Monroe against Respondent, or any other evidence from which one could infer a motive on Ms. Monroe's part to plant drugs on Respondent and fabricate her eyewitness testimony. All of the credible evidence was to the contrary. Ms. Monroe was not joyful in sharing her eyewitness account that implicated Respondent. In response to questions by Respondent's counsel, Ms. Monroe said that she was friends with Respondent and that they socialized away from work. Ms. Monroe did not seize the opportunity to throw Respondent under the proverbial bus when asked by Respondent's counsel if she believed that Respondent would steal drugs. Instead, she offered the following credible response: "I don't know how to answer that. I know what I saw goes against every grain of what I wanted to believe. I believe what I saw. I believe that I saw her put drugs of some sort in her personal shoulder bag." (Tr. 61).[5/]

26. Respondent was informed that she had to undergo a drug test, in accordance with hospital policy. She was taken by an employee health nurse, Bridgette, for a urine drug screen, which was conducted after Respondent signed the consent. (Under hospital policy, if Respondent had refused, she would have been immediately terminated). After the drug test, Bridgette escorted Respondent out of the building. Respondent did not go back to work while the hospital completed its investigation.

27. As part of the investigation, Mr. Pietranton researched the records of the hospital's orders of morphine and hydromorphone and records of the hospital's inventory. The parties stipulated that the hydromorphone ampules and morphine vials found in Respondent's purple pouch "were identified by their lot numbers and belonged to the hospital inventory." Jt. Pre-hearing Stip. at 7, ¶ 8.

28. Mr. Pietranton ran reports on Respondent's activity with respect to morphine vials and hydromorphone ampules that were removed from the two AcuDose machines in the Two North med room during the night shift in question and for a portion of the prior night shift (the reports, in evidence, detail the activity beginning at midnight on September 28, 2017).

29. Mr. Pietranton described the protocols for withdrawing these controlled substances during the night shift after the pharmacy is closed. If there is a physician order prescribing

specific doses at certain intervals or as needed, then the physician order is put in the system and a nurse can access the prescribed medication. The AcuDose machines are stocked with an inventory of medication contained in multiple trays. The nurse inputs information calling up a specific physician prescription for a specific patient and the AcuDose machine will unlock only the tray that has the prescribed medication. For narcotics such as the two at issue, the stock in further secured in individual locked pockets and a lighted trail will point the nurse to the individual pocket containing the vial or ampule that matches the prescription. When there are physician orders for medication in the system, a nurse can withdraw medication from the AcuDose machine without having a second nurse witness the withdrawal. The records show that all of Respondent's withdrawals of morphine and hydromorphone on September 28 and 29, 2017, were authorized by a physician's order, so no second nurse was required to witness the withdrawals.

30. When the prescribed dose of liquid medication in a physician order is less than the contents of the vial or ampule, hospital protocol is that the nurse withdrawing the vial or ampule must "waste" the excess amount (over the prescribed amount), and a second nurse authorized to use the AcuDose machine must input the passcode and fingerprint to indicate the second nurse witnessed the wasting of the excess medication. The liquid

medication is "wasted" into absorbent towels, or, in September 2017, nurses could also waste medication into the med room sink.

31. Mr. Pietranton conducted an audit that tracked and compared the following: Respondent's withdrawals of morphine and hydromorphone on September 28 and 29, 2017; physician orders in the system that authorized morphine and hydromorphone to be administered to the patients identified in each of Respondent's withdrawals of that medication; records reporting wasted amounts exceeding the physician-prescribed amounts; and records prepared by Respondent to report having administered morphine and hydromorphone to patients Respondent was caring for those nights.

32. Mr. Pietranton concluded there were no discrepancies in the amounts of morphine and hydromorphone removed from the AcuDose machines by Respondent compared to the amounts recorded as wasted plus the amounts recorded by Respondent as administered to patients.

33. If a nurse creates records of administering drugs to his or her patients but does not, in fact, administer those drugs to the patients, that discrepancy would not be revealed by the type of audit conducted by Mr. Pietranton. While Respondent pointed out in her PRO that it would be speculative to assume that this is what happened, i.e., that Respondent did not actually administer the morphine and hydromorphone in accordance with the records she created to report administering those

medications to patients on September 28 and 29, 2017, the point is that it is a valid hypothesis that would explain how Respondent could have secured the vials of morphine and ampules of hydromorphone belonging to the hospital inventory to put in her purple pouch and then in her tote bag, consistent with the AcuDose records and drug administration records. The records themselves do not prove that this occurred, although they do document that Respondent withdrew more than the number of vials and ampules of the two drugs that were found in her purple pouch. The records also document that Respondent withdrew virtually all of the morphine and hydromorphone from the two Acudose machines in the Two North med room over the September 28 to September 29, 2017, night shift, as evident from comparing the beginning and ending inventory counts at each of her withdrawals. But the proof that Respondent took vials of morphine and ampules of hydromorphone, along with supplies, put them in her purple pouch, and put her purple pouch in her tote bag comes primarily from the clear, credible eyewitness account by Ms. Monroe and the absence of any credible evidence refuting or undermining that eyewitness account.

34. When Mr. Pietranton reported to Ms. Beljin that he confirmed the narcotics found in Respondent's purple pouch were hospital property, Ms. Beljin asked those involved in the investigation to write up statements while the matter was fresh

in their minds. She also asked Ann Pasik, the risk manager, to notify the police. No record evidence was offered regarding a police report or results thereof; as previously noted, Ms. Pasik did not testify at the hearing.

35. Respondent's drug test results, returned several days later, were negative. But while a drug test was required under hospital protocol, the negative results reasonably were not considered to exonerate Respondent. The negative drug test results would mean only that Respondent had not taken the drugs tested within the window of time before the test when the drugs would be detected in her urine. The significance of the negative drug test results might be different if the eyewitness account had been that Respondent was seen injecting herself with a drug, rather than putting vials and supplies in her purple pouch and then in her tote bag where they were later found. As Ms. Beljin noted, if the drugs had been successfully taken from the facility, other things could be done with the drugs (such as using them later and/or selling them).[6/] Therefore, despite the negative drug test results, Ms. Beljin recommended that Respondent be terminated. Her recommendation was accepted and the hospital notified Respondent approximately one week after the drugs were found in her purple pouch that she was terminated.

36. Ms. Beljin reported the drug diversion incident to the Department, as is her duty as a licensed nurse herself. See

§ 464.018(1)(k), Fla. Stat. The Department conducted an investigation and on February 6, 2018, issued an Emergency Order, based on findings of fact and conclusions of law that are consistent in all material respects to the allegations and charges in the Administrative Complaint issued on March 7, 2018.

37. The Emergency Order immediately restricted Respondent's license by prohibiting her from practicing as a registered nurse in any setting where she would have access to controlled substances. No evidence was presented to indicate that Respondent appealed the Emergency Order, so presumably it has remained in effect pending the outcome of this proceeding.

CONCLUSIONS OF LAW

38. DOAH has jurisdiction over the subject matter of this proceeding and the parties thereto pursuant to sections 120.569 and 120.57(1), Florida Statutes (2019).

39. The Administrative Complaint sets forth allegations regarding the incident described above, for which the Department charges Respondent with specified violations and seeks to impose discipline against Respondent's license.

40. A proceeding to suspend, revoke, or impose other discipline upon a license is penal in nature. State ex rel. Vining v. Fla. Real Estate Comm'n, 281 So. 2d 487, 491 (Fla. 1973). Petitioner therefore bears the burden of proving the charges against Respondent by clear and convincing evidence, as

the parties acknowledged at the outset of the hearing. Fox v. Dep't of Health, 994 So. 2d 416, 418 (Fla. 1st DCA 2008) (citing Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996)).

41. As stated by the Florida Supreme Court:

> Clear 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.

In re Henson, 913 So. 2d 579, 590 (Fla. 2005) (quoting Slomowitz v. Walker, 492 So. 2d 797, 800 (Fla. 4th DCA 1983)). This burden of proof may be met where the evidence is in conflict; however, "it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., 590 So. 2d 986, 988 (Fla. 1st DCA 1991).

42. Disciplinary statutes and rules "must be construed strictly, in favor of the one against whom the penalty would be imposed." Griffis v. Fish & Wildlife Conser. Comm'n, 57 So. 3d 929, 931 (Fla. 1st DCA 2011); Munch v. Dep't of Prof'l Reg., Div. of Real Estate, 592 So. 2d 1136, 1143 (Fla. 1st DCA 1992); McClung v. Crim. Just. Stds. & Training Comm'n, 458 So. 2d 887, 888 (Fla. 5th DCA 1984).

43. Respondent may not be found guilty of an offense that was not charged in the Administrative Complaint. See, e.g., Trevisani v. Dep't of Health, 908 So. 2d 1108 (Fla. 1st DCA 2005) (administrative complaint charged physician with a failure to create medical records; proof of a failure to retain medical records cannot support a finding of guilt). Furthermore, due process prohibits the Department from taking disciplinary action against a licensee based on matters not specifically alleged in the charging instrument, unless those matters have been tried by consent. See Delk v. Dep't of Prof'l Reg., 595 So. 2d 966, 967 (Fla. 5th DCA 1992).

44. At issue in Count I is whether Petitioner proved that Respondent committed unprofessional conduct in violation of section 464.018(1)(h), by misappropriating drugs and supplies in violation of rule 64B9-8.005(2) (defining "unprofessional conduct" to include "[m]isappropriating drugs, supplies, or equipment").

45. The term "misappropriating" is not defined in the nursing regulatory statutes or rules, and thus, as set forth in Department precedent, the term should be accorded its common and ordinary meaning, which is appropriating or taking wrongly. See Dep't of Health, Bd. of Nursing v. Fischer, Case No. 12-0067PL (Fla. DOAH Sept. 21, 2012), RO at ¶ 73 (applying ordinary dictionary definitions of "misappropriating" to mean

appropriating or taking wrongly); adopted in pertinent part (Fla. DOH Bd. of Nursing Dec. 17, 2012), FO at 5, ¶ 22 (rejecting exception to use of ordinary definitions of "misappropriate"); and FO at 7 (adopting recommended paragraph 73).

46. Based on the Findings of Fact above, Petitioner proved by clear and convincing evidence that Respondent wrongly appropriated vials of morphine, ampules of hydromorphone, and supplies (two needles and one syringe). She may have initially taken the medication out of the AcuDose machines for the ostensible authorized purpose of administering the medicine to patients pursuant to physician orders allowing her to do so. However, the appropriation of those drugs turned into misappropriation when Respondent brought her own purple pouch into the med room for no legitimate purpose (previously having emptied the pouch of the blood pressure cuff it was designed to carry and ordinarily contained), and then put the drugs and supplies in her purple pouch. She then wrongly exercised her dominion and control over the drugs and supplies by putting the purple pouch filled with these items in her tote bag with the rest of her personal items, with the intent of leaving the hospital at the end of her shift with her tote bag, as was her routine practice. Respondent is guilty of engaging in unprofessional conduct by misappropriating drugs and supplies, in

violation of section 464.018(1)(h) and rule 64B9-8.005(2), as charged in Count I.

47. In Count II, Respondent is charged with violating section 464.018(1)(i). That statute provides that it is a violation for a nurse to engage or attempt to engage in the possession, sale, or distribution of controlled substances as set forth in chapter 893, for other than legitimate purposes authorized by chapter 464, part I (the Nurse Practice Act).

48. The parties stipulated that hydromorphone and morphine are controlled substances pursuant to chapter 893. There was no evidence proving that Respondent put these controlled substances in her purple pouch for any legitimate purpose. Instead, the fact that she left the med room and put her purple pouch containing the controlled substances into her tote bag with her other personal items shows that she intended to leave the hospital at the end of her shift with the controlled substances in her tote bag, consistent with her routine practice of transporting her personal items from and to work in the tote bag.

49. Based on the findings above, Petitioner proved clearly and convincingly that Respondent took actual possession of these controlled substances for illegitimate purposes when she placed them in her personal purple pouch and then put the purple pouch in her tote bag that she routinely took from and to work and intended to leave with that day. Respondent attempted to possess

these controlled substances more than temporarily, but the drugs were found by hospital personnel in her purple pouch in her tote bag and the drugs were removed from her possession before she could leave the premises at the end of her shift.

50. There was no question that the purple pouch belonged to Respondent, nor was there any question that the tote bag in which the purple pouch was found, with the controlled substances inside, was also Respondent's. Nor was there any dispute that Respondent's routine practice was to bring personal items to work in the tote bag, and leave after her shift with her tote bag.

51. Respondent argued at length in her PRO that in order to find that Respondent possessed or attempted to possess the drugs, it would be necessary to find that Respondent was in constructive possession for the whole shift of the tote bag and its contents, because the tote bag was left in an area that was accessible to at least a few others, and also because at other times (not that night), Respondent had given permission to others to go into her tote bag to get items in there, such as drinks she brought to work. Respondent's argument is not persuasive. Respondent failed to directly refute Ms. Monroe's clear and credible eyewitness account. Respondent did not explain why the blood pressure cuff that the purple pouch was designed to and routinely did carry was taken out of the purple pouch, or why Respondent still brought the cuff-less purple pouch to work in the tote bag

that night. Respondent did not deny that she took her purple pouch into the med room. Respondent did not deny that she put medication vials into the purple pouch, or that she then put the purple pouch in her tote bag. Respondent's general denial that she did not take the drugs was not credible, and was insufficient to overcome the lack of explanation for these specific matters, and the lack of evidence directly refuting Ms. Monroe's testimony. Ms. Monroe's clear, convincing, and unrefuted eyewitness account establishes the violation, and is not undermined by Respondent's point that she did not watch over her tote bag for whatever time remained in the night shift. The "constructive possession" cases discussed by Respondent, largely in the criminal context with its heightened burden of proof, are all inapposite. None involved circumstances analogous to those here, where clear credible eyewitness testimony establishes that Respondent put drug vials in the receptacle (her personal purple pouch), which she then put in her tote bag, where the drugs were found. Respondent is guilty of engaging or attempting to engage in possession of controlled substances for an illegitimate purpose, as charged in Count II.

52. The remaining issue for determination is the appropriate penalty for the proven violations. Penalties in a licensure discipline case may not exceed those in effect at the time of the violations. Willner v. Dep't of Prof'l Reg., Bd. of

Med., 563 So. 2d 805, 806 (Fla. 1st DCA 1990). Thus, as noted, the penalty provisions set forth below are those in effect in September 2017.

53. Section 464.018(2) provides that the Board may impose any of the penalties in section 456.072(2), Florida Statutes, against a licensee found guilty of violating any provisions in section 464.018(1). These penalties include license suspension or permanent revocation, probation, practice restrictions, administrative fine, reprimand, letter of concern, corrective action, and/or remedial education. See § 456.072(2), Fla. Stat.

54. Section 464.018(5) requires the Board to promulgate a rule establishing "guidelines for the disposition of disciplinary cases involving specific types of violations." Accord § 456.079, Fla. Stat. The appropriate penalties for the proven violations in this case must be consistent with the disciplinary guidelines prescribed by rule in effect at the time of the violations. See Parrot Heads, Inc. v. Dep't of Bus. & Prof'l Reg., 741 So. 2d 1231, 1233-1234 (Fla. 5th DCA 1999).

55. Rule 64B9-8.006 contains the Board's penalty guidelines. Paragraph (3)(f) of the rule contains the guideline for discipline for a violation of section 464.018(1)(h) through a violation of rule 64B9-8.005(2). For a first offense, the penalty guideline ranges from a minimum of a reprimand, a $250 fine, and continuing education, to a maximum of a $500 fine and

suspension with evaluation by the Intervention Project for Nurses (IPN) or probation. For a first offense violation of section 464.018(1)(i), rule 64B9-8.006(3)(g) provides for discipline ranging from a minimum of a $250 fine, suspension, and IPN evaluation, to a maximum of a $500 fine and suspension. There was no evidence of prior offenses by Respondent; Petitioner concedes as much by proposing penalties under the "first offense" rule provisions.

56. Rule 64B9-8.006(5) authorizes the Board to deviate from the foregoing guidelines upon proof by clear and convincing evidence in the hearing record of aggravating or mitigating circumstances. Neither party offered evidence or argument in their PROs specifically addressing the mitigating and aggravating circumstances in this rule. While Respondent previewed her intent to submit evidence regarding mitigating circumstances in her Answer to Administrative Complaint, no such evidence was offered at hearing and Respondent did not argue in her PRO for deviation from the penalty guidelines. Having reviewed the mitigating and aggravating circumstances in the Board's rule, the undersigned concludes there is no clear and convincing evidence warranting deviation from the rule's penalty guidelines.

57. Petitioner's PRO takes the position that the appropriate discipline in this case is the minimum first-offense penalty guidelines for both violations, added together. It is

noted that by adding together the minimum penalties from each violation, the combined penalty is still within the first-offense penalty range for either violation alone. Petitioner's position regarding the appropriate penalty to be imposed in this case is accepted as reasonable.

58. Section 456.072(4) provides that in addition to any other discipline imposed for a violation of a practice act, the Board shall assess costs related to the investigation and prosecution of the case.

## RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Health, Board of Nursing enter a final order finding that Janine Marie Leonard, R.N., violated section 464.018(1)(h) through a violation of rule 64B9-8.005(2), and that Janine Marie Leonard, R.N. violated section 464.018(1)(i); and for those violations, imposing the following discipline: license suspension for an indefinite period pending satisfactory completion of an IPN evaluation and any recommended treatment; a $500 administrative fine; such required continuing education as the Board deems appropriate; and costs of investigation and prosecution.

DONE AND ENTERED this 31st day of January, 2020, in Tallahassee, Leon County, Florida.

ELIZABETH W. MCARTHUR
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 31st day of January, 2020.

## ENDNOTES

[1/] Unless otherwise noted, references to Florida Statutes are to the 2017 codification, and references to rules are to the versions in effect at the time of the alleged incident on September 28 and 29, 2017.

[2/] Petitioner's Exhibit 1, a certified copy of Respondent's licensure file, was admitted primarily for the limited purpose of documenting Respondent's licensure file. Not subject to that limitation is the document at pages 75 through 82 of the licensure file: an Order of Emergency Restriction of License (Emergency Order), issued against Respondent by the Department on February 6, 2018, based on the same alleged incident at issue in this case. The parties agreed that the Emergency Order is relevant to this proceeding and it is admitted without limitation.

[3/] By agreeing to an extended deadline for post-hearing submissions beyond ten days after the filing of the transcript, the parties waived the 30-day time period for filing the Recommended Order. See Fla. Admin. Code R. 28-106.216.

[4/] Respondent offered the testimony of Crystal White, C.N.A., a certified nurse assistant who had worked on the night shift with

Respondent and Ms. Monroe in the past, but who had been on medical leave for a total of six months, spanning the timeframe of the incident. She had no personal knowledge of what happened during that night shift, but was offered as a "character witness" to attest to Respondent's good character. In contrast to Respondent's testimony about her upbringing, Ms. White testified that Respondent's "culture" and "background" caused her to be loud and to get hysterical: "She gets, like, hysterical. Because I know--you know, from culture or whatever. . . . [S]he's loud--I don't know the proper words for it--because of her background . . . that was just her culture because she's loud or whatever." (Tr. 156-157).

[5/] Respondent pointed to a few inconsistencies in Ms. Monroe's testimony, not regarding her eyewitness account of Respondent putting medication vials and supplies in her purple pouch and then putting her purple pouch in her tote bag, but regarding minor, collateral details. The material facts attested to by Ms. Monroe were clear, consistent, and credible. Any minor discrepancies or questions raised by Respondent fail to undermine Ms. Monroe's unrebutted eyewitness account. For example, Ms. Monroe testified that she reported what she observed to the Two North night shift charge nurse, identified as Janet Finger, who was Ms. Monroe's direct supervisor. Respondent testified that the night shift charge nurse at that time was Mira Manyak, replacing Janet Finger who had moved to Tennessee. There is no credible evidence to prove whether Janet Finger or Mira Manyak was on duty for the September 28 to September 29, 2017, night shift. Respondent admitted that sometimes she and Ms. Monroe were the only two nurses staffing the Two North night shift, because sometimes they were short-staffed.

Respondent also criticized Ms. Monroe for not recalling that she reported the drug diversion incident to Ms. Taylor, who was the Two North day shift charge nurse, when Ms. Taylor arrived at around 6:00 or 6:30 a.m. on September 29, 2017. Perhaps Ms. Monroe mistakenly recalled reporting the incident to the night shift charge nurse when she actually reported it to the day shift charge nurse. Respondent argued it is unlikely that Ms. Monroe would wait hours after observing drug diversion to report it to her supervisor, but there is no proof as to exactly when during the night shift the incident occurred, whether it was hours before Ms. Monroe reported the incident to the day shift charge nurse, or whether there was even a Two North night shift charge nurse working that night to report to. Regardless, even if Ms. Monroe did not immediately report the incident to her supervising charge nurse or to a higher authority (such as the

night shift house supervisor), that would not undermine her eyewitness account. The fact remains that Ms. Monroe reported the incident before her shift was over, while Respondent was still on the floor, and while Respondent's tote bag, with the purple pouch inside, was still in place where Respondent kept it.

[6/] Respondent's PRO proposed a finding that Respondent "has no reason to attempt to steal medications since she does not have a drug problem and she is not a drug dealer." (PRO at 13, ¶ 38). While Respondent did testify, when asked, that she does not have a drug problem and is not a drug dealer, Respondent was not asked and did not volunteer whether she had a drug problem or was a drug dealer in September 2017. The present tense of this line of inquiry makes the testimony and proposed finding irrelevant. Moreover, at least since February 2018, Respondent has been prohibited from working as a registered nurse in a place where controlled substances are accessible, so she has not had the opportunity that was available to her in September 2017.

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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.