STATE OF CONNECTICUT

BOARD OF EXAMINERS FOR NURSING

Department of Public Health

vs.

JoAnn Wojcik, LPN, Lic. No. 027143
Respondent

Petition No. 2005-0714-011-026

MEMORANDUM OF DECISION

Procedural Background

The Board of Examiners for Nursing (hereinafter "Board") was presented by the Department of Public Health (hereinafter "Department" or "Dept.") with a Statement of Charges and Motion for Summary Suspension dated August 18, 2005. Dept. Exh. 1. The Statement of Charges alleged violations of certain provisions of Chapter 378 of the General Statutes of Connecticut by JoAnn Wojcik, L.P.N (hereinafter "respondent") which would subject respondent's licensed practical nurse license to disciplinary action pursuant to Conn. Gen. Stat. §§ 19a-17 and 20-99(b).

Based on the allegations in the Statement of Charges and accompanying affidavits and reports, the Board found that respondent's continued nursing practice presented a clear and immediate danger to public health and safety. On September 7, 2005, the Board ordered, pursuant to its authority under § 4-182(c) and § 19a-17(c) of the General Statutes of Connecticut, that respondent's licensed practical nurse license be summarily suspended pending a final determination by the Board of the allegations contained in the Statement of Charges. Dept. Exh. 1.

The Board issued a Notice of Hearing dated September 7, 2005, scheduling a hearing for September 21, 2005. Dept. Exh. 1.

Respondent was provided notice of the hearing and charges against her. The Summary Suspension Order, Notice of Hearing and Statement of Charges were delivered to respondent by certified mail on September 9, 2005 and by state marshal on September 10, 2005. Dept. Exh. 2.

Respondent submitted a written Answer to the Statement of Charges. Board Exh. 1.

The hearing scheduled for September 21, 2005 was continued at respondent's request. The hearing was rescheduled and commenced on December 21, 2005, in Room 1-D, Legislative Office Building, Capitol Avenue, Hartford, Connecticut. Dept. Exh. 4.

On September 15, 2005, the respondent filed an Ex Parte Motion to Reinstate License. On September 19, 2005, the Department filed an objection to respondent's Ex Parte Motion to Reinstate License. On September 29, 2005, the Board denied respondent's motion. Dept. Exh. 5.

Respondent was present during the hearing on December 21, 2005 and was represented by counsel. Transcript, December 21, 2005, p. 2.

On January 18, 2006, respondent filed a Motion to Revoke requesting that the Summary Suspension ordered on September 7, 2005 be vacated. On January 20, 2006, the Department filed an objection to respondent's Motion to Revoke. Resp. Exh. B; Dept. Exh. 8. The Board denied respondent's motion on February 1, 2006. Transcript, February 1, 2006, pp. 6-12.

On January 31, 2006, the Department filed a Motion to Reopen Hearing. On February 1, 2006, after hearing oral argument, the Board granted the motion and scheduled the hearing for April 5, 2006. Respondent's attorney acknowledged on the record that the hearing was rescheduled to April 5, 2006. Dept. Exh. 6; Transcript, February 1, 2006, pp. 2-6, 12; Transcript, April 5, 2006, p. 3.

On April 5, 2006, the hearing concluded at the Hartford Hospital Campus, 181 Patricia M. Genova Drive, Newington, Connecticut.

Respondent was not present or represented by counsel during the hearing on April 5, 2006. Transcript, April 5, 2006, pp. 2-3.

Each member of the Board involved in this decision attests that he/she was present at the hearing or has reviewed the record, and that this decision is based entirely on the record, the law, and the Board's specialized professional knowledge in evaluating the evidence.

Findings of Fact

Based on the testimony given and the exhibits offered into evidence, the Board makes the following Findings of Fact:

1. Respondent was issued licensed practical nurse license number 027143 on May 8, 1998. Respondent was the holder of said license at all times referenced in the Statement of Charges. Dept. Exh. 1; Respondent Exh. A.

2. On or about May 21 and 22, 2005, while employed as a licensed practical nurse by AAA Staffing Service, Stratford, Connecticut respondent was assigned to work at Hewitt Memorial in Shelton, Connecticut.. Dept. Exh. 3-A4; Transcript, December 21, 2005, p. 37.

3. On or about May 23, 2005, the State of Connecticut Department of Consumer Protection Drug Control Division was contacted by Beverly Castor, Director of Nursing, Hewitt Memorial. Ms. Castor reported there were multiple occasions on May 21 and 22, 2005 that respondent signed out doses of narcotic pain medication for patients who had not required pain medications on a regular basis. In addition, a nurse who worked the shift following that of respondent noticed that a patient's liquid morphine appeared to be adulterated. Dept. Exh. 3-A4.

4. Respondent signed out doses of Percocet on proof of use sheet 997184 for patient K.S. at 8:00 a.m. and 2:00 p.m.; on May 21, 2005 and at 8:00 a.m. on May 22, 2005. Only the 8:00 a.m. dose on May 21, 2005 was charted on the corresponding medication administration record. Dept. Exh. 3-A4, A9, A10.

5. Respondent signed out two doses of Oxycodone/APAP 5/325 on proof of use sheet 819635 for patient M.V. with a date of May 23, 2005 and one dose with a date of May 24, 2005. Respondent did not work at Hewitt Memorial on these dates. There were no entries for May 23, 2005 or May 24, 2005 on the corresponding medication administration record. Dept. Exh. 3-A5, A13, A14.

6. Respondent signed out four doses of Oxycodone/APAP 5/325 on proof of use sheet 106580 for patient R.R. on May 21, 2005 but there are no entries on the corresponding medication administration record. Patient R.R's previous dose was on May 12, 2005. Patient R.R subsequently went to the hospital and was readmitted to Hewitt Memorial on May 16, 2005. Readmission orders were for the patient to receive a fentanyl 25mcg patch. There were no readmission orders for patient R.R. to receive Oxycodone/APAP 5/325. In addition, there were no nursing notes written for May 21, 2005 indicating that patient R.R. had a need for the Oxycodone/APAP 5/325. Dept. Exh. 3-A5, A17-A26.

7. Respondent signed out doses of Oxycodone/APAP 5/325 on proof of use sheet 843881 for patient E.P. at 9:00 a.m. and 3:00 p.m. on May 21 and 22, 2005. The patient's previous need for Oxycodone/APAP 5/325 was on April 12, 2005. Only one of the May 21, 2005 doses is charted on the medication administration record and there are no corresponding nursing notes explaining the need for the medication. A urine specimen collected from patient E.P. on May 23, 2005 was negative for the presence of Oxycodone/APAP 5/325. Dept. Exh. 3-A5, A27-A33.

8. Respondent signed out three doses of Oxycodone/APAP 5/325 on proof of use sheet 980981 for patient J.G. on May 21 and 22, 2005 but there are no entries on the corresponding medication administration record and there are no corresponding nursing notes explaining the need for the medication.. Proof of use sheet 980981 had been in the facility since January 12, 2005 without any entries prior to May 21, 2005. A urine specimen collected from patient J.G. on May 23, 2005 was negative for the presence of Oxycodone/APAP 5/325. Dept. Exh. 3-A5, A34-A40.

9. Respondent signed out one dose of Oxycodone/APAP 5/325 on proof of use sheet 1065803 for patient M.K. on May 21, 2005 and two doses on May 22, 2005. There are no corresponding nursing notes explaining the need for the medication. A urine specimen collected from patient M.K. on May 23, 2005 was negative for the presence of Oxycodone/APAP 5/325. Dept. Exh. 3-A5, A41-A46.

10. Robin Vendrome, LPN reported that while working at Hewitt Memorial on May 22, 2005, on the shift following respondent, she went to administer morphine 20mg/ml concentrate liquid to a patient. She noticed that that the medication was clear instead of the dark pink it was supposed to be. Respondent was responsible for the security of the medication on the previous shift. The vial of morphine was not tested to determine if it had been adulterated. Dept. Exh. 3-A5, A38; Transcript December 121, 2005, p. 32.

11. On or about October 9, 2004 respondent worked as a licensed practical nurse at Shelton Lakes Care Facility, Shelton, Connecticut Dept. Exh. 3-A6

12. On October 9, 2004, respondent signed out two tablets of Oxycodone 5mg on proof of use sheet 903834 for patient D.B. Respondent documented the tablets were signed out in error, however, there is no corresponding entry or co-signature indicating that the tablets were wasted. Dept. Exh. 3-A7, A53.

Conclusions of Law and Discussion

In consideration of the above Findings of Fact, the following conclusions are rendered:

JoAnn Wojcik held a valid licensed practical nurse license in the State of Connecticut at all times referenced in the Statement of Charges.

The Notice of Hearing and Statement of Charges provided sufficient legal notice as mandated by Conn. Gen. Stat. §§ 4-177(a) and (b), and 4-182(c). The hearing was held in accordance with Conn. Gen. Stat. Chapters 54 and 368a as well as §§ 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies.

The Notice of Hearing, Statement of Charges, and the hearing process provided respondent with the opportunity to demonstrate compliance with all lawful requirements for the retention of his license as required by Conn. Gen. Stat. § 4-182(c).

The Department bears the burden of proof by a preponderance of the evidence in this matter.

The **FIRST COUNT PARAGRAPH 3** of the Statement of Charges alleges that during approximately May 2005, while working as a licensed practical nurse at Hewitt Memorial in Shelton, Connecticut, respondent:

a. diverted oxycodone, oxycodone/APAP, and/or morphine;
b. adulterated a patient's morphine 20 mg/ml concentrate liquid;
b (2). failed to completely, properly and accurately document in patient or hospital records; and/or
c. falsified one or more Controlled Substance Receipt Records.

The **FIRST COUNT PARAGRAPH 4** of the Statement of Charges alleges that in or about May 2005, respondent abused or utilized to excess oxycodone, oxycodone/APAP, and morphine.

The **FIRST COUNT PARAGRAPH 5** of the Statement of Charges alleges that respondent's abuse of oxycodone, oxycodone/APAP, and morphine, does, and/or may affect her practice as a licensed practical nurse.

Respondent denies the allegations contained in paragraphs 3a, 3b, 3c, 4 and 5. Respondent neither admits nor denies the allegations in paragraph 3b(2). Board Exh. 1.

The Board finds that on numerous occasions while working at Hewitt Memorial, respondent signed out controlled substances on proof of use sheets without corresponding entries in the patients' medication administration records nor any documented justification for the medications in the nursing notes. In addition, urine tests proved that patients had not received the medications signed out by respondent. The Board can therefore infer that respondent did not administer the medications to the patients but diverted the medications for her own use. The Board further finds that respondent's abuse of oxycodone and oxycodone/APAP may affect her practice as a nurse.

Respondent during her testimony claims that she does not have a chemical dependency and that she did not divert medications. Respondent further claims that she delivered the medications to certified nurses aides to administer to patients because she was overwhelmed with her patient workload. The Board does not find respondent's testimony credible.

The testimony of seven certified nurses aides who worked with respondent at Hewitt Memorial that they were not asked to medicate patients (transcript April 5, 2006) and of the testimony of the Drug Control Agent assigned to investigate this matter (transcript December 21, 2005) was deemed credible by the Board.

Based on its findings, the Board concludes that respondent's conduct as alleged in Paragraphs 3a, 3b(2), 3c, and Paragraphs 4 and 5 as they pertain to oxycodone and oxycodone/APAP, is proven by a preponderance of the evidence presented. The Board further concludes that said conduct constitutes grounds for disciplinary action pursuant to Conn. Gen. Stat. §§ 20-99(b)(2) (5) (6) and 19a-17.

The Board concludes that insufficient evidence was presented to prove the allegations that respondent adulterated a patient's liquid morphine. Therefore, Paragraph 3b of the Statement of Charges is dismissed. In addition, the Board concludes there is insufficient evidence to prove the allegation that respondent abused morphine.

The **SECOND COUNT PARAGRAPH 9** of the Statement of Charges alleges that during approximately October 2004, while working as a licensed practical nurse at Shelton Lakes Care Facility, respondent:

a. diverted oxycodone;
b. failed to completely, properly and/or accurately document medical or hospital records; and/or,
c. falsified one or more Controlled Substance Receipt Records.

The **SECOND COUNT PARAGRAPH 10** of the Statement of Charges alleges that in or about October 2004, respondent abused or utilized to excess oxycodone.

The **SECOND COUNT PARAGRAPH 11** of the Statement of Charges alleges respondent's abuse of oxycodone does, and/or may, affect her practice as a licensed practical nurse.

Respondent denies the allegations contained in paragraphs 9a, 9c, 10 and 11. Respondent neither admits nor denies the allegations in paragraph 9b. Board Exh. 1.

The Board finds that on October 9, 2004, while working at Shelton Lakes Care Facility, respondent signed out two tablets of Oxycodone 5mg but documented on the proof of use sheet that they were signed out in error, however, there is no documentation that the two tablets were wasted. The Board can therefore infer that respondent did not waste the tablets she signed out but diverted them for her own use.

Based on its findings, the Board concludes that respondent's conduct as alleged in Paragraphs 9a, 9b, 9c, 10, and 11 of the Statement of Charges is proven by a preponderance of the evidence presented. The Board further concludes that said conduct constitutes grounds for disciplinary action pursuant to Conn. Gen. Stat. §§ 20-99(b)(2) (5) (6) and 19a-17.

Order

Pursuant to its authority under Conn. Gen. Stat. §§ 19a-17 and 20-99, the Board of Examiners for Nursing hereby orders the following:

1. That for Count One Paragraphs 3a, 3b2, 3c, 4, and 5 and Count Two Paragraphs 9a, 9b, 9c, 10, and 11 of the Statement of Charges, respondent's licensed practical nurse license number 027143, is revoked effective the date this Memorandum of Decision is signed by the Board.
2. The Board finds the violations set forth in Count One and Count Two are severable and each separate Count warrants the revocation of respondent's license.

The Board of Examiners for Nursing hereby informs respondent, JoAnn Wojcik, and the Department of Public Health of the State of Connecticut of this decision.

Dated at Hartford, Connecticut this 6th day of September, 2006.

BOARD OF EXAMINERS FOR NURSING

By Jean Dolbeins CRNA, APRN

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