BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

GEORGIA BOARD OF NURSING, Petitioner,	:	Docket No.:
v.	:	OSAH-PLBD-RN-1634115-60-Malihi
MARTHA GARRETT, Respondent.	:	

FILED OSAH APR 11 2016
Kevin Westray, Legal Assistant

INITIAL DECISION

The Georgia Board of Nursing ("Petitioner" or "Board") seeks to indefinitely suspend Respondent Martha Garrett's license to practice as a registered nurse ("RN") in the state of Georgia. An evidentiary hearing was held on March 24, 2016. Respondent appeared *pro se*. Reagan W. Dean, Senior Assistant Attorney General, represented the Board at the hearing.

After consideration of the evidence and arguments, and for the reasons set forth below, Respondent's license to practice as an RN is **SUSPENDED INDEFINITELY**, under the conditions set forth in section IV of this Initial Decision.[1]

I. Findings of Fact

1.

Respondent has been licensed as an RN in the State of Georgia since May 15, 2008, and was so licensed at all times relevant to this case. Respondent's license is currently active. *Testimony of Martha Garrett; Petitioner's Exhibit P-2.*

[1] At the hearing, Respondent requested a continuance in order to hire an attorney and have additional time to obtain certain records. Respondent had notice of the hearing date more than a month in advance, did not contact either the Court or the Board prior to the hearing, and was raising this issue for the first time. Furthermore, the Board had its witnesses present in court for the hearing. Therefore, Respondent failed to show good cause for a continuance, and the request was **DENIED**.

Investigation and Termination by Hospital

2.

On or about February 2, 2014, Respondent was working as an RN in the emergency room at the Medical Center of Central Georgia in Macon, Georgia ("MCCG"). *Testimony of Cheryl Varnadoe; Petitioner's Exhibit P-1.*

3.

The medical staff at MCCG utilizes an automated medication administration system known as PYXIS. To obtain any type of medication for a patient, a nurse accesses PYXIS using her fingerprint. From a touchscreen, the nurse selects a patient's name, which brings up a list of all the drugs already approved for that patient. The nurse selects the drug needed, and a corresponding drawer opens for that specific drug. The nurse completes an initial count, takes the required dosage for the patient, then completes an ending count. PYXIS maintains a log of all drugs dispensed, which can be reviewed to determine the dates and times a particular nurse has pulled medication for individual patients. *Testimony of Ms. Varnadoe.*

4.

PYXIS is designed to ensure patient safety and prevent medical staff from diverting medication. Diversion—in which medical staff takes a patient's medication for personal use—raises the concern that a medical staffer may be using and abusing the medication herself. *Testimony of Ms. Varnadoe.*

5.

After pulling a drug for a patient from PYXIS, nurses at MCCG are required to administer the drug immediately, and they must document that administration. Failure to

document the administration of medication puts patients at risk of receiving an improper dosage or not receiving any medication at all. *Testimony of Ms. Varnadoe.*

6.

On or about February 2, 2014, a nursing operations supervisor at MCCG investigated patient L.P.'s complaint that she had not received her pain medication. Upon review of the PYXIS log, the supervisor determined that Respondent had pulled a dosage of Dilaudid, a type of morphine, for L.P. at 6:45 p.m. on February 2, 2014. However, the supervisor did not find any documentation that Dilaudid had been administered to L.P. around that time, nor was there documentation that L.P. had been complaining of pain at 6:45 p.m. *Testimony of Ms. Varnadoe*; *Petitioner's Exhibit P-1.*

7.

After noting the above discrepancy with patient L.P.'s medication, the nursing operations supervisor proceeded to review the records of Respondent's removal of drugs from PYXIS for the two weeks preceding February 2, 2014. The supervisor found five additional discrepancies:

- On January 19, 2014, Respondent removed 5 milligrams of morphine for patient E.M. without documenting its administration.
- Also on January 19, 2014, Respondent removed 5 milligrams of morphine for patient W.P. without documenting its administration.
- On January 23, 2014, Respondent removed 1 milligram of Dilaudid for patient H.R., without documenting its administration.
- On January 25, 2014, Respondent removed 5 milligrams of morphine for patient H.J. There was no order from a physician for this medication and no documentation of its administration.
- On January 28, 2014, Respondent removed 5 milligrams of morphine for patient C.B., without documenting its administration.

Testimony of Ms. Varnadoe; Petitioner's Exhibit P-1.

8.

Based on the above discrepancies in the PYXIS records, MCCG's management instructed Respondent to undergo an unannounced drug screen when she arrived at work the next day, on February 3, 2014. Macon Occupational Medicine, which performed the test, subsequently reported to MCCG that Respondent had failed the drug screen, noting that she had "[n]o prescription for morphine or codeine." Respondent thereafter was placed on leave while the drug screen's results were submitted for further analysis. The results of the second analysis showed that Respondent had tested positive for three controlled substances: oxazepam, temazepam, and morphine. *Testimony of Ms. Varnadoe; Petitioner's Exhibit P-1.*

9.

Because Respondent had tested positive on her drug screen, MCCG policy required that she submit documentation showing that she was legally taking the type of prescription drugs identified in her drug screen. However, Respondent at no point presented documentation of any type of prescriptions. *Testimony of Ms. Varnadoe; Petitioner's Exhibit P-1.*

10.

On February 28, 2014, MCCG terminated Respondent, citing her violation of MCCG's policy by testing positive for controlled substances and then failing to provide documentation showing that she legally took the drugs in question. MCCG also cited Respondent's violation of safe practices by failing to properly document all medications administered to patients. *Testimony of Ms. Varnadoe; Petitioner's Exhibit P-1.*

11.

On the day of the termination, Cheryl Varnadoe, MCCG's director of operations and budget, attempted to contact Respondent by phone and email. Respondent responded by email

that day, stating that she had made three attempts to return calls to Macon Occupational Medicine to provide her prescription information, but "we were out of state at a funeral and kept missing each other." She also informed Ms. Varnadoe that she had taken a job in Maine. Respondent denied diverting medications and asserted that she was highly allergic to morphine and Dilaudid. However, she admitted in her email that, "[i]f I'm guilty of anything, it's missing documentation." *Testimony of Ms. Varnadoe; Petitioner's Exhibit P-1.*

12.

On March 5, 2014, Ms. Varnadoe sent another email to Respondent, again asking to speak with her as soon as possible. Respondent answered by email the next day, stating that she had left three voice mail messages with her prescription information for Macon Occupational Medicine. She also stated, "I completely own my failure, on occasion, to document meds given." She contended, however, that "an audit of nearly any nurse in that ER [emergency room] would reveal similar shortfalls." *Testimony of Ms. Varnadoe; Petitioner's Exhibit P-1.*

Investigation and Proposed Sanction by Board

13.

On March 5, 2014, MCCG notified the Board by letter of Respondent's termination and the grounds for that termination. *Testimony of Ms. Varnadoe; Petitioner's Exhibit P-1.*

14.

The Board proceeded to initiate an investigation into the grounds for Respondent's termination. Robert Hernandez, an investigator with the Secretary of State's Office, spoke with Respondent by phone on March 23, 2014, informing her of the investigation. Mr. Hernandez told Respondent that the Board was requesting both a written statement addressing the

accusations raised by MCCG, as well as copies of prescriptions for any controlled substances she was taking. Respondent told Mr. Hernandez that she would send him both a written statement and copies of her prescriptions. *Testimony of Robert Hernandez.*

15.

Mr. Hernandez testified that he never received a written statement or copies of prescriptions from Respondent. Following their phone conversation on March 23, 2014, Mr. Hernandez had no further contact with Respondent. He reported his findings to the Board on May 7, 2014. *Testimony of Mr. Hernandez.*

16.

Based on the investigation's findings, the Board now seeks an indefinite suspension of Respondent's RN license. Such suspension would be lifted upon Respondent demonstrating twelve consecutive months of sobriety. Once the suspension is lifted, the Board proposes that Respondent be placed on probation pursuant to a public consent order, whereby she must participate in an after-care program, undergo regular drug monitoring, and reimburse the Board for the costs of the instant administrative proceedings.

Testimony of Petitioner

17.

At the hearing, Respondent denied diverting medication while working as an RN at MCCG. She maintained that on February 2, 2014, she pulled Dilaudid for patient L.P. and administered the dosage, though she conceded that she failed to properly document the dosage's administration. Respondent also conceded that she failed to properly document medication administration in several other instances prior to February 2, 2014. Respondent agreed that the

failure to properly document the administration of drugs threatens patient safety. However, she described the failure to document as "quite a regular occurrence" in an emergency room, given the patient load and pace of treatment. She also contended that she has since made an effort to be "immaculate" with her documentation. *Testimony of Respondent.*

18.

Also at the hearing, Respondent denied using morphine and stated that she did not know why she tested positive for this controlled substance on February 3, 2014. She noted that she did not test positive for Adderall on February 3, even though she has had an ongoing prescription for that medication since 2011 and has tested positive for Adderall on six subsequent drug screens. Respondent further contended that, in the past, she has administered drug screens to patients that came back as negative for the very same drugs they had just taken. *Testimony of Respondent.*

19.

Respondent further testified that she provided information about her existing prescriptions to Macon Occupational Medicine over the phone in February 2014. She also asserted that she mailed Mr. Hernandez copies of her prescriptions "as soon as he asked me for them." Those prescriptions included one for Adderall that has been ongoing since 2011; a one-time prescription for Xanax in early 2014, before Respondent took a flight; and a one-time prescription for oxycodone in either 2011 or 2012 after being diagnosed with an ovarian cyst. However, Respondent did not send the documents to Mr. Hernandez by certified mail, and she does not know why he never received them. Respondent also testified that she no longer has copies of the prescriptions she sent Mr. Hernandez in 2014. She told the Court that she attempted to obtain new copies two weeks before the instant hearing, but had been informed she needed to submit a release form to the pharmacy's home office due to the age of the

prescriptions. As a result, she had not yet received her requested copies. *Testimony of Respondent.*

20.

Respondent testified that she currently is employed by Northside Hospital in Atlanta, Georgia, and that her employer is not aware of her 2014 termination from MCCG. She asked the Court not to "take away her ability to work," and instead issue a lesser sanction such as a restricted license or mandatory training. *Testimony of Respondent.*

II. Conclusions of Law

1.

Because the Board seeks to suspend Respondent's license, the Board bears the burden of proof. GA. COMP. R. & REGS. 616-1-2-.07(1)(a). However, Respondent bears the burden as to any affirmative defenses. *Id.* The standard of proof is preponderance of the evidence. GA. COMP. R. & REGS. 616-1-2-.21(4).

2.

The Board has the statutory authority to impose disciplinary sanctions against Respondent's license pursuant to the Georgia Registered Professional Nurse Practice Act, O.C.G.A. § 43-26-1, *et seq.*; the rules of the Georgia Board of Nursing, found at Ga. Comp. R. & Regs., Chapter 410; and the statutory provisions related to grounds for disciplinary actions by professional licensing boards, found at O.C.G.A. § 43-1-19.[2]

[2] O.C.G.A. § 43-26-5(c) also provides that Chapter 1 of Title 43 is expressly adopted and incorporated by reference into Chapter 26 as if all the provisions of Chapter 1 were included in Chapter 26.

3.

Georgia Code Section 43-1-19(a) authorizes the Board to discipline a licensee upon a finding that the licensee has:

> (6) Engaged in any unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice materially affects the fitness of the licensee or applicant to practice a business or profession licensed under this title, or of a nature likely to jeopardize the interest of the public, which conduct or practice need not have resulted in actual injury to any person or be directly related to the practice of the licensed business or profession but shows that the licensee or applicant has committed any act or omission which is indicative of bad moral character or untrustworthiness; unprofessional conduct shall also include any departure from, or the failure to conform to, the minimal reasonable standards of acceptable and prevailing practice of the business or profession licensed under this title;
>
> . . .
>
> (10) Displayed an inability to practice a business or profession licensed under this title with reasonable skill and safety to the public or has become unable to practice the licensed business or profession with reasonable skill and safety to the public by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material;
>
> . . .

O.C.G.A. § 43-1-19(a).

4.

Additionally, Georgia Code Section 43-26-40(a) authorizes the Board to discipline a licensee upon a finding that the licensee has:

> (3) Engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, **the term "unprofessional conduct" includes the improper charting of medication** and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing nursing practice;
>
> . . .

(6) Displayed an inability to practice nursing as a licensed practical nurse with reasonable skill and safety due to illness, use of alcohol, drugs, narcotics, chemicals, or any other types of material, or as a result of any mental or physical condition:

. . .

O.C.G.A. § 43-26-40(a) (emphasis added).

5.

When the Board finds that a licensee should be disciplined pursuant to O.C.G.A. § 43-1-19(a), the Board may take any one or more of the following disciplinary actions:

(1) Refuse to grant or renew a license to an applicant;

(2) Administer a public or private reprimand, but a private reprimand shall not be disclosed to any person except the licensee;

(3) Suspend any license for a definite period or for an indefinite period in connection with any condition which may be attached to the restoration of said license;

(4) Limit or restrict any license as the board deems necessary for the protection of the public;

(5) Revoke any license;

(6) Condition the penalty upon, or withhold formal disposition pending, the applicant's or licensee's submission to such care, counseling, or treatment as the board may direct;

(7) Impose a fine not to exceed $500.00 for each violation of a law, rule, or regulation relating to the licensed business or profession; or

(8) Impose on a licensee or applicant fees or charges in an amount necessary to reimburse the professional licensing board for the administrative and legal costs incurred by the board in conducting an investigative or disciplinary proceeding.

O.C.G.A. § 43-1-19(d).

6.

The Board proved, by a preponderance of the evidence, that Respondent engaged in unprofessional conduct that was harmful to the public by repeatedly failing to document the administration of patients' medications. *See* O.C.G.A. §§ 43-1-19(a)(6), 43-26-40(a)(3). Specifically, within a fifteen-day period, Respondent failed to document the administration of morphine or Dilaudid no less than six times. Respondent also conceded—in both emails to Ms. Varnadoe and in her testimony—that she failed to properly document the administration of medication in multiple instances. These lapses in record-keeping increase the risk of patients receiving improper dosages of medication. Furthermore, although Respondent asserted that improper documentation is common in a fast-paced emergency room, she acknowledged that it nonetheless threatens patient safety, and nothing in the evidence suggests that emergency rooms are held to a different standard for record-keeping.

7.

The Board also proved, by a preponderance of the evidence, that Respondent engaged in unprofessional conduct by diverting controlled substances from her workplace for her personal use. *See* O.C.G.A. §§ 43-1-19(a)(6), 43-26-40(a)(3). The evidence shows that Respondent tested positive for morphine on February 3, 2014, following a two-week period in which she pulled four 5-milligram doses of morphine from PYXIS without documenting their administration. Although Respondent contended she did not use any morphine herself, she has not offered any credible explanation as to why morphine otherwise appeared on the drug screen.[3] Accordingly, based on the drug screen's detection of morphine, Respondent's repeated failure to document the administration of morphine in the days leading up to the drug screen, and

[3] Respondent's testimony alluded to the possibility of the drug screen being inaccurate. However, this argument is belied by the fact that the drug screen's initial results were analyzed a second time, with the second analysis confirming the presence of morphine.

Respondent's inability to provide a credible explanation for the presence of morphine in her system, the evidence sufficiently demonstrates that Respondent was diverting morphine for her own personal use. Such conduct was unprofessional and deceptive, and it materially affected her fitness to practice nursing, in that it undermined the trust and confidence placed in Respondent by her supervisors, her nursing colleagues, and her patients.[4]

8.

The Board further proved, by a preponderance of the evidence, that Respondent displayed an inability to practice nursing with reasonable skill and safety due to her diversion and use of controlled substances. *See* O.C.G.A. §§ 43-1-19(a)(10), 43-26-40(a)(6). As discussed above, the evidence shows that Respondent repeatedly diverted morphine from her workplace, thus heightening the risk that her patients' proper morphine administration would be interrupted. Furthermore, the evidence shows that Respondent arrived at work on February 3, 2014, with three controlled substances in her system—morphine, oxazepam, and temazepam—for which she did not have a legal prescription.[5] Such misuse of controlled substances threatens Respondent's ability to treat patients safely and without impairment.

9.

After considering the evidence as a whole, this Court concludes that Respondent has committed serious violations of the laws governing the practice of nursing in Georgia. Given

[4] At the hearing, Respondent asserted that the drug screen performed on February 3, 2014, did not show the presence of Dilaudid (generic name hydromorphone), which was the drug she allegedly diverted from patient L.P. the day before the drug screen. Respondent is correct that there is no direct evidence that Respondent ever used Dilaudid herself. However, this does not detract from the evidence demonstrating that Respondent diverted *morphine* for her personal use. *Testimony of Petitioner & Ms. Varnadoe; Petitioner's Exhibit P-1.*

[5] Although Respondent contended that she provided prescription information to both Macon Occupational Medicine and Mr. Hernandez in 2014, and that she attempted to get copies of the same prescriptions for the instant hearing, this Court does not find her testimony credible. Moreover, Respondent failed to explain how the prescriptions she referenced in her testimony—for Adderall, Xanax, and oxycodone—would have led to her testing positive for morphine, oxazepam, and temazepam on February 3, 2014.

that Respondent has continued to work as a nurse since the events of February 2014, it is imperative that Respondent thoroughly address any issues with sobriety before continuing to treat patients. The Court therefore concludes that an indefinite suspension of Respondent's license is an appropriate sanction, during which Respondent shall seek appropriate treatment.

III. Decision

In accordance with the foregoing Findings of Fact and Conclusions of Law, Respondent's license to practice as an RN is hereby sanctioned as follows:

(1) Indefinite suspension: Respondent's license shall be **SUSPENDED INDEFINITELY**. During the period of suspension, Respondent shall not use the title "R.N." or otherwise engage in the practice of nursing. Respondent is not entitled to renew her license during the period of suspension. Failure to do so shall result in the revocation of her license as a matter of law.

(2) Petition for Restoration of License: Respondent shall be eligible to petition the Board for the lifting of such suspension and restoration of her license following 12 months of continuous sobriety. Such petition shall include documentation of the 12 months' continuous sobriety, as provided by an after-care program. This documentation shall include the results of drug screens, to be performed twice a month. Lifting of Respondent's suspension shall be in the Board's discretion. If the Board should deny the petition, Respondent may request a hearing to determine whether the Board has abused its discretion, and/or may submit a subsequent petition no sooner than ninety (90) days following the denial of her petition.

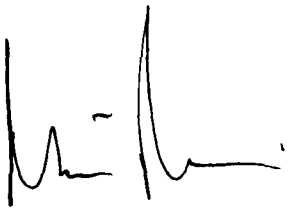
(3) Probation Terms: Upon granting Respondent's petition to lift the suspension, Respondent's license shall be restored under the terms and conditions set forth in a public consent order, as follows: These terms and conditions shall include the following:

   (a) Requirements for Respondent's continued participation in after-care treatment, as the Board deems necessary for the protection of the public;

   (b) Continued drug screen monitoring, as the Board deems necessary for the protection of the public;

(c) Reimbursement to the Board for the costs of the instant administrative proceeding of $ 1,925.

SO ORDERED this the 11th day of April, 2016.



MICHAEL MALIHI, Judge