IN THE MATTER OF PERMANENT REGISTERED NURSE LICENSE NUMBER 569448 ISSUED TO VICTORIA LEE FOUGHT	§ § § §	BEFORE THE TEXAS BOARD OF NURSING ELIGIBILITY AND DISCIPLINARY COMMITTEE

ORDER OF THE BOARD

TO: Victoria Lee Fought
1946 NE Loop 410
San Antonio, TX 78217

During open meeting held in Austin, Texas, on March 19, 2013, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, Chapter 301 of the Texas Occupations Code, for retention of Respondent's license(s) to practice nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by reference for all purposes and the Staff's recommended sanction of revocation by default. This Order

will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN.CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Registered Nurse License Number 569448, previously issued to VICTORIA LEE FOUGHT, to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

Entered this 19th day of March, 2013.

TEXAS BOARD OF NURSING

BY: Katherine A. Thomas

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Attachment: Formal Charge filed November 5, 2012.

CERTIFICATE OF SERVICE

I hereby certify that on the 22 day of March, 2013, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested
Victoria Lee Fought
1946 NE Loop 410
San Antonio, TX 78217

Via USPS First Class Mail
Victoria Lee (Fought) Steckler
2371 Stetler Drive
Coal township, PA 17866

BY: Katherine A. Thomas
KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

In the Matter of Permanent Registered Nurse License Number 569448 Issued to VICTORIA LEE FOUGHT, Respondent	§	**BEFORE THE TEXAS**
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	§	
	§	
	§	**BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, VICTORIA LEE FOUGHT, is a Registered Nurse holding License Number 569448 which is in delinquent status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about August 26, 2011, Respondent received a Final Order from the Florida Board of Nursing wherein a Settlement Agreement, signed by Respondent on May 20, 2011 was accepted by the Florida Board of Nursing wherein Respondent's license to practice professional nursing in the State of Florida was Suspended due to unprofessional conduct and being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals, and will remain in Suspension until Respondent received evaluations and enters the Florida Intervention Program for Nurses. A copy of the Final Order issued by the Florida Board of Nursing with Settlement Agreement, signed by Respondent on May 20, 2011, dated August 26, 2011 is attached and incorporated by reference as part of this charge.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8)&(10), Texas Occupations Code, and is a violation of 22 TEX. ADMIN. CODE §217.12(10)(B)&(C).

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license/s to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 Tex. Admin. Code §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1200.00).

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that to the extent applicable, based on the Formal Charges, the Board will rely on Adopted Disciplinary Sanction Policies for Nurses with Substance Abuse, Misuse, Substance

Dependency, or other Substance Use Disorder, for Lying and Falsification, which can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.texas.gov/disciplinaryaction/discp-matrix.html.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order(s) which is attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Final Order issued by the Florida Board of Nursing with Settlement Agreement, signed by Respondent on May 20, 2011, dated August 26, 2011.

Filed this 5th day of November, 2012.

TEXAS BOARD OF NURSING

R. Kyle Hensley

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Assistant General Counsel
State Bar No. 24036103
Lance Robert Brenton, Assistant General Counsel
State Bar No. 24066924
John R. Griffith, Assistant General Counsel
State Bar No. 24079751
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
Nikki Hopkins, Assistant General Counsel
State Bar No. 24052269
John F. Legris, Assistant General Counsel
State Bar No. 00785533
TEXAS BOARD OF NURSING
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6811
F: (512) 305-8101 or (512)305-7401

Attachments: Final Order issued by the Florida Board of Nursing with Settlement Agreement, signed by Respondent on May 20, 2011, dated August 26, 2011.

D/2012.06.19

FLORIDA DEPARTMENT OF HEALTH

Rick Scott
Governor

H. Frank Farmer, Jr., M.D., Ph.D., FACP
State Surgeon General

CERTIFICATION

I, Lawanda Bell, Deputy Agency Clerk and Custodian of Records, HEREBY certify the following to be true and correct as on file with the Department of Health.

Attached is a true and correct copy of the **Final Order** as maintained by the Department of Health. The attached is a regularly received and retained record of the **Board of Nursing vs. Victoria Lee Steckler; Case No. 2011-00262** and is received and retained in the ordinary course of business of the Department of Health.

Lawanda M Bell
Deputy Agency Clerk

STATE OF FLORIDA
COUNTY OF LEON

Before me, personally appeared Lawanda Bell whose identity is personally known to me as Deputy Agency Clerk, and who, acknowledges that his/her signature appears above.

Sworn and subscribed to, before me, this 14th day of October 2011.

Notary Public-State of Florida

RENADA CONLEY
Commission DD 818579
Expires November 9, 2012
Bonded Thru Troy Fain Insurance 800-385-7019

Type or Print Name

STATE OF FLORIDA
BOARD OF NURSING

Final Order No. DOH-11-2084-S-MQA
FILED DATE 8-26-11
Department of Health
By [signature]
Deputy Agency Clerk

DEPARTMENT OF HEALTH,

Petitioner,

vs.

Case No.: 2011-00262
License No.: RN 2247992

VICTORIA LEE STECKLER,

Respondent.
_____/

FINAL ORDER

THIS CAUSE came before the BOARD OF NURSING (Board) pursuant to Sections 120.569 and 120.57(4), Florida Statutes, on August 5, 2011, in Tampa, Florida, for the purpose of considering a settlement agreement (attached hereto as Exhibit A) entered into between the parties in this cause. Upon consideration of the settlement agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise fully advised in the premises, it is hereby

ORDERED AND ADJUDGED that the settlement agreement as submitted be and is hereby approved and adopted in toto and incorporated herein by reference. The costs are $5,878.14. Accordingly, the parties shall adhere to and abide by all the terms and conditions of the settlement agreement.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 25th day of July, 2011.

BOARD OF NURSING

JOE R. BAKER, JR.
Executive Director for
Jessie Colin, RN, PhD
Chair

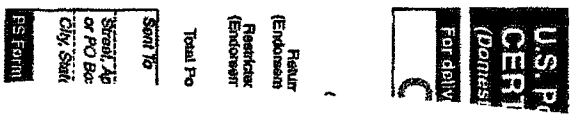
CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to VICTORIA LEE STECKLER, 1252 Cabana Road, Apt. 2, Riviera Beach, FL 33404; and by interoffice delivery to Lee Ann Gustafson, Senior Assistant Attorney General, Department of Legal Affairs, PL-01 The Capitol, Tallahassee FL 32399-1050, Jodi-Ann Johnson, Assistant General Counsel, Department of Health, 4052 Bald Cypress Way, Bin C-65, Tallahassee, Florida 32399-3265 this 26th day of July, 2011.

Angel Sanders

Deputy Agency Clerk

7011 1150 0001 4539 9201



Case No. 2011-00262

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

Case No. 2011-00262

v.

VICTORIA LEE STECKLER, R.N.,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Nursing against Respondent, Victoria Lee Steckler, R.N., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of nursing pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 464, Florida Statutes.

2. At all times material to this Complaint, Respondent was a registered nurse (R.N.) within the state of Florida, having been issued license number RN 2247992.

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3. Respondent's address of record is 1252 Cabana Road, Apt. #2, Riviera Beach, Florida 33404.

4. At all times material to this complaint, Respondent was licensed to practice as a registered nurse pursuant to Chapter 464, Florida Statutes.

5. On or about October 30, 2006, Martin Memorial Medical Center (MMMC) hired Respondent as a registered nurse.

6. At all times material to this complaint, Respondent worked in the medical intensive care unit (MICU) at MMMC.

7. MMMC utilized the Acudose automated medication dispensing system. Acudose consists of locked medication carts that secure and control access to controlled substances through a computer system. Each cart has a computer terminal on top of the cart that is linked to the pharmacy. Nurses can access Acudose with either an individual password or through a fingerprint scan. The nurse selects the medication needed and the patient for whom the medication is intended and the specific drawer that contains that medication unlocks and opens. Activity reports can be generated from Acudose that show all medications removed from the Acudose cart by a specific nurse. The activity reports indicate the

medication, dose, date, time, patient for whom the medication is intended, and nurse removing the medication.

8. In order to accurately record patient care, and to accurately account for controlled substances, MMMC required nurses to document the time each medication was administered to the patient on the patient's medical record. Nurses at MMMC were also required to use a portable scanning device which the nurses referred to as the "Bar Code Computer." The Bar Code Computer was linked to the patient's electronic medical record. Each time a medication was removed from Acudose, the nurse took the medication and the Bar Code Computer to the patient's bedside. Using the Bar Code Computer, the nurse scanned the bar code on the medication packaging and the bar code on the patient's identification bracelet. This system provided an additional checkpoint to ensure that the correct medication was being administered to the correct patient.

9. If a dose or partial dose of a controlled substance was removed from Acudose, but not administered to the patient, the nurse was required to discard the controlled substance in the presence of another licensed nurse. The nurse discarding the controlled substance, and the nurse witness, both entered their names into the Acudose computer to document

that the controlled substance was discarded. The discard of a controlled substance is referred to in Acudose as a "waste."

10. A physician's order was required for any medication administered to patients at MMMC. Physician orders were written on the Physician Order Sheet section of the medical records. It was common for MMMC nurses to receive orders from the physician verbally or over the telephone. When a nurse received such an order, he or she was required to document the order on the Physician Order Sheet section of the patient's medical record. The nurse was required to document the order, the physician's name, whether the order was received by telephone or verbally, that the order was read back to the physician to ensure accuracy, and the nurse would sign the order. Nurses documented telephone orders as "TORB" meaning "telephone order read back." Medication orders written on the Physician Order Sheet were faxed to the pharmacy. Pharmacy staff entered the orders into the Acudose system and into the patient's electronic medical record.

11. Many medications ordered by physicians at MMMC are ordered to be given "PRN" (as needed). Physicians wrote parameters for how often and in what dosages these medications were to be given. Medications

administered to treat pain were often ordered in this manner. After a nurse administered a medication to a patient to treat pain, the nurse would give the medication time to take effect and then return to conduct a reassessment of the patient's pain to determine if the pain medication was effective.

12. When Respondent began working at MMMC, she was monitored by the Intervention Project for Nurses (IPN).

13. IPN is the impaired practitioner program for the Board of Nursing, pursuant to Section 456.076, Florida Statutes. IPN is a program that monitors the evaluation, care and treatment of impaired nurses. IPN oversees random drug screens and provides for the exchange of information between treatment providers, evaluators and the Department for the protection of the public.

14. During Respondent's employment at MMMC, she was under a five-year monitoring contract which required her to remain free from all mood-altering, controlled, or addictive substances, including alcohol, and also required her to submit to random drug testing. Respondent started the IPN monitoring contract on or about July 29, 2005, and was scheduled to be completed with the monitoring on or about July 29, 2010.

15. On or about July 6, 2010, Respondent completed her IPN contract and was released from IPN monitoring.

16. On or about December 9, 2010, Respondent was on duty at MMMC in the MICU during the day-shift.

17. At or about 3:09 p.m., Respondent removed a vial of hydromorphone 1 milligram (mg) from Acudose, ostensibly for Patient L.Z. who was not under Respondent's care.

18. Hydromorphone, commonly known by the brand name Dilaudid, is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, hydromorphone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of hydromorphone may lead to severe psychological or physical dependence.

19. According to the physician order, Patient L.Z. could receive 1 mg of hydromorphone by intravenous injection (IV) every two hours as needed for pain.

20. The nurse caring for Patient L.Z. had just administered a dose of hydromorphone to L.Z. at 2:53 p.m., so according to the physician order,

L.Z. could not receive another dose of hydromorphone at 3:09 p.m., the time Respondent removed the drug from Acudose.

21. Respondent did not document the administration and/or the waste of the hydromorphone on Patient L.Z.'s medical record.

Patient W.T.

22. On or about December 10, 2010, at or about 11:00 p.m., Patient W.T., an 86 year old patient who had undergone surgery, was transferred to the MICU.

23. Patient W.T. had a physician's order for 2 mg to 4 mg of morphine by IV every four hours as needed for pain. Patient W.T. also had a physician's order for Percocet, one tablet, every four to six hours as needed for pain.

24. Morphine is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, morphine is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of morphine may lead to severe psychological or physical dependence.

25. According to the prescription label from Meridian Medical Technologies, a manufacturer of morphine sulfate for injection, morphine

should be used with extreme caution in aged or debilitated patients. Common side effects of morphine include nausea, vomiting, and a decrease in the propulsive contractions of the gastrointestinal tract which may cause constipation.

26. Percocet is the brand name for a drug that contains oxycodone and is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, oxycodone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of oxycodone may lead to severe psychological or physical dependence.

27. According to the prescription label from Cardinal Health, a manufacturer of Percocet, common side effects of Percocet include nausea, vomiting, and abdominal distension.

28. Contractions of the gastrointestinal tract are audible with a stethoscope and are called bowel sounds. Listening to bowel sounds is part of a nursing assessment of the gastrointestinal tract.

29. On or about December 11, 2010, at or about 5:30 a.m., a MICU nurse caring for Patient W.T. documented that W.T. vomited and had hypoactive bowel sounds, or bowel sounds occurring less often than

normal. The nurse also noted that Patient W.T.'s abdomen was distended. At or about 6:30 a.m., the MICU nurse notified Patient W.T.'s physician about W.T.'s nausea and vomiting and received a physician order for W.T. to have an abdominal x-ray.

30. On or about December 11, 2010, at or about 7:00 a.m., Respondent arrived at MMMC to work a day shift and took over the care of Patient W.T.

31. At or about 7:04 a.m., Respondent removed a 4 mg vial of morphine from Acudose, ostensibly for Patient W.T.

32. Respondent documented that she administered the 4 mg of morphine to Patient W.T. for pain at or about 7:10 a.m.

33. At or about 7:30 a.m., Respondent documented that she conducted a reassessment of Patient W.T.'s pain. Respondent documented that Patient W.T. was sleeping in response to the morphine she had administered at 7:10 a.m.

34. At or about 7:30 a.m., despite documenting that Patient W.T. was sleeping, Respondent removed a 2 mg vial of morphine from Acudose, ostensibly for W.T. who was not due to receive any more morphine until at or about 12:10 p.m., according to the physician order.

35. Despite documenting that W.T. was sleeping in one section of Patient W.T.'s medical record, in another section of W.T.'s medical record, Respondent documented that she administered 2 mg of morphine to W.T. at 7:30 a.m. for pain.

36. At or about 7:41 a.m., Respondent removed a 4 mg vial of morphine from Acudose, ostensibly for Patient W.T. who could not receive any more morphine at that time, according to the physician order.

37. Respondent did not document the administration and/or waste of the morphine she obtained at or about 7:41 a.m.

38. At or about 7:51 a.m., Respondent documented that Patient W.T. had a distended abdomen and his bowel sounds were absent.

39. At or about 7:56 a.m., Respondent removed a 2 mg vial of morphine from Acudose, ostensibly for Patient W.T. who could not receive any more morphine at that time, according to the physician order.

40. Respondent did not document the administration and/or waste of the morphine she obtained at or about 7:56 a.m.

41. At or about 8:00 a.m., Respondent obtained a new Physician Order Sheet, labeled it with Patient W.T.'s name and medical record number, and documented a physician order, ostensibly received by

telephone, to increase the frequency of W.T.'s morphine to 2 mg to 4 mg by IV every two hours as needed for pain. Respondent wrote "TORB" on the order, indicating that she received the order by telephone from Patient W.T.'s physician and read it back to the physician for accuracy.

42. Respondent faxed the morphine order to the pharmacy.

43. Respondent did not place a copy of the order in Patient W.T.'s medical record.

44. At or about 8:14 a.m., Respondent removed a 4 mg vial of morphine from Acudose, ostensibly for Patient W.T.

45. Respondent did not document the administration and/or waste of the morphine she obtained at or about 8:14 a.m.

46. At or about 8:26 a.m., Respondent removed a 2 mg vial of morphine from Acudose, ostensibly for Patient W.T.

47. Respondent did not document the administration and/or waste of the morphine she obtained at or about 8:26 a.m.

48. At or about 8:36 a.m., the pharmacy entered the order to increase Patient W.T.'s morphine, written by Respondent, into Acudose and W.T.'s electronic medical record.

49. At or about 9:00 a.m., Respondent documented that she administered 2 mg of morphine to Patient W.T. for pain. In a nursing note section of the medical record, Respondent documented that W.T. vomited.

50. At or about 9:03 a.m., Respondent removed a 4 mg vial of morphine from Acudose, ostensibly for Patient W.T. who was not due to receive another dose of morphine until 11:00 a.m., according to the telephone order that Respondent ostensibly received from W.T.'s physician.

51. Respondent did not document the administration and/or waste of the morphine she obtained at or about 9:03 a.m.

52. At or about 9:30 a.m., Respondent documented that she conducted a reassessment of Patient W.T.'s pain. Respondent documented that Patient W.T. was sleeping in response to the 2 mg of morphine she documented administering at 9:00 a.m.

53. At or about 9:30 a.m., despite documenting that Patient W.T. was sleeping in one section of the medical record; in another section of W.T.'s medical record, Respondent documented that she administered 4 mg of morphine to W.T. for pain at a level of six on a scale of one to ten, with one representing minimal pain, and ten representing the most severe pain.

54. At or about 10:23 a.m., Respondent removed one 4 mg vial of morphine from Acudose, ostensibly for Patient W.T. who could not receive any more morphine at that time, according to the telephone order, ostensibly received by Respondent.

55. Respondent did not document the administration and/or waste of the morphine she obtained at or about 10:23 a.m.

56. At or about 10:45 a.m., Patient W.T.'s physician wrote several orders on a Physician Order Sheet to treat W.T.'s nausea, vomiting, and distended abdomen. The physician placed the orders in Patient W.T.'s medical record. The physician ordered a suppository for constipation, and increased the dose of Reglan, a medication ordered for W.T. for symptoms of nausea and vomiting. The physician increased the Reglan dose from 10 mg to 20 mg of Reglan. The physician discontinued the order for Percocet, and wrote the following order, "Discontinue the 4 mg of morphine sulfate order, [change] morphine to 1-2 mg IV [every] 6 hours PRN for pain."

57. At or about 10:55 a.m., Respondent documented that she administered 2 mg of morphine to Patient W.T. for pain at a level of eight on a pain scale of one to ten.

58. At or about 10:55 a.m., Respondent had not yet faxed the physician's order to decrease the morphine to the pharmacy.

59. At or about 11:00 a.m., Respondent documented that she administered 4 mg of morphine to Patient W.T.

60. At or about 11:25 a.m., Respondent documented that she conducted a reassessment of Patient W.T.'s pain. Respondent documented that W.T. was sleeping in response to the 2 mg of morphine that Respondent documented administering at 10:55 a.m.

61. At or about 11:34 a.m., Respondent documented that she administered 20 mg of Reglan to Patient W.T. and noted in the medical records that the dose had been increased from 10 mg to 20 mg, as ordered by W.T.'s physician.

62. At that time, Respondent had seen the orders written by Patient W.T.'s physician at or about 10:45 a.m. Those orders included the order to decrease the dose and frequency of PRN morphine for Patient W.T. Respondent entered her signature below those orders, indicating that the orders were being implemented, but did not fax a copy of the orders to the pharmacy at that time.

63. After observing and implementing several of the orders written by the physician at about 10:45 a.m., Respondent continued to remove frequent doses of morphine from Acudose, ostensibly for Patient W.T., despite the fact that the physician order now only permitted W.T. to receive 1 mg to 2 mg by IV every 6 hours as needed for pain.

64. At or about 11:46 a.m., Respondent removed one 2 mg vial of morphine from Acudose, ostensibly for Patient W.T. who could not receive another dose of morphine until at or about 5:00 p.m., according to the new physician order.

65. Respondent did not document the administration and/or waste of the morphine she obtained at or about 11:46 a.m.

66. At or about 1:00 p.m., Respondent documented that she administered 2 mg of morphine to Patient W.T. for pain.

67. At or about 1:30 p.m., Respondent documented that she administered 4 mg of morphine to Patient W.T. for pain.

68. At or about 1:30 p.m., the pharmacy still had not received a copy of the orders written by the physician at or about 10:45 a.m.

69. At or about 2:27 p.m., Respondent removed one 4 mg vial of morphine from Acudose, ostensibly for Patient W.T.

70. Respondent did not document the administration and/or waste of the morphine she obtained at 2:27 p.m.

71. Patient W.T. did not have physician's orders to receive that high a dose of morphine, or morphine as frequently as Respondent was removing it from Acudose.

72. At or about 2:57 p.m., Respondent removed one 2 mg vial of morphine from Acudose, ostensibly for Patient W.T.

73. Respondent documented that she administered 2 mg to Patient W.T. at about 3:00 p.m. for pain at a level of seven on a one to ten scale.

74. At or about 3:30 p.m., Respondent documented a reassessment of Patient W.T.'s pain. Respondent documented that Patient W.T. was sleeping in response to the 2 mg of morphine she documented administering at 3:00 p.m.

75. Despite documenting that Patient W.T. was sleeping in one section of W.T.'s medical record; in another section of W.T.'s medical record, Respondent documented that she administered 4 mg of morphine to W.T. for pain at a level of seven on a one to ten pain scale.

76. At or about 3:45 p.m., the pharmacy received the physician written order to discontinue the order for 4 mg of morphine and start morphine 1 to 2 mg every six hours IV PRN, or as needed, for pain.

77. On or about December 11, 2010, Respondent removed morphine from Acudose, ostensibly for Patient W.T., 13 times, representing a total of 36 mg of morphine: significantly more morphine than authorized by the physician.

78. On or about December 11, 2010, Patient W.T. experienced symptoms that could have been caused by, or exacerbated by, morphine including nausea, vomiting, and decreased gastrointestinal motility.

79. On or about December 11, 2010, Respondent documented that she noted the physician order to decrease the morphine, yet continued to remove multiple doses of morphine from Acudose, ostensibly for Patient W.T.

80. On or about December 11, 2010, Respondent documented inconsistently in W.T.'s record, noting in one section that W.T. was sleeping and noting in another section that W.T. needed more morphine for pain.

81. On or about December 11, 2010, Respondent was removing multiple doses of morphine from Acudose, not to treat Patient W.T. for pain, but was removing the morphine for another unauthorized purpose.

Patient L.Z.

82. During that same shift, on or about December 11, 2010, Respondent was not assigned to provide care to Patient L.Z.

83. Respondent removed from Acudose one vial of 1 mg hydromorphone at or about 10:35 a.m., and another vial of 1 mg hydromorphone at or about 4:02 p.m., ostensibly for Patient L.Z.

84. Respondent did not document the administration and/or waste of the hydromorphone vials that she removed from Acudose on or about December 11, 2010, ostensibly for Patient L.Z.

85. On or about December 11, 2010, at or about 7:00 p.m., the Charge Nurse who had been on duty during the day (Day Charge Nurse) gave a nursing report to the Charge Nurse coming on duty for the night shift (Night Charge Nurse). The Day Charge Nurse notified the Night Charge Nurse that Respondent had removed hydromorphone for a patient who was not assigned to her care.

86. Both charge nurses discussed their concerns about this and also noted that Respondent was scheduled to work again the following morning, a Sunday, on or about December 12, 2010.

87. The Night Charge Nurse reviewed Acudose reports showing the controlled substances Respondent removed for patients during the day on or about December 11, 2010.

88. The Night Charge Nurse observed that Respondent had removed a total of 36 mg of morphine for Patient W.T.

89. On or about December 12, 2010, at or about 7:00 a.m., the Day Charge Nurse returned to work and the Night Charge Nurse reported her findings to the Day Charge Nurse about the amount of morphine Respondent had removed for Patient W.T. on the previous day.

90. On or about December 12, 2010, at or about 7:00 a.m., Respondent arrived at MMMC to work a day shift. She was scheduled to work until 7:00 p.m., but only worked until 1:45 p.m. During that time, Respondent removed eight vials of morphine and one vial of hydromorphone from Acudose, ostensibly for patients, but only documented administering two of the medications. The following table illustrates the details surrounding the removal of these medications.

Patient	Medication Removed from Acudose	Date and Time Removed	Waste	Physician Order	Time Drug Charted as Given	Comments
W.T.	One morphine 2 mg vial	12/12/10 7:26 a.m.	No waste	Morphine 1 mg to 2 mg every 6 hours IV as needed for pain.	8:54 a.m. 2 mg	No reference to pain in nurse notes.
M.L.F.	One morphine 4 mg vial	12/12/10 7:38 a.m.	No waste	Morphine 2 mg to 4 mg IV every 2 hours as needed for pain.	7:38 a.m. 4 mg	M.L.F. was on a ventilator and a continuous IV infusion of a sedative called midazolam.
M.L.F.	One morphine 4 mg vial	12/12/10 7:47 a.m.	No waste	See above.	Not charted as given to M.L.F.	M.L.F. could not receive another dose until 9:38 a.m.
M.L.F.	One morphine 4 mg vial	12/12/10 8:08 a.m.	No waste	Morphine 2 mg to 4 mg IV every 2 hours as needed for pain.	Not charted as given to M.L.F.	M.L.F. could not receive another morphine dose at this time.
M.L.F.	One morphine 4 mg vial	12/12/10 8:42 a.m.	No waste	See above.	Not charted as given to M.L.F.	M.L.F. could not receive morphine at this time.
M.L.F.	One morphine 4 mg vial	12/12/10 9:09 a.m.	No waste	Morphine 2 mg to 4 mg IV every 2 hours as needed for pain.	Not charted as given to M.L.F.	M.L.F. could not receive morphine at this time.

Patient	Medication Removed from Acudose	Date and Time Removed	Waste	Physician Order	Time Drug Charted as Given	Comments
M.L.F.	One morphine 4 mg vial	12/12/10 10:47 a.m.	No waste	See above.	Not charted as given to M.L.F.	M.L.F. cannot receive morphine this often.
M.L.F.	One morphine 4 mg vial	12/12/10 11:29 a.m.	No waste	Morphine 2 mg to 4 mg IV every 2 hours as needed for pain	Not charted as given to M.L.F.	M.L.F. cannot receive morphine this often.
L.Z.	One hydromorphone 1 mg vial	12/12/10 1:43 p.m.	No waste	Hydromorphone 0.5 mg to 1 mg IV every 2 hours as needed for severe pain.	Not charted as given to L.Z.	L.Z. was not assigned to Respondent's care.

91. On or about December 12, 2010, after receiving a report from the Night Charge Nurse, the Day Charge Nurse sat at the nursing station next to the Acudose machine and observed Respondent go straight to the Acudose machine, remove morphine out of Acudose, draw the medication up in a small syringe, drop the syringe into her pocket, and go directly to the employee bathroom.

92. On or about December 12, 2010, the Day Charge Nurse observed Respondent do this several times, about every 15 to 20 minutes;

each time Respondent drew the medication up in a small syringe, placed the syringe in her pocket, and entered the employee bathroom.

93. On or about December 12, 2010, the Day Charge Nurse observed Respondent exit the bathroom and drop a small syringe into the box used for discarding syringes, known as the "Sharps Box." The Day Charge Nurse instructed the Unit Secretary to observe Respondent because the Unit Secretary was seated behind the Acudose machine.

94. During this time, the Unit Secretary observed Respondent enter Acudose about five separate times and draw medication into a syringe, drop the syringe into her pocket, and go directly into the employee bathroom.

95. On or about December 12, 2010, at or about 1:45 p.m., the Director of MICU escorted Respondent to the Director's office and confronted her about removing excessive amounts of morphine. The Nursing Supervisor was also present.

96. During that meeting, Respondent was directed to submit to a drug test and was escorted to Human Resources in order to complete the test.

97. Respondent refused to take the drug test, stating that she was refusing due to principle.

98. On or about December 13, 2010, Respondent was terminated from her position at MMMC.

99. On or about January 27, 2011, Respondent provided the Department with a written response regarding this matter stating in part, "In regards to dispensing multiple amounts of drugs in a short time, I did dispense several morphines for the patient I was caring for. The patient was ventilated and required sedation with the every two hour turning and caring for the patient. To save time I dispensed several morphines. All morphines were utilized on this patient. When I was asked to go to Human Resources my Director did not allow me to document any further. Had I the opportunity to document it would have been noted that all morphines were given to the patient I was caring for."

100. According to Patient M.L.F.'s medical records, M.L.F. was ventilated, and was under sedation from a continuous infusion of midazolam, a sedative. Patient M.L.F. could have morphine every two hours, but if Respondent had given morphine to M.L.F. in this manner prior to being removed from MICU at about 1:45 p.m., M.L.F. would have

received morphine at 7:38 a.m., 9:38 a.m., 11:38 a.m., and 1:38 p.m., a total of four doses. Between 7:38 a.m. and 11:29 a.m., Respondent removed seven vials of morphine from Acudose, ostensibly for M.L.F.

101. Regarding Respondent's allegation that she did not have an opportunity to document her care of M.L.F., Respondent made notations or documented medications in M.L.F.'s medical record at 7:38 a.m., 8:00 a.m., 8:57 a.m., 9:00 a.m., 9:49 a.m., and 1:02 p.m.

102. On or about February 15, 2011, the Director of MICU was interviewed by a Department investigator. The Director explained that there were multiple 4 mg doses of IV morphine that Respondent pulled from Acudose that would be considered excessive. The Director also explained that Respondent did not scan the medication or the patient's identification bracelet with the Bar Code Computer. The Director explained that nurses are to scan both the medication and the patient's identification bracelet to verify that the right medication is given to the right patient. Regarding Respondent's behavior, the Director described Respondent as "emotionally impaired," stating that Respondent was a good nurse, but had unexpected angry outbursts at times and at times acted tearful and, "displayed every emotion you could imagine."

103. On or about February 16, 2011, a Department investigator interviewed the Day Charge Nurse who worked with Respondent on the weekend in which these incidents occurred. Regarding Respondent's behavior, the Day Charge Nurse stated that she never saw Respondent impaired, but that she was "a little bit off, has mental issues and is known to be on a lot of medications, anyway, a very hyper person."

104. On or about February 16, 2011, a Department investigator interviewed the MICU Unit Secretary who was on duty during the weekend in which these incidents occurred. The Unit Secretary stated she observed that at around noon, Respondent appeared to be impaired and was saying strange things and, "making off the wall comments." The Unit Secretary stated she has known Respondent since she was hired and had not seen this type of behavior from Respondent prior to this incident.

105. On or about February 16, 2011, a Department investigator interviewed the Nursing Supervisor on duty when these incidents occurred. The Nursing Supervisor stated that during the meeting with the Director, Respondent could not provide a reasonable answer to why she removed so much morphine and refused to take a drug test. Regarding Respondent's behavior, the Nursing Supervisor stated that a few days prior to the

incident she noticed that Respondent was, "very hyper and talkative," and "was not acting like herself." The supervisor also noticed that Respondent's appearance was not how it normally looked. The supervisor explained that Respondent, "was always very well groomed," but recently her appearance had changed and, "her hair was messy and her clothes did not look right." The Nursing Supervisor also stated that Respondent had been taking multiple breaks during her work shift.

106. On or about February 17, 2011, a Department investigator interviewed the Night Charge Nurse who was on duty the weekend in which these incidents occurred. The Night Charge Nurse examined the computer reports and observed that over the previous week, Respondent had been removing medication for patients that were not under her care. She also observed that Respondent had removed morphine 13 times, a total of 36 mg, on one patient. The Night Charge Nurse explained that giving that patient morphine every four hours would have been sufficient and stated, "[Respondent] could not have given that patient medication that many times; it was not logical."

COUNT ONE

107. Petitioner realleges and incorporates paragraphs one (1) through one hundred six (106), as if fully set forth herein.

108. Section 464.018(1)(h), Florida Statutes (2010), provides that unprofessional conduct as defined by Rule of the Board of Nursing constitutes grounds for disciplinary action.

109. Rule 64B9-8.005(1), Florida Administrative Code, provides that unprofessional conduct includes inaccurate recording.

110. As set forth above, Respondent engaged in unprofessional conduct by removing multiple doses of morphine and hydromorphone from Acudose, indicating in Acudose that the medications were intended for patients, but failed to document that she administered or otherwise accounted for the medications. Respondent documented inconsistent and nonsensical notations in Patient W.T.'s medical record by documenting in one section of the record that W.T. was sleeping in response to pain medication she administered and noting at the exact same time in another section of the record, that pain medication was administered to W.T. for pain described on a pain scale of one to ten.

111. Based on the foregoing, Respondent violated Section 464.018(1)(h), Florida Statutes (2010), engaging in unprofessional conduct as defined by Rule 64B9-8.005(1), Florida Administrative Code, to include inaccurate recording.

COUNT TWO

112. Petitioner realleges and incorporates paragraphs one (1) through one hundred six (106), as if fully set forth herein.

113. Section 464.018(1)(i), Florida Statutes (2010), provides that engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in chapter 893, for any other than legitimate purposes authorized by this part, constitutes grounds for discipline of a licensee by the Board of Nursing.

114. As set forth above, Respondent engaged or attempted to engage in the possession of hydromorphone and/or morphine, drugs set forth in Chapter 893, Florida Statutes, for an unauthorized purpose.

115. Based on the foregoing, Respondent violated Section 464.018(1)(i), Florida Statutes (2010), by engaging or attempting to engage in the possession, sale, or distribution of controlled substances as

set forth in chapter 893, for any other than legitimate purposes authorized by this part.

COUNT THREE

116. Petitioner realleges and incorporates paragraphs one (1) through one hundred six (106), as if fully set forth herein.

117. Section 464.018(1)(j), Florida Statutes (2010), provides that being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition constitutes grounds for discipline of a licensee by the Board of Nursing.

118. Registered nurses are required to assess the condition of their patients and make complex decisions regarding patient care. Mental fitness and emotional stability are essential traits that a registered nurse must possess in order to competently practice nursing.

119. As set forth above, Respondent is unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or as a result of any mental or physical condition. Respondent removed large amounts of morphine from Acudose for an unauthorized purpose, and was observed to exhibit

changes in her appearance and behavior that could be indicative of drug use. Other nurses observed Respondent taking medication directly into the employee bathroom and discarding a syringe directly after exiting the employee bathroom. Respondent refused to submit to a drug test and has a history of substance abuse as indicated by her previous involvement with IPN.

120. Based on the foregoing, Respondent violated Section 464.018(1)(j), Florida Statutes (2010), by being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition.

WHEREFORE, the Petitioner respectfully requests that the Board of Nursing enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 10th **day of** May, **2011.**

H. Frank Farmer, Jr., M.D., Ph.D.
State Surgeon General

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FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE MAY 11 2011

PCP: 5/10/11
PCP Members: L. Kirkpatrick & B. Kemp
/CS

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v.

CASE NO.: 2011-00262

VICTORIA LEE STECKLER, R.N.,

Respondent.
_____/

SETTLEMENT AGREEMENT

Pursuant to Section 120.57(4), Florida Statutes, the above named parties hereby offer this Agreement to the Board of Nursing as disposition of the Administrative Complaint, attached hereto as Exhibit "A", in lieu of any other administrative proceedings. The terms herein become effective only if and when a Final Order accepting this Agreement is issued by the Board and filed. In considering this Agreement, the Board may review all investigative materials regarding this case. If this Agreement is rejected, it, and its presentation to the Board, shall not be used against either party.

STIPULATED FACTS

1. Respondent is a **REGISTERED NURSE** in the State of Florida holding license number **2247992.**

2. The Respondent is charged by an Administrative Complaint filed by the Department and properly served upon Respondent with violations of Chapters 456

and/or 464, Florida Statutes. A true and correct copy of the Administrative Complaint is attached hereto and incorporated by reference as Exhibit A.

3. Respondent neither admits nor denies the factual allegations contained in the Administrative Complaint.

STIPULATED LAW

1. Respondent admits that she is subject to the provisions of Chapters 456 and 464, Florida Statutes, and the jurisdiction of the Department and the Board.

2. Respondent admits that the stipulated facts, if proven true, constitute violations of laws as alleged in the Administrative Complaint.

3. Respondent admits that the Agreement is a fair, appropriate and reasonable resolution to this pending matter.

PROPOSED DISPOSITION

1. The Board of Nursing shall reprimand the license of the Respondent.

2. The Respondent must pay investigative costs not to exceed **six thousand five hundred fifty-nine dollars and forty-four cents ($6,559.44)** within seven (7) years from the date of entry of the Final Order. However, if the Respondent is in the Intervention Project for Nurses (IPN), the payment is due **prior** to completion of IPN. If the Respondent's license is suspended by the terms of this agreement, the payment is due **prior** to the application for reinstatement of the license. If the Respondent is placed on probation, the payment is due **prior** to the completion of the probationary period. The Respondent has the responsibility to document financial hardship **prior** to the due date of the payment. Payment must be by cashier check or

money order only. Personal checks shall not be accepted. Partial payments shall be accepted. Payment shall be made to the Board of Nursing and mailed to, Compliance Management Unit, Bin C76, P.O. Box 6320, Tallahassee, Florida 32314-6320, Attention: Nursing Compliance Officer.

3. The license of **VICTORIA LEE STECKLER, R.N.**, is suspended until she personally appears before the Board and can demonstrate her/his present ability to engage in the safe practice of nursing. That demonstration shall include at least an in-depth psychological evaluation coordinated through the Intervention Project for Nurses, with an MMPI or other appropriate testing from a psychiatrist, psychologist or other licensed mental health counselor. The Respondent shall supply a copy of the Final Order to the evaluator. The evaluation must contain evidence that the evaluator knows of the reason for referral. The evaluator must specifically advise this Board that the Respondent is presently able to engage in the safe practice of nursing or recommend the conditions under which safe practice could be attained. Prior to appearance before the Board, the Respondent must also submit proof of continued treatment and counseling if recommended in the psychological evaluation and a reentry plan. The Board reserves the right to impose reasonable conditions of reinstatement at the time the Respondent appears before the Board to demonstrate the present ability to engage in the safe practice of nursing.

4. Within thirty (30) days, the Respondent shall return her/his license to the Board office, 4053 Bald Cypress Way, Bin C02, Tallahassee, Florida 32399-3252 or shall surrender the license to an Investigator of the Department of Health. The

Respondent's employer shall immediately be informed of the suspension in writing by the Respondent with a copy to the Board office.

5. The Respondent shall not violate Chapter 456 or 464, Florida Statutes, the rules promulgated pursuant thereto, any other state or federal law, rule, or regulation relating to the practice or the ability to practice nursing. Violation of an order from another state/jurisdiction shall constitute grounds for violation of the Board Order adopting this Agreement.

6. It is expressly understood that this Agreement is subject to the approval of the Board and Department and has no force and effect until an Order is entered adopting the Agreement.

7. This Agreement is executed by the Respondent for the purpose of avoiding further administrative action by the Board of Nursing regarding the acts or omissions specifically set forth in the Administrative Complaint attached hereto. In this regard, Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent prior to, or in conjunction with, consideration of the Agreement. Furthermore, should this joint Agreement not be accepted by the Board, it is agreed that presentation to, and consideration of, this Agreement and other documents and matters by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation, consideration or resolution of these proceedings. Respondent shall offer no evidence, testimony or argument that disputes or contravenes any stipulated fact or conclusion of law.

8. Respondent and the Department fully understand that this joint Agreement and subsequent Final Order incorporating same will in no way preclude additional proceedings by the Board and/or Department against the Respondent for acts or omissions not specifically set forth in the Administrative Complaint attached hereto. This Agreement relates solely to the current disciplinary proceedings arising from the above-mentioned Administrative Complaint and does not preclude further action by other divisions, departments, and/or sections of the Department, including but not limited to the Agency for Health Care Administration's Medicaid Program Integrity Office.

9. The Respondent waives the right to seek any attorney's fees or costs from the Department in connection with this disciplinary proceeding.

10. Respondent waives all rights to appeal and further review of this Agreement and these proceedings.

WHEREFORE, the parties hereto request the Board to enter a Final Order accepting and implementing the terms contained herein.

SIGNED this 20 day of May, 201_.

Victoria Steckler
VICTORIA LEE STECKLER, R.N.

Before me personally appeared Victoria Steckler whose identity is known to be by FLDL (type of identification), and who under oath, acknowledges that his/her signature appears above.
Sworn to and subscribed by Respondent before me this 20 day of May, 2011.

Laura J. Rivera
Notary Public
My Commission Expires: 5/17/14

LAURA J. RIVERA
MY COMMISSION # DD 995055
EXPIRES: May 17, 2014
Bonded Thru Notary Public Underwriters

APPROVED this 24th day of May, 2011.

H. Frank Farmer, Jr., M.D., Ph.D.
State Surgeon General

Counsel for Petitioner:
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