BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of	§
Registered Nurse License Number 730349	§
issued to LINDA NORLINE CUMBERLAND	§

ORDER OF THE BOARD

On this day, the Texas Board of Nursing, hereinafter referred to as the Board, accepted the voluntary surrender of Registered Nurse License Number 730349, issued to LINDA NORLINE CUMBERLAND, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

Respondent waived representation by counsel, informal proceedings, notice and hearing.

The Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Respondent's license to practice professional nursing in the State of Texas is currently in delinquent status.

2. Respondent waived representation by counsel, informal proceedings, notice and hearing.

3. Respondent received an Associate Degree in Nursing from Chaffey College, Rancho Cucamonga, California, on May 22, 2000. Respondent was licensed to practice professional nursing in the State of Texas in June 28, 2006.

4. Respondent's professional nursing employment history is unknown.

5. On or about July 5, 2013, Respondent's license to practice professional nursing was issued a Decision and Order by the California Board of Registered Nursing, Sacramento, California. A copy of the Decision and Order, effective July 5, 2013, is attached and incorporated, by reference, as part of this Order.

6. On July 25, 2013, the Board received a notarized statement from Respondent voluntarily surrendering the right to practice nursing in Texas. A copy of Respondent's notarized statement, dated July 25, 2013, is attached and incorporated herein by reference as part of this Order.

7. The Board policy implementing Rule 213.29 in effect on the date of this Agreed Order provides discretion by the Executive Director for consideration of conditional reinstatement after proof of twelve (12) consecutive months of abstinence from alcohol and drugs followed by licensure limitations/stipulations and/or peer assistance program participation.

8. The Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or chemical dependency.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient cause pursuant to Section 301.452(b)(8), Texas Occupations Code, to take disciplinary action against Registered Nurse License Number 730349, heretofore issued to LINDA NORLINE CUMBERLAND, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

4. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

5. Under Section 301.453(d), Texas Occupations Code, the Board may impose conditions for reinstatement of licensure.

6. Any subsequent reinstatement of this license will be controlled by Section 301.453(d), Texas Occupations Code, and 22 TAC§§213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

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ORDER

NOW, THEREFORE, IT IS ORDERED that the voluntary surrender of Registered Nurse License Number 730349, heretofore issued to LINDA NORLINE CUMBERLAND, to practice nursing in the State of Texas, is accepted by the Executive Director on behalf of the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice professional nursing, use the title of "registered nursing" or the abbreviation "RN"or wear any insignia identifying herself as a registered nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a registered nurse during the period in which the license is surrendered.

2. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order; and, RESPONDENT has obtained objective, verifiable proof of twelve (12) consecutive months of sobriety immediately preceding the petition.

3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

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

Effective this _25th_ day of July, 2013.

TEXAS BOARD OF NURSING

By: 

Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf
of said Board

7-25-13

I Linda Cumberland wish to surrender my Texas nursing license

Linda Cumberland

State of California

County of San Bernardino

Subscribed and sworn to (or affirmed) before me on this 25th day of July, 2013

JASON G. THOMAS
Commission # 1980253
Notary Public - California
San Bernardino County
My Comm. Expires Jun 27, 2016

Jason G. Thomas, Notary Public

I hereby certify the
foregoing to be a true copy
of the documents on file in our office.

BOARD OF REGISTERED NURSING

Louise R. Bailey, M. ED., RN
Executive Officer

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: LINDA NORLINE CUMBERLAND P.O. Box 803 Alta Loma, CA 91701 Registered Nurse License No. 568737 Respondent.	Case No. 2012-107 OAH No. 2011090427

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on July 5, 2013.

IT IS SO ORDERED this 6th day of June, 2013.

Raymond Mallel, President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: LINDA NORLINE CUMBERLAND, Registered Nurse License No. RN 568737, Respondent.	Case No. 2012-107 OAH Case No. 2011090427

PROPOSED DECISION

Michael A. Scarlett, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on March 19 and 20, 2012, at Los Angeles, California.

Linda Sun, Deputy Attorney General, represented Complainant Louise R. Bailey, M.Ed., RN.

Edward O. Lear, Attorney at Law, represented Linda Norline Cumberland (Respondent) who was present at hearing.

Oral and documentary evidence was taken and the matter was submitted for decision on March 20, 2012.

FACTUAL FINDINGS

1. On December 22, 2011, Louise R. Bailey, M.Ed., R.N. (Complainant) filed the First Amended Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs. On January 18, 2012, Respondent filed a Notice of Defense and the hearing in the above-captioned matter ensued.

2. On July 18, 2000, the Board issued registered nurse license number 568737 to Respondent. Respondent's license will expire on July 31, 2014, unless renewed.

Stipulation

3. On March 13, 2012, the parties entered into a Joint Stipulation in which Respondent stipulated to the truth of each and every factual allegation contained in

paragraphs 14-16 (page 4 line 1 though page 8 line 17) of the First Amended Accusation, with the following clarification: With regard to the allegations contained in paragraph 16 which refer to "No order" or "No physician order" or "No additional order", "Respondent stipulates that there were no written orders at the specified time, but reserves the right to present evidence that verbal orders existed."

Background

4. Respondent was employed as a registered nurse at Arrowhead Regional Medical Center (ARMC) from about July 15, 2000 to about February 17, 2009. She was initially assigned to the Burn Unit for about one year, but transferred to the Emergency Room (ER) because she enjoyed the "fast pace" of the ER. She worked in the ER for about three years and then transferred to the Pre-Op Unit. Respondent testified that she transferred to the Pre-Op Unit in 2004 because she was "burned out" in the ER. In 2006, Respondent requested a leave of absence from ARMC to accept a 13-week traveling nurse assignment in Texas. She obtained her registered nurse license in Texas for this assignment, but the Texas license is currently expired. When Respondent returned to ARMC in 2006, she was again assigned to the ER. From 2007 until February 2009, Respondent worked as a "charge nurse" in the ER. As the charge nurse, Respondent assisted the nurse manager by directing patient traffic, assigning patients to beds, transferring patients to other hospital units, ensuring nurses were taking breaks and covering for each other, and discharging patients. Respondent also monitored and supervised "jail check" patients and "5150" patients who were admitted into the ARMC ER. The ARMC handled a high volume of trauma cases in the ER and the hospital's ER is considered one of the busiest ERs in San Bernardino County. In February 2009, as a result of the complaint and investigation that resulted in the First Amended Accusation in this proceeding, Respondent was asked by management at ARMC to resign or she would be terminated. Respondent resigned from ARMC effective February 19, 2009.

The Pyxis System

5. At all times relevant to the allegations in the First Amended Accusation, ARMC used a drug dispensing system called the "Pyxis System" (Pyxis). The Pyxis is a computerized automated medication dispensing machine. The user must enter a password to gain access and dispense medication from the machine. The machine records the user name, patient name, and medication, dose, date and time of the medication withdrawal. The Pyxis system is integrated with the hospital pharmacy inventory management systems.

Audit of Respondent's Pyxis Medical Usage

6. On February 11, 2009, Respondent notified Linda Dunn (Dunn), the Assistant Nurse Manager in the ER and Respondent's supervisor, that she had received a telephone call from her landlord advising Respondent that a suspicious person was around her apartment. Respondent told Dunn there was an emergency at her residence and that she needed to leave work "right away." Dunn advised Respondent she could leave but that she would have to return later that afternoon. Dunn testified that Respondent's request was

unusual and that she became suspicious. Dunn reviewed Respondent's assignments and checked the Pyxis for the medications pulled by Respondent for that day. Dunn's review of Respondent's Pyxis usage and the charts of the patients assigned to Respondent revealed that medications had been pulled from Pyxis that were not administered to patients and that multiple medications had been pulled without the orders from doctors being documented in the patients' charts. Thereafter, Dunn reported the Pyxis discrepancies to her manager and a full investigation ensued. A pharmacy audit of Respondent's medical usage was requested for the proceeding one year, February 2008 through February 2009. The pharmacy audit revealed that Respondent pulled a high amount of Dilaudid in comparison to other nurses from February 2008 through February 2009.

7. Subsequently, a random three-month audit of Respondent's Pyxis usage and her patients' medical charts from November 2008 through February 2009, showed Respondent accessed and administered medications to 18 patients. The three-month audit provided the basis upon which the Board based the First Amended Accusation in this case. The audit revealed that medications were accessed and administered without a record of a physician's order authorizing the medications and that there were discrepancies in the dosages of medications accessed from the Pyxis and the dosages of medications administered to the patients for which the medications were intended. Respondent also failed to note in the patient's medical chart that the medication was wasted or returned if medication accessed from the Pyxis was not administered to the patient.[1] The medications accessed by Respondent from the Pyxis during this three-month period included Dilaudid, Morphine, Ativan, Norco, and Xanax.

8. The three-month revealed that on 21 occasions Respondent pulled medications from the Pyxis machine and the patients' medical charts showed no physician order for the access or administration of the medications to the patients. There were also 21 instances in which patients' medical charts revealed discrepancies between the dosages of medication accessed from the Pyxis machine and the dosages administered to the patients, and Respondent failed to note whether the medications were wasted or returned. On 13 occasions, Respondent pulled medications from the Pyxis and did not chart the medications in the patients' medical chart. The three-month audit revealed that 28 mg of Dilaudid, 10.5 mg of Morphine, 2 Norco tablets, and 3 mg of Ativan were unaccounted for in Respondent's medical chart notes for her patients. Finally, there were seven instances where Respondent accessed medications from the Pyxis after the patients had been discharged from the hospital.

Respondent's Testimony

9. Respondent became the charge nurse in the ARMC ER in 2007 and maintained that position until her resignation in February 2009. Dunn testified that as charge nurse, Respondent oversaw the flow of patients being admitted into the ER, covered other

[1] Wastage of medications requires the nurse that pulls the medication from the Pyxis to request a second nurse to witness the disposal of the medication and sign-off or document that the medications were "wasted."

nurses during their breaks, and helped out other nurses "all over" the ER. Respondent admitted that there were discrepancies between the medications she accessed from the Pyxis and the notes in the patients' medical charts regarding the administration of those medications. She admitted that she made charting errors including failing to accurately note the proper dosages of medications administered, failing to note wasted or returned medications in the patients' medical chart, and that she accessed medications pursuant to verbal orders by physicians but failed to follow-up and obtained signatures from physicians authorizing the verbal orders.

10. Respondent asserts that she always had verbal orders from the physicians authorizing her to pull the medications, although the patients' medical charts did not note the existence of the verbal orders or subsequent written orders or signatures by physicians authorizing the verbal orders. She explained that the ARMC ER is a hectic and fast pace facility that serves a high volume of patients. She maintained that verbal orders from physicians were frequently used to access medications from the Pyxis because of the urgency care needs of the ER. Respondent stated the AMRC ER was usually short-staffed, very busy, hectic, and operating at a fast pace, which contributed to the hectic nature of the work. She believed that contributed to her charting errors, including failing to chart verbal orders and obtaining sign-offs for the verbal orders from the physicians. When helping other nurses Respondent frequently pulled medications for those nurses based upon verbal orders, but relied on the other nurses to chart the medications in the patients' charts and to follow-up with the physician to confirm the verbal order. Respondent stated that her duties as a "charge nurse" caused her medication usage to be higher when compared to other nurses, and that she worked longer hours than most nurses in the ER.[2] Respondent candidly admitted that she was an aggressive nurse who was comfortable making decisions under stress and handling multiple patients in the AMRC ER, including pulling medications for other nurses based on verbal orders from physicians. She testified that certain physicians were very comfortable with working with her and always came to her with verbal orders because they were confident in her abilities.

11. Dunn testified that the ARMC policy regarding accessing and administering medications to patients required that: (1) there be a physician's order authorizing the medication; (2) the nurse document the administration of the medication in the patient's medical charts; (3) if the initial dose of medication does not resolve the patient's pain the nurse requests the physician's approval before more medication is pulled and administered; and (4) if a verbal order is received from the physician, the nurse must document the verbal order in the patient's chart and follow-up by documenting medical chart with the physician's signature for the verbal order within 48 hours. On February 11, 2009, when questioned by Dunn, Respondent did not state that she had verbal orders for the medications accessed from the Pyxis and administered to patients that day. Although Dunn did not recall whether she

[2] Respondent worked 12-hour shifts, working three to four days on, taking one day off. She typically worked five to six days per week for a total of about 60 hours per week. Respondent worked the increased number of hours because her son was in college out of state and she needed the money to pay his tuition.

specifically asked Respondent if verbal orders existed, Respondent told Dunn that she always pulled pain medications for her patients, which lead Dunn to believe Respondent was pulling medications without a physicians' order. Dunn advised Respondent that doing so was practicing medicine outside of her scope as a registered nurse. Dunn stated Respondent seemed to "shrug off" Dunn's concerns and stated that other nurses in the ER were afraid to pull pain medications without a physician's order. In June 2010, when interviewed by Board investigator Mario Castro, Respondent stated that she never pulled or administered medications without a physician's order. Respondent told Castro that because she was the most senior and "aggressive nurse" in the ER, she would take a high volume of verbal orders from doctors and would "jump in" and help other nurses who were not as aggressive or was tied up with other patients.

12. At hearing, Respondent testified that in February 2009, she believed she was being accused of taking drugs for personal use. She stated she did not "shrug off" Dunn's questions about pulling medications without a physicians' order. She was just surprised by Dunn's inquiry because medications were frequently pulled in the AMRC ER based upon physician verbal orders. Respondent denied telling Dunn she ever gave medications to patients without a physician's order, verbal or otherwise. She was aware of ARMC's policy regarding physicians' verbal orders, but was not clear how soon a nurse was required to obtain a physician's written sign-off. Respondent believed that the physician sign-off was probably required by the end of the nurse's shift.

13. Respondent also testified that discrepancies involving the access of medications for patients who had already been discharged typically were a result of providing medications to "drug seekers" who were frequently admitted into the AMRC ER. Respondent explained that these patients, although admitted, were frequently not assigned ER beds and were immediately discharged by the physicians to make room for other patients. The orders for medications were given by physicians but because they were discharged so quickly, the patient's records indicated a discharge before the nurse was able to administer the medication. The "drug seekers" or addicts would not leave the ER until they were given the medications, normally Morphine or Dilaudid, even though they had already been discharged.

Expert Witness Testimony

14. Cathy Horowitz, RN, PHN, (Horowitz) testified as an expert witness on behalf of the Board. After reviewing the Board's investigation records of the complaint filed against Respondent, including Mario Castro's July 19, 2010 investigation report, Respondent's personnel records from ARMC, and the pharmacy audits conducted by the ARMC, Horowitz concluded that Respondent obtained controlled substances from the Pyxis without a physician's order, possessed controlled substances that was not prescribed by a physician in that Respondent failed to administer, return, or waste unused amounts of controlled substances and/or account for the all controlled substances she removed from the Pyxis, and that Respondent furnished or administered a controlled substance to patients without a physician's order in that there were multiple occasions where Respondent accessed

medications from the Pyxis and administered to patients with no documentation that the medication had been ordered by a physician. Horowitz opined that Respondent failed to apply or exercise the "Patient's Five Rights" described as "right patient, right medication, right dose, right time, and right route" when she accessed medications from the Pyxis and administered them to patients without a physician's order that was documented in the patients' medical charts.

14(a) Horowitz concluded that Respondent's conduct in obtaining, possessing, and administering controlled substances constituted "an extreme departure from the standard of care, which under similar circumstances would have been exercised by a competent registered nurse." She opined that this extreme departure constituted gross negligence because Respondent "knew or should have known that obtaining, possessing, and administering controlled substances without a physician's order and properly accounting for the medications' whereabouts could have jeopardized the health or life of self, patients, and others by exposure to highly addictive and potentially harmful or lethal medication."

14(b) Horowitz further concluded that it was unprofessional conduct for Respondent to make false, grossly incorrect, grossly inconsistent, or unintelligible entries in patient or hospital records pertaining to controlled substances when Respondent "failed to correctly and consistently prepare complete documentation pertaining to the administration and accounting of controlled substances in the MAR and Narcotic Records." She opined that Respondent's failure to properly document the access and administration of the controlled substances to patients was an extreme departure from the standard of care and constituted gross negligence because failing to "prepare accurate, complete, and consistent records pertaining to acquisition, possession, administration, and waste or return of controlled substances could jeopardize the health or life of patients and others by failing to account for highly addictive and potentially harmful or lethal medications."

14(c) Finally, Horowitz opined that Respondent's failure to observe the proper procedures for returning or wasting, and documenting medications accessed from the Pxyis, but not administered to patients, was an extreme departure from the standard of care and constituted gross negligence.

15. Horowitz concluded that in her professional opinion, Respondent presents a clear and present danger to the public safety in the performance of registered nursing duties and it is not appropriate for Respondent to function in the capacity of a registered nurse. Respondent did not offer expert witness testimony in response to the Board's expert.

Ultimate Factual Findings

16. The aggressive and confident manner in which Respondent performed her duties as a charge nurse in the AMRC ER resulted in Respondent failing to obtain proper physician authorization for medications pulled from the Pyxis and administered to patients. The evidence established that verbal orders were routinely given in the AMRC ER by physicians because of the hectic and fast paced activity in the emergency room. However,

without proper documentation of the verbal orders or a subsequent written sign-off for the verbal order by the physician, the verbal orders are deemed not to exist. Even though Respondent asserts she had verbal orders from the physicians, the verbal orders were not confirmed in the patients' medical charts. Absent any indication in a patient's medical chart of the existence of a verbal order, it cannot be confirmed that the medications were pulled from the Pyxis and administered to patients based upon a physician's order. Thus, Respondent accessed medications from the Pyxis and administered the medications to the patients without having the proper authorizations from a physician. This conduct was an extreme departure from the standard and constituted gross negligence which could have jeopardized the health or life of her patients.

17. Respondent also failed to properly document the wastage or return of medications accessed from the Pyxis, but not administered to patients under her care. Respondent pulled medications from the Pyxis and failed to account for them in patients' medical charts in that she failed to properly document the wastage or return of the medications. Respondent admitted that she knew the proper procedures for wasting and returning unused controlled substances but failed to apply these procedures on 21 instances. Respondent's conduct in failing to properly waste or return controlled substances accessed from the Pyxis and not administered to patients, was an extreme departure from the standard of care, constituted unprofessional conduct and gross negligence in the performance of her duties, and placed the patients and others in jeopardy of harm.

18. The evidence did not establish that Respondent illegally obtained or possessed a controlled substance, or that she personally used or abused a controlled substance or dangerous drug. Respondent submitted to a drug test on February 11, 2009, the day the discrepancies in her medication usage was discovered by Dunn. Two attempts were made to obtain urine samples from Respondent but she was unable to produce a sufficient amount of urine to complete the test. Subsequently, on June 16, 2010, Respondent submitted to a drug test requested by the Board which revealed negative results for alcohol and control substances. Linda Dunn testified that she did not believe Respondent was accessing and personally abusing drugs and Board Senior Investigator Mario Castro testified that there was no evidence that Respondent was using or abusing drugs.

19. It was not established by clear and convincing evidence that Respondent was practicing medicine outside of the scope of her registered nurse license. Verbal orders were routinely given by physicians in the AMRC ER. The ER was frequently understaffed, hectic and fast paced, and as a charge nurse, Respondent was aggressive in performing her duties. Respondent prided herself on quickly processing and treating a high volume of ER patients, and physicians counted on Respondent to make decisions quickly with minimal supervision. While Dunn testified that she believed Respondent was pulling medications without a physician's order, she corroborated Respondent's testimony that physicians frequently give verbal orders in the very busy AMRC ER, and Respondent steadfastly asserted she always had verbal orders from the physicians before pulling medications from the Pyxis. Respondent accessed and administered medications to patients without documenting the existence of verbal orders or the a subsequent physician sign-off in the patients' medical

chart for the verbal order. Because Respondent failed to document the physicians' orders, verbal or otherwise, in the patients' medical charts, it must be concluded she administered or furnished medications without a physician's order which was below the standard of care and constituted gross negligence. However, it was not established by clear and convincing evidence that Respondent acted without authorization or directives from the physicians. Verbal orders were frequently given in the AMRC ER and, as the charge nurse, physicians depended upon Respondent to quickly process the patients through the ER. Because the evidence established verbal orders were frequently made by AMRC ER physicians, it cannot be established by clear and convincing evidence that Respondent's conduct, particularly given her duties as a charge nurse, amounted to practicing outside the scope of her license.

Evidence in Mitigation

20. In June 2008, Respondent was diagnosed with insomnia which was subsequently related to stress and anxiety. Respondent was treated with medications for her stress/anxiety and insomnia from June 2008 through March 2009. Respondent's stress and anxiety were caused by her only son leaving home to attend college in South Carolina in the Fall of 2007, and her decision to increase the number of hours she was worked at AMRC. Respondent stated that she worked additional hours both to help pay for her son's college tuition and to attempt preoccupy herself to overcome the anxiety and depression she felt when her son left for college. Respondent testified that that these circumstances contributed to the stress and anxiety she was under at work and negatively impacted her work performance.

21. Respondent's work performance evaluations at ARMC from 1994 to 2008 showed that she met or exceeded all areas of job performance during these evaluation periods. However, it was noted in 1993 that she was "below job standards" for punctuality and she had a "Letter of Reprimand" from AMRC for tardiness on January 22, 1998. Respondent also had a "Letter of Reprimand" from AMRC for failing to document on February 8, 2008.

22. Linda Dunn, Respondent's supervisor, told Board investigators that Respondent was a "good nurse" who always helped other nurses within her unit by covering patients not assigned to her, but that over time, Respondent appeared to burn-out. Dunn testified at hearing that she had a "good professional working relationship" with Respondent and that she (Dunn) was really "downhearted" as a result of the Board's investigation of Respondent. Dunn considered Respondent a friend and stated that there was no evidence that Respondent was personally using the controlled substances she accessed from the Pyxis and she did not believe Respondent was using the drugs. Dunn testified that she did not believe Respondent posed a risk to the public if she was allowed to retain her registered nursing license, but that she was concerned about Respondent's shoddy documentation of medications accessed from the Pyxis. On February 7, 2012, Dunn wrote a letter of recommendation for Respondent for employment at another facility. Dunn stated that she "had grown to trust [Respondent] with more and more responsibilities" and that Respondent have proven to be "reliable and efficient." Dunn also described Respondent as being "well-

liked at Arrowhead Regional Medical Center, by patients, physicians, and her peers," and being "dependable, a hard worker, and one who possessed good problem solving skills, which was essential for the role of being a Charge Nurse in a busy, dynamic, ever changing Emergency Department." Finally, Dunn described Respondent as "nothing short of a phenomenal employee while at employed at Arrowhead," stating that she was "more than happy" to have Respondent working for her.

23. Dr. Dorian Synder, MD, an Attending Physician at ARMC ER, wrote a letter on Respondent's behalf. Dr. Synder stated that she has known Respondent for 19 years and that Respondent had "behaved in [a] professional manner with her peers and displayed compassion and empathy for the patients she cares for." JoAnn Bakas, RN, wrote a character reference on behalf of Respondent stating that she had worked very closely with Respondent at AMRC and could not recall any event that would call Respondent's care or competence into to question. Bakas stated Respondent "always performed appropriately, efficiently, and faithfully," and that she "exhibited complete care and competence with professionalism to her patients and families." Bakas stated that even in light of the underlying offenses for which Respondent was charged, she "nevertheless unequivocally endorse' Respondent to hold a professional license. Finally, Linda A. Lindsey, a former employee at AMRC whose title was "Assistant Administrator/Fiscal Service-Performance Improvement" from July 2004 until Mach 2011, wrote a letter of recommendation on Respondent's behalf. Lindsey stated that she has known Respondent for over 20 years and was aware of the Board's allegations against Respondent. Lindsey stated that as a registered nurse, Respondent was busy most of the time and "appeared alert, organized, observant, and professional." She stated Respondent "always demonstrated a caring attitude toward her patients, her subordinate staff, and her peers," and that Respondent could be trusted to retain her nursing license.

24. In February and March 2012, Respondent completed a 23.5 hours of continuing education courses in Documentation for Nurses.

Cost Recovery

25. Complainant submitted evidence of the costs of investigation and prosecution of this case in the amount of $12, 502.00. These costs include 51.25 hours for Attorney General fees for a total of $8,712.50 and .50 hours of Legal Assistant Team costs for a total of $60; 20.5 hours of investigation costs for a total of $3,264.50; and expert witness cost of $465. These costs are reasonable and justified given the nature and scope of the allegations contained in Complainant's First Amended Accusation.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. The standard of proof that must be met to establish the charging allegations in this case is "clear and convincing" evidence. (*Ettinger v. Board of Medical Quality*

Assurance (1982) 135 Cal.App.3d 853.) This means the burden rests with Complainant to offer proof that is clear, explicit, and unequivocal, "so clear as to leave no substantial doubt; sufficiently strong to command the unhesitating assent of every reasonable mind. [Citations omitted.]" (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478, 487.)

Applicable Law

2. Business and Professions Code, section 2750 provides, in pertinent part, that "[e]very certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [article 3, commencing with section 2750]. As used in this article, 'license' includes certificate, registration, or any other authorization to engage in practice regulated by this chapter [chapter 6, commencing with 2700]." Expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. (Bus. & Prof. Code § 2764.) The Board may renew an expired license at any time within eight years after expiration. (Bus. & Prof. Code § 2811, subd. (b).)

3. Business and Professions Code, section 2761, subdivision (a)(1), provides, in pertinent part, that the Board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for a "[u]nprofessional conduct, which includes, but is not limited to, ... [i]ncompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

4. Business and Professions Code, section 2762 provides, in pertinent part that:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> [¶] . . . [¶]
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

5. California Code of Regulations, title 16, section 1442, provides that:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

6. California Code of Regulations, title 16, section 1443, defines "incompetence," as used in section 2761 of the Code, to mean "the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

Substantial Relationship

7. California Code of Regulations, title 16, section1444 provides in part:

> A[n] . . . act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. . . .

Causes for Discipline

8. Cause exists to discipline revoke Respondent's registered nurse license pursuant to Business and Professions Code sections 2761 subdivision (a)(1), for unprofessional conduct and gross negligence, in that Respondent accessed controlled substances and dangerous drugs from the Pyxis and administered these medications to 18 patients without proper physicians' orders, and failed to document the waste, return, and/or to account for medications administered to the 18 patients, conduct that is substantially related to the qualifications, functions and duties of licensee, by reason of Factual Findings 3 through 19.

9. Cause exists to discipline Respondent's registered nurse license pursuant to Business and Professions Code sections 2762, subdivision (a), for unprofessional conduct, in that Respondent furnished or administered a controlled substance to another without proper physicians' orders, conduct that is substantially related to the qualifications, functions and duties of licensee, by reason of Factual Findings 3 through 19.

10. Cause exists to discipline Respondent's registered nurse license pursuant to Business and Professions Code sections 2762, subdivision (e), for unprofessional conduct, in that Respondent made grossly incorrect or grossly inconsistent entries in 18 patients' medical

records by failing to correctly and consistently prepare and complete documentation pertaining to the administration, wastage and return, and/or accounting of controlled substances and dangerous drugs, conduct that is substantially related to the qualifications, functions and duties of licensee, by reason of Factual Findings 3 through 19.

11. Respondent's conduct arose directly out of her nursing responsibilities at the AMRC ER and to a substantial degree evidenced her present or potential unfitness to practice in a manner consistent with the public health, safety and welfare.

12. There was clear and convincing evidence that Respondent accessed controlled substances and dangerous drugs from the Pyxis and administered these medications to 18 patients without proper physicians' orders. Even though Respondent may have had verbal orders from physicians for some of these medications, the patients' medical records contained no notations of verbal orders or subsequent written authorizations by physicians for the medications. Verbal orders were frequently made by physicians in the AMRC ER and Respondent administered medications to patients based upon verbal orders from physicians. However, the patients' medical charts were not documented by Respondent to reflect the existence of verbal orders or subsequent written authorizations by the physicians. Without such documentation, it must be concluded that Respondent did not have physicians' orders to access and administer the medications to her patients. The failure to document the physician verbal orders or to obtain subsequent signed authorization by the physicians for the medications is an extreme departure from the falls below the accepted standards of nursing care.

13. Pursuant to a joint stipulation between the parties and Respondent's testimony, it was established by clear and convincing evidence that Respondent made errors and omissions in charting the administration of medications to 18 patients by failing to document wastage, return and/or to fully account for controlled substances and dangerous drugs she accessed from the Pyxis. As a result, significant discrepancies existed between the records of medications pulled from the Pyxis by Respondent and the medication charted as being administered to the patient. Although no patient harm resulted from Respondent's conduct, her actions jeopardized the patients' health, safety and welfare. Respondent's conduct represented an extreme departure from the standard of care and constituted unprofessional conduct and gross negligence

14. The medications that were typically ordered for patients with pain in the ER were Dilaudid and Morphine. Documenting the administration or wastage of these medications is a critical nursing function. Documentation of the physician's authorization for, and the administration of, such medications is always important, but in a hectic and fast paced environment such as the AMRC ER, where patients are transferred from one nurse to another, many times because of overlapping shifts, such accurate documentation is critical to the health and safety of the patients. If a nurse administers a medication but fails to document that fact, there is a danger that a physician or nurse who takes over the patient's care may administer the medication again. Given the pain medications administered in the

AMRC ER., overmedication creates a serious risk of injury. Respondent has a duty to document the physician's orders for, and the administration of all medications to her patients.

15. The evidence did not establish that Respondent unlawfully obtained or possessed controlled substances and dangerous drugs, or that she personally used or abused drugs accessed from the Pyxis at AMRC ER. There was also insufficient evidence to establish that Respondent acted outside the scope of her registered nurses license.

Evidence in Mitigation

16. There is significant evince in mitigation as is set forth in Factual Findings 20 through 24. Respondent was highly regarded as a charge nurse at the AMRC ER prior to Board's investigation in February 2009. She was considered a take charge, aggressive emergency room nurse that was trusted by the physicians in the AMRC ER and very competent in processing ER patients through the Department for treatment. Respondent's performance evaluations at AMRC indicated that she met or exceeded the expectations of her position from 1994 until 2008. Respondent was described by Linda Dunn, her immediate supervisor, as a very good nurse. Dunn did not believe that Respondent posed a significant risk to the safety of patients, although she was concerned about Respondent's poor charting and documentation practices. In February 2012, Dunn also provided an exemplary letter of recommendation for Respondent for a subsequent registered nurse position even though Respondent had been terminated by AMRC. Respondent also received positive letters of recommendations from a physician, a former administrator, and a nursing colleague who all worked with Respondent at AMRC and were familiar with both her job performance and the circumstances surrounding her termination from AMRC.

17. The evidence established that Respondent's conduct resulted from her being over aggressive in managing and treating patients in the AMRC ER. Because of the hectic, fast pace environment of the ER, understaffing, and the high volume of patients treated, Respondent failed to observe the appropriate standard of care in treating these patients. During the period of Respondent's misconduct between 2008 to 2009, Respondent was suffering from anxiety, depression, and working long hours. These factors contributed to Respondent the errors committed by Respondent in treating her patients.

18. Finally, Respondent has no prior history of disciplinary action by the Board and she has voluntarily taken continuing education courses to address her deficiencies in the area of documentation requirements for registered nurses.

19. When considering the totality of the evidence, it would not be pose a significant risk to the public or jeopardize the health, safety and welfare of the patients under Respondent's care, if she allowed to retain a properly restricted probationary registered nurse license.

Recovery of Costs

20. Business and Professions Code section 125.3 provides in part:

> (a) . . . in any order issued in resolution of a disciplinary proceeding before any board within the department . . . the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of investigation and enforcement of the case.
>
> [¶] . . . [¶]
>
> (d) The administrative law judge shall make a proposed finding of the amount of the reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). . . .

21. *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 held that the imposition of costs for investigation and did not violate due process in a case involving the discipline of a licensee. The Supreme Court set forth four factors that the licensing agency was required to consider in deciding whether to reduce or eliminate costs: (1) whether the licensee used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed; (2) whether the licensee had a " subjective" good faith belief in the merits of his position; (3) whether the licensee raised a "colorable challenge" to the proposed discipline; and (4) whether the licensee had the financial ability to make payments.

22. Cause exists to award the Board's cost of investigation and prosecution pursuant to Business and Professions Code section 125.3, in that the Board's costs are determined to be reasonable, by reason of Factual Finding 25 and Legal Conclusion 12. Respondent, however, prevailed as to the Board's second cause for discipline in that it is determined Respondent did not illegally obtain or possesses a controlled substance in violation of Section 2762, subdivision (a). It is also determined that Respondent had a subjective good faith belief in the merits of her defense. Consequently, a reduction in the Board's costs is warranted in this case. The Board's coast is reduced by one third based upon prevailing on one of the allegations contained in the Board's First Amended Accusation. Respondent shall reimburse the Board's costs in the amount of $8,338.83.

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ORDER

IT IS HEREBY ORDERED that Registered Nurse License Number 568737 issued to Respondent Linda Cumberland, is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following conditions.

1. Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

2. Respondent shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by the respondent to the Board in writing within seventy-two (72) hours of occurrence. To permit monitoring of compliance with this condition, respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

3. Respondent shall fully comply with the conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of the Respondent's compliance with the Board's Probation Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license status with the Board, including during any period of suspension.

4. Respondent, during the period of probation, shall appear in person at interviews/ meetings as directed by the Board or its designated representatives.

5. Periods of residency or practice as a registered nurse outside of California shall not apply toward a reduction of this probation time period. Respondent's probation is tolled, if and when he or she resides outside of California. Respondent must provide written notice to the Board within 15 days of any change of residency or practice outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state.

Respondent shall provide a list of all states and territories where he or she has ever been licensed as a registered nurse, vocational nurse, or practical nurse. Respondent shall further provide information regarding the status of each license and any changes in such license status during the term of probation. Respondent shall inform the Board if she applies for or obtains a new nursing license during the term of probation.

6. Respondent, during the period of probation, shall submit or cause to be submitted such written reports/declarations and verification of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to Respondent's compliance with all the conditions of the Board's Probation

Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

Respondent shall provide a copy of this decision to the nursing regulatory agency in every state and territory in which she has a registered nurse license.

7. Respondent, during the period of probation, shall engage in the practice of registered nursing in California for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

For purposes of compliance with the section, "engage in the practice of registered nursing" may include, when approved by the Board, volunteer work as a registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse.

The Board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

If Respondent has not complied with this condition during the probationary term, and Respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of Respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation shall apply.

8. Respondent shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Respondent shall cause to be submitted to the Board all performance evaluations and other employment related reports as a registered nurse upon request of the Board.

Respondent shall provide a copy of this decision to her employer and immediate supervisors prior to commencement of any nursing or other health care related employment.

In addition to the above, Respondent shall notify the Board in writing within seventy-two (72) hours after she obtains any nursing or other health care related employment. Respondent shall notify the Board in writing within seventy-two (72) hours after she is terminated or separated, regardless of cause, from any nursing, or other health care related employment with a full explanation of the circumstances surrounding the termination or separation.

9. Respondent shall obtain prior approval from the Board regarding Respondent's level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate - The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours Respondent works.

(c) Minimum - The individual providing supervision and/or collaboration has person-to-person communication with Respondent at least twice during each shift worked.

(d) Home Health Care - If Respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with Respondent as required by the Board each work day. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each work day. The individual providing supervision and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by the Respondent with or without Respondent present.

10. Respondent shall not work for a nurse's registry, in any private duty position as a registered nurse, a temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool.

Respondent shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the Board. Respondent shall not work in any other registered nursing occupation where home visits are required.

Respondent shall not work in any health care setting as a supervisor of registered nurses. The Board may additionally restrict Respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a Board approved continuing education program.

Respondent shall work only on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity.

If Respondent is working or intends to work in excess of 40 hours per week, the Board may request documentation to determine whether there should be restrictions on the hours of work.

11. Respondent, at her own expense, shall enroll and successfully complete a course(s) relevant to the practice of registered nursing no later than six months prior to the end of her probationary term.

Respondent shall obtain prior approval from the Board before enrolling in the course(s). Respondent shall submit to the Board the original transcripts or certificates of completion for the above required course(s). The Board shall return the original documents to Respondent after photocopying them for its records.

12. Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code Section 125.3 in the amount of $8,338.83. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

13. If Respondent violates the conditions of her probation, the Board after giving Respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline (revocation/suspension) of the Respondent's license.

If during the period of probation, an accusation or petition to revoke probation has been filed against Respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against the Respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the Board.

14. During respondent's term of probation, if he or she ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation, respondent may surrender his or her license to the Board. The Board reserves the right to evaluate Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, Respondent will no longer be subject to the conditions of probation.

Surrender of Respondent's license shall be considered a disciplinary action and shall become a part of Respondent's license history with the Board. A registered nurse whose license has been surrendered may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

(1) Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or

(2) One year for a license surrendered for a mental or physical illness.

DATED: April 11, 2013

MICHAEL A. SCARLETT
Administrative Law Judge
Office of Administrative Hearings

Exhibit A

First Amended Accusation Case No. 2012-107

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **LINDA NORLINE CUMBERLAND** **P.O. Box 803** **Alta Loma, CA 91701** **Registered Nurse License No. 568737** Respondent.	Case No. 2012-107 OAH No. L-2011090427 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about July 18, 2000, the Board issued Registered Nurse License Number 568737 to Linda Norline Cumberland (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2014, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

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8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY PROVISION

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUG DEFINITIONS

10. **Morphine Sulphate (Morphine)** – a Schedule II controlled substance pursuant to Health and Safety Code section 11055, and a dangerous drug pursuant to Business and Professions Code section 4022. It is a narcotic analgesic used for the relief of severe pain.

11. **Hydrocodone/Acetaminophen (Norco)** – a Schedule III controlled substance pursuant to Health and Safety Code section 11056, and a dangerous drug pursuant to Business and Professions Code section 4022. It is a narcotic indicated for the relief of moderate to moderately severe pain.

12. **Hydromorphone (Dilaudid)** – a Schedule II controlled substance pursuant to Health and Safety Code section 11055, and a dangerous drug pursuant to Business and Professions Code section 4022. It is a narcotic analgesic used for the relief of severe pain.

13. **Lorazepam (Ativan)** - a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, and a dangerous drug pursuant to Business and Professions Code section 4022. It is a Benzodiazepine used for the relief of anxiety, panic attacks, and chronic sleeplessness.

///

ARROWHEAD REGIONAL MEDICAL CENTER

14. Respondent was employed as a registered nurse in the Emergency Department of Arrowhead Regional Medical Center ("ARMC") from about July 15, 2000 to about February 17, 2009.

15. At all times relevant to the charges herein, ARMC used a drug dispensing system called the "Pyxis System". The Pyxis is a computerized automated medication dispensing machine. The user enters a password to gain access and dispense medication from the machine. The machine records the user name, patient name, medication, dose, date and time of the withdrawal. The Pyxis is integrated with hospital pharmacy inventory management systems.

16. On or about February 11, 2009, after Respondent abruptly left ARMC for personal reasons, a random audit of her medical usage was conducted for a three-month period prior to February 4, 2009, and the following discrepancies were found:

PATIENT 1 (S.T. #001172538)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
11-03-08 (1444 hours)	#1 Dilaudid 2 mg/ml	No order; not charted; no wastage or return of 2 mg

PATIENT 2 (D.D. #001802692)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-05-09 (1054 hours)	#1 Dilaudid 2 mg/ml	1 mg ordered; 1 mg charted; no wastage or return of 1 mg
01-05-09 (1233 hours)	#1 Dilaudid 2 mg/ml	1 mg ordered; 1 mg charted; no wastage or return of 1 mg
01-05-09 (1337 hours)	#1 Dilaudid 2 mg/ml	1 mg ordered; 1 mg charted; no wastage or return of 1 mg
01-05-09 (1521 hours)	#1 Dilaudid 2 mg/ml	No physician order; medication wasted

PATIENT 3 (N.M. #001524891)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-19-09 (1900 hours)	#1 Dilaudid 2 mg/ml	No order written when med was withdrawn; med wasted due to changed order
01-19-09 (1901 hours)	#2 Morphine @ 5 mg/ml (10 mg/ml total)	4 mg (no titrate) ordered; 2.5 mg charted; no wastage or return of 7.5 mg

PATIENT 4 (T.M. #001774266)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-23-09 (1443 hours)	#1 Dilaudid 2 mg/ml	No order; not charted; no wastage or return of 2 mg
01-23-09 (1443 hours)	Patient discharged	

PATIENT 5 (D.H. #001341821)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-23-09 (1331 hours)	#1 Morphine 5 mg/ml	1-5 mg ordered; 2.5 given in two divided doses
01-23-09 (1458 hours)	#1 Ativan 2 mg/ml	1 mg ordered; 1 mg charted; no wastage or return of 1 mg
01-23-09 (1543 hours)	#1 Dilaudid 2 mg/ml	0.5 mg ordered; 0.5 mg charted; 1.5 mg wasted
01-23-09 (1745 hours)	#1 Dilaudid 2 mg/ml	No additional order; med wasted
01-23-09 (1756 hours)	#1 Norco 5/325 mg tab	No order; med charted as given

PATIENT 6 (M.B. #000579780)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
12-12-08 (1048 hours)	#1 Dilaudid 2 mg/ml	1 mg ordered; 1 mg wasted
12-12-08 (1050 hours)	#1 Ativan 2 mg/ml	1 mg ordered; 1 mg charted; no wastage or return of 1 mg
12-12-08 (1101 hours)	#1 Dilaudid 2 mg/ml	1-2 mg ordered; 1 mg charted; no wastage or return of 1 mg

PATIENT 7 (I.G. #001535259)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
10-09-08 (0818 hours)	#1 Dilaudid 2 mg/ml	1-2 mg ordered; two divided doses charted
10-09-08 (1004 hours)	#2 Norco 10/325 mg tab	Different writing; no strength of quantity specified; not charted; no wastage or return of 2 tabs

PATIENT 8 (N.T. #001800873)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
12-22-08 (0823 hours)	#1 Dilaudid 2 mg/ml	1-2 mg ordered; two divided doses charted
12-22-08 (1004 hours)	#1 Dilaudid 2 mg/ml	No additional order written; not charted; no wastage or return of 2 mg
12-22-08 (1356 hours)	#1 Dilaudid 2 mg/ml	No additional order written; not charted; no wastage or return of 2 mg
12-22-08 (1400 hours)	Patient discharged	

PATIENT 9 (A.G. #001369990)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
12-23-08 (0754 hours)	#1 Dilaudid 2 mg/ml	1-2 mg ordered; 1 mg charted @ 0740 hours, 2 mg charted @ 0750 hours for a total of 3 mg; only 2 mg withdrawn from Pyxis
12-23-08 (0754 hours)	#1 Ativan 2 mg/ml	0.5 mg ordered; 1 mg charted; no wastage or return of 1 mg
12-23-08 (1120 hours)	#1 Dilaudid 2 mg/ml	2 mg ordered; 2 mg charted

PATIENT 10 (G.C. #000534464)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-16-09 (1149 hours)	#1 Dilaudid 2 mg/ml	No order written; med wasted
01-16-09 (1847 hours)	#2 Dilaudid @ 2 mg/ml (total 4 mg/ml)	No order written; not charted; no wastage or return of 4 mg

PATIENT 11 (J.L. #001231704)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-06-09 (1453 hours)	#1 Dilaudid 2 mg/ml	No order written; not charted; no wastage or return of 2 mg

PATIENT 12 (H.P. #001678076)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-08-09 (1240 hours)	Patient discharged	
01-08-09 (1242 hours)	#1 Dilaudid 2 mg/ml	No order written; med wasted

PATIENT 13 (M.S. #001561421)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-08-09 (1126 hours)	#1 Xanax 1 mg tab	1 mg ordered; 1 mg charted
01-08-09 (1126 hours)	#1 Morphine 5 mg/ml	Titrate 2-10 mg ordered; 5 mg charted
01-08-09 (1216 hours)	#1 Morphine 5 mg/ml	Titrate 2-10 mg ordered; 5 mg charted
01-08-09 (1433 hours)	#1 Dilaudid 2mg/ml	1 mg ordered; 1 mg charted; 1 mg wasted
01-08-09 (1840 hours)	Patient discharged	
01-08-09 (1846 hours)	#1 Dilaudid 2mg/ml	No additional order; not charted; no wastage or return of 2 mg

PATIENT 14 (M.M. #001147579)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-26-09 (1501 hours)	#1 Dilaudid 2 mg/ml	No order; not charted; closed visit dispense; med wasted

PATIENT 15 (M.S. #001376055)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-28-09 (0733 hours)	#1 Dilaudid 2 mg/ml	No order; not charted; no wastage or return of 2 mg
01-28-09 (0743 hours)	#1 Dilaudid 2 mg/ml	No order; med wasted
01-28-09 (0758 hours)	#1 Morphine 2 mg/ml	2 mg ordered; 2 mg charted

PATIENT 16 (F.O. #001617691)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-28-09 (1011 hours)	#1 Morphine 2 mg/ml	2 mg ordered; 2 mg charted
01-28-09 (1016 hours)	#1 Morphine 5 mg/ml	No additional order; 2 mg charted; no wastage or return of 3 mg
01-28-09 (1150 hours)	#1 Morphine 5 mg/ml	No additional order; 5 mg charted
01-28-09 (1150 hours)	#1 Dilaudid 2 mg/ml	No order; not charted; no wastage or return of 2 mg

PATIENT 17 (F.J. #001531429)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
02-04-09 (1110 hours)	#1 Dilaudid 2 mg/ml	No order; not charted; closed visit dispense; no wastage or return of 2 mg

PATIENT 18 (M.P. #001804589)

Date & Time	Drug and Quantity Withdrawn from Pyxis	Charting
01-19-09 (1717 hours)	#1 Dilaudid 2 mg/ml	No order; not charted; no wastage or return of 2 mg
01-19-09 (1725 hours)	Patient discharged	

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

17. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), in conjunction with California Code of Regulations, title 16, section 1442, on the grounds of unprofessional conduct, in that between November 2008 to February 2009, while employed as a registered nurse at ARMC, Respondent committed gross negligence by withdrawing controlled substances and dangerous drugs from the Pyxis machine for eighteen (18) patients, and failing to properly obtain and verify physician's orders, document, waste, account for the controlled substances and dangerous drugs and/or administer the correct dosage or medication to the patients. Complainant refers to and incorporates all the allegations contained in paragraphs 14 - 16, as though set forth fully.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Illegally Obtained or Possessed Controlled Substances)

18. Respondent is subject to disciplinary action under Code section 2762, subdivision (a), for unprofessional conduct, in that between November 2008 to February 2009, while employed as a registered nurse at ARMC, Respondent unlawfully obtained or possessed controlled substances and dangerous drugs without physician's orders, failed to account for the excess controlled substances and dangerous drugs withdrawn from Pyxis, and furnished or administered controlled substances and dangerous drugs to another without physician's orders. Complainant refers to and incorporates all the allegations contained in paragraphs 14 - 16, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Falsify, Make Grossly Incorrect, or Inconsistent Entries)

19. Respondent is subject to disciplinary action under Code section 2762, subdivision (e), for unprofessional conduct, in that between November 2008 to February 2009, while employed as a registered nurse at ARMC, Respondent falsified, or made grossly incorrect or grossly inconsistent entries in the MAR pertaining to controlled substances and dangerous drugs, which are inconsistent with the physician's orders and Narcotic Records. Respondent failed to correctly and consistently prepare and complete documentation pertaining to the administration and accounting of controlled substances and dangerous drugs in the MAR or Narcotic Records. Complainant refers to and incorporates all the allegations contained in paragraphs 14 -16, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 568737, issued to Linda Norline Cumberland;

2. Ordering Linda Norline Cumberland to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: December 22, 2011

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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