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

In the Matter of the Accusation Against: **CATHERINE JEAN KONICKI** 902 Everett Avenue Oakland, California 94602 Registered Nurse License No. 590013 Respondent.	Case No. 2007-291 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about June 4, 2007, Complainant Ruth Ann Terry, M.P.H, R.N, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2007-291 against Catherine Jean Konicki (Respondent) before the Board of Registered Nursing.

2. On or about October 23, 2001, the Board of Registered Nursing (Board) issued Registered Nurse License No. 590013 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on June 30, 2007.

3. On or about June 8, 2007, James Mirarchi, an employee of the Department of Justice, served by Certified Mail a copy of Accusation No. 2007-291, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 902

Everett Avenue, Oakland, California, 94602. A copy of the Accusation, the related documents, and Declaration of Service are attached as exhibit A, and are incorporated herein by reference.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

5. On or about July 23, 2007, the aforementioned documents were returned by the U.S. Postal Service marked "Unclaimed." A copy of the envelope returned by the post office is attached as exhibit B, and is incorporated herein by reference.

6. On or about July 19, 2007, the Board received a handwritten letter signed by Respondent and dated July 17, 2007, which purports to surrender Respondent's Registered Nurse License. A copy of the letter is attached hereto as exhibit C, and is incorporated herein by reference.

7. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

8. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2007-291.

9. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

10. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in exhibits A, B and C, finds that the allegations in Accusation No. 2007-291 are true.

11. The total costs for investigation and enforcement are $9,388.25 as of

October 12, 2007.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Catherine Jean Konicki has subjected her Registered Nurse License No. 590013 to discipline.

2. A copy of the Accusation and the related documents and Declaration of Service are attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation:

a. Gross Negligence/Incompetence;
b. Unprofessional Conduct;
c. Grossly Incorrect Medical Records;
d. Unlawful Possession/Use of Drugs.

ORDER

IT IS SO ORDERED that Registered Nurse License No. 590013, heretofore issued to Respondent Catherine Jean Konicki, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on February 29, 2008.

It is so ORDERED January 29, 2008

La Francine N. Tate

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

Attachments:

Exhibit A: Accusation No. 2007-291 , Related Documents, and Declaration of Service.
Exhibit B: Copy of Envelope Returned by Post Office.
Exhibit C: Letter from Respondent dated July 17, 2007.

Exhibit A

Accusation No. **2007-291**,
Related Documents and Declaration of Service

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BEFORE THE
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DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CATHERINE JEAN KONICKI** 902 Everett Avenue Oakland, California 94602 Registered Nurse License No. 590013 Respondent.	Case No. 2007-291 OAH No. **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H, R.N (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about October 23, 2001, the Board of Registered Nursing issued Registered Nurse License Number 590013 to Catherine Jean Konicki (Respondent). The License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2007, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section

references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (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 in pertinent part:

"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 pertinent part:

"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."

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."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means 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."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the

subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

DANGEROUS DRUGS/CONTROLLED SUBSTANCES

11. Section 4021 of the Code states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

12. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use, except veterinary drugs that are labeled as such, and includes the following:

"(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

"(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

13. **Demerol** is a brand name for Meperidine or Pethidine, a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(17) and a dangerous drug within the meaning of Code section 4022.

14. **"Dilaudid"** is a brand name for hydromorphone, and a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug within the meaning of Code section 4022.

15. **Fentanyl** is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(8) and is a dangerous drug per Business and Professions Code Section 4022. Fentanyl is a narcotic analgesic that is used to treat pain.

16. **Hydrocodone** is the generic name for **Vicodin**, a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(j) and a dangerous drug per Business and Professions Code section 4022. Hydrocodone is a narcotic analgesic that is used to treat pain.

17. **Morphine** is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M), and a dangerous drug per Business and Professions Code section 4022.

COST RECOVERY

18. 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.

FACTUAL SUMMARY

19. On or about March 17, 2007, in San Francisco, CA, Respondent was arrested and found to be in possession of crack cocaine.

20. On or about September 17, 2002, through October 17, 2002, Respondent was employed as a Registered Nurse at Stanford Hospital in Campbell, CA (hereinafter "the Hospital").

21. During her employment at the Hospital, Respondent made numerous

medication withdrawals from the Pyxis[1] without a physician's order and/or without adequately documenting the disposition of the medication. On or about October 17, 2002, during an interview with Hospital personnel, Respondent admitted that she had taken medications from the Pyxis and had diverted them for her own use.

22. A review of the Pyxis system revealed the following discrepancies:

Patient 2:

23. On September 18, 2002 at 21:30 hours, Patient 2's physician ordered Morphine Sulfate 05 mg IVP, may repeat at 5-minute intervals up to 20 mg maximum. The order was changed at 21:47 hours to 2-10 mg IM, may repeat at 5-minute intervals up to 30 mg. The order was changed on September 19, 2002 at 04:48 hours to Morphine Sulfate, 4 mg.

24. On September 18, 2002 at 23:18 hours, Respondent withdrew 4 mg of Morphine Sulfate from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition.

25. On September 19, 2002 at 05:14 hours, Respondent withdrew 100 mcg of Fentanyl from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 4:

26. On 9/19/02 at 19:35 hours, Patient 4's physician ordered Morphine Sulfate 4 mg every 30 minutes x 3 prn.

27. On 9/19/03 at 21:53 hours, Respondent withdrew Morphine Sulfate 4 mg from the Pyxis. Respondent failed to chart administration of the medication or otherwise account for its disposition.

Patient 5:

28. On 9/22/02 at 08:20 hours, Patient 5's physician ordered Morphine Sulfate 2-5mg IVP,may repeat q5 minutes up to 10 mg max. On 9/22/02 at 12:25 hours, the physician

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1. The Pyxis is a drug-dispensing machine that documents the withdrawal of medications by nurses in the hospital. In order to obtain medications from the Pyxis, a nurse must enter into the machine his or her log-on name and password.

ordered Vicodin 6 pk to go.

29. On 9/22/02 at 06:19 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

30. On 9/22/02 at 12:30 hours, Respondent documented administration of Vicodin 6 pk to the patient, but did not document a withdrawal from the Pyxis.

Patient 6:

31. On 9/22/02 at 17:36 hours, Respondent withrew two 100 mcg doses of Fentanyl from the Pyxis, but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 7:

32. On 9/26/02 at 06:23 hours, Respondent withdrew 100 mcg of Fentanyl from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 9:

33. On 9/26/02 at 09:53 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 10:

34. On 9/26/02 at 16:13 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 11:

35. On 9/26/02 at 16:29 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 12:

36. On 9/26/02 at 18:00 hours, Respondent withdrew Fentanyl 100 mcg twice from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 13:

37. On 10/6/02 at 02:50 hours, Patient 13's physician ordered Fentanyl 50 mcg IVP prn. The physician also ordered Morphine Sulfate 2-5 mg IVP,may repeat q5 minutes up to 10 mg max.

38. On 10/6/02 Respondent withdrew Fentanyl 200 mcg from the the Pyxis but failed to chart administration of the medication or otherwise account for its disposition.

Patient 14:

39. On 10/8/02 at 23:45 hours, Patient 14's physician ordered Vicodin Tablet 1-2 prn. On 10/9/02 at 01:50 hours, the physician ordered Vicodin 6 pk to go.

40. On 10/9/02 at 01:52 hours, Resondent withdrew Vicodin 1 tablet from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition.

Patient 15:

41. On 10/9/02 at 03:41 hours, Respondent made two withdrawals of Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 16:

42. On 10/9/02, Patient 16's physician ordered Fentanyl 25-50 mcg Q2 hours prn.

43. On 10/10/02 at 01:59 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition.

Patient 17:

44. On 10/10/02 at 18:41 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 18:

45. On 10/10/02 at 16:30 hours, Patient 18's physician ordered Dilaudid 1 mg 1m/IV x 1, may repeat x 1 prn.

46. On 10/11/02 at 00:04 hours, Respondent withdrew Diladid 2 mg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition.

Patient 19:

47. On 10/11/02 at 01:12 hours, Resondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 21:

48. On 10/12/02 at 14:00 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 22:

49. On 10/15/02 at 06:12 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 23:

50. On 10/17/02 at 06:11 hours, Respondent made two withdrawals of Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 26:

51. On 9/22/02 at 19:32 hours, Respondent withdrew Fentnyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition.

Patient 27:

52. On 9/25/02 at 12:35 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its

disposition.

Patient 29:

53. On 9/26/02 at 11:30 hours and at 13:43 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 30:

54. On 10/1/02 at 19:12 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 31:

55. On 10/3/02 at 18:08 hours and 20:38 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition.

Patient 32:

56. On 10/5/02 at 14:47 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition.

Patient 33:

57. On 10/5/02 at 16:51 hours Respondent withdrew Fentanyl 100 mcg from the Pyxis. At 17:09 hours Respondent withdrew Demerol 25 mg from the Pyxis. At 18:25 hours Respondent withdrew Morphine Sulfate 2 mg from the Pyxis. Respondent failed to chart administration of the medications or otherwise account for their disposition. There were no orders in place for administration of Fentanyl or Demerol to the patient.

Patient 36:

58. On 0/14/02 at 20:43 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

Patient 37:

59. On 9/19/02 at 18:48 hours, Respondent withdrew Fentanyl 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account for its disposition. There were no orders in place for administration of Fentanyl to the patient.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

60. Respondent is subject to disciplinary action under section 2761(a)(1) of the Code in that she acted with incompetence and/or gross negligence in carrying out usual certified or licensed nursing functions, as set forth above in paragraphs 20 - 59.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

61. Respondent is subject to disciplinary action under section 2761(a) of the Code in that she acted unprofessionally, as set forth above in paragraphs 19 - 59.

THIRD CAUSE FOR DISCIPLINE

(Grossly Incorrect Medical Records)

62. Respondent is subject to disciplinary action under sections 2761 and 2762(e) of the Code in that she made grossly incorrect, grossly inconsistent, or unintelligible entries in a hospital record pertaining to controlled substances, as set forth above in paragraphs 20 - 59.

FOURTH CAUSE FOR DISCIPLINE

(Unlawful Possession/Use of Drugs)

63. Respondent is subject to disciplinary action under sections 2761 and 2762(a) of the Code in that she unlawfully possessed a 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, as set forth above in paragraphs 19 - 59.

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 590013, issued to Catherine Jean Konicki Catherine Jean Konicki;

2. Ordering Catherine Jean Konicki 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: 6/4/07

RUTH ANN TERRY, M.P.H, R.N
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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