STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

IN RE:	)	
VICKI E. GARZA	)	**Docket No.'s 2010-603 &**
License No. 026.0021669	)	**2011-32**

STIPULATION AND CONSENT ORDER

STIPULATION

NOW COME the State of Vermont, by and through State Prosecuting Attorney S. Lauren Hibbert, and the Respondent, Vicki E. Garza, RN, who stipulate and agree as follows:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. § 129(a); 3 V.S.A. § 129a; 3 V.S.A. § 814(d); 26 V.S.A. § 1582; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Statement of Facts

2. Vicki E. Garza (the "Respondent") of South Burlington, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026.0021669. This license was originally issued on or about July 7, 1994 and expired on or about March 31, 2011. Respondent is also licensed by the State of Florida as a Registered Nurse under license number RN2993122. Respondent's Florida license was originally issued on or about November 6, 1995 and expired on or about April 30, 2011.

3. On or about November 16, 2010, the Board received a copy of the State of Florida Department of Health's Order of Emergency Suspension of License (the "Order") regarding Respondent. Attachment A. The Order, entered on or about September 23, 2010, indicated that Respondent had admitted to an impaired practitioner program in or around June 2009 that she had diverted narcotics from the facility where she worked, and that in or around August 2009, Respondent was diagnosed with opioid abuse. Attachment A. The Order further indicates that after Respondent obtained treatment and entered into a nursing monitoring contract in or around August and September 2009, Respondent returned to the practice of nursing in Florida and then admitted to the impaired practitioner program in or around May 2010 that she had diverted more narcotics. Attachment A. The Order further indicates that Respondent violated her nursing monitoring contract and was therefore dismissed from it, and that

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Respondent has been arrested in Florida for fraudulently obtaining a controlled substance. Attachment A. The Order suspended Respondent's Florida license on or about September 23, 2010, pending further proceedings. Attachment A.

4. On or about January 24, 2011 the Respondent was issued a citation for Possession and Control of Regulated Drugs: Fraud or Deceit in violation of 18 V.S.A. 4223(a)(e) due to allegations of her fraudulently procuring prescription drugs including Oxycodone and Hydrocodone. The Respondent appeared in Chittenden County Court on or about March 21, 2011. This case is currently pending and the Respondent has enter the Rapid Intervention Program with Chittenden County State's Attorney's Office. If the Respondent is successful in this program the current charges against her will be dismissed on or about June 15, 2011.

Charges

5. The act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:

   a. 26 V.S.A. § 1582(a)(3) (Is unable to practice nursing competently by reason of any cause) which includes performing unsafe or unacceptable patient care pursuant to ARBN Chapter 4, Subchapter 4, Rule II(B)(1); and failing to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Chapter 4, Subchapter 4, Rule II(B)(2);

   b. 26 V.S.A. § 1582(a)(7) (Engages in conduct of a character likely to deceive, defraud, or harm the public) which includes diverting supplies, equipment, or drugs for personal or other unauthorized use pursuant to ARBN Chapter 4, Subchapter 4, Rule II(D)(4);

   c. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession).

Understandings

6. This Stipulation is neither an admission of liability by the Respondent nor a concession by the State of Vermont that its charges are not well-founded. To avoid delay, uncertainty, inconvenience, and expense of protracted litigation of the charges above, the Parties reach a full and final Stipulation pursuant to these Understandings and the Order below. The Respondent does not dispute that the State could prove at least some of charges by a preponderance of the evidence if this matter went to a hearing and agrees that the conditions below are necessary and appropriate.

7. Respondent understands that the Nursing Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.

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8. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced her rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.

9. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties. This Stipulation completely resolves Docket Number 2010-603 and Docket Number 2011-32.

10. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.

11. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.

12. Respondent voluntarily waives her right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.

13. Respondent agrees that the Order set forth below may be entered by the Board.

ORDER

Based on the Stipulation above, it is **ORDERED AND ADJUDGED** as follows:

A. The Board of Nursing hereby **INDEFINITELY SUSPENDS** the Respondent's license to practice nursing for a **MINIMUM OF SIX (6) MONTHS from the date of entry below**. Within forty-five (45) days of requesting reinstatement, Respondent must: 1) obtain an independent evaluation report by a licensed professional specializing in drug and alcohol abuse pre-approved by the Board and who has verified receipt of this Order, the results of which must indicate that the Respondent does not present a risk to the safety, health or welfare of her potential patients; 2) submit to the Board the results of a minimum of six (6) random urine analyses, collected in an observed setting; administered by a person or entity that has been pre-approved by the Board; and analyzed by a lab qualified to analyze samples for forensic purposes and pre-approved by the Board, the results of which shall be negative; failure to appear for, refusal to provide, adulteration of, dilution of, or tampering with a sample for any urine analysis shall cause that screen to be presumed positive; 3) enter into a treating professional agreement with a treating professional pre-approved by the Board; and 4) enter into a substance abuse treatment plan approved by the Board with the pre-approved treating professional. The Respondent's license shall not be reinstated until these prerequisites are met, regardless of whether more than six (6) months have passed since the suspension went into effect. Once reinstated, Respondent's license will be **CONDITIONED FOR A MINIMUM OF THREE (3) YEARS** commencing with the date of reinstatement. The conditions will be as follows:

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(1) Re-issue of License.
Upon the commencement of these conditions, Respondent shall be issued a license labeled "conditioned."

(2) Length of Time of Conditions Imposed.
The conditions shall remain in place until Respondent has completed all conditions ordered. Respondent shall be subject to the conditions until Respondent completes a **minimum of three (3) years** of supervised nursing in which she works at least forty (40) hours every two (2) weeks as a nurse. Part time hours of less than forty (40) hours every two (2) weeks shall be credited on a prorated basis. Respondent shall be prohibited from working more than forty (40) hours per week.

(3) Completion of Substance Abuse Counseling and Treatment Plan.
Respondent shall enter into and continue substance abuse counseling with the treating professional pre-approved by the Board until the treating professional shall certify in writing to the Board that such counseling is no longer necessary. Respondent shall comply with the substance abuse treatment plan approved by the Board and the treating professional.

(4) Reports from Treating Professional.
Respondent shall authorize and cause her treating professional to submit to the Board evidence of satisfactory progress with the treatment plan during the effective period of this Consent Order. These reports shall be submitted in writing on forms issued by the Board. The first report is due commencing the month after the date of the commencement of the conditions and subsequent reports are due **monthly** thereafter.
Respondent shall authorize her treating professional to provide all information requested by the Nursing Board, either orally or in writing, at any time during the period this Consent Order is in effect.

(5) Participation in Recovery Group(s).
Respondent shall participate as recommended by her treating professional in substance abuse recovery group(s), and shall submit **quarterly** reports documenting such attendance on forms issued by the Board.

(6) Random Drug and Alcohol Testing.
Respondent shall submit to random drug and alcohol screenings at the request of the Board or its designee. Respondent shall designate a person or entity that has been pre-approved by the Board or its designee to administer random drug and alcohol screens. All testing shall be done on a random, unannounced basis and analyzed by a lab qualified to analyze samples for forensic purposes and approved by the Board. All urine specimens collected for tests shall be collected in an observed setting. All screens shall be negative.
Failure to appear for, refusal to provide, adulteration of, dilution of, or tampering with a sample for any urine screen shall cause that screen to be presumed positive. Any positive screen shall act as a violation of this Order.

(7) Abstain from Drug and Alcohol Use.

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Respondent shall abstain completely from the consumption or possession of alcohol and drugs with the exception of medications as outlined in paragraph A.(8) for the period of time described in A.(2).

(8) Drug Use Exception.

Respondent shall not take controlled substances unless medically necessary. Respondent may take scheduled/controlled medications lawfully prescribed for a bona fide illness or condition by a physician, dentist, or nurse practitioner whose identity shall be made known to the Board in writing by Respondent within forty-eight (48) hours of the prescription. Respondent shall cause the physician, dentist or nurse practitioner to inform the Board, in writing and on appropriate letterhead, of knowledge of Respondent's substance abuse issue(s) within seven (7) days of entering into the practitioner/patient relationship. Moreover, the Respondent shall cause this prescribing practitioner to inform the Board, in writing and on appropriate letterhead, of all scheduled/controlled medications prescribed – and the anticipation of how long such prescriptions will need to be taken – within seven (7) days of the prescription.

The Board or its designee may request at any time that the practitioner document the necessity for the prescribed scheduled/controlled medications or other medications known to have abuse potential. This includes medications to be administered as necessary. It is not anticipated that Respondent would be prescribed scheduled/controlled medication during the term of this Consent Order for a period greater than fourteen (14) days, but if so, then the conditions herein may be revoked by the Board.

Respondent shall provide the Board with a current medication list of any medications taken on a scheduled or as-needed basis on forms issued by the Board within seven (7) days of the date of reinstatement and shall update this list within forty-eight (48) hours of any change in these medications.

(9) Notification to Employers/Nursing School.

Respondent shall provide a copy of this Stipulation and Consent Order to all employers in any current or future setting in which Respondent practices as a nurse and inform them of Respondent's conditional license status.

Within ten (10) days of the date of entry of this Consent Order or of any subsequent nursing employment, Respondent shall cause Respondent's immediate supervisor to submit to the Board an employer agreement form approved by the Board, acknowledging receipt of the Stipulation and Consent Order and the ability to comply with the conditions in the Consent Order.

In the event the Respondent is attending a nursing program which has a clinical portion that involves actual patient care, Respondent shall provide a copy of the Stipulation and Consent Order to the Program Director. Respondent shall cause the Program Director to submit to the Board a nursing program agreement form approved by the Board, acknowledging receipt of the Stipulation and Consent Order and the ability of the program to comply with the conditions in the Consent Order during clinical experience.

(10) Reports from Employers/Program Director.

Within one (1) month of the date of reinstatement or within one (1) month of the commencement of nursing employment and monthly thereafter, Respondent shall cause

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every nursing employer the Respondent has worked for during the month to submit to the Board an evaluation of Respondent's work performance and attendance during that month. Moreover, on a **quarterly** basis, these reports shall include the results of the employer's medication audits of Respondent's medication administration and practices. These reports shall be submitted in writing on forms issued by the Board. All employer reports shall indicate satisfactory performance (ie., consistently meeting all standards of nursing practice) and attendance.

In the event the Respondent is attending a nursing program, Respondent shall cause the Program Director to submit to the Board, on a monthly basis, a written evaluation of her performance and attendance. These reports shall be submitted in writing on forms issued by the Board. All nursing program reports shall indicate satisfactory performance (ie., consistently meeting all standards of nursing practice) and attendance.

(11) Practice Under Supervision.

Respondent shall practice as a nurse only in a setting where Respondent has direct supervision for the entire shift by a licensed registered nurse that is in good standing with the Board.

(12) Administration of Medications.

Respondent is prohibited from administering any controlled substances. This condition may be removed only by the Respondent filing a petition with the Board after she has worked as a nurse for six (6) months for at least forty (40) hours every two weeks (or the part time equivalent) after the date of reinstatement.

In any such petition, the Respondent must demonstrate, to the satisfaction of the Nursing Board or its designee, that she can safely and competently administer such medications. In any such petition, the Respondent must include appropriate support from her treating professional and employer or nursing school administrator and a description of the documentation and inventory control procedures in place.

The removal of this prohibition shall not automatically result in the reinstatement of all medication privileges. The Board may gradually restore those privileges through whatever intermediary steps it determines are appropriate.

(13) Types of Employment Prohibited.

Respondent shall not work in a supervisory role. Respondent shall not work for a nurse registry, traveling nurse agency, float-pool, home health care agency, temporary nursing employment agency, or as a private duty nurse or personal care provider requiring a nursing or nursing assistant license during the effective period of this Consent Order.

(14) Interview with the Board or its Designee.

Respondent shall appear in person for interviews with the Board or its designee upon request.

(15) Out-of-State Practice.

Before any out-of-state practice can be credited toward fulfillment of these terms and conditions, Respondent shall first obtain approval from the Board prior to Respondent practicing nursing outside the State of Vermont. If Respondent fails to receive such approval

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before practicing nursing outside the State of Vermont, none of the time spent practicing nursing out-of-state will be credited toward the fulfillment of the terms and conditions of this Consent Order. The Board will approve out-of-state nursing practice so long as the Respondent can still comply with the provisions of this Consent Order.

If the Respondent receives discipline on a nursing license held in another state during the conditioned period, the Respondent must inform the Board of such, in writing, within ten (10) days of receiving such discipline.

(16) Notification of Place of Employment/Personal Address/Telephone Number.

Within ten (10) days of the date of entry of this Consent Order, Respondent shall notify the Board, in writing, of her current place of employment, personal address, and telephone number. Respondent shall further notify the Board, in writing, within forty-eight (48) hours of any change in employment (including resignation or termination), personal address, or telephone number.

(17) Notification to Other States.

In the event that the Respondent is licensed in nursing in any other state(s), she must inform the nursing licensing board of the state(s) in which the Respondent is licensed of the conditional status of her Vermont nursing license within thirty (30) days of the date of entry of this Order. If the Respondent fails to provide such notification, it will be considered a violation of this Order.

(18) License Renewal.

If the Respondent's license expires while this Order is still in effect, this Order does not automatically extend the license. In that situation, in order to continue to practice as a nurse, the Respondent must timely apply for renewal, pay the applicable fee and demonstrate that she has otherwise complied with the requirements for license renewal.

(19) Release of Information Forms.

The conditions of this Order require the Respondent to authorize drug and/or alcohol treatment providers to report information in verbal and/or written format and/or to discuss the Respondent and any and all treatment rendered to the Respondent for drugs and/or alcohol with the Board or its designee. The conditions of this Order must allow any and all information from the Respondent's treatment providers to also be provided to the Office of Professional Regulation investigators and that the information may be used for further prosecutions if so warranted or if the Office of Professional Regulation determines that said information violates the terms of this Order or any rules or laws governing the profession of nursing.

The Respondent is entitled to revoke this consent at any time. However, any revocation by the Respondent of such consent to disclosure during the term of this Order shall be considered a violation of this Order.

This consent expires when the conditions are removed from the Respondent's nursing license.

This Stipulation and Consent Order shall constitute a valid written consent pursuant to the requirements of 42 C.F.R. § 2.31.

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The Respondent understands that her treatment provider may require her to sign a separate and distinct consent meeting the requirements of 42 C.F.R. § 2.31.

(20) Costs.
The Respondent shall bear all costs of complying with this Consent Order.

(21) Violation of this Order.
If the Respondent violates the terms of this Order in any respect, the Board, after giving the Respondent notice and an opportunity to be heard, may rescind or modify this Order and impose additional appropriate disciplinary actions. If a complaint of unprofessional conduct is made against the Respondent during the term of this Order, this Order shall be automatically extended until the unprofessional conduct matter is concluded.

(22) Completion of Conditional License Period.
After the conditional license period, the Respondent may petition the Board to remove any and all conditions on her license. The Respondent must present proof that she has fully complied with the terms of this Order. The Respondent must also present proof of successful substance abuse rehabilitation and she must demonstrate, to the satisfaction of the Board, that she poses no danger to the public or the practice of nursing and that she can safely and competently perform the duties of a licensed nurse.

B. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.

C. This Stipulation and Consent Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. §129(a).

D. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

AGREED TO:

Dated: June 6, 2011

STATE OF VERMONT
SECRETARY OF STATE

By: S. Lauren Hibbert
S. Lauren Hibbert
State Prosecuting Attorney

VICKI E. GARZA
RESPONDENT

Dated: June 3, 2011

By: Vicki E Garza
Vicki E. Garza

STATE OF VERMONT
Prosecuting Attorney
Office of
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Montpelier, VT
05620-3602

APPROVED AS TO FORM:

Dated: 6/3/11

ATTORNEY FOR RESPONDENT

By: _____
Nancy Waples, Esq.

APPROVED AND SO ORDERED:

Dated: 6.13.11

VERMONT BOARD OF NURSING

By: _____
Chairperson

Date of Entry: 6/14/11

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STATE OF VERMONT
BOARD OF NURSING

In re: Vicki E. Garza License No. 026-21669	} } }	Docket No. 2010-603 (RN)

DECISION ON REQUEST FOR SUMMARY SUSPENSION ORDER

Appearances:
for Petitioner, State of Vermont: Betsy Ann Wrask
for Respondent: Did not appear

Presiding Officer: Larry S. Novins

Summary Suspension Order
FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

On December 13, 2010 this matter came before the Board of Nursing on the State's Request for a Summary Suspension pursuant to 3 V.S.A. § 814(c). Ms. Garza did not appear. The Board has authority to summarily suspend a license pending further action, if it determines that public health, safety, or welfare imperatively requires emergency action.

Findings of Fact

Based on a Review of the pleadings and the file, and on evidence presented to the Board at the hearing, the Board finds:

1. Ms. Garza is licensed by and subject to the disciplinary authority of this Board. 26 V.S.A. Chapter 28, 3 V.S.A. § 129, the Administrative Rules of the Office of Professional Regulation. 3 V.S.A. § 814(c) permits the Board to summarily suspend a license if it finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order.
2. The State has filed a "Request for Summary Suspension." A copy of the Request is attached to this Decision and Order. The Request alleges that Ms. Garza is addicted to controlled drugs and has fraudulently acquired them.
3. The State further alleges that the public health, safety or welfare imperatively requires emergency action.
4. Notice of this hearing was sent to Ms. Garza at her last known address via certified mail dated December 9, 2010. The file does not indicate whether the notice was received.
5. The Board has reviewed documents presented by the State.

6. The Board finds for purposes of this hearing that Ms. Garza is addicted to narcotic drugs and failed to disclose that on her most recent renewal application.
7. The allegations in the Request for Summary Suspension (copy attached) have been established to the necessary degree.
8. The evidence presented does imperatively require emergency action for the public health, safety, and welfare. Specifically, summary suspension is necessary to prevent Ms. Garza from practicing while impaired. If summary suspension is not ordered, the Board believes that patient harm will occur.

Conclusions of Law

Our Findings of Fact and Conclusions of Law in this Summary Suspension hearing are for purposes of deciding whether ***at this time*** there is an imperative need to take emergency action. 3 V.S.A. § 814(c). Our Findings and Conclusions herein are for purposes of this Order only.

The State's Request for a Summary Suspension is supported by the evidence presented. The Board concludes that the allegations in the Request for Summary Suspension have been established to the necessary degree. For purposes of this Summary Suspension Hearing, the Findings of Fact above do support Summary Suspension of Ms. Garza's license. There is an imperative need to take emergency action. 3 V.S.A. § 814(c).

Vermont law requires that unprofessional charges be filed promptly with Ms. Garza being afforded a prompt hearing. At any merits hearing in this matter, the State will bear the burden of proving unprofessional conduct. Our Findings and Conclusions in this matter will not absolve the State or Ms. Garza from producing or challenging relevant evidence at a merits hearing. The Findings of Fact and Conclusions of Law at a contested hearing will be based on the evidence admitted at that hearing only.

Order

The State's Request for Summary Suspension is **Granted.** Ms. Garza's license is summarily suspended pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined. 3 V.S.A. § 814(c).

APPEAL RIGHTS

This is a final administrative determination by the Vermont Board of Nursing.

A party aggrieved by a final decision of a board may appeal this decision by filing a written Notice of Appeal with the Director of the Office of Professional Regulation, Vermont Secretary of State, National Life Bldg., North, FL2, Montpelier, VT 05620-3402 within 30 days of the entry of this order.

If an appeal is filed, the Director of the Office of Professional Regulation shall assign the case to an appellate officer. The review shall be conducted on the basis of the record created before the board. In cases of alleged irregularities in procedure before the board, not shown in the record, proof on that issue may be taken by the appellate officer. 3 V.S.A. §§ 129(d) and 130a. To request a stay of the Board's decision, please refer to the attached stay instructions.

Vermont Board of Nursing

By: Ellen Leff
Ellen Leff, RN, Chair

Date: December 13, 2010

OFFICE OF PROFESSIONAL REGULATION

DATE OF ENTRY: 12/14/10

STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

IN RE:	)	
VICKI E. GARZA	)	Docket No. 2010-603
License No. 026.0021669	)	

REQUEST FOR SUMMARY SUSPENSION

Board Authority

1. The Vermont Board of Nursing (the "Board") has jurisdiction to investigate and adjudicate allegations of unprofessional conduct committed by Nurses pursuant to 3 V.S.A. §§ 129, 129a; 26 V.S.A. Chapter 28; the Administrative Rules of the Board of Nursing ("ARBN"); and the Rules of the Office of Professional Regulation.

2. The Board of Nursing is authorized by 3 V.S.A. § 814 to summarily suspend the license of a nurse when it finds that the public health, safety, or welfare imperatively requires emergency action.

Statement of Facts

3. Vicki E. Garza (the "Respondent") of South Burlington, Vermont is licensed by the State of Vermont as a Registered Nurse under license number 026.0021669. This license was originally issued on or about July 7, 1994 and is currently set to expire on or about March 31, 2011. Respondent is also licensed by the State of Florida as a Registered Nurse under license number RN2993122. Respondent's Florida license was originally issued on or about November 6, 1995 and is currently set to expire on or about April 30, 2011.

4. On or about November 16, 2010, the Board received a copy of the State of Florida Department of Health's Order of Emergency Suspension of License (the "Order") regarding Respondent. Attachment A. The Order, entered on or about September 23, 2010, indicated that Respondent had admitted to an impaired practitioner program in or around June 2009 that she had diverted narcotics for her own use from the facility where she worked, and that in or around August 2009, Respondent was diagnosed with opioid abuse. Attachment A. The Order further indicates that after Respondent obtained treatment in or around August 2009 and entered into a nursing monitoring contract with the Florida Board of Nursing which restricted her practice in or around September 2009, Respondent returned to the practice of nursing in Florida. Attachment A. However, the Order indicates that thereafter, Respondent admitted to the impaired practitioner program on or about May 28, 2010 that she had diverted more narcotics for her own use. Attachment A. The Order further indicates that Respondent violated her nursing monitoring contract and was therefore dismissed

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from it on or about July 13, 2010, and that Respondent had been arrested in Florida on or about July 16, 2010 for fraudulently obtaining a controlled substance. Attachment A. The Order suspended Respondent's Florida license on or about September 23, 2010, pending further proceedings. Attachment A.

5. On or about June 8, 2010, the Board received Respondent's Registered Nurse Renewal Application, dated June 3, 2010. In this application, Respondent answered "No" to the following questions:

   a. Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) restricted, suspended, revoked, or taken any other disciplinary action against a license, certificate, or registration that you hold or held in any profession or occupation?

   b. Are you currently under investigation by another licensing authority?

   c. Does your use of alcohol, drugs, or medications in any way impair or limit your ability to practice this profession with reasonable skill and safety?

   d. Are you currently addicted to or in any way dependent on the use of alcohol or habit forming drugs?

   e. Are you currently participating in a supervised program or professional assistance program which monitors you in order to assure that you are not engaging in the use of alcohol or controlled substances?

Request for Relief

6. The facts as set out above establish that in order to protect the public health, safety, or welfare of the people of the State of Vermont, emergency action is imperative.

7. The above acts and circumstances, alone or in combination, violate:

   a. 26 V.S.A. § 1582(a)(1) (Has made or caused to be made a false, fraudulent, or forged statement or representation in procuring or attempting to procure registration or renew a license to practice nursing);

   b. 26 V.S.A. § 1582(a)(3) (Is unable to practice nursing competently by reason of any cause);

   c. ARBN Chapter 4, Subchapter 4, Rule II(B)(1) and (2) ("Inability to practice nursing competently" includes: 1) performance of unsafe or unacceptable patient care; and 2) failure to conform to the essential standards of acceptable and prevailing nursing practice);

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d. ARBN Chapter 4, Subchapter 4, Rule II(C) ("Any cause" includes, but is not limited to, reasons of physical or mental disability or use of drugs, narcotics, chemicals, or any other type of materials);

e. 26 V.S.A. § 1582(a)(5) (Is habitually intemperate or is addicted to the use of habit-forming drugs);

f. 26 V.S.A. § 1582(a)(7) (Engages in conduct of a character likely to deceive, defraud, or harm the public) which includes diverting supplies, equipment, or drugs for personal or other unauthorized use pursuant to ARBN Chapter 4, Subchapter 4, Rule II(D)(4);

g. 3 V.S.A. § 129a(a)(1) (Fraudulent or deceptive procurement or use of a license);

h. 3 V.S.A. § 129a(b)(1) and (2) (Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: 1) performance of unsafe or unacceptable patient or client care; or 2) failure to conform to the essential standards of acceptable and prevailing practice); and

i. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession).

WHEREFORE, the State of Vermont respectfully requests that pursuant to 3 V.S.A. § 814(c), the Respondent's nursing license number 026.0021669 be summarily suspended, pending a hearing on the merits.

DATED at Montpelier, Vermont this 6th day of December, 2010.

STATE OF VERMONT
SECRETARY OF STATE

By: _____
BetsyAnn Wrask
State Prosecuting Attorney

nu.garza.sumsusp

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Final Order No. DOH-10-2230-EO-MQA
FILED DATE - 4-23-10
Department of Health
By: [signature]
Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

In Re: Emergency Suspension of the License of
Vicki Elizabeth Garza, R.N.
License No.: RN 2993122
Case Nos.: 2010-12431, 2010-14372

ORDER OF EMERGENCY SUSPENSION OF LICENSE

Ana M. Viamonte Ros, M.D., M.P.H., State Surgeon General, ORDERS the emergency suspension of the license of Vicki Elizabeth Garza, R.N., to practice as a registered nurse. Ms. Garza holds license number RN 2993122. Her address of record is 4105 Hillwood Road, Jacksonville, Florida 32223. The following Findings of Fact and Conclusions of Law support the emergency suspension of Ms. Garza's license to practice as a registered nurse.

FINDINGS OF FACT

1. The Department of Health (Department) is the state agency charged with regulating the practice of nursing pursuant to Chapters 20, 456 and 464, Florida Statutes. Section 456.073(8), Florida Statutes (2010), authorizes the State Surgeon General to summarily suspend Ms. Garza's license to practice as a registered nurse in accordance with Section 120.60(6), Florida Statutes (2010).

2. At all times material to this order, Ms. Garza was licensed to practice as a registered nurse pursuant to Chapter 464, Florida Statutes.

3. On or about June 16, 2009, the Nurse Administrator from Mayo Clinic in Jacksonville contacted the Intervention Project for Nurses (IPN) and reported that one of their employees, Ms. Garza, had been diverting Percocet and hydromorphone from

Attachment A

the Mayo Clinic Hospital for her own use. The Nurse Administrator stated that when confronted, Ms. Garza admitted to taking the drugs.

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

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

6. Opiate, or opioid, drugs have similar actions as the drug opium and are typically prescribed to treat pain. Opioid drugs are synthetically manufactured, while opiate drugs are naturally occurring, but the terms opioid and opiate are often used interchangeably. Opioid drugs are addictive and subject to abuse.

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

8. On or about June 17, 2009, Ms. Garza contacted IPN and admitted that she had been diverting hydromorphone from Mayo Clinic Hospital for about two months. She stated she had half of a milligram (mg) of hydromorphone leftover after administering some to a patient. She decided to try it, but could not explain to the IPN case manager why. After this Ms. Garza continued to divert the drug for her own use. Ms. Garza denied holding any prescriptions and denied any previous drug or alcohol abuse. The IPN case manager advised Ms. Garza about the requirements of IPN participation, including the requirements to refrain from nursing practice and submit to an IPN-facilitated evaluation.

9. On or about August 4, 2009, Ms. Garza submitted to an IPN-facilitated evaluation conducted by Eduardo A. Sanchez, M.D., a specialist in addiction psychiatry. During the evaluation, Ms. Garza admitted to diverting hydromorphone from the Mayo Clinic Hospital for her own use. Ms. Garza explained that she had taken a Percocet tablet she received from a family member to treat pain she was experiencing and found the experience extremely pleasant. Following this, Ms. Garza explained she began to take the unused leftover portion of hydromorphone syringes home instead of discarding the hydromorphone with a witness as required by her employer. Her failure to discard leftover hydromorphone initially went unnoticed so she took the drug home about seven times. Ms. Garza expressed embarrassment and remorse over diverting the drug. She denied any previous drug abuse history. Dr. Sanchez diagnosed Ms. Garza with opioid abuse and recommended intense drug counseling.

10. On or about August 12, 2009, the IPN case manager spoke with Dr. Sanchez to clarify his recommendations. Dr. Sanchez indicated he recommended that Ms. Garza receive intensive outpatient substance abuse treatment.

11. On or about August 12, 2009, the IPN case manager sent a letter to Ms. Garza that indicated she needed to enter into intensive outpatient substance abuse treatment. The letter contained the contact information for several facilities where Ms. Garza could receive the recommended treatment.

12. On or about August 24, 2009, Ms. Garza entered into intensive outpatient substance abuse treatment at the Sigma Center for Counseling.

13. On or about September 29, 2009, Ms. Garza signed a two-year IPN monitoring contract which required her to remain free from all mood-altering, controlled, or addictive substances including alcohol, complete treatment at Sigma Center for Counseling, attend a facilitated nurse support group, attend alcoholics anonymous/narcotics anonymous meetings, and submit to drug testing. Ms. Garza was approved to return to nursing practice provided she remained restricted from access to controlled substances for a period of six months.

14. Ms. Garza returned to work at the Mayo Clinic in Jacksonville. Ms. Garza worked in the Mayo Clinic Hospital.

15. On or about October 2, 2009, Ms. Garza completed intensive outpatient substance abuse treatment at Sigma Center for Counseling.

16. On or about April 16, 2010, after complying with her IPN monitoring contract without incident, Ms. Garza was approved by IPN to resume administering and having access to controlled substances in the course of her nursing practice.

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

18. In order to accurately record patient care, and to accurately account for controlled substances, Mayo Clinic Hospital required nurses to document the time each medication was administered to the patient on the patient's medication administration record (MAR). If a dose or partial dose of a controlled substance was removed from Pyxis, but not administered to the patient, the nurse was required to discard the controlled substance in the presence of another licensed nurse. The nurse discarding the controlled substance, and the nurse witness, both entered their names into the Pyxis computer to document that the controlled substance was discarded. The discard of a controlled substance is referred to in Pyxis as a "waste."

19. On or about May 17, 2010, Ms. Garza worked from 7:00 p.m. until 11:00 p.m. at Mayo Clinic Hospital and cared for patient H.W. who had an order permitting her to receive 0.25 mg of hydromorphone by intravenous (IV) injection every two hours as needed for pain.

20. At or about 7:09 p.m., Ms. Garza removed a hydromorphone 1 mg vial from Pyxis, ostensibly for H.W., but failed to document that she administered the hydromorphone to H.W. and did not document wasting any of the hydromorphone. At or about 8:22 p.m., Ms. Garza removed another 1 mg vial of hydromorphone from Pyxis, ostensibly for H.W. She documented administering 0.25 mg to H.W., but failed to document that she wasted the remaining 0.75 mg. At or about 10:29 p.m., Ms. Garza removed another 1 mg vial of hydromorphone from Pyxis, ostensibly for H.W. She documented administering 0.25 mg to H.W., but failed to document that she wasted the remaining 0.75 mg.

21. In summary, Ms. Garza removed a total of 3 mg of hydromorphone from Pyxis ostensibly for H.W., documented administering a total of 0.5 mg of the hydromorphone, but failed to account for 2.5 mg of the hydromorphone.

22. On or about May 19, 2010, Ms. Garza worked at Mayo Clinic Hospital and cared for patients C.W. and V.S. from at or about 7:00 a.m. until at or about 7:00 p.m.

23. C.W. had a physician order permitting her to receive 0.5 mg of hydromorphone by IV injection if needed for pain. Ms. Garza removed five 1 mg vials of hydromorphone from Pyxis, ostensibly for C.W., two at 7:28 p.m., one at 7:47 p.m., one at 7:53 p.m., and one at 9:42 p.m. Ms. Garza documented administering 0.5 mg to

C.W. at 7:48 p.m. and documented wasting 0.5 mg of the hydromorphone, accounting for one vial she removed. Ms. Garza failed to document that she administered or wasted the remaining four vials of hydromorphone totaling 4 mg of hydromorphone unaccounted for.

24. During that same shift, Ms. Garza removed 13, 1 mg vials of hydromorphone from Pyxis, ostensibly for V.S. Ms. Garza documented administering four 0.5 mg doses to V.S., but failed to account for 11 mg of hydromorphone as summarized in the following table.

May 19, 2010

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
V.S.	Two hydromorphone 1 mg vials (total 2 mg)	7:10 a.m.	None	Hydromorphone 2 to 4 mg TABLET every four hours if needed for pain, hydromorphone 0.5 mg IV at bedtime if needed for insomnia	Not charted	Hydromorphone by IV cannot be substituted for hydromorphone tablets. IV hydromorphone only ordered for bedtime. Failed to account for 2 mg.
V.S.	Two hydromorphone 1 mg vials (total 2 mg)	8:05 a.m.	None	See above	0.5 mg at 8:10 a.m.	Not ordered for daytime. Failed to account for 1.5 mg.
V.S.	Two hydromorphone 1 mg vials (total 2 mg)	9:42 a.m.	None	Hydromorphone 0.5 mg IV at bedtime if needed for insomnia	0.5 mg given at 9:45 a.m.	Not ordered for daytime. Failed to account for 1.5 mg

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
V.S.	Two hydromorphone 1 mg vials (total 2 mg)	12:31 p.m.	None	See above	0.5 mg given at 12:30 p.m.	Not ordered for daytime. Failed to account for 1.5 mg.
V.S.	Two hydromorphone 1 mg vials (total 2 mg)	2:01 p.m.	None	See above	0.5 mg given at 2:00 p.m.	Not ordered for daytime. Failed to account for 1.5 mg.
V.S.	One hydromorphone 1 mg vial	6:08 p.m.	None	See above	Not charted	Not ordered for daytime. Failed to account for 1 mg.
V.S.	One hydromorphone 1 mg vial	6:27 p.m.	None	See above	Not charted	Not ordered for daytime. Failed to account for 1 mg.

25. On or about May 22, 2010, Ms. Garza worked on the 3 North unit from at or about 3:00 p.m. to at or about 7:00 p.m. and cared for patient K.R. Ms. Garza then transferred to the 4 North unit and worked from at or about 7:00 p.m. to at or about 11:00 p.m. and cared for patients L.G. and C.H. Ms. Garza removed several vials of hydromorphone from Pyxis, ostensibly for these patients, and failed to document administering or wasting the drug. L.G. and C.H. did not have a physician order for hydromorphone. K.R. did have an order for hydromorphone, but Ms. Garza consistently removed twice the ordered dose and removed the hydromorphone more frequently than ordered as summarized in the following table.

May 22, 2010

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
K.R.	Two hydromorphone 1 mg vials (total 2 mg)	3:04 p.m.	None	Hydromorphone 1 mg IV every 3 hours as needed for pain	1 mg given at 3:06 p.m.	Removed twice the ordered dose. Failed to account for 1 mg.
K.R.	Two hydromorphone 1 mg vials (total 2 mg)	4:20 p.m.	None	See above	1 mg given at 4:20 p.m.	Removed twice the ordered dose and removed too early. Dose is not due until 6:06 p.m. Failed to account for 1 mg.
K.R.	One hydromorphone 1 mg vial	5:24 p.m.	None	See above	1 mg given at 5:30 p.m.	Removed too early. Dose is not due until 7:20 p.m.
K.R.	Two hydromorphone 1 mg vials	6:37 p.m.	None	See above	1 mg given at 6:40 p.m.	Removed twice the ordered dose. Removed too early. Dose is not due until 8:30 p.m. Failed to account for 1 mg.
K.R.	Two hydromorphone 1 mg vials	7:38 p.m.	None	See above	1 mg given at 7:40 p.m.	Removed twice the ordered dose. Removed too early. Dose is not due until 9:40 p.m. Failed to account for 1 mg.

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
L.G.	Two hydromorphone 1 mg vials	11:22 p.m.	None	No order	Not charted	Not ordered. Failed to account for 2 mg.
C.H.	Two hydromorphone 1 mg vials	11:23 p.m.	None	No order	Not charted	Not ordered. Failed to account for 2 mg.

26. On or about May 24, 2010, Ms. Garza worked from at or about 7:00 a.m. to at or about 3:00 p.m. on the 2 North unit and cared for patients J.H. and L.B. Ms. Garza then transferred to the 5 South unit and worked from at or about 3:00 p.m. until at or about 7:00 p.m. and cared for patient S.B. Ms. Garza removed several vials of hydromorphone, ostensibly for these patients, and failed to document administering or wasting the hydromorphone. Some of the hydromorphone was not ordered by the physician or was not ordered to be given so frequently. These discrepancies are summarized in the table below.

May 24, 2010

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
J.H.	Two hydromorphone 1 mg vials (total 2 mg)	7:24 a.m.	None	Hydromorphone 0.5 mg IV every 4 hours as needed for pain	Not charted	Removed two vials when only one needed.

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
L.B.	One hydromorphone 1 mg vial	8:42 a.m.	None	No order for hydromorphone	Not charted	Not ordered. Failed to account for 1 mg.
J.H.	Two hydromorphone 1 mg vials (total 2 mg)	8:57 a.m.	None	Hydromorphone 0.5 mg IV every 4 hours as needed for pain	0.5 mg at 9:00 a.m.	Removed two vials when one needed. If given at 7:24 a.m., not due until 11:24 a.m. Failed to account for 1.5 mg.
J.H.	One hydromorphone 1 mg vial	11:36 a.m.	None	See above	0.5 mg at 11:30 a.m.	Removed too early. Dose not due until 1:00 p.m. Failed to account for 0.5 mg.
L.B.	One hydromorphone 1 mg vial	2:18 p.m.	None	No order for hydromorphone	Not charted	Not ordered. Failed to account for 1 mg.
J.H.	Two hydromorphone 1 mg vials (total 2 mg)	2:19 p.m.	None	Hydromorphone 0.5 mg IV every 4 hours as needed for pain	0.5 mg at 2:30 p.m.	Removed two vials when one needed. Removed too early. Dose not due until 3:30 p.m. Failed to account for 1.5 mg.

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
J.H.	One hydromorphone 1 mg vial	2:58 p.m.	None	See above	0.5 mg at 3:00 p.m.	Removed too early. Dose not due until 6:30 p.m. Failed to account for 0.5 mg.
S.B.	One hydromorphone 1 mg vial	5:58 p.m.	None	Hydromorphone 0.5 mg IV every 2 hours as needed for pain	0.5 mg at 6:12 p.m.	Failed to account for 0.5 mg
S.B.	Two hydromorphone 1 mg vials (total 2 mg)	6:25 p.m.	None	See above	Not charted	Removed two vials when one needed. Removed too early. Dose not due until 7:58 p.m. Failed to account for 2 mg.
S.B.	Two hydromorphone 1 mg vials (total 2 mg)	7:38 p.m.	None	See above	Not charted	Removed two vials when one needed. If given at 6:25 p.m., not due until 8:25 p.m. Failed to account for 2 mg.

27. On or about May 25, 2010, Ms. Garza worked from at or about 7:00 a.m. until at or about 7:00 p.m. and cared for patients C.H., W.O., and S.T. Ms. Garza removed multiple vials of hydromorphone from Pyxis, ostensibly for these patients, and failed to document administering or wasting all of the hydromorphone. Several doses

removed were not ordered by the physician or not ordered so frequently. These discrepancies are summarized in the table below.

May 25, 2010

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
S.T.	Two hydromorphone 1 mg vials (total 2 mg)	7:17 a.m.	None	No order	Not charted	Not ordered by the physician. Failed to account for 2 mg.
S.T.	Two hydromorphone 1 mg vials (total 2 mg)	7:55 a.m.	None	No order	Not charted	Not ordered by the physician. Failed to account for 2 mg.
C.H.	Two hydromorphone 1 mg vials (total 2 mg)	9:11 a.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	1 mg at 9:15 a.m.	Removed twice the ordered dose. Failed to account for 1 mg.
C.H.	One hydromorphone 1 mg vial	10:08 a.m.	None	See above	1 mg at 10:15 a.m.	Removed too early. Dose is not due until 1:15 p.m.
S.T.	One hydromorphone 1 mg vial	11:34 a.m.	None	No order	Not charted	Not ordered. Failed to account for 1 mg.
W.O.	One hydromorphone 1 mg vial	11:34 a.m.	None	No order	Not charted	Not ordered. Failed to account for 1 mg.
S.T.	Two hydromorphone 1 mg vials (total 2 mg)	12:36 p.m.	None	No order	Not charted	Not ordered. Failed to account for 2 mg.

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
C.H.	Two hydromorphone 1 mg vials (total 2 mg)	3:36 p.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	1 mg at 3:30	Removed twice the ordered dose. Failed to account for 1 mg.
C.H.	Two hydromorphone 1 mg vials (total 2 mg)	5:01 p.m.	None	See above	1 mg at 5:00 p.m.	Removed twice the ordered dose. Removed too early. Dose is not due until 7:30 p.m. Failed to account for 1 mg.
C.H.	One hydromorphone 1 mg vial	6:02 p.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	1 mg at 6:00 p.m.	Removed too early. Dose is not due until 9:00 p.m.
C.H.	One hydromorphone 1 mg vial	6:57 p.m.	None	See above	1 mg at 7:30 p.m.	Removed too early. Dose is not due until 10:00 p.m.
C.H.	Two hydromorphone 1 mg vials (total 2 mg)	8:29 p.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	Not charted	Removed twice the ordered dose. Removed too early. Dose is not due until 11:30 p.m. Failed to account for 2 mg.

28. On or about May 27, 2010, at or about 3:00 p.m. until about 11:00 p.m. Ms. Garza worked on the 5 South unit and cared for patients I.J., P.R., R.B., and J.T. Ms. Garza removed multiple vials of hydromorphone from Pyxis, ostensibly for these

patients, and failed to document administering or wasting most of the hydromorphone removed. Several doses were not ordered or not ordered to be given so frequently. Ms. Garza's scheduled shift ended at 11:00 p.m., but she did not clock out until 1:00 a.m. After clocking out, Ms. Garza remained at Mayo Clinic Hospital and continued to remove hydromorphone from the 5 South Pyxis, ostensibly for patients. These discrepancies are summarized in the table below.

May 27, 2010 to May 28, 2010

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
I.J.	One hydromorphone 1 mg vial	3:33 p.m.	None	Hydromorphone 0.5 mg IV every 2 hours as needed for pain	0.5 mg at 3:45 p.m.	Failed to account for 0.5 mg.
P.R.	One hydromorphone 1 mg vial	4:06 p.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	1 mg at 4:00 p.m.	
P.R.	One hydromorphone 1 mg vial	4:22 p.m.	None	See above	Not charted	Removed too early. Dose not due until 8:06 p.m. Failed to account for 1 mg.
R.B.	One hydromorphone 1 mg vial	5:20 p.m.	None	Hydromorphone 0.5 mg IV every 2 hours as needed for pain	0.5 mg at 5:20 p.m.	Failed to account for 0.5 mg.
R.B.	One hydromorphone 1 mg vial	8:32 p.m.	None	Hydromorphone 0.5 mg IV every 2 hours as needed for pain	Not charted	Failed to account for 1 mg.

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
J.T.	One hydromorphone 1 mg vial	8:33 p.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	Not charted	Failed to account for 1 mg.
I.J.	One hydromorphone 1 mg vial	8:34 p.m.	None	Hydromorphone 0.5 mg IV every 2 hours as needed for pain	0.5 mg at 8:40 p.m.	Failed to account for 0.5 mg.
J.T.	One hydromorphone 1 mg vial	9:15 p.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	1 mg at 9:15 p.m.	Removed too early. If given at 8:33 p.m., this dose not due until 12:33 a.m.
J.T.	One hydromorphone 1 mg vial	9:16 p.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	0.5 mg at 10:09 p.m.	Removed too early. Dose not due until 1:15 a.m.
I.J.	One hydromorphone 1 mg vial	10:56 p.m.	None	Hydromorphone 0.5 mg IV every 2 hours as needed for pain.	0.5 mg at 11:00 p.m.	Failed to account for 0.5 mg.
J.T.	One hydromorphone 1 mg vial	10:58 p.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	Not charted	Removed too early. Dose not due until 2:09 a.m. Failed to account for 1 mg.
P.R.	One hydromorphone 1 mg vial	10:58 p.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	Not charted	Failed to account for 1 mg

Patient	Medication Removed from Pyxis	Time Removed	Waste	Physician Order	Time Drug Given on MAR	Discrepancies
R.B.	One hydromorphone 1 mg vial	5/28/10 12:56 a.m.	None	Hydromorphone 0.5 mg IV every 2 hours as needed for pain	Not charted	Failed to account for 1 mg.
I.J.	One hydromorphone 1 mg vial	5/28/10 12:58 a.m.	None	Hydromorphone 0.5 mg IV every 2 hours as needed for pain	Not charted	Failed to account for 1 mg.
P.R.	One hydromorphone 1 mg vial	5/28/10 12:58 a.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	Not charted	If given at 10:58 p.m., next dose not due until 2:58 a.m. Failed to account for 1 mg.
P.R.	One hydromorphone 1 mg vial	5/28/10 12:59 a.m.	None	See above	Not charted	Just removed a dose. Failed to account for 1 mg.
P.R.	Two hydromorphone 1 mg vials (total 2 mg)	5/28/10 04:44 a.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	Not charted	Not responsible for this patient at this time. Failed to account for 2 mg.
J.T.	Two hydromorphone 1 mg vials (total 2 mg)	5/28/10 4:43 a.m.	None	Hydromorphone 1 mg IV every 4 hours as needed for pain	Not charted	Not responsible for this patient at this time. Failed to account for 2 mg.

29. On or about May 28, 2010, a night-shift nurse on 5 South logged into Pyxis and noticed that hydromorphone had been removed by Ms. Garza for one of the

patients, but was not documented on the MAR. When asked, the patient denied receiving any hydromorphone. The night-shift nurse asked the pharmacy department for a Pyxis activity report showing medication removed by Ms. Garza. That report showed that Ms. Garza had removed 14 vials of hydromorphone. The night-shift observed that Ms. Garza had not documented the hydromorphone she removed and also observed that several vials of hydromorphone had been removed after the completion of Ms. Garza's shift. The night nurse notified the 5 South Nurse Manager.

30. On or about May 28, 2010, the 5 South Nurse Manager reviewed the Pyxis activity report and Ms. Garza's documentation. She obtained Pyxis activity reports from previous shifts and observed that Ms. Garza had removed several doses of hydromorphone without documenting that she administered the hydromorphone to the patients.

31. In the afternoon of on or about May 28, 2010, the 5 South Nurse Manager, a Human Resources representative, and the Nurse Administrator met with Ms. Garza and questioned her about the hydromorphone she had been removing from Pyxis. During that meeting, Ms. Garza admitted to staying at Mayo Clinic Hospital and removing vials of hydromorphone from Pyxis after the completion of her shift on or about May 28, 2010.

32. On or about May 28, 2010, the 5 South Nurse Manager contacted the IPN case manager and reported that an audit revealed multiple discrepancies between the controlled substances that Ms. Garza removed from Pyxis and Ms. Garza's documentation in the patients' medical records.

33. On or about May 28, 2010, the IPN case manager asked the IPN Drug Screen Specialist to direct Ms. Garza to submit to a random, observed urine drug test.

34. On or about May 28, 2010, Ms. Garza contacted the IPN case manager and admitted that she had been diverting hydromorphone from the workplace for her own use. The IPN case manager advised Ms. Garza to refrain from nursing practice and schedule another IPN-facilitated evaluation within the next two weeks.

35. On or about May 28, 2010, later in the afternoon, the 5 South Nurse Manager contacted IPN again and reported that she had met with Ms. Garza and she was terminated from her position at Mayo Clinic Hospital. The 5 South Nurse Manager reported that Ms. Garza had removed a total of 14 vials of hydromorphone that she did not account for. Ms. Garza's shift ended at 11:00 p.m., but she did not clock out until 1:00 a.m. After clocking out, Ms. Garza hid on the unit and continued to remove hydromorphone from Pyxis until about 4:00 a.m.

36. On or about June 8, 2010, Ms. Garza contacted IPN and reported that she scheduled an evaluation with Dr. Sanchez for on or about July 20, 2010 and was saving funds to pay for the evaluation. The IPN case manager provided Ms. Garza with information on the Hardship Evaluation Program, a program that provides funding for IPN-facilitated evaluations.

37. On or about June 10, 2010, a representative from Mayo Clinic Hospital contacted the Jacksonville Sheriff's Office and reported that Ms. Garza had been removing vials of hydromorphone from Pyxis without authorization.

38. On or about June 22, 2010, the Jacksonville Sheriff's Office filed an arrest warrant for Ms. Garza. According to the Affidavit for Arrest Warrant, Ms. Garza removed 19 vials of hydromorphone, ostensibly for patients that were not ordered by the physician, four of those vials removed after Ms. Garza was off shift. The arrest warrant also stated that Ms. Garza removed 80 vials of hydromorphone that she did not document or account for.

39. On or about June 24, 2010, Ms. Garza contacted IPN and reported that she was in New York with her family and was not planning to return to Florida for some time. Ms. Garza stated that there was a warrant out for her arrest due to her diversion of controlled substances from Mayo Clinic Hospital. The IPN case manager advised Ms. Garza that she violated her contract by moving to New York without notifying IPN. The IPN case manager explained that if Ms. Garza planned to stay in New York for a prolonged period of time, she would need to be monitored by an impaired nurse program in New York in order to stay in compliance with IPN. The IPN case manager advised Ms. Garza that she would be given two weeks to re-engage in all aspects of her IPN monitoring contract or she would be immediately dismissed from IPN.

40. On or about June 28, 2010, Ms. Garza contacted IPN and reported that she planned to return to Florida the following week. The case manager reminded Ms. Garza that she had been missing nurse support group meetings and required urine drug tests and had two weeks to re-engage in all aspects of her IPN monitoring contract or she would be dismissed from IPN.

41. On or about July 9, 2010, the IPN case manager contacted Ms. Garza and left her a voicemail message advising her that IPN had not heard from her and asking her to contact IPN or risk dismissal from IPN.

42. On or about July 13, 2010, after not receiving any further response from Ms. Garza, IPN dismissed Ms. Garza for failing to comply with the conditions of her monitoring contract.

43. On or about July 16, 2010, Ms. Garza was arrested for Fraudulently Obtaining a Controlled Substance in Jacksonville, Florida. The criminal case is still pending.

44. Section 464.018(1)(i), Florida Statutes (2009), subjects a licensee to discipline, including suspension, for engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in Chapter 893, Florida Statutes, for any other than legitimate purposes authorized by Part I of Chapter 464, Florida Statutes.

45. Ms. Garza engaged or attempted to engage in the possession of hydromorphone, a drug set forth in Chapter 893, Florida Statutes, for her own personal use. While at Mayo Clinic Hospital, Ms. Garza removed hydromorphone from Pyxis, ostensibly for patients, without documenting administering or wasting the hydromorphone. Several vials of hydromorphone were removed from Pyxis more frequently than authorized by the patients' physician orders and several vials of hydromorphone were removed for patients who did not have a physician's order to receive the drug at all. Ms. Garza also remained at Mayo Clinic Hospital and continued

to remove hydromorphone vials from Pyxis after her shift was over. When confronted, Ms. Garza admitted to diverting the hydromorphone for her own use.

46. Section 456.072(1)(hh), Florida Statutes (2010), subjects a licensee to discipline, including suspension, for being terminated from a treatment program for impaired practitioners, which is overseen by an impaired practitioner consultant as described in Section 456.076, Florida Statutes, for failure to comply, without good cause, with the terms of the monitoring or treatment contract entered into by the licensee, or for not successfully completing any drug treatment or alcohol treatment program.

47. Ms. Garza failed to comply with the terms of her IPN monitoring or treatment contract by failing to remain free from all mood-altering, controlled, or addictive substances including alcohol, and by ceasing to participate in all aspects of her IPN contract including urine drug testing and nurse support group.

48. Section 464.018(1)(j), Florida Statutes (2010), subjects a licensee to discipline, including suspension, for being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition.

49. Ms. Garza is unable to practice nursing with reasonable skill and safety to patients due to her opiate abuse and her recent diversion and abuse of the opiate drug hydromorphone. Within a month of having her restriction from access to controlled substances lifted by IPN, Ms. Garza began removing hydromorphone from Pyxis for her

own personal use and in only a short period of time, removed close to 80 vials of hydromorphone without authorization or proper documentation. Ms. Garza admitted to taking hydromorphone from Mayo Clinic Hospital for her own use. This behavior demonstrates that Ms. Garza is unable to practice nursing with reasonable skill and safety and is likely to continue to divert and abuse drugs while working as a nurse.

50. Section 120.60(6), Florida Statutes, authorizes the Department to summarily suspend a registered nurse's license if the Department finds that the nurse presents an immediate serious danger to the public health, safety, or welfare.

51. In the course of their practice, registered nurses have access to patient information, patient property, supplies, and medications including controlled substances that have a high likelihood for abuse and harm. Registered nurses must provide safe and effective care in a manner that respects patients' property and privacy. Due to the gravity of these responsibilities and the potential for abuse of the powerful drugs nurses have access to, nurses must possess good judgment and good moral character in order to perform their tasks. Ms. Garza's decision to divert hydromorphone from Mayo Clinic Hospital in or about June of 2009 when she initially contacted IPN, followed by her decision to divert hydromorphone from Mayo Clinic Hospital again in or about May of 2010, despite having gone through treatment and despite being monitored by IPN, demonstrates such a complete lack of judgment and moral character, and such a disregard for the laws and regulations governing nurses in this state that the safety of Ms. Garza's patients cannot be assured as long as she continues to practice nursing.

52. Because registered nurses are required to assess the condition of their patients and make complex decisions regarding patient care, mental fitness and emotional stability are essential traits that a registered nurse must possess in order to competently practice nursing. Ms. Garza's diagnosed opiate abuse and her continued diversion and abuse of the opioid drug hydromorphone, demonstrates that Ms. Garza does not possess the mental fitness and emotional stability necessary to practice nursing safely.

53. Ms. Garza's lack of good judgment and moral character, her disregard for the laws and regulations governing the practice of nursing, and her lack of mental fitness and emotional stability represent a significant likelihood that Ms. Garza will cause harm to the health, safety, or welfare of patients. This probability constitutes an immediate serious danger to the health, safety, or welfare of the citizens of the State of Florida. Nothing short of the immediate suspension of Ms. Garza's license will ensure the protection of the public from this danger.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the State Surgeon General concludes as follows:

1. The State Surgeon General of the Department has jurisdiction pursuant to Sections 20.43 and 456.073(8), Florida Statutes, and Chapter 464, Florida Statutes.

2. Ms. Garza violated Section 464.018(1)(i), Florida Statutes (2009), by engaging or attempting to engage in the possession, sale, or distribution of controlled

substances as set forth in Chapter 893, Florida Statutes, for any other than legitimate purposes as authorized by this Part I of Chapter 464, Florida Statutes.

3. Ms. Garza violated Section 456.072(1)(hh), Florida Statutes (2010), by being terminated from a treatment program for impaired practitioners, which is overseen by an impaired practitioner consultant as described in Section 456.076, Florida Statutes, for failure to comply, without good cause, with the terms of the monitoring or treatment contract entered into by the licensee, or for not successfully completing any drug treatment or alcohol treatment program.

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

5. Ms. Garza's continued practice as a registered nurse constitutes an immediate serious danger to the health, safety, or welfare of the public and this summary procedure is fair under the circumstances to adequately protect the public.

WHEREFORE, in accordance with Section 120.60(6), Florida Statutes, it is ORDERED THAT:

1. The license of Vicki Elizabeth Garza, R.N., license number RN 2993122, is immediately suspended.

2. A proceeding seeking formal suspension or discipline of the license of Vicki Elizabeth Garza, R.N., to practice as a registered nurse will be promptly instituted and acted upon in compliance with Sections 120.569 and 120.60(6), Florida Statutes.

DONE and ORDERED this 23 day of September, 2010.

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

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NOTICE OF RIGHT TO JUDICIAL REVIEW

Pursuant to Sections 120.60(6), and 120.68, Florida Statutes, this Order is judicially reviewable. Review proceedings are governed by the Florida Rules of Appellate Procedure. Proceedings are commenced by filing one copy of a Petition for Review, in accordance with Florida Rule of Appellate Procedure 9.100, with the District Court of Appeal, accompanied by a filing fee prescribed by law, and a copy of the Petition with the Agency Clerk of the Department within 30 days of the date this Order is filed.