

IN THE MATTER OF PERMANENT
CERTIFICATE NUMBER 601367 AND
PERMANENT CERTIFICATE NUMBER
124033 ISSUED TO
CATHERINE JEAN KONICKI

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BEFORE THE ELI
AND DISCIPLINA
COMMITTEE
OF THE TEXAS
BOARD OF NURS



I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.
Patricia A. Roman
Executive Director of the Board

ORDER OF THE BOARD

TO: Catherine Jean Konicki
1157 Ayala # 2
Sunnyvale, CA 94086

During open meeting held in Austin, Texas, on March 23, 2010, the Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case. This case was heard, and based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

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

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

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

The Committee finds that the Board is authorized to enter a default order pursuant to Texas

Government Code § 2001.056.

The Eligibility and Disciplinary Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by reference for all purposes and the Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing (22 TEX. ADMIN.CODE § 213.2(j)). All parties have a right to judicial review of this Order.

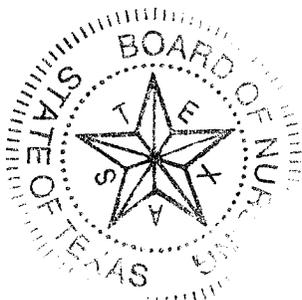
All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Certificate Number 601367 and Permanent Certificate Number 124033, previously issued to CATHERINE JEAN KONICKI, to practice professional and vocational nursing in the State of Texas be, and the same is hereby, REVOKED.

IT IS FURTHER ORDERED that Permanent Certificate Number 601367 and Permanent Certificate Number 124033, previously issued to CATHERINE JEAN KONICKI, upon receipt of this Order, be immediately delivered to the office of the Texas Board of Nursing.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multi-state privilege, if any, to practice professional and vocational nursing in the State of Texas.

Entered this 23rd day of March, 2010.



TEXAS BOARD OF NURSING

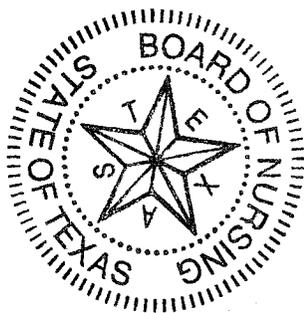
BY: Katherine A. Thomas
KATHERINE A. THOMAS, MN, RN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Re: Permanent Certificate Number 601367 and 124033
Issued to CATHERINE JEAN KONICKI
DEFAULT ORDER -REVOKE

CERTIFICATE OF SERVICE

I hereby certify that on the 24th day of March, 2010, a true and correct copy of the foregoing DEFAULT ORDER was served by placement in the U.S. Mail via certified mail, and addressed to the following person(s):

Catherine Jean Konicki
1157 Ayala # 2
Sunnyvale, CA 94086



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

**In the Matter of Permanent License Number 124033 § BEFORE THE TEXAS
and Permanent License Number 601367, §
Issued to CATHERINE JEAN KONICKI, Respondent § BOARD OF NURSING**

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, CATHERINE JEAN KONICKI, is a Vocational Nurse holding license number 124033 and Registered Nurse holding license number 601367, which are both in Delinquent status at the time of this pleading.

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

CHARGE I.

On or about February 29, 2008, Respondent's license to practice professional nursing in the State of California was REVOKED by the Board of Registered Nursing, Department of Consumer Affairs, State of California. A copy of the Default Decision and Order, dated February 29, 2008, is attached and incorporated by reference as part of this pleading.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

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

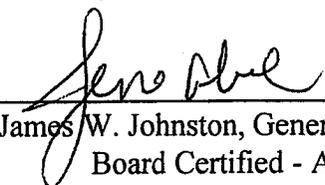
NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.state.tx.us.

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

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order which is attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Default Decision and Order issued by the Board of Registered Nursing, Department of Consumer Affairs, State of California, dated February 29, 2008.

Filed this 28th day of January, 2010.

TEXAS BOARD OF NURSING


James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300

Jena Renee Koslan Abel, Assistant General Counsel
State Bar No. 24036103

Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847

John F. Legris, Assistant General Counsel
State Bar No. 00785533

TEXAS BOARD OF NURSING
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6824
F: (512) 305-8101 or (512)305-7401

Attachments: Default Decision and Order issued by the Board of Registered Nursing,
Department of Consumer Affairs, State of California, dated February 29, 2008.

0999/D

1 EDMUND G. BROWN JR., Attorney General
of the State of California
2 FRANK H. PACOE
Supervising Deputy Attorney General
3 JONATHAN D. COOPER, State Bar No. 141461
Deputy Attorney General
4 California Department of Justice
455 Golden Gate Avenue, Suite 11000
5 San Francisco, CA 94102-7004
Telephone: (415) 703-1404
6 Facsimile: (415) 703-5480

7 Attorneys for Complainant

8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2007-291

13 **CATHERINE JEAN KONICKI**
14 902 Everett Avenue
Oakland, California 94602

**DEFAULT DECISION
AND ORDER**

15 Registered Nurse License No. 590013

[Gov. Code, §11520]

16 Respondent.

17 **FINDINGS OF FACT**

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

21 2. On or about October 23, 2001, the Board of Registered Nursing (Board)
22 issued Registered Nurse License No. 590013 to Respondent. The Registered Nurse License was
23 in full force and effect at all times relevant to the charges brought herein and expired on June 30,
24 2007.

25 3. On or about June 8, 2007, James Mirarchi, an employee of the Department
26 of Justice, served by Certified Mail a copy of Accusation No. 2007-291, Statement to
27 Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5,
28 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is 902

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

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

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

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

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

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

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

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

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

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

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

1 October 12, 2007.

2 **DETERMINATION OF ISSUES**

- 3 1. Based on the foregoing findings of fact, Respondent Catherine Jean
4 Konicki has subjected her Registered Nurse License No. 590013 to discipline.
- 5 2. A copy of the Accusation and the related documents and Declaration of
6 Service are attached.
- 7 3. The agency has jurisdiction to adjudicate this case by default.
- 8 4. The Board of Registered Nursing is authorized to revoke Respondent's
9 Registered Nurse License based upon the following violations alleged in the Accusation:
- 10 a. Gross Negligence/Incompetence;
11 b. Unprofessional Conduct;
12 c. Grossly Incorrect Medical Records;
13 d. Unlawful Possession/Use of Drugs.

13 **ORDER**

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

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

21 This Decision shall become effective on February 29, 2008.

22 It is so ORDERED January 29, 2008

23 LaTranese W. Tate
24 FOR THE BOARD OF REGISTERED NURSING
25 DEPARTMENT OF CONSUMER AFFAIRS

26 Attachments:

- 27 Exhibit A: Accusation No. 2007-291 , Related Documents, and Declaration of Service.
28 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

1 EDMUND G. BROWN JR., Attorney General
of the State of California
2 FRANK H. PACOE
Supervising Deputy Attorney General
3 JONATHAN D. COOPER, State Bar No. 141461
Deputy Attorney General
4 California Department of Justice
455 Golden Gate Avenue, Suite 11000
5 San Francisco, CA 94102-7004
Telephone: (415) 703-1404
6 Facsimile: (415) 703-5480

7 Attorneys for Complainant

8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

12 **CATHERINE JEAN KONICKI**
13 902 Everett Avenue
Oakland, California 94602

14 Registered Nurse License No. 590013

15 Respondent.

Case No. 2007-291

OAH No.

A C C U S A T I O N

16 Complainant alleges:

17 **PARTIES**

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

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

25 **JURISDICTION**

26 3. This Accusation is brought before the Board of Registered Nursing
27 (Board), Department of Consumer Affairs, under the authority of the following laws. All section
28

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

2 **STATUTORY PROVISIONS**

3 4. Section 2750 of the Business and Professions Code (Code) provides, in
4 pertinent part, that the Board may discipline any licensee, including a licensee holding a
5 temporary or an inactive license, for any reason provided in Article 3 (commencing with section
6 2750) of the Nursing Practice Act.

7 5. Section 2764 of the Code provides, in pertinent part, that the expiration of
8 a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding
9 against the licensee or to render a decision imposing discipline on the license. Under section
10 2811(b) of the Code, the Board may renew an expired license at any time within eight years after
11 the expiration.

12 6. Section 2761 of the Code states in pertinent part:

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

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

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

18 "..."

19 7. Section 2762 of the Code states in pertinent part:

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

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

28 "..."

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

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

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

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

12 "As used in Section 2761 of the code, 'incompetence' means the lack of possession
13 of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed
14 and exercised by a competent registered nurse as described in Section 1443.5."

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

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

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

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

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

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

1 medication withdrawals from the Pyxis¹ without a physician's order and/or without adequately
2 documenting the disposition of the medication. On or about October 17, 2002, during an
3 interview with Hospital personnel, Respondent admitted that she had taken medications from the
4 Pyxis and had diverted them for her own use.

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

6 Patient 2:

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

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

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

17 Patient 4:

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

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

23 Patient 5:

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

26 _____
27 1. The Pyxis is a drug-dispensing machine that documents the withdrawal of medications
28 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.

1 ordered Vicodin 6 pk to go.

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

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

7 Patient 6:

8

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

12 Patient 7:

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

16 Patient 9:

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

20 Patient 10:

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

24 Patient 11:

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

28 Patient 12:

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

4 Patient 13:

5 37. On 10/6/02 at 02:50 hours, Patient 13's physician ordered Fentanyl 50 mcg
6 IVP prn. The physician also ordered Morphine Sulfate 2-5 mg IVP, may repeat q5 minutes up to
7 10 mg max.

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

10 Patient 14:

11 39. On 10/8/02 at 23:45 hours, Patient 14's physician ordered Vicodin Tablet
12 1-2 prn. On 10/9/02 at 01:50 hours, the physician ordered Vicodin 6 pk to go.

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

15 Patient 15:

16 41. On 10/9/02 at 03:41 hours, Respondent made two withdrawals of Fentanyl
17 100 mcg from the Pyxis but failed to chart administration of the medication or otherwise account
18 for its disposition. There were no orders in place for administration of Fentanyl to the patient.

19 Patient 16:

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

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

25 Patient 17:

26 44. On 10/10/02 at 18:41 hours, Respondent withdrew Fentanyl 100 mcg from
27 the Pyxis but failed to chart administration of the medication or otherwise account for its
28 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

1 disposition.

2 Patient 29:

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

7 Patient 30:

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

11 Patient 31:

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

15 Patient 32:

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

19 Patient 33:

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

25 Patient 36:

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

1 Patient 37:

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

5 **FIRST CAUSE FOR DISCIPLINE**

6 (Gross Negligence/Incompetence)

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

10 **SECOND CAUSE FOR DISCIPLINE**

11 (Unprofessional Conduct)

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

14 **THIRD CAUSE FOR DISCIPLINE**

15 (Grossly Incorrect Medical Records)

16 62. Respondent is subject to disciplinary action under sections 2761 and
17 2762(e) of the Code in that she made grossly incorrect, grossly inconsistent, or unintelligible
18 entries in a hospital record pertaining to controlled substances, as set forth above in paragraphs 20
19 - 59.

20 **FOURTH CAUSE FOR DISCIPLINE**

21 (Unlawful Possession/Use of Drugs)

22 63. Respondent is subject to disciplinary action under sections 2761 and
23 2762(a) of the Code in that she unlawfully possessed a controlled substance as defined in Division
24 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or
25 dangerous device as defined in Section 4022, as set forth above in paragraphs 19 - 59.

26 **PRAYER**

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

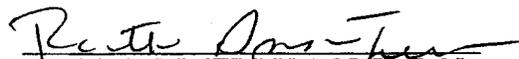
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1. Revoking or suspending Registered Nurse License Number 590013, issued to Catherine Jean Konicki Catherine Jean Konicki;

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

SF2007401270