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

10 In the Matter of the Accusation Against:
11 ROSE ANN MCKENZIE
12 1423 Mississauga Valley Blvd., #210
13 Mississauga, Ontario, Canada L5A4A5
Registered Nurse License No. 582112
14 Respondent.

Case No. 2008-274
OAH No.
**DEFAULT DECISION
AND ORDER**
[Gov. Code, §11520]

15
16 **FINDINGS OF FACT**

17 1. On or about April 1, 2008, Complainant Ruth Ann Terry, M.P.H., R.N., in
18 her official capacity as the Executive Officer of the Board of Registered Nursing, Department of
19 Consumer Affairs, filed Accusation No. 2008-274 against Rose Ann McKenzie (Respondent)
20 before the Board of Registered Nursing.

21 2. On or about June 19, 2001, the Board of Registered Nursing (Board)
22 issued Registered Nurse License No. 582112 to Respondent. The Registered Nurse License
23 expired on January 31, 2003, and has not been renewed.

24 3. On or about April 15, 2008, Shontane McElroy, an employee of the
25 Department of Justice, served by Certified and First Class Mail a copy of Accusation No.
26 2008-274, Statement to Respondent, Notice of Defense, Request for Discovery, and Government
27 Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board,
28 which was and is:

1 Rose Ann McKenzie
2 1423 Mississauga Valley Blvd., #210
3 Mississauga, Ontario, Canada L5A4A5.

4 A copy of the Accusation is attached as Exhibit A, and is incorporated herein by reference.

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

7 5. On or about May 8, 2008, the documents were returned by the U.S. Postal
8 Service marked "Moved Unknown."

9 6. Business and Professions Code section 118 states, in pertinent part:

10 "(b) The suspension, expiration, or forfeiture by operation of law of a license
11 issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the
12 board or by order of a court of law, or its surrender without the written consent of the board, shall
13 not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the
14 board of its authority to institute or continue a disciplinary proceeding against the licensee upon
15 any ground provided by law or to enter an order suspending or revoking the license or otherwise
16 taking disciplinary action against the license on any such ground."

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

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

22 8. Respondent failed to file a Notice of Defense within 15 days after service
23 upon her of the Accusation, and therefore waived her right to a hearing on the merits of
24 Accusation No. 2006-247.

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

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

30 10. Pursuant to its authority under Government Code section 11520, the Board

1 finds Respondent is in default. The Board will take action without further hearing and, based on
2 the evidence on file herein, finds that the allegations in Accusation No. 2008-274 are true.

3 11. The total cost for investigation and enforcement in connection with the
4 Accusation are \$9,547.25 as of May 15, 2008.

5 DETERMINATION OF ISSUES

6 1. Based on the foregoing findings of fact, Respondent Rose Ann McKenzie
7 has subjected her Registered Nurse License No. 582112 to discipline.

8 2. A copy of the Accusation is attached.

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

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

12 A. Business and Professions Code section 2761(a)(1) (Gross Negligence) in that
13 respondent engaged in gross negligence in carrying out usual nursing functions while employed
14 as a registered nurse (traveling nurse) at the University of California at San Francisco Medical
15 Center (UCSF).

16 ORDER

17 IT IS SO ORDERED that Registered Nurse License No. 582112, heretofore
18 issued to Respondent Rose Ann McKenzie, is revoked.

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

24 This Decision shall become effective on September 15, 2008.

25 It is so ORDERED August 15, 2008

26 LaTranene W. Tate
27 FOR THE BOARD OF REGISTERED NURSING
28 DEPARTMENT OF CONSUMER AFFAIRS

Exhibit A
Accusation No. 2008-276

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BOARD OF REGISTERED NURSING
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13 ROSE ANN MCKENZIE
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Mississauga, Ontario, Canada L5A4A5
15 Registered Nurse License No. 582112
16 Respondent.

Case No. *2008-274*

A C C U S A T I O N

18 Complainant alleges:

19 **PARTIES**

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

23 2. On or about June 19, 2001, the Board of Registered Nursing issued
24 Registered Nurse License Number 582112 to ROSE ANN MCKENZIE (Respondent). The
25 Registered Nurse License was in full force and effect at all times relevant to the charges brought
26 herein and expired on January 31, 2003. It is currently in delinquent status.

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1 JURISDICTION

2 3. This Accusation is brought before the Board of Registered Nursing
3 (Board), Department of Consumer Affairs, under the authority of the following laws. All section
4 references are to the Business and Professions Code unless otherwise indicated.

5 STATUTORY PROVISIONS

6 4. Section 2750 of the Business and Professions Code (Code) provides, in
7 pertinent part, that the Board may discipline any licensee, including a licensee holding a
8 temporary or an inactive license, for any reason provided in Article 3 (commencing with section
9 2750) of the Nursing Practice Act.

10 5. Section 2764 of the Code provides, in pertinent part, that the expiration of
11 a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding
12 against the licensee or to render a decision imposing discipline on the license. Under section
13 2811(b) of the Code, the Board may renew an expired license at any time within eight years after
14 the expiration.

15 6. Section 2761 of the Code states:

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

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

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

21 7. Title 16, California Code of Regulations, section 1442, states:

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

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1 d. At 8:00 p.m., Respondent conducted the initial screening assessment and at
2 9:00 p.m. she conducted the neurological assessment.

3 e. The PCA Narcotic Orders, which Respondent checked at 8:00 p.m. when she
4 received S.S. into 8L, required that S.S.'s respiratory rate, pain scale, sedation level and total
5 amount of Morphine Sulfate infused be monitored and the results be documented every two
6 hours for eight hours and then every four hours. But Respondent failed to follow those orders,
7 and, instead, monitored and documented these items at 8:30 p.m. (December 26), 12:00 a.m.
8 (December 27), and 5:00 a.m. (December 27). Respondent charted on the Spinal Cord Testing
9 Record at 8:00 p.m. and 12:00 a.m. (December 27) that S.S. was a 5 on his right and left sides.
10 Respondent charted on S.S.'s Neurological Assessment Record at 8:00 p.m., 12:00 a.m.
11 (December 27) and 4:00 a.m. (December 27).

12 f. At 6:00 a.m., on December 27, 2001, S.S. was found to be hypoventilating and
13 unresponsive. Narcan was administered but S.S. remained unresponsive. S.S. was transferred to
14 the Intensive Care Unit with a diagnosis of acute respiratory failure and shock. On March 27,
15 2002, S.S. was discharged from UCSF and transferred to St. Jude Hospital as a quadriplegic,
16 with brain damage, requiring lifelong care.

17 g. The community standard is that a nurse should monitor post-operative vital
18 signs such as heart rate, respiratory rate, blood pressure including oxygen saturation, when a
19 patient arrives on the floor, 15 minutes later, then every thirty minutes for two hours, then one
20 hour later, and then every four hours, or more frequently if ordered. Respondent took S.S.'s vital
21 signs at 8:00 p.m., 10:00 p.m., 2:00 a.m. (December 27), and 6:00 a.m. (December 27).

22 h. According to the Neurosurgery Orders, on December 26, 2001, at 5:00 p.m.,
23 S.S.'s neurosurgical team of doctors ordered the following medications: Percocet, Ziagen, Zerit,
24 Sustive, Valium, Acetaminophen, Diphenhydramine, Droperidol, Colace, Ambien and
25 Neurontin.

26 i. According to the PAC Narcotic Orders, on December 26, 2001, at 5:00 p.m.,
27 S.S.'s pain service team of doctors ordered the following medications for S.S.: Morphine,
28 Diphenendydramine, Droperidol, Lorazepam, and Naloxone (Narcan). These orders stated "no

1 IV (intravenous), PO (by mouth), IM (intramuscular) or SQ (subcutaneous) narcotics are to be
2 given unless ordered by the physician/service below.”

3 j. According to the PACU Admission/Discharge Orders, S.S.’s doctor ordered
4 Demerol for him.

5 k. S.S. received the following medications in the PACU: total of 20 mg. of
6 Morphine Sulfate IV, Demerol 50 mg IV, Ativan 0.5 mg, and the PCA pump was started with a
7 dose of 3 mg of Morphine Sulfate with a six minute delay and a one-hour limit of 35 mg.

8 l. Respondent administered the following medications in accordance with the
9 Neurosurgery orders: Morphine Sulfate 5 mg (8:30 p.m.), Percocet 2 tablets, Valium 5 mg,
10 Neurontin 200 mg (9:00 p.m.), Ambien 10 mg (10:00 p.m.), Tylenol 650 mg. (11:00 p.m.) and
11 Morphine Sulfate 5 mg and Ativan 1 mg. (12:00 a.m.). Administering some of these medications
12 violated the PCA order restrictions.

13 m. In providing nursing care to S.S., Respondent made several
14 documentation/assessment errors in failing to properly monitor the patient in the following
15 respects:

16 (1) She failed to properly monitor this patient by not following the doctor’s
17 orders from the pain management service team.

18 (2) She failed to get clarification about the two sets of medication orders: one
19 from the neurosurgery team and one from the pain management service team, thereby creating a
20 risk that the cumulative effect of the various medications would cause respiratory arrest.

21 (3) She failed to document and reassess the patient’s heart rate, respiratory rate,
22 blood pressure, oxygen saturation, pain scale, sedation level, and total amount of morphine
23 sulfate infused by the PCA pump every two hours for eight hours and then every four hours, as
24 ordered by S.S.’s pain management service team.

25 (4) As a result of respondent’s documentation and assessment errors, the patient
26 was placed at risk for a significant deterioration in respiratory status leading to his respiratory
27 arrest.

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PRAYER

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

1. Revoking or suspending Registered Nurse License Number 582112, issued to ROSE ANN MCKENZIE;

2. Ordering ROSE ANN MCKENZIE 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: 4/11/08

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

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STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS