

BEFORE THE INDIANA STATE
BOARD OF NURSING
CAUSE NO.: 94 NB 075

STATE OF INDIANA,

Petitioner,

v.

WALDEMAR A. POTARZYCKI, R.N.,
License No. 28123499,

Respondent.

FILED

JUN 01 1995

**HEALTH PROFESSIONS
BUREAU**

FINDINGS OF FACT AND ORDER

The Indiana State Board of Nursing ("Board") held an administrative hearing on May 18, 1995, in rooms 1 and 2 of the Conference Center, Indiana Government Center South, 402 West Washington Street, Indianapolis, Indiana, concerning disciplinary charges against the nursing license of Waldemar A. Potarzycki, R.N. ("Respondent").

The State of Indiana was represented by Andrew S. Peacock, Deputy Attorney General. Respondent appeared in person, acknowledged his right to be represented by counsel, and elected to proceed without the assistance of an attorney.

The Board, after considering the evidence presented and taking official notice of its file in this matter, by a vote of 8 to 0, issues the following Findings of Fact and Order:

FINDINGS OF FACT

1. Respondent, who resides at 6510 Covington Rd., #404 E, Ft. Wayne, Indiana 46804, is a registered nurse in the State of Indiana holding license number 28123499.

2. Respondent received timely and proper notice of the State's Complaint and of the hearing date and location in accordance with IC 4-21.5-3-8 and IC 4-21.5-3-20.

3. From on or about August 28, 1989, until November 18, 1994, Respondent was employed at the Lutheran Hospital of Indiana, Inc., 7950 W. Jefferson Blvd., Ft. Wayne, Indiana ("Lutheran").

4. During November of 1994, Respondent worked as a staff nurse on Medical-Surgical Unit 3-A at Lutheran.

5. On November 9, 1994, a patient on the Unit informed the Clinical Manager, Marcia Albany, R.N., that a nurse had entered his room and taken his PCA (patient controlled analgesia) syringe out of the locked IV pump on two (2) occasions.

a. The patient informed Ms. Albany that the nurse explained that the PCA "was plugged" on the first occasion that the syringe was removed. The patient reported that the second time the syringe was removed, the nurse stated there was a monitor in the hall which indicated that the syringe was getting low.

b. Respondent was the nurse who, on both occasions, removed the syringe. Respondent was not assigned to care for this patient on either evening.

6. On November 10, 1994, another patient informed Ms. Albany that Respondent took a PCA syringe into the bathroom and stated that it had an "air bubble" in it. The patient stated that after Respondent removed the syringe and replaced it in the pump, the medication (morphine, a schedule II controlled substance) failed to relieve her pain.

7. Laboratory analysis of the syringe referred to in rhetorical paragraph 6 revealed that the medication had been diluted.

8. Because of these unusual occurrences, Respondent was confronted. Respondent denied having a drug problem or being involved in the tampering with medications. Respondent was suspended without pay for a period of five (5) days in order that the investigation into this matter could be completed.

9. A review of charts on the Unit revealed the following discrepancies:

a. On October 31, 1994, chart #127028, Respondent signed out three (3) tubex of meperidine 50 mg. (a schedule II controlled substance). Respondent documented administering only one of these three (3) tubex.

b. On November 1, 1994, chart #010032, Respondent signed out two (2) meperidine 50 mg. tubex. One (1) tubex was recorded as given on the medication administration record (MAR). A "waste" of 30 mg. was also properly documented. Lutheran cannot account for the remaining 20 mg. of meperidine.

c. On November 2, 1994, chart #129028, Respondent signed out three (3) meperidine 50 mg. tubex but documented the administration of only two (2) of these tubex.

d. On November 9, 1994, chart #198490, Respondent signed out three (3) meperidine 75 mg. tubex. Respondent documented the administration of only one (1) of these three (3) tubex.

10. On November 18, 1994, Lutheran officials again met with Respondent about the discrepancies. Respondent continued to deny diversion, use, or tampering with the medication. Respondent's employment at Lutheran was terminated on November 18, 1994.

11. On November 21, 1994, Respondent contacted Marcia Albany, R.N., Clinical Manager. Respondent admitted to Ms. Albany that he had diverted medication from Lutheran

for his own use and that he had tampered with medication by diluting it. Respondent stated that after he diverted the medication, he would take it to the restroom and inject himself.

12. Respondent has not used any controlled substances since November 10, 1994.

13. Respondent is involved in a 12-Step recovery program. He has entered into a monitoring contract with the Indiana State Nurses Association Peer Review and Assistance Program. He regularly attends AA and Caduceus meetings.

14. Respondent continues to see his psychiatrist for depression. He takes Pamelor for this condition.

15. Respondent completed an intensive outpatient treatment program for chemical dependency at Lindenvue, Ft. Wayne, Indiana. Respondent currently attends aftercare sessions.

16. Respondent's conduct constitutes fraud or material deception in the course of professional services or activities in violation of IC 25-1-9-4(a)(1)(B); continuing to practice although unfit due to addiction to, abuse of, or severe dependency upon drugs which endangers the public by impairing Respondent's ability to practice safely in violation of IC 25-1-9-4(a)(4)(D) and diversion of a legend drug in violation of IC 25-1-9-4(a)(8)(A).

17. The violations listed in Finding No. 16, warrant the imposition of disciplinary sanctions on Respondent's Indiana nursing license.

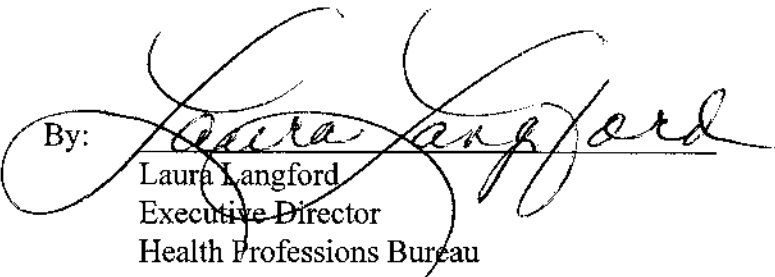
ORDER

Based upon the foregoing Findings of Fact, the Board issues the following Order:

Respondent's Indiana nursing license is **SUSPENDED** and Respondent shall not have the right to apply for reinstatement for a period of six (6) months from the date of this Order.

SO ORDERED this 1 day of June, 1995.

THE INDIANA STATE BOARD
OF NURSING

By: 

Laura Langford
Executive Director
Health Professions Bureau

copies to:

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SENT CERTIFIED MAIL NO. 2-405-708-568
RETURN RECEIPT REQUESTED.

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