



## FINDINGS OF FACT

1. That Teri Baldwin is licensed to practice as a registered nurse in the State of South Dakota and hold license number R-018106.
2. That Licensee was the co-owner of the Friendship Home Assisted Living Center in Deadwood, South Dakota.
3. That Licensee was the individual responsible for rendering care to the seven residents of the assisted living facility.
4. That on September 1 and 2, 2004, the South Dakota Department of Health conducted an inspection of the Friendship Home Assisted Living Center in Deadwood, South Dakota.
5. That as a result of the Department of Health inspection, the Friendship Home received over 37 major health and life safety code violations.
6. That on September 2, 2004, by order of the Department of Health, the assisted living residents of the Friendship Home Assisted Living Center were removed from the facility due to the conditions.
7. As a result of the September 2004 inspection, and after a hearing, the Friendship Home Assisted Living Center had its license revoked and the facility was closed.
8. Major health violations found against the provider/licensee included but are not limited to the following:

A. The Licensee failed to maintain clean and sanitary food handling, preparation, and storage.

B. The Licensee failed to maintain sanitary conditions of laundered personal clothing, towels, and bed linen.

C. The Licensee followed improper infection control practices during wound care for a resident with open wounds, did not have physician orders for the treatment of said wounds, had not documented the stage, color, size, odor, drainage, bed condition, and wound edges for two pressure sores, and followed a dressing procedure that she [Licensee] had learned from a physical therapist 20 years ago.

D. The Licensee failed to follow safe infection control practice which would prevent contamination of food.

E. The Licensee failed to conduct an annual tuberculosis risk assessment to guide the frequency of screening for residents and employees.

F. The Licensee retained a resident who required ongoing nursing care.

G. The Licensee failed to document weekly condition of the three residents retained in the facility.

H. The owner [Licensee] confirmed that they had taken three residents' shoes so that they "wouldn't run."

I. The Licensee failed to meet requirements to retain one resident on a therapeutic diet.

J. Skilled nursing services were provided by the RN/co-owner of the facility using techniques and practices that violated the residents' privacy, did not meet accepted standards of practice for infection control, and did not follow the manufacturer's direction in the use of dressings.

K. In administering medications, the Licensee dropped a physician's order from the MAR, decreased the number of times a resident received an albuterol inhaler without a physician's order because the inhaler made the resident "become agitated," and failed to regularly check medication administration records against doctor's orders.

L. The Licensee failed to retain monthly pharmacy drug regime reviews for three of the residents.

M. The Licensee failed to store medications in a place that was well illuminated and out of the reach of residents of the facility and children residing there.

N. The Licensee failed to properly dispose of unused legion and control drugs for a resident who died at the facility.

9. Major life safety code violations against the provider/licensee included, but are not limited to the following:

A. Failed to properly clean and sanitize common use items in the facility;

B. Failed to maintain the facility in clean, orderly, and good condition;

- C. Failed to store cleaners, chemicals, poisons, flammables and combustibles safely;
- D. Failed to prevent overflowing and uncovered refuse receptacles both in the facility and outside on the grounds;
- E. Failed to protect the facility against vermin and other wild animals;
- F. Failed to maintain the outside area to avoid injury or harm to the residents;
- G. Failed to install grab bars in two common toilet areas and common bathing areas;
- H. Failed to hold night emergency egress and relocation drills;
- I. Failed to test fire alarms on annual basis and did not have fire extinguishers monthly;
- J. Failed to ensure exits were readily accessible at all times;
- K. Failed to provide egress windows in a bedroom; and
- L. Failed to ensure all door were maintained and operable to protect occupants from smoke, fire, and fumes.

From the following Findings of Facts, the Board draws the following:

### **CONCLUSIONS OF LAW**

1. The South Dakota Board of Nursing has jurisdiction and authority over this matter pursuant to SDCL §§ 36-9-1.1 and 36-9-49.

2. The Licensee's conduct as identified in the Findings of Fact are inconsistent with the health and safety of persons entrusted to her care and violates the statutes, rules, and regulations regarding the practice of nursing and are in violation of SDCL § 36-9-49(5) and (10).

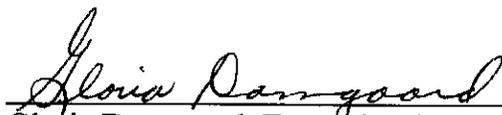
THEREFORE, let an Order be entered accordingly:

**ORDER**

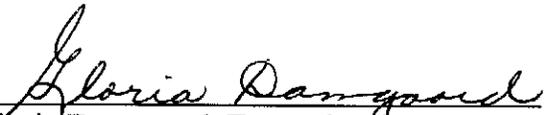
Based on the Findings of Facts and Conclusions of Law, the South Dakota Board of Nursing hereby order:

1. That the Licensee's license to practice nursing in the State of South Dakota is hereby revoke.
2. That the Licensee may petition pursuant to SDCL § 36-9-57 for reinstatement of her license and any time for "good cause."
3. The Licensee shall turn in her license to the Board of Nursing within ten (10) days of this Order.
4. The Licensee is hereby notified that any practice as or holding herself out as a registered nurse during the term of this revocation is a violation of SDCL § 36-9-69.

Dated this 8th day of April, 2005.

  
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Gloria Damgaard, Executive Secretary  
South Dakota Board of Nursing

The above captioned Findings of Fact and Conclusions of Law were adopted by the South Dakota Board of Nursing on the 8<sup>th</sup> day of April, 2005, by a vote of 8-0.

  
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Gloria Damgaard, Executive Secretary  
South Dakota Board of Nursing