SOUTH DAKOTA BOARD OF NURSING

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IN THE MATTER OF THE LICENSURE PROCEEDINGS	:	
	:	**ORDER OF SUMMARY SUSPENSION AND NOTICE OF HEARING**
RE: ANN MARIE MECHTENBERG, RN	:	
License No. R028205,	:	
Licensee.		

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WHEREAS, Ann Marie Mechtenberg, RN, ("Licensee"), is licensed to practice as a registered nurse in the State of South Dakota and holds license number R028205; and

WHEREAS, that on or about August 16, 2012, the South Dakota Board of Nursing ("Board") received a call from Bob Stahl, the Administrator of Licensure and Certification Programs with the South Dakota Department of Health. Mr. Stahl informed the Board that the Department of Health had issued a Summary Suspension and Closure Order on August 9, 2012 to the Hudson Nursing Home in Hudson, South Dakota. Mr. Stahl informed the Board that the South Dakota Division of Criminal Investigation (DCI) was investigating, among other matters, allegations of abuse and neglect of residents. Stahl also noted numerous concerns raised regarding the handling of medications, and reviewed with the Board's representative two scenarios which raised concern for nursing practices at the facility; and

WHEREAS, on August 23, 2012, Board investigator, Kathleen Tinklenberg, met with Investigator Andrew Albers of the Licensure and Certification Program of the State of South Dakota, Department of Health regarding the closure of the Hudson Nursing Home. Mr. Albers was the primary surveyor of the facility for several inspections and the closing. At this meeting, Mr. Albers voiced multiple concerns regarding the nursing practices and the nursing administration of the facility before its closure. Mr. Albers raised concerns regarding specific patient care reviews, including a head injury, and the death of a resident; and

WHEREAS, Mr. Albers discussed the various Department of Health surveys and the concerns raised with nursing care at the facility. He also indicated that the South Dakota DCI was actively investigating the matter in regard to allegations of potential abuse or neglect in the facility; and

WHEREAS, the Board obtained the Department of Health survey reports for the following visits: October 6, 2011; November 10, 2011; February 8, 2012; March 20, 2012; April 17, 2012; June 19, 2012; July 30, 2012; and August 9, 2012. The Department of Health also provided the Board with medical records for residents for whom there had been some identified concerns. The Board was also able to obtain the DCI investigative reports; and

WHEREAS, after review of the Department of Health Survey dated July 30, 2012, the Board identified findings regarding the Licensee regarding inconsistencies in

Licensee's documentation regarding a resident's fall and the Licensee's testimony to the surveyor. The information that the Licensee provided to the surveyor was different than what she had written in the medical records; and

WHEREAS, another finding identified regarding this Licensee was in the second Department of Health survey, also dated July 30, 2012. This survey noted a number of medication errors made by the Licensee. In addition, the survey had cited the facility for this Licensee's medication errors, poor nursing practice, failure to have controlled substance destruction cosigned, not writing up medication errors, taking doses of controlled medications from the wrong medication cart, and allowing Certified Nurse Aides (CNAs) access to the narcotic keys, and giving them the passcodes to the medication cart; and

WHEREAS, on or about January 2, 2013, the Board received a complaint against said Licensee from a daughter of a resident who had lived at the Hudson Nursing Home. The daughter stated that the Licensee had failed to clearly communicate pertinent information to the family after her father's fall at the facility and his impending transfer to a hospital. Licensee failed to tell them of the severity of the resident's condition and the significance of his changing vital signs. There was inadequate documentation of the actual injuries, which involved an orbital fracture. There were no notations by the Licensee of any observations of this resident prior to the incident.

Licensee admittedly did not relay the seriousness of the patient's condition. The Licensee was also inaccurate in her documentation concerning when she had advised the physician of this patient's injury; and

WHEREAS, shortly after receiving the above complaint, the Board received another complaint. This complaint was from a former CNA at the Hudson Nursing Home regarding the care provided by the Licensee. On a shift they worked together, the complainant alleged that the Licensee failed to provide nursing care to a resident who was in respiratory distress and discomfort and who ultimately expired. Licensee was tending to another resident's wound vacuum equipment most of the shift. Nursing assessments and adequate documentation were absent in regard to the patient with respiratory distress; and

WHEREAS, based upon the above complaints and the survey reports, a disciplinary case was opened for Licensee; and

WHEREAS, after thoroughly reviewing the investigative materials, the medical records and documents that the Board had obtained, Board investigator, Kathleen Tinklenberg, pursuant to ARSD 20:48:08:10, notified the Licensee in regard to the scheduling of an Informal Meeting. An Informal Meeting Notice was sent to Licensee on or about January 2, 2013 of her Informal Meeting for January 29, 2013. The Board was then contacted by Attorney Melissa Hinton, advising that she would be representing Licensee at the Informal Meeting; and

WHEREAS, prior to the time for Informal Meeting, it was brought to the Board's attention that due to the closure of the facility, Licensee was unable to obtain medical records that were under the Department of Health's control. Arrangements were then made for the Licensee and her attorney to review the medical records in question prior to the Informal Meeting; and

WHEREAS, on or about January 25, 2013, Board investigator Kathleen Tinklenberg also contacted DCI. As they were still in their investigation, Kathleen Tinklenberg recommended that the Board defer Licensee's Informal Meeting to a later date, wanting to ensure that further investigation by the Board would not interfere with any criminal investigation or with the Medicare Fraud Compliance Unit ("MFCU") investigation. Once it was determined that the Board could proceed, the Informal Meeting was held on June 18, 2013; and

WHEREAS, the meeting was conducted with the Licensee at the Board office in Sioux Falls, South Dakota. An audio recording was made of this Informal Meeting; and

WHEREAS, at the Licensee's Informal Meeting with her attorney, Board investigator Kathleen Tinklenberg reviewed with the Licensee the current issues that had been identified in the complaints from the resident's daughter, the CNA at the Hudson Nursing Home regarding Licensee's nursing care, and the various issues identified in the two Department of Health surveys, both dated July 30, 2012; and

WHEREAS, during the Board's investigation, it was also noted that the Licensee was still on probation by the South Dakota Board of Nursing at the time that she started at Hudson Nursing home on or about April 16, 2012. It was noted that the Director of Nursing at the facility was acting as Licensee's worksite monitor as part of Licensee's probation. Despite the Licensee's numerous medication errors, inadequate nursing assessment and documentation, and giving the nursing aides access to the medication cart code and keys to the medication cart, the Director of Nursing wrote to the Board that Licensee "Does well" when asked about Licensee's critical thinking and ability to establish compliance with the facility's policies and procedures; and

WHEREAS, once the investigation and the informal meeting were complete, information regarding this Licensee was presented to the Board at its July 19, 2013 meeting. The Board voted to request a Voluntary Surrender Consent Order from the Licensee, and if that was not agreed to, to issue a Summary Suspension and Notice of Hearing; and

WHEREAS, based upon the above, it is concluded that the public health, safety, and welfare imperatively require emergency action in that Licensee's actions may endanger the health and safety of those persons entrusted to her care and that the Licensee's license should be summarily suspended.

WHEREAS, based upon the Affidavit of Kathleen J. Tinklenberg and the above stated conduct, the Board has concluded that the public health, safety and welfare require

emergency action, in that Licensee's actions may endanger the health and safety of those who are, or will be, entrusted to her care in the future; and

WHEREAS, the Board, has a statutory obligation to protect the health, safety and welfare set forth in SDCL §36-9, including the protection of the public from unsafe nursing practices and practitioners.

NOW THEREFORE IT IS HEREBY ORDERED:

1. That the Board has jurisdiction of the Licensee and the subject matter of this Order.

2. That based on the above, the Board specifically finds that the public health, safety and welfare require emergency action against Licensee's license.

3. That based on the above, the Board specifically finds that the actions of the Licensee endanger the public health, safety and welfare, and imperatively require emergency action in that Licensee may endanger the health and safety of those persons who are or will be entrusted to her care in the future and that these are matters of a nature that would constitute further grounds for discipline of her license to practice nursing under SDCL § 36-9-49.

4. Based upon these findings, Licensee's license to practice nursing in South Dakota is hereby summarily suspended. Licensee may petition according to SDCL § 36-9-57 for reinstatement of her license at any time for "good cause".

Should Licensee change her home state under the Nurse Licensure Compact, then Licensee's practice privilege is subject to the same requirements as set forth in this order as her South Dakota license.

5. That Licensee shall turn in her license to the Board within ten (10) days from the date of this Order and it shall be kept by the Board until further action on this matter.

6. Licensee is hereby notified that any practice of or holding herself out as a registered nurse during the terms of this Order of Summary Suspension is a violation of SDCL § 36-9-68.

7. This action is reportable discipline and will be published in the Board's newsletter and posted on its website and reported into the National Practitioner Data Bank (NPDB) as required by law.

The South Board of Nursing at its meeting on the 18th day of July, 2013 approved issuing this Order of Summary Suspension consistent herein as follows:

IT IS HEREBY ORDERED that the above was adopted as an Order of the South Dakota Board of Nursing on the 18th day of July, 2013 by a vote of 11-0.

Dated this 4 day of September, 2013.

SOUTH DAKOTA BOARD OF NURSING

Gloria Damgaard

Gloria Damgaard, RN, MS
Executive Director

NOTICE OF HEARING

The South Dakota Board of Nursing pursuant to SDCL §§ 1-26-16, 1-26-27, and 1-26-29, hereby provides this Notice of Hearing to Ann Marie Mechtenberg, RN, License No. R028205 as follows:

1. The South Dakota Board of Nursing ("Board") is duly appointed regulatory authority of the state of South Dakota.

2. That the Licensee was licensed to practice as a registered nurse in the state of South Dakota and held License No. R028205.

3. The Board has jurisdiction and authority over this matter pursuant to SDCL §§ 36-9-9.1 and 36-9-49.

4. That on July 18, 2013, the Board issued its Order of Summary Suspension against the Licensee pursuant to SDCL § 1-26-29 with a date for hearing to be determined.

5. This matter is an adversarial proceeding and Licensee has the right to be present at the hearing and to be represented by an attorney. These due process rights will be forfeited if they are not exercised at the hearing.

6. The hearing will address the Board's assertion, as set forth in its Summary Suspension, that the Licensee, by her conduct, violated SDCL §§ 36-9-49 (5), (7) and (10).

7. At the hearing, the Board will determine whether the Licensee's license shall remain suspended, revoked, or subject to other disciplinary action as determined by the evidence presented.

8. Licensee has a right to request that the agency use the Office of Hearing Examiners for this proceeding by giving notice of the request to the Board no later than ten (10) days after the service of this Notice of Hearing on Order of Summary Suspension.

9. A decision issued by the Board after the hearing may be appealed to the circuit court and to the South Dakota Supreme Court as provided by law.

Dated this 4th day of September, 2013.

SOUTH DAKOTA BOARD OF NURSING

Gloria Damgaard

Gloria Damgaard, RN, MS
Executive Director