

Dakota. Three witnesses testified in person during this hearing. These included, the Licensee, Dr. Chris J. Nordgren (for the Board), and Dr. Beth Kelsey (for the Licensee). Exhibits number 1, 3, 5, 6, and 7 were introduced into evidence by the Board, all of which were admitted without objection. Exhibits A, B, C, D, and E were introduced into evidence by the Licensee and were received without objection. The entire hearing was fully transcribed by a court reporter. At the close of the testimony, the Board moved into executive session pursuant to SDCL § 1-25-2 on motion duly made and unanimously carried to deliberate regarding its decision.

At the close of deliberation, the Board came back into open session with parties present where one motion was made by the Board: "That the South Dakota Board of Nursing indefinitely suspend the license of Jacquelyn Wickstrom." This motion was adopted on a vote of 7-0.

The Board considered the evidentiary testimony of the witnesses, the exhibits admitted into evidence, and other documents on file, and being charged with the statutory obligation to protect the public health, safety, and welfare as set forth in SDCL § 36-9, the Board hereby makes the following:

FINDINGS OF FACT

1. That Jackie J. Wickstrom, RN ("Licensee"), is licensed to practice as a registered nurse in the State of South Dakota and holds license number R-029423.

2. Licensee was born on January 26, 1959.
3. Licensee worked as a certified nursing assistant (CNA) from 1990 through 1996.
4. Licensee obtained her associates degree in nursing (RN) in 1997 from the Sisseton Wahpeton Community College.
5. Following graduation, Licensee worked several years at the Lake Area Hospital. From September 2002 to August 2010, Licensee worked summers at Strand-Kjorsvig Community Rest Home in Roslyn, South Dakota, while she worked as a school nurse at the Waubay School District from April 2003 through September 2012.
6. After moving from Waubay to Iroquois, South Dakota, Licensee began working at SunQuest Healthcare Center in Huron, South Dakota, on October 22, 2012. Her employment there continued until December 18, 2012.
7. Following the end of her employment from SunQuest, Licensee began working for Universal Pediatrics in December 2012, caring for one infant on a one-on-one basis.
8. In the latter part of 2012, Licensee was going through what she called a contentious and bitter divorce.

9. The divorce caused Licensee a significant amount of anxiety as her ex-husband was stalking her and threatening to harm her. Licensee never got a protection order against her husband.

10. Licensee began seeing a counselor, Angela Severson, for individual therapy sessions beginning in November 2012. This was to address her life stressors and to identify positive coping techniques. Licensee continues to work with Ms. Severson for stress management and feelings associated with her anxiety.

11. On or about December 20, 2012, the Licensee contacted the Board's investigator, Kathleen Tinklenberg and self-reported that she (Licensee) had taken Ativan (which had been prescribed for anxiety) for the first time on December 18, 2012.

12. After taking the Ativan, Licensee went to work at SunQuest Healthcare Center and once there, passed out three times, alleging it was a reaction to Ativan.

13. At that time, Licensee's blood sugar was high, her speech was mumbled, and she felt dizzy.

14. The Licensee was asked to go home. She was not sure whether she had been terminated at that time or not as she had already given her employer a month's notice in late November and had another job lined up.

15. Subsequently, the Board received a complaint from Licensee's Director of Nursing who reported that the Licensee on December 18, 2012, reported to work impaired and fainted twice while on duty.

16. This complaint also indicated that the Licensee had received counseling on December 14, 2012, for concerns brought to the Director of Nursing for Licensee's harsh treatment of a resident.

17. On December 14, 2012, Licensee was angry and frustrated with co-workers, a central supply employee and a maintenance worker, when they did not answer an "out of chair" alarm.

18. At the time of the alarm, the Licensee quickly returned another patient to her room and admits that she might have pushed the patient in the wheelchair too fast, causing the patient to complain, "my legs".

19. Licensee felt resident care was a team effort and these non-nurse employees should have helped. The situation made Licensee mad.

20. As to the events of December 18, 2012, the Licensee had been prescribed Ativan by her physician to help her deal with anxiety.

21. Licensee admitted that she had taken Ativan 1 mg for the first time at home with her morning medications at 5:30 a.m. and went to her scheduled work shift at 7:00 a.m.

22. Licensee believed that she would be perfectly fine to take this new medication, Ativan, before work.

23. Licensee was prescribed hydrocodone on December 10, 2012, following a fall at work where she injured her knee.

24. Licensee indicated that she only took only one tablet of the prescription hydrocodone for pain at or near the time of the injury. Licensee later stated that she was also taking hydrocodone to help her sleep at night.

25. Several days after the Ativan incident, the Director of Nursing received a phone call from someone alleging to be the Licensee. Licensee denied making any such call. The long term care facility then issued a letter to the Licensee advising her that she was not allowed on the facility property for any reason, nor could she contact employees or management staff.

26. At the time of hand delivery of the letter by the sheriff, the Licensee read the letter, crumpled it up, and threw it at the sheriff.

27. After the incident at work, Licensee discontinued taking the Ativan and in the middle of January 2013 she was prescribed the anti-anxiety medication, Lexapro by her nurse practitioner, Lynette Steen.

28. The South Dakota Board of Nursing, at its February 28, 2013, meeting, discussed the allegations of the Licensee reporting to work impaired. The Board, at that

time, by unanimous vote, ordered that the Licensee voluntarily refrain from practice and undergo a psychological evaluation by Dr. J. Chris Nordgren with a report to be sent to the Board by May 6, 2013.

29. Licensee was advised of the Board's order through a letter to her attorney dated March 5, 2013.

30. In the written request for the psychological evaluation, the Board also enclosed a copy of a Voluntary Refrain form for Licensee to sign.

31. On March 13, 2013, the Licensee, through her attorney, asked the Board to reconsider the necessity of a Voluntary Refrain pending the results of her evaluation.

32. On March 14, 2013, all members of the Board were contacted via e-mail with Licensee's request asking for the Board to reconsider their action requiring a Voluntary Refrain from Practice pending the psychological evaluation. The Board considered the request for reconsideration, but denied the request.

33. The Board's denial of Licensee's request was relayed to Licensee's attorney on March 15, 2013. When the Licensee received the Board's decision, the Licensee told her attorney that she would "think about this over the weekend and contact [the attorney] on Tuesday with her decision."

34. It was relayed to Licensee's attorney that the Voluntary Refrain was not optional and concerns were expressed regarding Licensee's unwillingness to voluntarily refrain pending the evaluation.

35. On April 1, 2013, Licensee's attorney notified the Board that he had received the Voluntary Refrain from his client, but that Licensee had only dated it and had not signed it.

36. Licensee could not explain why she did not sign the Voluntary Refrain. She stated she was waiting for the Board to tell her when she had to stop working.

37. The Board did ultimately receive the signed Voluntary Refrain from the Licensee on April 5, 2013.

38. Licensee underwent a psychological evaluation with Dr. J. Chris Nordgren on April 26, 2013.

39. Dr. Nordgren obtained written information from the Licensee prior to conducting his evaluation.

40. Dr. Nordgren spent 4 to 5 hours in dialogue with the Licensee, as well as administering a number of tests, including the Minnesota Multiphasic Personality Inventory (MMPI-2RF), the Montreal Cognitive Assessment (MoCA). Dr. Nordgren performed supplemental cognitive assessment tests, conducted a diagnostic interview, and also reviewed information provided by the South Dakota Board of Nursing.

41. In the interview, Licensee told Dr. Nordgren that she was currently practicing as a nurse at Universal Pediatrics in Huron, taking care of one patient and putting in 10 hour shifts, working 40 hours per week.

42. At another point in the evaluation, Licensee then reported to Dr. Nordgren that she is allowed to practice during this interim period on some sort of provisional status.

43. When the Board received Dr. Nordgren's report, the Board noted that Licensee stated she was working and had made a representation that she was allowed to practice during this interim period on a provisional status. It was at this time that the Board first became aware that Licensee had not abided by her Voluntary Refrain.

44. Upon receiving this report, concerns were raised about the Licensee's follow through with the directives of the Board.

45. When asked about the representations to Dr. Nodgren, Licensee, through her attorney, admitted that she did continue to work despite the Board's directive to refrain from practice and her signing the Voluntary Refrain.

46. Licensee's non-compliance with the Voluntary Refrain was presented to the full Board on May 30, 2013.

47. Because the Licensee continued to work when she had signed a Voluntary Refrain, the Board summarily suspended the licensee of Ms. Wickstrom and noticed her for a formal hearing.

48. Licensee's MoCA test administered by Dr. Nordgren indicated that Licensee is functioning cognitively within normal limits.

49. Licensee reported to Dr. Nordgren generalized anxiety disorder symptoms when anxious and worried, including insomnia, increased muscle tension, fatigue, and distraction.

50. Licensee reported to Dr. Nordgren a life-long history of obsessions and compulsions that Dr. Nordgren found consistent with obsessive compulsive disorder (OCD). Dr. Nordgren reported that these symptoms have caused Licensee significant stress in relationships and take up a significant amount of time and cause her significant distress.

51. Dr. Nordgren found that the Licensee did have depression and minimized her depression report. He did state that Licensee had had severe depression in December 2012, lasting into mid-January 2013, and that she also had had a suicidal ideation during that time.

52. Licensee does not currently present as a danger to herself or any other individual.

53. Dr. Nordgren found that the Licensee has a tendency to under-report her symptoms, problems, and concerns. Dr. Nordgren found that Licensee minimized her self report to him and also through the psychological testing. He found that her uncooperative approach to the psychological evaluation introduced an element of uncertainty as to the results.

54. Nursing is a stressful profession. It needs attention to detail and requires good judgment. Nursing also requires knowledge of medications, their administration and reaction.

55. Dr. Nordgren's psychological evaluation dated April 26, 2013, concluded that the Licensee has significant factors that interfere with her ability to function as a nurse. These include a tendency to be uncooperative in her self report and reports of significant anxiety disorder symptoms.

56. Dr. Nordgren recommended the need for cognitive behavioral therapy for her symptoms, as well as a review by her medical provider of her medications.

57. According to Dr. Nordgren, no psychosocial or medical intervention can be effective with this Licensee to otherwise facilitate her ability to function as a nurse until she elects to be more open and honest with those evaluating her and providing intervention.

58. Dr. Nodgren's testimony was credible.

59. Licensee also underwent a psychological evaluation by Dr. Beth Kelsey, who is a licensed professional counselor-mental health, qualified mental health professional.

60. Dr. Kelsey is not a clinical psychologist.

61. Dr. Kelsey performed her evaluation and testing on July 11, 2013.

62. On the Minnesota Multi-phasic Personality Inventory - 2 (MMPI-2), Dr. Kelsey stated that Ms. Wickstrom scored high on the possibility of developing an addictive disorder or abusive disorder, although her history did not bear out such a disorder.

63. Although finding Licensee's testing was within normal limits, Dr. Kelsey opined that Licensee had an adjustment disorder with anxiety and dependency issues.

64. Dr. Kelsey did note excessive anxiety in Licensee.

65. While indicating that Licensee was capable of immediately returning to her past work as a nurse, Dr. Kelsey did opine that Licensee's situation at this time would not allow her to work in a number of settings, such as in ICU, based on her evaluation.

From the foregoing Findings of Fact, the Board draws the following:

CONCLUSIONS OF LAW

1. That 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. That the Board had the opportunity to hear all testimony in this hearing, to witness the demeanor of the witnesses, and to view all evidence submitted in the case.

3. Licensee disregarded the directive by the Board when she continued to practice after signing the Voluntary Refrain.

4. That Licensee's conduct, as identified in the Findings of Fact, is by clear and convincing evidence in violation of SDCL § 36-9-49(5) and (10) in that she has acted negligently, willfully, or intentionally acted in a manner inconsistent with the health or safety of persons entrusted to her care; and that she is guilty of incompetent, unprofessional or dishonorable conduct.

5. That the Licensee's mental condition as identified in the Findings of Fact is, by clear and convincing evidence, a violation of SDCL § 36-9-49.1, in that her current mental health condition endangers the health or safety of those persons who are or will be entrusted to her care.

6. That ARSD 20:48:04:01(1)(d) provides that the Board recognizes "The Scope and Standards of Practice" (2004), and the "Code of Ethics for Nurses with Interpretive Statements" (2001), as published by the American Nurses Association as a criteria for assuring safe and effective practice following licensure. The code of ethics requires an RN to function within established legal guidelines and to uphold the basic standards of nursing practice.

7. The evidence of violations of the Nurse Practice Act by Licensee are clear and convincing and the Board of Nursing has met its burden of proof.

THEREFORE, let an order be entered accordingly:

ORDER

Based on the Findings of Fact and Conclusions of Law, the South Dakota Board of Nursing hereby orders:

1. That the Licensee's license to practice nursing in the State of South Dakota is hereby indefinitely suspended.

2. That Licensee may petition for reinstatement of her license at any time for "good cause" pursuant to SDCL § 36-9-57.

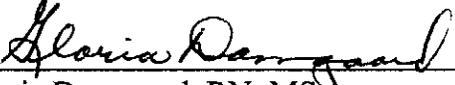
3. The Licensee shall turn in her license to the Board within ten (10) days from the date of this order, if she has not already done so under her previous order of suspension.

4. That the Licensee is hereby notified that any practice as or holding herself out as a registered nurse during the term of this suspension is in violation of SDCL § 36-9-69.

Name of Document: Findings of Fact, Conclusions of Law and Order of Suspension
Licensee: Jackie J. Wickstrom

Dated this 8th day of October, 2013.

SOUTH DAKOTA BOARD OF NURSING



Gloria Damgaard, RN, MS
Executive Director