

primarily night shifts, often 12 hours in length (7 p.m. to 7 a.m.), at this location and interacted minimally with daytime staff.

3. In the week prior to January 6, 2016, the Licensee worked four out of five nights.
4. On or about January 6, 2016, a med cup full of various medications was alleged by facility staff to have been found locked in the top drawer of a medication cart following Licensee's shift and after the Licensee had already returned home from her shift.
5. No records exist which indicate that Licensee did not administer all her required medication during that shift.
6. Licensee had counted narcotics when she came on, and when she left, but did not notice the med cup in the drawer.
7. The Licensee was woken at her residence by the care facility and hospital staff and summoned back to the facility to answer some questions about the meds.
8. At the time of the meeting, Licensee was not under the impression she was being disciplined.
9. Licensee decided to end her contract early and return to South Carolina.
10. Licensee refused to take a drug screen through the facility at that time. Licensee had been awakened and summoned to work and was tired and upset.
11. Within 28 hours of the meeting, the Licensee had received a drug screen through her travelling agency, which was negative.
12. The long term care facility contacted the Board on January 6, 2016 with a report that the med cup had been found and that Licensee had refused drug screens and ended her contract early.

13. The Board investigator began an investigation of the situation and attempted to make contact with Licensee.

14. Phone calls to Licensee on February 22, 2016, March 18 and March 22, 2016 failed to reach the Licensee. These phone calls failed to make contact with Licensee because one phone was no longer accessible and service on the other had been discontinued due to financial hardship on the part of the Licensee.

15. Board staff further continued their attempts to contact Licensee through mailings dated February 22, 2016 and March 24, 2014 to an Ohio address that board staff had ascertained in the NURSUS database.

16. Licensee failed to appear at the April 6, 2016 informal meeting which was scheduled with the Board investigator.

17. On May 4, 2016 the Board issued an Order of Summary Suspension and Notice of Hearing. This action revoked Licensee's privilege to practice in South Dakota and noticed a hearing for June 9, 2016 at 1:30 p.m. Notice was sent by certified mail to both the listed Ohio address and a newly identified South Carolina address found in NURSUS. The Ohio pleading was returned, but the South Carolina copy was not.

18. Licensee did receive the notice in South Carolina.

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

CONCLUSIONS OF LAW

1. That the Board has jurisdiction and authority over this matter pursuant to SDCL §§ 36-9-1.1 and 36-9-49. The Board also has jurisdiction pursuant to SDCL § 36-9-92 Article V, as it relates to the Interstate Nurse Licensure Compact.

2. The notices to the Licensee for the informal hearing from the Board did not timely arrive for the reasons laid out in the Findings of Fact.

3. That there is insufficient evidence to conclude that the Licensee failed to administer patient medication or attempted to divert medications for her own use.

THEREFORE, let an order be entered accordingly:

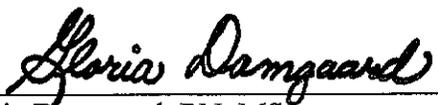
ORDER

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

1. That the complaint against the Licensee be dismissed.
2. That the Licensee's privilege to practice in the State of South Dakota pursuant to the Interstate Nurse Licensure Compact be reinstated.

IT IS HEREBY ORDERED that the above is adopted as an Order of the South Dakota Board of Nursing this 9th day of June, 2016 by a vote of 9-0.

SOUTH DAKOTA BOARD OF NURSING



Gloria Damgaard, RN, MS
Executive Director