SOUTH DAKOTA BOARD OF NURSING

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

IN THE MATTER OF THE LICENSURE PROCEEDINGS	:	
	:	**FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF REINSTATEMENT WITH PROBATION AND REMEDIATION**
RE: MARLA R. (NELSON) HUSTON, LPN,	:	
License No. P009114,	:	
Licensee.		

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

The South Dakota Board of Nursing's ("Board") hearing on the Summary Suspension of the license of the Licensee, Marla R. (Nelson) Huston, LPN, license number P009114, ("Licensee") came on for hearing before the South Dakota Board of Nursing at its office in Sioux Falls, South Dakota on April 21, 2010, at 1:30 p.m. Licensee, Marla R. Huston, appeared in person to present evidence on her behalf. The Board appeared by and through its attorney, Kristine Kreiter O'Connell. The Board considered the evidentiary testimony of Larry Eickhoff, Administrator of the Good Samaritan Luther Manor nursing facility, and the Licensee. The Board also considered the Exhibits (numbered 1 through 5) entered into evidence, the Affidavit and other documents on file in this case, and being charged with the statutory obligation to protect the public health, safety, and welfare as set forth in SDCL § 36-9, including the protection of the public from unsafe nursing practices and practitioners, the Board hereby makes the following:

FINDINGS OF FACT

1. That Marla R. Huston is licensed to practice as a practical nurse in the State of South Dakota and holds license number P009114.

2. That the Licensee received her practical nursing education from Western Iowa Tech and was originally issued her South Dakota practical nurse license following examination on May 6, 2002.

3. Following licensure, the Licensee worked for the Good Samaritan Center in Sioux Falls, South Dakota, the Canton Good Samaritan and most recently, the Good Samaritan Luther Manor.

4. That on August 11, 2009, the South Dakota Board of Nursing received a complaint from the Good Samaritan Luther Manor alleging that the Licensee did not render appropriate nursing care for a post-vertebroplasty patient, who was under her care, on July 12, 2009 at 6:00 p.m. until July 13, 2009 at 6:00 a.m.

5. Licensee was assigned as the charge nurse on the east wing of Good Samaritan Luther Manor on July 12, 2009 from 6:00 p.m. until July 13, 2009 at 6:00 a.m.

6. Forty of the forty-one bed census on the east wing were occupied that night.

7. Seven of those occupied beds are considered rehabilitation beds; one room of which the vertebroplasty patient occupied.

8. Facility staffing on the east wing consisted of five (5) nurse aides and one (1) medication aide from 6:00 p.m. to 10:00 p.m. and two (2) nurse aides from 10:00 p.m.

to 6:00 a.m.

9. The vertebroplasty patient had been admitted to Good Samaritan Luther Manor on July 3, 2009.

10. Licensee had worked with this patient before while working on the east wing.

11. Licensee documented the administration of Lorcet, Xanax, Valium, and Ambien to the vertebroplasty patient at 12:00 midnight on July 12, 2009.

12. Licensee documented patient response to these medications at 1:00 a.m. on July 13, 2009 as "resting with eyes closed" when in fact the Licensee did not observe the patient at 1:00 a.m.

13. Licensee completed an incident detail report on July 12, 2009 at 12:00 midnight indicating that she and a nurse aide were assisting the vertebroplasty patient with the commode and used the appropriate equipment (i.e., a gait belt and walker) when in fact no gait belt was used. The patient's knees allegedly gave out and the patient was lowered to the floor.

14. Licensee did an assessment of the patient while the patient was on the floor and the patient was assisted with a lift device back to bed.

15. Licensee wrote in her report that the patient denied pain with any movement.

16. Licensee and the nurse aide did not follow the care plan for the use of assistive devices when the patient was assisted to the commode.

17. The Licensee charted in the interdisciplinary progress notes that at 5:30 a.m. on July 13, 2009, the patient wanted to get up and go to bathroom using total lift, stated that the left knee was stiff and sore, and documented no redness, swelling or bruising noted to the knee.

18. The Licensee did not objectively nor subjectively assess the patient at 5:30 a.m., but relied on information that was given to her by the nurse aide.

19. Progress notes entered July 13, 2009, at 10:55 a.m. by a nurse who cared for the patient following Licensee, indicated that the patient was not able to bear weight on her leg and had decreased range of motion in the left knee and complained of pain in the knee.

20. The patient was transferred to a hospital for an x-ray, and the x-ray revealed a fracture.

21. During investigation of the incident, the Licensee falsely stated that a gait belt was used at the time the patient was assisted to the commode.

22. Licensee changed her story during the course of the investigation, admitting that a gait belt was, in fact, not used.

23. A review of video monitoring in the east wing hallway revealed that the Licensee was seen leaving the patient's room at about 12:00 midnight and was not seen again entering the patient's room for the rest of her shift or until she clocked out at 7:05 a.m.

patient's room at the time she did the assessment; however, this was not corroborated by the video. Licensee later indicated that she may have used the manual blood pressure cuff that she stated that she kept in her pocket until break time at 2:00 a.m.

25. Licensee admits that the 5:30 a.m. charting regarding the patient was not her own assessment, but based on what the CNAs had reported.

26. Licensee failed to follow-up with proper assessment of a patient who had been lowered to the floor.

27. Licensee's documentation in the interdisciplinary notes was not truthful in regards to her documented assessment.

28. Licensee's documentation in her incident report was inaccurate.

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

CONCLUSION OF LAW

1. That the Board has jurisdiction and authority over this matter pursuant to SDCL §§ 36-9-1.1 and 36-9-49.

2. That the Licensee negligently, willfully, and intentionally acted in a manner inconsistent with the health and safety of persons entrusted to her care pursuant to SDCL § 36-9-49(5).

3. That the Licensee, on the night of July 13, 2009, was guilty of incompetent, unprofessional, and dishonorable conduct pursuant to SDCL § 36-9-49(10).

4. That the Licensee's conduct as identified in the Findings of Fact is, by clear

4. That the Licensee's conduct as identified in the Findings of Fact is, by clear and convincing evidence, in violation of the code of ethics required of an LPN to function within an established guideline and uphold the basic standards of nursing practice as cited in ARSD 20:48:04:01(1)(d).

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 as a practical nurse in the State of South Dakota is hereby reinstated and placed on probationary status for twelve (12) months or one year of active practice as a practical nurse.

2. That the Licensee shall, at any time during the term of probation, report in person to such meetings of the Board or to its designated representative as directed and fully cooperate with the Board or its representative in the terms of this probation.

3. The Licensee shall, during this year of probation, provide quarterly written self and work-site supervisor reports addressing Licensee's progress as an employee. The supervisor's reports shall provide and/or address:

a. Licensee's attendance and reliability;

b. Licensee's ability to practice professional nursing, including the exercise of clinical decision making and adherence to documentation standards;

c. Ability to carry out assigned functions, including medication administration, decision making, critical thinking, and ability to establish priorities in compliance with the facilities policies and procedures;

d. Licensee's ability to handle stress;

e. Number of hours Licensee worked during the reporting period;

f. Number of medication errors and types of medication errors;

g. Any other information that the supervisor believes would assist the Board in its ultimate review of the case; and

4. Licensee shall not violate and law or regulation regarding the practice of nursing.

5. The Licensee will be issued a renewal certificate, which the Board office will have stamped "PROBATION".

6. Licensee shall notify the Board in writing within one week of any change in nursing employment, address and/or telephone number.

7. Licensee shall also complete the following learning modules: (1) Ethics of Nursing Practice; (2) Medication Errors: Detection and Prevention; and (3) Documentation, a Critical Aspect of Client Care. The Licensee is responsible to purchase and complete these modules and return them to the Board office with successful certificates of completion no later than July 1st, 2010. Licensee can register for these modules on the following website: www.learingext.com.

8. At the end of the twelve (12) months, the Licensee shall petition the Board for closure of the probationary terms with successful completion of the terms as outlined in this Order.

9. If any condition of this probation is violated, the Licensee agrees that the Board may take such action as the Board deems necessary up to and including a total and complete revocation of Licensee's licensing rights in the State of South Dakota.

10. The Licensee shall not practice nursing in any State other than South Dakota which is a party state to the Nurse Licensure Compact, without prior written authorization from both the Board and the Nursing Regulatory Authority in the party state in which the Licensee desires to practice.

11. This probation also affects Licensee's practice privilege to practice in South Dakota should Licensee change her home state under the Nurse Licensure Compact and Licensee's practice privilege

12. This is reportable discipline and will be published in the Board's newsletter and posted on its website and reported into the Healthcare Integrity and Protection Data Bank (HIPDB) and National Practitioner Data Bank (NPDB) as required by law. Additionally, as this is reportable discipline, Licensee shall provide an affirmative response to inquires of disciplinary action on further renewals and other nursing related inquiries.

IT IS HEREBY ORDERED that the above Findings of Fact, Conclusions of Law and Order of Reinstatement with Probation and Remediation is adopted by the South Dakota Board of Nursing on the 21st day of April, 2010, by a vote of 8 to 0.

Dated this 29th day of April, 2010

SOUTH DAKOTA BOARD OF NURSING

Gloria Damgaard

Gloria Damgaard, Executive Director