

05-1520

**BEFORE THE
SOUTH DAKOTA BOARD OF NURSING**

**IN THE MATTER OF THE
LICENSURE PROCEEDINGS**

RE: JEANETTE KREITEL,

**FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND
ORDER OF SUSPENSION**

License No. R-028064

Licensee.

BON 5-01

This matter came on regularly for hearing before the South Dakota Board of Nursing ("Board") for a due process hearing on the Summary Suspension of the license of Jeanette Kreitel, RN, License No. R-028064 ("Licensee"), on April 7, 2005, at 9:00 a.m., in the conference room of the South Dakota Board of Nursing in Sioux Falls, SD, Julie M. Johnson, Hearing Examiner, Office of Hearing Examiners, State of South Dakota, presiding. Licensee appeared personally, and by and through her attorney, John Shaeffer, Flandreau, South Dakota. The Board appeared by and through its attorney, Kristine Kreiter O'Connell. A quorum of the Board of Nursing was present in person throughout these proceeding, in accordance with SDCL 36-9-18. The members of the Board of Nursing present for this hearing were: Chair, Linda Bunkers; Diana Berkland, Teresa Disburg, June Larson, Christine Pellet, Donald Simmons (public member), Deb Soholt, and Robin York. Board member Pat Wagner was present for most of the hearing, but had to depart before the end and before the determination was made. There was no objection to any member of the Board of Nursing sitting on this case. This meeting was an open meeting under the laws of the State of South Dakota. Nine

witnesses testified in person, including: Dr. Shawn Culey, Jenny Longstreet, Joyce Engelbretson, Betty Gage, Anita Tigner, John Roth, Walden Peterson, Cathy Pierson, and the Licensee. The witnesses were sequestered pursuant to agreement of the parties in a prehearing conference, which motion was granted. Exhibits 1 through 14 were introduced in evidence by the Board, all of which were without objection (except Exhibit 3) and received into the record as evidence. Exhibits A, F and G were introduced in evidence by the Licensee, and received without objection. Licensee moved the introduction of other exhibits, which were not exchanged with counsel for the Board. Those exhibits were not in compliance with the prehearing order, and were not received into the record. The entire hearing was fully transcribed by a court reporter, and a transcript produced. At the close of testimony, the Board of Nursing moved into executive session pursuant to SDCL 1-25-2, on motion duly made and unanimously carried, to deliberate regarding their decision. At the close of deliberation, the Board of Nursing came back into an open meeting, with the parties present, where two motions were made by the Board and acted upon: 1) to find by clear and convincing evidence that the Licensee had violated SDCL 36-9-10 by negligently or intentionally acting in a manner inconsistent with the health or safety of persons entrusted to her care, and that Licensee had violated SDCL 36-9-10 by her unprofessional or dishonorable conduct, which was adopted on an 8-0 unanimous vote; and 2) to indefinitely suspend the license of Licensee under SDCL 36-9-57, which was adopted on a 7-1 vote. The Board of Nursing adjourned the hearing, after making their decision on the record and in open meeting, at approximately 11:00 p.m.

Based on the testimony of the witnesses, the exhibits received in the record, and the law applied to the facts, together with the Board's statutory obligation to protect the public health, safety and welfare under SDCL 36-9, the Board makes and files the following:

FINDINGS OF FACT

I.

Licensee is licensed to practice as a registered nurse in the State of South Dakota and holds license number R-028064. Licensee obtained an Associate Degree in nursing from the University of South Dakota in 1994, after her children were raised. Licensee's nursing experience included a position of Staff Coordinator at Bethany Meadows Nursing Home in Sioux Falls, South Dakota, and a position of Director of Assisted Living at Waterford in Sioux Falls, South Dakota. In her previous position at Bethany Meadows, Licensee worked with John Roth, current Administrator of Palisades.

II.

Licensee became the Director of Nursing ("DON") of the Palisades Manor Nursing Home ("Palisades") in Garretson, South Dakota, on or about April 29, 2004. Licensee came to Palisades because of her longstanding work relationship with Palisades' administrator, John Roth, who hired her. Licensee was not hired originally to be the Director of Nursing, but emerged in that role after others left Palisades, and within a few weeks of her employment relationship with Palisades.

III.

Upon taking the DON position, Licensee, in her first staff meeting, differentiated between her licensed and non-licensed staff by referring to the non-licensed staff as

“unprofessionals.” This was disrespectful and lacked human dignity. She later submitted a written apology to the staff as she had offended the staff. Licensee said CNAs are “scum of the earth.”

IV.

Licensee was disrespectful of the human dignity and her relationships with other health care professionals, under the Code of Ethics, in several other ways. Licensee reprimanded her staff and ancillary support personnel in front of others. Licensee would degrade the Palisades' Medical Director, Dr. Culey, in front of other staff and showed disrespect to the Medical Director. Licensee failed to communicate with the Medical Director and the clinic about resident issues. This lack of communication caused growing distrust of Licensee by the physicians. Medical Director, Dr. Culey, was intimidated by Licensee. All of the doctors at the Dell Rapids Clinic found Licensee difficult to work with. The doctors of the clinic signed a letter to the Administrator reflecting their mutual problems with Licensee. Exhibit 4. Licensee would discipline staff for minor infractions by putting them on probation and would decrease their hours from 40 to 16 hours per week. In some cases, this operated to force them to terminate their employment. Licensee reprimanded staff for assisting in the care of Palisades' residents for whom she had personal dislike. When asked by ancillary services to arrange meetings to discuss the needs of the residents, Licensee's response was “I don't have time for you.” Licensee would change staff shift schedules, hours and duties, which caused anger and discord and left staff no option but to resign. When an upset staff member came to Licensee, her response was “I don't do tears.” Licensee used retaliation tactics against those who did not agree with her or follow her dictates.

Licensee caused psychological harm to her staff. Staff felt that they needed to "watch their backs" when it came to Licensee.

V.

Early in her tenure as DON, Licensee took away care items from the residents, including peri wash, denture cleanser, and under pad as cost cutting measures.

VI.

Licensee centralized a lot of functions and lines of authority and communication during her tenure requiring that matters come directly to her. Licensee ordered that all MDS data, previously entered by each department head, no longer be entered by them, but only by Licensee and the Associate Director of Nursing. Licensee eliminated the Palisades' ward secretary position so that Licensee would have control of monitoring doctors' orders, all lab data, arranging all appointments, and assuring all communications would come through her. Licensee wanted to centralize all information coming in and being disseminated from Palisades to assure it would come through her. Licensee advised her staff not to talk to families or to doctors and that all information needed to go through her. Licensee assisted in having Palisades' phones and computer terminals removed to assure that all communications would come through her.

VII.

Licensee hired Cathy Pierson for another position, but became as Assistant Director of Nursing, due to the departures of other staff. Cathy Pierson had known Licensee well previously, including the fact that she lived with her.

VIII.

Licensee did away with the successful Quality of Life meetings as she did not feel that the meetings met a need at Palisades.

IX.

Licensee asked non-credentialed staff to resign and reapply the next day to prevent the visiting Department of Health from finding that improperly credentialed staff members were employed by Palisades. Licensee specifically ordered the staff member who was asked to resign and reapply "not to tell anyone." Licensee failed to make sure that CNAs were properly credentialed.

X.

The turnover rate at Palisades increased significantly after Licensee began her employment. Licensee targeted staff to be fired and left them no option but to resign. Many long term employees, some with decades of service, left employment under Licensee's directorship.

XI.

Licensee directed her staff to tamper with an incident report involving a resident (JC) by selecting the words for the staff, typing the report herself, and not conveying the information of what actually happened as reported by the staff. Licensee instructed staff what to write in the resident's (JC) chart and what to tell the family, which was done to cover up possible abuse of the resident by another staff member. Licensee did not see to it that the family of JC was contacted regarding the incident. Licensee told staff what to say to law enforcement in regards to the (JC) incident in complete contradiction of the 911 call placed by staff. Licensee ordered staff to tell the officer that the incident was

an employee versus employee matter rather than a staff versus resident matter, which covered up possible abuse. Licensee improperly invoked the federal "HIPAA" law as a basis to prevent staff from cooperating with law enforcement or from discussing or investigating any other care concerns at Palisades. Staff felt they had no choice but to follow Licensee's instruction as to the handling of the incident report involving resident (JC) even though the staff felt what Licensee was doing was improper.

XII.

Licensee failed to investigate the reported staff-witnessed sexual abuse of resident (AB) and failed to report the matter to the Department of Health. Licensee failed to take seriously the report of alleged sexual abuse of resident (AB) as there had been no other complaints. The record contains a graphic depiction of this incident which is not repeated here.

XIII.

Licensee withheld medication from a resident without a doctor's order and allowed nurses the discretion to use their judgment in doing so as well. Licensee failed to report the withholding of medication to the Department of Health when specifically requested to do so by the Medical Director.

XIV.

Licensee failed to set up an appointment for a resident when specifically asked to do so by the Medical Director.

XV.

Licensee authorized the removal of oxygen from a resident during mealtimes without a doctor's order.

XVI.

Licensee would order ambulation of residents who were in significant pain or unable to tolerate the activity.

XVII.

Licensee instructed staff not to call families when incidents occurred or errors were made.

XVIII.

Licensee forbid the consultant pharmacist to talk with staff about resident issues, but directed the pharmacist to only report to Licensee. Licensee terminated the consultant pharmacist without credible explanation

XIX.

The morale of the staff at Palisades was low under Licensee's directorship.

XX.

Licensee's management style was "my way or the highway." Licensee managed by fear, intimidation and a very heavy hand.

XXI.

The Board of Nursing summarily suspended Licensee's nursing license on or about February 8, 2005, and scheduled a due process hearing April 7, 2005, on the summary suspension. In the summary suspension, the Board ordered the Licensee to do several things, including sitting for a psychiatric evaluation. Licensee's psychiatric evaluation found her to be emotionally compensated. Licensee's psychological evaluation found that she is not motivated to change her principles. Exhibit 14.

XXII.

To the extent any of the foregoing are improperly designated and are instead conclusions of law, they are hereby redesignated and incorporated herein as conclusions of law.

Based on the foregoing Findings of Fact, the Board makes and files the following:

CONCLUSIONS OF LAW

I.

The South Dakota Board of Nursing has jurisdiction and authority over this matter pursuant to SDCL §§ 36-9-1.1 and 36-9-49. The Office of Hearing Examiners has the authority to conduct this hearing and rule on the evidence on behalf of the Board of Nursing, under SDCL 1-26 and 1-26D. The Board of Nursing has the authority to make the decision in this matter.

II.

The Board of Nursing had the opportunity to view all of the testimony in this 12-hour hearing, to witness the demeanor of all of the witnesses, and to view all of the evidence in the context of the Code of Ethics of Nursing. The Board of Nursing had an opportunity to view and resolve any conflicts in the testimony during the hearing. The witnesses for the Board of Nursing and some of the Licensee's witnesses were credible. Dr. Culey was very credible, had a very clear memory of these events, and had no conflict of interest in these proceedings. Walden Peterson was not a credible witness.

III.

The evidence is clear and convincing that the Licensee violated SDCL § 36-9-49(5), in that the Licensee negligently and intentionally acted in a manner inconsistent with the health and safety of persons entrusted to her care. The Board of Nursing met its burden of proof.

IV.

The evidence is clear and convincing that the Licensee violated SDCL § 36-9-49(10) in that she is guilty of unprofessional and dishonorable conduct. The Board of Nursing met its burden of proof.

V.

The Board takes judicial notice of the "Standards of Clinical Nursing Practice" 1991, and the "Code for Nurses with Interpretive Statement" 1985, as published by the American Nurses Association, and as provided by the Board of Nursing's own Administrative Rules, ARSD 20:48:04:01, as a criteria for assuring safe and effective standards for nursing practice following licensure. The Code of Ethics requires an RN to function within an established legal guideline and uphold the basic standards of nursing practice. Licensee has violated such Code of Ethics and the standard of nursing practice in several ways. The violations of several of the Code of Ethics constitute violations of SDCL 36-9-49. The evidence of the ethical violations is clear and convincing, and the Board of Nursing met its burden of proof.

VI.

The Board of Nursing possesses specialized knowledge and special expertise in these matters, which it brings to factual and legal/ethical determinations such as this.

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V.

To the extent any of the foregoing are improperly designated and are instead findings of fact, they are hereby redesignated and incorporated herein as findings of fact.

Therefore, based on the Findings of Fact and Conclusions of Law, the Board of Nursing hereby makes and files the following:

ORDER

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 suspended,
2. That the Licensee may petition for reinstatement of her license at any time for "good cause", under SDCL 36-9-57;
3. That the Licensee shall turn her license into the Board of Nursing within ten (10) days from the date of this Order;
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 a violation of SDCL § 36-9-68;
5. That the Licensee be required to reimburse the South Dakota Board of Nursing herein for actual expenses incurred as a result of this action as provided for in

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SDCL § 1-26-29.1 in the sum of \$15,328.85. Further, that should Licensee seek reinstatement, the BON shall first determine that this amount has been fully reimbursed.

Dated this 3rd day of May, 2005.

Linda Bunkers
Linda Bunkers, Chair
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 3rd day of May, 2005, by a voice vote of 8-0, with a quorum present at all times and in an open meeting by telephone and notice given to the parties.

Gloria Damgaard
Gloria Damgaard, Executive Secretary
South Dakota Board of Nursing

CERTIFICATE OF SERVICE

I hereby certify that on the 4th day of May, 2005, I sent to John A. Shaeffer, Shaeffer Law Office, Post Office Box 304, Flandreau, South Dakota 57028, attorney for Licensee, a true and correct copy of the foregoing Findings of Fact, Conclusions of Law, and Order of Suspension by first-class mail, postage prepaid.

I certify that this is a true copy of a record on file in the Board of Nursing of the State of South Dakota.

Gloria Damgaard
For the South Dakota Board of Nursing

Date 6-15-05
[Signature]
Signature, Authorized Representative