The South Dakota Board of Nursing’s ("Board") hearing on the Summary Suspension of the Licensee Shelby L. McKelvey, L.P.N., license number P009914 ("Licensee"), came on for hearing before the South Dakota Board of Nursing at its office in Sioux Falls, South Dakota on January 22, 2009, at 3:30 p.m. Licensee, Shelby McKelvey, having received notice of the hearing and having been given the opportunity to confront Board witnesses and to present evidence on her behalf, did not appear in person nor by an attorney. The Board appeared by and through its attorney, Kristine K. O’Connell.

The Board considered the evidentiary testimony of Kathleen Rausch, Board of Nursing Program Specialist/Investigator. The Board also considered Exhibits (numbered 1 through 10 inclusive) 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 Shelby L. McKelvey, L.P.N., is licensed to practice as a practical nurse in the State of South Dakota, and holds license number P009914.

2. That Licensee was initially licensed as an L.P.N. in the State of South Dakota on January 26, 2007.

3. Prior to becoming an L.P.N., Licensee worked as a Certified Nurse Aide (C.N.A.) for Interim Health Care, Good Samaritan, and Covington Heights in Sioux Falls, South Dakota.

4. The Licensee worked as a C.N.A. for Covington Heights in Sioux Falls from May 24, 2004, up until the time she became an L.P.N. Licensee had good performance evaluations as a C.N.A. while employed by Covington Heights.

5. Licensee, upon receiving her L.P.N. license, continued to work for Covington Heights, however, in the L.P.N. role.

6. Licensee's first performance evaluation as an L.P.N. occurred on October 15, 2007. At that time she met the expectations of her job, but it was noted that she needed to continue to work on her personal growth and on nursing process follow through.

7. On November 18, 2007, Licensee received an Employee Memorandum for failure to report to work as scheduled on November 6, 2007, after asking for the day off.

8. On March 3, 2008, Licensee received an Employee Memorandum for poor work quality and/or productivity when she failed to give scheduled medications to two or more residents on March 2, 2008, and for a lack of assessment skills when assessing
residents' current condition and follow through with physician orders. The plan was to meet weekly with the Director of Nursing Services to review her work quality.

9. On May 23, 2008, Licensee received an Employee Memorandum for failure to perform assigned duties in an appropriate manner or at the assigned times. A plan was implemented whereby Licensee was to be re-educated on the charge nurse role and review her job description.

10. On June 25, 2008, Licensee received an Employee Memorandum for improper conduct whereby she failed to disclose all of the details surrounding the end of life of a resident to the family and physician on June 18, 2008.

11. On June 18, 2008, while giving report to the charge nurse, Licensee was summoned by a C.N.A. who advised that a resident was gasping for air and may be choking.

12. Licensee proceeded to complete her report on a patient when she was again summoned by the C.N.A.

13. Licensee gathered suction equipment and went to the resident’s room and attempted to suction the patient, at which time the resident stopped breathing and expired.

14. The patient was a do-not-resuscitate patient.

15. After the patient’s death, the Licensee called the family and the physician and reported to them that the resident had been found passed away in her sleep.

16. The Licensee’s statement to the family and to the physician was false.

17. Licensee admitted to providing inaccurate information regarding the resident’s death to the family and to the physician.
18. Licensee was suspended and ultimately discharged from her employment for improper conduct, failure to disclose all details surrounding the end of life of a resident, and for violation of the code of conduct for improper response to an emergency situation.


20. On her application, Licensee indicated that she had worked as an L.P.N. at Covington Heights from May 2004 to June 2008. She indicated that the reason for her leaving her position was that she started a business.

21. On her application to Universal Pediatrics Licensee checked the box “No” when asked if she had been disciplined or discharged for misconduct or unsatisfactory service or forced to resign from any position.

22. The inaccuracies on the application were discovered by Universal Pediatrics Services when Licensee advised them that her license had been summarily suspended.

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

CONCLUSIONS OF LAW

1. 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 Licensee’s conduct as identified in the Findings of Fact are inconsistent with health and safety of persons entrusted to her care and violates the statutes, rules, and regulations regarding the practice of nursing and are in violation of SDCL § 36-9-49(7) and (10).
3. That the Licensee's conduct as identified in the Findings of Fact are inconsistent with ARSD 20:48:04:01(1)(d) which provide that the Board recognizes the "Scope and Standards of Practice," 2004, and the "Code of Ethics," 2001, as published by the American Nurses Association as critical for assuring safe and effective practice following licensure. The Code of Ethics requires an L.P.N. to function within an established legal guideline and uphold the basics standards of nursing practice.

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 licensed practical nurse in the State of South Dakota is hereby indefinitely suspended.

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

3. That the Licensee shall turn in her license to the Board of Nursing within ten (10) days of this Order.

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

Dated this 28th day of January 2009.

SOUTH DAKOTA BOARD OF NURSING

[Signature]
Gloria Damgaard, Executive Director
The above Findings of Fact, Conclusion of Law, and Order of Suspension were adopted by the South Dakota Board of Nursing on this 22\textsuperscript{nd} day of January, 2009, by a vote of 8 – 0.

Dated this 28\textsuperscript{th} day of January 2009.

SOUTH DAKOTA BOARD OF NURSING

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Gloria Damgaard, Executive Director
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