



§ 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 Susan E. Palombo (“Licensee”) is licensed to practice as a practical nurse in the State of South Dakota and holds license number P009900.
2. That Licensee was initially licensed in the State of Ohio on August 26, 1993 and endorsed her L.P.N. license to the State of South Dakota on December 18, 2006.
3. That the Licensee was employed at the Bethany Lutheran Home (“Bethany”) as an L.P.N. from June 19, 2007, until termination on or about July 2, 2007.
4. Licensee did not disclose employment with the Tri State Agency working in nursing facilities in Wakonda, Faulkton, or Pierre, South Dakota, on her application with Bethany.
5. Licensee worked aide shifts at Bethany on June 23 and 24, 2007. Licensee worked intern shifts on June 25, 26, 27, 28, and 30, 2007. Licensee did not work on June 29, 2007.
6. On Sunday, July 1, 2007, Licensee was scheduled to work the day shift from 6:30 a.m. to 2:30 p.m.
7. Upon starting her shift, Licensee stated to her nursing supervisor, Pat Bawdon, that she did not feel well, but indicated that she felt she was well enough to work her shift. The nursing supervisor consented to let the Licensee switch her assigned

unit with another nurse, allowing Licensee to work in the Serenity Gardens unit, a quieter unit, and where she had worked the day before.

8. At 6:40 a.m., the nursing supervisor again asked the Licensee if she needed to be replaced. The Licensee indicated that she was “fine to work”. Licensee received report from the night shift nurse, again stating she was okay to work.

9. The nursing supervisor was available to take over Licensee’s duties for that shift if needed.

10. At 7:00 a.m., a CNA from Serenity Gardens reported to the nursing supervisor that the Licensee was asleep at the desk and had not yet taken on any nursing responsibilities for her shift. The nursing supervisor called to the floor and talked to Licensee who answered the phone and stated that everything was “fine and quiet and going very well”.

11. Shortly thereafter, the nursing supervisor went to Serenity Gardens and found the Licensee with her head on the desk. When the nursing supervisor appeared, the Licensee jumped up and went to the med-cart.

12. The nursing supervisor informed the Licensee that a replacement nurse was coming. The Licensee refused to have the nursing supervisor prepare and give the residents morning medications. Licensee again indicated that she was fine and could handle it.

13. At 9:10 a.m., the nursing supervisor returned to the unit and noted that the replacement nurse was there and the Licensee had gone home.

14. The nursing supervisor went into a small kitchen area and found a plastic bag from the unit's med-cart in the garbage can. There was no other trash in the garbage can other than the med-cart bag. The clear med-cart bag was full of medication cups with pills and applesauce as well as empty packages from patches applied to residents.

15. The medications in the garbage were identified as 8:00 a.m. medications intended for the residents of Serenity Gardens.

16. Licensee had initialed the Medication Administration Record as if the residents had received their 8:00 a.m. medications.

17. The nursing staff worked to match and identify the medications with the intended residents. Many of the medications could be identified. It was ascertained that five residents did not receive any of their 8:00 a.m. medications. There were three sets of medications that could not be identified. There were two pills in applesauce that could not be identified.

18. The discarded medications included crucial and essential medications for the residents, that if omitted, could be detrimental to the residents' health.

19. The staff could not ascertain whether patients who were scheduled to have insulin did or did not receive their insulin injections that morning.

20. All patients on Serenity Garden needed to be monitored closely that day for any untoward effects due to not receiving their morning medications. Many of these patients had dementia and could not be relied upon to tell the staff if they had received their medications or not.

21. No patient harm was identified as a result of Licensee's omissions.

22. All patients' doctors and families were notified of the medication omissions.

23. During the investigation of the incident, Licensee was contacted by the Director of Nursing and Licensee pleaded with her to "please don't turn me in".

24. Bethany reported the Licensee's actions to the South Dakota Board of Nursing as well as the South Dakota Department of Health.

25. Licensee was thereafter scheduled for an Informal Meeting with the South Dakota Board of Nursing staff. She did not attend the scheduled Informal Meeting, but corresponded with the Board staff stating "instead of leaving work and marking "calcium and vitamin" refused, I wrongfully through [sic] the pills in the trash so I could conclude my shift. There is no excuse for my actions and I do not dispute the facts as I understand them".

26. Licensee has several medication errors and medication administration issues while employed at Bethany. These included, not giving medications, popping pills into her hand instead of a medication cup, carrying insulin needles uncovered down the

hallway, not double checking medications with the Medication Administration Record, setting up medications from the wrong patients bottle, and providing PRN medications (stool softener and Tylenol) from the residents' own supply cart to take them herself or to offer them to other staff.

From the following 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 Licensee's conduct as identified in the Findings of Fact are inconsistent with the 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(5) and (10).
3. The Licensee is also in violation of the Scope and Standards of Practice, 2004 and the Code of Ethics, 2001, as published by the American Nurse's Association as criteria 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 basic standards of nursing practice.

THEREFORE, let an order be entered accordingly:

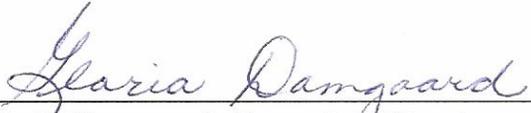
## ORDER

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 practical nurse in the State of South Dakota is hereby suspended.
2. That the Licensee may petition according to SDCL § 36-9-57 for reinstatement of her license at any time 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.

The South Dakota Board of Nursing at its meeting on November 1, 2007, approved this Order of Suspension as written, without modifications and issues this Order of Suspension consistent herein as follows:

IT IS HEREBY ORDERED that the above is adopted as an Order of the South Dakota Board of Nursing this 1st day of November, 2007, by a vote of 9-0.

  
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Gloria Damgaard, Executive Director  
South Dakota Board of Nursing