The South Dakota Board of Nursing’s (“Board”) hearing on the Summary Suspension of the license of the Licensee, Hildreth Danae Rodlund, LPN, license number P010134, (“Licensee”), came on for hearing before the South Dakota Board of Nursing at its office in Sioux Falls, South Dakota on January 26, 2011, at 1:30 p.m. Licensee, Hildreth Rodlund, 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 appeared in person or by an attorney.

The Board appeared by and through its attorney, Kristine K. O’Connell. The Board considered the evidentiary testimony of Janet Ostby, Administrator of the Greenleaf Assisted Living Center. The Board also considered the Exhibits (numbered 1-2 inclusive) entered into evidence, the Affidavit of Kathleen Rausch 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 Hildreth D. Rodlund is licensed to practice as a practical nurse in the State of South Dakota and holds license number P010134.

2. That on August 10, 2010, the South Dakota Board of Nursing ("Board") received a complaint from the Licensee’s employer, Greenleaf Assisted Living Center in Sisseton, South Dakota.

3. The Licensee had been employed full time at Greenleaf beginning on May 25, 2010. She was hired as an evening supervisor. Her shifts started at 1:30 p.m. and ended at 9:30 p.m.

4. In July 2010, the Licensee had been counseled on two occasions by her employer for being tardy for work, calling in sick, making personal phone calls at work, and finding replacements to cover her scheduled shifts.

5. On July 14, 2010, the Licensee gave her two week notice to quit to her job at Greenleaf. Licensee later rescinded that notice returning to full-time employment on August 1, 2010.

6. On August 6, 2010, Licensee came to work for her evening shift.

7. At approximately 4:30 p.m., Licensee received an outside telephone call. Following the call, she told the Assistant Administrator that she was not feeling well and
wanted to go home.

8. Licensee was unsuccessful in finding a replacement to cover the rest of her shift. License later advised the Assistant Administrator that she was feeling better and would be able to stay and finish her shift. The Assistant Administrator then left the facility.

9. At approximately 5:00 p.m. the Licensee left the building without telling her co-workers. The Licensee left the facility keys in the medication cart and did not count the controlled substance medications with anyone before she left. All medications were accounted for.

10. Members of the administration attempted to reach the Licensee by phone that night, but Licensee did not respond to any of the phone calls.

11. On August 7, 2010, Licensee was scheduled to work the evening shift. Licensee did not show for her shift, nor did she call her employer.

12. The Administrator again attempted to call the Licensee without response.

13. On August 13, 2010, Licensee was sent a letter terminating her employment with Greenleaf. Licensee did pick up her last paycheck from Greenleaf.

14. The Board of Nursing’s disciplinary investigator, upon receiving Greenleaf’s complaint, set an Informal Meeting with the Licensee for October 14, 2010. The Licensee did not show up for the scheduled meeting, nor did she call informing the Board that she would not be able to attend.
15. Two days after the missed Informal Meeting, Board staff contacted Licensee by phone and they set a mutually agreeable date to reschedule the Informal Meeting.

16. On the agreed upon date, October 21, 2010, the Licensee did not attend the Informal Meeting, nor did she call informing the Board that she could not attend.

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.

2. That the Licensee’s conduct as identified in the Findings of Fact constitute abandonment of her shift and abandonment of the residents at the assisted living center.

3. 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(5), (7) and (10).

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 indefinitely 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 the date 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 the 26th day of January, 2011, approved this Order of Suspension by a vote of 9 - 0 and issues its Order of Suspension consistent herein as follows:

IT IS NOW HEREBY ORDERED:

That the above is adopted as an Order of the South Dakota Board of Nursing.

Dated this 1st day of February, 2011.

SOUTH DAKOTA BOARD OF NURSING

[Signature]
Gloria Damgaard, Executive Director