



Pursuant to SDCL 1-26-25, the Board issues its final decision in writing through these written Findings of Fact and Conclusions of Law as well as a separate written Order issued pursuant to these Findings of Fact and Conclusions of Law.

Being charged with the statutory obligation to protect the public health, safety and welfare set forth in ARSD 20:48:04:01, *et al.*, including the protection of the public from unsafe nursing practices and practitioners, the Board hereby makes the following:

### **FINDINGS OF FACT**

1. Between October 22, 2018 and April 23, 2019, Licensee was employed as a traveling nurse with Aureus Medical Group and had been assigned to provide nursing services to Rapid City Regional Hospital Progressive Care Unit in Rapid City, South Dakota.
2. A pharmacy report conducted by Rapid City Regional Hospital, pharmacist Dana Darger, identified significant red flags in the quantity of drugs Licensee dispensed and to whom the drugs were to be administered.
3. According to the pharmacy report, in some instances drugs were dispensed for patients who were reporting no pain.
4. The pain medications involved with the deviations were primarily oral tablet medications.
5. The pharmacy director, Dana Darger, performed a more detailed investigation after the initial pharmacy report identified red flags.
6. After spending four to six hours investigating pharmacy and Medtox reports and corresponding patient records, Dana Darger noted, when comparing Licensee's injectable opiate use to all other nurses on the same machines, Licensee was the third highest dispenser overall at

10 doses. There were many users in the 9-11 dose range. However, when comparing hydrocodone, oxycodone, and oxycodone/APAP, Licensee had greater than 150 tablets compared to the next highest at 46.

7. Exhibit 3, the pharmacy reports prepared by Dana Darger, showed instances of Licensee administering pain medications to patients who reported no pain, had a pain scale of zero, or who did not receive pain medications from any other nurse.

8. Mr. Darger expressed significant concerns that Licensee was diverting patient medications to Licensee's supervisor, Brenna Schmaltz.

9. Brenna Schmaltz reviewed the report and concerns with the pharmacy department.

10. Brenna Schmaltz investigated other evidence of diversion. She learned that Licensee frequently leaves the floor during his shift. Ms. Schmaltz spent approximately one hour reviewing reports and records.

11. On February 14, 2019, Rapid City Regional Health confronted Licensee regarding the narcotic administration concerns.

12. Licensee denied diverting any medications.

13. Rapid City Regional Hospital requested a urine test, and Licensee agreed to be tested. The test results returned negative.

14. Nonetheless, Rapid City Regional Hospital terminated Licensee's employment and reported Licensee to the Board of Nursing due to suspected narcotic diversion.

15. Aeurus also terminated Licensee's contract as a result of the termination from Rapid City Regional Hospital and pending complaint with the Board of Nursing.

16. Board staff investigated the complaint and advised Licensee of the complaint.

Board staff requested a response from Licensee and offered an informal interview to discuss his response to the complaint.

17. Licensee did not respond to the complaint or schedule an informal meeting with the staff investigator to discuss or respond to the complaint, despite acknowledging receipt of the notice of the complaint. Licensee admitted he did not return phone calls or e-mails from board staff investigator Francie Miller.

18. Licensee could not provide a reasonable and acceptable response to his failure to document pain for patients to whom he administered pain medication.

19. Licensee acknowledged a failure to document.

20. Licensee admitted that he did not inform his current employer of the pending complaint in South Dakota.

21. The Board finds, by clear and convincing evidence, that Licensee diverted medications during his employment with Rapid City Regional Hospital and that such diversion amounts to unsafe nursing practice, substandard care, and unprofessional and dishonorable conduct.

22. The Board finds, by clear and convincing evidence, that Licensee engaged in grossly inadequate documentation during his employment with Rapid City Regional Hospital and that such documentation practices amounts to unsafe nursing practice and substandard care.

#### **CONCLUSIONS OF LAW**

1. That the Board has jurisdiction and authority over this matter pursuant to ARSD 20:48:04:01.

2. Under SDCL 36-9-49(10), the Board of Nursing may take disciplinary or corrective action if Licensee engaged in unsafe nursing practice, substandard care, or unprofessional or dishonorable conduct.

3. Under SDCL § 36-9-49(4), the Board of Nursing may take disciplinary or corrective action, including suspension, if Licensee has committed an alcohol or drug related act or offense that interferes with the ability to practice nursing safely.

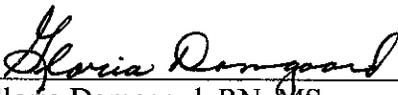
4. The Board has a statutory obligation to protect the public health, safety and welfare set forth in SDCL § 36-9-1.1, including the protection of the public from unsafe nursing practices and practitioners.

4. The Board concludes that, given the evidence presented, Licensee has engaged in conduct in violation of SDCL § 36-9-49(4), in that Licensee has committed an alcohol or drug related act or offense that interferes with the ability to practice nursing safely.

5. The Board concludes that, given the evidence presented, Licensee has engaged in conduct in violation of SDCL § 36-9-49(10), in that Licensee engaged in unsafe nursing practice, substandard care, or unprofessional or dishonorable conduct, including but not limited to the scope and standards of nursing practice contained in this Board's administrative rules.

Dated this 8<sup>th</sup> day of October, 2019.

SOUTH DAKOTA BOARD OF NURSING

  
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Gloria Damgaard, RN, MS  
Executive Director

