SOUTH DAKOTA BOARD OF NURSING

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IN THE MATTER OF THE LICENSURE PROCEEDINGS	:	**DOH 20-13**
RE: AMY NANNEMANN, RN	:	
License Nos.: WY RN34577	:	**ORDER FOR SUMMARY SUSPENSION OF PRIVILEGE TO PRACTICE**
Licensee.	:	

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WHEREAS, Amy Nannemann, RN ("Licensee"), is licensed to practice as a registered nurse in the State of Wyoming and holds license number WY RN34577;

WHEREAS, the South Dakota Board of Nursing ("Board") received a Motion for Summary Suspension of licensee's Privilege to Practice and Affidavit Supporting Motion for Summary Suspension requesting the Board issue an Order for Summary Suspension pursuant to SDCL § 1-26-29; and

WHEREAS, the Board considered the Motion and Affidavit for Summary Suspension and, after meeting and discussing the Motion and Affidavit on the 19th day of November, 2020, approved this Order of Summary Suspension by a majority vote of 11-0.

It is hereby ORDERED:

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

2. The Board has jurisdiction over the Licensee and the subject matter of this Order.

3. The Board accepts the facts contained in the Affidavit Supporting Motion for

Summary Suspension and specifically finds, pursuant to SDCL 1-26-29, that the actions of the Licensee as set forth and incorporated herein from the Affidavit endanger the public health, safety and welfare, and imperatively require emergency action in that Licensee may endanger the health and safety of those persons who are or will be entrusted to her care in the future and that these are matters of a nature that would constitute further grounds for discipline under SDCL § 36-9-49.

4. Based upon these findings, Licensee's privilege to practice nursing in South Dakota is hereby summarily suspended.

5. Licensee is hereby notified that any practice of nursing in the State of South Dakota during the terms of this Order of Summary Suspension is a violation of SDCL § 36-9-68(5).

6. This action is reportable discipline and will be published in the Board's newsletter and posted on its website and reported into the National Practitioner Data Bank (NPDB) as required by law.

7. This summary suspension continues pending proceedings for revocation or other action. Contested case proceedings under SDCL 1-26 shall be promptly instituted so that the Board may enter a final determination regarding disciplinary or corrective action after a formal contested case hearing.

Dated this 19th day of November, 2020.

SOUTH DAKOTA BOARD OF NURSING

Linda Young, RN, MS, FRE

Executive Director

SOUTH DAKOTA BOARD OF NURSING

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IN THE MATTER OF THE LICENSURE PROCEEDINGS	:	
	:	**DOH 20-13**
RE: AMY NANNEMANN, RN		
	:	**AFFIDAVIT SUPPORTING MOTION FOR SUMMARY SUSPENSION**
License Nos.: WY RN34577		
	:	
Licensee.		
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STATE OF SOUTH DAKOTA)
: SS
COUNTY OF MINNEHAHA)

I, Francie Miller, being first duly sworn on oath, depose and state as follows:

1. I am a contract employee of the South Dakota Board of Nursing ("Board") and am employed as a Nurse Program Specialist working primarily in the area of investigations and disciplinary issues.

2. I offer this Affidavit based on my personal knowledge and in support of the separately submitted Motion for Summary Suspension.

3. Amy Nannemann, RN ("Licensee") is licensed to practice as a registered nurse in the State of Wyoming and license number WY RN34577.

4. In my position as Nurse Program Specialist for the Board, I am responsible under ARSD 20:48:08:11 for receiving, reviewing and investigating all complaints submitted to the Board.

5. On or about September 8, 2020, I received an e-mail complaint from Christina Mulvehill, RN BSN, a nurse manager with Monument Health in Rapid City, South Dakota, regarding Licensee. A copy of the e-mail I received is attached as **Exhibit A**.

6. Mulvehill explained how Licensee started working with Monument Health on June 29, 2020.

7. On the weekend of September 5-6, 2020, while Licensee was working at Monument Health, a CRN found an oxycodone tablet still in the wrapper on the ground on the NE pod on 8th floor.

8. The CRN researched and found that Licensee was the only RN to pull oxycodone from the Omnicell in the last twenty-four hours. Licensee had scanned the oxycodone into an eMAR at 0430 as given to a patient.

9. However, when the CRN asked the patient who Licensee had documented as receiving the medication, if she had pain medication, the patient (who was alert and oriented) stated that she never asked for paid medication and had not taken any.

10. Licensee was the only nurse who had documented oxycodone for this patient. The CRN also reported Licensee and another nurse had an unresolved discrepancy the prior week regarding a narcotic count in the Omnicell.

11. When Licensee returned for her next shift, the CRN asked Licensee about the oxycodone found on the floor. Two CRNs were in the office with Licensee. Licensee initially seemed confused when confronted and then said that if she scanned the medication that she must have given it. Then afterward she said that she pulled it for the patient, took it in the room, and then the patient refused so Licensee was going to return the medication but must have dropped it.

12. Both CRNs described the conversation with Licensee as "off." The CRN told Licensee to adjust the eMAR to accurately document that the patient did not receive the medication.

13. Later, on September 16, 2020, Monument Health staff, including the pharmacy director, nursing unit director, clinical nurse manager, and human resources business partner, met with Licensee to discuss concerns regarding Licensee's pain medication administration and documentation. The pharmacy director explained that Licensee was the only nurse providing certain patients pain medication. Licensee did not comment.

14. The Monument Health staff also discussed a situation when Licensee documented pulling medication for the wrong patient. The pharmacy direction mentioned that, even if she pulled the medication on the wrong patient, the medication order had been discontinued. Licensee did not comment.

15. Due to the evidence Monument Health staff had that indicated Licensee was diverting patient's pain medication, staff asked Licensee to submit to a drug test. Licensee did not initially respond, so the human resource business partner asked Licesee why she would be concerned about taking a drug test.

16. Licensee admitted that she had taken her mother's Percocet three days prior to the meeting. Licensee refused the drug test, resulting in termination of her employment.

17. The Monument Health notes from this meeting with Licensee are attached as **Exhibit B**. The pharmacy records that caused Monument Health concerns regarding Licensee diverting patient pain medication are attached as **Exhibit C**.

18. When I receive a complaint, I send the Licensee a letter advising them I received a complaint regarding his or her license and give the Licensee an opportunity to respond. Attached as **Exhibit D** is the letter I sent to Licensee on October 1, 2020.

19. For this complaint, since Wyoming is Licensee's home state, I reached out to the Wyoming State Board of Nursing to see if Wyoming preferred to investigate the complaint. The Wyoming State Board of Nursing initially told me that it would investigate the complaint and proceed with a hearing on Licensee's license on January 13, 2020. Based on that information, I did not pursue an investigation. However, the Wyoming Board later told me on October 27, 2020, that it would not be investigating unless she tried to renew her license in Wyoming. My correspondence with the Wyoming State Board of Nursing is attached as **Exhibit E**.

20. Since then, I have repeatedly tried to discuss the complaint with Licensee. Licensee has not responded to me. My more recent correspondence with Licensee is attached as **Exhibit F**.

21. Based upon the allegations in the complaint and my initial investigation, as well as Licensee not responding to me, I find the public health, safety, and welfare imperatively require emergency action in that Licensee's actions may endanger the health and safety of persons entrusted to Licensee's care and that Licensee's license should be summarily suspended until further Order of the Board.

Dated this 9th day of November, 2020.

Francie Miller,
Nurse Program Specialist

Subscribed and sworn to before me
this 9 day of November, 2020.

Erin M. Matthias
Notary Public - South Dakota
My commission expires: 01/08/2026