

**SOUTH DAKOTA BOARD OF NURSING**

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IN THE MATTER OF THE LICENSURE  
PROCEEDINGS :

**DOH 19-13**

RE: EDWIN STEWART, LPN :

**FINDINGS OF FACT AND  
CONCLUSIONS OF LAW**

License No. P007650, :

Licensee. :

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The South Dakota Board of Nursing (“Board”) noticed a contested case hearing in the above licensure proceedings to be held at the Office of the Board of Nursing, on September 19, 2019, at 1:00 p.m.

The South Dakota Board of Nursing presided over the proceedings, along with Administrative Law Judge Catherine Williamson, Office of Hearing Examiners.

Licensee Edwin Stewart, LPN, signed an admission of service of his receipt of the Complaint and Notice of Hearing, but Licensee failed to appear at the hearing. Licensee did not request a continuance of the hearing or otherwise indicate to the Board that he could not attend the noticed contested case hearing.

Michele Munson, the attorney prosecuting the licensing matter, presented argument and evidence to the Board, including telephonic testimony from witnesses Joelle Meade, RN and Christine Francis, RN DON, and live testimony from Francie Miller, Board staff. The proceeding was transcribed by a court reporter.

At the conclusion of the hearing, the Board considered the testimony from witnesses, exhibits offered during the hearing, argument of counsel, as well as the entire record before the

Board. After deliberations, the Board entered a verbal order by a vote of 8-0 to suspend Licensee's South Dakota license, P007650.

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. Licensee has been licensed as a licensed practical nurse in South Dakota since November 20, 1991.
2. On January 23, 2019, Licensee was employed as an LPN at Prairie Hills Care and Rehabilitation Center, a long-term care facility, in Rapid City, South Dakota.
3. On January 23, 2019, a resident on Licensee's floor for whom Licensee was responsible, rolled out of bed.
4. A Certified Nursing Assistant (CNA), Emily Fode, found the resident on the floor with emesis on himself. It appeared to Fode that the resident had hit his head as he fell out of bed.
5. Fode immediately ran down the hall of the facility to get Licensee, who was her supervising nurse on duty and responsible for the resident's care.
6. Licensee was counting narcotics with the medication aide when Fode approached him about the fallen resident.

7. Licensee did not stop counting narcotics to assist Fode or the resident.
8. Licensee did not stop counting narcotics to assess the resident, as required by the facility's written policy.
9. About 8-10 minutes after Fode advised Licensee of the resident's fall, Licensee came to the resident's room. By that time, Fode was assisting the resident off the floor on her own.
10. Licensee grabbed the resident's arm when he arrived in the room and told Fode that, "we used the Hoyer, right?" Licensee was insisting to Fode that she lie about not following the correct lifting policy.
11. After Licensee and Fode removed the resident from the floor, Licensee left the room again without assessing the resident. Instead, Licensee returned to the room with a neurological flowsheet already filled out.
12. Licensee did not complete a neurological assessment or head-to-toe assessment, even though he reported that he had.
13. Fode took the resident's vital signs, recorded them, and went to the first floor to inform Joelle Meade, a registered nurse working on another wing. Meade immediately went upstairs and assessed the resident. Meade also contacted the Director of Nursing (DON), Christine Francis, RN DON.
14. Francis instructed Meade to send the resident to the emergency room for an evaluation and asked that Meade cover the floor while she spoke with Licensee.
15. When Meade told Licensee to report to the DON, Licensee decided to quit instead and left his duty station.

16. Francis reported Licensee's conduct to the Board of Nursing.

17. Francie Miller is the board staff member responsible for investigating all complaints the Board receives that allege a violation of the Nurse Practice Act.

18. Ms. Miller provided notice of the complaint to Licensee and allowed Licensee the opportunity to respond to the complaint in writing and through an informal interview. Licensee provided only a partial written response to the complaint. Licensee did not meet with Ms. Miller for an informal interview.

19. Licensee admitted receiving notice of the formal hearing on the complaint, yet Licensee did not appear for the hearing or otherwise contact the Board regarding the hearing.

#### **CONCLUSIONS OF LAW**

1. 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. 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 clear and convincing evidence exists that Licensee 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 and employer policies, through his treatment toward a resident under his care and by leaving his duty station.

5. The Board concludes that clear and convincing evidence exists that Licensee engaged in unprofessional or dishonorable conduct in violation of SDCL § 36-9-49(10) in that Licensee failed to follow employer policies on two occasions for fall management or neurological assessment and falsified documentation by completing assessment paperwork without conducting the assessment and encouraged staff to falsify information regarding the manner of lifting the resident.

6. The Board concludes that clear and convincing evidence exists that Licensee engaged in unprofessional conduct in violation of SDCL § 36-9-49(10) by the way he responded to the Board of Nursing with respect to the complaint and otherwise failed to appear at the hearing.

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

SOUTH DAKOTA BOARD OF NURSING

  
Gloria Damgaard, RN, MS  
Executive Director

**SOUTH DAKOTA BOARD OF NURSING**

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IN THE MATTER OF THE LICENSURE  
PROCEEDINGS :

RE: EDWIN STEWART, LPN :

License No. P007650, :

Licensee. :

**DOH 19-13**

**ORDER OF SUSPENSION**

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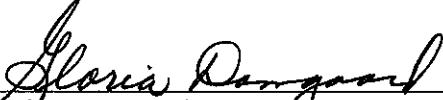
The South Dakota Board of Nursing, having separately entered Findings of Fact and Conclusions of Law following a contested case hearing before the Board on September 19, 2019, and having verbally ordered on the 19th day of September, 2019, to suspend Licensee's South Dakota license, P007650, hereby issues Licensee this Order of Suspension for violation of SDCL § 36-9-49 consistent with the Board's Findings of Fact and Conclusions of Law, incorporated herein by reference.

It is hereby ORDERED:

1. Licensee's license to practice as a licensed practical nurse in the State of South Dakota is hereby suspended.
2. Licensee is hereby notified that any practice of or holding himself out as a licensed practical nurse during the term of this suspension is in violation of SDCL § 36-9-68.

Dated this 8th day of October, 2019.

SOUTH DAKOTA BOARD OF NURSING

  
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 Gloria Damgaard, RN, MS  
 Executive Director