BEFORE THE KANSAS STATE BOARD OF NURSING
LANDON STATE OFFICE BUILDING
900 S.W. JACKSON, ROOM 551-S
TOPEKA, KANSAS 66612-1230

IN THE MATTER OF:	)	CASE NO. 92-386-8
	)	
PAMELA SMITH-CARTER	)	
LICENSE NO. 13-062032-102	)	

INITIAL ORDER

NOW ON THIS 9th day of December, 1994, the above-captioned matter comes on for hearing before Terry E. Beck, Hearing Officer designated by the Kansas State Board of Nursing to hear this matter.

The Petitioner appears by and through Assistant Attorney General Mark S. Braun, the Board's Disciplinary Counsel. The Respondent appears in person, and through her attorney, Thomas J. Wilder.

The matter proceeds to hearing. Petitioner presents its case. Petitioner called Janet Bonnel as its witness. Petitioner's Exhibits 1-3, inclusive, were offered and admitted without objection. Petitioner rested. Respondent presented her case. Respondent called Lisa Teixeira and herself as witnesses. Respondent's Exhibits 1-3, inclusive, were offered and admitted over Petitioner's objection to Respondent's Exhibit 3. Respondent

rested. Counsel for both sides made closing arguments

After hearing the evidence, statements of counsel, and being otherwise well and duly advised in the premises, the Hearing Officer makes the following findings of fact and conclusions of law:

1. Respondent is alleged to have committed acts in violation of the Kansas Nurse Practice Act, specifically, **K.S.A. 65-110(a)(6)**, as defined by **K.A.R. 60-3-110(a)(3)**. It is alleged that the Respondent, while employed at the Courtyard Terrace, Topeka, Kansas, failed to take appropriate action or to follow policies or procedures in the practice situation designed to protect the patient, by failing to report or investigate complaints of a patient who reported to the Respondent that she had been raped or molested by a male staff member. It is alleged that the Respondent did not chart the incident for four days and only after an investigation had been initiated.

2. The Respondent denies that her actions are a violation of the Kansas Nurse Practice Act and denies that she acted inappropriately in light of all of the facts at her disposal at the time and that she used reasonable judgment in handling the situation in question.

3. On November 10, 1992, an LPN asked Janet Bonnel, Administrator of Courtyard Terrace, how the investigation was going concerning a rape that had occurred at the facility. Ms. Bonnell had not been told of any rape and the LPN advised that it had happened on the preceding weekend. The Respondent was the charge

nurse on duty at the time of the alleged incident and was also acting Director of Nursing at the time. Ms. Bonnel checked medical records of the facility and did not find any documentation concerning any resident's report of a rape. Ms. Bonnel contacted the Respondent at home, leaving messages on her answering machine and called the Topeka Police Department to report the incident. Further investigation did eventually reveal that a male employee of the facility did, in fact, sexually abuse a resident identified in these proceedings by both parties as "Jane Doe", on November 7, 1992.

4. Ms. Bonnel testified that the policy of the facility in such situations would have been for the charge nurse to immediately notify the Administrator of the facility or, alternatively, notify the owner, notify the Topeka Police Department, and notify the Department of Health and Environment. The Respondent was aware of those policies.

5. The Respondent was questioned by Ms. Bonnel concerning the matter on November 11, 1992. The Respondent felt that nothing had actually happened and that since the resident "Jane Doe", was occasionally delusional, that the incident had not in fact happened. Thus, she did not make any report nor documentation concerning the matter. On November 11, 1992, she did, at the request of the Administration, make a late entry concerning the matter in the chart. That late entry was introduced as part of the medical records of "Jane Doe" as Petitioner's Exhibit 2.

6. In Petitioner's Exhibit 2 on November 11, 1992, the Respondent charted as follows:

> "On November 7, 1992, Lorraine Delarosa, CNA, told me that 'Jane Doe' was making a statement that she had been raped, that was approximate between 10:00 a.m. and 11:00 a.m. I asked 'Jane' questions regarding this. She seemed to space out and just starr(sp) straight ahead. I did not hear resident make a statement that she had been raped. Lorraine did not report to me any other statements made by resident that shift or did any other CNA. Resident continued to act her usual self throughout the day such as laying in the floor, and yelling out."

7. In Petitioner's Exhibit 1, the Respondent made a written statement dated November 12, 1992, as follows:

> "Jane Doe' did not report to me an incident of rape. A nurse aide Lorraine Delarosa stated she heard 'Jane' make such statements. I assessed the resident and questioned her about it and she made no such comments. And no such comments where(sp) made from her during that day shift. Considering the resident's medical diagnosis and periods of confusion I observed throughout the day and believed there was no evidence to persue(sp) the issue. I was notified on Tuesday, November 10 that the resident continued to complain and that her case was being investigated. I believe I as a nurse performed my duty under my assessment of the situation."

"Such statements" could only refer to the statement contained in the first portion of Petitioner's Exhibit 1 that: "On Sat Nov 7, 1992 a resident reported that she had been raped."

8. At the hearing the Respondent testified that on the date in question a CNA, Lorraine Delarosa, told her that "Jane Doe" was "saying something about a rape" and that she couldn't quite understand what she was saying and wanted the Respondent to talk to

her. The Respondent talked to "Jane Doe" and observed that she was "out of it" and made no statement about a rape. Therefore, she concluded that nothing had happened and made a decision not to chart the matter. She further testified that it is impossible to chart every little thing that happens on a shift and that she exercised her best judgment in making that decision. However, both of the reports concerning the incident in Petitioner's Exhibits 1 and 2 plainly state that the resident reported to Lorraine Delarosa that she had been raped and that Lorraine Delarosa had reported that to the Respondent.

9. **K.S.A. 39-1402** imposes a duty upon the Respondent, as a licensed professional nurse, to report immediately any information or cause a report of any information concerning abuse to be made in any reasonable manner to the Department of Health and Environment, if she has reasonable cause to believe that a resident is being of has been abused, neglected, or exploited, or is in a condition which is a result of such abuse, neglect or exploitation. **K.S.A. 65-1120** provides that the Board may take disciplinary action if a licensee is found after hearing to be guilty of unprofessional conduct as defined by Rules and Regulations of the Board. Rape of a resident, unquestionably, would constitute abuse.

10. **K.A.R. 60-3-110** defines "unprofessional conduct" to include failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard the patient.

11. Grantedly, everything that happens on a shift cannot be charted or reported. However, the duty to report incidents of abuse as contained in **K.S.A. 39-1402** is unequivocal and defines explicitly a licensed nurse's obligation to report such. Such an incident would constitute a practice situation in which the appropriate action would be to make a report of such an incident. The evidence further shows that it was the policy and procedure of the institution that such an incident be reported to the Administrator and/or owner of the facility as well as law enforcement authorities and the Department of Health and Environment. Respondent's own charting and account of the event by notations made November 11., 1992, in the patient chart and November 12, 1992, in the employee counselling form were to the effect that Lorraine Delarosa heard "Jane Doe" make statements concerning being raped. Such statements by the patient, even though she is occasionally delusional, trigger the duty to report. Failure to report such complaints of the patient or even note them in the chart for further follow-up, constitute a failure to take appropriate action and follow policies and procedures in the practice situation designed to safeguard the patient. Thus, it is held that the Respondent violated the Kansas Nurse Practice Act.

12. The Hearing Officer is cognizant of the fact that at the time of the incident, the Respondent had been a licensed professional nurse for approximately 2 years and had the position of Acting Director of Nursing thrust upon her due to the termination of the prior Director of Nursing. Further, the Hearing

Officer is aware that the Respondent has practiced at a highly satisfactory level since the date of this incident and the Hearing Officer believes the Respondent is unlikely to fail to report or chart such an incident in the future.

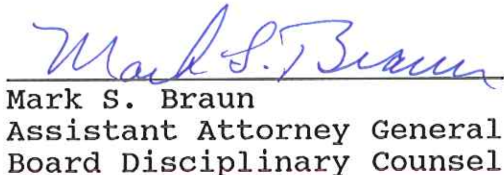
ORDER

Based on the foregoing findings of fact and conclusions of law, IT IS THEREFORE ORDERED that the appropriate disciplinary action in this matter is a private censure of the Respondent pursuant to **K.S.A. 65-1120**. IT IS ALSO ORDERED that costs in the amount of twenty five ($25.00) dollars shall be assessed against the Respondent. Counsel for the Petitioner is ORDERED to draft the Initial Order in conformance with the Hearing Officer's Memorandum Decision rendered January 3, 1995.

IT IS SO ORDERED.

Terry E. Beck
Hearing Officer

PREPARED AND SUBMITTED BY:



Mark S. Braun
Assistant Attorney General
Board Disciplinary Counsel

NOTICE REGARDING RELIEF FROM THIS ORDER
STATEMENT OF APPEAL RIGHTS

This is an Initial Order. The parties to whom this Initial Order is issued may file a petition for review with the Agency Head within fifteen (15) days after service of this order. The Petition

for review must state the specific grounds upon which relief is requested. Unless a later date is stated within the Initial Order, a stay is granted, or the order is reviewed, an Initial Order shall become a final order without further notice or proceedings thirty (30) days after the date of service as indicated by the attached certificate of service.

CERTIFICATE OF SERVICE

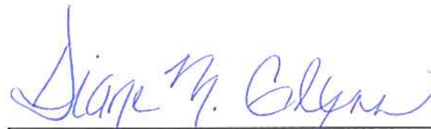
This is to certify that a copy of the foregoing INITIAL ORDER was served by depositing same in the United States Mail, first class postage prepaid, this 24th day of January, 1995 to:

Pamela Smith-Carter
827 Tyler
Topeka, Kansas 66612

Thomas J. Wilder
Sloan, Listrom, Eisenbarth, Sloan and Glassman
714 Capitol Federal Building
700 Kansas Avenue
Topeka, Kansas 66603-3881

and hand delivered to:

Mark S. Braun
Assistant Attorney General
Disciplinary Counsel
Kansas State Board of Nursing
Landon State Office Building
900 SW Jackson, Suite 551-S
Topeka, Kansas 66612-1230



Diane M. Glynn, J.D., R.N.
Practice Specialist