FILED
MAY 5 2010
KSBN

BEFORE THE KANSAS STATE BOARD OF NURSING

IN THE MATTER OF

Cynthia L. Davis
License No. 13 70161 092

Case No. 99 584 3
08 164 1
OAH No. 10BN0050

INITIAL ORDER

Now on this 31st day of March 2010, the above-captioned matter comes on for hearing before the Kansas State Board of Nursing. Sandra L. Sharon was duly appointed as Presiding Officer pursuant to K.S.A. 77-514. The Petitioner, the Kansas State Board of Nursing (Board), appears through Assistant Attorney General, Alma A. Heckler, Disciplinary Counsel for the Board. The Respondent, Cynthia L. Davis, appears in person. Witnesses were: Shirley Endres, John Childers, Kathleen Chalkey, and Ms. Davis.

Findings of Fact

1. On December 21, 2007, the respondent was employed by a nursing placement agency and she was assigned to work at the Kansas Soldiers' Home in Ft. Dodge, Kansas. The respondent was to work the 6:00 a.m. to 2:00 p.m. shift. She had worked at the Kansas Soldiers' Home the day prior, December 20, 2007.

2. On December 21, 2007, the respondent requested orientation to the facility and the floor on which she was working. She was informed there would be no orientation and that her job duties were to take blood sugar readings and give insulin. The respondent was informed of the identification system the Kansas Soldiers' Home employed. Each resident had an ID wristband; also, the patient's picture was posted outside the door of his room. The medication book utilized by the Kansas Soldiers' Home had the same picture in the book along with the patient's name, medications he required, and the dose he would need.

3. Even though the identification system used by the Kansas Soldiers' Home was explained to the respondent, she gave insulin to a resident who was not to receive insulin at all.

4. There is no documentation that the respondent properly followed up on this medication error. She did not contact the patient's doctor. There is no medication error report and there is no documentation in the nursing notes.

5. The respondent was asked to leave the Kansas Soldiers Home shortly after the Director of Nursing learned of the respondent's error.

6. In March 2009, the Board began to have concerns regarding the respondent's safety to practice nursing. The Board had information that the respondent had a previous back injury and had never been released to work to nursing by her physicians.

7. The respondent was referred to the Kansas Nurse Assistance Program (KNAP).

8. On March 29, 2009, Kathleen D. Chalkey, LPN, sent correspondence to the respondent indicating that she would need to contact KNAP within 15 days of the correspondence. The purpose for her referral to [redacted] was to evaluate her for impairments and whether she was safe to practice nursing.

9. John Childers, of the [redacted] corresponded with the respondent in writing. Twice he requested release of information authorization so that [redacted] could obtain medical records from the respondent's physicians in order to assess her impairments and ability to practice nursing.

10. The respondent failed to provide [redacted] with release of information authorizations. At hearing, the respondent indicated that she believed she told her doctors to release the information. However, [redacted] followed up in writing regarding the respondent's failure to provide release of information authorization. The respondent did not respond to [redacted] and her [redacted] case was closed June 16, 2009.

11. The respondent testified that she was not currently working as a nurse and could not due to back problems from falling off a ladder. The respondent also indicated she has a left wrist condition that prevents her from performing nursing duties. The respondent's medical records indicate that she cannot lift 30 pounds and cannot lift 20 pounds frequently. The respondent is on Loritab every four hours for the pain she experiences. Even though the respondent indicated she currently cannot work as a nurse, she contradicted herself and testified she could work two to three days a week in a clinical setting.

12. At hearing, when asked the five Rs of medication administration, the respondent was unable to recite them. This question was specifically asked to the respondent because of her medication error at the Kansas Soldiers Home.

13. The Board has concerns regarding the respondent's ability to practice nursing. These concerns are fueled by the respondent's medication error, giving the wrong person insulin at the Kansas Soldiers Home, her failure to check the ID band when giving the wrong medication, experiencing physical conditions which limit her ability to perform nursing tasks, being on controlled substances, being unable to cite the 5 Rs of medication administration, and her failure to follow through with [redacted]

Conclusions of Law

1. The Kansas State Board of Nursing has the authority to deny, revoke, limit, or suspend a license or application for license to practice nursing in the State of Kansas. Kansas Statutes Annotated (K.S.A.) 65-1120.
2. Reasons to deny, revoke, limit, or suspend a license to practice nursing in the State of Nursing include:
    - Showing unprofessional incompetency through one or more instances involving failure to adhere to applicable standard of care to a degree which constitutes gross negligence. K.S.A. 65-1120(a)(3) and K.S.A. 65-1120(e)(1).
    - By showing of unprofessional incompetency demonstrated by a pattern or practice of behavior which manifests incapacity or incompetence to practice nursing. K.S.A. 65-1120(a)(3) and K.S.A. 65-1120(e)(3).
    - Demonstrating unprofessional conduct by failing to follow policies or procedures in the practice of nursing designated to safeguard the patient. K.S.A. 65-1120(a)(3) and Kansas Administrative Regulation (K.A.R.) 60-3-110(c).
    - Demonstrating unprofessional conduct by willfully or negligently failing to appropriate action to safeguard a patient from incompetent practice of a Registered Nurse or Licensed Practical Nurse. K.S.A. 65-1120(a)(6) and K.A.R. 60-3-110(k).
    - Demonstrating unprofessional conduct by failing to complete the requirements of the impaired provider program of the Board. K.S.A. 65-1120(a)(6) and K.A.R. 60-3-110(s).

Discussion

1. The respondent's failure to check a resident's ID band at the Kansas Soldiers Home and administering medication incorrectly is a violation of the Kansas Nurse Practice Act. K.S.A. 65-1120(a)(3) and (6), K.S.A. 65-1120(e)(1) and K.A.R. 60-3-110(c) and (k).

2. The respondent's inability to cite the 5 Rs of medication administration is a violation of the Kansas Nurse Practice Act. K.S.A. 65-1120(a)(3) and K.S.A. 65-1120(e)(3).

3. The respondent's inability to show that she has been released by her physicians to practice nursing, considering her inconsistent testimony that she has a physical condition which prevents her from nursing, and then contradicting that saying she believes she could physically practice nursing is a violation of the Kansas Nurse Practice Act. K.S.A. 65-1120(a)(3) and K.S.A. 65-1120(e)(3).

4. The respondent's complete failure to cooperate and follow through with [redacted] is a violation of the Kansas Nurse Practice Act. K.S.A. 65-1120(a)(6) and K.A.R. 60-3-110(s).

Conclusion

The Board's Petition to revoke the respondent's license is affirmed.

Cost of this action shall be assessed against the respondent in the amount of $70.00 pursuant to K.S.A. 65-1120(d).

Appeal Rights and Other Administrative Relief

Pursuant to K.S.A. 77-527, either party may request a review of this initial order by filing a petition for review with the Kansas State Board of Nursing. A petition for review must be filed within 15 days from the date this initial order was served. Failure to timely request a review by the Kansas State Board of Nursing may preclude further judicial review. The petition for review shall be mailed or personally delivered to: Mary Blubaugh, Executive Director, Board of Nursing, Landon State Office Building, Suite 1051, 900 SW Jackson, Topeka, KS 66612-1230.

Pursuant to K.S.A. 77-531, if the initial order is served by mail, three days are added to the time limits set out above.

Pursuant to K.S.A. 77-530, if a request for review is not made in the time and manner stated above, this initial order shall become effective as a final order 30 days after service.

OFFICE OF ADMINISTRATIVE HEARINGS

Sandra L. Sharon
Presiding Officer
Office of Administrative Hearings

CERTIFICATE OF SERVICE

On May 5, 2010, I mailed a copy of this document to:

Cynthia L. Davis
278 Homestead Ln.
Florissant, CO 80816

Mary Blubaugh, Executive Director
Alma A. Heckler, Assistant Attorney General
Kansas State Board of Nursing
900 SW Jackson, LSOB, Ste. 1051
Topeka, KS 66612

[redacted]

Staff Person
Office of Administrative Hearings

BEFORE THE KANSAS STATE BOARD OF NURSING
Landon State Office Building, 900 S.W. Jackson #1051
Topeka, Kansas 66612-1230

FILED
JAN 11 2010
KSBN

IN THE MATTER OF
CYNTHIA L. DAVIS
License No. 13-70161-092

Case No. 99-584-3, 08-164-1

PETITION

COMES NOW the petitioner, the Kansas State Board of Nursing, by and through Assistant Attorney General assigned to the Board, Alma A. Heckler, and for its cause of action states that:

1. Respondent, Cynthia L. Davis, is licensed to practice nursing in Kansas through 9/30/2010. The Board has jurisdiction over the respondent and the subject matter of this action.

2. Respondent's address of record is 278 Homestead Lane, Florissant, CO 80816.

3. After an investigation, the Board's investigative committee found reasonable grounds to believe that the respondent violated the Kansas Nurse Practice Act, K.S.A. 65-1120, and referred this matter for further proceedings.

4. The Kansas State Board of Nursing has the authority under K.S.A. 74-1106 et seq. to examine, license and renew license for duly qualified applicants and may limit, deny, suspend or revoke a license or authorization to practice nursing, may issue a public or private censure and levy administrative fines consistent with K.S.A. 74-1110, if a violation of K.S.A. 65-1120(a) is established.

FACTS COMMON TO ALL COUNTS

5. The facts below are common to all counts:

(a) In Kansas State Board of Nursing (KSBN) Case No. 08-164-1 the respondent was directly referred by the Board to the [redacted] in March of 2009 for an evaluation of her safety to practice. Respondent was employed by Healthy Hearts Staffing Agency in Colby, Kansas and was assigned to the Kansas Soldier's Home. On or

about 12/21/07 the respondent administered insulin to the wrong patient, failed to notify the patient's doctor and failed to document the incident. Respondent was terminated from Healthy Hearts in January 2008 due to this incident and for misuse of time during scheduled work.

(b) Respondent reports she also worked for Absolute Professional Staffing, in Topeka, Kansas in December 2007 but allegedly self-terminated with the agency in January 2008 due to her decision to care for her father. Respondent also reports she injured her back in 1999 and has never been released to return to work. Respondent is also licensed to practice nursing in Colorado.

(c) In Case No. 99-584-3 respondent, while employed at Phillips Hospital in Phillipsburg, Kansas, allegedly slept while on duty, committed policy and procedure violations, failed to take appropriate action and verbal abuse of patients and other staff. Respondent was terminated on 5/2/2000.

(d) Respondent failed to follow through with her direct referral to the [redacted] by the board in March 2009 for a "safety to practice evaluation". He[redacted] case closed in May 2009 due to her failure to supply an evaluation or to sign releases of information forms for[redacted]

VIOLATIONS

6. Respondent has violated the Kansas Nurse Practice Act as follows:

Count 1: K.S.A. 65-1120(a)(3), Professional Incompetency by K.S.A. 65-1120(e)(1), one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board.

Count 2: K.S.A. 65-1120(a)(3), Professional Incompetency by K.S.A. 65-1120(e)(3), a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice nursing.

Count 3: K.S.A. 65–1120(a)(6), unprofessional conduct by K.A.R. 60-3-110(c), failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard each patient.

Count 4: K.S.A. 65–1120(a)(6), unprofessional conduct by K.A.R. 60-3-110(k), willfully or negligently failing to take appropriate action to safeguard a patient or the public from incompetent practice performed by a registered professional nurse or a licensed practical nurse.

Count 5: K.S.A. 65–1120(a)(6), unprofessional conduct by K.A.R. 60-3-110(s), failing to complete the requirements of the impaired provider program of the board.

WHEREFORE, petitioner requests a finding that the respondent has violated the Nurse Practice Act, that respondent's license to practice nursing in Kansas be revoked, and that costs of this action be assessed to the respondent in the amount of $70.00.

Respectfully submitted,

Stephen N. Six
Kansas Attorney General

By: _____

Alma A. Heckler, #11555
Assistant Attorney General
Kansas State Board of Nursing
Landon State Office Building
900 SW Jackson #1051
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