FILED
MAR 26 2014
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BEFORE THE KANSAS STATE BOARD OF NURSING

Landon State Office Building, 900 S.W. Jackson #1051
Topeka, Kansas 66612-1230

IN THE MATTER OF
PATRICIA L. BURRIS
License No. 13-93247-122

Case No. 13-336-8

SUMMARY ORDER

Now this 26th day of March, 2014, the above matter comes before the Kansas State Board of Nursing (Board) pursuant to authority granted to the Board by K.S.A. 65-1120. The Board hereby proposes to find facts and take disciplinary action against the registered nurse license of Patricia L. Burris, (Licensee) by way of Summary Order as provided by K.S.A. 77-537.

FINDINGS OF FACT

1. (a) Licensee is licensed to practice nursing in the state of Kansas as a registered nurse through 12/31/2014. The Board has jurisdiction over the licensee and the subject matter of this action.

(b) Licensee's address of record is 5431 SW Sena Drive, Topeka, Kansas 66604.

(c) Licensee was employed by Select Specialty Hospital, Topeka, Kansas from August 15, 2011 to November 9, 2012.

(d) On or about November 6 and 7, 2012 licensee was assigned to a patient 3392. Patient 3392 was ordered to receive Ceftriaxone (2 grams) at 1600 every day. Patient 3392 reported to an RN that the antibiotic, Ceftriaxone was not hung and administered by the licensee. Administration of the antibotic was reported in the MAR at 1500 on 11/7/2012. Patient 3392 reported that the licensee or shift nurse assigned, hangs the antibiotic at the same time each day (approximately at 1800 when his nocturnal tube feeding is also initiated). Patient 3392 recalled that licensee had taken down the IV tubing from the previous day and thrown it away in the trash receptical in his room. The trash was checked and the tubing for 11/6/2012 was in the trash but the tubing for the medication administration for 11/7/2012 was not found in the trash. The tubing should have been replaced and so the staff checked the Scan Req Inventory system to find out whether or not IV tubing was charged to Patient 3392 on 11/7/2012. No tubing had been charged to patient 3392 on 11/7/2012. No tubing was found by staff attached to the pump or in the room.

(e) Patient 3392 did not receive the Ceftriaxone. The Med Dispense machine was checked to see if a dose was removed for patient 3392 but no dose was dispensed. A trash can in the medication room did hold a 100 ml. saline bag marked with a patient 3392 pharmacy sticker for Ceftriaxone (2 gram) 1400 dose. The saline bag had been emptied by cutting off the right hand corner with scissors. The bag had not been punctured and the seal had not been removed. This is not the usual way saline bags are opened for use. Further investigation revealed an uncapped vial of Ceftriaxone (2 gram) in the sharps container of room number 824. Patient 3392 was not in room number 824. Room 824 had been most recently occupied by a

different patient. Ceftriaxone was not prescribed for the other patient. Patient in room 824 died very recently.

(f) Patient 3394, who was also assigned to the licensee on or about November 6 and 7 of 2012. Patient 3394 should have received IV Meropenem and IV Mycamine in the mid afternoon. Licensee documented the administration of both drugs on the MAR at 1405 and 1500. Two 100 ml. saline bags bearing pharmacy stickers for patient 3394 were found in the medication room trash can. Again both bags had been emptied by cutting off the right hand corner with scissors. The bags had not been punctured and the seal had not been removed. This is not the usual way saline bags are opened for use. Uncapped vials of the medications, Meropenem and Mycamine were found in the sharps container of a recently expired patient. Again these medications had not been prescribed for the deceased patient. Medication dispense records indicate that licensee failed to administer both drugs at 1405 and 1500 to patient.

(g) The licensee was placed on probation and terminated by Select Specialty Hospital on or about November 9, 2012. The licensee failed to respond to the Board.

CONCLUSIONS OF LAW

2. Pursuant to K.S.A. 65-1120(a), the Kansas State Board of Nursing may deny, revoke, limit or suspend any license, certificate of qualification or authorization to practice nursing as a registered professional nurse, as a licensed practical nurse, as an advanced registered nurse practitioner or as a registered nurse anesthetist that is issued by the board or applied for under this act or may publicly or privately censure a licensee or holder of a certificate of qualification or authorization, if the applicant, licensee or holder of a certificate of qualification or authorization is found to have violated the Nurse Practice Act. The above fact findings establish evidence that the applicant violated the following provisions of the Nurse Practice Act:

(a) K.S.A. 65–1120(a)(1), to be guilty of fraud or deceit in practicing nursing or in procuring or attempting to procure a license to practice nursing;

(b) K.S.A. 65-1120(a)(3), to have committed an act of professional incompetency as defined in subsection (e); (1) one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determinied by the board;

(c) K.S.A. 65-1120(a)(6), to be guilty of unprofessional conduct as defined by rules and regulations of the board; K.A.R. 60-3-110(d) inaccurately recording, falsifying, or altering any record of a patient or agency or of the board;

3. Licensee's conduct described herein violates the Kansas Nurse Practice Act.

4. K.S.A. 77-511(a)(2)(A) of the Kansas Administrative Procedure Act authorizes the use of summary proceedings by a state agency if the use of summary proceedings does not violate any provision of law, the protection of the public interest does not require the state agency to give notice and an opportunity to participate to persons other than the parties, and the state agency believes in good faith, after investigation of the facts, that the allegations will be supported to the applicable standard of proof.

5. The role of the Kansas State Board of Nursing is to protect citizens of Kansas.

IT IS THEREFORE ORDERED BY THE KANSAS STATE BOARD OF NURSING THAT

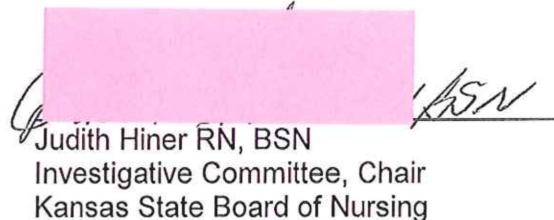
1. **Licensee's license is revoked.**

2. **Licensee shall not practice nursing in the state of Kansas.**

3. **Licensee shall pay $70.00 costs of this action to the Board within thirty (30) days of the effective day of this Order.**

Pursuant to K.S.A. 77-537, this decision, which is called a Summary Order, is subject to your request for a hearing. If you desire a hearing, you must submit or direct a written request for hearing to: Kansas State Board of Nursing, Legal Division, 900 SW Jackson, Suite 1051, Topeka, Kansas 66612-1230, (785) 296-4325. THIS REQUEST MUST BE SUBMITTED WITHIN FIFTEEN (15) DAYS FROM THE DATE OF THIS ORDER. If a hearing is not requested in the time and manner stated, this Summary Order becomes effective as a final order, without further notice, upon the expiration of the time for requesting a hearing. If a hearing is requested, the prior issuance of a summary order shall not affect the burden of proof.

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

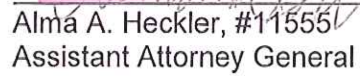


Judith Hiner RN, BSN
Investigative Committee, Chair
Kansas State Board of Nursing

CERTIFICATE OF SERVICE

I certify that on the 26th day of December, 2014, the foregoing copy of the Summary Order was served by depositing the same in the United States Mail, first-class postage prepaid, addressed to the following:

Patricia Burris
5431 SW Sena Drive
Topeka, Kansas 66604



Alma A. Heckler, #11555
Assistant Attorney General