BEFORE THE KANSAS STATE BOARD OF NURSING
Landon State Office Building
900 SW Jackson, Suite 1051
Topeka, Kansas 66612-1230
(785) 296-2949

Filed
NOV 3 0 2004
Board of Nursing

IN THE MATTER OF

MARTA DeANGELIS,
Formerly MARTA SCHWACH
License No. 14-49479-121

Case No. 02-648-7

MEMORANDUM DECISION AND INITIAL ORDER

NOW ON this 29th day of November, 2004, the above matter comes on for decision. The Board filed a Petition in this matter on December 10, 2003, alleging four incidents constituting six violations of the Kansas Nurse Practice Act, KSA 65-1120(a) (KNPA). An amended Petition was filed August 24, 2004, that re-alleged the original violations and added another concerning an incident on or about August 12, 2001, but constituting six violations of the KNPA. After number of continuances requested by both parties, a hearing was held November 17, 2004. The Petitioner appeared by Betty Wright, Disciplinary Counsel for the Board of Nursing and the Respondent, appeared pro se, by telephone. Both parties presented their evidence and arguments on the issues presented.

It should be noted the Respondent submitted a rather thick, approximately 1 1/4 inch, packet of documents that she wished the Hearing Officer to consider. These were collectively marked Respondent's Exhibit 1, and admitted. The Petitioner had twenty-six exhibits, numbered 1-26, inclusive, that were also admitted. The Petitioner called two witnesses, Susan Malick, RN, and Kathleen Chalkley, Investigator. The Respondent

presented testimony on her own behalf. The matter was taken under advisement and is now ready for decision.

Being duly and well advised in the premises, the Hearing Officer finds as follows:

1. The Board has jurisdiction of the subject matter and the parties.

2. Part of the documents submitted by the Respondent indicated that she had been awarded Social Security Disability benefits and had not worked since June, 2002. Inquiry was made of the Respondent who indicated that she was too ill to safely practice nursing and did not believe that she would ever be healthy enough to again be able to safely practice. She candidly admitted that a finding of a violation of KSA 65-1120(a)(3), (e)(3), Professional Incompetency by "other behavior which demonstrates a manifest incapacity to practice nursing" would be warranted and that she would not object to a suspension on that basis. Therefore, the Hearing Officer finds, by stipulation of the Respondent that a violation of KSA 65-1120(a)(3), (e)(3), has occurred and that the Respondent is physically ill to the degree that demonstrates a manifest incapacity to practice nursing.

3. The rest of the Petitioner's case centers on incidents alleged to have occurred while the Respondent was employed at the Menorah Medical Center in Overland Park.

4. Four of the incidents [paragraphs 6(a) – 6(d) of the Amended Petition] allegedly occurred May 22, 2002. The first alleges that Respondent diverted Tylenol #3 from patient BW and/or the Medical Center and documented that the patient was given Tylenol #3, but instead given ordinary Tylenol. The second alleges that the Respondent documented that she have care to patients BW and CK, but that the care was not, in fact,

given. The third alleges the Respondent signed out percocet for patient JS but did not document it on the MAR, and diverted it to her own use. The fourth alleges that the Respondent signed out Tylenol #3 for patient JP forty minutes after that patient had been discharged, thus diverting the drug.

5. The Petitioner's evidence on these allegations is largely circumstantial and relies, to a large degree, on hearsay evidence. Some of that hearsay evidence would be admissible under the business record exception (Menorah medical records), but some of it, if it had been objected to, would not have been admissible (the patient statements). All of the hearsay evidence has been considered although the weight given to the hearsay should be adjusted due to its nature. The Respondent denies the substance of these allegations and provided in her testimony an explanation for what had happened. She had no memory of some of the matters.

6. Taking all of the evidence as a whole on these alleged incidents (paragraphs 6(a) through 6(d)), the Petitioner failed to meet the requisite burden of proof of clear and convincing evidence. Clear and convincing evidence, it has been held, is not a quantum of proof, but rather a quality of proof. *Fox v. Wilson,* 211 Kan. 563, 578-79, 507 P.2d 252 (1973); *In re Estate of Shirk,* 194 Kan. 671, 672, 401 P.2d 279 (1965). The common definition of clear and convincing evidence was iterated in *Nordstrom v. Miller,* 227 Kan. 59, 65, 605 P.2d 545 (1980), as follows: "'[T]he witnesses to a fact must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the details in connection with the transaction must be narrated exactly and in order; the testimony must be clear, direct and weighty; and the witnesses must be

lacking in confusion as to the facts at issue.' *Modern Air Conditioning, Inc. v. Cinderella Homes, Inc.*, 226 Kan. 70, 78, 596 P.2d 816 (1979)."

7. The deficiency in the Petitioner's proof on these allegations is that there is such a substantial reliance upon hearsay evidence. No witness having direct knowledge of the events was presented. Ms. Malick did not have any direct knowledge of the incidents, but relied on medical records. Ms. Chalkley, likewise, had no direct evidence, but presented the hearsay testimony of persons not present to be cross-examined. There is no direct evidence that the Respondent diverted drugs as alleged or that the Respondent failed to administer the care that was documented in the patient records. The Hearing Officer is left to judge which of two opposing recitation of events is true. For instance, the hearsay statement of patients BW and CK indicate that they received no care, but the Respondent says that they did. The patient charts show they received the care. But neither BW or CK were presented to testify. The clear and convincing standard of proof has not been met relative to the allegations contained in paragraphs 6(a) through 6(d) of the Amended Petition.

8. Paragraph 6(e) of the Amended Petition alleges that the Respondent, on August 12, 2001, gave three 4 mg. doses of morphine to patient DS, but did not indicate any wastage from the 8 mg. pre-filled morphine syringes from which they were administered. Menorah Medical Center policy and procedure required that any such wastage be documented and witnessed. The records show that it was the Respondent who administered the medication as ordered by the physician, but there is no record of wastage, nor is there any "sign-off" by another nurse who witnessed the wastage. Policy and procedure of the Medical Center required that such wastage be documented and that

another nurse witness and sign off on the wastage. At the very least, this evidence establishes a violation of KSA 65-1120(a)(6), Professional Incompetency as established by KAR 60-3-110(c), failing to take appropriate action or to follow policies and procedures in the practice situation designed to safeguard each patient. Thus, the Hearing Officer finds that the Respondent has committed this violation as alleged.

9. The purpose of the Kansas Nurse Practice Act, K.S.A. 65-1113, *et. seq.*, is the same as that of the Kansas Healing Arts Act (K.S.A. 65-2801 *et. seq.*) as stated in *Vakas v. Kansas Board of Healing Arts,* 248 Kan. 589, 808 P.2d 1355 (1991), Syl. ¶ 1: "to protect the public 'against unprofessional, improper, unauthorized and unqualified practice ... and from unprofessional conduct by persons licensed to practice under this act.'"

10. In and of itself, this violation of the KNPA concerning patient DS would not warrant a suspension of the Respondent's license. However, this violation, coupled with the stipulation of being unsafe to practice, a violation of KSA 65-1120(a)(3), (e)(3), Professional Incompetency by "other behavior which demonstrates a manifest incapacity to practice nursing," mandates that the Respondent's license be indefinitely suspended.

IT IS THEREFORE ORDERED that the Respondent's license as a registered professional nurse, No. 14-49479-121, be and is hereby indefinitely suspended and the Respondent prohibited from practicing as a registered professional nurse in Kansas.

IT IS FURTHER ORDERED that the costs be assessed to the Respondent in the amount of $70.00.

IT IS FURTHER ORDERED that the Respondent return her nursing license card to the Board of Nursing, forthwith.

TERRY E. BECK, Hearing Officer

NOTICE OF RIGHT TO APPEAL

The procedures available and time limitations for seeking review or other relief as follows:

Any party, within fifteen (15) days after service of this notice, may file a petition for review with the agency head, send your request to:

Mary Blubaugh, Executive Director, Board of Nursing
Landon State Office Bldg.
Suite 1051, 900 SW. Jackson
Topeka, KS 66612-1230.

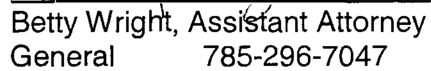
The petition for review shall state its basis, pursuant to K.S.A. 77-527.

TERRY E. BECK, Hearing Officer

CERTIFICATE OF SERVICE

I hereby certify that on the ~~29th~~ 30th day of November, 2004, I deposited a true and correct copy of the above MEMORANDUM DECISION AND INITIAL ORDER in the United States mail, postage prepaid to:

Marta DeAngelis
1710 Picton Lane
Rockport, TX 78382



Betty Wright, Assistant Attorney General 785-296-7047