BEFORE THE KANSAS STATE BOARD OF NURSING

IN THE MATTER OF
JODY SUE HONEYMAN
License No. 13-100446-012

Case Nos. 10-1276-8 &14-1886-8
OAH No. 16BN0096

INITIAL ORDER

Now on this 1ST day of November 2016, the above-captioned matter comes on for hearing before the Kansas State Board of Nursing (Board/Petitioner) pursuant to K.S.A. 77-536. Sandra L. Sharon was duly appointed Presiding Officer/Administrative Law Judge pursuant to K.S.A. 77-514. The Petitioner, the Kansas State Board of Nursing, appears by Assistant Attorney General Michelle David, Disciplinary Counsel for the Board. The respondent, Jody Sue Honeyman, appears in person.

Findings of Fact

1. The respondent is a Registered Nurse (RN), licensed to practice nursing in the State of Kansas. In October 2005, the respondent was a Licensed Practical Nurse (LPN). She entered into a Consent Agreement to Suspend License with a Stay on or about October 26, 2005.

2. The Consent Agreement identifies a history of criminal behavior and convictions by the respondent from 1990 through 2000. This history includes possession of marijuana and methamphetamine in 1990, attempted manufacture and distribution of methamphetamine in 1999, theft of a saddle and violin in 1999, and possession of methamphetamine in 2000.

3. In 2014, the respondent was arrested and pled no contest to possession of marijuana and placed on four months unsupervised probation.

4. In 2014, the respondent was employed at Washburn Institute of Technology (Washburn Tech). She was the instructor for a Certified Nurse Aide (CNA) course, LPN courses, and was the instructor of a special grant course, A-OK.

5. The respondent was popular with her students and had a high success rate of student success and course completion.

6. On or about May 16, 2014, Washburn Tech received a request from Aldersgate Village that the respondent no longer accompany students to its facility to supervise students performing clinical practice.

7. On or about May 20, 2014, the respondent was given an Instructor Improvement Plan. The plan addresses behavioral issues. Some of the issues addressed were sending e-mails containing inappropriate language, discussing staff at clinical facilities, discussing

personal issues with students, adhering to clinical site requirements, and assuring clinical learning is carried out appropriately.

8. On July 22, 2014, while supervising student clinical learning at Lexington Park, the respondent was observed at a table with her head down. She was approached by Heather Benney, the Assistant Director of Nursing (ADON). She did not respond to verbal cues from the ADON. It was a physical touch that roused her. The ADON asked the respondent if she was ok, or if she should get a crash cart. The respondent assured her she was ok but had an abscessed tooth and was trying to get the pain under control.

9. The ADON was informed by one of her employees that the respondent was observed sleeping on a couch in a common area of the facility the day before. A review of the facility video surveillance of July 21, 2014 shows the respondent curled up on a chair or loveseat from 9:05 to 9:46. The ADON's testimony was that the respondent did not move from her position in the chair the entire time.

10. On July 22, 2014, Washburn Tech was notified of the respondent sleeping while she was supposed to be supervising student clinical learning. Two individuals from Washburn Tech arrived at Lexington Park, excused the students and relieved the respondent of her duties. She was placed on suspension by Washburn Tech, and her employment was terminated by Washburn University President, Jerry B. Farley, by letter dated July 30, 2014.

11. The respondent testified she was not originally scheduled to supervise the clinical learning on July 21, 2014 and July 22, 2014 at Lexington Park. She claims she was begged to accept the assignment and had to cancel dental treatment in order to accept the assignment.

Applicable Law

1. Upon violation of the Kansas Nurse Practice Act the Board has the authority to deny, revoke, limit, or suspend any license to practice nursing in the State of Kansas or any application for a license to practice nursing. K.S.A. 65-1120(a).

2. It is a violation of the Kansas Nurse Practice Act to commit an act of unprofessional conduct by failing to take appropriate action or by failing to follow policies and procedures in the practice situation to safeguard each patient. K.S.A. 65-1120(a)(6) and K.A.R. 60-3-110(c).

3. It is a violation of the Kansas Nurse Practice Act to commit an act of professional incompetency failing to adhere to the applicable standards of care to a degree which constitutes gross negligence, as determined by the Board. K.S.A. 65-1120(e)(1).

4. It is a violation of the Kansas Nurse Practice Act to commit an act of professional incompetency through a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice nursing. K.S.A. 65-1120(e)(3).

5. The Board must show by a preponderance of the evidence that the respondent has violated the Kansas Nurse Practice Act and revocation of her license is justified. A preponderance of the evidence means the truth of the facts asserted is more probable than not. Or to quantify it, the evidence shows by more than fifty percent that the events occurred.

Discussion

1. It is the faculty member who is responsible for students in the clinical learning setting. K.A.R. 30-2-105(c). While the respondent was supervising students at Lexington Park, she was the responsible party for providing a safe environment for student and patients. On July 21, 2014 and July 22, 2014, the respondent failed to meet this responsibility. On July 22, 2014, the respondent was observed by the ADON of Lexington Park at a table, with her head down, unresponsive. The ADON believed the respondent to be asleep. The respondent denies she was sleeping. Nevertheless, she was unresponsive to the ADON until physically nudged. At that point, the respondent explained she was not well and was trying to deal with the pain of an abscessed tooth. The ADON was concerned about the patients at her facility to the extent she felt compelled to report the respondent's behavior to Washburn Tech.

2. Further, after the July 22, 2014 incident, the ADON was informed by concerned staff of the respondent's behavior the prior day, July 21, 2014. Review of the facility's video surveillance shows the respondent sleeping and not supervising students for over 45 minutes. It was the ADON's testimony that her review of the video showed the respondent sleeping the entire time. The respondent argues that the physical evidence of this event are pictures that show her lying in a chair at 9:05, 9:25, and 9:46 and she could have been up in between each of the time stamped pictures. Either way, whether she slept for over 45 minutes, or whether she took the opportunity to lay down three separate times in 45 minutes, the respondent was clearly not supervising students in their clinical learning. This is a violation of K.S.A. 65-1120(a)(6) and K.A.R. 60-3-110(c).

3. On July 21, 2014 and July 22, 2014, the respondent failed to adhere to the applicable standard of care outlined for patients and student clinical learning as outlined at K.A.R. 60-2-10(c). This failure amounts to gross negligence. Although not defined by the Board, in general legal terms, gross negligence is an intentional failure to perform a duty, not just a simple inadvertence to act. While the respondent argues that she was not well and needed time to prepare for supervising students, she knew she was not well when she accepted the assignment, as demonstrated by her cancelling her dental appointment. If the respondent was not able to adequately perform her duties, she had the obligation not to accept the assignment. Once she accepted the assignment she became responsible to perform the duties as previously discussed. She did not. This is a violation of K.S.A. 65-1120(e).

4. The respondent's pattern of professional behavior was called into question by at least two facilities, Aldersgate Village and Lexington Park. She also acted inappropriately through

e-mail on several occasions bringing disrepute to herself and her employer. Further, her clinical learning supervision was of the nature that Washburn Tech was notified and action was taken to intercede with her actual clinical work. These behaviors demonstrate a pattern of practice and other behaviors that manifest the incapacity to effectively practice nursing. This is a violation of K.S.A. 65-1120(e)(3).

5. The respondent presented evidence that she was a good instructor. She was effective and her students liked her. However, this evidence misses the mark. This case is not about the respondent's teaching skills. It is about her actions and judgment as a licensed registered nurse.

Conclusion

The Board has shown by a preponderance of the evidence that the respondent has demonstrated unprofessional and incompetent behavior. The petition of the Board to revoke the respondent's license to practice nursing in the State of Kansas is granted.

Cost of this action shall be assessed against the respondent in the amount of $100.00 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, 900 SW Jackson, Suite 1051, 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.

Sandra L. Sharon
Administrative Law Judge/Presiding Officer
Office of Administrative Hearings
1020 S. Kansas Ave.
Topeka, KS 66612
Telephone: 785-296-2433

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PETITION

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

1. Respondent, Jody Sue Honeyman, is licensed to practice nursing in Kansas through January, 2018. The Board has jurisdiction over the respondent and the subject matter of this action.

2. Respondent's address of record is 5518 SW 31st Terrace Topeka, Kansas 66614-4009.

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. According to a report, it is alleged that while licensee was employed by Topeka Community Center, Topeka, Kansas, licensee failed to assess and treat a patient's pain.

b. This incident occurred on or about the 3rd day of September 2010.

c. Licensee also answered "no" to the license discipline question.

d. This occurred on or about the 2nd day of November 2013.

e. According to another report, it is alleged that while licensee was employed at Washburn Institute of Technology, Topeka, Kansas licensee was unprofessional repeatedly in her behavior.

f. Licensee repeatedly failed to adequately supervise the nursing students assigned to her and repeatedly slept while on duty at the clinical site.

g. These incidents allegedly occurred during April 2014 through July 2014.

VIOLATIONS

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

Count 1: K.S.A. 65-1120(a)(6) to have committed an act of 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 to safeguard each patient.

Count 2: K.S.A. 65-1120(e)(1) to have committed an act of professional incompetency as defined in subsection (e) in one or more instances involving failure to adhere to the applicable standards of care to a degree which constitutes gross negligence, as determine by the board.

Count 3: K.S.A. 65 1120(a)(1) unprofessional conduct by fraud or deceit in practicing nursing.

Count 4: K.S.A. 65-1120 (e) (3) professional incompetence as defined as a pattern of practice or other behavior which demonstrates a manfiest incapacity or incompetence to practice nursing

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 $100.00.

Respectfully submitted,

Derek Schmidt
Kansas Attorney General

By: _____

Michael R. Fitzgibbons #12287
Assistant Attorney General
Kansas State Board of Nursing
Landon State Office Building
900 SW Jackson #1051
Topeka, KS 66612