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

FILED
SEP 18 2009
KSBN

IN THE MATTER OF
LILLIAN COLYN
License No. 23-32287-092

Case No. 03-663-4, 04-672-4, 05-425-4, 05-736-4, 06-280-4

SUMMARY ORDER

Now this 17th day of September, 2009, 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 licensed practical nurse reinstatement application of Lillian Colyn (Applicant) by way of Summary Order as provided by K.S.A. 77-537.

FINDINGS OF FACT

1. (a) Applicant was previously licensed to practice nursing in the state of Kansas. Applicant's license to practice nursing in the state of Kansas as a licensed practical nurse lapsed on or about 9/30/2006. Applicant submitted an application for reinstatement of Applicant's license to practice nursing in the state of Kansas. The Board has jurisdiction over the Applicant and the subject matter of this action.

(b) Applicant's address of record is PO Box 55, Iuka, KS 67066.

(c) On or about 1/16/2007, the Board received Applicant's application for reinstatement of Applicant's license to practice nursing in the state of Kansas.

(d) Review of the Application and other information gathered by the Board revealed the following information upon which this action is based.

(e) On or about 5/25/03 while working as an LPN at Larned State Hospital, Kansas staff reported that a patient was upset and crying. The patient advised staff that the Applicant told her that if she did not eat her food that the Applicant would force her to eat by "tubing". Staff reported that "tubing" meant forcing food into a patient through a tube.

(f) On or about 3/18/04 the Applicant entered a letter agreement with the KSBN to complete continuing nursing education. Applicant completed the continuing nursing education.

(g) On or about 7/9/04 while working in the Sexual Predator Treatment Program of Larned State Hospital, Kansas the Applicant was found sleeping in a chair by staff members.

(h) On or about 1/20/05 while working as a LPN at Larned State Hospital, Kansas, Applicant was preparing a medication cart for distribution of medications to patients. While Applicant was speaking in an animated manner she struck the medication cart, spilling some of the medications onto the floor. Applicant picked up the medications from the floor and placed them back onto the medication cart. Applicant proceeded to administer the medications to the patients instead of disposing of them per hospital policy.

(i) Staff reported that prior to 1/20/05 the patient had complained to Applicant's supervisor about Applicant's manner when passing medications. On or about 1/20/05 Larned State Hospital staff overheard a verbal exchange between the Applicant and the complaining patient. As Applicant was administering medications to the patient, Applicant told the patient that she did not appreciate it when someone goes over her head about something. Staff reported that in a raised voice, the Applicant told the patient that she was the nurse, what she said goes.

(j) On or about 2/2/05 Applicant was on duty at Larned State Hospital and was giving her shift report to an RN the Applicant stated a patient "was pulling his shit again" and the Applicant was no longer going to tolerate it. The Applicant then stated "I threw him in seclusion with his underwear on and a mattress pad." Applicant then stated "decided to let him out at 0400." Applicant stated she had called the Physician to let the Physician know that the Applicant felt "he needs to be in seclusion per nursing discretion." Applicant laughed and stated "he will learn that I will not tolerate his crap. I'm tired of running back and forth from the annex to the Dillon building. I am not going to continue to do this." Hospital policy did not allow Applicant, as an LPN, to place the patient in seclusion.

(k) On or about 2/3/05 while on duty at Larned State Hospital, the Applicant read aloud to a patient from the patient's medical record what an RN had charted about this patient. Other patients were present and heard the Applicant.

(l) On or about 4/5/05 and 4/19/05 Applicant was working at Hays Medical Center, Kansas. Applicant's assignment was to sit one to one with a security patient during the night shift. The Applicant was observed by staff to be sleeping while on duty. Applicant had pulled up a second chair, took her shoes off and covered herself with a blanket.

(m) On or about 4/29/05 Applicant was working at St. Joseph Medical Center, Kansas. Applicant's was assignment was to sit one to one with a security patient during the night shift. Applicant was observed by staff to be sleeping while on duty. Further staff observed that Applicant removed the security patient's leg cuffs while Applicant was sitting with the patient in violation of hospital policy.

(n) The above incidents were investigated by the KSBN. On or about 3/7/06 the board determined that Applicant should complete continuing nursing education. In a letter agreement the Applicant agreed to complete the continuing nursing education. The Applicant submitted certificates of completion to the KSBN on or about 7/13/06.

(o) On or about 3/14/06 the KSBN received additional information regarding the Applicant and opened a new investigation which led to the following information.

(p) On or about 2/24/06 Applicant was employed at Lakewood Senior Living of Pratt, Pratt, Kansas. Applicant contacted a resident of Lakewood for administration of medications. The resident refused to take the medications which were in pill form. According to witnesses in the resident's room the Applicant advised the resident that she had to take the medications and proceeded to shove the pills into the resident's mouth. The resident spit the medications back at the Applicant and the pills landed on the floor. The resident told the Applicant that she would kick the Applicant if the Applicant tried it again. The pills were picked up of the floor and wiped off. The Applicant physically restrained the resident so the Applicant wouldn't get kicked. The Applicant told the resident that she would obtain a physician order for a restraint if the resident

attempted to kick the Applicant. The Applicant then placed the medications a spoon and again attempted unsuccessfully, to place them in the resident's mouth.

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)(6), unprofessional conduct by K.A.R. 60-3-110(e)(3), physical abuse, which shall be defined as any act or failure to act performed intentionally or carelessly that causes or is likely to cause harm to a patient by any threat, menacing conduct, or other nontherapeutic or inappropriate action that results in or might reasonably be expected to result in a patient's unnecessary fear or emotional or mental distress.

(b) K.S.A. 65–1120(a)(6), unprofessional conduct by K.A.R. 60-3-110(g), verbal abuse, which shall be defined as any word or phrase spoken inappropriately to or in the presence of a patient that results in or might reasonably be expected to result in the patient's unnecessary fear, emotional distress, or mental distress.

(c) 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.

(d) 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.

3. Applicant'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 and 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.

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. Applicant's reinstatement application to practice nursing in the state of Kansas is denied.

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.

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.

[redacted]

Janet Jacobs, LPN
Investigative Committee, Chair
Kansas State Board of Nursing

CERTIFICATE OF SERVICE

I certify that on the 21st day of September 2009, 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:

Lillian Colyn
PO Box 55
Iuka, KS 67066

[redacted]
Alma A. Heckler, #11555
Assistant Attorney General