BEFORE THE KANSAS STATE BOARD OF NURSING

IN THE MATTER OF
SHANNON MELINDA BERRY
License No. 23-24479-022

Case No. 11-1101-5 & 14-1363-6

OAH No. 15BN0173

INITIAL ORDER

Now on this 19th day of November 2015, 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 Administrative Law Judge/Presiding Officer pursuant to K.S.A. 77-514. The Petitioner, the Kansas State Board of Nursing, appears by Assistant Attorney General Michael R. Fitzgibbons, Disciplinary Counsel for the Board. The Respondent, Shannon Melinda Berry, appears in person.

Findings of Fact

1. On or about March 5, 2011, while employed as a Charge Nurse at Wichita Nursing Center, the Respondent was called to a resident's room by a Certified Nurse Aide (CNA).

2. Upon entering the room, the Respondent found a resident entangled in bedrails and with labored breathing. The Respondent and the CNA could not free the resident. Another party was called to assist. Once the resident was free of the bedrails, the resident was laid on the floor. At that point, the resident was no longer breathing. The Respondent left the resident and went to the nursing station because she was unaware of the resident's status regarding resuscitation. The Respondent called the Director of Nursing (DON) of the facility for instruction. The DON instructed the Respondent that the resident was a full code. The Respondent requested the DON come to the facility to assist her. The Respondent also called for emergency assistance. The Respondent did not return to the room to attend to the resident. When emergency assistance arrived CPR was initiated on the resident.

3. The resident was first found by the CNA at approximately 7:15 p.m. Emergency personnel arrived at approximately 7:40 p.m. and began their resuscitation efforts. Time of death for the resident was called at 7:58 p.m.

4. The Respondent's report of the event indicated that she had to leave the resident to check on the resident's code status and call 911. The Respondent reported that the facility did not have a cordless phone so she was stuck at the nursing station. Her report also indicates that the DON told the Respondent that the resident had a Do Not Resuscitate order. The Respondent indicated that since this incident she has learned she should send staff members to retrieve charts and call for emergency assistance while she stays to attend the resident in an emergency situation.

5. On or about April 27, 2014, the Respondent was employed at Golden Living Center El Dorado. She was informed by a resident that earlier that day during a transfer, the resident heard a pop in her lower right leg. The resident complained of pain and requested the nurse contact the doctor. The Respondent did not perform an assessment on the resident's leg nor did the she call the resident's physician. Ultimately, it was determined that the resident had a lower right leg fracture.

6. The Respondent's report of the incident indicates that she was not told about the resident's pain until another nurse asked her, on her way off duty, whether the pain was reported to the resident's physician. The Respondent indicated that because she was leaving the facility early, she could stay and take care of it but was assured by the other nurse that the other nurse would take care of it and the Respondent should go ahead of leave.

7. Another nurse at the facility, while charting at the nursing station, overheard the resident tell the Respondent about the pain in her leg and the request to contact the resident's doctor. The DON at Golden Living Center El Dorado interviewed the resident on April 28, 2014. The resident reported to the DON that the resident reported the popping incident, that the resident was experiencing pain, and the resident asked the Respondent to contact the physician.

8. In discussing the incident with a Board investigator, the Respondent stated that the resident never reported pain in her lower leg to her and the resident did not complain of any pain that she didn't always complain of, so why should she call the doctor?

Applicable Law

1. The Kansas State Board of Nursing 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 and K.S.A. 74-1106(c)(4)

2. It is a violation of the Kansas Nurse Practice Act to commit unprofessional conduct by the failing to take appropriate action or to follow policies and procedures in a practice situation designed 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 professional incompetency in one or more instances involving a failure to adhere to the applicable standard of care to a degree which constitutes gross negligence. K.S.A. 65-1120(e)(1).

4. It is a violation of the Kansas Nurse Practice Act to commit professional incompetency by a pattern or 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. A preponderance of the evidence mean the weight of the evidence tips in one direction more than fifty percent.

Discussion

1. In each reported incident, the Respondent's version of the events differs in the significant facts; thereby, bringing her credibility into question.

2. In the first instance, March 5, 2011, the Respondent indicates that her DON told her the resident was a Do Not Resuscitate (DNR) patient. In reality, the patient was a full code and the Respondent was required to provide medical attention in the event the need arose. Claiming that the DON told her that the resident was a DNR would relieve the Respondent of her duty to provide necessary care. The Respondent's claim is inconsistent with the facts. The DON testified that she told the Respondent the resident was a full code and to hang up, call for emergency help, and provide care. The Respondent then requested the DON come to the facility. If, in fact, the DON told the Respondent that the resident was a DNR, there would be no cause for the Respondent to request the DON come to the facility to assist her.

3. In the incident of April 27, 2014, the Respondent reported that she knew nothing of the resident's report of pain in her leg until leaving the facility when another nurse questioned her about it. This position is inconsistent with the other nurse who was on duty that day and testified that she overhead the resident report her pain to the Respondent and request the Respondent contact a doctor. The Respondent's statement is also inconsistent with the investigation concluded on April 28, 2014, where the resident reported to the DON that she reported pain to the Charge Nurse on duty, the Respondent. Finally, the Respondent's statement of the event is inconsistent with her later statement to the Board's investigator, Lauren Wolf, RN. The Respondent said the resident complains of pain everyday so why would she call the MD? This would indicate that the resident did complain of pain to the Respondent and she chose not to follow up.

4. On March 5, 2011, when the Respondent failed to provide emergency services and to attend to her resident, she failed to take appropriate action designed to safeguard her patient. This is a violation of K.S.A. 65-1120(a)(6) and K.A.R. 60-3-110(c).

5. When the Respondent failed to take appropriate action on March 5, 2011, she failed to adhere to the applicable standard of care, for a full code order. Further, the Respondent was not even aware of the resident's code status and had to call outside the facility to find what it was. This constitutes gross negligence. Gross negligence is failing to perform a duty with reckless disregard of the consequences for the life of her patient. This lack of care was intentional and purposeful by the Respondent. This is a violation of K.S.A. 65-1120(e)(1).

6. On April 27, 2014, when the Respondent failed to assess a resident's complaint and contact the physician, she failed to take appropriate action designed to safeguard her

resident. This is unprofessional conduct pursuant to of K.S.A. 65-1120(a)(6) and K.A.R. 60-3-110(c).

7. Further, when the Respondent failed to assess the resident's complaint of pain and contact the physician, she failed to adhere to a standard of care to a degree which constitutes gross negligence. The Respondent purposefully failed to perform a duty. This failure was an act beyond simple inadvertence. This is a violation of K.S.A. 65-1120(e)(1).

8. In both instance, the Respondent chose a pattern of practice which manifests the incapacity or incompetence to practice nursing. This is a violation of the Kansas Nurse Practice Act at K.S.A. 65-1120(e)(3).

Conclusion

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

2. 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

CERTIFICATE OF SERVICE

On Dec. 17, 2015, I mailed this original document through State Building Mail to:

Mary Blubaugh
Executive Administrator
Kansas State Board of Nursing
900 SW Jackson, LSOB, Ste. 1051
Topeka, KS 66612
Telephone: 785-296-4325

and a copy of this document through State Building Mail to:

Michael R. Fitzgibbons
Assistant Attorney General
Disciplinary Counsel for the Kansas State Board of Nursing
900 SW Jackson, LSOB, Ste. 1051
Topeka, KS 66612
Telephone: 785-296-4325

and a copy of this document through first class mail to:

Shannon Melinda Berry
307 N. Quinton
Wichita, KS 67208

Staff Person
Office of Administrative Hearings