

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE BOARD OF NURSING

In the Matter of Nell Egi, L.P.N., License
No. 38686-3

FINDINGS OF FACT,
CONCLUSIONS,
AND RECOMMENDATION

This matter came on for hearing before Administrative Law Judge Beverly Jones Heydinger at 9:30 a.m. on November 16, 2000, at the Office of Administrative Hearings, 100 Washington Avenue South, Suite 1700, Minneapolis, Minnesota. Peter Kreiser, Assistant Attorney General, 1400 NCL Tower, 445 Minnesota Street, St. Paul MN 55101, appeared for the Complaint Resolution Committee, Board of Nursing. David C. Olson, Esq., Lanners & Olson, P.A., 12805 Highway 55, Suite 102, Plymouth, MN 55441 appeared for Nell Egi, the Respondent. The record closed on December 15, 2000, upon receipt of the final post-hearing submission.

This report is a recommendation, not a final decision. The Minnesota Board of Nursing will make the final decision after a review of the record and may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendation. Under Minn. Stat. § 14.61 (2000), the Board shall not make a final decision until this Report has been made available to the parties for at least ten days. The parties may file exceptions to this Report and the Board must consider the exceptions in making a final decision. Parties should contact the Board to learn the procedure for filing exceptions or presenting argument.

STATEMENT OF ISSUE

Based upon all of the proceedings herein, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. Nell Egi, the Respondent, has been licensed as a practical nurse since 1975. She has specialized in geriatric care.
2. The Respondent was employed at Bywood East Health Care Center in Minneapolis, Minnesota from September, 1994 to May, 1997.^[1] During the time she was employed there, issues were raised concerning her charting and medication management. The Board of Nursing conducted an investigation following the Respondent's termination.

3. Among Respondent's responsibilities was the preparation of Monthly Summary Reports for residents. She was ordinarily expected to prepare two summaries each shift. She did not receive specific training, but was guided by a co-worker and samples.^[2]

4. At the time Respondent started working, there were overdue summaries, and that recurred later in her employment when she began to float among the floors.^[3]

5. All of the allegations arose during the last nine months of the Respondent's employment at Bywood East.

Resident #1, "LD"

6. On November 10, 1996, the chart for LD shows that Ativan was administered on three occasions within 24 hours.^[4] The Respondent recorded each entry. The physician's order for LD was for a maximum of two Ativan (Lorazepam) per 24 hours.^[5] There was no evidence that the Respondent actually administered the Ativan three times.

7. On August 3, 1996, a Monthly Summary Report was prepared by Bonnie Johnson, an LPN at Bywood East.^[6] On September 15, 1996, the Monthly Summary Report was prepared by the Respondent.^[7] The two monthly summaries are virtually identical. The chart notes from August 3 to September 15 do not show any information that was incorrectly included or excluded from the September 15 monthly report.^[8]

8. On October 7, 1996, the Respondent prepared the next Monthly Summary Report. It was virtually identical to the report prepared in September.^[9] The chart notes from September 15 to October 7 do show that LD had a nosebleed on September 30^[10] but the incident was not significant enough to be recorded in the monthly summary. The chart notes do not show any other information that was incorrectly included or excluded from the October 7 report.^[11]

9. On November 4, 1996, the Respondent prepared the next Monthly Summary Report. It was virtually identical to the report prepared in September and October.^[12] The chart notes do not show any information that was incorrectly included in or excluded from the November 4 report.^[13]

10. The Board's expert, Chere L. Rikimoto, R.N., asserted that LD had a vision impairment that should have been recorded, but the Director of Nursing, Mary Louise Lundquist, disagreed that LD had any significant vision impairment. Also, Ms. Rikimoto noted that the charts reflect that LD is restless at night and does not sleep well. This is reflected on the Night Chart Summaries.^[14] Although this is not included in the monthly summary reports prepared by the Respondent, it is also missing from the monthly summary reports prepared by others for August and December. The evidence was inconclusive about the significance of reflecting the restlessness only in the Night Summaries.^[15]

Resident #2, "LW"

11. The Respondent prepared a monthly summary report dated March 30, 1997 for LW. In the narrative, Respondent stated *inter alia* that the patient "is no longer toileted because he is bed bound and does not ambulate."^[16] When describing the patient's transferring and walking, the report states the patient needs and receives assistance from two persons or a mechanical device. These statements are not inconsistent.

12. In the same monthly report, the Respondent stated under "Tube feedings", "No". This was an error since the record is clear that LW required tube feedings. The monthly report contains several references in the narrative to the patient's reliance on tube feeding. Under "Eating", the entry states: "Needs and receives total feeding from another person, tube feeding, or intravenous feeding." Under "Special Treatments", tube feeding is listed. The Documentation comments state: "[LW] has a Gastronomy Tube and receives all meds, food, and water per the tube."^[17]

Resident #4, "EM"

13. Resident #4 had necrotic areas on her toes and other skin breakdown requiring daily care.^[18] This can be a serious condition and requires careful monitoring.^[19]

14. The monthly summary prepared by the Respondent on May 11, 1997 refers generally to decubiti and regular, routine skin care. It also references two small decubiti on the coccyx, but does not make special mention of the necrotic areas on the toes.^[20] There are notations about toe care in the nurses' notes for April 9, May 1 and 2, although it appears that routine care was provided, as set forth in the care plan.^[21] It cannot be determined from the record if the failure to specifically mention the toes in the monthly summary violates the minimum standards for acceptable documentation since there was no change in the patient's condition or care plan and both were referenced in the summary. Similarly, the patient had a blister on her knee during the period covered by the report. The Director of Nursing stated that she would not fault a nurse for failing to refer to the blister in the monthly report since the blister had fully healed by the time the report was prepared.^[22]

15. On April 22, 1997, within the period covered by the same report, EM had laser eye surgery.^[23] Her recovery was routinely followed in the nurses' notes, including reference to the patient's continued pain on May 4, 1997,^[24] and redness through May 5, 1997.^[25] On May 8, it is charted that the patient is having no continued redness or pain.^[26] There is no reference in the monthly report to the eye surgery or monitoring of the eye during the month.

Resident #5, "PC"

16. From April 6 through May 21, 1997, there are numerous references in the nurses' notes to PC talking or laughing to herself.^[27] The Respondent prepared the Monthly Summary Report dated May 22, 1997.^[28] Despite the repeated references in

the patient's chart, the summary report states: "Haldol is presently 2MG @ hs with no abnormal behaviors noted, (talking and/or laughing to herself)."^[29] The Respondent explained that she had not actually observed PC talking or laughing to herself during the shifts that she had worked, and therefore did not include it. PC's behavior was significant and repeatedly referenced.

Resident #6, "MA"

17. On May 24, 1997, MA was brought up from the dining room because she was not feeling well. The Respondent determined that she had a temperature of 102.9 degrees, and at around 5:00 p.m., according to standing orders, gave the patient acetaminophen, and called the patient's doctor. A second call was placed to the doctor at 6:15 p.m., and to his answering service at 7:00 p.m. Soon thereafter, the doctor returned the call and ordered administration of an antibiotic, which was administered. At 10:25 p.m., the patient had a temperature of 102.7. At 10:55, the Respondent spoke with the doctor about the results of tests that had been administered to the patient, and discussed the patient's care. At 12:35 a.m. on May 25, the nursing staff was in contact with the doctor again because of the patient's continuing poor condition, and the doctor ordered the patient to be sent to Unity hospital. Acetaminophen was administered prior to the patient's departure for the hospital by ambulance.^[30]

18. There was a standing order to provide acetaminophen every 4 hours to a patient with a temperature over 101 degrees.^[31] However, no acetaminophen was administered between 5:00 p.m. and 12:35 a.m.

19. The Director of Nursing testified that the Respondent should have followed the standing orders and continued to provide acetaminophen every 4 hours, and failed to do so. Her opinion is further supported by the Board's expert, Ms. Rikimoto. The Respondent maintains that once the doctor was contacted and prescribed an antibiotic that the doctor's order overrode the standing order and she should not have administered additional acetaminophen without specific orders. Neither Ms. Lundquist nor Ms. Rikimoto agree. In their professional opinion, acetaminophen should have been given every four hours, and knowledge of the correct use of acetaminophen with antibiotics is expected of an LPN. The standing orders do state that in emergencies, the doctor will be contacted,^[32] as was done in this case.

20. The minimum standard of acceptable and prevailing nursing practice is to follow a standing order to administer acetaminophen every four hours to a resident with a temperature above 101 degrees.

Resident #7

21. On June 21, 1998, the Respondent was employed at Lyngblomsten Care Center. She had been assigned by a temporary agency to provide nursing services, and was assigned to pass medications to a group of patients. Kristine Rogers, R.N., was the house supervisor on duty during the Respondent's shift, with overall responsibility for the care of the patients and supervision of the staff.^[33]

22. A disagreement arose between the Respondent and the nursing staff concerning Lyngblomsten's policy on administration of insulin. The policy was that all insulin would be double-checked by a second nurse prior to administration. The Respondent was not aware of the policy, and was upset when it was brought to her attention, believing that she had been singled out for extra oversight because of her race. Ms. Rogers explained the policy to her, and provided some additional orientation to the Respondent.^[34]

23. Later in the morning, Ms. Rogers overheard a patient telling the Respondent that the patient had not received her insulin before breakfast, as ordered. Ms. Rogers claims that the Respondent told the patient that the insulin had been discontinued; the Respondent denies it. The medication sheets did not indicate if insulin had been given as ordered. Ms. Rogers and the Respondent disagreed about what had transpired and whether the patient did in fact receive the insulin. The Respondent had initialed the medication administration record for other medications administered that morning, but had not initialed the insulin.^[35] The physician was called and an insulin dosage administered at 10:30 in the morning.^[36] Either the medication was not administered before breakfast, or it was not correctly charted. The minimum standard of acceptable and prevailing nursing practice is to administer insulin at the time ordered and accurately chart its administration.

24. Medication for two other patients was not administered to them as ordered on that same morning.^[37] There is a dispute about why the medications were not given. The evidence is inconclusive about whether this violated minimum standards of acceptable and prevailing nursing practice.

25. Any finding of fact more properly termed a conclusion is hereby adopted as a conclusion.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Board of Nursing and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 14.50, 148.261 and 214.10 (1998).
2. The Board has given proper notice of the hearing in this matter and has fulfilled all relevant substantive and procedural requirements of law and rule.
3. By improperly charting the administration of Ativan for Resident #1, the Respondent failed to meet minimum standards for acceptable documentation and management of medical records, in violation of Minn. Stat. § 148.261, subd. 1(15).
4. By failing to include Resident #4's eye surgery in the Monthly Summary Report, the Respondent failed to meet minimum standards for acceptable documentation and management of medical records, in violation of Minn. Stat. § 148.261, subd. 1(15).

5. By incorrectly stating in the Monthly Summary Report that Resident #5 had “no abnormal behaviors (talking and/or laughing to herself)”, the Respondent failed to meet minimum standards for acceptable documentation and management of medical records, in violation of Minn. Stat. § 148.261, subd. 1(15).

6. By failing to administer acetaminophen every four hours to Resident #6, as directed in the doctor’s standing order, the Respondent failed to meet minimum standards of acceptable and prevailing nursing practice, in violation of Minn. Stat. § 148.261, subd. 1(6).

7. By failing to properly administer insulin and chart its administration to Resident #7, the Respondent failed to meet minimum standards of acceptable and prevailing nursing practice in violation of Minn. Stat. § 148.261, subd. 1(6) and improperly documented records in violation of Minn. Stat. § 148.261, subd. 1(15).

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

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RECOMMENDATION

IT IS HEREBY RECOMMENDED: that the Board take disciplinary action against the Respondent.

Dated this 12th day of January, 2001

S/ Beverly Jones Heydinger

BEVERLY JONES HEYDINGER
Administrative Law Judge

Reported: Six Tapes

NOTICE

Pursuant to Minn. Stat. § 14.62, subd. 1 (2000), the Board is required to serve its final decision upon each party and the Administrative Law Judge by first class mail.

MEMORANDUM

The burden of proof is on the Complaint Resolution Committee to establish violations of the professional licensing standards by a preponderance of the evidence. Allegations attacking a person's professional and personal reputation and character must be carefully considered, and because of the gravity of the decision to be made, the evidence weighed in the balance must have "heft".^[38] Although hearsay is admissible in administrative proceedings, hearsay evidence alone must be carefully considered if it is the sole basis for the allegation of professional misconduct.

Accurate, thorough charting is very important to providing quality medical care and to assuring that each caregiver is fully informed about the patient's medical history and current status. Charting errors must be considered in that light. Ordinarily medication errors are serious. In this case, there are instances where either there was a medication error, or a mistake with the charting. In those instances, even if the error was in the charting, it is a significant error that could compromise the patient's treatment because it could mislead other caregivers.

For example, Resident #1 was prescribed two administrations of Ativan per day, as needed. Three were charted on November 10, 1996. If three were administered, it would be a significant medication error. The Complaint Review Committee provided no evidence that three doses were administered. The Respondent testified that she was not certain whether she had improperly administered the medication three times or incorrectly charted the dosages administered. Given that the Committee bears the burden of proof, one can conclude only that a charting error was made.

The same type of mistake occurred with administration of insulin to Resident #7, but in this instance, the failure to administer medication was consistent with the resident's claim that she had not received it. Even if the insulin was given, but not recorded, it was a significant charting error that could adversely effect the resident's care and mislead other care providers, as is apparent from the confusion surrounding Resident #7's insulin and the decision to administer insulin at an unscheduled time.

The Respondent's failure to include eye surgery in the monthly summary prepared on May 11, 1997 for Resident #4 is significant. The surgery and follow-up care were regularly charted for several days, and the occurrence of surgery is sufficiently significant to warrant inclusion in the monthly medical history. Respondent's incorrect statement that Resident #5 had no abnormal behaviors during the period covered by the report dated May 22, 1997 was also significant because it could mislead caregivers referring to the report for accurate information about the resident's condition.

However, some of the charting errors included in the allegations against the Respondent were minor and would have had no possible detrimental effect on the patient's care. The duplication of the monthly summary reports for Resident #1 is in this category. It is clear that the reports were copied verbatim, but the Committee did not

prove any significant omission or inclusion that would have adversely affected the resident's care. Any mistakes in the monthly report for Resident #2 were inconsequential, when taken in the context of the report as a whole. No care giver reading and relying on the report for a synopsis of the resident's condition would have been either misled or confused by the mistake. Failure to mention one nosebleed for Resident #1 and a healed blister for Resident #4 seem similarly insignificant.

The Committee proved that failure to administer acetaminophen to Resident #6 every four hours violated the standards of acceptable and prevailing nursing practice. However, the violation should be placed in context. It is clear that the Respondent was closely attending to and monitoring the resident's care, that the doctor was called immediately to get clear direction, and called again when the resident's condition seemed to deteriorate. Also, a registered nurse was on duty and aware of the resident's condition and care.

The Respondent correctly stated that standing orders could be discontinued at the nurse's discretion if not used in the prior 60 days,^[39] but that would have no application to these facts since acetaminophen had been administered at approximately 5:00 p.m. on May 24.

Although the Respondent did not administer medications as directed at Lyngblomsten Care Center on June 21, 1998, the committee failed to prove that Respondent violated minimum standards of acceptable and prevailing practice. She was assigned to work at Lyngblomsten by a temporary agency, and it is unclear whether she had passed medications there previously, whether she received orientation or was familiar with the facility's practices. At least some of the patients were at church, and there was no evidence of when or how frequently the medications were to be administered. Thus, the evidence did not support a conclusion that minimum standards were not met.

The Respondent was not an entirely credible witness. She was somewhat evasive in her answers, guarded and defensive. She did make some errors in charting, some of which were not significant. Her attempts to rationalize insignificant errors detracted from her credibility. For example, Respondent tried to rationalize her error on Resident #2's monthly summary, claiming that she had seen LW receive some food by mouth. This is inconsistent with the other entries on the monthly report and the doctor's orders^[40] and is not credible. The Complaint Resolution Committee's decision to pursue some minor charting errors or inconsistencies may have contributed to the Respondent's defensiveness, but does not fully justify her refusal to acknowledge the errors she made.

BJH

^[1] Testimony of Nell Egi.

^[2] Testimony of N. Egi.

- [\[3\]](#) Id.
- [\[4\]](#) Ex. C-53, showing administration at 4 p.m. 10 p.m. and 10:35 p.m.
- [\[5\]](#) Ex. C-52.
- [\[6\]](#) Ex. C-92-94.
- [\[7\]](#) Ex. C-88-90.
- [\[8\]](#) See chart entries, Ex. C-39-49.
- [\[9\]](#) Ex. C-85-87.
- [\[10\]](#) Ex. C-38,
- [\[11\]](#) Ex. C-34-39.
- [\[12\]](#) Ex. C-81-83.
- [\[13\]](#) Ex. C-30-34.
- [\[14\]](#) Ex. C-84, 91.
- [\[15\]](#) Ex. C-78-80. 92-94.
- [\[16\]](#) Ex. D-54.
- [\[17\]](#) Ex. D-53,54.
- [\[18\]](#) Ex. F-20-21.
- [\[19\]](#) Test. of Rikimoto.
- [\[20\]](#) Ex. F-42-44.
- [\[21\]](#) Ex. F-31, 27; F-21.
- [\[22\]](#) Test. of Lundquist.
- [\[23\]](#) Ex. F-28.
- [\[24\]](#) Ex. F-27.
- [\[25\]](#) Ex. F-26.
- [\[26\]](#) Id.
- [\[27\]](#) Ex. G-17-22.
- [\[28\]](#) Ex. G-29-31.
- [\[29\]](#) Ex. G-30.
- [\[30\]](#) Ex. H- 22-25.
- [\[31\]](#) Ex. H-33.
- [\[32\]](#) Ex. H-34.
- [\[33\]](#) Testimony of K. Rogers and N. Egi.
- [\[34\]](#) Id.; Ex. 7.
- [\[35\]](#) Ex. 8-3.
- [\[36\]](#) Ex. 8-2-4.
- [\[37\]](#) Test. of K. Rogers; Ex. A-42-43.
- [\[38\]](#) In the Matter of Wang, 441 N.W.2d 488, 492 (Minn. 1989).
- [\[39\]](#) See Ex. H-34.
- [\[40\]](#) Ex. D-2.