



KANSAS

Filed

JUL 15 2005

Board of Nursing

KANSAS STATE BOARD OF NURSING
MARY BLUBAUGH MSN, RN, EXECUTIVE ADMINISTRATOR

KATHLEEN SEBELIUS, GOVERNOR

July 15, 2005

Kathryn Ashford
206 East St
Topeka, KS 66749

Case 01-505-6, 01-034-6, 99-691-6, 99-597-6

SUMMARY ORDER

Dear Ms. Ashford:

The Disciplinary Committee of the Kansas State Board of Nursing has reviewed your application materials and on behalf of the Board members I am denying your reinstatement application to practice nursing as a registered nurse (R.N.) in Kansas. This denial is based upon the following:

FINDINGS OF FACT

1. Respondent has submitted an application for a reinstatement of her nursing license received by the Board 5/11/2005.
2. Respondent was originally licensed in 1987. She purposefully allowed her license to lapse 7/31/2002 while Case 01-505-6 was being resolved.

Case 99-597-6

3. Respondent has a history investigative cases with the board. On or about 6/14/1999 a patient was banging on the Locked Room Restriction door. When the respondent approached the patient from the outside of the door and asked the patient to stop banging the patient would stop. As soon as the respondent would leave the door the patient would start banging again. The respondent did not attempt to see why the patient was banging or open the door to check on the patient. No other interventions were initiated. The patient had been banging her head and as a result the patient had swelling, bruising around her right eye and complained of pain. The respondent failed to assess the patient. The Investigative committee inactivated the case but noted the file could be reopened in the event of future incidents.

Case 99-691-7

4. On or about 8/4/1999 the respondent was developing a personal, non-therapeutic relationship with a mental patient under her care as a nurse at Osawatomie State Hospital, Osawatomie, KS. The staff found poetry, a note, a greeting card, and a photograph from the respondent. The respondent was required to complete three hours of CNE on "Nursing Ethics" and three hours of CNE on "Professional Boundaries regarding patient/nurse". The CNE were received on 8/23/2000.

Case 01-034-6

5. On or about 12/31/2000 at approximately 1555 a resident approached the nurses' desk in her wheelchair to receive her 1600 pain medication. The respondent asked the resident what she wanted and the resident said she was waiting for her pain pill. The respondent was heard telling the resident "you are always sick. If it weren't for you people I could be out partying." The resident responded "then go." At approximately 1645-1700 the respondent approached the resident in the dining room. Words were exchanged between them. The resident stated that the respondent slammed down a utility container holding blood sugar supplies and medications were knocked over on the table. The resident further stated the respondent did not like the way she grabbed a cotton ball to wipe her finger. At that point the respondent became nasty and told the resident she was taking her out of the dining room. The resident said "no your not" and grabbed hold of the table and would not let go. The respondent attempted to pull the wheelchair away from the table and was unsuccessful. The respondent then left the room. The respondent was terminated for verbal abuse. The Board asked her complete six hours of CNE on "Stress Management". The CNE were received by the Board 6/28/2001.

Case 01-505-6

6. On or about 7/13/2000, respondent was employed as an RN at Pinecrest Nursing Home, Humboldt, Kansas. A resident, Ms. PS was in pain and had a fecal impaction. The resident's husband was trying to remove it. The spouse asked two aids for help and both said they would get the respondent. The respondent did not go to the room and finally the spouse removed the impaction. The resident's husband left the facility 30 minutes later and at that time the respondent had still not assessed the patient. The respondent was sitting at the nurses' station when he left. The nurse aid heard the respondent say, "His fingers are longer than mine. If he can't get it out I can't." The respondent failed to assess the patient.

CONCLUSIONS OF LAW

7. K. S. A. 65-1120(a) provides that it is a ground for denial of a license if the applicant is found to be guilty of violating the nurse practice act. The above incidents established evidence that the respondent violated:

K.S.A. 65-1120 (a) (3) to have committed an act of professional incompetency as defined in subsection (e); *Professional incompetency defined.* As used in this section, "professional incompetency" means: (1) One or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes gross negligence, as determined by the board;

K.S.A. 65-1120 (a) (3) to have committed an act of professional incompetency as defined in subsection (e); *Professional incompetency defined.* As used in this section, "professional incompetency" means: (3) a pattern of practice or other behavior which demonstrates a manifest incapacity or incompetence to practice nursing.

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;

K.S.A. 65-1120(a)(6), unprofessional conduct by K.A.R. 60-3-110 (e) 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. This term may include any of the following: (3) 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;

K.S.A. 65-1120 (a) (3) to have committed an act of professional incompetency as defined in subsection (e); *Professional incompetency defined.* As used in this section, "professional incompetency" means: (2) repeated instances involving failure to adhere to the applicable standard of care to a degree which constitutes ordinary negligence, as determined by the board;

8. K.S.A. 77-511(a)(2)(a) of the Kansas Administrative Procedure Act authorizes the use of summary proceedings by a state agency when denying an application.
9. Your conduct described herein violated the Kansas Nurse Practice Act.
10. If the information provided is incorrect, or if you wish to dispute this matter, please let us know immediately by following the procedure for requesting a hearing. A copy of your application will be sent to you upon request.
11. 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 above, this Summary Order becomes effective and final upon the expiration of the time for requesting a hearing.


Kelly Arpin, L.P.N.
Board Member

CERTIFICATE OF SERVICE

I certify that on the 15th day of July, 2005, 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:

Kathryn Ashford
206 East St
Topeka, KS 66749

Betty Wright, Assistant Attorney General
Kansas State Board of Nursing
900 SW Jackson, Ste 1051
Topeka KS 66612-1230
785-296-7047
