

Before the
Administrative Hearing Commission
State of Missouri



STATE BOARD OF NURSING,)	
)	
Petitioner,)	
)	
vs.)	No. 10-1846 BN
)	
VERNALISA WYATT,)	
)	
Respondent.)	

DECISION

We find cause exists to discipline the licensed practical nursing license of Vernalisa Wyatt because she abused and neglected a resident in her care and was placed on the Employee Disqualification List.

Procedure

On September 21, 2010, the State Board of Nursing (“the Board”) filed its complaint asking this Commission to find that cause exists to discipline Wyatt’s license as a Licensed Practical Nurse (“LPN”). After numerous unsuccessful attempts to notify Wyatt and serve her, we held a hearing on April 20, 2012 after notice by publication. Wyatt did not attend the hearing. Before a decision was reached, Wyatt contacted this Commission and requested a new hearing. We granted her request and a new hearing was held on November 5, 2012. Rodney P.

Massman represented the Board, and Wyatt represented herself. The matter became ready for our decision on March 6, 2013, when Wyatt's written argument was due.

Findings of Fact

1. The Board is an agency of the State of Missouri created and established by Missouri law for the purpose of executing and enforcing Chapter 335¹, the Nursing Practice Act.

2. Wyatt is licensed by the Board as an LPN. Wyatt's license was current and active at all times relevant to this action. However, Wyatt's license lapsed on May 31, 2010.

3. At all times relevant to this action, Wyatt was employed by Myers Nursing Home ("the Facility") in Kansas City, Missouri as an LPN/charge nurse. The responsibilities of a charge nurse include making the rounds of the residents in between the certified nurse's aide's (CNA) rounds and assessing their condition; giving medications to residents as ordered or required and charting the administration of medications; and notifying the doctor when a resident has problems.

4. Doreen Crutchfield is the Administrator of the Facility. She conducted the Facility's investigation into allegations of abuse and neglect against Wyatt and terminated Wyatt's employment at the Facility after the investigation substantiated the allegations. Crutchfield was employed there at all relevant times, but failed to discover or address Wyatt's verbally abusive conduct at issue in this case prior to the death of a resident.

A.I.

5. On December 6-7 2007, Wyatt was working the 11 pm to 7 am shift at the Facility.

6. One of the residents whose care Wyatt was responsible for on that shift was A.I.

¹ Statutory references, unless otherwise noted, are to the 2012 Supplement to the Revised Statutes of Missouri.

7. A.I. had had symptoms of vomiting and nausea for several days prior to December 6, 2007. His doctor had ordered anti-nausea medication and insulin for his diabetes.

8. During the early morning hours of December 7, 2007, A.I.'s condition deteriorated.

9. A.I.'s roommate, P.K., and a CNA on duty with Wyatt were concerned with A.I.'s condition and asked Wyatt to check on him several times.

10. Wyatt waited more than two hours before checking on A.I. She did not check on him regularly, and she failed to assess his deteriorating health condition. She did not give A.I. any of the medications ordered by the doctor, and she did not notify the doctor or send A.I. to a hospital for evaluation.

11. Wyatt made only one entry on A.I.'s chart at 2 am on December 7, 2007 that he was complaining of an upset stomach.

12. Shortly after 7 am on December 7, 2007 A.I. was found in his room by the morning charge nurse. A.I. had fallen over on his bed and was unresponsive.

13. A.I. died a short time later, before emergency personnel arrived and before he could be transported to a hospital.

Other Residents

14. At least 15 residents of the Facility reported that Wyatt used abusive language toward them and refused to meet their needs in a timely manner, including administering their medications.

Investigation and Discipline by the Facility and DHSS

15. On January 4, 2008, Wyatt was placed on immediate suspension from the Facility for at least five days pending the outcome of an investigation. The investigation was initiated in response to a report by a Missouri Department of Health and Senior Services ("DHSS") survey

team that happened to be in the Facility conducting an audit, who were told about incidents involving Wyatt by residents of the Facility.

16. On January 8, 2008 Wyatt's employment at the Facility was terminated after the investigation substantiated allegations of neglect and abuse.

17. On September 4, DHSS completed a complaint investigation at the Facility. This investigation was also in response to the allegations of neglect and abuse reported by the survey team.

18. On September 5, 2008, a Notice of Violation was sent to Wyatt in which DHSS proposed to place Wyatt on the Employee Disqualification List ("the EDL") for a period of three years.

19. On February 20, 2008, DHSS issued a Decision and Order finding that Wyatt "recklessly neglected a resident of a licensed facility while employed at that facility" and ordering that her name be placed on the EDL.

20. On March 25, 2009, Wyatt was placed on the EDL for a period of three years after the investigation conducted by DHSS.

The Board's Investigation and Complaint

21. On September 8, 2008, the Board received a letter from DHSS informing the Board of the results of its investigation of the allegations of abuse and neglect made against Wyatt and that Wyatt was being referred to the EDL.

22. The Board conducted an investigation into the allegations of abuse and neglect involving A.I. and verbal abuse of other residents.

23. On September 21, 2010 the Board filed a complaint with this Commission asking that we find that cause exists to discipline Wyatt's license.

Conclusions of Law

We have jurisdiction to hear the complaint.² The Board has the burden of proving that Wyatt has committed an act for which the law allows discipline.³ The Board argues that there is cause for discipline under section 335.066:

2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:

* * *

(5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096;

* * *

(12) Violation of any professional trust or confidence;

* * *

(15) Placement on an employee disqualification list or other related restriction or finding pertaining to employment within a health-related profession issued by any state or federal government or agency following final disposition by such state or federal government or agency.

I. Credibility

This Commission must judge the credibility of witnesses, and we have the discretion to believe all, part, or none of the testimony of any witness.⁴ When there is a direct conflict in the testimony, we must make a choice between the conflicting testimony.⁵

² Section 621.045.

³ *Missouri Real Estate Comm'n v. Berger*, 764 S.W.2d 706, 711 (Mo. App., E.D. 1989).

⁴ *Harrington v. Smarr*, 844 S.W.2d 16, 19 (Mo. App., W.D. 1992).

Other than Wyatt's belated testimony at the second hearing, the evidence in this case consists primarily of the investigative reports of the Facility, DHSS and the Board, and DHSS' Decision and Order placing Wyatt on the EDL. Although Crutchfield testified at both hearings, she had little firsthand knowledge of the incidents that led to Wyatt's termination and placement on the EDL. Crutchfield's competence was also questioned for her failure to discern patient verbal abuse alleged by her and the Facility against Wyatt. Either she was indifferent to the conduct, or critically incapable of talking with any of the 15 patients that complained about Wyatt. As such, her testimony has low credibility, but when compared with the utter lack of evidence presented by Wyatt, it allows the Board to meet its burden in this case. Pro se litigants should not confuse 'telling of their story' with the presentation of cogent evidence in an organized manner for the Commission. The reports of these three separate investigations, which were replete with all sorts of hearsay, were admitted into evidence without objection. They reached the same conclusion – that competent evidence existed to substantiate the allegations of abuse and neglect against Wyatt.

Wyatt's oral and written testimony was inconsistent with and contradicted almost all of the other accounts of the events in question in many respects. Wyatt maintains that the residents and staff who spoke to investigators were lying, that many of the residents were abusive to her, and that Crutchfield, who testified, had it in for her. Although Wyatt stated in each investigation that she had proof and witnesses, she failed to produce any documents, witnesses or witness statements in support of her version of the facts.

II. Subdivision (5) Professional Standards

The Board alleges that Wyatt's conduct constitutes misconduct, misrepresentation, gross

⁵844 S.W.2d at 19.

negligence and incompetency in the performance of her duties as an LPN.

Incompetency is a general lack of professional ability, or a lack of disposition to use an otherwise sufficient professional ability, to perform in an occupation.⁶ We follow the analysis of incompetency in a disciplinary case from the Supreme Court, *Albanna v. State Bd. of Reg'n for the Healing Arts*.⁷ Incompetency is a “state of being” showing that a professional is unable or unwilling to function properly in the profession.⁸

Gross negligence is a deviation from professional standards so egregious that it demonstrates a conscious indifference to a professional duty.⁹ Expert testimony is required to establish the standard of care and that the conduct of the professional violated that standard of care.¹⁰

Misconduct means “the willful doing of an act with a wrongful intention[;] intentional wrongdoing.”¹¹ Misrepresentation is falsehood or untruth made with the intent and purpose of deceit.¹²

The Board failed to introduce testimony from an expert to substantiate a breach in the standard of care. Without that testimony, we will not conclude that gross negligence is a basis for discipline. Misconduct, however, can be shown for the licensee’s “indifference to the natural consequences” of her conduct. Wyatt’s multiple separate acts of refusing the requests of health care professional and patient by not checking on A.I., refusing to administer his medication or assess him, and her abusive behavior towards residents constitute misconduct.

⁶ *Tendai v. Missouri State Bd. of Reg'n for the Healing Arts*, 161 S.W.3d 358, 369 (Mo. banc 2005).

⁷ 293 S.W.3d 423 (Mo. banc 2009).

⁸ *Id.* at 435.

⁹ *Id.* at 533.

¹⁰ *Luscombe v. Missouri State Board of Nursing*, WD75049 (Ct. App., W.D., January 8, 2013).

¹¹ *Missouri Bd. for Arch'ts, Prof'l Eng'rs & Land Surv'rs v. Duncan*, No. AR-84-0239 (Mo. Admin. Hearing Comm'n Nov. 15, 1985) at 125, *aff'd*, 744 S.W.2d 524 (Mo. App., E.D. 1988).

¹² *Id.* at 794.

Despite being told by at least three people that A.I. was in distress and being urged to check on him, Wyatt did not check on A.I. more than twice in eight hours and did not monitor or assess his apparently deteriorating condition or administer any medication to alleviate his suffering. She made only one entry on A.I.'s chart at 2 am that he was complaining of an upset stomach. Wyatt's refusal to check on A.I. regularly during her shift to assess his condition, and her refusal to administer any medications to A.I. or to notify the doctor of his declining condition, demonstrate a conscious lack of concern for the serious risk to A.I.'s welfare and an intent not to care for the duties and lives entrusted to her. Wyatt's history of verbal abuse of residents while she was supposed to be providing care is further evidence of Wyatt's unwillingness to function properly as an LPN.

Wyatt committed misconduct. There is cause for discipline under § 335.066.2(5).

III. Subdivision (12) Professional Trust

The Board argues that Wyatt violated a professional trust or confidence. Professional trust is reliance on the special knowledge and skills that professional licensure evidences.¹³ It may exist not only between the professional and his clients, but also between the professional and his employer and colleagues.¹⁴

DHSS' Decision and Order found that as charge nurse, Wyatt was responsible for A.I.'s care and had a duty to provide reasonable and necessary services to ensure his welfare. A.I. and the Facility had reasonable expectations that Wyatt would follow doctors' orders on administering medication to A.I. and properly monitor or assess A.I.'s condition. The residents and the Facility had reasonable expectations that Wyatt would provide proper care and treatment to the residents and treat them with respect. Wyatt violated professional confidence when she

¹³ *Trieseler v. Helmbacher*, 168 S.W.2d 1030, 1036 (Mo. 1943).

¹⁴ *Cooper v. Missouri Bd. of Pharmacy*, 774 S.W.2d 501, 504 (Mo. App., E.D. 1989).

failed to use her special knowledge and skills as an LPN to provide the reasonable and necessary services to ensure A.I.'s welfare and when she used foul language toward the residents.

There is cause for discipline under section 335.066.2(12).

III. Subdivision (15) Employee Disqualification List

Pursuant to §§ 197.500 and 660.300, DHSS maintains a list of individuals who have been determined to have abused or neglected a patient, resident or consumer, among other offenses. The acts must have occurred while the individual was employed at a long-term care facility or certain other entities. Pursuant to § 660.315, no person whose name appears on the EDL may be employed by a health care provider.

The DHSS Decision and Order placing Wyatt on the EDL found that there was sufficient evidence that Wyatt "recklessly neglected" A.I. That Decision and Order and the investigative report it was based on were entered into evidence without objection at the hearing on the Board's complaint. Wyatt admits that she was placed on the EDL as a result of her conduct involving A.I.

Section 335.066.2(15) clearly states that a nurse may be disciplined for being placed on this list. Nothing in that subsection requires that discipline cannot occur after the nurse's time period on the list has expired; it is placement on the list that triggers the possibility of discipline.

Even if Subsection (15) could be read to require that discipline can only be imposed while the nurse is on the EDL, Wyatt is precluded from using the timing of these proceedings as a defense because her own conduct caused unnecessary delay. The Board filed its complaint seeking discipline on September 21, 2010, well within the three-year period imposed by DHSS. Wyatt was aware that there was a pending disciplinary action by the Board. She claims she never received notice of the Board's complaint until after the first hearing. Wyatt testified,

however, that she does live at the address where correspondence from this Commission was sent by certified mail twice, and returned as unclaimed, and where the Board made multiple good faith attempts to have her served. If Wyatt had not avoided personal service, the hearing would have been held almost a year before the three-year period expired.

There is cause for discipline under § 335.066.2(15).

Summary

We find cause exists to discipline Wyatt under § 335.066.2 (5), (12) and (15).

SO ORDERED on September 12, 2013.

\s\ Nimrod T. Chapel, Jr.
NIMROD T. CHAPEL, JR.
Commissioner