STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATE OF NEBRASKA ex rel. MICHAEL T. HILGERS, Attorney General, Plaintiff, vs. SCHNEIDERS, CURLEE, Defendant.	240960 LPN FINDINGS OF FACT AND CONCLUSIONS OF LAW; ORDER

STATEMENT OF THE CASE

A Petition for Disciplinary Action and Temporary License Suspension was filed in this matter on July 24, 2024, alleging that Defendant, Curlee Schneiders, practiced her profession with gross incompetence and/or gross negligence, and committed various acts of unprofessional conduct. On July 26, 2024, an Order for Temporary Suspension was entered against the Defendant's practical nurse license.

SUMMARY OF THE HEARING

A hearing was held in this matter on October 31, 2024, January 21, 2025, and January 22, 2025, in Lincoln, Nebraska, before Susan Strohn and Robert E. Harkins, DHHS Hearing Officers. Jeanne Burke and Mindy Lester, Assistant Attorneys General, appeared on behalf of the State of Nebraska. Defendant appeared with her counsel of record Julie Jorgensen. Testimony and exhibits were received into evidence.

The Hearing Officer makes the following proposed Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Proper notice of this hearing was provided to the parties.

2. On December 8, 1995, DHHS issued single state Practical Nurse License #16144 to Defendant. Defendant's license is currently suspended pursuant to an Emergency Suspension Order.

3. At all times relevant to these proceedings, Defendant was employed as a licensed practical nurse at the Eastern Nebraska Veteran's Home ("E.N.V.H.") in Bellevue, Nebraska. The

Defendant's job description required her to direct and monitor the care provided by certified nursing assistants (CNAs) consistent with each resident's plan of care.

4. On or about June 1, 2024, to June 2, 2024, Defendant was on duty as the charge nurse in E.N.V.H.'s Motivation Unit from 6:00 p.m. to 6:00 a.m.

5. A video recording from the Motivation Unit's surveillance cameras revealed the following:

a. At approximately 1:15 a.m. on June 2, 2024, the Defendant is seen seated at the nursing station desk wearing wired earphones connected to her personal cell phone in violation of E.N.V.H.'s policy prohibiting employee use of personal cell phones in member care areas. At the administrative hearing, Defendant testified that at that time she was listening to the news on her phone while completing charting duties.

b. At approximately 1:16 a.m., E.V.M. ("CNA 1"), an experienced CNA who was working her first shift in the Motivation Unit after completing new employee orientation, can be seen wheeling E.N.V.H. Resident F.H. into the Motivation Unit's dayroom, approximately fifteen (15) feet from the Defendant's seated position at the nursing station. F.H. was a 76-year-old non-ambulatory vulnerable adult Vietnam veteran diagnosed, inter alia, with dysphagia (i.e., difficulty swallowing), vascular dementia, COPD, and bipolar disorder. In addition, F.H. had a standing medical order for a soft mechanical diet. Defendant had worked at the E.N.V.H. for approximately five (5) years and was aware of F.H.'s medical condition and diagnoses.

c. At approximately 1:20 a.m., CNA 1 leaves the dayroom to get a sandwich for F.H. per Defendant's request. In a subsequent interview with a DHHS Investigator, CNA 1 stated Defendant never mentioned F.H.'s special diet or advised F.H. was a choking hazard. CNA 1 also advised Defendant never checked to see if the sandwich she provided F.H. complied with F.H.'s dietary restrictions. It was later determined F.H. was not wearing his dentures at the time of this incident.

d. At approximately 1:22 a.m., CNA 1 provided F.H. with a turkey and cheese sandwich. A subsequent investigation established the sandwich provided to F.H. was labelled a "regular" sandwich contraindicated by F.H.'s mechanical soft diet. A few moments after providing F.H. a sandwich, CNA 1 leaves the dayroom, leaving Defendant as the only staff member present. At this time, F.H. is seated in his wheelchair with his back to Defendant and commences to eat the sandwich.

The surveillance video continues to show Defendant looking down at her cellphone, using wired earphones. At the time of this incident, the E.N.V.H. had a Dysphagia Management Policy that required nursing staff to observe all members at mealtime for signs and symptoms of dysphagia, which include coughing or choking.

e. From approximately 1:25 a.m. to 1:28 a.m., F.H. continues to eat his sandwich with his back to Defendant. During this time, Defendant continues to look down at her phone and, with the exception of a one or two second glance in Defendant's direction, fails to monitor F.H.

f. At approximately 1:28 a.m., CNA 1 returns to the dayroom, but leaves a moment later to attend to other residents. Defendant is the only staff member in the dayroom, and with the exception of a one second glance in F.H.'s general direction, she continues looking down at her phone.

g. At approximately 1:32 a.m., F.H. begins to choke. Defendant continues to look down at her cellphone while utilizing earphones and does not notice F.H.'s distress.

h. At approximately 1:33 a.m., F.H. slumps back in his wheelchair and loses consciousness. Defendant failed to look up or otherwise respond to Defendant.

i. At approximately 1:36 a.m., CNA 1 returns to the dayroom. F.H. has been unconscious for approximately three minutes and remains motionless in his wheelchair. Defendant continues looking downward at her desk and fails to notice F.H.'s condition.

j. At 1:39 a.m., CNA 2 enters the dayroom, and observed F.H. CNA 2 later advised he told CNA 1 F.H. did not appear to be breathing. Defendant remained at the nurse station desk and did not respond to F.H., who has now been unconscious for six (6) minutes.

k. At approximately 1:42. a.m., CNA 1 checks on F.H. by placing her hand on his chest and alerts Defendant, who leaves the nurse's station and helps CNA 1 place F.H. on the floor after sweeping F.H.'s mouth and removing a piece of sandwich. Defendant then returns to the nurse's station in violation of E.N.V.H.'s Emergency Response Policy, which requires the charge nurse to direct CNA staff to contact the House Supervisor and call 911, while the charge nurse performs CPR.

l. At approximately 1:43 a.m., Defendant began chest compressions. F.H. has now been unconscious for ten (10) minutes.

m. At approximately 1:52 a.m., first responders from the Bellevue Police Department and Bellevue Fire Department arrived, and attempted unsuccessfully to resuscitate F.H.

6. On or about June 2, 2024, the E.V.N.H. Medical Director reviewed the surveillance video and concluded "it appears, member [F.H.] choked on sandwich, causing choking, bronchospasms, respiratory arrest, resulting in death."

7. On June 7, 2024, E.N.V.H. staff interviewed CNA 1, who stated she believed Defendant was "facetiming" on her cell phone during incident. CNA 1 also stated she was unaware of F.H.'s physician ordered diet and conceded she did not confirm the diet orders for F.H. because "I took her [Defendant's] word for it." When asked to walk the interviewers through the E.N.V.H.'s Emergency Plan, CNA 1 responded, "I don't know. No we probably did everything wrong."

8. On June 26, 2024, a DHHS Investigator interviewed Defendant. Defendant advised she instructed CNA 1 to give F.H. a sandwich but did not specify F.H.'s dietary restrictions but told CNA 1 any liquids provided to F.H. must be thickened. Defendant stated she believed CNA 1 should have checked F.H.'s dietary restrictions before providing the sandwich. In addition, Defendant conceded she was listening to the news on her phone but denied she was "facetiming" at the time of the incident.

9. On June 26, 2024, after an internal investigation, E.N.V.H. terminated Defendant's employment for alleged incompetence, professional negligence, and unprofessional conduct.

10. On June 28, 2024, a DHHS Investigator interviewed CNA 1, who stated she was "stupid" for giving F.H. a sandwich. CNA 1 also advised Defendant never told her F.H. was a choking hazard or had a special diet and that she (CNA 1) did not check to see what type of sandwich she gave F.H.

11. At the administrative hearing, Defendant testified she assumed CNA 1 would check on her own to determine F.H.'s dietary status but added she did tell CNA 1 F.H. was a choking hazard. Defendant provided a rationale for using headphones, specifically to drown out other noise around her work station that was "giving her a headache". Defendant testified she did observe and monitor F.H. and that he did not appear to be in distress. Defendant testified there was some delay in beginning CPR because she went briefly to the nurse's station to verify F.H.'s code status. In addition, Defendant's past coworkers testified to Defendant's skill and competence as a nurse.

CONCLUSIONS OF LAW

Jurisdiction is based upon Neb. Rev. Stat. §§38-176 and 38-186. The practice of nursing is regulated under the Uniform Credentialing Act to protect the health and safety of Nebraska citizens. Neb. Rev. Stat. §38-103. A credential to practice as a practical nurse may be disciplined for "(6) Practice of the profession... (c) with gross incompetence or gross negligence"; and "(24) Unprofessional conduct as defined in section 38-179." Neb. Rev. Stat, §38-178.

Unprofessional conduct means "means any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or the ethics of the profession, regardless of whether a person, consumer, or entity is injured, or conduct that is likely to deceive or defraud the public or is detrimental to the public interest, including, but not limited to... "(17) Such other acts as may be defined in rules and regulations." Neb. Rev. Stat. §38-179. Applicable Nebraska regulations governing the practice of nursing define unprofessional conduct to include "(1) Failure to utilize appropriate judgment in administering safe nursing practice based upon the level of nursing for which the individual is licensed"; "(2) Failure to exercise technical competence based upon the level of nursing for which the individual is licensed in carrying out nursing care"; "(3) Failure to follow policies or procedures implemented in the practice situation to safeguard patient care"; "(10) Committing any act which endangers patient safety or welfare"; and "(12) Failure to exercise supervision as set in 172 NAC 99 over persons who are authorized to practice only under the direction of the licensed nurse or licensed practitioner." 172 NAC 101-006.

Registered nurses, licensed practical nurses, and licensed practitioners may provide direction in the provision and management of consumer care. The method and degree of direction may vary based upon consumer condition, the interventions to be applied, and the qualification and competency of the person providing the interventions. 172 NAC 99-005. Licensed practical nurses provide direction to unlicensed persons providing auxiliary patient care services. 172 NAC 99-005.02. A license practical nurse must exercise competence in providing and directing nursing interventions. 172 NAC 99-005.04(A). A licensed practical nurse must provide nursing interventions according to the direction and instructions identified by a registered nurse or licensed practitioner. Direction can be provided by protocols. 172 NAC 99-005.04(C). "Direction" is defined as the provision of guidance and supervision by a licensed nurse or licensed practitioner who is responsible to manage the provision of nursing interventions by another licensed or unlicensed person. 172 NAC 99-005. "Unlicensed person" is defined as a person who does not have a license to practice nursing and who functions in an assistant or subordinate role to the licensed nurse. 172 NAC 99-002.19. "Supervision" is defined as the provision of oversight, which includes maintaining accountability to determine whether or not nursing care is adequate and

delivered appropriately. 172 NAC 99-002.18. The licensed nurse is responsible and answerable for decisions and action or inaction of self or others, and for the resultant consumer outcomes related to decisions and action or inaction. 172 NAC 99-002.01.

Gross negligence is not defined in the Uniform Credentialing Act, However, the Nebraska Supreme Court has defined gross negligence as great or excessive negligence, which indicates the absence of even slight care in the performance of a duty. Youngs v. Potter, 237 Neb. 583, 467 N.W. 2d 49 (1991). It has also been defined as "the intentional failure to perform a manifest duty in reckless disregard of the consequences as affecting the life or property of another." Gross negligence definition, *Black's Law Dictionary* 717, (6th ed. 1997).

The State proved by clear and convincing evidence that Defendant practiced her profession with gross negligence or incompetence. In addition, the State proved by clear and convincing evidence that Defendant committed unprofessional conduct by failing to conform to the acceptable and prevailing practice of her profession, and by failing to conform to regulations requiring her to utilize appropriate nursing judgement, exercise technical competence, follow policies and procedures implemented to safeguard patient care, and by committing an act which endangered patient care. Finally, Defendant engaged in unprofessional conduct by failing to exercise appropriate supervision of an unlicensed CNA as required by Nebraska regulations. All of Defendant's actions, and inactions, constitute strong grounds for discipline.

The evidence established Defendant was acutely aware of F.H.'s numerous medical diagnoses and limitations, including, most importantly, dysphagia and the physician's order for a mechanical soft diet. Defendant was also aware of the E.N.V.H. policy requiring staff to observe dysphagia diagnosed residents while eating. CNA 1, while experienced, was working her first shift in the Motivation Unit, a fact also known to Defendant. Despite Defendant's knowledge, she inexplicably, and inexcusably, failed to adequately supervise CNA 1 by notifying CNA 1 of F.H.'s special dietary needs. Defendant's testimony that she advised CNA 1 that F.H. was a "choking risk" was not credible, based on her previous inconsistent statements to a DHHS Investigator, CNA 1's consistent statements to both the DHHS Investigator and E.N.V.H. staff that Defendant did not advise her of F.H.'s propensity for choking, and Defendant's inaccurate testimony that she monitored F.H.

Defendant also testified and argued she did observe F.H. while he ate the sandwich. However, the surveillance tapes entered into evidence, and played with minute detail at the administrative hearing, completely discredit this testimony. F.H. eats the sandwich for several minutes with his back towards Defendant. Defendant barely glances up from her phone, and her testimony that she was charting is dubious based on other evidence presented at the hearing.

After F.H. began choking, ten (10) agonizing minutes elapsed before Defendant or other staff under Defendant's supervision recognized F.H. was in obvious medical distress.

Defendant attempts to shift culpability for the tragic and completely preventable death of F.H. to CNA 1 is misplaced. It is clear that Nebraska regulations required Defendant to properly supervise CNA 1 as an unlicensed person. The surveillance footage shows that CNA 1 was only present in the Motivation Unit for a few minutes as she was attending to other members in their rooms. Consequently, Defendant was the only staff member who had the opportunity to adequately monitor F.H. while he ate. Defendant's two one or two second glances in the general direction of F.H. while his back was turned to her in no way constitutes "observation" even under the loosest possible definition. In short, the evidence conclusively established Defendant acted with wanton disregard of the duty owed to F.H. Defendant's conduct clearly rises to the level of gross negligence and shockingly unprofessional conduct.

Upon the completion of any hearing held regarding discipline of a credential, the director may dismiss the action or impose any of the following sanctions: (1) Censure; (2) Probation; (3) Limitation; (4) Civil penalty; (5) Suspension; or (6) Revocation. Neb. Rev. Stat. §38-196.

The Supreme Court of Nebraska outlined certain factors to be considered in a disciplinary proceeding against a professional license. Those factors include:

(1) the nature of the offense,
(2) the need for deterring others,
(3) the maintenance of the reputation of the [profession] as a whole,
(4) the protection of the public,
(5) the attitude of the offender generally, and
(6) the offender's present or future fitness to continue in the practice of [the profession].

Poor v. State, 266 Neb. 183, 195,663 N.W.2d 109, 118-19 (2003), *citing State ex rel. NSBA v. Brown*, 251 Neb. 815, 821, 560 N.W.2d 123, 129 (1997).

The nature of Defendant's offense could not be more serious. Defendant's actions led to the death of a medically compromised and vulnerable elderly war veteran. Defendant utterly failed in her duty to protect her patient. The need for deterring others from conduct even remotely similar to Defendant's egregious behavior is obvious. Defendant's actions have dealt an incredibly significant blow to the reputation of her esteemed profession and Defendant's continued practice would constitute an unacceptably grave risk to public safety. Defendant, while expressing remorse for the death of F.H., fails to accept full culpability for the tragic consequences of her actions. Based on the evidence presented, which established Defendant's appalling indifference to her professional duties and responsibilities, it is clear that Defendant is not currently fit to practice her profession.

Any sanction short of revocation would minimize Defendant's conduct and would constitute a serious affront to the reputation of her profession and would promote disrespect for the laws and regulations governing the practice of nursing and the credential disciplinary process. Therefore, it is recommended that the Chief Medical Officer adopt the recommendation of the Nebraska Board of Nursing to revoke Defendant's Nebraska practical nurse license.

ORDER

Based upon the foregoing proposed Findings of Fact and Conclusions of Law, I recommend that the Defendant's license to practice as a Licensed Practical Nurse in the State of Nebraska be REVOKED, effective ten (10) days from the date of this Order.

Date: 2/10/25

[redacted]
Robert E. Harkins, Hearing Officer

I hereby adopt the foregoing proposed Findings of Fact and Conclusions of Law and recommended Order in the above captioned proceedings as my official and final Order.

IT IS SO ORDERED.

Date: Feb 10, 2025

[redacted]
Timothy Tesmer, MD
Chief Medical Officer
Division of Public Health
Department of Health and Human Services

NOTICE

Pursuant to the Administrative Procedure Act, NEB. REV. STAT. § 84-901 *et seq.*, this decision may be appealed by filing a petition in the district court of the county where the action is taken within thirty days after the service of the final decision by the agency.

CERTIFICATE OF SERVICE

The undersigned certifies that a copy of the foregoing was sent on the date below by United States Mail, postage prepaid, and/or electronically to the following:

CURLEE SCHNEIDERS 12743 S 29TH ST BELLEVUE NE 68123
JULIE JORGENSEN ATTORNEY AT LAW 11422 MIRACLE HILLS DR STE 400 OMAHA NE 68154
JEANNE BURKE ASSISTANT ATTORNEY GENERAL AGO.HEALTH@NEBRASKA.GOV

Date: February 10, 2025

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STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

STATE OF NEBRASKA ex rel. MICHAEL T. HILGERS, Attorney General,	)	
Plaintiff,	)	**ORDER FOR TEMPORARY SUSPENSION OF LICENSE TO PRACTICE AS A PRACTICAL NURSE**
vs.	)	
CURLEE M. SCHNEIDERS, L.P.N.,	)	
Defendant.	)	

THIS MATTER came on for consideration before the Nebraska Department of Health and Human Services Division of Public Health Chief Medical Officer on Plaintiff's Petition for: Disciplinary Action and Temporary License Suspension ("Petition") and upon the affidavit in support of the request for temporary suspension. The Chief Medical Officer finds reasonable cause exists under Neb. Rev. Stat. §§ 38-183 (Reissue 2016) and 38-178 (Supp. 2023) for the suspension of the Defendant's practical nurse license on the basis that the Defendant's continued practice at this time would constitute an imminent danger to public health and safety.

IT IS THEREFORE ORDERED:

1. The license (#16144) of the Defendant, Curlee M Schneiders, L.P.N, to practice as a practical nurse is suspended effective upon service of this Order upon the Defendant in accordance with Neb. Rev. Stat. § 38-183 (Reissue 2016).

2. Pursuant to Neb. Rev. Stat. § 38-183 (Reissue 2016), the hearing on the merits of the allegations of the Petition shall be held. A separate Notice of Hearing shall be issued by the Nebraska Department of Health and Human Services Division of Public Health to be served upon the Defendant along with the Order and the Petition. The

Defendant shall have the opportunity to appear and defend against the Petition at such time and place. The Defendant is further notified that she may present such witnesses and such evidence at said time and place as she may care to present in answer to the allegations of the Petition, and she may be represented by legal counsel at said hearing.

3. The investigative report and supporting documents attached to the affidavit of Patricia Lemke are hereby sealed and shall remain a non-public record pursuant to Neb. Rev. Stat. § 38-1,106 (Reissue 2016).

4. The Sarpy County, Nebraska, Sheriff is appointed, pursuant to 184 NAC 006.01E, to personally serve the Defendant with copies of this Order and the Petition.

DATED this 24 day of July, 2024.

BY: [redacted]

Chief Medical Officer/~~Director~~
Division of Public Health
Nebraska Department of Health and Human Services

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

STATE OF NEBRASKA ex rel. MICHAEL T. HILGERS, Attorney General,	)	
Plaintiff,	)	**PETITION FOR: DISCIPLINARY ACTION AND TEMPORARY LICENSE SUSPENSION**
vs.	)	
CURLEE M. SCHNEIDERS, L.P.N.,	)	
Defendant.	)	

The Plaintiff alleges as follows:

ALLEGATIONS COMMON TO ALL CAUSES OF ACTION

1. Jurisdiction is based on Neb. Rev. Stat. §§ 38-176 (Reissue 2016) and 38-183 (Cum. Supp. 2020), and 38-186 (Supp. 2023).

2. At all times relevant herein, the Defendant, Curlee M. Schneiders, L.P.N., has been the holder of a practical nurse license (#16144) issued by the Department of Health and Human Services Division of Public Health ("Department").

3. The Department is the agency of the State of Nebraska authorized to enforce the provisions of the Uniform Credentialing Act regulating the practice of physical therapy.

4. The Nebraska Board of Nursing considered the investigation of this matter and made recommendations to the Attorney General to file disciplinary proceedings against the Defendant's license to practice as practical nurse in Nebraska.

5. At all times relevant herein, the Defendant was employed as licensed practical nurse at E.N.V.H. in Bellevue, Nebraska. The Defendant's job description

required her to direct and monitor for safe and effective care provided by certified nursing staff consistent with each resident's plan of care.

6. On or about June 1-2, 2024, the Defendant was working as the charge nurse in the Motivation Unit from 6:00 p.m. to 6:00 a.m.

7. At or about 1:15 a.m. on June 2, 2024, the Defendant was seated at the nursing station desk wearing wired earphones connected to her personal cell phone in violation of E.N.V.H.'s cell phone policy prohibiting employee use of personal cell phones in member care areas.

8. At or about 01:16 a.m., a certified nursing assistant (CNA 1) wheeled Resident F.H. into the day room/ common area located an estimated 15 feet from the nursing station desk, where Defendant was seated. F.H., was a vulnerable, non-ambulatory, older adult diagnosed with, *inter alia*, dysphagia with a standing medical order for a soft mechanical diet.

9. At or about 1:20 a.m., the Defendant directed CNA 1, who was working her first shift following new employee orientation on the Motivation Unit, to give F.H. a sandwich. The Defendant failed to direct CNA 1 to verify FH's dietary order before delivering food to him.

10. At or about 1:22 a.m., CNA 1 handed F.H. a turkey and cheese sandwich in non-compliance with his medical order for soft mechanical food. The Defendant failed to verify or direct CAN 1 to verify that the delivered sandwich complied with F.H.'s medical order for mechanical soft food.

11. After delivering the sandwich, CNA 1 left F.H. alone to eat. The Defendant failed to observe or direct CNA 1 to remain in the day room to observe F.H. while he was

eating for signs and symptoms of dysphagia in violation of the E.N.V.H. Dysphasia Management Policy

12. At or about 1:31 a.m., the Defendant was sitting at the nursing station, using her phone, wearing an ear bud in her left ear, looking down at the desk, and was not monitoring F.H.

13. At or about 1:32 a.m., F.H. began to choke. The Defendant did not look up or respond to F.H. while he was choking.

14. At or about 1:34 a.m., F.H. passed out, leaned back in his wheelchair, his head tilted backwards, and his legs outstretched. The Defendant did not look up or respond to F.H. in his apparent unconscious position.

15. At or about 1:36 a.m., F.H. was motionless in his wheelchair while the Defendant was looking downward at the desk with an ear bud in her left ear.

16. At or about 1:39 a.m., C.N.A. 2 entered the day room/common area, observed F.H., and told C.N.A. 1 that F.H. did not appear to be breathing. The Defendant remained at the nurse station desk and did not respond to F.H., who was motionless.

17. At or about 1:42 a.m., CNA 1 placed her hand on F.H.'s chest and alerted the Defendant, who stood up and walked over to F.H. The Defendant and CNA 1 positioned F.H. on the floor. Defendant swept his mouth and found a piece of sandwich. The Defendant then left F.H., returned to the nursing station desk, and then entered the nursing office in violation of the E.N.V.H. Emergency Response policy, which requires the charge nurse to direct the certified nursing staff to contact the House Supervisor, call 911, and obtained AED equipment, while the charge nurse initiates cardiac pulmonary resuscitation (CPR).

18. At or about 1:43 a.m., the Defendant returned to F.H. and began chest compressions and then performed intermittent CPR.

19. Between 1:52 and 1:53 a.m., officers from the Bellevue Police Department and Bellevue Fire and Rescue arrived, assumed coding F.H., and attempted unsuccessfully to resuscitate F.H.

20. On or about June 2, 2024, the E.N.V.H. Medial Director reviewed the video and determined F.H.'s death was related to being given a regular sandwich, causing him to choke, go into bronchial spasms, which resulted in respiratory arrest.

21. On or about June 26, 2024, the Defendant was interviewed to by a DHHS Investigator. The Defendant admitted that she told CNA 1 to give F.H. a sandwich without informing her that F.H. was on a mechanical soft foods diet.

22. The Defendant admitted to the DHHS Investigator that she did not continuously monitor F.H. while he was eating.

23. The Defendant admitted to the DHHS Investigator that she had an ear bud in her left ear and was listening to the news until she rose to assist CNA 1 with F.H.

24. The Defendant admitted to the DHHS Investigator that she did not know F.H.'s code status, delayed starting C.P.R. on F.H., and did not direct CNA 1 or 2 to call 911 immediately.

FIRST CAUSE OF ACTION

25. Paragraphs 1 through 24 are incorporated herein by reference.

26. Neb. Rev. Stat. § 38-178(6) (2023 Supp.) provides a professional license may be disciplined for the practice of the profession with gross incompetence or gross negligence.

27. The Defendant's conduct, outlined above, constitutes gross incompetence and/or gross negligence and is grounds for discipline.

SECOND CAUSE OF ACTION

28. Paragraphs 1 through 24 are incorporated herein by reference.

29. Neb. Rev. Stat. § 38-178(24) (2023 Supp.) provides a professional license may be disciplined for unprofessional conduct as set forth in §38-179.

30. Neb. Rev. Stat. § 38-179 (2023 Supp.) defines unprofessional conduct as the failure to conform to the standards of acceptable and prevailing practice of a profession, regardless of whether a person, consumer, or entity is injured, including but not limited to ... (17) such other acts as may be defined by rules and regulations.

31. Title 172 NAC 101-006 governing the Practice of Nursing defines unprofessional conduct as:

a. (1) Failure to utilize appropriate judgment in administering safe nursing practice based upon the level of nursing for which the individual is licensed;
b. (2) Failure to exercise technical competence based upon the level of nursing for which the individual is licensed in carrying out nursing case;
c. (3) Failure to follow policies or procedures implemented in the practice situation to safeguard patient care;
d. (10) Committing any act which endangers patient safety or welfare; and
e. (12) Failure to exercise supervision as set forth in 172 NAC 99 over persons who are authorized to practice only under the direction of the license nurse or licensed practitioner.

32. The Defendant's conduct, set forth above, constitutes unprofessional conduct and is grounds for discipline.

PRAYER FOR RELIEF

WHEREFORE, the Plaintiff prays that the Chief Medical Officer temporarily suspend the Defendant's license to practice as a practical nurse pursuant to Neb. Rev. Stat. § 38-183 (Reissue 2016), set this matter for hearing, enter an order for appropriate disciplinary action pursuant to Neb. Rev. Stat. § 38-196 (Reissue 2016), and tax the costs of this action to the Defendant.

STATE OF NEBRASKA, ex rel.
MICHAEL T. HILGERS, Attorney General,
Plaintiff,

BY: MICHAEL T. HILGERS, #24483
Attorney General

By [redacted]
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