BEFORE THE MINNESOTA

BOARD OF NURSING

In the Matter of
Randy D. Hopp, RN, LPN
License Nos. R 158640-0, L 50619-3

ORDER OF
UNCONDITIONAL LICENSE

Pursuant to a Stipulation and Consent Order issued by the Minnesota Board of Nursing (hereinafter "Board") on August 12, 2004, I have reviewed the materials submitted by Randy D. Hopp, RN, LPN (hereinafter "Licensee"), pursuant to that Order, and have determined that Licensee complied with and fulfilled all the conditions of that Order. NOW, THEREFORE:

IT IS HEREBY ORDERED that an unconditional license to practice registered and practical nursing in the State of Minnesota be conferred upon Licensee, such license to carry all duties, benefits, responsibilities, and privileges inherent therein through Minnesota statute and rule.

Dated: April 24, 2006

STATE OF MINNESOTA

BOARD OF NURSING

SHIRLEY A. BREKKEN
Executive Director

BEFORE THE MINNESOTA

BOARD OF NURSING

In the Matter of
Randy D. Hopp
R.N. License No. 158640-0
L.P.N. License No. 50619-3

STIPULATION AND CONSENT ORDER

STIPULATION

Randy D. Hopp, R.N., L.P.N. ("Licensee"), and the Minnesota Board of Nursing Review Panel ("Review Panel") agree the above-referenced matter may be resolved without trial of any issue or fact as follows:

I.

JURISDICTION

1. The Minnesota Board of Nursing ("Board") is authorized pursuant to Minnesota Statutes sections 148.171 to 148.285 (2002) to license and regulate registered and licensed practical nurses and to take disciplinary action as appropriate.

2. Licensee holds licenses from the Board to practice professional and practical nursing and is subject to the jurisdiction of the Board with respect to the matters referred to in this Stipulation and Consent Order.

II.

CONFERENCE

3. On December 16, 2003, Licensee appeared before the Review Panel, composed of Glenda Moyers, Board member, and Mariclaire E. England, Nursing Practice Specialist for the

Board, to discuss allegations contained in a Notice of Conference dated November 19, 2003. Peter Krieser, Assistant Attorney General, represented the Review Panel at the conference.

4. Licensee was advised by the Board's representatives that he may choose to be represented by legal counsel in this matter. Licensee knowingly waived legal representation.

III.

FACTS

5. The parties agree this Stipulation and Consent Order is based upon the following facts:

a. On September 2, 1998, the Office of Health Facility Complaints ("OHFC"), Minnesota Department of Health ("MDH"), found evidence through documentation and staff interviews that physical abuse of a resident occurred resulting from an incident at Red Wing Health Center ("RWHC"), Red Wing, Minnesota, when Licensee performed an invasive catheterization procedure on a resident without a physician's order and the resident sustained injuries.

b. On May 27, 1999, Licensee met with a Review Panel to discuss allegations contained in a Notice of Conference dated May 4, 1999. The allegations involved Licensee's nursing practice while he was employed as a licensed practical nurse at Mayo Clinic, Rochester, Minnesota, concerning interpersonal relationships with co-workers and patients and the inappropriate treatment of the vulnerable adult while he was employed by a temporary agency assigned to RWHC. As a result of the conference, Licensee entered into an Agreement for Corrective Action ("Agreement") signed August 5, 1999. On January 14, 2000, the Review Panel informed Licensee that he met the requirements of his agreement.

c. While Licensee was employed as a licensed practical nurse from March 4, 1999 to July 23, 1999 at Good Samaritan Center ("Comforcare"), Austin, Minnesota, the following occurred:

1) On June 16 and June 17, 1999, the OHFC conducted an investigation into the abuse of a vulnerable adult. The report of the investigation dated July 28, 1999, indicated:

a) An 89-year-old resident had diagnoses including pathologic fracture of vertebrae, irritable colon, cardiovascular disease, osteoporosis, dementia and macular degeneration. The resident was at risk for falling and required a soft lap cushion in her wheelchair to prevent her from ambulating independently. The resident did not like the soft cushion and frequently removed it. A physician's progress note dated May 28, 1999 stated, "Demented; objects to soft cushion on w/c (wheelchair) but she cannot walk alone as she is unstable. Not sure of full understanding."

b) On May 31, 1999, at approximately 2:30 p.m., Licensee observed the resident walking independently with a walker in the dining room. Licensee approached the resident, turned her around and asked her to return to her wheelchair. The resident was resistant. When the resident was placed in a wheelchair, she began flailing her arms as Licensee placed the soft lap cushion. At approximately 3:00 p.m., staff observed a 2 cm skin tear on the resident's right forearm and requested a registered nurse ("RN") to assess the resident's skin tear. The resident accused the RN, then Licensee, of holding her arm. The OHFC concluded that the evidence of physical abuse was inconclusive. Subsequently, Licensee's employment was terminated.

d. While Licensee was employed as a licensed practical nurse at Rochester Healthcare Center ("RHC"), Rochester, Minnesota, from August 2, 1999 to January 3, 2001, the following occurred:

1) A resident had been recently hospitalized after a fall and was cognitively impaired. The resident routinely received morphine for pain and Haldol as needed for restlessness. On June 8, 2000, at approximately 9:30 p.m., Licensee administered to the resident 0.4 rather than 0.2 Haldol and morphine. At approximately 11:30 p.m., the resident died.

2) Another resident received intermittent catheterization and was asked by staff regarding the frequency and need for catheterization. The resident is cognitively impaired and demonstrated short and long term memory impairment. On July 15, 2000, the resident requested to be catheterized on three separate occasions. The resident also reported she did not receive pain medication when requested. When interviewed by an investigator of the OHFC Licensee reported the resident declined his offer of catheterization, but Licensee failed to administer the requested pain medication to the resident.

3) In reports by the OHFC dated August 31, 2000, it was determined neglect of health care was inconclusive in the above instances.

4) On October 3, 2000, Licensee was issued a Re-education Form for concerns about his medication administration and resident complaints. Licensee stated he never intended to withhold pain medication, harm anyone or cause distress. Licensee was reminded it was not within his responsibility or scope of practice to recommend a resident reduce pain medication and pain medication should not be withheld.

5) On November 11, 2000, Licensee was issued a written warning after he failed to document a resident's fall. On October 7, 2000, Licensee documented a late entry in the resident's medical record that was not completed with the incident report at the time of the incident. The corrective action taken included writing a one-page report on the necessity of documenting in the medical record at the time of the incident, and Licensee was to serve as chair of the Falls Committee for one year.

6) Licensee resigned his employment effective January 3, 2001.

e. While Licensee was employed at Riverside Trace Healthcare & Rehabilitation Center ("RTHRC"), Rochester, Minnesota, and working at Bear Creek Care and Rehabilitation Center, from February 19, 2001 to October 3, 2002, the following occurred:

1) On April 17, 2001, Licensee was issued an oral warning after he was observed by state surveyors administering inhalers to residents without allowing adequate time between inhalations.

2) On April 20, 2001, Licensee was issued a written warning and counseled regarding residents' rights after a report that he "yelled" at a resident on April 19, 2001.

3) On October 15, 2001, Licensee was issued a second written warning for failure to comply with a resident's care plan, and Licensee was instructed not to provide care to this resident in the future, because the resident stated Licensee handled him in a firm manner.

4) On December 14, 2001, Licensee received verbal counseling after he told a resident to wait until after breakfast to be toileted. In addition, staff discussed

Licensee's rude behavior and inappropriate conversation and the difference between joking and seriousness in conversations with co-workers.

5) On July 11, 2002, Licensee was issued a written warning for an incident involving a resident and another staff member. On June 27, 2002, staff found the resident sitting on the side of her bed and screaming "Ella, Ella," which means help now. As staff left the resident's room, Licensee told staff to shut the door. Licensee said the resident had been yelling all day and he was tired of hearing it. Staff reminded Licensee that the resident would not know to use her call light because of her dementia. Licensee raised his voice and told staff he had the situation under control. Licensee refused to open the door. Staff felt threatened and intimidated by Licensee.

6) On August 22, 2002, the OHFC conducted an investigation at RTHRC into the report of the abuse of resident DP, a vulnerable adult. The OHFC report dated October 9, 2002, indicated the following:

a) Resident DP's diagnoses included a history of cerebral vascular accident with right-sided weakness, myocardial infarction, hypertension and aphasia. Resident DP was alert and oriented and communicated by using an alphabet board. DP has a history of being resistive to cares and striking out at staff with his left arm. On August 18, 2002, the following occurred:

1) At approximately 7:15 p.m. a nursing assistant registered ("NAR") answered resident DP's call light for assistance in making a telephone call. The call could not be completed and at approximately 8:00 p.m., the NAR responded to DP's call light and again assisted DP, who was unable to reach the person he was calling. Licensee

entered DP's room and asked why DP kept activating his call light. The NAR explained resident DP wanted help making a telephone call and she would return later to help him. She then went to another resident's room located directly next to DP's room. The NAR heard noises that sounded like the bedside wheels were being hit or moved and returned to DP's room to investigate the sounds. Licensee was standing near the resident and facing him. The resident's glasses were off of his face, he was swinging his legs, and he had a laceration on the right side of his nose, which was bleeding. Licensee stepped back from the resident's bed and said, "Wait a minute, what just happened here. Why is DP so upset." Staff saw applesauce and soda had been spilled on the resident's bed and floor and there was soda on the front of the resident's shirt. The resident was shaking and crying. When asked what happened, resident DP spelled out, "He hit me" on his alphabet board. Staff found resident DP's glasses on the floor. One lens was found under the resident's bed, and the other lens was found in the wastebasket.

2) Licensee left DP's room and returned with steri-strips for the resident's laceration. When resident DP saw Licensee he became agitated, appeared frightened, and started swinging his arm. DP calmed as soon as Licensee left the room. Licensee failed to follow the directive on DP's care plan and treatment sheet which stated "2 people to go into room for all cares etc." Licensee failed to document the incident in DP's medical record and only noted that the resident was upset. Licensee failed to complete an incident report, document the laceration on DP's nose, and notify the nursing supervisor, physician and the resident's family. In addition, Licensee failed to comply with facility policy and procedure to observe DP's condition following the incident.

b) The OHFC concluded that a preponderance of the evidence indicated Licensee was responsible for the physical abuse of resident DP.

7) On October 3, 2002, Licensee's employment was terminated.

f. Beginning September 17, 2002, Licensee was again employed at Comforcare. On October 7, 2002, Licensee resigned his employment effective October 22, 2002, stating he had completed his registered nurse licensure and he was moving out of town.

g. On October 18, 2002, Licensee was licensed by the Board to practice registered nursing.

h. On November 13, 2002, the Board received a report indicating that Licensee was culpable for substantiated maltreatment of a vulnerable adult as a result of his physical abuse of DP at RTHRC in violation of Minnesota Statutes section 245A, subd. 3.d.(b) and if Licensee was not a health related licensed professional, the Commissioner of Human Services would disqualify him for serious and recurring maltreatment.

i. At Licensee's conference with the Review Panel on December 16, 2003, and in his written response to the Notice of Conference dated December 3, 2003, Licensee denied striking DP and stated DP struck himself in the face while attempting to hit Licensee. Licensee admitted he did not follow DP's care plan that directed two staff be present at all times when providing care to DP. Licensee also stated DP's roommate might have observed the interaction. Licensee is currently employed at an acute care facility in Kansas. The Board referred the matter to the Minnesota Attorney General's Office ("AGO") for an investigation. The information obtained during the investigation included the following:

1) During an interview with an AGO investigator, DP's roommate, who was not interviewed during the MDH investigation, stated he did not observe what happened due to a curtain separating the two beds, but said he "heard a lot of noise so something must have happened." He stated when the curtain was then opened, he observed an injury on DP's face.

2) On March 4, 2003, Licensee was charged in Olmstead County District Court, Rochester, Minnesota, with one count of Mistreatment of a Resident/Patient, one count of Criminal Neglect, and one count of Assault in the Fifth Degree.

3) On February 4, 2004, Licensee entered an Alford Plea and pled guilty to the charge of Assault in the Fifth Degree, a gross misdemeanor, and the charges of Mistreatment of a Resident/Patient and Criminal Neglect were dismissed.

4) On April 15, 2004, Imposition of Licensee's sentence was stayed for a period of 18 months with the following conditions: 1) comply with the rules and regulations of probation; 2) pay a $440.00 fine; 3) no contact directly or indirectly with DP or his spouse; and 4) no similar offenses.

j. By letter dated May 2, 2004, Licensee informed Board staff that he wanted to retain his Minnesota nursing licenses even though he did not plan to return to Minnesota. Licensee denied assaulting DP and stated he entered an Alford Plea because he could not afford the cost of a trial. Licensee stated he now had a conviction for "something that I did not do."

IV.

LAWS

6. Licensee acknowledges the conduct described in section III. above constitutes a violation of Minnesota Statutes section 148.261, subdivision 1(3), (5), (6), (11) and (18) (2002), and justifies the disciplinary action described in section V. below.

V.

DISCIPLINARY ACTION

The parties agree the Board may take the following disciplinary action and require compliance with the following terms:

A. Conditions on Licenses

7. The Board places the following **CONDITIONS** on Licensee's licenses:

a. One-on-One Instruction. Within five months of the date of this Order, Licensee shall complete one-on-one instruction with a nurse consultant. The instruction shall last eight hours or until such time as the evaluator determines is sufficient to achieve the learning objectives, whichever is greater. The nurse consultant must be approved by Board staff, for purposes of this Order, before the consultation begins. In order for the Board to consider approving a consultant, Licensee shall submit or cause to be submitted the resume or curriculum vitae of the proposed consultant and proposed course outline. Licensee is permitted to complete the one-on-one instruction in another jurisdiction, provided he obtains pre-approval from Board staff. Licensee is responsible for arranging and paying for the instruction. The instruction shall address: (1) conflict management with patients who are abusive, non-complaint or mentally impaired; (2) the importance of complying with a patients plan of care; (3) documentation and

observation of patients after the occurrence of an injury or incident, including the importance of notifying the patient's physician, family members and Licensee's nursing supervisor of alleged abuse; and (4) the Vulnerable Adult Act, including definition of physical and verbal abuse. The nurse consultant shall submit a report directly to the Board, addressing the following:

1) Verification the nurse consultant has reviewed a copy of this Stipulation and Consent Order;

2) An evaluation of Licensee's understanding of the subjects of the instruction prior to beginning the consultation;

3) A description of the content and method of instruction provided during the consultation;

4) A statement indicating what Licensee learned and achieved through the instruction and how the learning was evaluated;

5) Any recommendations for additional education directed at improving Licensee's nursing practice; and

6) Any other information the nurse consultant believes would assist the Board in its ultimate review of this matter.

b. Compliance With Consultant's Recommendations. Licensee shall promptly comply with any recommendations for additional education made by the nurse consultant. Licensee must submit written documentation, such as measurable learning objectives and qualifications of the instructor, in order to receive prior approval from Board staff of classes that Licensee takes in fulfillment of this requirement. Each class must meet the continuing nursing education requirements found in Minnesota Rules 6310.2800, subpart 3 (2003).

Licensee shall submit verification of participation for any class taken in fulfillment of this requirement.

c. Typewritten Report. Within one month of the date of completion of the one-on-one instruction, Licensee shall submit to the Board a typewritten report at least five pages in length addressing what he learned and achieved through the one-on-one instruction. Licensee shall reflect on the situation described in section III and describe the knowledge he has gained and how he will apply his knowledge to his current and future nursing practice.

d. Report from Nursing Supervisor. Licensee shall cause to be submitted to the Board a report from a registered nurse who is his supervisor, if Licensee is employed in nursing. The report shall be submitted every six months and at any time upon request of the Board. Each report shall provide and address:

1) In the first report, verification Licensee's supervisor has received and reviewed a copy of this Stipulation and Consent Order;

2) The date of Licensee's employment;

3) Licensee's attendance and reliability;

4) Licensee's ability to carry out assigned functions;

5) Licensee's ability to handle stress, and interact with patients in a professional manner;

6) Number of hours licensee worked during the reporting period; and

7) Any other information the supervisor believes would assist the Board in its ultimate review of this matter.

e. Self-Report. Licensee shall submit to the Board a report from Licensee himself. The report shall be submitted every six months and at any time upon request of the Board. Each report shall provide and address:

1) The type of nursing or other employment in which Licensee has been involved;

2) Licensee's work schedule;

3) How Licensee has applied the information he has gained from the one-on-one instruction to his nursing practice;

4) How Licensee identifies when he has too many demands at work and strategies he uses to resolve conflict with patients; and

5) Any other information Licensee believes would assist the Board in its ultimate review of this matter.

f. Report From Probation Officer. Licensee shall cause to be submitted a report from his probation officer. The report shall be submitted every six months and at any time upon request of the Board. Each report shall provide information regarding Licensee's compliance with all terms of his probation, including any criminal charges against him.

8. Licensee shall notify each present and future nursing supervisor of this Stipulation and Consent Order within ten days of the date of the Order or commencing employment. Licensee shall provide the supervisor with a copy of the entire signed Stipulation and Consent Order.

9. Waivers. At any time while this Stipulation and Consent Order is in effect and at the request of the Board, Licensee shall sign health record and employment waivers supplied by

the Board to allow representatives of the Board to discuss Licensee's case with and to obtain written evaluations and reports and copies of all Licensee's health, mental health, or employment records from his physician, mental health professional, therapist or others from whom Licensee has sought or obtained treatment, support, assistance or employment.

B. Removal of Conditions

10. The conditions upon Licensee's licenses shall be administratively removed following 18 months from the date of this Order and upon payment of the civil penalty, successful completion of the one-on-one consultation, compliance with the consultant's recommendations, submission of reports from Licensee, his nursing supervisor and his probation officer, and written notification to Licensee by the Board of the removal of the conditions.

C. Civil Penalty

11. The Board imposes a **CIVIL PENALTY** in the amount of $400.00. The civil penalty shall be paid by cashier's check or money order made payable to the Minnesota Board of Nursing and shall be delivered personally or by mail to the Minnesota Board of Nursing, c/o Shirley A. Brekken, Executive Director, 2829 University Avenue S.E., Suite 200, Minneapolis, Minnesota 55414, within 60 days of the date of service of this Order.

VI.

CONSEQUENCES FOR NONCOMPLIANCE OR ADDITIONAL VIOLATIONS

12. It is Licensee's responsibility to ensure all payments, reports, evaluations, and documentation required to be filed with the Board pursuant to this Stipulation and Consent Order are timely filed by those making the payment or preparing the report, evaluation, or documentation. Failure to make payments or file reports on or before their due date is a violation

of this Stipulation and Consent Order. The information contained in the reports, evaluations, and documentation is confidential and shall be submitted to the Board by United States mail, courier, or personal delivery only.

13. If Licensee fails to comply with or violates this Stipulation and Consent Order or it is determined Licensee has further violated Minnesota Statutes sections 148.171 to 148.285 (2002) or Minnesota Rules chapters 6301 to 6340 (2003), the Review Panel may, in its discretion, seek additional discipline either by initiating a contested case proceeding pursuant to Minnesota Statutes chapter 14 (2002) or by bringing the matter directly to the Board pursuant to the following procedure:

a. The Review Panel shall schedule a hearing before the Board. At least 20 days before the hearing, the Review Panel shall mail Licensee a notice of the violation(s) alleged by the Review Panel. In addition, the notice shall designate the time and place of the hearing. Within ten days after the notice is mailed, Licensee shall submit a written response to the allegations. If Licensee does not submit a timely response to the Board, the allegations may be deemed admitted.

b. The Review Panel, in its discretion, may schedule a conference with Licensee prior to the hearing before the Board to discuss the allegations and to attempt to resolve the allegations through agreement.

c. Prior to the hearing before the Board, the Review Panel and Licensee may submit affidavits and written argument in support of their positions. At the hearing, the Review Panel and Licensee may present oral argument. Argument shall not refer to matters outside the record. The evidentiary record shall be limited to the affidavits submitted prior to the hearing

and this Stipulation and Consent Order. The Review Panel shall have the burden of proving by a preponderance of the evidence that a violation has occurred. If Licensee has failed to submit a timely response to the allegations, Licensee may not contest the allegations, but may present argument concerning the appropriateness of additional discipline. Licensee waives a hearing before an administrative law judge, discovery, cross-examination of adverse witnesses, and other procedures governing hearings pursuant to Minnesota Statutes chapter 14.

d. Licensee's correction of a violation before the conference, hearing, or meeting of the Board may be taken into account by the Board but shall not limit the Board's authority to impose discipline for the violation. A decision by the Review Panel not to seek discipline when it first learns of a violation shall not waive the Review Panel's right to later seek discipline for that violation, either alone or in combination with other violations, at any time while Licensee's licenses are in a conditional status.

e. Following the hearing, the Board will deliberate confidentially. If the allegations are not proved, the Board shall dismiss the allegations. If a violation is proved, the Board may impose additional discipline, including additional conditions or limitations on Licensee's practice, or revocation of Licensee's licenses.

f. Nothing herein shall limit the Review Panel's or the Board's right to temporarily suspend Licensee's licenses pursuant to Minnesota Statutes section 148.262, subdivision 3, based on a violation of this Stipulation and Consent Order or based on conduct of Licensee not specifically referred to herein. Similarly, nothing herein shall limit the Review Panel's or the Board's right to automatically suspend Licensee's licenses pursuant to Minnesota Statutes section 148.262, subdivision 2.

VII.

ADDITIONAL INFORMATION

14. In the event Licensee should leave Minnesota to reside or to practice outside of the state, Licensee shall give the Board written notification of the new location, as well as dates of departure and return. Periods of residency and practice outside of Minnesota will not apply to the reduction of any period of Licensee's conditional licenses in Minnesota unless Licensee demonstrates that the practice in another state conforms completely with this Stipulation and Consent Order. If Licensee leaves the state, the terms of this Order continue to apply unless waived in writing.

15. Within ten days of execution of this Stipulation and Consent Order, Licensee shall provide the Board with the addresses and telephone numbers of Licensee's residence and all agencies or facilities and locations at which Licensee has become employed or performs volunteer nursing. Licensee shall inform the Board within ten days if he becomes employed at any additional agencies or facilities or moves and shall provide the new or additional address and telephone number.

16. Within ten days of execution of this Stipulation and Consent Order, Licensee shall provide the Board with the names of all states in which Licensee is licensed to practice professional and practical nursing or has applied for licensure as a registered or practical nurse.

17. Licensee waives the contested case hearing and all other procedures before the Board to which Licensee may be entitled under the Minnesota and United States constitutions, statutes, or rules.

18. Licensee waives any claims against the Board, the Minnesota Attorney General, the State of Minnesota, and their agents, employees, and representatives related to the investigation of the conduct herein, or the negotiation or execution of this Stipulation and Consent Order, which may otherwise be available to Licensee.

19. This Stipulation and Consent Order, the files, records, and proceedings associated with this matter shall constitute the entire record and may be reviewed by the Board in its consideration of this matter.

20. Either party may seek enforcement of this Stipulation and Consent Order in any appropriate civil court.

21. Licensee has read, understands, and agrees to this Stipulation and Consent Order and has voluntarily signed the Stipulation and Consent Order. Licensee is aware this Stipulation and Consent Order must be approved by the Board before it goes into effect. The Board may either approve the Stipulation and Consent Order as proposed, approve it subject to specified change, or reject it. If the changes are acceptable to Licensee, the Stipulation and Consent Order will take effect and the order as modified will be issued. If the changes are unacceptable to Licensee or the Board rejects the Stipulation and Consent Order, it will be of no effect except as specified in the following paragraph.

22. Licensee agrees that if the Board rejects this Stipulation and Consent Order or a lesser remedy than indicated in this settlement, and this case comes again before the Board, Licensee will assert no claim that the Board was prejudiced by its review and discussion of this Stipulation and Consent Order or of any records relating to it.

23. This Stipulation and Consent Order shall not limit the Board's authority to proceed against Licensee by initiating a contested case hearing or by other appropriate means on the basis of any act, conduct, or admission of Licensee which constitutes grounds for disciplinary action and which is not directly related to the specific facts and circumstances set forth in this document.

VIII.

DATA PRACTICES NOTICES

24. This Stipulation and Consent Order constitutes disciplinary action by the Board and is classified as public data pursuant to Minnesota Statutes section 13.41, subdivision 5 (2002). Data regarding this action will be provided to data banks as required by Federal law or consistent with Board policy. While this Stipulation and Consent Order is in effect, information obtained by the Board pursuant to this Order is considered active investigative data on a licensed health professional, and as such, is classified as confidential data pursuant to Minnesota Statutes section 13.41, subdivision 4 (2002).

25. This Stipulation contains the entire agreement between the parties, there being no other agreement of any kind, verbal or otherwise, which varies this Stipulation.

CONSENT:

BOARD OF NURSING
REVIEW PANEL

RANDY D. HOPP, R.N., L.P.N.
Licensee

Dated: 8/5/04, 2004

GLENDA MOYERS
Board Member

Dated: 8-12, 2004

ORDER

Upon consideration of the Stipulation, the Board places Licensee's licenses in a **CONDITIONAL** status and issues Licensee a **CIVIL PENALTY** and adopts all of the terms described above on this 12th day of August, 2004.

MINNESOTA BOARD
OF NURSING

SHIRLEY A. BREKKEN
Executive Director

AG: #1246917-v1

STATE OF MINNESOTA
BOARD OF NURSING
2829 University Avenue SE, #500 Minneapolis, MN 55414-3253

January 14, 2000

Randy D Hopp
1118 8th Ave NW
Rochester MN 55901

Dear Mr. Hopp:

This is to acknowledge receipt of your letter dated January 7, 2000, with attachments. We also acknowledge receipt of a letter from Sharlla A. Regehr, RN, ART, MS, dated January 12, 2000, with attachments. This information has been reviewed and included in your file.

You have now met all requirements of the Agreement for Corrective Action dated August 6, 1999. Therefore, in accordance with paragraph 5. of your Agreement for Corrective Action, this matter is dismissed. The Agreement and this letter are classified as public documents.

This matter may be re-evaluated should the Board receive a complaint of a similar nature in the future. The Review Panel encourages you to continue to apply to your practice the principles you have learned from the corrective actions. If you have any questions, please contact me at (612) 617-2276 or our toll-free number, 1-888-234-2690.

Best wishes as you continue your nursing career.

Sincerely,

Shirley A. Brekken
Executive Director

SAB:mjs

(612) 617-2270 – Voice
(888) 234-2690 – Voice
(MN, IA,ND,SD,WI)

e-mail: nursing.board@state.mn.us
www.nursingboard.state.mn.us

(612) 617-2190 – Fax
(800) 627-3529 – TTY

BEFORE THE MINNESOTA

BOARD OF NURSING

REVIEW PANEL

In the Matter of
Randy D. Hopp, L.P.N.
License No.: 50619-3

AGREEMENT FOR
CORRECTIVE ACTION

This Agreement is entered into by and between Randy D. Hopp, L.P.N. ("Licensee") and a Review Panel of the Minnesota Board of Nursing ("Review Panel") pursuant to the authority of Minnesota Statutes section 214.103, subdivision 6(a)(2). Licensee and the Review Panel hereby agree as follows:

FACTS

1. On May 27, 1999, Licensee met with the Review Panel composed of John McKenzie, Board member, and Shirley A. Brekken, Associate Executive Director, to discuss allegations regarding Licensee's nursing practice contained in a Notice of Conference dated May 4, 1999. Louis Hoffman, Assistant Attorney General, represented the Review Panel at the conference. Licensee was advised by the Review Panel that he may choose to be represented by legal counsel in this matter. Although aware of this opportunity, Licensee waived representation by counsel. Licensee and the Review Panel have agreed to enter into an Agreement for Corrective Action to address the concerns identified below.

2. a. While Licensee was employed as a practical nurse at Mayo Clinic, Rochester, Minnesota, the following occurred:

1) On March 26, 1997, Licensee participated in a corrective action conference to discuss his interpersonal relationships with female co-workers. The issues included Licensee's adjustment of a necklace, reaching into a female co-worker's shirt pocket near the breast area to retrieve or replace money, slapping nurses on the buttocks, and cutting an employee's laboratory coat with a scissors. Licensee received a written warning. Licensee was

instructed not to have physical or bodily contact with other employees and was required to enroll in a mutual respect/sexual harassment class.

2) On October 22, 1997, patient WS presented to dermatology outpatient surgery for excision of a mole from her neck and a cyst from her back. While providing care, Licensee made comments or asked questions which made WS uncomfortable, such as whether she intended to live with her boyfriend. Licensee failed to prevent WS from being exposed when she turned over on the examination table. WS was embarrassed and asked to be covered. Licensee told WS that he had seen everything before. Licensee rested his hand on WS's buttocks area during the procedure. Licensee asked WS if she had any other moles and tugged at the front of the examination gown without warning or permission. Following the procedure, Licensee instructed WS to dress and left the room to schedule a follow-up appointment. Licensee returned and entered the examination room unannounced and without knocking, which caused further exposure of WS.

3) Licensee was placed on suspension while the facility investigated the incident and his position was terminated on August 27, 1997. Subsequently, Licensee called patient WS because he lost his job. WS obtained a restraining order.

b. While Licensee was employed by Help Network and working as a practical nurse at Red Wing Health Center, Red Wing, Minnesota, the following occurred:

1) Resident MP, a 21-year-old vulnerable adult, was completely dependent upon staff for all activities of daily living. On October 12, 1998, Licensee catheterized resident MP without a physician's order and in violation of facility policy. The resident sustained a reddened, swollen, painful penis and, despite intervention, the symptoms persisted for more than eight hours. Licensee failed to document the procedure in the resident's treatment record, failed to document the appearance of the urine in the medical record, and failed to inform the oncoming shift of the catheterization.

2) Licensee told staff he catheterized resident MP because the resident's urine had a foul odor. Licensee also said the urine looked clear so he dumped it out.

3) On September 2, 1998, the Office of Health Facility Complaints ("OHFC"), Minnesota Department of Health, investigated a report of the physical abuse of a vulnerable adult, resident MP. OHFC found evidence through documentation and staff interviews that physical abuse occurred.

3. In a written response to the allegations dated May 8, 1999, and during the May 27, 1999 meeting with the Review Panel, Licensee stated the following:

a. Licensee completed a mutual respect course at the Mayo Clinic. Licensee stated the entire unit was required to attend the course. Licensee also stated that he treats coworkers with the same respect that he would want from his coworkers.

b. Licensee denied that he acted inappropriately with patient WS during the excision procedure. Licensee admitted he asked the patient if she had any other moles that she was concerned about, but did not touch her gown. Licensee stated patient WS was fully clothed when he re-entered the room following the procedure. Licensee admitted that he should not have contacted the patient about his termination from the facility.

c. Licensee stated that when he asked a permanently employed nurse if Red Wing Health Center had a standing order for an "in and out" catheterization, he was told, "yes." Licensee did not check for the order. Licensee stated he performed the catheterization appropriately. Licensee admitted that he should not have dumped the specimen that he collected and he should have documented his activities about this incident. Licensee stated that he regrets any injury he caused the resident.

CORRECTIVE ACTION

4. Based on the discussion at the conference, the Review Panel views Licensee's conduct inappropriate under Minnesota Statutes section 148.261 and Licensee agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify corrective action. Licensee agrees to address the concerns identified by taking the following corrective actions:

a. One-on-One Instruction. Within six months of the date of this Agreement, Licensee shall complete one-on-one instruction with a nurse consultant. The instruction shall

last four hours or until such time as the evaluator determines is sufficient to achieve the learning objectives, whichever is greater. The nurse consultant shall be approved in advance by Board staff and must be knowledgeable in boundaries issues. Licensee is responsible for arranging and paying for the instruction. The instruction shall address scope of practical nursing practice and nurse-patient boundaries, including patient contact outside of the nurse-patient relationship. The nurse consultant shall submit a report directly to the Board, addressing the following:

1) Verification the nurse consultant has reviewed a copy of this Agreement for Corrective Action;

2) An evaluation of Licensee's understanding of the subjects of the instruction prior to beginning the consultation;

3) A description of the content and method of instruction provided during the consultation;

4) A statement indicating what Licensee learned and achieved through the instruction and how the learning was evaluated;

5) Any recommendations for additional education directed at improving Licensee's nursing practice; and

6) Any other information the nurse consultant believes would assist the Board in its ultimate review of this matter.

b. Compliance with Consultant's Recommendations. Licensee shall promptly comply with any recommendations for additional education made by the nurse consultant. Licensee must submit written documentation, such as measurable learning objectives and qualifications of the instructor, in order to receive prior approval from Board staff of classes that Licensee takes in fulfillment of this requirement. Each class must meet the continuing nursing education requirements found in Minnesota Rules 6310.2800, subpart 3. Licensee shall submit verification of participation for any class taken in fulfillment of this requirement.

c. Typewritten Paper. Within one month of completion of one-on-one instruction, Licensee shall submit to the Board a three-to-five-page typewritten paper addressing

what he learned and achieved through his one-on-one consultation. Licensee shall reflect on the situation described in paragraphs 2-3 and describe how he will apply his knowledge to his current and future nursing practice. Licensee shall cite to at least 3 sources, with one source being the Nurse Practice Act.

OTHER INFORMATION

5. Upon Licensee's satisfactory completion of the corrective action referred to above, the Review Panel agrees to dismiss the complaint(s) concerning the matters referred to in paragraphs 2-3 above. Licensee agrees that the Review Panel shall be the sole judge of satisfactory completion. Licensee understands and further agrees that if, after dismissal, the Review Panel receives additional complaints alleging conduct similar to that referred to in the facts above, the Review Panel may reopen the dismissed complaints.

6. If Licensee fails to complete the corrective action satisfactorily, or if the Review Panel receives additional complaints alleging conduct similar to that referred to in the facts above, the Review Panel may, in its discretion, reopen the investigation and proceed according to Minnesota Statutes chapters 14, 148.171-148.285, and 214. Failure to complete corrective action satisfactorily constitutes failure to cooperate under Minnesota Statutes section 148.265 and may subject Licensee to disciplinary action by the Board. In any subsequent proceeding, the Review Panel may use Licensee's agreements herein as proof of the allegations in paragraphs 2-3 above.

7. The effective date of this Agreement shall be the date it is executed by the Review Panel. The Agreement shall remain in effect until the Review Panel dismisses the complaint, unless the Review Panel receives additional information which renders corrective action inappropriate. Upon receipt of such information, the Review Panel may, in its discretion, proceed according to Minnesota Statutes chapters 14, 148.171-148.285, and 214.

8. Licensee understands this Agreement does not constitute disciplinary action. Licensee further understands and acknowledges this Agreement and the dismissal letter issued upon successful completion of the corrective action are classified as public data pursuant to Minnesota Statutes section 13.41, subdivision 4.

9. Licensee hereby acknowledges he has read and understands this Agreement and has voluntarily entered into it. This Agreement contains the entire agreement between the Review Panel and Licensee, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this Agreement.

RANDY D. HOPP, L.P.N.
Licensee

Dated: 7/25/99

JOHN MCKENZIE
For the Review Panel

Dated: 8-5-99

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