BEFORE THE INDIANA STATE BOARD OF NURSING
CAUSE NUMBER: 2023 NB 0018

IN THE MATTER OF THE LICENSE OF:

MILTON EDWARD RUTAN, L.P.N.

LICENSE NUMBER: 27042873A (ACTIVE)

FINDINGS OF FACT, ULTIMATE FINDINGS OF FACT, CONCLUSION OF LAW, AND ORDER

The Indiana State Board of Nursing ("Board") held an administrative hearing on December 14, 2023, in Conference Room B of the Indiana Government Center South located at 302 West Washington Street, Indianapolis, Indiana 46204, concerning an Administrative Complaint filed against the Indiana nursing license of Milton Edward Rutan, L.P.N. ("Respondent") on February 8, 2023.

The State of Indiana ("Petitioner") was represented by counsel, Deputy Attorney General Ryan P. Eldridge. Respondent failed to appear in person or by counsel.

The Board, after taking official notice of the file in the matter and pursuant to Ind. Code § 4-21.5-3-24, by a vote of 6-0-0 finds Respondent to be in DEFAULT. The Board by a separate vote of 6-0-0 issues the following Findings of Fact, Ultimate Findings of Fact, Conclusion of Law, and Order.

FINDINGS OF FACT

Parties

1. The Office of the Attorney General ("OAG") is empowered under Ind. Code § 25-1-7-7 to prosecute this action on behalf of Petitioner against Respondent's license.

2. Respondent is a Licensed Practical Nurse (L.P.N.), in the State of Indiana, having been issued license number 27042873A by examination on October 4, 1996, and expires on October 31, 2024.

3. Respondent's address on file with the Indiana Professional Licensing Agency ("IPLA") is 7494 S. County Road 200 E., Brownstown, Indiana 47220.

Jurisdiction

4. Between September 20, 2021, and November 23, 2021, the OAG received six (6) consumer complaints filed against Respondent, and an investigation was then conducted as authorized by Ind. Code § 25-1-7-5(b)(4).

5. After investigation, the OAG determined that the complaints had merit.

6. The OAG having tendered meritorious complaints, the Board has jurisdiction to hear this matter under Ind. Code § 25-1-7-5(b)(1).

7. Further, at all times relevant, Respondent was a "practitioner" as that term is defined by Ind. Code § 25-1-9-2.

8. As such, the Board has authority to hear this case and to impose any of the sanctions enumerated under Ind. Code § 25-1-9-9.

Respondent's Misconduct

9. At all relevant times, Respondent was employed as a L.P.N. at Jackson County Jail in Brownstown, Indiana. Respondent had been employed at this location for approximately ten (10) years.

10. At all relevant times, T.C., a twenty-three (23) year-old female, was one of Respondent's patients at Jackson County Jail. As such, Respondent was in charge of her medical care while she was incarcerated.

11. Patient T.C. suffered from sickle cell disease.

12. On or about May 26, 2021, T.C. started her incarceration at Jackson County Jail. At this time, Respondent did not evaluate her. T.C. had been previously seen at Schneck Medical Center, of which Respondent was aware.

13. During her visit at Schneck Medical Center, prior to her incarceration, sickle cell medication was listed in the medical records.

14. Between May 26, 2021 and July 15, 2021, Respondent did not complete any evaluations of T.C.

15. On July 15, 2021, T.C. started to feel ill in the afternoon. T.C. exhibited signs of illness by holding her stomach, appearing lethargic, and vomiting.

16. On July 15, 2021, during the night, a sick call was placed for T.C. because she was vomiting in her cell. T.C. was later brought a bedpan by a guard.

17. On July 16, 2021, Respondent checked on T.C. in the morning. At the time, Respondent took her blood pressure and pulse, but did not take her temperature as he did not have a thermometer on his person. At this time, Respondent noted dark vomit in a bedpan in T.C.'s cell.

18. A jail officer later took T.C.'s temperature.

19. T.C. continued to exhibit symptoms such as soiling herself, inability to walk properly, and fall(s). T.C. was left in her soiled underwear for an extended period of time.

20. In the afternoon, T.C. was moved from her cell to a holding cell. Almost immediately, T.C. fell to the ground. T.C. told another inmate that she has sickle cell disease.

21. Respondent claimed that he was not aware of T.C.'s sickle cell disease until the afternoon of July 16, 2021.

22. T.C. continued to stagger around the holding cell, and she fell onto a sleeping inmate. At this time, T.C. pleaded for help.

23. Shortly thereafter, T.C. was pulled up by her arms and moved out of the 1st holding cell to a solitary holding cell. At this time, T.C. appeared spacey and dazed. Almost immediately, T.C. took off her jumpsuit and underwear. T.C. continued to demonstrate visible struggles and a dazed state.

24. In the separate holding cell, T.C. fell and hit her head on the top bunk. T.C. then fell to the ground. Almost immediately, a guard checked on T.C. She was sitting on the ground with her half-on underwear and moaning. The guard did not help her and left the cell.

25. Respondent failed to evaluate T.C. after she hit her head.

26. Approximately an hour later, Respondent appeared and asked T.C. to get dressed to get her medication. Respondent left the holding cell without helping T.C.

27. Within a few minutes, Respondent came back to the holding cell and told T.C. that this was her last chance to get dressed or he will leave. Respondent left the holding cell without helping T.C. This was the last time that Respondent visited T.C.

28. T.C. was unable to dress herself.

29. Within the next approximately thirty (30) minutes, two (2) female guards appeared and asked T.C. to get dressed. As they closed the cell door, T.C. pleaded again for help.

30. Within a few minutes, two (2) female guards appeared again at the holding cell and one guard attempted to help T.C. get dressed. The guard(s) threatened to leave if T.C. was faking her illness. T.C. was told to get dressed so that she can be taken to medical. T.C. was not taken to medical.

31. E.M.S. arrived at the jail in the afternoon. T.C. was unsteady, dressed herself in a blanket, was moaning, and tried to lay on the stretcher but missed it. E.M.S. assisted T.C. getting onto the stretcher. At this time, T.C. was still naked. Shortly thereafter, T.C. was wheeled away on the stretcher still moaning.

32. T.C. was then transported to the hospital. At this time, T.C. was reported to have yellowing of sclera and lips. T.C. was moaning and intermittently spoke unintelligible speech. Also, T.C. had a hematoma on her right forehead which officers claimed was from “hit[ting] her head pretty hard on the top bunk” earlier during the day.

33. On July 16, 2021, T.C. died within approximately two (2) hours of leaving the jail. The primary impression was listed as cardiac arrest, while the secondary impression was listed as anemia and metabolic acidosis.

34. In addition, Petitioner submitted evidence to the Board regarding another inmate, Joshua McLemore, who was kept in solitary confinement for approximately three (3) weeks, experienced an altered mental state that went untreated, lost approximately forty-five (45) pounds from refusal to eat, and died of multiple organ failure. This inmate was under the care of Respondent at Jackson County Jail.

ULTIMATE FINDINGS OF FACT

Count 1
Disregarding a Patient's Dignity

35. Respondent's conduct constitutes a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question as evidenced by Respondent's violation of 848 IAC 2-3-3(3). Specifically, Respondent violated 848 IAC 2-3-3(3) when he disregarded a patient's dignity by allowing T.C. to remain naked in a holding cell while in a dazed and ill state, in addition to failing to evaluate T.C. or fully review T.C.'s medical records.

Count 2
Abandonment or Neglect of T.C.

36. Respondent's conduct constitutes a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question as evidenced by Respondent's violation of 848 IAC 2-3-3(7). Specifically, Respondent violated 848 IAC 2-3-3(7) when he abandoned or neglected T.C. by his failure to appropriately care for her on July 16, 2021, and his failure to evaluate her prior to this date.

Count 3
Unsafe Judgment

37. Respondent's conduct constitutes a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question as evidenced by Respondent's violation of 848 IAC 2-3-3(1). Specifically, Respondent violated 848 IAC 2-3-3(1) when he used unsafe judgment as evidenced by his actions on July 16, 2021, and by neither evaluating T.C. prior to July 16, 2021, nor obtaining and fully reviewing her Schneck records of which he was aware.

Count 4
Failure to Respect Dignity and Rights of Patient

38. Respondent's conduct constitutes a violation of Ind. Code § 25-1-9-4(a)(3) in that Respondent has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question as evidenced by Respondent's violation of 848 IAC 2-3-2(5) Specifically, Respondent violated 848 IAC 2-3-2(5) when he failed to respect the dignity and rights of T.C. who suffered from sickle cell disease.

Count 5
Failure to Keep Abreast of Current Professional Theory and Practice

39. Respondent's conduct constitutes a violation of Ind. Code § 25-1-9-4(a)(4)(B) in that Respondent has continued to practice although Respondent has become unfit to practice due to failure to keep abreast of current professional theory or practice. Specifically, Respondent violated Ind. Code § 25-1-9-4(a)(4)(B) by his failure to adequately care for T.C. on July 16, 2021, and failure to evaluate her prior to this date.

Count 6
Professional Incompetence

40. Respondent conduct constitutes a violation of Ind. Code § 25-1-9-4(a)(4)(A) in that Respondent has continued to practice although practitioner has become unfit to practice due

to professional incompetence. Specifically, Respondent violated Ind. Code § 25-1-9-4(a)(4)(A) by his failure to adequately care for T.C. on July 16, 2021, and failure to evaluate her prior to this date.

CONCLUSION OF LAW

41. Respondent's violations of Ind. Code § 25-1-9-4 is cause for disciplinary sanctions which may be imposed singly or in combination such as censure, a letter of reprimand, probation, suspension, revocation, and/or a fine up to the amount of one thousand dollars ($1000.00) per violation as detailed in Ind. Code § 25-1-9-9.

ORDER

Based upon the above Findings of Fact, Ultimate Findings of Fact, and Conclusion of Law, the Board issues the following Order:

1. Respondent's Indiana nursing license is **REVOKED.**

2. Respondent shall, pursuant to Ind. Code § 4-6-14-10(b), pay a **FEE** of **FIVE DOLLARS ($5.00)** to be deposited into the Health Records and Personal Identifying Information Protection Trust Fund. This fee shall be paid by check or money order payable to the State of Indiana, and submitted to the following address:

Office of the Indiana Attorney General
Attn: Executive Assistant, Consumer Protection
302 West Washington Street, 5th Floor
Indianapolis, IN 46204

SO ORDERED, this 4th day of March, 2024.

INDIANA STATE BOARD OF NURSING

By:_____for
Jennifer Miller, R.N.,
President
Indiana State Board of Nursing

CERTIFICATE OF SERVICE

I certify that a copy of the "Findings of Fact, Ultimate Findings of Fact, Conclusion of Law, and Order" has been duly served upon:

Milton Edward Rutan
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Service via U.S. Mail
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Explanation of Service Methods
Personal Service: by delivering a true copy of the aforesaid document(s) personally.
Service by U.S. Mail: by serving a true copy of the aforesaid document(s) by First Class U.S. Mail, postage prepaid.
Service by Email: by sending a true copy of the aforesaid document(s) to the individual's electronic mail address.