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STATE OF WISCONSIN		
BEFORE THE BOARD OF NURSING		
IN THE MATTER OF DISCIPLINARY		
PROCEEDINGS AGAINST		
THOOLESINGS NOT LINET		
KAREN SUE MEAD, LPN,	FINAL DECISION AND ORDER	
RESPONDENT.	LS9905149NUR	
RESPONDENT.	L39903149NOK	
		98 NUR 172
		30 NOR 1/2

The parties to this action for the purposes of §227.53, Wis. Stats., are:

Ms. Karen Sue Mead, LPN W287 N3241 Lakeside Dr. Pewaukee, WI 53072

Board of Nursing P.O. Box 8935 Madison, WI 53708-8935

Department of Regulation and Licensing Division of Enforcement P.O. Box 8935 Madison, WI 53708-8935

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

- 1. Respondent Karen Sue Mead, (dob 4/2/1957) is and was at all times relevant to the facts set forth herein a licensed practical nurse licensed in the State of Wisconsin pursuant to license #20183, originally granted on 5/31/1978.
 - 2. Respondent's most recent address on file with the Department of Regulation and Licensing is W287 N3241 Lakeside Dr., Pewaukee, WI 53072
- 3. At all times relevant to this action Respondent was employed as a licensed practical nurse at Virginia Health Care Center, 1451 Cleveland Ave., Waukesha, WI 53186.
- 4. Respondent was one of the nurses responsible for the security of controlled substances during her duty shift. Virginia Health Care Center performed a Controlled Substance Audit commencing February, 1998. Many control sheets had no corresponding Medical Administration Record (MAR) entries and MAR entries had no corresponding control sheets. The sheets with discrepancies all had Respondent's initials on them. On the following dates controlled substances under Respondent's supervision could not be accounted for:

7/27/1998 2 propoxyphene missing from resident F.M.

9/2/1998 1 propoxyphene missing from resident C.O

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9/7/1998 1 propoxyphene missing from resident M.
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9/8/1998 1 hydrocodone missing from resident N.M.

9/8/1998 1 propoxyphene missing from resident R.S.

9/14/1998 2 lorazepam missing from resident B.S.

9/16/1998 1 hydrocodone missing from resident L.C.

9/16/1998 1 propoxyphene missing from resident C.O.

9/16/1998 1 propoxyphene missing from resident H.S.

9/20/1998 1 propoxyphene missing from resident C.O.

9/20/1998 1 propoxyphene missing from resident H.S.

9/23/1998 1 propoxyphene missing from resident F.M.

9/23/1998 1 hydrocodone missing from resident L.C.

9/23/1998 1 propoxyphene missing from resident H.S.

9/25/1998 2 oxycodone missing from resident G.K.

9/27/1998 1 Darvocet missing from resident M.G.

9/27/1998 1 hydrocodone missing from resident M.K

9/27/1998 2 propoxyphene missing from resident H.S.

9/27/1998 1 hydrocodone missing from resident L.C.

9/28/1998 2 oxycodone missing from resdient G.K.

9/28/1998 1 propoxyphene missing from resident C.O.

- 5. Respondent was disciplined by her employer on 3/30/1998 and 6/16/1998 for failing to properly chart PRN medications administered to a patient and failing to chart the results of PRN medication with a pain scale.
- 6. On 9/25/1998, and 9/28/1998, Respondent signed out oxycodone two times from Resident G.K.'s control sheet. However, the Medication Administration Record (MAR) has no entry of the medication being administered, refused, or destroyed. Resident G.K. has a physician's order for oxycodone for pain PRN. Resident G.K. stated she did not complain of pain, did not request oxycodone, did not refuse oxycodone, and did not receive any oxycodone.
- 7. On 12/28/1998, Respondent reported that a resident had refused the medication and she had destroyed four oxycodone tablets without a witness, contrary to institution policy and procedure.
 - 1. Respondent admitted that she filled in the pain scale on each patient's patient record without conducting a follow up assessment after medications had been administered.

CONCLUSIONS OF LAW

By the conduct described in paragraphs 4, 5, 6, 7, and 8, above, Karen Sue Mead is subject to disciplinary action against her license as a licensed practical nurse in the state of Wisconsin, pursuant to $\S441.07(b)$ and (d) Wis. Stats. and \S N 7.03(1)(a) and (b) and \S N 7.04(2), (6)and (15). Wis. Adm. Code.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED, that the attached Stipulation is accepted.

IT IS FURTHER ORDERED that Karen Sue Mead is REPRIMANDED for her unprofessional conduct in this matter.

IT IS FURTHER ORDERED that the license of Respondent to practice as licensed practical nurse in the state of Wisconsin is LIMITED as follows:

a. Respondent shall certify to the Board the successful completion of an approved course of training in medication administration and documentation and an approved course in nursing ethics, within 9 months of the date of this order. Within 2 months of the date of this Order, Respondent shall submit to the Board designee an outline of the required training for approval, which shall contain the name of the institution providing the instruction, the name of the instructor, and the course content.

Failure by Respondent to fully and timely comply with the requirements of this Order shall result in the suspension of Respondent's license to practice as a nurse without further notice or hearing, until such time as full compliance with the provisions of this Order has been attained.

b. Until certification of successful completion of the required training, Respondent

shall not engage in direct patient care.

c. Respondent shall provide her nursing employers with a copy of this Order before engaging in any nursing employment.

The rights of a party aggrieved by this Decision to petition the Board for rehearing and to petition for judicial review are set forth on the attached "Notice of Appeal Information".

This Order shall become effective upon the date of its signing.

Dated this May 14th, 1999.

WISCONSIN BOARD OF NURSING, by:

Timothy D. Burns, CRNA

Chair