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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE

DISCIPLINARY PROCEEDINGS

AGAINST:

DEBORAH L. ROGAHN, R.N.	**FINAL DECISION AND ORDER**
RESPONDENT	**LS0109064NUR**

Division of Enforcement Case No. 00 NUR 194

The parties to this action for the purposes of section 227.53 of the Wisconsin statute are:

Deborah L. Rogahn

5320 W. Pleasant Drive

Mequon, WI 53092

Department of Regulation and Licensing

Division of Enforcement

PO 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. Deborah L. Rogahn (DOB 12-03-48) is duly licensed as a registered nurse in the state of Wisconsin (license #30-52938). This license was first granted on November 6, 1970.

2. Rogahn's most recent address on file with the Wisconsin Board of Nursing is 5320 W. Pleasant Drive, Mequon, WI 53092.

3. At all times relevant to the incidents involved herein, Rogahn was employed as a private duty nurse with the Horizon Home Care and Hospice (HHCH), 8949 N. Deerbrook Trail, Brown Deer, Wisconsin. Rogahn has been employed as a nurse with HHCH for approximately eight years.

4. During the course of her duties, Rogahn was assigned to provide nursing care for a female infant who was born on March 24, 1999. The infant, hereinafter referred to as the "patient" had birth-related cognitive and physical disabilities. HHCH admitted the patient in June 1999, with physician orders for private duty nursing 7 days per week, 1 to 8 hours per day. The nursing duties included medication administration, gastric tube feedings, therapies, bathing and daily cares.

5. The patient's medical conditions are birth-related asphyxia, convulsions and gastrostomy. At the time of the alleged incidents, the patient suffered from tracheal spasms and reflux, which required frequent suctioning to prevent aspiration. The patient also had arching and spasms related to uncontrolled pain. The arching consisted of an unpredictable jerking of the patient's body. The patient had limited head and neck control. The patient could not sit up or roll over on her own.

6. Rogahn provided nursing care for the patient during the day shift, approximately one day per week for nine months, beginning in September 1999. Rogahn would occasionally work extra days to fill-in for other nurses who were on leave.

7. On May 2, 2000, without the knowledge or consent of Rogahn or her employer, the patient's parents placed a hidden video camera in their home and filmed Roghan during her shift.

8. On May 4, 2000, at the beginning of her next shift, Rogahn was told by the patient's parents that they did not want her to provide nursing care to their child. Rogahn was told by the parents that they had received reports from their older son that the patient cried more during her shift. Rogahn was not informed about the videotape or allowed to view it.

9. Four days after her termination, on May 8, 2000, the patient's mother complained to HHCH that she found a finger nail sized cut on the patient's arm and small bruises on the patient after one of Roghan's previous shifts. The parents had not reported these alleged injuries to HHCH when they were discovered and did not have photographs to substantiate their allegations.

10. On July 17, 2000, Ann Kirsch, the HHCH Clinical Manager, spoke to the patient's mother concerning the videotaping of Rogahn, after another nurse reported to the employer that the videotaping had occurred. The patient's mother admitted to Kirsch that she had videotaped Rogahn but did not submit the tape or report the incident to HHCH because she did not want to cause any trouble.

11. On July 18, 2000, Ann Kirsch and Susan Wollmer, the Case Manager, viewed the videotape and interviewed Rogahn. The videotape started at the beginning of Rogahn's shift on May 2, 2000, at 6:30 a.m., and showed the night shift nurse suctioning the patient. After the procedure was finished, Rogahn was holding the patient, trying to calm her. Rogahn next placed the patient in her infant seat and rocked the seat in an effort to calm the patient who continued to cry. Rogahn talked to the patient and asked the patient to settle down.

12. During the course of the videotaping, Rogahn prepared the supplies for the patient's bath. After the bath, the videotape shows that Rogahn returned the patient to her infant seat and began her gastric tube feeding. During the feeding, Rogahn was sitting next to the patient. Rogahn appeared to be looking at a television and did not maintain frequent eye contact with the patient.

13. The videotape shows that as the patient's feeding progresses, the patient began to have difficulty breathing. Rogahn then moved the patient forward in her infant seat and began to suction her airway. Patient appeared to vomit and Rogahn remarked to the patient that she was throwing up her feeding. Rogahn then removed the patient from her infant seat and as she moved her, the patient's head bumped the metal rim of the seat. Rogahn then flipped the patient over onto the floor on her stomach. As she lifted and flipped the patient, the patient's face appeared to hit the carpeted floor. The patient remained on the floor with her head turned to the side while Rogahn verbally comforted her and patted her back.

14. When asked about her handling of the patient as shown on the videotape, Rogahn stated that she had to turn the patient over so that she would not aspirate while vomiting. Rogahn attributed the patient's crying to the fact that she did not carry the patient all the time. She explained that when she was preparing the patient's medications or getting supplies, she would not carry the patient because it was not safe. Rogahn indicated that feeding the patient in her infant seat appeared to work best because the patient's alignment was straighter.

15. Several of the nurses who worked with the patient confirmed that the patient often cried, arched and was irritable during their shifts. One of the nurses indicated that the patient needed a lot of suctioning, thumping on the chest, walking, and holding because she was in constant pain. Another nurse stated that it was difficult to hold the patient because she was always arching and posturing. The nurse found that rocking or consoling the patient was inadequate to relieve the patient's discomfort.

16. Several of the nursing staff indicated that they fed the patient while she was laying flat as this appeared to work best for her. Dr. Duquesnoy, the patient's physician, confirmed that it would not be inappropriate or unreasonable to feed the patient in a prone or flat position. Dr. Duquesnoy also stated that the patient's parents had not talked to him about poor nursing care and he did not believe that the underlying issue was a nursing problem.

17. Susan Wollmer, the HHCH Case Manager, indicated that she supervised the nursing staff and conducted monthly visits at each site. Wollmer had not received any complaints about the quality of the Roghan's nursing care from Rogahn's other patients.

18. Mary Haynor, the HHCH Administrator, reviewed the videotape of Rogahn and prepared the DHFS Caregiver Misconduct Report. She stated that the main focus of her investigation was the nurse's intent. Haynor reviewed the portion of the tape showing the patient's head hitting the floor and attributed to the patient's head hitting the floor to difficulty of handling a heavy infant who had limited head and neck control. Haynor did not find any evidence that Rogahn acted with intent to harm the patient. Rogahn was disciplined by HHCH Rogahn for less

than optimal care.

In resolution of this matter, Rogahn consents to the entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

Deborah L. Rogahn, by the conduct described above, has violated Wisconsin Administrative Code § N 7.03 (1) (b).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that Deborah L. Rogahn R.N. shall within ninety (90) days from the date of this Order, submit proof of having successfully completed not less than four (4) hours of one-on-one training with a licensed professional who has expertise in the nursing care for developmentally disabled infants under the age of 24 months.

IT IS FURTHER ORDERED that the Nursing Board shall pre-approve the professional selected by Respondent to conduct the training and shall approve the content of the training. The trainer shall evaluate Respondent's skills and knowledge related to the handling, transfer, feeding and aspiration of disabled infants, as well as any other procedures relevant to the incidents described herein. The trainer shall be provided a copy of the Board order and shall view the videotape and if necessary, conduct an oral or written examination of Respondent as part of the evaluation and training process.

IT IS FURTHER ORDERED that Respondent shall pay the costs of the training. All information related to implementation of the order, including the material for pre-approval by the Board and written verification of successful completion shall be submitted to the Department Monitor at the address below:

Department Monitor

Department of Regulation and Licensing

P.O. Box 8935

Madison, WI 53708-8935

tele: (608) 267-9817

IT IS FURTHER ORDERED THAT Respondent shall not provide nursing care to developmentally disabled infants, under the age of 24 months, until she has verified completion of the training described above.

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

WISCONSIN BOARD OF NURSING

By: Ann Brewer 9-6-01

A member of the Board Date