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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST:

SUZANNE M. HIGGINS, LPN,	FINAL DECISION AND ORDER
RESPONDENT	LS0203018NUR

Division of Enforcement Case No. 00 NUR 297

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

Suzanne M. Higgins

3267 North 82nd Street

Milwaukee WI 53222

Board of Nursing

PO Box 8935

Madison, WI 53708-8935

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, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

In the interest of resolving this matter, Respondent neither admits nor denies the allegations against her and consents to the entry of the following Findings of Fact, Conclusions of Law and Order.

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

FINDINGS OF FACT

1. Suzanne M. Higgins (D.O.B. 01/25/1960) is duly licensed as a practical nurse in the state of Wisconsin (license #29998). This license was first granted on 12/01/1989.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 3267 North 82nd Street, Milwaukee, WI 53222.

3. At all times relevant to this action, Respondent worked as a licensed practical nurse at River Hills West Health Care Center ["River Hills"], 321 Riverside Drive, Pewaukee, Wisconsin. River Hills is a long-term care facility

4. On December 1, 1999 at approximately 6:00 a.m., a licensed practical nurse checked on the condition of PC, an elderly female resident of River Hills. The LPN charted that she was unable to detect a pedal pulse in PC's left foot. She also noted a small bruise on the top of PC's left foot, that her left foot was ruddy colored and that it was slightly cool.

5. On December 1, 1999, Respondent was a P.M. shift nurse at River Hills who provided care to resident PC.

6. The information contained in paragraph 4 above was included on the facility's 24-hour Change of Condition report form. Interim charting on the day shift showed no follow-up regarding the lack of a pedal pulse for this resident.

7. Respondent's charting for PC on December 1, 1999 shows no follow-up assessment of PC's foot by Respondent, nor does it show that Respondent reported this change in condition to PC's physician.

8. Respondent next worked at River Hills on December 2, 1999. Respondent's charting for PC fails to include any assessment of PC's left foot.

9. Respondent's next charting for resident PC was on December 7, 1999. On that date, PC's granddaughter (a registered nurse) and her granddaughter's husband (an anesthesiologist) visited PC and examined her left foot. They then requested that arrangements be promptly made for PC to see a vascular specialist. Respondent did not at that time conduct an independent assessment of PC's foot. Her charting for PC on that date fails to include any documentation of pedal pulse, nor does the charting contain any reference to examination for capillary refill, temperature of foot or comparison of PC's left foot with her right.

10. In response to the family's request referred to above, Respondent charted that she prepared a "MD slip." Respondent did not contact PC's physician, nor did she make any entry on the 24-hour report form for this resident.

11. Respondent next cared for this resident on December 8, 1999. Respondent did not on that date conduct an independent assessment of PC's foot. Her charting for PC on that date fails to include any documentation of pedal pulse, nor does the charting contain any reference to examination for capillary refill, temperature of foot or comparison of PC's left foot with her right. Respondent did arrange for PC to be seen for a vascular consultation on the following day.

12. On December 9, 1999, Respondent accompanied PC to her physician's appointment. . Respondent did not on that date conduct an independent assessment of PC's foot. The vascular surgeon who examined PC on December 9, 1999 found no pulse in PC left foot and observed that PC's left foot was mottled, "ice cold" and "essentially dead."

13. In resolution of this matter, Respondent consents to the issuance of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter, pursuant to sec. 441.07, Stats.

2. The Wisconsin Board of Nursing is authorized to enter into the attached stipulation, pursuant to sec. 227.44(5), Stats.

3. By the conduct described above, Suzanne M. Higgins is subject to disciplinary action against her Wisconsin nursing license, pursuant to sec. 441.07(1), Wis. Stats., and Wis. Admin. Code §§N7.03 (1) and N7.04 (4) and (15).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that Suzanne M. Higgins LPN (license #29998) is REPRIMANDED.

IT IS FURTHER ORDERED that the Wisconsin nursing license of Suzanne M. Higgins (license #29998) is LIMITED as follows:

1. Respondent shall comply with all statutes and code provisions relating to the practice of nursing.

Practice restrictions

2. Until otherwise ordered by the Board

a. Respondent shall practice only in settings where she works under supervision by another nurse or other licensed health care professional. Respondent shall refrain from nursing employment as a charge nurse.

b. Respondent shall refrain from nursing employment as a pool nurse; and

c. Respondent shall refrain from nursing employment as a visiting nurse or other home care practitioner

Education Requirement

3. Within twelve (12) months from the effective date of this Order, Respondent shall submit documentation of successful completion of at least twelve (12) hours of continuing nursing education approved by the Board in the

subject areas of patient charting and legal aspects of nursing and six (6) hours in caring for patients with circulatory problems, or in other areas approved by the Board. To be acceptable, a course shall be pre-approved by a member or designated agent of the Board of Nursing. Acceptable documentation shall include certification from the sponsoring organization as well as a statement signed by Respondent verifying that she attended the course in its entirety.

Required reporting

4. For a period of at least one [1] year from the date of this Order, Respondent shall arrange for quarterly reports from her nursing employer(s) reporting the terms and conditions of her employment and evaluating her work performance. These reports shall be submitted to the Department Monitor in the Department of Regulation and Licensing Division of Enforcement.

5. Respondent shall notify the Department Monitor of any change of employment during the time in which the Order is in effect. Notification shall occur within fifteen (15) days of a change of employment and shall include an explanation of the reasons for the change.

Department Monitor

6. The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with the terms of this Order, including receiving reports and coordinating all requests for approval of education or other petitions. The Department Monitor may be reached as follows: Department Monitor c/o Division of Enforcement, PO Box 8935, Madison, WI 53708-8935. TEL (608) 267-3817 FAX (608) 266-2264

Petition for Termination of restrictions

7. Upon completion of: one [1] year of complete, successful and continuous compliance with the terms of this Order that includes one [1] year of nursing employment under the terms of this Order; Respondent may petition the Board to revise or eliminate any of the above conditions. Denial in whole or in part of a petition under this paragraph shall not constitute denial of a license and shall not give rise to a contested case within the meaning of Wis. Stats. §§227.01(3) and 227.42.

Agency Caregiver Finding

8. If Respondent fails to fully and completely comply with all terms and conditions set forth above or if the Department receives a subsequent credible allegation against Respondent of abuse, neglect or misappropriation, the Department Monitor shall without further notice or hearing notify the Wisconsin Department of Health and Family Services that the findings set forth in this Order shall thereafter constitute an agency finding of neglect for the purposes of secs. 48.685 and 50.065, Wis. Stats. Respondent shall then REFRAIN from any nursing employment in any facility licensed by the Wisconsin Department of Health and Family Services until such time as Respondent successfully completes a rehabilitation review administered by DHFS.

SUMMARY SUSPENSION

9. Violation of any of the terms of this Order may in addition be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license pursuant to the procedures set forth in Wis. Admin. Code RL Ch. 6. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order.

Effective date of Order

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

BOARD OF NURSING

By: Linda Sanner	3-1-02
On behalf of the Board	Date