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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE

DISCIPLINARY PROCEEDINGS

AGAINST:

LYNETTE E. KRAMER, R.N.	**FINAL DECISION AND ORDER**
RESPONDENT	**LS0204045NUR**

Division of Enforcement Case No. 99 NUR 251

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

Lynette E. Kramer

W868 Froelich Road

Sullivan, WI 53178

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. Lynette E. Kramer (DOB 05-26-55) is duly licensed as a registered nurse in the state of Wisconsin (license #30-65221). This license was first granted on September 17, 1976.

2. Kramer's most recent address on file with the Wisconsin Board of Nursing is W868 Froelich Road, Sullivan, WI 53178.

3. At all times relevant to the incidents involved herein, Kramer was self-employed as the owner of Care & Comfort Associates, Inc., ("CCA"), a home health care business, located at W868 Froelich Road, Sullivan, Wisconsin 53178.

4. On August 4, 1999, the State of Wisconsin, Bureau of Quality Assurance ("BQA") received a report from a client's father alleging that Respondent had abused a client at the client's home while employed by CCA.

5. The report to BQA alleged that Respondent "closes the cuff on the client's ventilator so he could not talk" and that the client was afraid of Respondent because "she has threatened to close it all the time that she is his nurse if he tells anyone." The report also indicated that other nurses have notified the family that the client was lethargic and the staff was concerned that the client may have been over-medicated.

6. The report was forwarded by BQA to the Department of Regulation and Licensing ("DRL") on the basis that BQA did not have jurisdiction over individuals whose credentials are regulated by DRL.

7. The BQA report was screened and opened by DRL as a complaint for investigation. During the course of the investigation, a number of individuals who were involved in the client's care were interviewed, including the Respondent, the nursing staff, the client and the client's family.

8. During the course of the investigation, an allegation was made by the client's father and some of the nursing staff that the Respondent had made inappropriate statements or threats to the client about placing him in a nursing home. Another witness alleged that Respondent conducted personal business while on duty and did not respond to requests to provide care to the client.

9. During the course of the investigation, an allegation was made by one of the nursing assistant's and the client's father that Respondent would neglect the client while she was talking on the telephone. The nursing assistant alleged that on one occasion while Respondent was on the telephone, the client began coughing and appeared to need suctioning. The assistant alleged that she asked Respondent to check the client but Respondent indicated that she had just suctioned the client and she needed to complete her conversation.

10. The client's father alleged that he was also present during the coughing incident and threatened to suction the client himself if Respondent would not get off the telephone. The client's father alleged that he observed that the client's tracheostomy tube dislodged due to the coughing and that a large mucous plug had to be removed from the client's throat.

11. During the course of the investigation, additional information was provided from other nursing staff who had worked with Respondent and the client. These staff members alleged that the client and his family had never complained about Respondent inappropriately closing his cuff. They alleged that Respondent had never instructed them to close the client's cuff as means of behavior modification. These staff members further alleged that the client never indicated that he was afraid of Respondent or that Respondent had threatened to place him in a nursing home if she did not manage his care. They indicated that Respondent was a competent and caring professional who exhibited a high degree of professionalism on the job.

12. The uncontroverted information gathered during the investigation confirmed the following:

a.) Respondent provided home health care to the client, referred to hereinafter as "DE" for period of three years, beginning on September 4, 1996. Respondent provided case management and direct patient care to DE through her company, Comfort Care and Associates, Inc., referred to hereinafter as "CCA."

b.) In addition to case management services, Respondent scheduled herself to work as a shift nurse for which she received a separate hourly wage. As a shift nurse, Respondent provided direct patient care to DE.

c.) DE is a forty-five year old adult male patient who was severely injured in a traffic accident in 1995. DE requires 24-hour, seven-day per week, skilled nursing care and is dependent on nursing staff and family for all his physical cares.

d.) DE's medical diagnosis is C2 quadriplegic, with a gastrostomy tube, heart pacemaker and tracheostomy. DE is ventilator dependent, bilaterally blind, partially deaf, and has impaired cognitive abilities due to head injuries.

e.) DE has a cuffed tracheostomy, which allows him to achieve some limited vocalization when the cuff is deflated or "open", as air passes over his vocal chords.

f.) DE did not like his cuff inflated or "closed" when he was awake because he could not talk. When the cuff was closed, DE's only form of communication was an audible "clicking" of his tongue or shaking of his head.

g.) DE was known to react negatively to having his cuff closed for even a few minutes. DE would shake his head or click to let the staff know that he did not want his cuff closed. Sometimes DE would agree to let the staff close his cuff if he was short of breath but then only for a few minutes before he would get upset about it being closed.

h.) DE's cuff was required to be "closed" by all of the nursing staff periodically during each shift. The cuff was "closed," per medical orders, whenever the trachea secretions were suctioned or the tracheostomy was cleaned. The cuff was also closed when DE was eating and when he was resting or sleeping.

i.) DE's physician indicated that the ventilator works betters when the cuff is closed. The inflating or "closing" of the tracheostomy cuff improves blood oxygenation, facilitates rest or sleep, and prevents accidental aspiration. DE's physician was aware that DE did not like his cuff closed, but never received any complaints from DE about Respondent closing the cuff.

j.) DE was a difficult patient to care for who often became agitated and made vulgar and offensive remarks to the nursing staff. DE could become easily upset with staff. Many of the nursing staff had learned to tolerate DE's outbursts.

k.) DE was prone to anxiety and depression. DE would make statements that he felt like he was choking or could not breathe. He was prone to aspiration and respiratory infections. DE was lethargic and would often sleep up to six hours in a 12-hour nursing shift.

l.) DE suffered from headaches, hallucinations and expressed irrational thoughts. DE was treated with a number of psychotropic medications. DE's medication was repeatedly adjusted by his physician and psychiatrist in an effort to improve his symptoms.

m.) While legitimate medical reasons existed for Respondent and the nursing staff to deflate or "close" DE's cuff, DE and his family may not have understood or agreed with the closure of his cuff at times.

n.) Respondent and DE's father had a strained relationship and were not on good terms. DE's father was known to use profanity and make vulgar and sexually inappropriate remarks about Respondent and some of the female nursing staff.

o.) It became increasingly difficult for DE's wife to handle the continual complaints from DE's father about Respondent. DE's wife and Respondent talked about options for DE's care. Respondent told DE's wife that if she could not find another home health agency, DE would probably end up in a nursing home.

p.) DE's wife held the Power of Attorney for Health Care, which included the authority to admit DE to a nursing home. DE's wife was given a Client's Rights and Responsibilities form provided by CCA, which stated that she had the right to make decisions regarding DE's health care and selection of health care providers, including the right to file a complaint about CCA.

q.) Respondent admits that while DE was sleeping, she sometimes conducted personal business, including making numerous personal and business telephone calls. The majority of Respondent's telephone calls were made to individuals or health care facilities on behalf of her home health company. Respondent also made personal calls to her family, friends and business associates.

r.) Respondent also admits that she occasionally conducted interviews at DE's residence for staff related to DE's care. Respondent admits that she sometimes conducted telephone interviews of staff for other client cases, while she was on duty to care for DE.

s.) Respondent admits that she occasionally washed her soiled garments at DE's residence while on duty. Respondent also admits that she did other personal grooming, such as fixing her hair and cosmetics while on duty.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter, pursuant to sec. 441.07 (d), Wis. Stats. and is authorized to enter into the attached stipulation, pursuant to sec. 227.44(5), Wis. Stats.

2. By the conduct described in the paragraphs above, Lynette E. Kramer has violated §N 7.04 (4), Wis. Adm. Code.

3. The Findings of Fact set forth above constitute an agency finding of abuse or neglect within the meaning of secs. 48.685 and 50.065, Wis. Stats. and shall be reported to the Department of Health and Family Services for rehabilitation review.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

(1) Respondent, Lynette E. Kramer R.N. (#30-65221), shall successfully complete three (3) credits in a Board-approved Ethics course and six (6) hours in a Board-approved Patient's Rights course within one (1) year from the date of this Order. The course titles and name of the educational provider selected by Respondent to fulfill this Order shall be submitted to the Board of Nursing for pre-approval within 30 days from the date of this Order.

(2) Respondent shall not provide direct patient nursing care in a home health care setting Respondent until she has completed at least 800 hours of direct patient care under the direct supervision of a Registered Nurse. Respondent must submit the name of the supervised work-site and the name of her direct supervisor to the Board for pre-approval. Respondent's supervisor shall submit work reports to the Board, after every 200 hours of work completed by Respondent and indicate whether Respondent is abiding by all rules and laws governing the nursing profession. Respondent must provide a copy of the Board Order to her employer-supervisor.

(3) Respondent shall successfully complete a rehabilitation review administered by the Wisconsin Department of Health and Family Services, and refrain from nursing employment in any Wisconsin DHFS-licensed facility until she has successfully passed the rehabilitation review.

(4) Respondent shall complete uncompensated volunteer service of no less than ninety (90) hours to a charitable or civic organization. The volunteer services shall be pre-approved by the Board of Nursing and shall be supervised by a representative of the organization. Respondent shall provide a copy of the Order to the supervisor. Upon completion of Respondent's volunteer service, the organization shall provide written verification to the Department Monitor. Respondent's volunteer service must be completed within one (1) year from the effective date of the Order.

(5) Respondent shall provide the names, addresses and telephone numbers of her current home health clients to the Department Monitor within five (5) working days of the effective date of this Order. Respondent shall provide written notice of the limitation on her license regarding direct patient care in a home health care setting to all current and future clients to whom she provides direct patient care. If Respondent obtains any new case management clients, she must notify the Monitor within five (5) working days of the names, addresses and telephone numbers of her new clients. These notification requirements shall remain in effect until the limitations upon Respondent's nursing license are removed.

(6) Respondent shall provide a copy of the monthly nursing schedule for any client that is provided direct patient care by Respondent's company. Respondent shall also provide a monthly written statement from her bookkeeper verifying that Respondent has not billed or been paid for direct nurse care for any of her home health care clients. These reporting requirements shall remain in effect until the limitations are removed from Respondent's license by the Board.

(7) Upon completion of Respondent's supervised work, education and volunteer service, Respondent may personally appear before the Board and petition for the removal of the limitations upon her license. The 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 secs. 227.01(3) and 227.42, Wis. Stats.

(8) Respondent shall pay partial costs of the investigation in the amount of five hundred ($500.00). The partial costs shall be due in full within 90 days of the date of this Order.

(9) Respondent shall submit written verification in regard to her compliance with the requirements set forth above to the Department Monitor for approval by the Board to:

Department Monitor

Department of Regulation and Licensing

P.O. Box 8935

Madison, WI 53708-8935

tele: (608) 267-3817

IT IS FURTHER ORDERED that in the event that Respondent fails to fully and timely comply with the requirements set forth in the paragraphs above, her Wisconsin license to practice as a registered nurse shall be SUSPENDED, without further notice or hearing, until she has complied with the terms of this Order. Violation of any of the terms of this Order may 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 448.02(4) Wis. Stats. and 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.

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

WISCONSIN BOARD OF NURSING

By: Linda Sanner 4-4-02

A member of the Board Date