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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY	:	
PROCEEDINGS AGAINST :		
	:	FINAL DECISION AND ORDER
DIANE M. BLACK, LPN,	:	LS0206261NUR
RESPONDENT	:	

Division of Enforcement Case No. 00 NUR 295

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

Diane M. Black

325 Benton Street

Cambridge, WI 53523

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

For the purpose of settlement of this matter, Ms. Black neither admits nor denies the allegations against her. Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Diane M. Black, LPN (D.O.B. 03/26/1966) is duly licensed as a practical nurse in the state of Wisconsin

(license #30281). This license was first granted on 06/06/1990.

2. Ms. Black's most recent address on file with the Wisconsin Board of Nursing is 325 Benton Street, Cambridge, WI 53523.

3. At all times relevant to this action, Ms. Black was working as a licensed practical nurse at Skaalen Sunset Home, 400 North Morris, Stoughton, Wisconsin.

4. On or about October 2, 2000 and prior to 1100 hours Respondent charted administration of both 0830 and 1230 nebulizer treatment for resident RG as given. Respondent knew or should have known at the time of administration of the second treatment that RG's portable oxygen tank was not functioning properly, but performed no intervention to remedy the situation.

5. On or about October 9, 2000 Respondent failed to take the morning blood glucose reading for resident AN, but charted a 0830 glucose level of 168 for this resident.

6. On or about October 9, 2000 Respondent failed to take the morning blood glucose reading for resident SN, but charted a 0700 glucose level of 96 for this resident.

7. On or about October 9, 2000 Respondent failed to take the morning blood glucose reading for resident CC, but charted a 1100 glucose level of 128 for this resident.

8. On or about October 10, 2000 Respondent failed to take the morning blood glucose reading for resident SN, but charted a 0700 glucose level of 98 for this resident.

9. On or about October 11, 2000, Respondent failed to take morning blood glucose readings for resident AN, but charted a 0830 glucose level of 148 and a 0900 glucose level of 201 for this resident.

10. On or about October 11, 2000 Respondent failed to take the morning blood glucose reading for resident SN, but charted a 0700 glucose level of 100 for this resident.

11. On or about October 11, 2000 Respondent failed to take the morning blood glucose reading for resident CC, but charted a 0700 glucose level of 89 for this resident.

12. On or about October 13, 2000 Respondent failed to take the morning blood glucose reading for resident AN, but charted a 0900 glucose level of 108 for this resident.

13. On or about October 13, 2000 Respondent failed to take the morning blood glucose reading for resident SN, but charted a 0700 glucose level of 131 for this resident. Respondent charted administration of regular insulin at 0700 hours for SN as well as administration of NPH insulin at 0800 hours.

14. On or about October 13, 2000 Respondent failed to administer nebulizer treatments as ordered for resident RG.

15. On or about October 19, 2000 Respondent did not chart the morning blood glucose reading for resident SN. When questioned regarding the blood sugar for the resident, Respondent reported a 0700 glucose level of 168. Respondent was directed to retake the reading. Respondent later falsely reported that she had re-tested the resident and reported a second confirmatory reading of 166. The blood glucose for SN was independently taken and revealed a reading of 86.

CONCLUSIONS OF LAW

By the conduct described above Respondent violated 441.07(1), Wis. Stats. and Wis. Admin. Code §§ N 7.03(1)(a and N 7.04(4), (6) and (15). Furthermore, the Findings of Fact set forth above constitute an agency finding withir the meaning of secs. 48.685 and 50.065, Wis. Stats.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that

1. Diane M. Black shall SURRENDER her license to practice as a practical nurse in the state of Wisconsin (license #30281).

2. Ms. Black shall return to the Department her current LPN registration card, as well as any and all other official indicia of licensure within her possession.

IT IS FURTHER ORDERED that

3. Should Ms. Black reapply for Wisconsin licensure, the Board may in its sole discretion determine whether, and under what terms and conditions, this license may be reissued.

4. This Order shall become effective on the date of its signing.

BOARD OF NURSING

By: Linda Sanner 9-5-02

A Member of the Board Date