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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
ROBYN M. BURTON, LPN,	:	LS0306061NUR
RESPONDENT	:	

Division of Enforcement Case No. 99 NUR 306

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

Robyn M. Burton

N9516 Lake Road

Ripon, WI 54971

Board of Nursing

PO Box 8935

Madison, WI 53708-8953

Department of Regulation and Licensing

Division of Enforcement

PO Box 8935

Madison, WI 53708

The parties in this matter agree to the terms and conditions of the Attached Stipulation as the final decision of this matter, subject to 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 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. Robyn M. Burton (D.O.B. 06-12-1956) is duly licensed as a practical nurse in the state of Wisconsin (license #26494). This license was first granted on 12-02-1983. Prior to these proceedings and since her licensure in 1983, Respondent has not been the subject of an investigation by the Board of Nursing and has never been the subject of discipline.

2. Respondent's home address is N9516 Lake Road, Ripon, WI 54971.

3. At all times relevant to this action, Respondent was working as the administrator and as a licensed practical nurse at Michalene's Supportive Care Retirement Community (Michalene's), a community based residential facility in Ripon, Wisconsin. Respondent is currently employed at Michalene's in the position of LPN/Administrator.

4. On or about December 4, 1998, the Department of Health and Family Services (DHFS), Division of Supportive Living, Bureau of Quality Assurance, issued a statement of deficiency to Michalene's. The Notice of Deficiency sets forth the following alleged deficiencies:

    a. The facility retained a resident (resident #2) who was abusive to other residents and did not take measures to minimize the risk.

    b. The facility did not give immediate notice to the designated representative of resident #1 (the patient who was injured by resident #2) that resident #1 was abused.

    c. The facility did not conduct an investigation into an allegation of abuse as reported by staff and a resident; and

    d. The facility did not provide prompt and adequate treatment appropriate to resident #1's needs.

5. The above-referenced deficiencies were based (at least in part) upon the following allegations:

    a. On July 7, 1998, Michalene's admitted resident #2 as a resident at the facility. Resident #2 was a 56-year-old man who presented with diagnoses, among other things, of Huntington's chorea and chronic undifferentiated schizophrenia. Respondent was responsible for admitting resident #2 to the facility.

    b. During his stay at Michalene's between July 7, 1998 and November 17, 1998, resident #2 exhibited ongoing and significant behavior patterns which were harmful to others, including striking out, yelling, swearing, removing his clothes in common areas, and defecating and urinating in common areas. Resident #2's individual service plan at Michalene's failed to address these problem areas and failed to identify measures to be taken to supervise, control and prevent harm to residents.

    c. On exact dates unknown, but during the latter half of 1998 and prior to November 10, 1998, facility staff informed Respondent on several occasions of allegations that resident #2 had struck a resident at the facility.

    d. Respondent failed to investigate these allegations, failed to prepare a report of the allegations for the resident's file and failed to file the report with the Department of Health and Family Services.

e. On or about November 10, 1998, and between 5:30 and 6:00 am, resident #2 repeatedly struck resident #1. Resident #1 was subsequently diagnosed with a fracture to the lower sternum, multiple lower left rib fractures, and severe bruising to his left arm.

f. Aides on duty promptly informed Respondent of the incident referred to in paragraph e above.

g. Respondent failed to timely provide notice of this incident of physical abuse to resident #1's designated representative.

h. Respondent failed to adequately assess resident #1 after the attack, failed to timely notify resident #1's physician of the attack and failed to obtain appropriate medical care for resident #1 following the attack.

6. The owner of the facility opted to pay a forfeiture in resolution of the Notice of Deficiency. Respondent did not participate in this decision, and contests many of the allegations set forth above.

a. Respondent enclosed a letter with the required Plan of Correction that set forth some of her disagreements with the allegations set forth in the Statement of Deficiency. A copy of that letter is set forth and attached to this Stipulation as Exhibit A.

b. Respondent subsequently attempted to appeal the Statement of Deficiency and noted in her appeal that she disagreed with the major allegations set forth in the Statement of Deficiency. The appeal was denied on the basis that it was not timely.

c. Respondent then filed a Notice of Claim with the Office of the Attorney General, stating that the Statement of Deficiency set forth incorrect allegations that would potentially harm her as a licensed practical nurse. Respondent did not pursue this claim, as she believed that the matter with the Board of Nursing would be satisfactorily resolved.

7. Respondent specifically contends:

a. The documentation accompanying Resident #2 from the facility in Michigan to Michalene's in July 1998, indicate that Resident #2 had a decreased "level of activity. No obvious delusions or violence."

b. Resident #2 at no time urinated on food at Michelene's.

c. Resident #2's Individual Service Plan addressed the fact that Resident did become upset with certain staff members and that he could "become combative/agitated if provoked."

d. Respondent's investigation found that Resident #1 may have thrown a glass of water at Resident #2, which caused Resident #2 to become angry with Resident #1.

e. Resident #2 did strike Resident #1, in view of several staff members, on November 10, 1998.

Respondent was notified of this incident while she was at home, and she arrived at the facility within approximately ten minutes of the incident.

f. Respondent noted in a late entry to Resident #2's medical record that Respondent attempted to contact the family of Resident #2 shortly after the altercation but was unable to reach the family.

g. Respondent also noted that there was a small area of bruising on Resident #1's upper left arm after the altercation and noted in the record that the Resident's left arm range of motion was without complaint. Respondent also noted in her interview with the Department of Regulation and Licensing that she assisted Resident #1 with a bath after the incident and noted small bruising on the upper left arm. She also recalled that Resident #1 played the pump organ immediately after the incident, and that he played without difficulty. The medical record noted that the Resident #1's bruising to the left arm was completely gone by December 4, 1998.

h. Resident #1's family never requested that Resident #1 be transferred from Michalene's, even during the time that Resident #2 remained in the facility, until Resident #1's health required that he be transferred to a skilled nursing facility.

8. DHFS surveys of Michalene's subsequent to December 1998 have been free of significant deficiencies and free of any deficiencies specifically related to Respondent's practice as a licensed practical nurse.

9. In order to resolve this matter with minimal cost and to reach a final resolution of a matter that has been pending since November, 1998, Respondent consents to issuance of the following Conclusions of Law and Order.

Conclusions of Law

1. By the conduct described above, Respondent is subject to discipline pursuant to Wis. Admin. Code Section N7.03(1).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the license of Robyn M. Burton to practice as a practical nurse in the State of Wisconsin is LIMITED as follows:

Required Reporting

1. 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.

2. During the time that this Order is in effect, Respondent shall notify the Department Monitor of all DHFS surveys, compliance checks or other investigative visits conducted at Michalene's within fifteen (15) days of a

survey, compliance check or other investigative visit. Respondent shall timely comply with any requests from the Department Monitor for follow-up documentation associated with a survey, compliance check or investigative visit. Respondent shall notify the Department Monitor of all investigations that directly involve Respondent within fifteen (15) days of such investigation and shall timely comply with any requests from the Department Monitor for follow-up documentation associated with such investigation.

Continuing Education

3. Within six [6] months of the effective date of this Order, Respondent shall submit to the Department Monitor acceptable documentation of successful completion of at least twenty [20] hours of continuing nursing education in the subject areas of a) legal aspects of licensed practical nursing, and b) nursing assessment, charting and documentation.

4. Since the commencement of the Board's investigation of this matter, Respondent has completed the following courses of study:

Course	**Sponsor**	**Date**	**CE Hours**
a. Supervision and Delegation for LPN's	Moraine Park Tech	02/24/1999	6.0
b. Administrator's Course*	ALFA University	01/14/2000	n/a
c. Alzheimer's Care Program*	ALFA	07/17/2001	n/a
d. Caregiver Program Update	DHFS	10/09/2001	
e. Civil Rights Training	Fond du Lac DSS	01/18/2002	3.0
f. Embracing the Future	WALA	03/19/2002	14.5
g. Admissions & Discharges	WALA	09/25/2002	
h. Documentation Dangers: Legal and Practical Aspects	MESI	10/10/2002	7.0
* Home study			

5. The Board accepts the training set forth above as completion of rehabilitative continuing education as required pursuant to this Order.

6. Respondent shall be and has been responsible for all expenses incurred for training and other reporting as required by this Order.

Department Monitor

7. The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with the terms of this Order, including coordinating all requests for approval of education or other petitions. The Department Monitor may be reached as follows:

Department Monitor

Division of Enforcement

P.O. Box 8935

Madison, Wisconsin 53708-2264

FAX (608) 266-2264

TEL. (608) 261-7938

Petition for Modification or Termination of Limitations

8. Respondent may at any time following one (1) year of full and complete compliance with the term of this Order 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. Sec. 227.01(3) and 227.42.

Summary Suspension

9. 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 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.

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

BOARD OF NURSING

By: Linda Sanner 6-6-03

On behalf of the Board Date