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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	LS0403044NUR
PAT LANGFORD, L.P.N., RESPONDENT.	:	

FINAL DECISION AND ORDER

The parties to this action for the purposes of § 227.53, Stats., are:

Pat Langford, L.P.N.
E12655 Weigands Bay N
Merrimac, WI 53561

Wisconsin Board of Nursing
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation and Licensing
Division of Enforcement
P.O. 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 of Nursing. 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. Pat Langford, L.P.N., Respondent, date of birth March 1, 1942, is licensed by the Wisconsin Board of Nursing as a licensed practical nurse in the state of Wisconsin pursuant to license number 32571, which was first granted August 5, 1994.

2. Respondent's last address reported to the Department of Regulation and Licensing is E12655 Weigands Bay N, Merrimac, WI 53561.

3. During November 2001, Respondent was employed as a licensed practical nurse at Heartland Country Village (Heartland), a 50 bed nursing home located in Black Earth, Wisconsin.

4. Heartland’s medication count policy follows standard nursing practice which requires an accounting of all controlled substances at the time the nursing shifts change. The outgoing and incoming nurses are to conduct a count of controlled substances in a manner which allows each nurse to observe the count. The purpose of the policy is to identify the shi during which any discrepancy in the count occurs and the person who was responsible for the controlled substances at the time of the occurrence.

5. A count of controlled substances was completed when Nurse Rigby began his shift at 7:00 p.m. on November 6. All controlled substances were accounted for at that time.

6. When Respondent relieved Nurse Rigby the morning of November 7, neither Respondent nor Nurse Rigby

counted the controlled substances.

7. During Respondent's shift, Respondent gave her keys, including the keys to the locked medication cart, to a certified nursing assistant (CNA) so the CNA could obtain an item from a locked area. The CNA was not authorized to possess the keys to the medication cart.

8. On November 7 at 1:30 p.m., a third nurse began her shift, counted the controlled substances and found that 39 tablets of Vicodin for one of the residents were unaccounted for and missing. Vicodin is a brand of drug which contains hydrocodone in an amount which makes it a schedule III controlled substance, pursuant to § 961.18(5), Stats.

9. Upon learning of the missing medications, the Director of Nursing (DON) searched the medication room and the medication cart and exhausted all possibilities of the medications being misfiled or destroyed in error. The DON then interviewed Respondent, Nurse Rigby and the third nurse, each of whom had access to the key to the narcotics box in the med cart. All staff denied any knowledge of what had happened to the 39 tablets of Vicodin.

10. Because Respondent and Nurse Rigby had failed to count the controlled substances at the time of their shift change, the DON was unable to determine when the Vicodin was no longer accounted for and was unable to determine who was responsible for the missing controlled substances.

11. Because Respondent had given her keys, including the keys to the locked medication cart, to a certified nursing assistant during Respondent's shift, the DON was unable to determine who was responsible for the missing controlled substances.

12. As a result of Respondent's failure to follow Heartland's policies regarding controlled substances, it could not be determined what happened to the missing drugs.

13. Respondent received a written warning from Heartland for giving the medication cart keys to an unauthorized person and for failing to comply with the facility's policy which required the counting of narcotics by the outgoing and incoming nurse.

14. The only other complaint that the Board has ever received regarding Respondent's practice as a nurse concerned an allegation unrelated to medications. That complaint was investigated by the Division of Enforcement and it was determined that Respondent had not violated any rule or statute enforced by the Board.

CONCLUSIONS OF LAW

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

2. The Wisconsin Board of Nursing has authority to enter into this stipulated resolution of this matter pursuant to § 227.44(5), Stats.

3. Respondent, by engaging in the conduct set out above, has committed negligence, as defined by Wis. Adm. Cod N 7.03(1) and is subject to discipline pursuant to § 441.07(1)(c), Stats.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. Respondent, Pat Langford, L.P.N., is hereby REPRIMANDED for the above conduct.

2. Respondent shall, within 120 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of $200.00 pursuant to § 440.22(2), Stats.

3. Payment shall be mailed or delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264
Telephone (608) 267-3817

The rights of a party aggrieved by this Decision to petition the Section for rehearing and to petition for judicial review ar set forth on the attached "Notice of Appeal Information".

Dated at Madison, Wisconsin this 4th day of March, 2004.

Jacqueline A. Johnsrud, R.N.
Chairperson
Board of Nursing