

# WISCONSIN DEPARTMENT OF REGULATION & LICENSING



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STATE OF WISCONSIN  
BEFORE THE BOARD OF NURSING

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IN THE MATTER OF THE DISCIPLINARY :  
PROCEEDINGS AGAINST :  
 : LS0404223NUR  
JOHN RIGBY, R.N., :  
RESPONDENT. :

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FINAL DECISION AND ORDER

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

John Rigby, R.N.  
P.O. Box 671  
Spring Green, WI 53588

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. John Rigby, R.N., Respondent, date of birth January 28, 1948, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 127695, which was first granted September 5, 1997.
2. Respondent's last address reported to the Department of Regulation and Licensing is P.O. Box 671, Spring Green, WI 53588.
3. During November 2001, Respondent was employed as a registered 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 shift 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 Respondent began his shift at 7:00 p.m. on November 6. All controlled substances were accounted for at that time.
6. When Nurse Langford relieved Respondent the morning of November 7, neither Respondent nor Nurse Langford counted the controlled substances.

7. 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.

8. 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 Langford 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.

9. Because Respondent and Nurse Langford 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.

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

11. Respondent received a written warning from Heartland for failing to comply with the facility's policy which required the counting of narcotics by the outgoing and incoming nurse.

12. Neither the Board nor the Division of Enforcement has ever received any other complaint regarding Respondent's practice as a nurse.

#### 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, John Rigby, R.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 are set forth on the attached "Notice of Appeal Information".

Dated at Madison, Wisconsin this 22<sup>nd</sup> day of April, 2004.

Jacqueline A. Johnsrud, R.N.

Chairperson

Board of Nursing