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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
LYNNE D. ZIMMER, R.N., RESPONDENT.	:	FINAL DECISION AND ORDER Case no. LS 0412012 NUR

[Division of Enforcement Case # 01 NUR 049]

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Lynne D. Zimmer, R.N.
152 Dewberry Lane
Mountain Home, AR 72653

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Board of Nursing
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

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. Lynne D. Zimmer, R.N., Respondent, date of birth April 28, 1953, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 82304, which was first granted September 23, 1982.

2. Respondent's last address reported to the Department of Regulation and Licensing is 152 Dewberry Lane, Mountain Home, Arkansas 72653, where she moved in March 2005.

3. Wisconsin and Arkansas are party states of the Nurse Licensure Compact which provides for multistate licensure privileges and allows a nurse with a license from a "home state" to engage in the practice of nursing in all other party states, which are called "remote states."

4. Because Respondent has changed her primary state of residence to the State of Arkansas, that State has become her "home state" under the Nurse Licensure Compact. As a result, Respondent must obtain a license in her new "home state" of Arkansas and upon her doing so, her license in her old "home state" of Wisconsin would become invalid.

COUNT I

5. Beginning on September 28, 1995, Respondent was employed as a registered nurse by Lutheran Social Services (LSS) Home Care in Waukesha, Wisconsin.

a. She was assigned to the Lake Geneva branch of LSS where her responsibilities included skilled nursing, supervision of home health aides and personal care workers and maintaining client files in accordance with state and federal regulations.

b. Her duties included making visits to patients' residences to supervise personal care workers/home health aides. Respondent was to record the visit and submit a billing document for each visit.

c. Respondent was the only RN in the office and was frequently asked to cover home visits when personal care workers and home health aides were sick, on vacation or otherwise unavailable.

d. In January of 2001, LSS determined that over the past year, Respondent had submitted billings on behalf of LSS claiming that supervisory visits had occurred on dates and times when no such visits had occurred. There was no documentation to establish that 46 visits, which had been billed to Medicaid or Medical Assistance during the calendar year of 2000, had actually occurred.

e. Prior to this time period, the time a visit occurred on a date was not recorded. Respondent contends that she was led to believe that accurate recording of the time of a visit was not important for billing purposes.

f. When confronted by her supervisor, Respondent admitted that she sometimes entered the incorrect date of a visit on billings so it would appear the visit was done within a period of time which would qualify for payment. Payment was received by the agency and not by Respondent. She also admitted that she submitted a few billings for supervisory visits that had not occurred.

e. On February 5, 2001, Respondent's employment was terminated by LSS, which had to return $1,842.34 to Medicaid or Medical Assistance for billings Respondent had submitted for supervisory visits which could not be documented as accurate.

COUNTS II & III

6. From February 12, 2001 until her employment was terminated on March 31, 2004, Respondent was employed as a registered nurse by Mercy Health System at the hospital in Janesville, Wisconsin. Respondent worked as a staff nurse on the inpatient Medical Unit.

7. On August 19, 2001 shortly after 9:00 pm, Ms. A, who was suspected to have viral meningitis, was admitted from the Emergency Department to the unit.

a. Ms. A was placed in contact isolation.

b. Vitals were to be taken every 2 hours the first four times and then every 4 hours the next four times and then once a shift.

c. Neuro checks were to be done every 2 hours the first four times and then every 4 hours the next four times and then once a shift.

d. Another nurse cared for Ms. A until Respondent's shift began at 7 a.m. on 10/20. The Neurological Flow Sheet shows that the other nurse performed the 2 hour checks, the last of which was completed at 6 a.m.

e. Respondent was to take vitals and do a neuro check at 10 a.m., but did not do them and never came into Ms. A's room until 12:30 p.m.

f. During the morning of 10/20, the physician wrote an order that the culture was negative to that point and Ms. A could be discharged at the end of follow up. At 12:50 p.m. on 10/20, the physician wrote the order discharging Ms. A.

g. Although Respondent did not take the vitals or perform the neuro check, she noted on the flow sheet in the patient's chart that she had performed some of the assessments, including checking the pupils. Respondent did observe and speak to the patient which allowed her to make some determination that the patient was neurologically intact.

h. Ms. A was not harmed by Respondent's conduct.

COUNT IV

8. While employed at Mercy, Respondent failed to follow policies when administering medications to Mr. B, an 87 year old man, on the Medical Unit, as follows:

a. Policy required that patients receiving IV Dilantin be placed on a cardiac monitor, unless the patient's

physician ordered otherwise. On November 15 & 16, 2003, Respondent violated the policy when she administered a dose of Dilantin 250mg IV to Mr. B without placing the patient on a cardiac monitor and without an order by his physician that he not be placed on a cardiac monitor.

b. Respondent was not aware of the policy which required cardiac monitoring with administration of Dilantin. Respondent was informed of the policy the next day as a result of this event.

c On November 15, 2003, Respondent administered Trandate 20mg IV to Mr. B. Policy restricted that medication from use on the medical unit.

d. Prior to administering the Trandate, Respondent consulted the floor medication book and contacted the pharmacy. She was not told that Trandate could not be given on the general medical floor.

e. Mr. B was not harmed by Respondent's conduct.

COUNT V

9. On March 20, 2004, Mr. C, who was 60 years of age, went to the emergency department at Mercy complaining of jaw and chest pain. Enzyme levels and an ECG taken in the emergency department were negative, but Mr. C was admitted to the Medical Unit at 8:30 am to have serial enzymes to rule out myocardial infarction.

a. At the time of the transfer to the unit Respondent was given the report by the emergency department nur Respondent performed the admitting assessments and procedures on the unit and was assigned to prov care to Mr. C from the time he was admitted to the unit to the end of her shift at 6:00 p.m.

b. At the time of Mr. C's admission, oxygen was ordered at 2 liters. Respondent instructed Mr. C to wear the Cannula, but he refused to do so. Respondent did not place the oxygen on Mr. C, but noted in the record that she had done so.

c. At the time of Mr. C's admission, bedrest was ordered. Respondent instructed Mr. C that he was to stay in bed, but did not enforce the order and allowed Mr. C to be up and out of bed as he desired.

d. Patients are to be assessed and reassessed based on need and significant changes are to be reported to the patient's physician. Respondent only partially completed the initial pain assessment for Mr. C and Respondent recorded only one additional pain assessment during her entire shift. Mr. C's admitting diagnosis of chest pain required frequent and regular reassessment of pain

e. Mr. C complained of chest pain which radiated to the left arm. Respondent did not call the physician to report the chest pain but instead provided Mr. C with a Kpad for discomfort. This was not an appropriate intervention for this complaint of pain.

f. At the time of admission blood was ordered to be drawn and tested for Creatine phosphokinase (CPK) and Troponin I levels at noon and 6 p.m. on March 20 and in the AM on March 21. CPK is an enzyme found predominantly in the heart, brain, and skeletal muscle. When the total CPK level is substantially elevated, it usually indicates injury or stress to one or more of these areas. Troponin levels are used in persons who have chest pain to determine if the person has had a heart attack or other heart damage.

g. Results of blood testing done at noon on March 20 were:

1) CPK level was 276 [Normal range is 24 to 194 U/mL.]

2) Troponin level was 0.13 ng/mL [People without heart damage have troponin levels less than 0.5 ng/ml.]

h. Respondent did not call the physician to report the elevated enzymes.

i. Results of blood testing done at 6:00 p.m. on March 20 were CPK - 926 and Troponin - 0.66, a significant increase in the cardiac enzymes which are potential indicators of muscle damage to the heart. These results were not reported until after Respondent's shift.

j. Respondent returned at 6:00 a.m. on March 21 and contends that she was told at morning report that labs were "Okay." The results of blood testing at 6:00 a.m. on March 21 were CPK - 1072 and Troponin - 1.11, which indicated continued potential heart muscle damage. The lab results were placed in the chart during Respondent's shift, but the physician was not notified of the lab values. Respondent contends that when she discovered the lab values she paged the physician and he arrived on the floor before answering his page.

k. Mr. C had cardiac catheterization on March 22 and was found to have three vessel coronary artery disease. He had PTCA with stenting of his left circumflex artery with good results and was discharged on March 29, 2004. Mr. C's ultimate outcome was not affected by Respondent's conduct.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. § 441.07 and authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).

2. By making false billing records to be submitted for payment to Medicaid or Medical Assistance, Respondent, ha engaged in a practice or behavior which violates the minimum standards of the profession necessary for the protection of th health, safety, or welfare of a patient or the public and has committed misconduct or unprofessional conduct, as defined by Wi Adm. Code § N 7.04 and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d). [Count I]

3. By failing to perform the assessment and ordered neurological check on Ms. A, Respondent, has engaged in a practice or behavior which violates the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient or the public and has committed misconduct or unprofessional conduct, as defined by Wis. Adm. Code § N 7.04(6) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d). [Count II]

4. By making a false entry in Ms. A's records, Respondent, has committed misconduct or unprofessional conduct, as defined by Wis. Adm. Code § N 7.04(6) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d). [Count III]

5. By performing the acts relating to Mr. B, Respondent, has engaged in practices or behavior which violate the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient or the public and has committed misconduct or unprofessional conduct, as defined by Wis. Adm. Code § N 7.04(6) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d). [Count IV]

6. By performing the acts relating to Mr. C, Respondent, has engaged in practices or behavior which violate the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient or the public and has committed misconduct or unprofessional conduct, as defined by Wis. Adm. Code § N 7.04(6) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d). [Count V]

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. The SURRENDER of the license of Lynne D. Zimmer, R.N., Respondent, as a registered nurse in the state of Wisconsin is hereby ACCEPTED.

2. Respondent's "multistate licensure privilege" in Wisconsin, pursuant to any license granted by another Nursing Licensure Compact party state, shall be LIMITED, as follows:

a. Respondent shall not practice in Wisconsin until Respondent has provided proof sufficient to this Board, or its designee, of Respondent's satisfactory completion of "Ethics of Nursing Practice," an online continuing education course offered by the National Council of State Boards of Nursing, or a similar course which has first been approved by this Board, or its designee.

b. Respondent may practice in Wisconsin only in settings, which have first been approved by this Board or its designee.

c. Respondent shall be supervised in Wisconsin by a staff supervisor who is a registered nurse ("the RN

supervisor"). The RN supervisor shall be provided a copy of this Final Decision and Order prior to Respondent commencing practice at that setting.

d. The RN supervisor shall provide to this Board reports regarding Respondent's practice. If Respondent's contract is for 6 months or more, the reports shall be quarterly, otherwise they shall be provided monthly. The report shall be submitted on a date and in a format to be determined by the Department Monitor. It is Respondent's responsibility to make certain that the reports are filed appropriately.

e. Respondent may petition this Board to modify or remove these limitations, but the decision whether to do so shall be in the sole discretion of the Board.

f. 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 "multistate licensure privilege" in Wisconsin. This Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline against Respondent's "multistate licensure privilege" in Wisconsin for a violation of any of the terms of this Order. In the event Respondent fails to timely submit any payment of the costs as Respondent's "multistate licensure privilege" in Wisconsin SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

3. 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 $1,800.00 pursuant to Wis. Stat. § 440.22(2).

4. Notices, petitions, requests, evidence of completion of education and payment shall be mailed, e-mailed, faxed or delivered to:

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

5. This Order is effective on the date of its signing.

Wisconsin Board of Nursing

By: Jacqueline Johnsrud, RN — June 9, 2005
A Member of the Board — Date