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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
SANDRA JORVE STOCK, R.N., RESPONDENT.	:	LS0501277NUR

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

Sandra Jorve Stock, R.N.
2058 Leona Street
Friendship, WI 53934

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. Sandra Jorve Stock, R.N., Respondent, date of birth January 22, 1946, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 120342, which was first granted July 13, 1995.

2. Respondent's last address reported to the Department of Regulation and Licensing is 2058 Leona Street, Friendship WI 53934.

Original Discipline

3. On May 14, 1999, the Board issued a Final Decision and Order in Disciplinary Proceedings against Sandra Jorv Stock, R.N., case number LS-99051416-NUR. In that matter:

a. The Board found that from March 1998 to December 8, 1998, Respondent, while employed as a registere nurse at Adams County Memorial Hospital in Friendship, Wisconsin, removed prescription pads from the ER unit an forged prescription orders for at least 3040 tablets of Darvocet-N-100 tablets which she then obtained from pharmacie for her personal use. The Board found that this was in violation of Wis. Adm. Code §§ N 7.03(2) and N 7.04(1), (2 and (15).

b. The Board ordered:

i. The suspension of Respondent's license for not less than two years.
ii. Successive 3-month stays of the suspension upon compliance with limitations placed on Respondent' license. The limitations related to rehabilitation, monitoring, treatment and practice.

4. From May 14, 1999 to September 6, 2001, Respondent received consecutive stays of the suspension an modifications to the original limitations.

2001 Violations of Order

5. On September 6, 2001, the Board considered Respondent's request for a further 3-month stay of the suspension of he license. The Board had been notified that a urine screen on August 20, 2001 was positive for propoxyphene. Responden denied that was possible and the sample was being retested at the time of the Board's meeting. The Board granted a 2-mont stay and determined to consider the matter further when the final results of the August 20 screen were known.

6. On November 2, 2001, the Board again considered Respondent's request for a 3-month stay of the suspension. Th Board also considered information that the results of all required urine screens had not been received. The Board, therefore granted a 1-month stay, and determined that the Board would consider the matter on December 6, 2001, when the results of a required urine screens have been submitted.

7. On December 18, 2001, the Board denied Respondent's request for a 3-month stay based on there being insufficien evidence that Respondent had fully complied with all terms and conditions of her limited license during the previous 3 months.

8. On February 7, 2002, the Board again denied Respondent's request for an additional 3-month stay, based on ther being insufficient evidence that Respondent had fully complied with all terms and conditions of her limited license during th previous 3 months.

9. Respondent's license continued to be suspended from December 18, 2001 until May 8, 2002 when the Board grante a 3-month stay based on compliance with the limitations.

2003 Violations of Order

10. On November 7, 2003, the Board considered Respondent's petition for termination of the limitations on her license, c an additional 3-month stay. The Board also considered Respondent's consumption of what appeared to be very large amount of hydrocodone. In an Order dated November 11, 2003, the Board granted a 1-month stay and invited Respondent to appea at its December 5 meeting.

11. On December 5, 2003, Respondent appeared before the Board in support of her request for a further stay. It wa determined that Respondent was in violation of the Board's May 14, 1999 Order based on the following:

Failure to appear for a urine screen on November 17, 2003.
Failure to call on November 25, 2003 when Respondent had been selected to provide a urine screen.
Failure to call on two other occasions.
Continued excessive consumption of prescribed controlled pain medications which Respondent obtained from multiple sources.

12. As a result, in an Order dated December 10, 2003, the Board terminated the stay of suspension and suspende Respondent's license as a registered nurse. The Board also ordered that Respondent could petition the Board for a further sta of suspension when she was able to submit evidence satisfactory to the Board that she could safely resume practice.

13. Respondent's license was suspended from December 10, 2003 until June 28, 2004, when the Board granted a 3-montl stay based on compliance with the limitations.

2004 Violations of Order

14. The limitations on Respondent's license require that she participate in a program of random drug and alcohol screens The program requires that she call its notification system each and every day to find out if she has been chosen to submit specimen for testing that day. If she has been chosen to submit a specimen, she must do so at a designated collection site.

15. Since receiving the stay of suspension on June 28, 2004, Respondent failed to call the program notification system on th following dates and did not submit specimens if selected for testing on those dates:

July 3, 4, 10, 11, 12, 14, 17, 18, 24, 25, and 31.
August 1, 7, 8, 14, 15, 21, 22, 28, 29, and 30.
September 4, 5, 6, 7, 11, 12, 18, 19, 25 and 26.
October 1, 2, 3, 5 (scheduled for testing), 6, 9, 10, 15, 16, 17,18, 23, 24, 27, 28, 30 and 31.
November 1
November 4 to at least December 14, inclusive (scheduled for testing on 5 days).

16. Respondent sent the Department Monitor a letter which was received on August 13. It said that she had called notification system on August 9 and was chosen to be tested that day, but when she called the lab where she was to submit specimen, she found there were no technicians available to do the testing. The Department Monitor confirmed with the lab t this was true.

17. Respondent faxed a letter to the Department Monitor on November 9 in which she said she had stayed home with a illness from October 26 through November 3 and did not call the notification system on those dates. Her physician confirme that she was seen in the clinic on November 3 for a urinary tract infection. On December 15, the Department Monitor calle Respondent's employer who reported that Respondent worked 9 hours on October 26. Illness is not an excuse for failing t call the notification system.

18. A physician with Wisconsin Heart Cardiac and Vascular Specialists faxed a note to the Department Monitor on Octobe 7 which said that Respondent had been hospitalized from October 4 through October 6 and had received narcotics for pain.

19. Respondent made no other contacts with the Department Monitor to explain why she had not called the notification sit on any other dates.

20. The last date on which Respondent submitted a specimen for testing was October 22.

21. On December 15, 2004, the Department Monitor left Respondent a voice mail message that she was non-compliar with the limitations on her license because she had not been calling the notification system and had not been submittin specimens for testing. Later that day, Respondent left a voice mail message for the Department Monitor and said that she ha not been calling in because she could not afford to pay for the testing.

CONCLUSIONS OF LAW

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

2. Respondent, by violating the Board ordered limitations on her license, committed misconduct and unprofessiona conduct as defined by Wis. Adm. Code § N 7.04(14), which subjects Respondent to discipline pursuant to Wis. Sta § 441.07(1)(d).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. The SURRENDER by Sandra Jorve Stock of her license as a registered nurse in the state of Wisconsin is hereb

ACCEPTED, effective immediately.

2. Respondent shall, within 90 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of $515.00 pursuant to Wis. Stat. § 440.22(2).

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

Dated at Madison, Wisconsin this 27th day of January, 2005.

Jacqueline Johnsrud
Chairperson
Board of Nursing