WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
PATRICIA A. BARRETT, L.P.N., RESPONDENT.	:	LS0503102NUR

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

Patricia A. Barrett, L.P.N.
6731 E. Evans Drive
Scottsdale, AZ 85254

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. Patricia A. Barrett, L.P.N., Respondent, date of birth March 17, 1943, is licensed by the Wisconsin Board o Nursing as a licensed practical nurse in the state of Wisconsin pursuant to license number 4574, which was first granted Januar 11, 1963.

2. Respondent's last address reported to the Department of Regulation and Licensing is 6731 E. Evans Drive Scottsdale, AZ 85254.

3. During the events of this matter, Respondent was employed as a licensed practical nurse at Cedar Crossing Elde Services, a community based residential facility in Baraboo, Wisconsin. In that employment during 2002, Respondent provide nursing services to Ms. A, a 79-year-old resident of that facility. Ms. A's medical history included Parkinson's Disease dementia, hypertension, osteoporosis and hypothyroidism. Ms. A's medical records also documented that Ms. B, Ms. A' daughter, was to be notified if Ms. A had a change in condition.

4. At approximately 9:00 p.m. on April 27, 2002, Ms. A began exhibiting symptoms of a cerebral vascular acciden (stroke). Ms. A had a marked increase in blood pressure, was non-responsive and had flaccidity of the right side. The following occurred:

a. A staff member called Respondent immediately, informed her of Ms. A's change in condition and requested further instructions.

b. Respondent did not come to the facility. Instead, she told the staff member to pinch Ms. A, tickle her feet and try to get a verbal response. The staff member did as directed and reported to Respondent that Ms. A moved a little and had a small amount of drool on the right side of her mouth. Respondent told her to keep watching Ms. A and to take her vital signs every half hour. Respondent then hung up.

c. At 10:30 p.m., the staff member again called Respondent and informed her that Ms. A was still unresponsive to verbal stimuli.

d. At approximately 10:50 p.m., Respondent called the daughter, Ms. B, informed her of the change in Ms. A's condition and asked if Ms. B wanted 911 called. Ms. B instructed the staff to call 911.

e. Staff called 911 at approximately 11:30 p.m. Ms. A was transported to the emergency room at St. Clare Hospital in Monroe, arriving at 11:58 p.m., nearly three hours after first exhibiting a change in condition.

5. Ms. A was hospitalized from April 27-28, 2002 through May 3, 2002 with an Acute Cerebral Infarction, Le Cerebral Hemisphere. Ms. A required a gastrostomy tube, was aphasic with right sided paralysis and on May 3, 2002, wa transferred to a long term care facility.

6. The Wisconsin Department of Health and Family Services investigation found that Respondent had violated:

a. Wis. Adm. Code § HFS 83.21(4)(p) by failing to provide Ms. A with prompt and adequate treatment appropriate to the resident's need.

b. Wis. Adm. Code § HFS 83.19(1)(d) by not providing immediate notice to Ms. A's physician and her daughter, Ms. B, of a significant adverse change in the resident's physical or mental condition.

7. Respondent has retired from nursing and is currently residing in Arizona.

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 engaging in conduct which was a substantial departure from the standard of care ordinaril exercised by a competent licensee, has committed negligence as defined by Wis. Adm. Code § N 7.03(1) and is subject t discipline pursuant to Wis. Stat. § 441.07(1)(c).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. Respondent, Patricia A. Barrett, L.P.N., is hereby REPRIMANDED for the above conduct.

2. Respondent's license is LIMITED in that Respondent shall not practice nursing under this license. The Board will remove this limitation when Respondent has provided the Board with proof, which the Board finds sufficient, that she has taken and completed additional education which addresses the deficiencies evidenced by the conduct set out above.

3. Respondent shall, within 90 days of the date of this Order, pay to the Department of Regulation and Licensin costs of this proceeding in the amount of $720.00 pursuant to Wis. Stat. § 440.22(2).

4. 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

Wisconsin Board of Nursing

By: Jacqueline Johnsrud 3-10-05
A Member of the Board Date