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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
MARK M. FALCON, R.N., RESPONDENT.	:	FINAL DECISION AND ORDER LS0510064NUR

02 NUR 012

The parties to this action for the purposes of Wis. Stats. sec. 227.53 are:

Mark M. Falcon, RN
826 N 14th St # 401
Milwaukee, WI 53233

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

PROCEDURAL HISTORY

The parties in this matter, Mark M. Falcon, R.N. personally, and through his attorney, Marilyn Carroll, and James E. Polewski, Attorney for Complainant, agree to the terms and conditions of the attached Stipulation as final disposition of this matter, subject to the approval of the Board of Nursing.

The Board has reviewed the Stipulation and considers it acceptable.

Accordingly, the Board adopts the attached Stipulation and makes the following

FINDINGS OF FACT

1. Mark M. Falcon (D.O.B. February 12, 1956) is duly licensed in the state of Wisconsin as a registered nurse (license # 128130). This license was first granted on November 25, 1997.

2. Mark M. Falcon's latest address on file with the Department of Regulation and Licensing is 826 N 14th St. # 401, Milwaukee, WI 53233.

Resident LJ

3. On 10-19-2001, Resident LJ, a 73 year old man with a history of diabetes, was assessed at the Veteran's Administration Hospital ER for a low blood sugar level of 25. The ER doctor contacted the nursing home and advised that Resident LJ's blood sugar level needed to be monitored when he returned to the nursing home. Respondent was the PM nurse on duty and was in charge of Resident LJ's care. Respondent administered Metformin (Glucophage) 500mg, 8 units of NPH, and 8 units of regular insulin to Resident LJ. However, the Respondent failed to check Resident LJ's blood sugar level, failed to assess Resident LJ's diabetic status, did not write any progress notes on Resident LJ during his shift, and did not communicate Resident LJ's condition to the floor nurse on report.

4. During the next shift, staff charted that Resident LJ had earlier been in the ER for low blood sugar, but that no follow-up blood sugar level check had been done. A blood sugar level test was then done which showed that Resident LJ had a dangerously low blood sugar level of 32. Resident LJ was brought to the nurse's station for treatment.

Resident JM

5. Resident JM was an 81 year old man with a gastric feeding tube and a Foley catheter. Physician Orders required that 300 cc/hr of Jevity be administered to the patient via his feeding tube three times a day. Every six hours the

feeding tube had to be flushed with 220cc of water. The Foley catheter had to be irrigated with 50ccs of water or saline PRN.

6. On Oct. 28, 2001 Respondent was the PM nurse on duty and was in charge of Resident JM's care. Respondent failed to assess Resident's lack of urine output, and failed to document the input & output.

7 During the next shift, staff charted that Resident JM's bladder was distended and uncomfortable, there was no urine in the drainage bag, and that no output had been reported all PM shift. It was discovered that the Foley catheter balloon had deflated and the Foley catheter had advanced up the ureter. 30 ccs of red blood was drained, followed by a total of 2300 ccs of clear yellow urine.

8. It was also discovered that Resident JM's feeding tube had been turned off, but not disconnected, hadn't been flushed, and was clogged. The J tube was plugged and had to be corrected. Respondent was not aware that Resident JM's feeding tube had been turned off and clogged, and failed to document the input and output.

9. Respondent did not fill out any psychotic behavior records for Resident JM for any day, including the October 28, 2001 PM shift.

Resident MM

10. Resident MM was a 93 year old resident that had been admitted after discharge from the hospital after a small bowel obstruction was resolved. Resident MM had a Physician's order for Coumadin 5 mg po q day. When Respondent admitted Resident MM to the nursing home on December 17, 2001, he failed to review the hospital's discharge summary and orders and did not note on the Admission Physician's Orders sheet that the Coumadin therapy was to be continued.

Other incidents

11. On October 27, 2001 Respondent did not complete documentation in the patient progress notes of the care that was provided to seven residents that were on 24 hour report.

12. On October 28, 2001 Respondent charted the same blood pressure reading of 130/70 for six residents. Respondent explained that his charting was inaccurate because he always rounds each blood pressure reading to the nearest whole number. For example, a blood pressure reading of 64 – 75 would have been rounded to 70.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing is authorized to enter into the attached Stipulation, pursuant to Wis. Stat. s. 227.44 (5).

2. By failing to assess residents in a timely manner, failing to follow-up on residents' condition, failing to document and report changes in resident's condition to other nurses or physicians, and failing to document the administration of medications, Mark M. Falcon, RN is subject to disciplinary action against his license to practice as a registered nurse in the state of Wisconsin, pursuant to Wis. Stat. s. 441.07(1)(d), and Wis. Adm. Code ss. N 7.03(1)(b), (c), and (d) and N 7.04(6).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. Respondent Mark M. Falcon, RN is REPRIMANDED.

2. Respondent shall, within nine (9) months from the date of this Final Decision and Order, submit acceptable documentation of successful completion of the National Council of State Boards of Nursing continuing education course on Documentation, or an alternative continuing education course pre-approved by the Board for a minimum of 6 hours credit in the area of Documentation and Record Keeping.

3. Respondent shall, within nine (9) months from the date of this Final Decision and Order, submit acceptable documentation of successful completion of the National Council of State Boards of Nursing continuing education course on Ethics of Nursing Practice, or an alternative continuing education course pre-approved by the Board for a minimum of 6 hours credit in the area of Nursing Ethics and legal responsibilities.

4. Acceptable documentation of completion of continuing education shall include: certification from the sponsoring organization as well as a statement signed by Respondent verifying his attendance at the course and completion of course requirements. This education is in addition to the continuing education requirement to maintain licensure.

5. Respondent will be responsible for paying the full cost of attendance at these courses.

6. The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with the terms of this Order, including receiving reports and coordinating all requests for approval of education or other petitions. The Department Monitor may be reached as follows:

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

7. Respondent shall, within one year of the date of this Order, pay to the Department of Regulation and Licensin COSTS of this proceeding in the amount of $1,000 (ONE THOUSAND DOLLARS) pursuant to Wis. Stat. § 440.22(2) Payment shall be made in no more than four equal installments. Payment shall be mailed or delivered to the Departmer Monitor at the above address.

This Order shall become effective on the date of its signing.

Wisconsin Board of Nursing

By: Jacqueline Johnsrud, RN
A Member of the Board

October 6, 2005
Date