

# 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 :

MARY C. TOGSTAD, RN,  
RESPONDENT.

:  
:  
:  
:

FINAL DECISION AND ORDER  
LS0508314NUR

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Division of Enforcement  
02NUR077; 03NUR054

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

Mary C. Togstad, RN  
21 La Crescenta Circle  
Madison, WI 53716

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 & Licensing  
1400 East Washington Avenue  
P.O. Box 8935  
Madison, WI 53708-8935

PROCEDURAL HISTORY

A formal disciplinary proceeding was commenced on 8/31/05 by the filing of a Notice of Hearing and a formal Complaint with the Wisconsin Board of Nursing and with the Administrative Law Judge. The evidentiary hearing is scheduled for 1/17/06 through 1/19/06. 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 Wisconsin Board of Nursing. The Board has reviewed the attached Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Mary C. Togstad, date of birth 03/23/58, is duly licensed as a registered nurse in the state of Wisconsin, license # 96462. This license was first granted on 03/20/87.
2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 21 La Crescenta Circle, Madison, Wisconsin 53716
3. At all times relevant to this action, Respondent was working as a registered nurse in the state of Wisconsin.

4. Respondent has tendered the voluntary surrender of her license to practice as a registered nurse in the state of Wisconsin. This voluntary surrender of Respondent's license to practice as a registered nurse is made as one of the terms of the stipulated resolution of this formal disciplinary proceeding.

### COUNT I

5. On 9/11/03, Respondent was convicted on a plea of no contest to the crime of forgery in violation of Wis. Stat. § 943.38(2). The Judgment of Conviction was based on an incident which occurred on 2/4/02 in which Respondent forged the signature of Karil Walther, RN on a credit card sales draft drawn upon the Visa credit card account of Karil Walther, made payable to Target, in the sum of \$179.27, Respondent having obtained the credit card without Karil Walther's consent while Karil Walther RN and Respondent were engaged in their employment as registered nurses at Meriter Park Hospital in Madison, Wisconsin.

6. Respondent was convicted of a crime substantially related to the practice of professional nursing.

### COUNT II

7. On 1/30/03, Respondent was employed as a registered nurse at the University of Wisconsin Hospital and Clinics. Respondent was working in the SOS (Save Our Shift) unit and, as a member of this unit, was available to fill in as needed in the hospital.

8. On 1/30/03, Respondent arrived for work at the hospital at approximately 7:30 a.m. to 7:40 a.m. At approximately 8:10 a.m. Respondent was paged to the MRI unit to monitor a patient who had been transported to the MRI unit for a MRI scan of her cervical spine and to transport the patient back to her room after completion of the MRI.

9. Respondent, shortly after her arrival on the MRI unit, represented to other nursing staff present that the patient may need conscious sedation and pain medication following completion of the MRI. Respondent accessed the Accu-dose system in the nurses' office on the MRI unit at 08:27:57 a.m. and retrieved 1 morphine sulfate, 4 mg. injectable. She also obtained at least 3 syringes of saline and 1 syringe of midazolam.

10. The MRI was performed on the patient at approximately 8:30 a.m. After the MRI was completed, the patient was transferred from the MRI table onto the cart to be used for transporting the patient back to her room.

11. After the patient was transferred back onto the cart, Respondent left the patient unattended while she went into the bathroom. Respondent took the morphine sulfate and the saline syringes with her into the bathroom.

12. Respondent, while in the bathroom, diverted the morphine sulfate for her personal use and self-injected the morphine sulfate. Respondent replaced the contents of the morphine sulfate syringe with saline from the saline syringes she had in her possession.

13. Respondent, after returning from the bathroom to attend to her patient, advised Mary Blum, RN that she had not administered any of the morphine sulfate to the patient but that she intended to take the morphine sulfate with her when she transported the patient back to her room in case the patient developed pain during the transport. The patient was not reporting any pain at that time.

14. Mary Blum, RN instructed the Respondent to return the morphine sulfate to the Accu-dose system before transporting the patient back to her room. Respondent advised Mary Blum, RN that she had already engaged the syringe and that she believed that the proper procedure under these circumstances was to waste the morphine sulfate rather than return it to the Accu-dose system. Mary Blum, RN continued to insist that Respondent return the morphine sulfate to the Accu-dose system. Respondent complied by returning the morphine sulfate syringe to the Accu-dose system at 08:51:59 a.m.

15. The contents of the morphine sulfate syringe returned to the Accu-dose system by the Respondent were tested and determined to contain morphine sulfate in a concentration of 0.27 mg/ml rather than the 4 mg/ml as recorded on the label of the syringe indicating that the contents of the syringe had been tampered with.

16. Respondent voluntarily provided a urine specimen for drug testing. The testing on the urine specimen disclosed the presence of morphine.

17. Respondent was unable to provide a credible explanation for the presence of the morphine in her urine.

18. Morphine sulfate is a drug within the meaning of Wis. Admin. Code § N7.04(2) and § N7.02(2).

## COUNT V

19. On 5/20/03, the Respondent presented to Byron Marquez, D.O. at his office at the UW Health Clinic, 5001 Monona Drive, Monona, Wisconsin complaining of pain due to thrombophlebitis in her left lower leg. Dr. Marquez examined Respondent and recommended that she use nonsteroidal anti-inflammatories. He also wrote and delivered to the Respondent a prescription for 20 Vicodin 500 mg.

20. Respondent altered the prescription for Vicodin without Dr. Marquez's knowledge or consent by changing the number of Vicodin prescribed from 20 to 60.

21. On 5/20/03, Respondent, knowing said prescription for Vicodin had been altered, presented the prescription to pharmacist Huan Hoang at the Shopko Pharmacy, 2101 West Broadway, Monona, Wisconsin to be filled. Pharmacist Hoang, suspecting that the prescription may have been altered, attempted to contact Dr. Marquez for verification but Dr. Marquez's office was closed. Pharmacist Hoang partially filled the prescription by dispensing 6 Vicodin to Respondent.

22. On 5/21/03, pharmacist Amy Schellpfeffer from the Shopko Pharmacy contacted Dr. Marquez and ascertained that the prescription for Vicodin had been altered. Dr. Marquez directed that no additional Vicodin be dispensed to the patient from this altered prescription.

## CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction to act in this matter, pursuant to Wis. Stat. § 441.07, and is authorized to enter into the attached Stipulation and Order, pursuant to Wis. Stat. § 227.44(5).

2. The conduct described in paragraphs 5 and 6, above, constitutes a violation of Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(1) in that Respondent was convicted of a crime substantially related to the practice of professional nursing.

3. The conduct described in paragraphs 7 through 18, above, constitutes a violation of Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(2) in that Respondent obtained and administered a drug, morphine sulfate, other than in the course of legitimate practice.

4. The conduct described in paragraphs 19 through 22, above, constitutes a violation of Wis. Stat. §§ 441.07(1)(d) and 450.11(7)(e); and Wis. Admin. Code § N 7.04(1) in that on 05/20/03 Respondent made and uttered a false and forged prescription order for Vicodin.

5. The Wisconsin Board of Nursing has the authority pursuant to Wis. Stat. § 440.22 to assess the costs of this proceeding against the Respondent.

6. This Final Decision and Order shall not be construed as a Board of Nursing finding of caregiver misconduct, abuse or neglect of a client, or misappropriation of the property of a client within the meaning of Wis. Stat. §§ 48.685 and 50.065.

## ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. The voluntary surrender of the license of Mary C. Togstad to practice as a registered nurse in the state of Wisconsin is hereby accepted effective immediately upon the signing of this Final Decision and Order.

IT IS FURTHER ORDERED that:

2. If Mary C. Togstad shall at any time in the future make application for any license or registration or certification issued by the Wisconsin Board of Nursing, the Board of Nursing may, in acting on this application, review and give

consideration to this Final Decision and Order and may review and give consideration to the documentation in the investigative files maintained by the Division of Enforcement in the Department of Regulation and Licensing, investigative files 02NUR077 and 03NUR054, to assist the Wisconsin Board of Nursing in determining the status of Mary C. Togstad's rehabilitation and current competence to practice and to determine the necessity for further treatment and monitoring as conditions of her licensure.

3. If Mary C. Togstad shall at any time in the future make application for any license or registration or certification issued by the Wisconsin Board of Nursing, the Board of Nursing shall not be obligated to act on her application until all of the terms of this Final Decision and Order, including the payment of the costs of this proceeding, have been satisfied.

IT IS FURTHER ORDERED that:

4. Counts III and IV of the Complaint shall be and hereby are dismissed.

IT IS FURTHER ORDERED that:

5. Mary C. Togstad shall, within one year from the date of this Order, pay costs of this proceeding in the amount of \$3,650. Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed 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

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

Wisconsin Board of Nursing

By: Marilyn Kaufmann Ph.D., RN  
A Member of the Board

1/26/06  
Date