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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
RESPONDENT IN CASE 02 NUR 025	:	WITH REGARD TO KARRIE CUNNINGHAM RN LS0601262NUR

(DOE CASE FILE 02 NUR 025)

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

Karrie Cunningham RN
3160 Terry Lane
Eau Claire, WI 54703

State of 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

An informal complaint is pending before the Board of Nursing in this matter. By way of resolution of this case, the parties, Karrie Cunningham, RN, personally and by her attorney, Harry R. Hertel, Hertel & Gibbs, S.C., and Pamela M. Stach, Attorney for the Department of Regulation and Licensing, Division of Enforcement, agreed to the terms and conditions of the attached Stipulation as the 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 in this matter adopts the attached stipulation and makes the following:

FINDINGS OF FACT

l. Karrie Cunningham, RN, Respondent herein, d/o/b 11-6-79, of 3160 Terry Lane, Eau Claire, WI. 54703, is duly licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin under license number 146375 which was granted on February 19, 2004.

2. At all times relevant hereto, Respondent was employed as a licensed practical nurse (license # 303200, granted 9-12-01) at Dove Health Care, a 140 bed skilled nursing home.

3. Respondent subsequently was licensed by the Wisconsin Board of Nursing as a registered nurse on February 19, 2004, and is currently employed in that capacity in the Sacred Heart Behavioral Health Unit at Sacred Heart Hospital in Eau Claire, Wisconsin.

4. On September 7, 2001, a 58 year old female resident was admitted to Dove Health Care with a diagnosis of progressive multiple sclerosis.

5. On October 10, 2001, the patient exhibited signs of muscle tightening among other changes in her physical condition.

6. On October 11, 2001, the treating physician prescribed Baclofen 10 mg. three times a day for treatment of the muscle tightening.

7. On October 13, 2001, the patient's condition changed and the staff was unable to wake her sufficiently to provide nutrition or perform therapy.

8. Respondent was on duty on October 13th and attributed the change in condition to the Baclofen. At approximately 1700 she discontinued the drug and sent a notification to the physician by facsimile. Respondent did not contact the physician by telephone.

9. October 13th was a Saturday and the physician's office was closed at the time the facsimile was sent.

10. Respondent did not perform or document any neurological assessment of the patient.

11. Respondent did not document any rationale for discontinuation of the Baclofen on October 13th .

12. Respondent did not notify the RN on duty of the continued withholding of the medication or request an assessment of the patient's condition by the RN.

13. On October 14th, at approximately 1830, Respondent took the patient's vital signs and noted the patient to be incontinent in her bowel movements at three different times with no attempt to request a bedpan which was atypical behavior for the patient. Respondent did not contact the patient's physician.

14. Respondent did not report the patient's change of condition to the RN on duty nor request an assessment by the RN of the patient's condition.

15. On October 15th, the physician ordered Baclofen to be given to the patient at night only.

16. On October 15th, at approximately 2200, Respondent gave the patient her night dosage of Baclofen and subsequently noted the patient to be flushed on her face and chest with a temperature of 99.1, a racing pulse of 116, respirations at 24 and blood pressure of 118/69. Respondent faxed this information to the physician but did not contact him by telephone or other means. The physician's office was closed at the time the facsimile was sent by Respondent.

17. On October 16, 2001, the patient was transferred to Luther Hospital where she was diagnosed with a

cerebrovascular accident and urinary tract infection.

18. On October 19, 2001, the patient was transferred back to Dove Health Care.

19. The patient was readmitted to Luther Hospital on October 22, 2001, and died on October 27, 2001 of acute staph aureus endocarditis leading to emboli to both sides of the brain with a right sided stroke.

20. Subsequent to these incidents, Respondent successfully completed education and training in the Chippewa Valley Technical College Nursing Program and graduated from that program as a registered nurse in December 2003. Respondent's transcripts are attached hereto as Exhibit A.

21. Respondent has cooperated fully throughout this investigation and voluntarily agrees to entry of this Order.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction in this proceeding pursuant to Wis. Stat. sec. 441.07.

2. The Wisconsin Board of Nursing has the authority to resolve this matter by stipulation without an evidentiary hearing pursuant to Wis. Stat. sec. 227.44(5).

3. Respondent's conduct has violated Wis. Stat. sec. 441.07 (1)(c) and Wis. Adm. Code sec. N 7.03(1) in the following respects:

A. Respondent failed to notify the physician that she was withholding medications on October 13th at 1700.

B. Respondent failed to notify the physician of the resident's change in condition which was significant enough to prompt her to hold the Baclofen on October 13th.

C. Respondent failed to chart the resident's change of condition and the rationale for withholding the medication.

D. Respondent faxed information to the physician when she knew or should have known the office was closed rather than notifying the physician by other means.

E. Respondent failed to report the resident's change of condition to the RN on duty on October 14th and did not request an assessment by the RN of the patient's change of condition.

F. Respondent failed to report the resident's change of condition including the elevated pulse and respirations to the physician on October 15th at 2220.

G. Respondent failed to report the resident's change of condition to the RN on duty on October 15th at 2220 and failed to ask the RN to assess the resident's change of condition at that time.

ORDER

NOW THEREFORE IT IS ORDERED that the Stipulation of the parties is hereby accepted.

IT IS FURTHER ORDERED that Karrie Cunningham RN, Respondent, is hereby REPRIMANDED.

IT IS FURTHER ORDERED that the Board of Nursing recognizes Respondent's additional education as set forth in paragraph 20 of the Findings of Fact and the attached Exhibit A and finds no further reeducation is necessary to address the

violations.

IT IS FURTHER ORDERED that Karrie Cunningham, RN shall pay costs in this matter in the amount of $800 payable to the Department of Regulation and Licensing within ninety days of the effective date of this Order. Payment of costs shall be 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

In the event Respondent fails to timely submit any payment of the costs as ordered, the Respondent's license SHALL BE SUSPENDED, without further notice or hearing,

IT IS FURTHER ORDERED THAT this Order is effective upon signing.

Dated at Madison, Wisconsin this 26th day of January, 2006.

STATE OF WISCONSIN
BOARD OF NURSING

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