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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
MARY WEBER, R.N., RESPONDENT.	:	LS0601265NUR

Division of Enforcement Case 02 NUR 182

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

Mary Weber, R.N.
1445 Lakeview Drive, #3
Ft. Atkinson WI 53538

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

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 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 Weber, R.N. (Respondent) was born on September 19, 1958 and is licensed as a registered nurse in the state of Wisconsin pursuant to license number 126396, first granted on June 25, 1997. Respondent's address of record with the Department of Regulation and Licensing is 1445 Lakeview Drive, Apartment 3, Ft. Atkinson, Wisconsin 53538.

2. On April 20, 2002, Respondent was working at the Rock County Health Care Center, Janesville, Wisconsin. At approximately 3:15 a.m. on April 20, 2002, a nurse's aide asked Respondent to check on Resident J.M., a 70 year old woman, because the Resident's breathing sounded congested to the aide

3. Respondent observed the Resident, and raised the head of the Resident's bed. Respondent did establish that the Resident had a pulse and was breathing, but did not obtain pulse or respiration measurements, and did not evaluate the Resident for edema even though she described the Resident's breathing at the time she first entered the room as "awful rattle"

. Respondent deferred vital signs until a later time, and did not accurately inform the supervising nurse of the Resident's condition.

4. At 4:45 a.m. two nurse's aides entered the Resident's room for a regular check, and found the Resident pulseless and not breathing, but warm to the touch. They called Respondent, who entered the Resident's room and spent some time evaluating the Resident. Respondent then left the Resident's room, leaving the CNAs there, and went to the nurse's station to check the Resident's chart to see if the Resident was a "no code" resident.

5. Respondent returned to the Resident's room with the crash cart at approximately 4:55 a.m. Respondent had difficulty opening the crash cart and fumbled with the microShield, the barrier for artificial respiration, and it was approximately 5:00 a.m. when she began performing cardiopulmonary resuscitation of the Resident on the bed, without a backboard, solo, and without tilting the Resident's head or clearing the Resident's airway.

6. Respondent stopped performing CPR after approximately 4 minutes, before any other CPR certified person had arrived.

7. Effective CPR requires the rescuer to tilt the patient's head back, check the airway to make sure it is unobstructed, and ensure that the patient is on an unyielding surface so that chest compressions actually compress the heart to pump blood through the patient's lungs.

8. Minimally competent nursing practice in a long term care facility requires that a nurse accurately and effectively evaluates a Resident who appears to be in respiratory distress.

9. Minimally competent nursing practice in a long term care facility requires that a nurse effectively manage respiratory emergencies and delegate appropriately to auxiliary personnel.

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this matter pursuant to Wis. Stat. s. 441.07.

2. Respondent's failure to fully and accurately evaluate the condition of the Resident when the nurse's aide requested her professional expertise at 3:15 a.m. was unprofessional conduct within the meaning of Wis. Admin. Code s. N 7.03(1)(b).

3. Respondent's failure to appropriately manage the cardiopulmonary resuscitation attempt on the Resident was unprofessional conduct within the meaning of Wis. Admin. Code s. N 7.03(1)(b).

ORDER

1. Now, therefore, the license previously issued to Mary Weber, R.N., is SUSPENDED for not less than two-and-a-half years (30 months).

2. It is further ordered that the suspension is STAYED, provided that Respondent Mary Weber, R.N.:

a. may not work for a temporary nursing pool agency, or do private duty nursing, or any form of home care nursing.

b. may not work in any setting in which she is not under the contemporaneous supervision of a licensed registered nurse or a licensed physician. "Contemporaneous supervision" means that the supervisor is in the facility at the same time as Respondent, but does not require that the supervisor be constantly in the same room as Respondent.

c. obtains re-certification in basic CPR every year.

d. completes 6 hours of continuing nursing education in the topic of assessment of the elderly within six months of the effective date of this Order.

e. completes 6 hours of continuing nursing education in the topic of nursing documentation within six months of the effective date of this Order.

f. completes 6 hours of continuing education in the topic of stress management within six months of the effective date of this Order.

g. has her employer submit a report to the Board every three months, with the first such report due 30 days from the effective date of this Order, evaluating the quality of her nursing during the preceding three months and reporting any perceived significant deficiency in her skills.

(1.) Each report from Respondent's employer shall be mailed to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

3. It is further ordered that the stay of suspension may be withdrawn if the Board or its designee determines, on the basis of the reports required by paragraph 2. g. above, that Respondent Mary Weber, R.N., has failed to maintain satisfactory nursing standards, or that she has failed to comply with any other portion of this Order.

4. It is further ordered that Respondent shall obtain approval from the Board or its designee for every course of continuing education she proposes to take in compliance with this order, before she takes it, and she shall make application for approval of courses by writing to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

5. It is further ordered that Respondent shall, within one year from the date of this Order, pay costs of this proceeding in the amount of One Thousand Four Hundred Thirty Eight ($1438.00) dollars. Payment shall be made in no more than four equal installments, 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

6. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit any payment of the fails to pay costs as ordered or fails to comply with the ordered continuing education the Respondent's license(#126396) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

7. This Order is effective on January 1, 2006, or the date of its signing, whichever is later.

Wisconsin Board of Nursing

By: Marilyn Kaufmann Ph.D., RN 1/26/06
A Member of the Board Date