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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
ROCELYN D. WALLIS, R.N. RESPONDENT.	:	LS07012513NUR

Division of Enforcement Cases # 04 NUR 279, 05 NUR 9

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

Rocelyn D. Wallis, R.N.
RR 1, Box 77
Glidden, WI 54527

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 Settlement Conference was held in this matter pursuant to Wis. Adm. Code § RL 2.036. 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. 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. Rocelyn Dwan Wallis (D.O.B. 11/28/39) is duly licensed in the state of Wisconsin as a registered nurse (license 117436). This license was first granted on 8/5/94. Respondent has an MS in psychiatric nursing, and was formerly licensed in Illinois from 10/17/1979, to 5/31/2004, and in Michigan under the name Rocelyn D. White Wallis, from 9/14/1994, to 3/31/2001.

2. Respondent is, and was at the times described below, taking prescription medications which have been legitimately prescribed to her and which have a side effect of causing drowsiness in some patients.

3. On 12/8/04, Respondent was providing home care for patient G.S., a ventilator-dependent child born in 2001. Respondent was observed to be asleep while on duty, between 4 and 5 PM. Respondent denies that she was asleep, and states that she was merely sitting with her eyes closed; the Board credits the witness's version.

4. On and between 11/8/04 and 12/3/04, Respondent provided home care for patient T.B., a child born in 2004 and who had a tracheostomy due to cerebral palsy with respiratory failure. On two occasions, Respondent was observed to be asleep while on duty during a night shift. Respondent denies that she was asleep, and states that she was merely sitting with her eyes closed; the Board credits the witness's version.

5. On and between 7/1/04, and 9/28/04, Respondent provided home care for patient C.F., a woman born in

1953 who had ALS and who was not ambulatory and who could not talk, because she has a tracheostomy. On 7/15/04, Respondent took the patient to the commode. While the patient was on the commode, home health agency staff arrived at the home to discuss additional staffing. Respondent left the patient on the commode during the entire time that the staff were there, approximately 3 hours. Respondent notes that the patient had an alarm which could have been used at any time if the patient was uncomfortable or wished to be moved; the Board finds that this is an inadequate justification for leaving the patient on a commode for such a length of time. On 7/14/04, Respondent administered two albuterol nebulizer treatments to the patient, 2 hours apart, when the physician's order was for such treatments each 4 hours, as needed. Respondent's assessment of the patient was that the patient needed an additional treatment some 2 hours after the initial treatment, but Respondent failed to contact the physician for authorization to exceed the dosage set forth in the written order.

6. On 9/27/04, Respondent conducted a breast exam of patient C.F., but failed to chart the exam or the results, although she felt some firm tissue and orally advised the patient's husband that this should be checked by a physician.

7. On 12/27/03, Respondent was found to be asleep while on duty on the night shift at Court Manor Health and Rehabilitation Services, a nursing home in Ashland, Wisconsin. Respondent denies that she was asleep, and states that she was merely sitting with her eyes closed; the Board credits the witness's version.

CONCLUSION OF LAW

By the conduct described above, respondent is subject to disciplinary action against her license to practice as a registered nurse in the state of Wisconsin, pursuant to Wis. Stat. § 441.07(1)(b) and (d), and Wis. Adm. Code §§ N 7.03(1)(a), (b), (c), and N 7.04(1) and (15).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that :

1. Rocelyn D. Wallis, R.N., is REPRIMANDED for her unprofessional conduct in this matter.

2. The license of Rocelyn D. Wallis, R.N., to practice as a nurse in the state of Wisconsin is LIMITED as follows:

   a. Respondent shall not engage in the care of any ventilator-dependent patient in a non-institutional setting.
   b. Respondent shall provide her present and future nursing employers with a copy of this Order before engaging or continuing in any nursing employment.
   c. No later than 6/30/07, Respondent shall successfully complete 6 hours of continuing education in the area of medication administration and proper documentation. She shall also, before 6/30/07, successfully complete 6 hours of continuing education in the area of patient rights and responsibilities. The proposed courses shall be submitted for pre-approval by the Board or its designee, through the Department Monitor; courses which have not been pre-approved are taken entirely at Respondent's own risk. It is Respondent's responsibility to ensure that satisfactory documentation of her successful completion of the courses is received before the due date.
   d. Respondent shall not work more than 8 hours in any 24 hour period, nor work before 6 AM or after 8 PM. She may work until 11 PM in a hospital as defined under Wis. Stat. § 50.32(2), where there is another licensee of the Board also awake, on duty, and immediately available.

3. 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 Costs as set forth below, the Respondent's license SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

IT IS FURTHER ORDERED that respondent shall pay the costs of investigating and prosecuting this matter, in the amount of $2,150, on or before 3/1/08. In the event Respondent fails to timely submit any payment of costs, the

Respondent's license SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

WISCONSIN BOARD OF NURSING

By: Marilyn Kaufmann 1/25/07
A Member of the Board Date