WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
MARY ANN PERYER, L.P.N., RESPONDENT.	:	LS 0702131 NUR

[Division of Enforcement Case #'s 04 NUR 332 & 05 NUR 187]

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

Mary Ann Peryer, L.P.N.
1019 Frontage Road, Apt. 2
Osceola, WI 54020

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

PROCEDURAL HISTORY

This disciplinary proceeding was commenced by the filing and service of a Complaint and Notice of Hearing on February 13, 2007. 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 this Stipulation and considers it acceptable.

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

FINDINGS OF FACT

1. Mary Ann Peryer (f/k/a Wilson), L.P.N., Respondent, date of birth November 15, 1957, is licensed by the Wisconsin Board of Nursing as a licensed practical nurse in the state of Wisconsin pursuant to license number 303525, which was first granted March 12, 2002.

2. Respondent's last address reported to the Department of Regulation and Licensing is 1019 Frontage Road, Apt 2, Osceola, WI 54020.

04 NUR 332

3. Respondent was employed by Osceola Medical Center as a licensed practical nurse in the L.O. Simenstac Nursing Care Unit (nursing home) in Osceola, Wisconsin. In that employment, Respondent provided nursing care to Ms. A, a 92-year-old resident of the nursing home.

4. On May 21, 2004, Ms. A's hemoglobin was 13.4 g/dL, within the normal range of 11.5 to 16.5.

5. On July 13, 2004, Ms. A's physician ordered ibuprofen 400 m.g. for arthritis pain in her knee. On September 9 2004, Ms. A's hemoglobin was 11.8, which her physician noted as being slightly low. The physician also noted that she was o ibuprofen which could be causing some gastrointestinal (GI) blood loss and ordered that it be given with meals.

6. On September 19 and 20, 2004, Ms. A had symptoms which could have been the result of mini-strokes and he physician ordered dipyridamole 75 m.g. 3 times a day and aspirin 162 m.g. four times a day. Each of the medications ca cause bleeding.

7. On October 11, 2004, two nurse aides (CNAs) checked on Ms. A during 10:00 p.m. rounds. While changing Ms. A's incontinent pad, the CNAs noticed a smell like a GI bleed and saw that Ms. A had a black and bloody stool. The CNAs notified Respondent and asked her to come into the room to look at it.

8. The only light in the room was the entry light which was just inside the doorway. Ms. A was in the second bed furthest from the doorway. Neither Respondent nor the CNAs turned on another light. Respondent came into the room bu did not go to Ms. A's bedside to view the stool or gather information about Ms. A's condition. Respondent left the room an commented that the stool was probably dark because Ms. A was taking Vitamin K or iron. Ms. A was taking a multipl vitamin, but no vitamin K or iron supplements. One of the CNAs did chart in the bowel movement book that Ms. A's stoo was bloody.

9. Respondent did not call and report Ms. A's changed condition to her physician or the on call physician. Respondent did not chart anything regarding Ms. A's stool. At shift change, Respondent did not notify the incoming nursing staff of Ms. A having a black or bloody stool.

10. On the evening shift of October 12, 2004, a CNA saw that Ms. A had an incontinent pad full of what looked lik "grape jelly" and reported it to RN A, the registered nurse on duty. RN A went into Ms. A's room and noted that the stoo was moderate in amount, dark in color, shiny and mucus-like. The CNA told RN A that Respondent had said the abnorma colored stool was caused by Vitamin K. RN A did not call and report Ms. A's condition to her physician or the on cal physician. RN A said she intended to report the unusual stool to the night shift so Ms. A's condition would be monitored, bu RN B and RN C, the nurses who worked that night shift denied being told.

11. During the October 12-13 night shift, Ms. A was in distress, crying and saying that her stomach hurt. RN C gav Ms. A Ativan and Wygesic. At approximately 4:30 a.m. on October 13, 2004, Ms. A had blood with clots in her incontinen pad. RN C notified the physician and Ms. A was transferred to the hospital emergency room. Her hemoglobin was very lo at 5.5 g/dL. Ms. A was aggressively treated with: IV fluids, fresh frozen plasma, IV Vitamin K for a slightly elevated INR o 1.5, and multiple blood transfusions. The following day, Ms. A died of an acute gastrointestinal hemorrhage.

12. Respondent failed to observe the conditions, signs and symptoms of Ms. A and failed to record them and t report these significant changes to the appropriate person, all of which was a substantial departure from the standard of car ordinarily exercised by a competent nurse.

05 NUR 187

13. Respondent was employed as a licensed practical nurse at Frederic Nursing and Rehabilitation Community (facility), in Frederic, Wisconsin.

14. On April 13, 2005, Mr. A (78 years of age) was admitted to the facility following right leg surgery to repai fractures of his tibia and fibula.

a. Mr. A's incision was closed with staples. The required nursing treatments noted in his chart included wound checks to be done each a.m. and p.m. and dressing changes to be done each a.m.

b. Mr. A had a follow-up appointment scheduled for May 12 with his orthopedic surgeon.

c. Mr. A was confused intermittently.

d. Mr. A had an order for 1 or 2 oxycodone PRN (as needed) for pain. During April, he requested and received the medications about once each day. In May, he received the medication once on the 1st, 7th and 8th.

15. Mr. A's recovery was proceeding uneventfully, until May 10 at 1:17 a.m. when staff found him on the floor in his room after he fell out of bed. The staff working the May 9-10 night shift acted appropriately. Because Mr. A's vital signs were stable and he was able to move his extremities with no complaints of pain, they did not remove the bandage to check the wound site.

16. RN C worked the day shift on May 10.

a. At 6:45 a.m., she gave Mr. A two oxycodone for right leg pain and noted it as effective. She did not examine Mr. A's wound or assess the cause of the pain.

b. She notified Mr. A's legal guardian of the fall.

c. At 10:00 a.m., she sent a fax to Mr. A's physician notifying him of a no injury fall and that Mr. A had a scheduled appointment with his orthopedic surgeon for May 12 and requesting an extension of the order for PRN pain medication, which was to expire May 13. The physician extended the order later that day.

d. At 1:20 p.m., she gave Mr. A an oxycodone for right leg pain and noted relief at 2:30 p.m. She did not examine Mr. A's wound or assess the cause of the pain.

e. Mr. A asked RN C to send him to the hospital because of the pain, but she declined to do so. RN C did not examine Mr. A's wound or assess the cause of the pain at any time on that shift.

f. She did not perform the AM wound check or dressing change which the nursing treatments required on her shift.

g. However, she documented in the treatment book that she did them both. Her taped report to the next shift said was doing the dressing change and wound check before leaving, but she forgot to do them.

17. Respondent began her shift at 2:00 p.m. on May 10:

a. RN C told Respondent that Mr. A had requested to be sent to the hospital but that he had an appointment with his orthopedist in two days and should not be sent to the hospital.

b. Respondent noted that Mr. A refused to get out of his bed during this shift and said his leg hurt too badly. He continued to complain of pain. When Respondent offered pain medication, he refused it saying that it did not help. He demanded that he be taken to the hospital and have an x-ray because of the pain, but Respondent declined to do so.

c. Respondent took his vitals and looked at the outside of his dressing to determine if it was in place. Despite Mr. A's continuing complaints of pain, Respondent did not examine Mr. A's wound or assess the cause of the pain.

d. Respondent did not perform the wound check which the nursing treatment required to be done on her shift because she believed RN C had just done the dressing change and wound check as Respondent's shift was beginning and there was no need to do a second wound check during her shift.

18. At 5:38 a.m. on May 11, another RN checked the wound and changed the dressing. She reported that the surgical incision healed with a small scab and scant yellow drainage.

19. RN C worked the day shift on May 11.

a. At 12:30 p.m., she gave Mr. A an oxycodone for right leg pain and noted some relief.

b. She performed the ordered p.m. wound check shortly before 1:00 p.m. and discovered that the

stapled area had come apart. There was no swelling and Mr. A was afebrile. She called and reported this to Mr. A's physician.

20. At 3:00 p.m., Mr. A was transported to the hospital's emergency department for evaluation. He returned at 5:0(p.m. with additional orders, including the antibiotic Keflex. At 5:52 a.m. on May 12, a wound care note said that the incisio line had an open area 12 cm long by 2.5 cm wide by 1 cm deep. Mr. A went to his appointment with the orthopedic surgeo later that morning. Because the incision site had been open overnight, the orthopedic surgeon had Mr. A hospitalized until Ma 26, when he returned to the facility.

21. Respondent failed to examine Mr. A's wound or attempt to determine the cause of his pain all of which was a substantial departure from the standard of care ordinarily exercised by a competent nurse.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. § 441.07 and ha authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).

2. Respondent, by engaging in the conduct set out above, has committed negligence as defined by Wis. Adm. Cod § N 7.03(1)(c), which subjects Respondent to discipline pursuant to Wis. Stat. § 441.07(1)(c).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. The license of Mary Ann Peryer, L.P.N., Respondent, as a licensed practical nurse in the state of Wisconsin of is hereby SUSPENDED for a period of 30 days, which shall commence on the 30th day following the date of this Order.

2. Respondent's license is LIMITED as follows:

a. Respondent shall provide proof sufficient to the Board, or its designee, of Respondent's satisfactor completion of a total of twelve (12) hours of continuing education in the following areas: six (6) hours in patien assessment and six (6) hours in wound care, which courses shall first be approved by the Board, or its designee.

b. The Board shall issue an Order removing this limitation requiring education, upon Respondent providing proof sufficient to the Board, or its designee, that she has completed the education.

3. Respondent shall, pursuant to Wis. Stat. § 440.22(2), pay to the Department of Regulation and Licensing costs this proceeding, as follows: $360.00 within 180 days of the date of this Order and an additional $360.00 within one year of t date of this Order.

4. All payments, requests and evidence of completion of the education required by this Order shall be mailed, fax or delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264
Telephone (608) 267-3817

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

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

Wisconsin Board of Nursing

By: Marilyn Kaufmann 7/26/07
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
MARY ANN PERYER, L.P.N., RESPONDENT.	:	LS 0702131 NUR

[Division of Enforcement Case #'s 04 NUR 332 &05 NUR 187]

It is hereby stipulated and agreed, by and between Mary Ann Peryer (f/k/a Wilson), L.P.N., Respondent; and John R. Zwieg, attorney for the Complainant, Department of Regulation and Licensing, Division of Enforcement, as follows:

1. This Stipulation is entered into as a result of a pending disciplinary proceeding against Respondent's licensure by the Division of Enforcement (files 04 NUR 332 & 05 NUR 187). Respondent consents to the resolution of this matter by stipulation and without a hearing.

2. Respondent understands that by signing this Stipulation, she voluntarily and knowingly waives her rights, including the right to a hearing on the allegations against her, at which time the state has the burden of proving those allegations by a preponderance of the evidence; the right to confront and cross-examine the witnesses against her; the right to call witnesses on her behalf and to compel their attendance by subpoena; the right to testify herself; the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision; the right to petition for rehearing; and all other applicable rights afforded to her under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and any other provisions of state or federal law.

3. Respondent has been provided an opportunity to obtain advice of legal counsel prior to signing this Stipulation.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Board. The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's Order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall be returned to the Division of Enforcement for further proceedings. In the event that this Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. Attached to this Stipulation are Respondent's current wall and wallet registration certificates. If the Board accepts the Stipulation, Respondent's license shall be reissued at the time the suspension is terminated in accordance with the terms of the attached Final Decision and Order. If the Board does not accept this Stipulation, Respondent's certificates shall be returned to Respondent with a notice of the Board's decision not to accept the Stipulation.

7. The parties to this Stipulation agree that the attorney or other agent for the Division of Enforcement and any member of the Board ever assigned as a case advisor in this investigation may appear before the Board in open or closed session, without the presence of the Respondent or her attorney, if any, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with the Board's deliberations on the Stipulation. Additionally, any such case advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

8. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

9. Respondent is further informed that should the Board adopt this Stipulation, the Board's Final Decision and Order would constitute an agency finding within the meaning of Wis. Stats. §§ 48.685 and 50.065. Should Respondent wish to work in a Wisconsin DHFS-licensed facility, she will need to pass a Rehabilitation Review through DHFS prior to

commencement of such employment.

10. The Division of Enforcement joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.

_____ _____

Mary Ann Peryer, L.P.N. Date
Respondent
1019 Frontage Road, Apt. 2
Osceola, WI 54020

_____ _____

John R. Zwieg Date
Attorney for Complainant
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

[04 NUR 332 & 05 NUR 187: Costs $720.00]

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