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
ROSALIND P. SEVERSON, R.N., RESPONDENT.	:	LS07100414NUR

[Division of Enforcement Case # 04 NUR 290]

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

Rosalind P. Severson, R.N.
W9345 Cty Rd O
Wautoma, WI 54982

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

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 adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Rosalind P. Severson, R.N., Respondent, date of birth May 13, 1963, is licensed by the Wisconsin Board o Nursing as a registered nurse in the state of Wisconsin pursuant to license number 143613, which was first granted March 27 2003.

2. Respondent's last address reported to the Department of Regulation and Licensing is W9345 Cty Rd O Wautoma, WI 54982.

3. Respondent was employed as a registered nurse (RN) at Wisconsin Veterans Home (WVH), in King, Wisconsi

4. Following a hospitalization at Riverside Medical Center in Waupaca, Wisconsin, for a myocardial infarction, Mr. A (DOB 10/18/14) was admitted to WVH on April 16, 2004. Mr. A was receiving three medications one time each day to prevent blood clots: aspirin (81 m.g.), clopidogrel (75 m.g.), and Coumadin (5 m.g.).

5. The RN who worked the AM shift was the admitting RN and transcribed Mr. A's admission orders. The hospital discharge instructions included a physician's order for daily INR checks (International Normalized Ratio) to measure Mr. A's coagulation tendency. That RN called the admitting physician to discuss the admission orders. The physician approved all of the orders except the order for the daily INR, stating that the INR testing was a 'hospital order' and that she

would take care of the needed order when she came to see Mr. A.

6. Respondent worked the PM shift on Mr. A's unit on April 17 and 18. She obtained and recorded Mr. A's vita signs each day, as required for a new resident.

7. On April 19, 2004, Respondent observed and documented that Mr. A had cranberry colored urine in his Fole bag. Respondent's note in Mr. A's record says that Mr. A had complained to his son of pain with urination and suggested th bleeding could have been caused by trauma from Mr. A pulling on the catheter tube.

8. On April 26, a nursing assistant had reported to the RN working the unit that Mr. A had a "big bruise" on his hip. That RN examined Mr. A and documented in his record that he had a 4 inch by 2 inch bruised area in the right abdominal fold. She described it as "ecchymotic," which is a skin discoloration caused by the escape of blood into the tissues from ruptured blood vessels. The bruise was not reported to a physician. Mr. A's blood pressure was taken for the last time on that date.

9. On April 30, Mr. A had an epistaxis (nosebleed) which the RN working on the unit stopped with pressure. Tha nurse noted it in Mr. A's record and that further epistaxis should be monitored. It was not reported to a physician.

10. On Saturday, May 1:

a. At 3:00 p.m., Mr. A's son expressed concern to Respondent that Mr. A had dry blood under his nose. Respondent told him about Mr. A's bloody nose the previous evening and said she didn't know the cause. Responder noted in the record that she would inform Mr. A's primary RN of all of the son's concerns.

b. At 7:30 p.m., Respondent noticed that Mr. A's right thumb was bleeding from what resembled the site of lancet puncture for glucose testing and the bleeding would not stop. Respondent checked Mr. A's record and saw h was receiving Coumadin. She looked for results of an INR but did not find one. Respondent did not check to see i there was an order for an INR. Respondent notified the on-call physician of Mr. A's nosebleed the previous evening an the bleeding from his thumb. The physician ordered that Mr. A's Coumadin be held on Sunday and that an INR be don on Monday, May 3.

c. At 9:45 p.m., Respondent examined Mr. A and noted that the abdominal bruise reported on April 26 ha spread across his abdomen to the left side above the navel and up almost to his armpit. Mr. A complained of pain in hi back and rectum. Respondent again contacted the on-call physician who moved up the INR to the morning of Sunday May 2 and ordered that Mr. A's aspirin be held Sunday and Monday until they had the INR results.

11. On Sunday, May 2:

a. Although WVH staff had been performing blood draws for other laboratory tests prior to this date, the were unable to perform the blood draw for the INR check because of Mr. A's "very poor veins." At noon, he wa taken to the hospital to have the blood drawn and then returned to the unit. The INR for a patient on anticoagulant should be between 2.0 and 3.0. An INR of 4 or more indicates a risk of uncontrolled bleeding. Mr. A's INR was ove 9.5. Because this was a critical value, the lab called the results to WVH at 2:50 p.m. The charge nurse on duty notifie the on-call physician who directed that Mr. A's aspirin and Coumadin continue to be held until his primary physicia could be contacted.

b. At 5:00 p.m., Respondent noted in the record that Mr. A had a slight nosebleed at supper time, whic stopped on its own. Respondent did not notify a physician of the nosebleed and did not check Mr. A's pulse or bloo pressure or perform any other physical assessment to determine if he had an adequate volume of blood.

c. At 6:30 p.m., Respondent observed and noted that Mr. A's urine was bloody and his stool was dar chocolate colored without visible blood. She performed a hemoccult which was positive for blood in his stool. Respondent did not notify a physician of this finding and did not check Mr. A's pulse or blood pressure or perform an other physical assessment to determine if he had an adequate volume of blood.

12. The morning of May 3, Mr. A's primary physician saw him and ordered that: INRs be performed that day an the next day, his Coumadin be held until further notice and 10 m.g. of Vitamin K be given that day to promote clotting. Tha morning's INR was 119, which the lab called into WVH at 10:00 a.m. At 11:40 a.m., Mr. A died. His body was released to funeral home on that date and he was cremated without an autopsy being performed.

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. Respondent, Rosalind P. Severson, R.N., is hereby REPRIMANDED for the above conduct.

2. Respondent's license is LIMITED as follows:

   a. Within 180 days of the date of this Order, Respondent shall provide proof sufficient to the Board, or it designee, of Respondent's satisfactory completion of a total of six (6) hours of continuing education on dealing witl cardiac conditions in adults, including medication, which course(s) shall first be approved by the Board, or its designee.

   b. Upon Respondent providing proof sufficient to the Board, or its designee, that she has completed the education, the Board shall issue an Order removing this limitation of Respondent's license.

3. Respondent shall, within 90 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of $370.00 pursuant to Wis. Stat. § 440.22(2).

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

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

5. In the event that Respondent fails to pay costs as ordered or fails to comply with the ordered continuing education, Respondent's license SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

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

Wisconsin Board of Nursing

By: Marilyn Kaufmann 10/4/07
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
ROSALIND P. SEVERSON, R.N., RESPONDENT.	:	LS _____ NUR

[Division of Enforcement Case # 04 NUR 290]

It is hereby stipulated and agreed, by and between Rosalind P. Severson, R.N., Respondent; Stephen O. Murray of Otjen, Van Ert & Weir, S.C., attorneys for 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 investigation of Respondent's licensure by the Division of Enforcement (file 04 NUR 290). Respondent consents to the resolution of this investigation by stipulation and without the issuance of a formal complaint.

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 obtained advice of legal counsel prior to signing this Stipulation.

4. Respondent neither admits nor denies the allegations in this matter but 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. 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, 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.

7. 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.

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

Rosalind P. Severson, R.N.
Respondent
W9345 Cty Rd O
Wautoma, WI 54982

Date

Stephen O. Murray
Otjen, Van Ert & Weir, S.C.
Attorneys for Respondent
450 Science Drive, Suite 110
Madison, WI 53711

Date

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

Date