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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
ANGELA M. LUEDTKE, R.N., RESPONDENT.	:	LS07110812NUR

[Division of Enforcement Cases # 04 NUR 099, 05 NUR 018, 06 NUR 378, 07 NUR 120, and 07 NUR 184]

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

Angela M. Luedtke, R.N.
1813 S. 14th Street
Manitowoc, WI 54220

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

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. Angela M. Luedtke, R.N., ("Respondent") was born on January 8, 1974, and is licensed to practice professional nursing in the state of Wisconsin pursuant to license number 140536. This license was first granted on April 2, 2002.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing is Route 1, Box 153, Coila, Mississippi 38923, but she is actually resident at 1813 S. 14th Street, Manitowoc, Wisconsin 54220.

3. Respondent was employed by the University of Mississippi Medical Center in Jackson, Mississippi during January 2004.

4. On January 27, 2004, due to suspicions that Respondent was diverting medications intended for patients,

Respondent was asked to take a urine drug screen. Respondent refused.

5. In conjunction with the request to take a urine drug screen, Respondent's purse was searched. Several ampoules of morphine were discovered hidden in her wallet, and several tablets of Percocet were discovered concealed in a pack of cigarettes she was carrying.

6. On March 5, 2004, Respondent provided a handwritten confession to officials of the State of Mississippi, stating that while she had been employed at the University of Mississippi, she had taken approximately four tablets of Percocet from the facility daily, as well as six to eight vials of morphine.

7 Between October 2004 and January 31, 2005, Respondent was employed at Indywood, LLC, a personal care home in Indianola, Mississippi. Because of suspicions that Respondent was diverting narcotic medications, her employer monitored a bottle of narcotic medication that had been prescribed for a resident at the home. The bottle was kept in Respondent's desk for the resident.

9. Over a period of several days, substantially more medication was removed from the bottle during Respondent's shift than was administered to the resident. On January 27, 2005, the bottle contained 80 ml. of medication at the beginning of Respondent's shift, and it was empty and found in a waste basket at the end of Respondent's shift.

10. Respondent told the director of nursing that she had poured out the resident's medication because it was too much of a temptation; Respondent told the owner of the home that she had administered all of the medication to the resident. Respondent's employment was terminated.

11. Respondent was employed as a nurse at Shady Lane, Inc., a nursing care center in Manitowoc, Wisconsin, between August 19 and October 24, 2006.

12. On October 15, 2006, Respondent was observed by a medical technician removing three Duragesic patches from a medication drawer. Respondent told the medical technician that she was removing the patches to destroy them, as the physician had discontinued the medication order. At the end of Respondent's shift, there was no record of the Duragesic patches having been destroyed.

13. Respondent's supervisor telephoned Respondent and asked her if Respondent knew where the Duragesic patches for the discontinued order had gone. Respondent's supervisor reported that Respondent stated she would check her pockets, and that Respondent told her supervisor the patches were not in her pockets.

14. Later that same night, Respondent returned to the facility and gave her supervisor four Duragesic patches, cut in half. Respondent told her supervisor that she had cut them in half, but forgot to discard them.

15. Respondent's supervisor stated that the Duragesic patches did not appear to have any medication remaining under the plastic covering.

16. Respondent was employed at Aurora Bay Care hospital in Green Bay, Wisconsin, through a nursing staffing agency, on the night shift on February 22, 23, and 24, 2007.

17. Her supervisor reported that Respondent took the narcotic keys home with her at the end of her shift, and that she left the hospital promptly at 7:30 a.m. on February 23, 2007, without giving report.

18. Her supervisor reported that during her shift on February 23, 2007, Respondent went out to her car several times during her shift, on one occasion for forty-five minutes; that Respondent was frequently in the restroom for up to twenty minutes at a time, and that Respondent could not concentrate on her tasks. Respondent again left the hospital promptly at the end of her shift, without giving report; on her way out, Respondent told the day charge nurse that if Respondent's supervisor had any questions, she could call Respondent at home.

19. Her supervisor reported that during Respondent's shift on February 24, 2007, that the night charge nurse had

discovered that there were several narcotics unaccounted for and not charted.

20. On investigation, Aurora Bay Care discovered that Respondent had removed two Dilaudid PCA syringes from the narcotic supplies for one patient, but only charted one. The other syringe was located in a sharps container, half empty.

21. Further, Respondent had removed five Demerol syringes for one patient, instead of the three that the medication order permitted. Respondent had charted administration of three, and had not documented the other two in any way.

22. Respondent was found to have hung IV fluids containing dextrose for each of two diabetic patients, one of whom required additional treatment for excessively high blood sugar levels.

23. On further investigation, a security guard at the hospital reported that he had observed Respondent attempting to open the sharps container in which the half empty Dilaudid syringe referred to in paragraph 20, above, was found.

24. Aurora Bay Care informed Respondent not to return for her scheduled shift on February 25, 2007.

25. Respondent provided a written statement to an investigator for the Division of Enforcement, stating that she had accidentally wasted half of a Dilaudid syringe required for the patient referred to in paragraph 20, above, by leaning against the plunger while it was in her pocket, causing it to leak into that patient's drawer and onto Respondent's clothes. Respondent wrote that she hung what was left, but had to hang a second syringe before her shift ended.

26. Respondent worked as a professional nurse at Select Specialty Hospital at West Allis Memorial Hospital, West Allis, Wisconsin, ("Select") as an employee of Healthcare Specialists Medical Staffing on March 17, 18, and 19, 2007.

27. On March 23, 2007, the Director of Clinical Services for Select reported to the Department of Regulation and Licensing that an audit of user reports for the MedDispense system and patient charts revealed that Respondent pulled narcotics from the system during her shifts that are not consistent with Respondent's documentation, including pulling narcotics for some patients who were not assigned to Respondent's care.

28. Select reported that for the three shifts that Respondent worked, Select is unable to reconcile 86 mg. of morphine, four tablets of Percocet, 6 mg. of lorazepam, 16 mg. of Dilaudid, and 450 mg. of Demerol.

29. Respondent provided a written statement to the Division of Enforcement, explaining that she has been bipolar since December 2006, and that on her last day of work at Select, she was in a manic phase, with which she was unfamiliar and did not recognize. She wrote that because she wanted to "stop the racing" she took nine 50 mg. vials of Demerol, intending to commit suicide with it. She wrote that she "poked" herself, but was unable to inject the medication because she did not want strangers "finding me that way" and therefore wasted the drug down a bathroom sink.

30. Respondent states that she attempted suicide in December 2006, and in January 2007. Respondent further reports that she was hospitalized for the December 2006 suicide attempt, and again after her arrest in March 2007 for stealing the drugs from Select. Respondent has declined to permit agents of the Board of Nursing to review of her medical records.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction to act in this matter, pursuant to Wis. Stat. § 441.07, and is authorized to enter into the attached Stipulation and Order, pursuant to Wis. Stat. § 227.44(5).

2. The conduct described in paragraph(s) 3 through 29, above, constitutes a violation of Wisconsin Administrative Code § N7.04(2).

3. The conduct described in paragraph(s) 3 through 29, above, constitutes a violation of Wisconsin

Administrative Code § N7.03(3).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. The license of Angela M. Luedtke, R.N., to practice professional nursing in the state of Wisconsin is hereby REVOKED.

IT IS FURTHER ORDERED that:

2. Respondent may apply for re-instatement of the license one year after the date of this Order, subject to the following conditions:

a. Respondent shall provide the name, address, and telephone number of each of her physicians and therapists, as well as a release permitting agents of the Board to obtain copies of all of her medical and mental health records, and to discuss her condition with each of her physicians and therapists.

b. Respondent shall cooperate fully with the Board and its agents, to permit the Board to determine what limitations, if any, the Board should impose on a re-instated license to practice professional nursing.

3. Respondent shall, within 270 days from the date of this Order, pay costs of this proceeding in the amount of One Thousand Five Hundred Forty ($1,540.00) dollars. Payment shall be made 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
Telephone (608) 267-3817
Fax (608) 266-2264

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

Wisconsin Board of Nursing

By: Marilyn Kaufmann 11/8/07
A Member of the Board Date