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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDING AGAINST	:	
	:	FINAL DECISION AND ORDER
FRANK V. SACCO, R.N.,	:	LS0801181NUR
RESPONDENT.	:	

Division of Enforcement Case # 06 NUR 347]

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

Frank V. Sacco, R.N.
1602 E. Moonbeam Trail
Appleton, WI 54915

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. Frank V. Sacco, R.N., was born on September 13, 1960 is duly licensed as a professional nurse in the state of Wisconsin license # 140631. This license was first granted on February 11, 2002.

2. Respondent's most recent address on file with the Board of Nursing is 1602 E. Moonbeam Trail, Appleton, Wisconsin 54915.

3. At all times relevant to this action, Respondent was working as a professional nurse at ManorCare Health Services in Appleton, Wisconsin.

4. On July 27, 2006, a 57 year old female patient with Downs Syndrome was admitted to Manorcare Health Services following hospitalization for implantation of a pace maker. During that hospitalization she suffered respiratory failure which necessitated the placement of a tracheostomy tube.

5. From July 28, 2006 through August 4, 2006, the resident did not allow staff to clean her tracheostomy tube.

6. On August 6, 2006, while Respondent was administering a tube feeding, the resident became cyanotic and her respirations changed. Respondent did not determine if the airway was occluded and did not attempt to suction the resident even though a suctioning machine was in the room. Respondent called 911 and applied a tracheostomy cuff to administer oxygen. The resident's measured oxygen saturation level at the time was 25%.

7. Emergency Medical Technicians arrived within four minutes from receipt of the call. They noted that resident was unresponsive and that she was exhibiting agonal breathing. They applied a bivalve mask to the resident, and without attempting suctioning, transferred the resident to the hospital located across the street.

8. The resident was unresponsive at the hospital, her pupils fixed and dilated, and she continued with agonal breathing. The staff at the emergency room suctioned the resident, with the result that a large quantity of mucus secretions was cleared from the tracheostomy tube. Despite rescue efforts, the resident died in the emergency room. The physician in charge noted that the probable cause of death as respiratory failure due to plugging of the resident's tracheostomy tube.

9. ManorCare provided continuing education in the area of tracheostomy care, suctioning, and assessment to Respondent and all other ManorCare nurses.

CONCLUSIONS OF LAW

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

2. Respondent's failure to determine if the resident's airway was blocked, and his failure to suction the resident's tracheostomy tube, as described in paragraph 6, above, was unprofessional conduct contrary to Wis. Stats sec. 441.07(1)(d) and Wis. Admin Code sec. NUR 7.03(1)(b).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED, that the attached Stipulation is accepted:

IT IS FURTHER ORDERED, effective the date of this order that:

1. Frank V. Sacco, RN is REPRIMANDED.

2. Respondent shall, within six months from the date of this Order, successfully complete a minimum of twelve (12) hours of continuing education in the area of emergency assessment and treatment in long term care.

3. The Board or its designee must approve all continuing education programs prior to Respondent enrolling in, attending, or completing a continuing education program. Respondent shall send a Certificate of Completion for each continuing education program to the Department Monitor upon successful completion of each continuing education program.

2. Respondent shall, within NINETY (90) days from the date of this Order, pay COSTS of this proceeding in the amount of EIGHT HUNDRED FIFTY ($850.00) 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

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 pay costs as ordered or fails to comply with the ordered continuing education, the Respondent's license (# 140631) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

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

Board of Nursing

By: Marilyn Kaufmann 9/4/08
A Member of the Board Date