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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF	:	
DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
	:	
VICTORIA L. BEYER, R.N.,	:	LS0805011NUR
RESPONDENT.	:	

Division of Enforcement Cases #04 NUR 64, 06 NUR 240

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

Victoria L. Beyer, RN
1140 Grassy Plains Dr.
Neenah, WI 54956

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

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. Victoria L. Beyer (D.O.B. 4-6-70) is duly licensed in the state of Wisconsin as a professional nurse (license #135569). This license was first granted on 7-21-2000.

2. On 2/5/06, Respondent was employed as a staff nurse at the New London Family Medical Center. Patient #1 had been on IV pain medication and was to be transitioned to oral dosage units. Respondent represents to the Board that the first day the patient came in, he was in terrible pain and she restarted his IV as authorized by the orders, and gave him the medication authorized. The patient stated that he was very grateful, as the pain had been so unbearable that he actually wanted to die. She then left instructions to the LPN to leave the IV in, but it was removed anyway, contrary to her RN instructions. The next night when Respondent again came on duty, the patient continued to have significant pain, but since the IV had been removed, rather than re-insert it she injected the medication directly, IM. The Board finds that this constitutes a change of route of administration without an order.

3. On 2/26/06, at the same facility, Patient #2 was prescribed Bumex®, but through pharmacy error, it was not in the patient's medication drawer. Respondent represents to the Board that this was a morbidly obese patient, 400 pounds or more, whom she judged to be in desperate need of his Bumex. At this facility, after hours medications are obtained through the ER, and when she went down to get some Bumex, they were busy and said that they could not get to this for some time. Respondent expressed her view to staff that this was quite urgent, and the patient could not wait, and returned to the floor. The ER then sent up one tablet of 1mg Bumex, although the patient had been ordered to receive 2mg IV. She consulted another more experienced nurse whose name she does not recall, but who also worked in the ICU at Appleton; this other nurse suggested using Lasix, which was at hand. Respondent then went through the patient's chart to see if there was any contraindication for Lasix, and found that the patient had been prescribed Lasix before, without apparent problem. She then

performed the calculations for dosage, and administered it. The patient excreted some 3-4 liters immediately following administration. She later discussed her action with a nurse practitioner covering the patient, and obtained a one-time order for this substitution, which she "back-timed" in the chart by some six hours to cover her administration. Notwithstanding her laudable motives, the Board finds that this constitutes a change of medication without an order, and falsification of a patient chart.

4. On a day near 2/26/06, at the same facility, Respondent placed a Foley catheter in Patient #3 without an order. Respondent represents to the Board that the patient's physician had previously stated to her that the physician would always trust Respondent's judgment concerning such an action, and that if Respondent felt that catheterization was needed, she should simply perform the catheterization and prepare an order, which the physician would sign the next morning. Respondent represents to the Board that she relied upon this statement, but forgot to prepare the order for the physician to sign. The Board finds that this constitutes either an invasive procedure without an order, or failure to properly document, and is a violation either way.

5. On and between 12/29/06 and 2/18/07, Respondent diverted a controlled substance, hydrocodone, by the use of the following scheme: on several occasions, Respondent posed as a representative of W.B., who is a relative of Respondent's, and telephoned the office of W.B.'s physician, requesting a refill of W.B.'s prescription for a previously prescribed hydrocodone product. In fact, W.B.'s need for this product had ceased, and W.B. did not authorize Respondent to request such a refill. Respondent then went to the pharmacy normally used by W.B., and represented herself as being there on behalf of W.B. She picked up the prescription, and kept the medication for her own use.

6. On 4/30/07, Respondent was convicted of misdemeanor obtaining controlled substances by fraud in the Circuit Court for Winnebago County, Wisconsin, growing out of the facts set forth in par. 5, above.

7. Respondent has been assessed by an appropriate professional, and found not to have any current alcohol or drug dependence, or need for treatment for substance abuse. Respondent represents to the Board that her use of hydrocodone is related to chronic back pain, for which she is now receiving appropriate medical care and treatment, under the supervision of a physician.

8. For personal reasons, Respondent does not desire to practice nursing, and chooses to surrender her license at this time.

CONCLUSIONS OF LAW

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

B. The conduct described in pars. 2-4, above, violated Wis. Stat. § 441.07(1)(b) and (d), and Wis. Adm. Code §§ N 7.03(1)(a) and (b), and N 7.04(5) and (15). Such conduct constitutes unprofessional conduct within the meaning of the Code and statutes.

C. The conduct described in pars. 5-6, above, violated Wis. Adm. Code §§ N 7.03(2) and N 7.04(1), (2) and (15). Such conduct constitutes unprofessional conduct within the meaning of the Code and statutes.

ORDER

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

IT IS HEREBY FURTHER ORDERED that the SURRENDER of the license and privilege of Victoria L. Beyer, R.N., to practice as a nurse in the state of Wisconsin is ACCEPTED. Respondent shall not practice nursing in Wisconsin, including under the Nurse Licensure Compact, without a Wisconsin license. Respondent may petition for reinstatement at any time.

IT IS HEREBY FURTHER ORDERED that Respondent shall pay costs of $1,350, to the Department of Regulation and Licensing.

Dated at Madison, Wisconsin this May 1, 2008.

WISCONSIN BOARD OF NURSING, by:

Marilyn Kaufmann
Chairperson