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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
LEAH F. HALL, L.P.N., RESPONDENT.	:	LS0805015NUR

[Division of Enforcement Case #'s 03 NUR 051 & 05 NUR 248]

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

Leah F. Hall, L.P.N.
2728 W. Line Street
Bishop, CA 93514

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 in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Leah F. Hall, L.P.N., ("Respondent"), date of birth October 30, 1951, is licensed by the Wisconsin Board o Nursing as a licensed practical nurse in the state of Wisconsin pursuant to license number 20090, which was first granted Ma 31, 1978.

2. Respondent's address of record with the Department of Regulation and Licensing is 2728 W. Line Street Bishop, CA 93514.

COUNT I

3. On all dates relevant to Count I, Respondent was employed as a licensed practical nurse at Middleton Village Nursing and Rehabilitative Center, 6201 Elmwood Avenue, Middleton, Wisconsin ("Middleton Village").

4. On January 29, 2003, Patient DG, DOB 09/03/1915, was discharged from St. Mary's Hospital to Middleton Village Nursing for short term rehabilitation. Patient DG had severe radicular pain in his thigh, which interfered with his mobility and left him unable to care for himself at home. Secondary diagnoses included upper gastrointestinal bleeding and exacerbation of chronic obstructive pulmonary disease.

5. On January 29, 2003, Patient DG signed a document declining a "do not resuscitate" order, and indicating:

> YES, I do wish Cardiopulmonary Resuscitation efforts. I understand that the Emergency Medical System will automatically be activated (Ambulance transfer to the hospital).

6. On February 6, 2003, the Comprehensive Care Plan for Patient DG indicated a nursing diagnosis of impaired breathing patterns related to a history of COPD. The Comprehensive Care Plan directed staff to monitor and report incidents in which Patient DG experienced shortness of breath, labored breathing and/or cyanosis.

7. The Comprehensive Care Plan for Patient DG also indicated a nursing diagnosis of altered cardiac output related to diagnoses of hypertension and anemia. The Comprehensive Care Plan directed staff to monitor and report incidents in which Patient DG had cool, pale and clammy skin, or blue lips or nails.

8. Between February 7, 2003 and February 8, 2003, Patient DG had periodic episodes of shortness of breath, which were typically relieved with albuterol treatments, administered via nebulizer.

9. On February 8, 2003, Patient DG began the day resting quietly, with blood pressure of 104/60, oxygen saturation at 92%, and a respiration rate of 16 breaths per minute. He experienced an episode of shortness of breath, which was relieved with nebulized albuterol. At 1:00 p.m., his blood pressure was 118/60; his oxygen saturation level was 92%, and his respiration rate was 28 breaths per minute, with decreased breath sounds in the bases. Nursing staff noted that his skin was pink, and his appetite moderate.

10. On February 8, 2003, Respondent assumed responsibility for Patient DG's care at 2:00 p.m. Respondent's first notation concerning Patient DG was documented at 1600 hours (4:00 p.m.), although the written notation was amended to reflect a time of 1800 hours (6:00 p.m.). The amendment was not initialed or otherwise acknowledged or explained. Respondent reported that Patient DG said he was "just not feeling right." At that point his oxygen saturation level was 94% and he was receiving oxygen through a nasal canula. His lung sounds were diminished in the bases bilaterally, and his blood pressure was low at 98/60. Respondent observed that Patient D.G.'s "color [is] pasty [and] extremities cool to the touch." Respondent did not report her observations to a physician or registered nurse.

11. By 8:00 p.m., Patient DG continued to say he did not "feel right." Respondent's notes indicated that Patient DG's vitals had not changed but his lips were cyanotic. Respondent noted that Patient DG answered questions appropriately and tolerated a nebulizer treatment. The head of Patient DG's bed was elevated 45 degrees and he continued to take oxygen. Respondent did not notify a physician or registered nurse of Patient DG's symptoms.

12. Respondent's next note, at midnight, indicated that Patient DG's color remained pasty and his lips cyanotic. His blood pressure was 100/60; oxygen saturation 94% on 2.5 L oxygen by nasal cannula, and respirations 28/min, and he evidenced increased shortness of breath on exertion. Respondent did not notify a physician or registered nurse of Patient DG's symptoms.

13. On February 9, 2006, at 1:30 a.m., according to Respondent, Patient DG was asleep and resting comfortably.

14. The following is Respondent's entry for February 9, 2003 at 3:25 a.m.:

> [Patient DG] turned on Call light told CNA he was unable to breath[e], CNA called nurse,

> I responded immediately as I entered doorway resident took one large inspiration [with] no expiration. Became unresponsive, attempted deep sternal rub [with] no response. Unable to detect breath sounds unable to detect [apical pulse, no blood pressure, no] intestinal sounds. Call placed to 911. Paramedics arrived [at] 0350 began a cardiac lead. Began manual CPR [with] no response. They [stopped] all rescue attempts [at] 0410. Call placed to coroner by Rescue squad, coroner was informed of Dx and of Teri Patwells last orders and Progress notes. Call placed to Dr. Ozers who is the on call for Dr. Hernandez. Dr. Ozers pronounced him dead [at] 0420. Coroner returned call informed him of Dr. Ozers pronouncement. The coroner stated we may release the body to…whatever funeral home family decides.

15. Administration at Middleton Village initiated an internal investigation into the death of Patient DG. On February 10, 2003, Judy Cupples, RN, Director of Nursing at Middleton Village asked Respondent for her version of events. The following is Ms. Cupples' report of Respondent's account:

> [Respondent] states that CNA [Kathryn O'Haver] answered Patient DG's call light. [Patient DG complained of shortness of breath] and Kathryn elevated his head of bed. Kathryn then came to PC hall to get [Respondent]. They went together to Patient DG's room. Kathryn went to call 911, Respondent called all staff to come to room 44. Respondent states that she started CPR by herself with no response from the resident. She said she did CPR with no protective equipment. No other staff came to the room until the Paramedics arrived. It took the Paramedics about 5 minutes for response from the first group to arrive and another 5 minutes for the second group of Paramedics to get to the facility.

16. Kelly Salgado ("Salgado") was the other LPN on duty at Middleton Village during the night shift of February 9, 2003. As Salgado was working on another hall, a CNA came to her and told her that Patient DG had died and Respondent needed her. Salgado went to the nurses' station as Respondent was leaving to head toward Patient DG's room, and Salgado followed her. When Salgado arrived in Patient DG's room, Respondent stood next to Patient DG and shook him. Respondent said, "I came in here and he took his last breath and he passed away." Salgado asked Respondent if Patient DG was a full code and Respondent indicated that he was. Salgado then told Respondent that if Patient DG was a full code, they should be doing CPR until the paramedics arrived. As Salgado moved toward Patient DG, the paramedics arrived.

17. Middleton EMS received the call concerning Patient DG at 3:31 a.m., and arrived at the scene at 3:39 a.m. The record states:

> No CPR in progress upon arrival, no active [do not resuscitate order]…arrived on the scene to find [patient] supine, head elevated in bed, on [oxygen] by cannula. Verified no vitals—absent pulse/resps. Middleton PD applied AED, no shock advised. CPR initiated, w/pocket mask.

18. Middleton Police Officers Daniel Jones and Rich O'Connor arrived at Middleton Village at about the same time as Middleton EMS. One of the nursing home staff members who was in Patient DG's room when Officer Jones arrived told Jones that CPR had not been initiated. Jones does not recall which staff member made the statement. Jones and a Middleton EMT then started CPR, and continued until Madison Fire Department paramedics arrived.

19. On May 5, 2005, Respondent told Department of Justice investigator Chuck Miller that she commenced CPR immediately after telling the CNA to call 911. Respondent said that she performed CPR until she was relieved by emergency personnel. Miller reminded Respondent that emergency medical technicians had reported that no one was doing CPR when they arrived and that the patient was positioned upright, with the nasal cannula in place. Respondent said she stopped CPR, raised the bed and put the nasal cannula back in place to see whether Patient DG had resumed breathing. Respondent stated that the emergency personnel arrived while she had Patient DG elevated and with the nasal cannula in place.

20. Respondent's behavior in not alerting a physician or registered nurse of Patient DG's deteriorating condition through the evening of February 8, 2003 and the morning of February 9, 2003, was contrary to the patient's care plan and placed Patient DG at unreasonable risk of serious harm.

21. Respondent's failure to correctly and continuously administer cardiopulmonary resuscitation until emergency medical services arrived to relieve her placed Patient DG at unreasonable risk of serious harm.

COUNT II

22. At all times relevant to Count II, Respondent was employed as a licensed practical nurse at Oak Park Nursing and Rehabilitation Center, Madison, Wisconsin ("Oak Park").

23. On July 24, 2005, at approximately 7:00 a.m., Activity Aid Melissa Pryce reported for work at Oak Park and saw Respondent dispensing medications. Pryce observed Respondent wearing a white shirt with red and blue stripes and a draw-string. Pryce noted that the shirt resembled a shirt belonging to Resident MB. Pryce was familiar with the shirt because Pryce had occasionally done Resident MB's laundry.

24. When Pryce approached Respondent from behind, Pryce saw that a number, "308B" was written on the back of the shirt. The number, written in black magic marker, was Resident MB's room number.

25. It is the practice of Oak Park to mark residents' clothing by writing the resident's room number on the back of each article of clothing with black magic marker.

26. Pryce contacted a social worker at Oak Park and an internal investigation ensued.

27. On July 24, 2005, Oak Park's Director of Nursing, Janelle Zacho, R.N., met with Respondent and retrieved the shirt in question. Respondent told Zacho she "purchased the shirt at a rummage sale at a Catholic church, near downtown, by State Street." Respondent could not recall the name of the church.

28. When asked why Resident MB's room number was marked on the shirt, Respondent said that the church that hosts the rummage sale gets donations from a local nursing home. Respondent did not know which particular nursing home donated the items.

29. Respondent denied taking the shirt or any other item from a resident.

30. On July 25, 2005, Zacho showed Resident MB the shirt she retrieved from Respondent. Resident MB identified the shirt as hers. Zacho looked through Resident MB's belongings and was unable to find a white shirt with red and blue stripes that resembled the shirt retrieved from Respondent.

31. On July 28, 2005, Oak Park staff member Lenny Leonhardt identified the shirt as one Resident MB had purchased from Wal-Mart. Leonhardt was with Resident MB at the time of purchase.

32. Other Oak Park staff members—Rochelle Lewis, Nicole Watson, Priscilla Anderson and Erin Radant--confirmed that the shirt had previously been worn by Resident MB.

33. Director of Nursing Zacho contacted the three Catholic churches near downtown Madison. According to Zacho, representatives of all three churches said their churches did not host rummage sales with items donated by local nursing homes. Zacho further contacted Madison area nursing homes and learned that only one other facility had a third floor. That facility did not label residents' clothing with markers, but rather used a distinct labeling system.

34. Respondent obtained Resident MB's shirt, a thing of value, without Resident MB's consent.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. § 441.07 and has 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 in Count I, paragraph 20, above, has violated standards of practice for licensed practical nurses, as set forth in Wis. Adm. Code § N 6.04(1)(c) and has committed unprofessional

conduct as defined by Wis. Adm. Code § N 6.05 and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

3. Respondent, by engaging in the conduct set out in Count I, paragraph 21, above, has Committed unprofessional conduct as defined by Wis. Adm. Code § N 7.04 and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

4. Respondent, by engaging in the conduct set out in Count II, paragraph 34, above, has committed unprofessional conduct as defined by Wis. Adm. Code § N 7.04(12) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. The SURRENDER by Leah F. Hall, L.P.N., Respondent, of her license as a practical nurse in the State of Wisconsin is hereby ACCEPTED.

2. Respondent may not petition the Board of Nursing for the reinstatement of her license until after six (6) months from the date of this Order, and the following terms and conditions have been satisfied:

a. Any such petition shall be accompanied by payment in the amount of $3,633.48, payable to the Department of Regulation and Licensing, which represents the costs of this proceeding, and which the Board could have assessed, pursuant to Wis. Stat. § 440.22(2), at the time of surrender or imposition of other discipline.

b. Respondent shall have, at Respondent's own expense, undergone a mental health assessment by an experienced mental health care practitioner.

i. The assessor must not have treated Respondent at any time and shall have been approved by the Board, with an opportunity for the Division to make its recommendation, prior to the evaluation being performed.

ii. The Division shall provide the assessor and Respondent with those portions of the investigative file which the Division believes may be of assistance in performing the assessment, including Respondent's treatment records or evaluations in the possession of the Division. Respondent may provide the assessor with any information Respondent believes will be of assistance in performing the assessment and shall immediately provide copies of that information to the Division.

iii. Respondent shall authorize the assessor to provide the Board, or its designee, and the Division with the assessment report and all materials used in performing the assessment and shall provide the Board, or its designee, and the Division with the opportunity to discuss the assessment and findings with the assessor.

iv. The assessor shall have provided an opinion to a reasonable degree of professional certainty that Respondent is able to practice with reasonable skill and safety of patients and public and does not suffer from any condition which prevents her from practicing in that manner.

c. If the assessor has rendered the opinion required by subparagraph b.iv., the Board may reinstate Respondent's license. The Board may limit Respondent's license in a manner to address any concerns the Board has as a result of the conduct set out in the findings of fact or the period of time Respondent has not practiced nursing and to address any recommendations resulting from the assessment, including, but not limited to:

i. Psychotherapy or other treatment, at Respondent's expense, by a practitioner approved by the Board, to address specific treatment goals, with periodic reports to the Board by the therapist.

ii. Additional professional education in any identified areas of deficiency.

iii. Restrictions on the nature of practice or practice setting or requirements for supervision of practice, by a professional approved by the Board, with periodic reports to the Board by the supervisor.

d. Respondent shall appear before the Board on an annual basis, if requested by the Board, to review the progress of any treatment and rehabilitation.

3. If limitations are placed on Respondent's license, Respondent may petition the Board to modify or end the

limitations.

4. If Respondent believes that the Board's refusal to reinstate her license is inappropriate or that any limitation imposed or maintained by the Board under paragraphs 2c or 3 is inappropriate, Respondent may seek a class 1 hearing pursuant to Wis. Stat. § 227.01(3)(a) in which the burden shall be on Respondent to show that the Board's decision is arbitrary or capricious or inconsistent with this Order. The suspension or limitations on Respondent's license shall remain in effect until there is a final decision in Respondent's favor on the issue.

5. All requests, notifications and payment shall be mailed, faxed 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

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

Wisconsin Board of Nursing

By: Marilyn Kaufmann 5/1/08
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
LEAH F. HALL, L.P.N., RESPONDENT.	:	LS _____ NUR

[Division of Enforcement Case #'s 03 NUR 051 & 05 NUR 248]

It is hereby stipulated and agreed, by and between Leah F. Hall, L.P.N., Respondent; and Sandra L. Nowack 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 o Enforcement (files 03 NUR 051 & 05 NUR 248). Respondent consents to the resolution of this investigation by stipulation an 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 o her behalf and to compel their attendance by subpoena; the right to testify herself; the right to file objections to any propose decision and to present briefs or oral arguments to the officials who are to render the final decision; the right to petition fo rehearing; and all other applicable rights afforded to her under the United States Constitution, the Wisconsin Constitution, th 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 o 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 does no accept this Stipulation, Respondent's certificates shall be returned to Respondent with a notice of the Board's decision not t 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, 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.

_____ _____

Leah F. Hall, L.P.N.
Respondent
2728 W. Line Street
Bishop, CA 93514

Date

_____ _____

Sandra L. Nowack
Attorney for Complainant
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

Date