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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
DAWN M. BENISH, L.P.N., RESPONDENT.	:	LS0809041NUR

[Division of Enforcement Case # 05 NUR 031]

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

Dawn M. Benish, L.P.N.
P.O. Box 156
Lyndon Station, WI 53944

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. Dawn M. Benish, L.P.N., Respondent herein, whose date of birth is August 1, 1968, is duly licensed by the Wisconsin Board of Nursing as a licensed practical nurse in the state of Wisconsin under license number 305035, which was granted on May 14, 2004.

2. Respondent's last known address filed with the Department of Regulation and Licensing is P.O. Box 156, Lyndon Station, WI 53944.

3. At the time of the events set out below, Respondent was employed as a licensed practical nurse at the Tomah Health Care Center in Tomah, Wisconsin.

4. Resident A, a seventy four year old male, was admitted to Tomah Health Care Center in September 2004 with a history of cardiac problems and dementia, along with various other medical conditions.

5. On January 19, 2005, an assessment of the resident revealed oxygen saturation levels were good and that his pulse rate was normal.

6. On the evening of January 19th, two CNA found the resident slumped over in his chair, quiet and sleepy, which was unusual behavior for him. The CNAs reported the resident’s condition to Respondent, who was the nurse on

duty on that wing.

7. Respondent checked on the resident and noted that his skin color to be pasty grey but attributed that to his lack of sleep the previous night. Respondent also checked the resident's oxygen saturation levels and found them to be very low at 74-78%. The resident had a standing order for 2 liters of oxygen per minute when his saturation levels fell below 90%. Respondent gave the resident 1.5 liters of oxygen, instead of the ordered 2 liters, and the resident's oxygen saturation levels rose to the low 80's

8. Respondent advised the RN on duty of the resident's change in condition but did not give the RN the actual numbers of the oxygen saturation levels. Respondent assumed the RN would assess the resident but did confirm this with the RN.

9. Because it was normal for the resident's oxygen saturation levels to lower in the evening and the staff routinely dealt with that condition by placing the resident in a supine position, the RN did not feel it necessary to assess the patient.

10. At approximately 9:15 p.m., facility staff assisted the resident to bed and took his vitals which reflected a pulse rate of 103, respiration 24, and blood pressure 87/64. Respondent directed a CNA to take Mr. A's vitals every 15 minutes, including his oxygen saturation levels, and to report to her any changes.

11. Over the next several hours, the CNA took Mr. A's vitals. Respondent asked the CNA repeatedly if she was taking Mr. A's vitals but failed to ask what the vitals were or to look at the notes the CNA had been keeping. Respondent contends that she expected the CNA to report any significant changes.

12. At approximately 1:25 a.m. on January 20, another CNA came onto the unit and recognized that the resident's vitals were unusual for him and called Respondent to the unit. At that time, the resident's blood pressure was 60/38. Respondent contacted the Emergency Room at Tomah Memorial Hospital who directed that the resident be immediately transferred by ambulance. When the ambulance arrived at approximately 2:00 a.m., the resident's blood pressure was 58/34.

13. The resident was diagnosed with pneumonia, a myocardial infarction, and septic shock upon arrival at the Emergency Room. He passed away shortly thereafter.

14. Respondent failed to adequately notify the RN of changes in the resident's condition by failing to provide the RN with the actual oxygen saturation levels in the early evening of January 19th; and failing to communicate the vital signs to the RN at 9:15 of the evening of the 19th.

15. Respondent failed to document her communication with the RN in the early evening of January 19th.

16. By requiring a nursing assistant to evaluate the vital signs to determine if they required reporting to Respondent, the Respondent delegated a duty to a nursing assistant which was beyond the permissible scope of duties for a nursing assistant.

17. Respondent's conduct as described herein constitutes failure to observe the conditions, signs and symptoms of a patient, record them, or report significant changes to the appropriate person.

18. Respondent was required by her employer, Tomah Health Care Center, to work with a RN until completion of a refresher course on nursing assessment.

19. In May 2005, Respondent successfully completed a 1 credit refresher course "LPN Refresher-Interventions" at Southwest Wisconsin Technical College in Fennimore, Wisconsin.

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's conduct as herein described constitutes a violation of Wis. Stat. § 441.07(1)(c) and Wis. Admin. Code §§ N 7.03(1)(a) and (c), N 6.03 (4).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the Stipulation of the parties is hereby accepted.

IT IS FURTHER ORDERED that:

1. Respondent, Dawn M. Benish, L.P.N., is REPRIMANDED for the above conduct.

2. Respondent's license as a licensed practical nurse in the State of Wisconsin shall be limited to require that, within nine (9) months of the date of this Order, Respondent shall obtain a total of three (3) hours of continuing education on the role of the practical nurse in managing and directing patient care, including communications with nursing assistants and registered nurses.

3. The Board recognizes Respondent's successful completion of the course "LPN Refresher-Interventions," in lieu of any further discipline addressing assessment and documentation.

4. Respondent shall be responsible for obtaining the course(s) required under this Order, for providing adequate course description(s) to the Department Monitor, and for obtaining pre-approval of the course(s) from the Board of Nursing, or its designee, prior to commencement of the program(s).

5. Within thirty (30) days following completion of the course(s) identified in paragraph 2 above, Respondent shall file with the Board of Nursing certification(s) from the sponsoring organization(s) verifying her attendance at the required course(s).

6. All costs of the educational program(s) shall be the responsibility of Respondent.

7. Upon successful completion of the educational program(s) and payment of the costs set forth below, Respondent's license shall be restored to unlimited status.

IT IS FURTHER ORDERED that:

8. Respondent shall, by January 30, 2009, pay costs of this proceeding in the amount of nine hundred fifty ($950.00) dollars. Payment shall be made to the Wisconsin Department of Regulation and Licensing, and mailed 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

9. In the event that Respondent fails to pay costs as ordered or fails to comply with the ordered continuing education, Respondent's license (#305035) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

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

Wisconsin Board of Nursing

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