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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
JUDITH E. FLEEMAN, L.P.N., RESPONDENT.	:	LS0809045NUR

[Division of Enforcement Case # 04 NUR 349]

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

Judith E. Fleeman, L.P.N.
746 Lee Avenue
Brillion, WI 54110

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. Judith E. Fleeman, L.P.N., Respondent herein, whose date of birth is December 29, 1942, is duly licensed by the Wisconsin Board of Nursing as a licensed practical nurse in the state of Wisconsin pursuant to license number 20894, which was granted on November 28, 1978.

2. Respondent's last known address filed with the Department of Regulation and Licensing is 746 Lee Avenue , Brillion, WI 54110.

3. On October 29, 2004, while employed as a licensed practical nurse by Angel HealthCare of America, Inc., a home health service located in Appleton, Wisconsin, Respondent worked the PM shift at Peabody Manor, a nursing home in Appleton. Complaints about Respondent's nursing practice on that day were made by three residents:

a. Ms. A (DOB 6/6/49), was admitted to the nursing home on October 25 for short-term hip and knee rehabilitation after hospitalization following an automobile accident. Ms. A had fractured her ribs and pelvis and displaced her sacroiliac joint. Ms. A also had a history of multiple sclerosis. Ms. A's hospital discharge notes and nursing care plan showed that Ms. A needed assistance with ambulating, transferring and toileting.

1) Ms. A required toileting assistance and put on her call light. When Respondent came into Ms. A's room, she commented that she was busy passing medications and asked Ms. A if she could go by herself. Ms. A told Respondent that her orders said she needed assistance and that she did not feel

comfortable attempting to go by herself.

2) Respondent assisted Ms. A to the bathroom and asked if she would be able to get back by herself. Ms. A told Respondent that she would be OK on the toilet and Respondent left the room.

3) A short while later, a CNA (certified nursing assistant) entered Ms. A's room and found Ms. A crying in the bathroom. Ms. A told the CNA that Respondent told her she was too busy passing meds and did not have time to take her to the bathroom. Ms. A also told the CNA that Respondent kept questioning if Ms. A could go to the bathroom by herself. The CNA helped Ms. A back to bed.

4) Respondent failed to recognize that Ms. A was a fall risk and failed to assist the patient ,or to delegate to a CNA the assistance of, Ms. A to the bathroom.

b. Ms. B (DOB 5/5/16) was admitted to the nursing home on October 7 for short term hip rehabilitation. At 2:58 p.m. on October 29, Ms. B's physician faxed new orders for Ms. B to receive Ditropan at night and Cipro every day for 7 days.

1) Ms. B reported that Respondent only gave her 2 pills rather than the 4 pills she usually gets. Respondent failed to give Ms. B the Ditropan, later explaining that she could not locate the medication.

2) At approximately 3:00 a.m. on October 30, a registered nurse gave Ms. B the medications that Respondent failed to administer.

3) Respondent failed to take the necessary steps to ensure that Ms. B received her medication, by either locating the medication, having the medication reissued or informing the RN that the medication was missing and had not been provided to the patient as ordered.

c. Ms. C (DOB 2/10/41) was admitted to the nursing home on October 19 for short-term rehabilitation following hospitalization for a fractured hip resulting from a fall. Ms. C's treatment records showed that her staples were to be removed on the October 29 PM shift.

1) At approximately 10:40 p.m., while Ms. C was asleep, Respondent came into Ms. C's room, turned on the light and woke her up, stating that she needed to remove her staples.

2) Ms. C refused to allow Respondent to remove the staples at that time.

3) Respondent failed to plan in advance about the staple removal and should have delegated this task to the next shift without waking Ms. C. Respondent also should have informed her supervisor that the staples had not been removed, as ordered.

4. Respondent failed to document in the progress notes any of these events involving the three residents.

5. As a result of Respondent's conduct, the Director of Nursing at Peabody Manor notified Angel HealthCare that Respondent was not permitted to return to their facility.

6. Respondent is not currently employed as a licensed practical nurse.

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, in each of the instances as set out above, constitutes violations of Wis. Stat. § 441.07(1)(c) and Wis. Admin. Code §§ N 7.03(1) (b) (c) and (d).

ORDER

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

IT IS FURTHER ORDERED that:

1. Respondent, Judith E. Fleeman, 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 continuing education in the following areas: six (6) hours in medication administration and a minimum of two (2) hours in nursing ethics.

3. Respondent shall be responsible for obtaining the courses required under this Order, for providing adequate course descriptions to the Department Monitor, and for obtaining pre-approval of the courses from the Board of Nursing, or its designee, prior to commencement of the programs.

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

5. All costs of the educational programs shall be the responsibility of Respondent.

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

IT IS FURTHER ORDERED that:

7. Respondent shall, by December 3, 2008, pay costs of this proceeding in the amount of eight hundred ($800.00) 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

8. In the event that Respondent fails to pay costs as ordered or fails to comply with the ordered continuing education, Respondent's license (#20894) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

9. 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