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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF	:	
DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
	:	
ROXANNE DAVIS, L.P.N.,	:	LS0910012NUR
RESPONDENT.	:	

Division of Enforcement Case #04 NUR 38, 04 NUR 74

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

Roxanne Davis
E3525 Garvey Rd
Plain, WI 53577

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. Roxanne [no middle name] Davis (dob: 5/25/61) is and was at all times relevant to the facts set forth herein a practical nurse licensed in the State of Wisconsin pursuant to license # 31511. This license was first granted 12/04/92.

2. On 1/4/04, and while employed as a practical nurse at the Central Wisconsin Center, Respondent administered two dosage units of a prescribed medication, which were in pill form, to a resident by placing them in applesauce and feeding them to the resident by placing a spoonful of the applesauce, containing the pills, in the resident's mouth. The resident then experienced a gagging reflex and did not swallow the pills; Respondent then attempted to re-administer them orally. The resident's chart clearly stated that the resident was to be administered all oral medication and nutrition through a gastronomy tube.

3. After this error was called to her attention, Respondent failed to chart the incident or to notify her supervisor of the error.

4. On 2/22/04, and while employed as a practical nurse at the Central Wisconsin Center, Respondent administered a prescribed dose of liquid phenytoin, a prescription medication, to a resident. The bottle containing this medication was discovered to be on a table in an area accessible to residents, the next morning. Respondent denies that she failed to place the container back into the locked medication cabinet as required by policy, and represents to the Board that supervisors were required to walk through the area at least twice, during the hours before the medication was discovered and did not report finding the medication. The Board finds that no other staff person had any reason to handle this medication container, and that the most reasonable inference is that Respondent inadvertently left it on the table instead of replacing it in the locked medication cabinet.

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 paragraphs 2 through 4, above, violated Wis. Adm. Code §§ N 7.03(1)(b), (c), and (d), and N 7.04(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 FURTHER ORDERED, that Roxanne Davis, L.P.N., is REPRIMANDED for her unprofessional conduct in this matter.

IT IS FURTHER ORDERED, that Respondent shall, no later than 3/1/10, complete 4 hours of continuing education in the area of preventing medication errors and safe handling of medication, which shall have been pre-approved by the Board or its designee.

IT IS FURTHER ORDERED, that 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 demonstrate timely compliance with the ordered continuing education, the Respondent's license SHALL BE SUSPENDED, without further notice or hearing, until Respondent has demonstrated compliance with the ordered continuing education.

IT IS FURTHER ORDERED, that Respondent shall pay Costs of $2,050, to the Department of Regulation and Licensing, before April 5, 2011. In the event Respondent fails to timely submit full payment of costs, or the Respondent's license SHALL BE SUSPENDED, without further notice or hearing, until Respondent has paid the costs in full, together with any accrued interest.

Dated at Madison, Wisconsin this October 1, 2009.

WISCONSIN BOARD OF NURSING, by:

Marilyn Kaufmann
Chairperson