WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
WILLIAM T. ZELLNER, R.N., RESPONDENT.	:	ORDER000031

Division of Enforcement Case No. 07 NUR 091

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

William T. Zellner, R.N.
3862 S. Lake Drive #204
St. Francis, WI 53235

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. William T. Zellner, R.N., Respondent, date of birth December 28, 1954, is licensed by the Wisconsin Board of Nursing as a registered nurse in the State of Wisconsin pursuant to license number 119915-30, which was first granted June 28, 1995.

2. Respondent's address of record with the Department of Regulation and Licensing is 3862 S. Lake Drive #204, St. Francis, Wisconsin 53235.

3. At all times relevant to this matter, Respondent was employed as a registered nurse with Aurora Visiting Nurse Association of Wisconsin, 11333 W. National Ave., Milwaukee, Wisconsin 53227.

4. On January 17, 2007, Respondent undertook care of 87 year-old Patient AB. Patient AB had been discharged from a hospital stay with end-stage heart failure, severe mitral valve regurgitation, and other diagnoses.

5. Patient AB was released from the hospital with a peripheral IV left in place. The family complained that her arm was swollen and red, and she was in discomfort as a result. Respondent called a physician but apparently got no response. Ultimately, on January 17 or 18, 2007, Patient AB pulled the IV out on her own. On January 18, 2007, Respondent took a physician's verbal order to discontinue the IV. Respondent did not write an order as is required. On January 19, 2007, Respondent documented that the IV had been discontinued, but did not document accurately that the patient pulled it out on her own a day or two earlier.

6. Between approximately January 17, 2007, and January 23, 2007, Patient AB developed the need to frequently urinate. She and her caretakers were up hourly, around the clock, and the family requested a catheter. Respondent did not follow up on the family's request and did not report Patient AB's frequent urination to her physician as is required with any change in condition. Respondent did not adequately document the issue.

7. Patient AB had trouble breathing, was anxious and on oxygen. Respondent dismissed the family's request for additional length of oxygen tubing, and failed to take action on the patient's anxiety and complaints that her thoughts were racing.

8. When confronted with the family's concerns, Respondent said that he was aware that the patient was urinating at night and the family requested a catheter. Respondent acknowledged that he did not discuss the issue with the physician as he was more concerned with other issues and thought the family was "jumping to conclusions".

9. Patient AB had a pressure wound on her heel. Respondent missed it and specifically documented that there were no wounds. Respondent explained that he felt, rather than saw the heel.

10. Patient AB's care plan required that she be weighed daily or every other day. Although he documented that Patient AB was weighed, Respondent confirmed the family's claim that he did not weigh Patient AB, despite her chronic heart failure. Respondent said he told Patient AB's daughter to weigh Patient AB daily.

11. Respondent admits documentation errors but denies any errors in patient care. Respondent states that the patient at issue should have been in hospice rather than in home care.

He called the error to the attention of the visiting nurse agency and provided care beyond that required.

12. A performance evaluation completed on April 12, 2006, included an assessment of how well Respondent "Contacts physicians to report alterations in the patient's health status, to verify and share information or to obtain medical orders." The reporter noted that Respondent's "follow through needs to improve—Report to cc—make sure he has orders for all procedures."

13. The same evaluation made an assessment of Respondent's communication, "as evidenced by having less than three valid complaints per year." The reporter documented "A few complaints this year—not wearing yellow gown with MRSA patient—x2". It was also mentioned that he needed to follow up more timely on corrections in paperwork.

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 above, has committed negligence as defined by Wis. Adm. Code § N 7.03(1)(b) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

3. Respondent, by engaging in the conduct set out above, has committed negligence as defined by Wis. Adm. Code § N 7.03(1)(c) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

4. Respondent, by engaging in the conduct set out above, has committed negligence as defined by Wis. Adm. Code § N 7.04(6) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. Respondent, William T. Zellner, R.N., is hereby REPRIMANDED for the above conduct.

2. Respondent's license is LIMITED as follows:

a. Within 180 days of the date of this Order, Respondent shall provide proof sufficient to the Board, or its designee, of Respondent's satisfactory completion of 13 hours of continuing education as follows: 4 hours in medical documentation, 4 hours in

ethics, 3 hours in palliative care, and 2 hours in wound assessment and care, which course(s) shall first be approved by the Board, or its designee.

b. Upon Respondent providing proof sufficient to the Board, or its designee, that she has completed the education, the Board shall issue an Order removing this limitation of Respondent's license.

3. Respondent shall, within 90 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of $400.00 pursuant to Wis. Stat. § 440.22(2).

4. Requests for approval, notification of completion of educational programs and payment shall be faxed, 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

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

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

WISCONSIN BOARD OF NURSING

By: Marilyn Kaufmann
A Member of the Board

1/28/10
Date