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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
GINA L. INDRA, L.P.N., RESPONDENT.	:	Order 0000113

Division of Enforcement Case #07 NUR 291

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

Gina L. Indra
115 N. 8th St.
Watertown, WI 53094

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. Gina Lynn Indra (dob: 11/30/66) 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 #34108. This license was first granted 3/25/97. Respondent was previously disciplined by the Board on 1/7/00, in file 99 NUR 296, for failing to timely renew her nursing license while actively practicing nursing, for several months. She was reprimanded and ordered to pay the costs of the investigation.

2. In 1999, Respondent suffered a torn rotator cuff and had several dental procedures, for which she was prescribed opioid medications for pain. She represents to the Board that she became dependent upon these medications, and when her physicians attempted to reduce or stop her medications, she engaged in "doctor shopping" to obtain them. She represents to the Board

that she voluntarily sought treatment in 2000, was treated for 5 years at a methadone clinic. In 2005 she refused to provide urine samples for screening, and was discharged from the clinic; Respondent represents to the Board that she could not, at that time, afford to pay for the urine drug screens following her insurance company's refusal to cover them. All her urine drug screens before that time were negative for unprescribed medications, and positive for methadone, and she had a record of compliance with all requirements of the program. The Board was not informed of any of these events until the current investigation was conducted.

3. Since that time, and while employed as a practical nurse at the Monroe Manor Extendicare, Inc., a skilled nursing facility in Monroe, Wisconsin, Respondent experienced an injury while lifting a patient on April 11, 2007, and was prescribed a course of a hydrocodone product for this injury. She was subsequently prescribed oxycodone products, and is currently prescribed methadone, for continuing pain related to this injury.

4. On or about 4/23/07, Respondent documented on the "narcotic count sheet" that she removed two pills of a hydrocodone product from a resident's supply, for the resident, and administered them to the resident. The Medication Administration Record also contains documentation that two pills of this product were administered to the resident. On the same day, Respondent signed out an additional pill of this product from the facility's contingency box, for the same resident, but did not document administration of the medication to the resident, on the Medication Administration Record.

5. On 7/18/07, Respondent was on duty at a time when the facility's contracted pharmacy delivered medications for patients. These medications included a "blister pack" of 31 pills of an oxycodone 5mg product, a Schedule II opioid, for a patient. This medication, including the entire blister pack containing the medication could not be found the next day, nor could any documentation of its delivery or acceptance be found.

6. At the same time described in par. 5, above, while the pharmacy delivery driver was present, Respondent stated to the driver that she needed an analgesic, and removed a pill from the facility's convenience or contingency box . The convenience box contains a variety of prescription medications, including a prescription-strength ibuprofen 400mg product, and also contains a separately locked contingency box with opioids and benzodiazepines which are controlled substances. A later inventory of the contingency box showed that one pill of a hydrocodone product, a Schedule III controlled substance, could not be accounted for.

7. Respondent denies that she took any hydrocodone product, and represents to the Board that she took an ibuprofen 400mg product from the convenience box. She further represents to the Board that this was a common and accepted practice at this facility.

8. The Board does not accept a representation that a nursing home facility would permit staff to take a prescription-only product from a convenience box, for their personal use, and further states that even if a facility did so, a licensee of the Board may not ingest a prescription medication without a prescription from an authorized prescriber.

9. On 8/2/07, Respondent removed two pills containing an oxycodone 5mg product for a resident of the facility, from the blister-pack for that resident; she documented that she administered the medication to the resident at approximately 1500. On 8/3/07, the blister-pack was found to be missing from the medication cart, when the nurse on duty went to obtain the medication for the resident at 1700; it was also discovered that the "controlled substances record" sheet for that resident was also missing on 8/3/07. No other nurse administered this medication to this patient between 8/2/07 and the time the medication was discovered to be missing. Respondent denies taking this medication.

10. Respondent denies any unprofessional conduct, but for personal reasons, chooses to surrender her license.

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 9 through 9, above, violated Wis. Adm. Code §§ N 7.03(2) and N 7.04(1), (2) and (15). Such conduct constitutes unprofessional conduct within the meaning of the Code and statutes.

ORDER

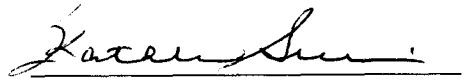
NOW, THEREFORE, IT IS HEREBY ORDERED, that the attached Stipulation is accepted.

IT IS FURTHER ORDERED, effective the date of this Order, the SURRENDER of the license to practice nursing of Gina L. Indra, L.P.N., is ACCEPTED. Respondent shall not practice nursing, including under the Nurse Licensure Compact, in Wisconsin, without a current license from the Board. Respondent may petition for reinstatement at any time, and the Board may grant reinstatement subject to whatever terms and conditions the Board, in its sole discretion, deems appropriate.

IT IS FURTHER ORDERED, that Respondent the COSTS of this matter, in the amount of $1,500, are WAIVED, but Respondent may be ordered to pay them as a condition of reinstatement.

Dated at Madison, Wisconsin this March 25, 2010,

WISCONSIN BOARD OF NURSING, by:



Chairperson

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