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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
JUDITH M. STEMPER, R.N., RESPONDENT.	:	Order 0000202

[Division of Enforcement Case # 08 NUR 218]

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

Judith M. Stemper, R.N.
23 N. Saint Joseph Lane
Fond du Lac, WI 54935

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Board of Nursing
Department of Regulation & 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 the attached Stipulation and considers it acceptable.

Accordingly, the Board adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Judith M. Stemper, R.N., Respondent, date of birth October 31, 1949, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 112875, which was first granted March 24, 1993.

2. Respondent's last address reported to the Department of Regulation and Licensing is 23 N. Saint Joseph Lane, Fond du Lac, WI 54935.

3. During the events of this matter, Respondent was employed as a registered nurse by the Department of Corrections (DOC) – Bureau of Health Services and worked as a Nurse Clinician 2 in the Health Services Unit (HSU) at Taycheedah Correctional Institution in Fond du Lac, Wisconsin.

4. On October 15, 2007:

a. An inmate was scheduled for court and a corrections officer brought her to the HSU for her seizure medications before they left. Because the inmate had had three seizures the day before, officer stated "wouldn't that be a good idea to give her that seizure med for her journey to Milwaukee?" Respondent responded "I don't know. Do you even know what you're talking about?"

b. Respondent looked for the inmate's medical file for a few minutes but could not find it. She then sat back down and continued a conversation she had been in the middle of when the officer and inmate came in.

c. An LPN came out of the medication room and administered the medication to the inmate because it did not appear that Respondent was going to do so.

5. On October 17, 2007:

a. An inmate was complaining of flu like symptoms and was brought to the HSU for an assessment. Respondent instructed a medical assistant to take the inmate's vital signs and then place her in the observation room. The medical assistant did so and recorded the vital signs in the inmate's medical file.

b. Respondent failed to assess the inmate or follow up on her vital signs prior to leaving her shift and failed to inform the oncoming charge nurse that the inmate was in the observation room.

c. Approximately one half hour later, the charge nurse found out that the inmate was in the observation room. The inmate needed IV therapy for dehydration.

6. On October 19, 2007:

a. An inmate had fallen out of her wheelchair and was lying on the floor. The inmate was complaining of shoulder pain and that she could not get herself back up into the wheelchair.

b. Respondent refused to help the inmate up, stating that she had been instructed in orientation never to pick up anyone off the floor, but instead to call an ambulance. Another nurse that was present confirmed the orientation instructions but during later interviews, the orientation instructor and several other staff nurses stated that they were never instructed in orientation not to help an inmate up.

c. After several minutes, the inmate managed to get herself back into her wheelchair. It was later determined that the inmate had suffered a dislocation of her right shoulder from her fall.

7. Investigatory meetings were held and it was determined that Respondent failed to respond appropriately to inmates in distress. In addition, Respondent failed to provide truthful, accurate and complete information during the investigatory meetings. On January 11, 2008, as a result of her conduct, Respondent's employment was terminated for violation of DOC Work Rules.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction to act in this matter, pursuant to Wis. Stat. § 441.07, and is authorized to enter into the attached Stipulation and Order, pursuant to Wis. Stat. § 227.44(5).

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

ORDER

IT IS ORDERED:

1. Respondent, Judith M. Stemper, R.N., is REPRIMANDED for the above conduct.

2. Respondent's license to practice nursing in the State of Wisconsin, and her privilege to practice pursuant to the Multi-State Nurse Licensure Compact, is LIMITED for a period of at least two (2) years from the date of this Order, as follows:

a. Respondent shall provide a copy of this Final Decision and Order immediately to supervisory personnel at all settings where Respondent works as a nurse or caregiver or provides health care.

b. Respondent shall practice only in a work setting pre-approved by the Board or its designee. Respondent may not work in a home health care, hospice, pool nursing or agency setting.

c. Respondent shall practice only under the direct supervision of a licensed nurse or other licensed health care professional approved by the Board or its designee.

d. Respondent's supervisors shall provide written reports on Respondent's work performance to the Department Monitor on a quarterly basis, as directed by the Department Monitor. It shall be Respondent's responsibility to ensure that the reports are made in a timely manner.

e. Respondent shall notify the Department Monitor of each employment as a nurse and the name and contact information for her supervisor at each employment, within 10 days of becoming employed as a nurse.

3. Respondent shall, within 180 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of $300.00, pursuant to Wis. Stat. § 440.22(2).

4. All requests, petitions and payments required by this Order shall be mailed, faxed 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, Respondent's license may, in the discretion of the Board or its designee, 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: _____
A Member of the Board

5/6/10
Date

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