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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
DALE A. NIENHAUS, L.P.N., RESPONDENT.	:	Order 0000296

Division of Enforcement Case #07 NUR 345

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

Dale A. Nienhaus
811 Oregon St.
Saint Croix Falls, WI 54024

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. Dale A. Nienhaus (dob: 12/8/45) 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 #34282. This license was first granted 8/20/97.

2. On 9/5/07, Respondent was employed as a practical nurse at Good Samaritan Society—St. Croix, a skilled nursing facility in St. Croix Falls, Wisconsin. Respondent's practice was observed on this day by an auditor who was a nurse. The following observations were made by the auditor: Respondent was observed to administer a pill of prednisone without food, contrary to the physician's order; some medications were not administered within one hour of the scheduled time for administration; and Respondent administered some PRN medications without a

request for them and without asking the resident if the resident desired the medication. Respondent denies these allegations, and denies any unprofessional conduct.

3. On 9/12/07, Respondent was again observed, by a different auditor who was a nurse. The following observations were made:

a) Shortly after 5 PM, Respondent informed the auditor that he was finished with medication administration until 8 PM, but the auditor observed that the Medication Administration Record showed that approximately 85% of the medications scheduled to be administered at 4, 5, and 6 PM had not been documented as given, while some of the medications scheduled for HS were documented as given

b) A dose of an oxycodone product ordered for HS was documented by Respondent as given at 8 PM, although the auditor observed the time to be approximately 5 PM

c) For another resident a dose of a vitamin and a dose of Aricept® ordered for HS were documented as having been given while an order for Lasix® scheduled for 5 PM was not documented as having been administered

d) For another resident the 4, 5, 8 PM, and HS medication were documented as having been administered while a scheduled dose of acetaminophen for 4 PM had not been documented as given.

e) Respondent was observed to document that he applied a transdermal nitroglycerin patch to a resident, when in fact he failed to apply the patch until the auditor asked him about it; when Respondent applied the patch he failed to don gloves and in fact touched the medicated portion of the patch with his finger while applying it, and then failed to wash his hands until reminded by the auditor.

f) Respondent then administered a codeine with acetaminophen product which had been ordered PRN for a resident, without a request for the medication, without documenting any pain, and without asking the resident if she wanted it; when the auditor asked about this Respondent stated that unless he administered it now, the resident would wake up later and ask for it.

g) The auditor also observed that Respondent mixed a prescription triamcinolone cream with an over-the-counter clotrimazole cream, for application to a resident by a CNA, without a prescriber's order.

h) The auditor also observed that Respondent did not appear to visualize three checks by comparing the labels to the MAR. Respondent was observed to allow medications to remain unsecured on the top of the cart in the corridor, while Respondent was in a resident's room administering medications.

Respondent denies these allegations, and denies any unprofessional conduct.

4. Respondent is not currently engaged in nursing practice, and has not engaged in practice since being terminated by his employer on 9/13/07. Respondent has retired as a nurse, and solely to settle this matter and not as an admission, agrees to surrender his license to resolve this investigation.

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 3, above, if proved, would violat Wis. Stat. § 441.07(1)(c) and Wis. Adm. Code §§ N 7.03(1)(b) and N 7.04(5) and (15). Such conduct constitutes unprofessional conduct within the meaning of the Code and statutes.

ORDER

IT IS ORDERED, that the attached Stipulation is accepted.

IT IS FURTHER ORDERED, effective the date of this Order, the SURRENDER of the license of Dale A. Nienhaus L.P.N., is ACCEPTED. Respondent shall not practice nursing without a license from the Board, including under the Nurse Licensure Compact.

IT IS FURTHER ORDERED, that the Costs of this matter, in the amount of $400, are waived, but if Respondent ever seeks licensure by the Board, he shall pay them before any such license may be granted.

Wisconsin Board of Nursing

By: Kathleen Sweeney
A Member of the Board

7/22/10
Date

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