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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
MICHAEL A. HAFEMANN, R.N., RESPONDENT.	:	ORDER0000388

[Division of Enforcement Case No. 09 NUR 004]

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

Michael Hafemann, R.N.
3220 W. Lakefield Drive
Milwaukee, WI 53215

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

Wisconsin Board of Nursing
Department of Regulation and Licensing
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 adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Michael Hafemann, R.N., Respondent, date of birth March 31, 1969, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 123392-30, which was first granted July 6, 1996.

2. Respondent's last address reported to the Department of Regulation and Licensing is 3220 W. Lakefield Drive, Milwaukee WI 53215.

3. During the events of this matter, Respondent was employed as a registered nurse (RN) at Wheaton Franciscan Healthcare-St. Joseph in Milwaukee, Wisconsin. Respondent was employed from December 2, 2007 through December 9, 2008 in the Intensive Care Unit.

4. On November 17, 2008, Respondent was assisting another RN in the ICU with care for Patient A. Although Patient A had an order for oral Percocet (a brand of oxycodone and a

schedule II controlled substance) to be taken every four hours as needed, Patient A's pain was controlled by IV morphine and the patient had not been taking any oral analgesics. At 17:19 and again at 21:41, Respondent accessed the locked Automatic Dispensing Unit (ADU) and obtained two tablets of Percocet which he designated were to be given to Patient A. Respondent did not record in the medical administration record (MAR) for Patient A that he gave the Percocet to Patient A and did not record that the Percocet was destroyed or returned to the ADU.

5. On November 21, 2008, Respondent obtained two tablets of Percocet from the ADU at 08:26 and designated they were for Patient B, who was under another RN's care. When he was asked why he had done so, Respondent said the pharmacy had delayed entering an order for Percocet for his patient, Patient C, into the ADU and he needed to provide Percocet to Patient C. When asked where the Percocet were, Respondent said they were in his pocket. The other RN told him to return them to the ADU and he did so at 09:55.

6. On November 29, 2008, Respondent was assisting another RN turn Patient D in bed. Although Patient D had an order for oral Percocet, Patient D's pain was controlled by fentanyl and the patient had not been taking any oral analgesics. Respondent returned to Patient D's room with 2 Percocet he had obtained from the ADU for Patient D and the other RN told Respondent that the patient's pain was being controlled by fentanyl and the Percocet wasn't needed. Respondent never recorded in the MAR or anywhere else whether the Percocet was administered, returned to ADU or destroyed.

7. Respondent's employer required him to produce a sample for drug screen testing and the results were negative except for Vicodin for which he had a prescription. Respondent denied diverting the Percocet for himself or others. He attributed the lack of record of what happened to the Percocet to his sloppy documentation and poor nursing practice.

8. On December 2, 2008, Respondent was suspended from his employment pending further investigation and on December 9, 2008 Respondent's employment was terminated for failure to appropriately dispense and record narcotics and inappropriate charting of patient care.

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's conduct violated the minimum standards of the profession necessary for the protection of the health safety and welfare of a patient or the public, which is misconduct and unprofessional conduct as defined by Wis. Adm. Code § N 7.04(Intro.) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

ORDER

1. Respondent, Michael A. Hafemann, R.N., is hereby REPRIMANDED for the above conduct.

Education

2. Respondent's license is LIMITED as follows:

a. Within 90 days of the date of this Order, Respondent shall successfully complete six (6) hours of continuing education in record keeping and documentation, which has been approved by the Board or its designee.

b. Within 14 days of completion of the last of the continuing education, Respondent shall provide proof to the Board, or its designee, that the approved education has been completed and the Board or its designee shall issue an order removing this limitation from Respondent's license.

Notice and Reports

3. For two (2) years from the date of this Order, Respondent's license is LIMITED as follows:

a. Respondent shall provide a copy of this Final Decision and Order immediately to supervisory personnel at all settings where Respondent presently works as a nurse or caregiver or provides health care. If Respondent begins employment at any other setting as a nurse or caregiver or provides health care, he shall upon employment immediately provide a copy of this Final Decision and Order to supervisory personnel at that setting.

b. Respondent shall notify the Department Monitor of each employment as a nurse or caregiver or provides health care and the name and contact information for her supervisor at each employment, within 10 days of becoming employed as a nurse.

c. 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. The first report by each supervisor shall state that the supervisor has been provided and read a copy of this Final Decision and Order. It shall be Respondent's responsibility to insure that the reports are made in a timely manner.

4. Respondent shall, within 120 days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of (three hundred and fifty dollars) $350.00 pursuant to Wis. Stat. § 440.22(2).

5. Any requests, reports, evidence of completion of educational programs and payment 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

6. 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 timely submit payment of the costs or fails to comply with the ordered continuing education as set forth above, the Respondent's license (No.123392-30) may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs or completion of the continuing education.

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

Wisconsin Board of Nursing

By: _____ 9-2-10

A Member of the Board Date