WISCONSIN DEPARTMENT OF REGULATION & LICENSING

Wisconsin Department of Regulation & Licensing
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Regulation & Licensing website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Regulation and Licensing from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Regulation and Licensing data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Regulation and Licensing, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Regulation and Licensing is shown on the Department's Web Site under "License Lookup." The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca .
- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DRL website: An individual who believes that information on the website is inaccurate may contact the webmaster at web@drl.state.wi.gov

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
KAREN A. REILLY, R.N. RESPONDENT.	:	FINAL DECISION AND ORDER FOR REMEDIAL EDUCATION
	:	ORDER 0000508

[Division of Enforcement Case No. 05 NUR 288]

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

Karen A. Reilly, R.N.
32641 Yahnke Road
Burlington, WI 53105

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 Wisconsin Board of Nursing ("Board"). The Board has reviewed the attached Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Karen A. Reilly, R.N., Respondent, date of birth August 4, 1954, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 123419, which was first granted July 6, 1996.

2. Respondent's last address reported to the Department of Regulation and Licensing is 32641 Yahnke Rd, Burlington, WI 53105.

3. At all times relevant to this action, Respondent was working as registered nurse at Mount Carmel Medical and Rehabilitation Center (the facility) in Burlington, Wisconsin.

4. On December 2, 2004, Patient WK was admitted to the facility for rehabilitation following hospitalization for a cholecystectomy with complications. The initial care plan for Patient WK acknowledged the potential for impaired skin integrity and suggested positioning and pressure relieving devices as approaches.

5. On March 5, 2005, Patient WK fell, sustaining a left hip fracture. On March 21, 2005, it was discovered that Patient WK also had a left femur fracture. The fractures required surgical intervention and on April 5, 2005, Patient WK was readmitted to the facility after surgery on the femur fracture, with methicillin resistant staphylococcus aureus (MRSA) in the surgical incision.

6. MRSA is a type of staph bacteria that is resistant to certain antibiotics, including methicillin and other more common antibiotics such as penicillin and amoxicillin. MRSA can lead to skin infections, and more serious infections may cause pneumonia, bloodstream infections or surgical wound infections.

7. On April 5, 2005, the nurses' notes indicated Patient WK had a left hip incision with serous drainage. A wound vac dressing was applied to the incision area. Also noted were three open areas to the coccyx: one area approximately the size of a quarter; the other two estimated to be 1 cm each. The nurses applied xenaderm.

8. On April 6, 2005, nurses described Patient WK's surgical wound as being 19 cm long by 3 cm wide at its widest point, and 2.5 cm deep at the deepest point. The wound had moderate drainage. The right buttock open area was 3 cm by 2 cm, 75% yellow, and 25% red, with moderate drainage. The left buttock open sore was 1.5 cm by 1.5 cm, and dark red in color.

9. On May 11, 12, 26 and 28, 2005, Respondent was a night duty nurse at the facility and was responsible for the care of Patient WK, among others.

10. On May 28, 2005, Respondent documented treatment of Patient WK's coccyx pursuant to orders. Respondent further observed, "left buttock, bony process appeared to be turning red, applied flexan for protection." Facility records included no additional nurses notes documentation on this date from Respondent concerning Patient WK.

11. State surveyors' documents report that on June 1, 2005, Patient WK became diaphoretic and his blood pressure dropped to 86/48. He was transferred to the hospital and admitted through the ER. Admission notes indicated, "multiple bedsores in the coccyx area."

12. Surveyors further documented that on June 2, 2005, the hospital's wound care nurse documented Patient WK's pressure sores as follows:

1. Left hip-surgical—13.5 cm x 18 cm, with a width of 1.5 cm and a depth of .25 cm
2. Right medial thigh—Stage 2—2.5 cm x .7 cm
3. Left heel—Stage 2—closed blister—2.5cm x 2.7 cm
4. Right achilles—Stage 2—1.0 cm x .5 cm

5. Right knee—Stage 2—1.4 cm x 1.4 cm
6. Left of sacrum—Stage 3—2.0 cm x 1.4 cm
7. Sacrum (coccyx)—Stage 4—4.0 cm x 7.0 cm
8. Right lateral foot—Stage 1—1.0 cm x 1.0 cm
9. Right scrotum—Stage 2—1.8 cm x 1.5 cm
10. Right ischium—Stage 4—4.5 cm x 4.5 cm
11. Left ischium—Stage 2—1.0 cm x .8 cm
12. Right buttocks—Stage 2—2.0 cm x 3.0 cm

13. According to surveyors, the hospital's wound nurse further documented "Sharp debridement of necrotic tissue from both Stage IV ulcers to coccyx and right ischium. These two ulcers down to bone but no bone exposed as of yet."

14. State survey documents indicated that the hospital's discharge summary of June 7, 2005 included final diagnoses of: "pneumonia, sepsis, possibly due to level 4 bed sores, left thigh wound secondary to incision and drainage of MRSA infection, history of hypertension, hyperlipidemia and general debility due to multiple medical issues, and urosepsis." Patient WK was released from the hospital to Hospice Care.

15. On June 6, 2005, the hospital informed the facility of Patient WK's pressure sores. The facility initiated an investigation, which included an interview of Respondent. Respondent further indicated the other areas of pressure wounds sort of "ran together" and were about 1½ inches in diameter, were Stage 3, and were yellow with darkened areas due to accuzyme.

16. In a June 27, 2005 interview, Respondent rec alled Patient WK's open coccyx wound, indicating that it was an open area, and required a large flexan to cover it. She described a large flexan as being approximately 4 inches by 4 inches square. Respondent explained that she had been doing Patient WK's treatments but did not measure the wounds because she believed the issue would be addressed by the wound team. Respondent did recall that at the end of May, she had observed the areas were "getting worse" and had noted some necrotic (black) tissue.

17. On March 23, 2006, in a written statement provided through counsel, Respondent reported that she fully performed all required treatment of Patient WK's injuries and, specifically: "These treatments consisted of cleansing of [Patient WK's] open areas with normal saline, then application of Accuzyme, a debriding agent, followed by Calcium Alginate, and then application of a Flexan covering."

18. Although it was not documented in Patient WK's health care records, on March 23, 2006, Respondent stated that she verbally "reported the observation of the red area on May 28, 2005 to the day shift nurse" and communicated "in writing with the facility's wound care nurse."

19. Respondent failed to fully document her observations of deterioration in Patient WK's wounds and her communication with other staff concerning Patient WK. Respondent's failure created an unacceptable risk that the severity of Patient WK's wounds would not be known or addressed expediently, which in turn creates an unacceptable risk of additional infection, illness and death.

20. Additional investigation has revealed that, during the period at issue, a nurse other than Respondent was responsible for wound rounds, which included weekly measurements of Patient WK's wounds. The wound care nurse was further responsible for recommending treatment changes based on Patient WK's wound status.

21. Between May 28, 2005 and March 20, 2006, Respondent has completed the following continuing education:

a. "Infection Control Program," 2 hours;
b. "Wound and Skin Assessment Documentation," 1 hour;
c. "Types of Abuse and reporting," .5 hours;
d. "Legal Implications of Documentation," 1 hour;
e. "Wound Care Documentation." .5 hours.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. § 441.07 and authority to enter into this stipulated resolution pursuant to Wis. Stat. § 227.44(5).

ORDER

IT IS HEREBY ORDERED that the stipulation of the parties is approved.

IT IS FURTHER ORDERED as follows:

1. Respondent shall, within six (6) months of the date of this Final Decision and Order, take and complete 4 hours of continuing education in patient assessments and documentation. Each course attended in satisfaction of this Order must be preapproved by the Board of Nursing or its designee. Respondent shall be responsible for locating courses satisfactory to the Board of Nursing and for obtaining the required approval of the courses from the Board of Nursing or its designee. Respondent shall, within 60 days of completion of this educational requirement, file an affidavit with the Board of Nursing stating under oath that she has attended in its entirety each of the courses approved for satisfaction of this requirement along with supporting documentation of attendance from the sponsoring organizations. This affidavit and the supporting documentation of attendance shall be filed with:

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

All certifications, affidavits or other documents required to be filed with the Board of Nursing shall be deemed filed upon receipt by the Department Monitor.

2. Respondent shall be responsible for paying the full cost of attendance at these courses.

3. Respondent shall, within ninety days from the date of this Order, pay costs of this proceeding in the amount of $600.00. Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

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

4. 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 costs as ordered or fails to comply with the ordered continuing education as set forth above, the Respondent's license (No. 123419) 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.

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

Wisconsin Board of Nursing

By: Kathleen Sullivan
A Member of the Board

12-2-10
Date

05NUR288/REILLY/NOWACK/LG/11-22-10