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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
MARY C. KELLEY, R.N., RESPONDENT.	:	Order 0000620

Division of Enforcement Cases #07 NUR 392, 09 NUR 235

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

Mary C. Kelley
13638 Briarwood Lane
Roscoe IL 61073

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. Mary Christine Kelley, f/k/a Mary Christine Glynn (dob: 12/14/50) was at all times relevant to the facts set forth herein a professional nurse licensed in the State of Wisconsin pursuant to license #152803. Respondent is also licensed in Illinois, where her license is current; she has never been disciplined in Illinois.

07 Nur 292

2. On 11/1/07, and while employed as a professional nurse at Mercy Hospital, Janesville, Wisconsin, Respondent withdrew 4 syringes (a total of 10mg) of injectable morphine, a Schedule II controlled substance, from the hospital's Pyxis system. She documented administration of 4mg,

but did not document the use or waste of 6mg. When requested to explain this by hospital staff, she was unable to explain this discrepancy.

3. Upon further investigation by the hospital of all documentation by Respondent for the previous 4 weeks, of the 25 patients who had orders for injectable morphine and hydromorphone (also a Schedule II controlled substance) and who were nursed by Respondent, 16 had similar discrepancies; in some of these cases the patients had no order for the medication at all, and in some others there was no indication of any administration, in the patient's chart. When requested to explain this by hospital staff, Respondent was unable to explain these discrepancies.

4. Respondent was criminally charged with possession of a controlled substance without authorization, growing out of the above incidents. She entered a plea of no contest and was permitted to enter a deferred judgment process by the Rock County Circuit Court; she was placed on probation for 18 months, on 1/9/09. She was not required to engage in any treatment or testing, while on probation. She completed probation, and the charge was dismissed on 5/19/10.

09 Nur 235

5. On and between 4/9/09 and 5/1/09, and while employed in the Emergency Department at the Monroe Clinic, Monroe, Wisconsin, Respondent:

A) Removed (1) 2mg hydromorphone injectable on 5/1/09 at 02:20 purportedly for patient J.T. There is no evidence in the clinic's records that the medication was administered, wasted or returned to Pyxis.

B) Removed (1) 2mg hydromorphone injectable on 4/11/09 at 06:13, purportedly for patient E.E. There is no evidence in the clinic's records that the medication was administered, wasted or returned to Pyxis.

C) Removed (1) 2mg hydromorphone injectable on 4/9/09 at 04:03, purportedly for patient L.V. There is no evidence in the clinic's records that the medication was administered, wasted or returned to Pyxis.

D) Removed (1) 2mg hydromorphone injectable on 4/16/09 at 19:20, purportedly for patient H.P. There is no evidence in the clinic's records that the medication was administered, wasted or returned to Pyxis.

E) Removed (1) 2mg hydromorphone injectable on 4/25/09 at 1:09, purportedly for patient J.D. On 4/25/09 at 07:24 Kelley documented waste of 1mg. There is no evidence in the clinic's records that the remaining 1mg of medication was administered, wasted or returned to Pyxis.

F) Removed (1) 2mg hydromorphone injectable on 4/26/09 at 06:25, purportedly for patient B.M. There is no evidence in the clinic's records that the medication was administered, wasted or returned to Pyxis.

G) Removed (3) 2mg hydromorphone injectables on 4/12/09 at 19:49, 20:05, and 22:41, purportedly for patient J.C. Records show (1) 2mg administered at 20:00. For the other (2) injectables, there is no evidence in the clinic's records that the medication was administered, wasted or returned to Pyxis.

At least one of these patients was billed for an injection of 2mg of hydromorphone which the patient did not, in fact, receive.

6. Respondent is not currently engaged in nursing practice in Wisconsin, her license having expired on 2/28/10. She has the statutory right to renew this license upon payment of fees until 2/28/15.

CONCLUSIONS OF LAW

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

B. The conduct described in paragraphs 2, 3, and 5, above, violated Wis. Adm. Code § 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 ORDERED, that the attached Stipulation is accepted.

IT IS FURTHER ORDERED, effective the date of this Order, the SURRENDER of the license, including the right to renew the license, of Mary C. Kelley, R.N., is ACCEPTED. Respondent shall not practice nursing in Wisconsin, including under the Nurse Licensure Compact.

IT IS FURTHER ORDERED, Respondent shall pay costs of $1650, to the Department of Regulation and Licensing, within 6 months of this Order.

Wisconsin Board of Nursing

By: _____ 1-27-11
A Member of the Board Date

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