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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
SHARON M. POLANSKI, R.N., RESPONDENT.	:	Order 0000624

Division of Enforcement Case #08 NUR 084

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

Sharon M. Polanski
14900 165th Ave.
Bloomer, WI 54724

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. Sharon M. Polanski (D.O.B. 7/11/1941) is duly licensed in the state of Wisconsin as a professional nurse (license # 40076). This license was first granted on 11/16/1962. All of the below actions occurred while Respondent was employed at the Hetzel Care Center, a skilled nursing facility in Bloomer, Wisconsin,

2. Respondent, on 10/14/2006, failed to completely document physician's order changing the warfarin dosing for resident J.D.; the information was not documented in the physician's orders record nor was the information relayed to the pharmacy. After being notified by her employer of her failure to completely document Respondent was given a detailed

checklist on how to properly document orders; Respondent updated resident J.D.'s records later the same day.

3. On 12/16/2006 Respondent failed to assess resident M.R. in a timely manner, following a report that the resident was experiencing diarrhea and vomiting. The assessment done almost four hours after Respondent was notified. The assessment done on resident M.R. was inadequate and/or inadequately documented, in that there was no estimate of the amount of fluid loss, or assessment of possible dehydration.

4. On 1/7/2007 Respondent failed to assess or check the vital signs of resident J.B., and/or failed to document her assessment and the resident's vital signs, following her receipt of a report from a CNA that the resident's blood pressure was 85/55.

5. On 10/14/2007, Respondent failed to completely process physician's orders and left documentation incomplete for resident D.P., stating that there was too much work for her to get done. Physician's orders were documented in physician's orders section of the patient's health care record but were not included in the nurses' notes.

6. On the same date, Respondent took physician's orders over the phone which prescribed insulin to be given at noon to resident W.B., and a glipizide dosage was also changed for him. Respondent administered insulin at 4:30 p.m., four and a half hours later than ordered. Respondent failed to document the medication changes in the nurses' notes and failed to document any assessment of patient vitals, blood sugar levels, and dressing changes for this resident.

7. Respondent was found by co-workers to have fallen asleep while at work on more than one occasion.

8. Respondent was terminated from her position on 11/28/2007.

CONCLUSION OF LAW

By the conduct described above, respondent is subject to disciplinary action against her license to practice as a nurse in the state of Wisconsin, pursuant to Wis. Stat. § 441.07(1)(b), (c) and (d), and Wis. Adm. Code §§ N 7.03(1)(a), (b), (c), (d), and N 7.04(4) and (15).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Sharon M. Polanski, R.N., is REPRIMANDED for her unprofessional conduct in this matter.

2. The license of Respondent to practice as a nurse in the state of Wisconsin is LIMITED as follows:

a. Respondent shall, no later than six months from the date of this Order, demonstrate successful completion of six continuing education credits in recordkeeping and charting, six credits in ethics, and three credits in assessment, which shall have been pre-approved by the Board or its designee. The Learning Extension course "Documentation: A Critical Aspect of Client Care" is approved as meeting the records and charting requirement. The Learning Extension courses "Ethics of Nursing Practice" and/or "Professional Accountability & Legal Liability for Nurses" are each approved as meeting the ethics requirement. It is Respondent's responsibility to locate, obtain approval for, and successfully complete a course in patient assessment.

b. Respondent shall provide her nursing employers with a copy of this Order before engaging in any nursing employment.

c. Upon demonstration of successful completion of the required continuing education, this limitation shall be terminated by staff, without further order of the Board.

3. 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 demonstrate compliance with the ordered continuing education as set forth above, the Respondent's license (#40076) may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has demonstrated successful completion of the continuing education.

IT IS FURTHER ORDERED that respondent shall pay the costs of investigating and prosecuting this matter, in the amount of $800, within six months of this Order. If not paid, Respondent's license may, in the discretion of the Board or its designee, be SUSPENDED without further notice or hearing, until they are paid in full, together with any accrued interest.

WISCONSIN BOARD OF NURSING

By: _____ January 27, 2011
A Member of the Board Date

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