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Before The
State Of Wisconsin
BOARD OF NURSING

In the Matter of the Disciplinary Proceedings
Against **LISA KAY DEWALL, R.N.**, Respondent

FINAL DECISION AND ORDER
Order No. 0000631

Division of Enforcement Case # 08 NUR 195

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

Lisa Kay DeWall, R.N.
209 North Farm Road, Apt. 16
Oconto Falls, WI 54154

Wisconsin Board of Nursing
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

These proceedings were initiated when the Department of Regulation and Licensing, Division of Enforcement (the "Division") filed a formal Complaint against the Respondent, Lisa DeWall. The Division filed said Complaint with the Division of Hearings and Appeals on or about April 13, 2010. On the same date, the Division sent a copy of the Complaint and a Notice of Hearing via certified and regular mail to Respondent DeWall at her most recent address on file with the Department of Regulation and Licensing; 209 N. Farm Road, Oconto Falls, WI, 54154. The Notice of Hearing stated that Respondent DeWall was required to file a written Answer to the Complaint within 20 days, failing which "[she would] be found to be in default and a default judgment [could] be entered against [her] on the basis of the Complaint and other evidence and the Wisconsin Board of Nursing [could] take disciplinary action against [her] and impose the

costs of the investigation, prosecution and decision of this matter upon [her] without further notice or hearing."

On April 28, 2010, Division of Enforcement attorney Arthur Thexton forwarded the undersigned Administrative Law Judge (ALJ) an e-mail he had received from Respondent DeWall, requesting an extension of time in which to file her Answer. Respondent DeWall stated that she was "having trouble finding [her] papers," and [would] be out of the country [teaching skydiving] for May June [sic] and July. An exchange of several e-mails between the undersigned ALJ and Respondent DeWall followed, culminating on May 3, 2010, with the respondent admitting that she would be out of the country for at least four, and possibly six months, and indicating that she would like to have the case stayed until she returned. The undersigned ALJ responded to both parties as follows:

> A 4-6 month extension for an Answer is more than I can allow. I have reviewed the Complaint in this matter, and do not believe it will be difficult for you to respond to, once you have the "papers" you are presently having trouble finding. I would advise you to ask Attorney Thexton for the documents that you need as soon as possible. I am confident that Attorney Thexton will be able to figure out a way to get these documents to you before the week's end.
>
> In light of the above, and the fact that you are leaving the country shortly and will probably have to send your Answer from overseas, I will give you an additional 45 (forty-five) days to file your Answer. This means that your Answer must be *received* by June 11, 2010. If it is not, I will consider you to be in default. (*See* Wis. Admin. Code sec. RL 2.14).
>
> Finally, I request that you provide Mr. Thexton and myself with an address and/or phone number that you can be reached at in Trinidad. And please remember that any document you file with me must also be filed with Attorney Thexton at the Department of Regulation.

Attorney Thexton e-mailed Respondent DeWall "all discoverable documents within the Division's file" on May 3, 2010. Nevertheless, no Answer was ever filed. Nor did Respondent DeWall ever provide the undersigned ALJ with an address or phone number at which she could be found while abroad. On or about June 23, 2010, the Division, by Attorney Thexton, filed a Notice and Motion for Default Order. On June 24, 2010, the undersigned ALJ issued a Notice of Telephone Default Motion Hearing that set said telephone default motion hearing for July 12, 2010. This Notice further instructed Respondent DeWall to (again) contact the undersigned ALJ to provide the telephone number for which she could be reached for the July 12, 2010, hearing. It was sent to Respondent DeWall at the e-mail address she had sent her previous correspondences from. (*See supra*).

Respondent DeWall failed to contact the undersigned ALJ with a telephone number at which she could be reached at for the July 12, 2010, default hearing, thus, the telephone conference that was conducted on that date was without her participation. The undersigned ALJ summarily accepted Attorney Thexton's default motion and issued a Notice of Default

instructing Respondent DeWall that she was in default and that findings would be made and an Order entered on the basis of the Complaint and other evidence. The Notice of Default further ordered Attorney Thexton to provide the undersigned ALJ with the Division's written recommendations for discipline and the assessment of costs in this matter by July 16, 2010. It was emailed to Respondent DeWall at the e-mail address she had sent her previous correspondences from. Attorney Thexton provided the undersigned ALJ with the Division's written recommendations as to discipline and costs on or about July 12, 2010. Respondent DeWall has failed to respond to either the Notice of Default issued against her, or the written recommendations provided by Attorney Thexton on July 12, 2010.

FINDINGS OF FACT

1. Lisa Kay DeWall, R.N., Respondent, date of birth September 22, 1972, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 126064, which was first granted April 28, 1997.

2. Respondent's address of record with the Department of Regulation and Licensing is 1810 Brookfield Drive, Neenah, WI 54956.

3. At all times relevant to this matter, Respondent was employed by the Department of Corrections (DOC)-Bureau of Health Services and worked as a registered nurse at Taycheedah Correctional Institution in Fond du Lac, Wisconsin.

4. At 3:00 a.m. on August 15, 2007, security staff were in the process of moving Inmate A when she became uncharacteristically belligerent and uncooperative. Respondent was not assigned to the inmate's unit, but happened to be present on another matter, so she waited to see what would transpire. In the meantime, Respondent learned that Inmate A was taking warfarin, an anti-coagulant ("blood-thinner").

5. A corrections officer told Respondent that Inmate A had vomited, was uncharacteristically combative, would not follow simple commands, and repeatedly tried to put a pillowcase over her head.

6. Inmate A's roommate informed Respondent that she believed Inmate A had ingested a full bottle of aspirin (100/325mg) at approximately 3:00 p.m. on August 14, 2007. Aspirin also has anti-coagulant effects.

7. Vomiting, confusion, and combativeness are all signs of potential overdose and/or internal bleeding.

8. According to Department of Corrections Nursing Protocol for Poisoning/Overdose, staff need to perform an assessment which includes inquiring about the type and amount of substance exposed or ingested, and to inquire as to the time of ingestion. A physical examination should take place to include assessing vital signs, respiratory status

and observation of general appearance and to note any signs of severe reaction to poisoning or overdose. The nurse should also refer the case to a practitioner either on-site or on-call.

9. Respondent documented her contact with Inmate A as follows:

> Progress Notes (8/15/07 0350)
> s/ Pt being TLU'd for disruptive behavior
> o/ Per pt's roommate, pt allegedly took an entire bottle f ASA@1500 on 8/14/07. She states it was a clear bottle of ASA that she had purchased from canteen. She has apparently misused her meds in the recent past & therefore now has all her meds controlled. Pt was very un-cooperative w/ officers for TLU: p approx 20 min. officers able to get pt in van to transport to seg. Ø apparent injuries noted, pt has Ø complaints needing medical attention & no active bleeding anywhere. RN did notify captain of roommates statement regarding pt taking whole bottle of ASA & of pt being on warfarin & to use caution due to ↑ risk of bleeding.
> a/ Visual stand-by for TLU
> p/ Pt taken to seg w/out injury or complaints needing medical attention. FU w/ HSU prn.

10. Respondent did not follow Nursing Protocol for Poisoning/Overdose and failed to conduct a proper medical assessment of Inmate A:

a. At no time did Respondent check Inmate A's vital signs, Respondent did not question the inmate about the alleged overdose, and she did not ask the inmate about potential complaints.

b. Respondent did not contact Poison Control or call the on-call physician.

c. Although Respondent correctly noted in Inmate A's chart that her roommate said she took a whole bottle of aspirin around 3:00 p.m. on August 14, 2007, Respondent provided little information to the security staff other than to handle Inmate A carefully because she could bleed easily.

11. Respondent stated that she would classify an overdose as being urgent to emergent depending on how the patient presents, but when she was told that Inmate A ingested a whole bottle of aspirin, Respondent said she saw nothing to indicate that this was an urgent or emergent situation. She also expected that if the patient needed to be assessed while in the segregation unit, another nurse would be responsible.

12. By 7:00 a.m. on August 15, 2007, Inmate A was in medical distress and vomiting blood. Inmate A was transported to an area hospital where she presented with an elevated aspirin level, critical INR, and elevated potassium. Her hemoglobin and hematocrit were low due to internal hemorrhaging and she was in intensive care for two days.

13. Respondent practiced in a manner below professional nursing standards when she failed to conduct an assessment of a patient on anitcoagulants who reportedly ingested a bottle of aspirin, who had vomited, and who appeared confused and combative.

14. Respondent's documentation that Inmate A had no complaints requiring medical attention and had no active bleeding was unfounded because Respondent did not conduct an assessment or interview the inmate. Respondent's conclusions and documentation without assessment fell below standards of the nursing profession.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. § 441.07.

2. Wis. Stat. § 441.07 provides, in relevant party, "[t]he board may... revoke, limit, suspend or deny renewal of a license of a registered nurse... if the board finds that the person committed any of the following: ...(c) [a]cts which show the registered nurse ... to be unfit or incompetent by reason of negligence....

3. Pursuant to Wis. Admin. Code § N 7.03(1)(b), "negligence" includes, "[a]n act or omission demonstrating a failure to maintain competency in practice and methods of nursing care."

4. Pursuant to Wis. Admin. Code § N 7.03(1)(c), "negligence" includes, "[f]ailing to observe the conditions, signs and symptoms of a patient, record them, or report significant changes to the appropriate person."

5. Respondent, by engaging in the conduct set out above, was negligent as defined by Wis. Admin. Code § N 7.03(1)(b) and (c) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

6. By nature of her failure to cooperate in these proceedings, Respondent DeWall should be assessed the full amount of recoverable costs. *See In the Matter of Disciplinary Proceedings against Elizabeth Buenzli-Fritz* (LS 0802183 CHI).

EXPLANATION OF VARIANCE

Pursuant to Wis. Stat. § 227.46(4), in any case which is a class 2 disciplinary proceeding the hearing examiner shall prepare a proposed decision, which includes findings of fact, conclusions of law, order and opinion, in a form that may be adopted as the final decision in the case. Based upon the evidence presented in this proceeding, the Board finds it appropriate and necessary to vary the disciplinary terms of the proposed order, under its authority as the final decision maker, to reflect the seriousness of the Respondent's misconduct. Specifically, the Board has varied the terms to suspend the Respondent's license until such time as she complies with the remedial education deemed and to impose practice and work-setting limitations upon her license designed to monitor her nursing practice and protect the public.

In addition, the Board of Nursing has supplemented the proposed decision to include its consideration and analysis of following factors relevant to imposition of full costs against the Respondent:

1) The number of counts, charged, contested, and proven;
2) The nature and seriousness of the misconduct;
3) The level of discipline sought by the parties;
4) The respondents cooperation with the disciplinary process;
5) Prior discipline, if any;
6) The fact that the Department of Regulation and Licensing is a "program revenue" agency, whose operating costs are funded by the revenue received from licensees and the fairness of imposing the costs disciplining a few members of the profession on the vast majority of the licensees who have not engaged in misconduct.

The Board finds that Respondent, by the nature of being in default, did not present any evidence regarding any of the above factors that would mitigate the imposition of full costs in this proceeding. The Board further finds that all of the counts charged were deemed admitted and proven to the requisite standard of proof and there was no argument that any of the factual findings were investigated and litigated unnecessarily. The nature of the alleged misconduct is without doubt very serious and potentially life-threatening. Finally, the Respondent's failure to cooperate with the disciplinary process does not reflect well on her respect for the Board's regulatory authority. Accordingly, it would be fundamentally unfair to assess the costs of this disciplinary action upon the fellow members of the profession who have not engaged in such conduct.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. The registered nurse license of Respondent, Lisa Kay DeWall, R.N., (lic. # 126064-30) is SUSPENDED for her unprofessional conduct in this matter.

2. Respondent's license shall remain SUSPENDED until she satisfactorily completes a total of twelve (12) hours of continuing education in the following areas: eight (8) hours in patient assessment, including signs and symptoms of overdose, and four (4) hours in medical record-keeping, which course(s) shall first be approved by the Board, or its designee. The course "Documentation: A Critical Aspect of Client Care" offered by the Learning Extension of the National Council of State Boards of Nursing is pre-approved as meeting the requirement for a course in record-keeping.

3. Upon reinstatement, Respondent's license shall be LIMITED for a period of at not less than two (2) years, subject to the following terms and conditions:

a) Respondent shall not work as a nurse or other health care provider in home health care, hospice or a private duty setting.

b) Respondent shall practice only under the direct supervision of a licensed nurse or other licensed health care professional approved by the Board or its designee.

c) Respondent shall provide a copy of this Final Decision and Order and all other subsequent orders to her current and future supervisory personnel at all settings where Respondent works as a nurse or care giver.

d) Respondent shall arrange for written work reports be submitted from her supervisors to the Department Monitor on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent's work performance.

4. Requests for approval, notification of completion of educational programs and payment of costs shall be faxed, mailed 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

5. Respondent shall pay the full costs of this proceeding pursuant to Wis. Stat. § 440.22(2) within sixty (60) days of the order fixing costs. In the event Respondent fails to timely submit payment of costs, her license SHALL BE SUSPENDED, without further notice or hearing, until she has complied with the terms of this Order.

Dated at Madison, Wisconsin on January 27th, 2011.

STATE OF WISCONSIN
BOARD OF NURSING

Kathleen L. Sullivan, R.N.,
Chair

1-27-11
Date