WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
LEAH M. TANNER, R.N., RESPONDENT.	:	ORDER 0000996

[Division of Enforcement Case #09 NUR 404]

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

Leah M. Tanner, R.N.
6588 Ort Drive
Rhinelander, WI 54501

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

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

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 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. Leah M. Tanner, R.N., ("Respondent") was born on April 7, 1973, and is duly licensed as a registered nurse in the State of Wisconsin (license #157782-30). This license was first granted on February 12, 2007.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 6588 Ort Drive, Rhinelander, Wisconsin 54501.

3. At the time of the events set out below, Respondent was employed as a registered nurse at Aspirus Hospital in Wausau, Wisconsin.

4. On December 8, 2008, patient A, a 61 year old male, was admitted into Aspirus Hospital for a surgical procedure of Anterior/Posterior L4-L5 back surgery. During the procedure, patient A's left leg went cold and he went through an emergency Femoral to Femoral bypass. Patient A also developed compartment syndrome in his left leg. Patient A was in the Intensive Care Unit (ICU) until December 10, 2008, when he was then transferred out to the Orthopedic/Neurology Unit. Registered nurse JH was the nurse that provided the care for patient A during the PM shifts on December 10, 2008 and December 11, 2008.

5. On December 10, 2008, Respondent reported at approximately 11 P. M., and was assigned patient A through a verbal change of shift report from nurse JH. During this change of shift report, patient A's doctor telephoned after receiving an update on patient A's status and gave a medication order to start patient A on an IV Lasix drip of 10 mg/hr. Nurse JH wrote the order, read it back to the doctor for verification, and sent the order to the hospital pharmacy.

6. Both JH and the Respondent spoke to doctor at this time regarding the medication ordered, as this particular continuous medication drip is not typically given on the nursing unit. Nurse JH transcribed the order as she understood it; and Respondent misinterpreted the order differently than what Nurse JH had written based on her understanding of the doctor's order.

7. Respondent was responsible for administering the IV Lasix drip. Respondent administered 10 ml/hr of the IV Lasix drip, rather than the 10 mg/hr during her eight hour shift.

8. In her administration of the IV Lasix drip to patient A on December 10 and 11, 2008, Respondent misinterpreted and misunderstood the medical order communicated by patient A's doctor and deviated from the standard practice and minimum competence in nursing.

CONCLUSIONS OF LAW

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

2. Respondent, by engaging in the conduct as set out above, has committed negligence defined by Wis. Admin. Code § N7.03(1) and is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Respondent, Leah M. Tanner, R.N., is hereby **REPRIMANDED** for the above conduct.

2. Respondent shall, within ninety (90) days of the date of this Order, complete six (6) hours of pre-approved continuing education in the proper administration of medication. Respondent is responsible for finding an appropriate course and submitting the course information to the Board for approval prior to taking the course. Respondent shall provide evidence of satisfactory completion on the continued education to the Department Monitor.

3. Respondent shall, within ninety (90) days of the date of this Order, pay to the Department of Regulation and Licensing costs of this proceeding in the amount of FOUR HUNDRED AND FIFTY DOLLARS ($450.00), pursuant to Wis. Stat. § 440.22(2).

4. Notification of completion of continued education and payments 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
Telephone (608) 267-3817
Fax (608) 266-2264

5. 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 that Respondent fails to pay costs as ordered or fails to comply with the ordered continuing education, Respondent's license may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

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

Wisconsin Board of Nursing

By: _____ 7/21/11
A Member of the Board Date