WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
MARY E. RASHEL, R.N., A.P.N.P., RESPONDENT.	:	ORDER 0001240

Division of Enforcement Case #09 NUR 424

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

Mary E. Rashel, R.N., A.P.N.P.
2061 Hwy K
Hartford, WI 53027

Wisconsin Board of Nursing
P.O. Box 8935
Madison, WI 53708-8935

Department of Safety & Professional Services
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 Elizabeth Rashel (D.O.B. 11/10/1954) is duly licensed in the state of Wisconsin as a professional nurse (license # 30-63334). This license was first granted on 9/30/1975. Respondent is certified as an advanced practice nurse prescriber (certification # 33-224). This certification was first granted on 9/22/1995. She is not licensed in any other jurisdiction.

2. On July 13, 2009, judgment was entered in the Circuit Court for Washington County, Wisconsin, finding that Respondent was negligent with respect to the care of patient G.B, a 77 year old woman. Respondent is a certified registered nurse anesthetist who provided

anesthesia services on January 20, 2005, during a procedure to both biopsy the right breast and excise a rectal polyp, during which the patient died.

3. The plaintiffs' expert testified as follows: shortly after the procedure began, the pulse oximeter ceased providing information to Respondent. Respondent believed that the equipment was malfunctioning, and attempted to reposition the equipment. Plaintiff's expert opined that it was error to assume equipment failure rather than to attend to the patient first and foremost and by the time Respondent realized that the patient was actually in distress, it was too late to rescue the patient.

4. Following this incident, Respondent entered into a proctoring agreement in April, 2005, under which she reviewed her anesthesia plans of care with an anesthesiologist, who also supervised her work. The proctoring agreement was successfully completed following 3 weeks of such review and supervision, and Respondent has continued to practice without incident.

CONCLUSION OF LAW

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

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the attached stipulation is accepted, and:

IT IS FURTHER ORDERED that Mary E. Rashel, R.N., A.P.N.P., is REPRIMANDED for her conduct in this matter.

IT IS FURTHER ORDERED that Respondent shall pay the costs of investigating and prosecuting this matter, in the amount of $450, within 90 days 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, including any accrued interest.

WISCONSIN BOARD OF NURSING

By: _____ December 1, 2011
A Member of the Board Date 12/1/2011

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