

## WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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STATE OF WISCONSIN  
BEFORE THE BOARD OF NURSING

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IN THE MATTER OF THE LICENSE OF :  
RENEE E. ROSENCRANS, R.N., : FINAL DECISION AND ORDER  
LICENSEE. : FOR REMEDIAL EDUCATION  
: **ORDER 0006403**

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Division of Legal Services and Compliance Case No. 18 NUR 061

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

Renee E. Rosencrans  
4409 Fairfield Drive  
Janesville, WI 53546

Wisconsin Board of Nursing  
P.O. Box 8366  
Madison, WI 53708-8366

Division of Legal Services and Compliance  
Department of Safety and Professional Services  
P.O. Box 7190  
Madison, WI 53707-7190

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final disposition of this matter, subject to the approval of the Wisconsin Board of Nursing (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, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Licensee Renee E. Rosencrans, R.N., (Licensee), (DOB November 11, 1962) is licensed in the state of Wisconsin as a Registered Nurse (R.N.), having license number 93105-30, first issued on March 26, 1986, and current through February 28, 2020. Licensee's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 4409 Fairfield Drive, Janesville, Wisconsin 53546.

2. At all times relevant to this proceeding, Licensee was employed as an R.N. at a rehabilitation facility (Facility), located in Stoughton, Wisconsin.

3. On Friday, January 5, 2018, the Nurse Manager for the 3<sup>rd</sup> floor (Nurse Manager), noted that two (2) non-controlled medications were missing from the contingency box. The Nurse

Manager identified that two (2) drawers in the contingency box had their seals broken and the contents removed. The two (2) corresponding medications were loratadine and cyclobenzaprine.

4. The corresponding contingency box log did not reflect any medication removal from the 2<sup>nd</sup> or 3<sup>rd</sup> shifts. The Controlled Substance Binder and the Medication Administration Record (MAR) likewise did not reflect any medication administration of loratadine or cyclobenzaprine.

5. Licensee was identified as the only nurse on the 3<sup>rd</sup> floor during the shifts in question.

6. The Facility Executive Director reviewed the 3<sup>rd</sup> floor medication room video feed and confirmed Licensee was the only person observed entering the med room on January 4, 2018, on the video footage.

7. The Facility Human Resources Director interviewed the Residents to assess if they experienced any change in pain management. All residents interviewed reported stable pain management.

8. The Facility provided copies of Licensee's employee counseling records. There were three (3) prior incidents of Licensee failing to follow procedures relating to documenting medication administration.

9. The Facility provided copies of their contingency usage sheet, which is used when medication is taken out of the contingency medication box. There was no record of either the loratadine or cyclobenzaprine being signed out by Licensee.

10. The Facility provided copies of the MAR and there was no record of Licensee logging the medication taken from the contingency box.

11. Licensee admitted working the P.M. shift on January 4, 2018.

12. Licensee stated that a new resident admission occurred during her shift and that pharmacy arrived during the night shift with the resident's medication. Licensee administered the medications to the new resident that were present, and all medication was signed out accordingly on the MAR with Licensee's initials per the policy.

13. Licensee stated the resident informed her two (2) of the resident's medications were not present as ordered, "loratadine and an anti-depressant." Licensee told the resident that she would check the contingency box for the remaining two (2) medications. Licensee wrote down on a piece of paper the two (2) different medications and doses, so she could ensure she obtained the correct medications from the contingency box.

14. Once in the 3<sup>rd</sup> floor medication room, Licensee noted that both medications were listed on the contingency box medication record sheet. Attached to the box was a folder with the sign out forms. Licensee double checked the medication list to ensure the proper number drawer

and unit in the contingency box. Licensee then opened the drawers and removed the green zip tie/seal on the drawers containing the “loratadine and the anti-depressant” needed for the resident.

15. Licensee states she went to document what she took but realized she did not have a pen on her, only a black marker. Facility policy stated that only black pen is supposed to be used when signing out medications.

16. Licensee stated she left the 3<sup>rd</sup> floor medication room to go obtain a black pen and planned to return immediately to complete the sign out form.

17. Licensee was outside of the 3<sup>rd</sup> floor medication room and was called to multiple resident rooms. Due to the needs of Licensee’s residents, Licensee was unable to get back to the medication room and complete the sign out before shift end.

18. Licensee denied any knowledge of the alleged missing Cyclobenzaprine. The resident Applicant entered the contingency box for did not have an order for Cyclobenzaprine and Licensee did not access the box for another resident during her sixteen (16) hour shift. Licensee stated she does not know where Cyclobenzaprine is located in the contingency box. Licensee stated there are no records pertaining to when the pharmacy replaces the contingency box, so Licensee has no knowledge as to when the medication was last replaced or how many personnel have had access to it or removed medications prior to Licensee accessing the contingency medication box.

19. Licensee admits not following the policy of signing out medications at the time of removal and initialing them on the MAR per facility policy.

20. In resolution of this matter, Licensee consents to the entry of the following Conclusions of Law and Order.

#### CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

#### ORDER

1. The attached Stipulation is accepted.
2. Within six (6) months of the date of this Order, Renee E. Rosencrans, R.N., (Licensee) shall at her own expense take and successfully complete six (6) hours of education on the topic of medication administration as follows:
  - a. Each course attended in satisfaction of this Order must be pre-approved by the Board or its designee. Licensee shall be responsible for locating course(s) satisfactory to the Board and for obtaining the required approval of the courses from the Board or its designee. Licensee must take and pass any exam offered for the course(s).

b. Licensee shall submit proof of successful completion of the education in the form of verification from the institution providing the education to the Department Monitor at the address stated below. None of the education completed pursuant to this requirement may be used to satisfy any education requirements that have been or may be instituted by the Board or Department.

3. Request for approval of courses and proof of successful course completion shall be sent by Licensee to the Department Monitor at the address below:

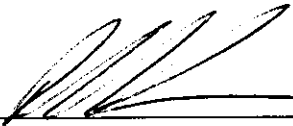
Department Monitor  
Division of Legal Services and Compliance  
P.O. Box 7190, Madison, WI 53707-7190  
Telephone (608) 267-3817; Fax (608) 266-2264  
[DSPSMonitoring@wisconsin.gov](mailto:DSPSMonitoring@wisconsin.gov)

You may also submit this information online via DSPS' Monitoring Case Management System, here: <https://app.wi.gov/DSPSMonitoring>

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

WISCONSIN BOARD OF NURSING

by:

  
\_\_\_\_\_  
A Member of the Board

9/17/19  
\_\_\_\_\_  
Date

STATE OF WISCONSIN  
BEFORE THE BOARD OF NURSING

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IN THE MATTER OF THE LICENSE OF :  
RENEE E. ROSENCRANS, R.N., : STIPULATION  
LICENSEE. :  
**ORDER 0006403**

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Division of Legal Services and Compliance Case No. 18 NUR 061

Licensee Renee E. Rosencrans, R.N., and the Division of Legal Services and Compliance, Department of Safety and Professional Services, stipulate as follows:

1. This Stipulation is entered into as a result of a pending investigation by the Division of Legal Services and Compliance. Licensee consents to the resolution of this investigation by Stipulation.

2. Licensee understands that by signing this Stipulation, Licensee voluntarily and knowingly waives the following rights:

- the right to a hearing on the allegations against Licensee, at which time the State has the burden of proving those allegations by a preponderance of the evidence;
- the right to confront and cross-examine the witnesses against Licensee;
- the right to call witnesses on Licensee's behalf and to compel their attendance by subpoena;
- the right to testify on Licensee's own behalf;
- the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision;
- the right to petition for rehearing; and
- all other applicable rights afforded to Licensee under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and other provisions of state or federal law.

3. Licensee is aware of Licensee's right to seek legal representation and has been provided an opportunity to obtain legal counsel before signing this Stipulation.

4. Licensee agrees to the adoption of the attached Final Decision and Order for Remedial Education by the Wisconsin Board of Nursing (Board). The parties to the Stipulation consent to the entry of the attached Final Decision and Order for Remedial Education without further notice, pleading, appearance or consent of the parties. Licensee waives all rights to any appeal of the Board's order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall then be

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returned to the Division of Legal Services and Compliance for further proceedings. In the event that the Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. The parties to this Stipulation agree that the attorney or other agent for the Division of Legal Services and Compliance and any member of the Board ever assigned as an advisor in this investigation may appear before the Board in open or closed session, without the presence of Licensee, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with deliberations on the Stipulation. Additionally, any such advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order for Remedial Education.

7. Licensee is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order for Remedial Education is a public record and will be published in accordance with standard Department procedure.

8. The Division of Legal Services and Compliance joins Licensee in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order for Remedial Education.

Renee E. Rosencrans RN  
Renee E. Rosencrans, R.N., Licensee  
4409 Fairfield Drive  
Janesville, WI 53546  
License No. 93105-30

7-24-19  
Date

Amber Cardenas  
Amber Cardenas, Attorney  
Division of Legal Services and Compliance  
Wisconsin Department of Safety and  
Professional Services  
P.O. Box 7190  
Madison WI 53707-7190

7.25.19  
Date