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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
DANNY A. REYNOLDS, L.P.N., RESPONDENT.	:	FINAL DECISION AND ORDER
	:	ORDER 0001645

The State of Wisconsin, Board of Nursing, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Hearing Examiner, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Hearing Examiner, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Board of Nursing. Let a copy of this order be served on the respondent by certified mail.

A party aggrieved by this decision may petition the board for rehearing within twenty (20) days after service of this decision pursuant to Wis. Stats. sec. 227.12. The party to be named as respondent in the petition is Danny A. Reynolds.

A party aggrieved by this decision who is a resident of this state may also petition for judicial review by filing the petition in the office of the clerk of the circuit court for the county where the party aggrieved resides within thirty (30) days after service of this decision. A party aggrieved by this decision who is not a resident of this state must file the petition for judicial review in the office of the clerk of circuit court for Dane County. A party aggrieved must also serve the board and other parties with a copy of the petition for judicial review within thirty (30) days after service of this decision pursuant to Wis. Stats. sec. 227.16. The party to be named as respondent in the petition is the State of Wisconsin Board of Nursing.

Dated this 19 day of July, 1984.

pc017-552

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	PROPOSED DECISION
DANNY A. REYNOLDS, L.P.N., RESPONDENT.	:	

The parties to this proceeding for the purposes of Wis. Stats. sec. 227.16 are:

Danny A. Reynolds
3380 North 38th Street
Milwaukee, Wisconsin 53216

Board of Nursing
1400 East Washington Avenue, Room 174
P. O. Box 8936
Madison, Wisconsin 53708

Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue, Room 183
P. O. Box 8936
Madison, Wisconsin 53708

An evidentiary hearing was held in the above-captioned matter. The respondent, Danny A. Reynolds, appeared personally and by his attorney, Stephen M. Chandler. Appearing for complainant was Attorney Steven M. Gloe. Prior to the commencement of the evidentiary hearing, testimony was received and arguments made by counsel upon respondent's motion to dismiss the case. Attached hereto, and incorporated herein, is an order denying respondent's motion.

Based upon the evidence in the record, the examiner recommends that the Board of Nursing adopt as its final decision the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Danny A. Reynolds (Reynolds), who resides at 3380 North 38th Street, Milwaukee, Wisconsin, was at all times relevant to the proceedings herein, duly licensed as a licensed practical nurse (license #21008) in the State of Wisconsin. His license was issued on November 28, 1978.

2. On June 17, 1980, Reynolds was working as a licensed practical nurse on the third floor day tour at Bethel Care Center, 2125 West Kilbourn Avenue, Milwaukee, Wisconsin. Reynolds' duties in this capacity included the passing of 9:00 a.m. and 1:00 p.m. medications to the patients assigned to his care.

3. Reynolds arrived for work at Bethel Care Center on June 17, 1980 at approximately 9:30 a.m. At some time prior to 10:00 a.m., he requested that the Assistant Director of Nursing, Betty Deering, give him permission to leave the facility due to illness. Deering denied Reynolds' request, indicating that there was not a nurse available to replace Reynolds on his shift. She stated that Reynolds could leave after passing the 1:00 p.m. medications to the patients on the third floor of the facility.

4. Reynolds' passing of medications during the 9:00 a.m. and 1:00 p.m. rounds involved approximately 30-35 patients and the administration of approximately 90-100 unit doses of medications per round. Reynolds disposed of the following 9:00 a.m. medications without delivering them to the patients as assigned:

a. One (1) Chlorpromazine 25 mg. tablet.
b. One (1) multiple vitamin capsule.
c. One (1) Lanoxin .25 mg. tablet.
d. One (1) Pavabid 150 mg. capsule.
e. One (1) DSS 250 mg. capsule.
f. One (1) Kaon tablet.
g. One (1) Chlordiazepoxide 5 mg. capsule.
h. One (1) B complex vitamin with vitamin C capsule.
i. One (1) Folic acid 1 mg. tablet.
j. Two (2) Cogentin 1 mg. tablets.

5. Reynolds falsely charted the medications referred to above in paragraph 4 as having been given.

6. With the exception of approximately three patients, Reynolds did not pass the 1:00 p.m. medications.

7. Sometime between 12:00 and 12:30 p.m., Reynolds informed Deering that he had completed his duties. Accordingly, Deering granted Reynolds permission to leave the facility due to illness.

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this matter pursuant to Wis. Stats. sec. 441.07.

2. The conduct of Reynolds as described within the Findings of Fact constitute unfitness by reason of negligence, within the meaning of Wis. Stats. sec. 441.07(1)(c); misconduct and unprofessional conduct, within the meaning of Wis. Stats. sec. 441.07(1)(d); an intentional and repeated failure to execute a medical order for medication, within the meaning of Wis. Adm. Code sec. N 11.03(1)(c); falsification of patient records, within the meaning of Wis. Adm. Code sec. N 11.03(3)(c); and negligence, within the meaning of Wis. Adm. Code sec. N 11.04(1).

ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Danny A. Reynolds to practice as a licensed practical nurse in the State of Wisconsin shall be, and hereby is, suspended for a period of thirty days; such suspension commencing thirty days following the date of the final decision of the Board of Nursing.

OPINION

The respondent, Danny A. Reynolds, is charged with having failed to pass, or administer, medications to patients at the Bethel Care Center in Milwaukee, Wisconsin on June 17, 1980. On that date Reynolds was responsible for passing medications to the patients on the third floor of the facility. Medications were given to the patients during Reynolds' shift at 9:00 a.m. and 1:00 p.m. It is alleged that Reynolds failed to pass all of the 9:00 a.m. medications and, instead, disposed of some of them in a disposal or trash bag which was tied to the handle of his medication cart, although he indicated upon the patients' charts that the medications had been given. Furthermore, he is charged with having failed to distribute the 1:00 p.m. medications, despite informing his supervisor that he had passed them to the patients. He was permitted to leave the facility due to his representation of feeling ill.

The conduct of Reynolds is alleged to constitute a basis for disciplinary action against his license as a licensed practical nurse pursuant to Wis. Stats. sec. 441.07(1)(c), which permits the Board of Nursing to impose sanctions for conduct demonstrating unfitness or incompetency by reason of negligence, and pursuant to Wis. Stats. sec. 441.07(1)(d), prohibiting misconduct or unprofessional conduct. Reynolds' conduct is further alleged to violate Wis. Adm. Code ss. N 11.03(1)(c), which prohibits an intentional, repeated or gross failure to execute a medical order for medication; N 11.03(3)(c), regarding the falsification of patient records; and, N 11.04(1), defining unprofessional conduct as including negligence.

On June 17, 1980, Betty Deering was the Assistant Director of Nursing at Bethel Care Center. She testified that between 9:00 a.m. and 10:00 a.m. Reynolds indicated to her that he was not feeling well and requested permission to leave the facility. Deering stated that she informed Reynolds that there was not a nurse available to replace him at that time, but that he could leave after he had passed the 1:00 patient medications. Later, between 12:00 and 12:30 p.m., Reynolds returned to Deering, again requesting permission to leave. Deering testified that she inquired as to whether he had completed his work and that Reynolds indicated that he had. She then gave Reynolds permission to leave.

At approximately 3:00 p.m. that same day, the Director of Nursing, Alice Whitmore, was summoned to the third floor of the facility by an employee, Claire Mennig. She was informed that Mennig had removed the trash bag from the medication cart of Reynolds and handed it to an aid

who noticed that the bag contained unopened medication packets. Whitmore took the medication cart and trash bag to an office for her inspection. Betty Deering was present at this inspection with Whitmore. She testified that she discovered several unopened medication packets. Also contained within the trash bag were opened and empty packets, as well as medications mixed with medication cups and water cups. Deering prepared a list of the medications found in the trash bag at that time. (Complainant's Ex. 1.) She further noted that the 9:00 a.m. medications for one patient were still in the patient's medication tray, and that the 1:00 p.m. medications were in the individual cassettes for the patients.

At approximately 3:30 p.m. that day, Reynolds returned to the facility to sign-out for some medication. At that time he was confronted with having failed to pass the 9:00 a.m. and 1:00 p.m. medications. Reynolds denied not having passed the 9:00 a.m. medications and indicated that he had permission to leave the facility without passing the 1:00 p.m. medications. Reynolds was fired.

Reynolds indicated at the evidentiary hearing that he did not pass the 1:00 p.m. medications. He stated that at approximately 12:15 p.m., he requested permission to leave the facility, and that when asked by Deering whether he had completed his work, he answered in the affirmative. Reynolds claims that what he meant was that he had completed his required work up until that time (approximately 12:15 p.m.), but that he did not intend to signify that he had passed the 1:00 p.m. medications. In short, Reynolds believes that with regard to his not passing the 1:00 p.m. medications, there was at worst a simple misunderstanding between him and his supervisor as to what he meant.

Reynolds also denied failing to pass all of the 9:00 a.m. medications, despite the fact that many of the medications were found within the trash bag tied to his medication cart. The implicit explanation for the presence of the 9:00 a.m. medications in the trash bag, if Reynolds' testimony is to be credited, is that someone other than Reynolds placed the items in his cart's trash bag in an attempt to frame him. However, no testimony was presented at the evidentiary hearing which would suggest that anyone had a motive for attempting to create problems for Reynolds by placing medications and unopened medication packets within the trash bag on his cart. Reynolds did not testify to any specific personnel problems he had incurred, nor did any of the other witnesses. The record is devoid of any motive personnel at the facility might have for attempting to fabricate a scenario to frame Reynolds.

Reynolds, however, makes a similar argument--that he had no motive for failing to pass the 9:00 a.m. medications found in the trash bag of his cart, or for not passing the 1:00 p.m. medications if he had been instructed to the contrary. He claims the failure to pass the 9:00 a.m. medications found in the trash bag would not have significantly reduced his work load, since he administered approximately 90-100 unit dose medications to 30-35 patients during each round. Furthermore, it is argued that if he did dispose of some of the 9:00 a.m. medications in the trash bag (which was somewhat transparent) and left the facility without passing the 1:00 p.m. medications contrary to his instructions, it is obvious that such conduct would be discovered. In other words, he would obviously be caught.

In resolving the contradictory testimony presented, it is my opinion that the testimony of the personnel at the Bethel Care Center is credible, and that of Reynolds is not. Again, there is no rationale or motive ascertainable from this record which would attach any motivation to the facility's personnel to concoct a situation whereby Reynolds would be implicated in misconduct. None of the personnel testified to any such animosity, nor did Reynolds. On the other hand, Reynolds did have a motive--that being his desire to leave the facility due to illness. His time-card covering the date in question (Complainant's Ex. 3) indicates that Reynolds arrived for work at 9:30 a.m. on the morning of June 17th. Betty Deering testified that Reynolds made his request to her for permission to leave between 9:00 a.m. and 10:00 a.m. Since, according to Reynolds, it takes about one hour to complete the passing of the medications, it is reasonable to infer that at the time Reynolds initially approached Deering about leaving, he had not yet started, or at least, completed the passing of the 9:00 a.m. medications. When Deering would not allow him to leave, it is not unreasonable to assume that Reynolds may have been upset at Deering's decision. This would account for passing some, but not all of the 9:00 a.m. medications, as well as leaving Deering with the impression that he had passed the 1:00 p.m. medications when, in fact, he had not. He simply wanted to leave the facility.

Furthermore, Reynolds' testimony is inconsistent in other aspects. He stated that he did not pass any of the 1:00 p.m. medications. Yet, the patient charts for three individuals indicate that he did. The practice at the facility was for the administering nurse to initial the medication charts of each patient when the medication was given. When queried about the fact that Reynolds' initials appeared upon three such charts as having administered medications to three patients, he indicated that it was possible that he had initialed the involved charts. The presence of Reynolds' initials upon patient charts, in conjunction with his denial of having passed any 1:00 p.m. medications, is inconsistent. Furthermore, if Reynolds did pass some 1:00 p.m. medications, but not complete his round, this infers again that Deering's decision not to allow him to leave the facility until after all 1:00 p.m. medications were passed had upset him. It may be reasonably inferred that at some point during his 1:00 p.m. round, he became upset (as he had during his 9:00 a.m. round when he did not pass all the required medications) and simply decided to leave. Someone else could pass the medications, and, if challenged later, Reynolds would simply deny any allegations and claim that he was framed somehow.

It is my opinion that although the proof against Reynolds is largely circumstantial, it is sufficient when combined with the credibility of the testimony of complainant's witnesses, and the inconsistencies in Reynolds', to find that the allegations have been established in this case.

The remaining issue to be determined is the appropriate discipline, if any, to be imposed against the license of Reynolds. It is my opinion that a suspension is necessary in this case. The failure to pass medications needed by patients is a serious act of misconduct. In this case, there is no evidence that any patient was placed in any physical

danger due to Reynolds' conduct. In my opinion, Reynolds exercised very poor judgment in not passing medications out of apparent displeasure with his supervisor's decision not to allow him to leave the facility. His conduct does not demonstrate incompetency to practice as a licensed practical nurse in terms of his technical proficiency; but rather, demonstrates an inappropriate response to what he likely viewed as an unreasonable denial of his request to leave the facility due to illness.

In my opinion, under the circumstances of this case, Reynolds' license should be suspended by the Board.

Dated at Madison, Wisconsin this 22nd day of June, 1984.

Respectfully submitted,

Donald R. Rittel

Donald R. Rittel
Hearing Examiner

940-843

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST DANNY A. REYNOLDS, L.P.N., RESPONDENT.	:	ORDER DENYING RESPONDENT'S MOTION TO DISMISS

On the date of the evidentiary hearing upon the Complaint filed in the above-captioned matter, respondent's motion to dismiss the Complaint was heard and evidence taken thereon. The grounds for respondent's Motion were that the action was barred by laches and that the delay in commencing the proceeding was unreasonable and therefore constituted a denial of respondent's right to due process under the constitutions of the United States and the State of Wisconsin.

Testimony upon the motion was taken from the respondent and the program assistant to the Board of Nursing. The alleged conduct which is the subject of this disciplinary proceeding occurred on June 17, 1980. The Notice of Hearing and Complaint commencing this action were initially mailed to respondent on February 24, 1983. Thus, the approximate 32 month span from the time of the alleged conduct of respondent and the commencement of the disciplinary proceeding is argued by respondent to give rise to the applicability of the doctrine of laches to this proceeding, as well as to constitute an unreasonable delay in initiating formal proceedings.

Prior to discussing the testimony taken upon the motion, the issue of laches may be resolved as a matter of law. The leading case regarding the defense of laches in this type of administrative proceeding is State v. Josefsberg, 275 Wis. 142 (1957). In that case the Wisconsin Supreme Court considered a fact situation in which license revocation proceedings were brought against a physician on the ground that he had obtained a license by fraudulent and deceptive means. The initial fraud had occurred several years prior to the commencement of the revocation proceedings. The physician raised the defense of laches. The Court, in affirming the trial court's determination that the defense of laches was not available to the physician, stated as follows:

> "The (trial) court's decision, however, was based on the principle that laches on the part of the government in bringing suit is not to be a defense in the case of a claim which is founded on a sovereign right. The (trial) court held that in this instance the state was acting in its sovereign capacity for the protection of the public, and that in a matter of this kind no omission of duty on the part of its officers or agents is imputed to the state. We are constrained to conclude that such determination was correct." Josefsberg, at 153.

It is clear that the holding in Josefsberg is not limited to situations in which fraud on behalf of the licensee is alleged. The unambiguous language of the case denies the availability of the defense to a licensee in a proceeding which is brought by the state in its sovereign capacity. This principle was reiterated with approval in State v. Chippewa Cable Co., 21 Wis. 2d 598, 608 (1963). It is clear that this disciplinary proceeding constitutes an action which falls directly under the rationale set forth in Josefsberg and later affirmed in Chippewa Cable. Accordingly, respondent's motion with regard to the doctrine of laches must be denied.

As stated, however, respondent also argues for dismissal upon that basis that the 32 months between the alleged conduct and the commencement of this disciplinary proceeding constitutes an unreasonable delay by complainant, and thus serves as a denial of due process.

Respondent resided at 24th and Kilbourn in Milwaukee at the time of incident alleged within the Complaint. Respondent's recollection was not very clear on the point, however sometime during the following year he moved to 26th and Kilbourn. He did not recall notifying the Board of Nursing of this change of address, or whether he left a forwarding address at the post office. In December, 1980, respondent contacted the Department of Regulation and Licensing and was informed that a formal investigation concerning the incident at Bethel Care Center was being conducted. In July, 1981, respondent joined the Army and was initially stationed at Fort Sam Houston, Texas. Two months later he was transferred to Fort Bennings, Georgia, where he remained for 8-10 months prior to being transferred to Fort Sheridan, Illinois. In December, 1982, respondent returned to Milwaukee, Wisconsin, and testified that he notified the Board of his new address at that time.

The Board mailed renewal applications to its licensees in March, 1983. At that time, the address on file with the Board office for the respondent was "Building 1374-E2, Fort Sam Houston, Texas." The renewal application mailed to respondent was returned as "not deliverable". Board office policy is to destroy renewal applications returned as non-deliverable after a two month retention period. Respondent's license was renewed in April, 1983, upon his contacting the Board office for that purpose.

Respondent claims that his address could have been ascertained during the period between the alleged incident and the issuance of the Complaint, although he concedes that he may have not been the easiest person to locate. He contends that the delay in issuing the Complaint has resulted in his inability to locate an important witness who respondent claims told him that the witness had been in a meeting with supervisors at Bethel in which derogatory statements were made concerning respondent's work performance. Such testimony, it is argued, would assist him in his defense to this action by tending to show that the personnel at Bethel were "out to get him", and therefore fabricated their stories concerning the allegations in the Complaint. Respondent argues that the passage of

time between the alleged incident and the filing of the Complaint has prejudiced his ability to defend by virtue of his current inability to find a key witness, which, it is assumed, would have been available had the Complaint been issued at some earlier time.

Complainant argued that the time period between the incident and issuance of the Complaint was not unreasonable. He argued that the appropriate statute of limitations were this a civil court case, is three years. Accordingly, by that standard there was no unreasonable delay. Furthermore, complainant highlights the difficulty in finding respondent given his frequent changes of address during the time in question, changes of which he did not inform the Board. The difficulty which respondent may have faced in defending himself while stationed in the Army in other states had the Complaint issued earlier was cited in support of complainant's contention that to issue the Complaint any earlier would have truly acted prejudicially upon respondent's ability to attend a hearing and defend himself. Finally, complainant indicates that subsequent to his discharge from Bethel, respondent filed a discrimination complaint with another governmental agency. Accordingly, respondent was aware that certain legal implications might result from the incident at Bethel, and that he had the obligation to make sure that he was aware of his witness' whereabouts, if he were needed in the future.

In reviewing the facts testified to at the motion hearing, and after consideration of argument by counsel, it is my opinion that under the circumstances of this case the delay in filing the Complaint was not undue, nor has it been established that respondent's inability to find his "key" witness was solely or primarily the result of the time period which expired between the incident and issuance of the Complaint. Again, it should be noted that respondent was aware of the investigation concerning his license by no later than December, 1980, which is approximately six months following the incident and seven months prior to his entering the Army. To the extent that respondent was concerned as to the ultimate disposition of the investigation, and was aware of the need to have an important witness testify if a hearing resulted, it would seem that he must bear the burden of assuring that he knew the whereabouts and availability of this individual in the event a formal hearing resulted. Needless to say, if he truly desired to receive any communications from the Board regarding the investigation, renewal, or other appropriate licensing matters, he had a further responsibility to inform the Board of his current mailing address after each relocation. He failed to do this.

It is my opinion, under the facts presented, that there was no unreasonable delay in filing the Complaint in this case, and accordingly, respondent's motion must be denied.

Dated: June 22, 1984.

Donald R. Rittel

Donald R. Rittel
Hearing Examiner

631-625