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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 FREITAG MEYER, L.P.N., RESPONDENT.	:	ORDER0001639

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

Mary Freitag Meyer, L.P.N.
P.O. Box 2435
Cody, WY 82414

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

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

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 Mary Freitag Meyer, L.P.N.

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 peitition 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.

FINDINGS OF FACT

1. Mary Freitag Meyer, hereinafter referred to as respondent, was at all times material to this proceeding licensed as a practical nurse in the State of Wisconsin. This license was issued on June 3, 1977. Respondent has a mailing address of P.O. Box 2435, Cody, Wyoming 82414.

2. At all times relevant to this proceeding, respondent was working as a licensed practical nurse at Fairhaven Home for Senior Citizens, 435 Starin Road, Whitewater, Wisconsin.

3. During the time period from January 15, 1982, through May 11, 1982, respondent diverted approximately 10 units of Tylenol #3 from patient supplies at Fairhaven Home. Tylenol #3 contains codeine, a controlled substance.

4. There is not clear and convincing evidence that respondent diverted any Empirin #3 from patient supplies at Fairhaven Home between January 15, 1982, and May 11, 1982.

5. There is not clear and convincing evidence that respondent diverted two tablets of Tylenol #3 from patient B.L.'s supplies at Fairhaven Home on or about June 15, 1983.

6. There is not clear and convincing evidence that respondent attempted to substitute a plain Tylenol tablet for Tylenol #3 in her administration of medications to patient W.L. at Fairhaven Home on or about October 27, 1983.

CONCLUSIONS OF LAW

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

2. In diverting Tylenol #3 from patient supplies while working as a licensed practical nurse at Fairhaven Home for Senior Citizens, as found in paragraph 3 of the Findings of Fact, respondent acted in violation of Wis. Stats. sec. 441.07(1)(d), and Secs. N 11.03(3)(b) and N 11.04(1), Wis. Adm. Code (1980).

3. There is no clear and convincing evidence that respondent diverted Tylenol #3 on or about June 15, 1983, or that she attempted to substitute plain Tylenol for Tylenol #3 in administering medications to a patient on or about October 27, 1983.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Mary Freitag Meyer, L.P.N., to practice as a practical nurse be, and hereby is, suspended indefinitely commencing on the date hereof.

IT IS FURTHER ORDERED that the suspension of license set forth above be, and hereby is, stayed for a period of 60 days from the date hereof.

IT IS FURTHER ORDERED that as a condition of reinstatement of her license, Mary Freitag Meyer, L.P.N. shall submit to the Board of Nursing a report prepared by a psychologist or psychiatrist satisfactory to the board reflecting that a psychological assessment has been performed and that Mary Freitag Meyer has no mental or physical problems, including dependence upon alcohol or other drug, which would impair her ability to safely and competently practice as a practical nurse. The psychiatrist or psychologist, to be satisfactory to the board, must have a background of treatment of drug and alcohol dependence.

IT IS FURTHER ORDERED that as a condition of reinstatement of her license, Mary Freitag Meyer, L.P.N., shall submit to the Board of Nursing a report prepared by her current employer establishing that she is performing satisfactorily in her employment.

IT IS FURTHER ORDERED that upon submission to the board of the reports described herein, Mary Freitag Meyer may petition the board for reinstatement of her license, and if the reports are satisfactory to the board, the board shall restore the license.

EXPLANATION OF VARIANCE

The Board of Nursing has accepted the hearing examiner's Findings of Fact and Conclusions of Law. The board has not, however, adopted the hearing examiner's recommendation that Ms. Meyer be reprimanded. Because of the nature of the findings, wherein Ms. Meyer is found to have diverted a controlled substance, the board feels something more than a reprimand is both warranted and necessary. By suspending the license indefinitely and staying the suspension for 60 days, the board has provided for restoration of the license without interruption of Ms. Meyer's privilege to practice on the condition that prior to the expiration of the 60 day stay she is able to provide information satisfactory to the board of her continuing ability to practice safely and competently. If, on the other hand, she is unable to provide that information, then it is appropriate that the suspension of her license go into effect until and unless she is.

Dated at Madison, Wisconsin this 19th day of June, 1986.

STATE OF WISCONSIN
BOARD OF NURSING

by Suzanne Schuber
A Member of the Board

WA:lml
718-759

BEFORE THE STATE OF WISCONSIN
BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
MARY FREITAG MEYER, L.P.N., RESPONDENT.	:	NOTICE OF FILING PROPOSED DECISION

To: Clark Dempsey
Attorney at Law
144 West Main Street
Whitewater, Wisconsin 53190

Steven M. Gloe
Attorney at Law
Department of Regulation and Licensing
Division of Enforcement
P. O. Box 8935
Madison, Wisconsin 53708

PLEASE TAKE NOTICE that a Proposed Decision in the above-captioned matter has been filed with the Board of Nursing by the Hearing Examiner, Donald R. Rittel. A copy of the Proposed Decision is attached hereto.

If you are adversely affected by, and have objections to, the Proposed Decision, you may file your objections, briefly stating the reasons and authorities for each objection, and argue with respect to those objections in writing. Your objections and argument must be submitted and received at the office of the Board of Nursing, Room 174, Department of Regulation and Licensing, 1400 East Washington Avenue, P. O. Box 8935, Madison, Wisconsin 53708, on or before May 12, 1986.

The attached Proposed Decision is the Examiner's recommendation in this case and the Order included in the Proposed Decision is not binding upon you. After reviewing the Proposed Decision together with any objections and arguments filed, the Board of Nursing will issue a binding Final Decision and Order.

Dated at Madison, Wisconsin this 25th day of April, 1986.

Donald R. Rittel
Hearing Examiner

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST MARY FREITAG MEYER, L.P.N., RESPONDENT.	PROPOSED DECISION

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

Mary Freitag Meyer, L.P.N.
P.O. Box 2435
Cody, WY 82414

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

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

A hearing was held in the above-captioned matter. Steven M. Gloe, attorney, appeared for the Department of Regulation and Licensing, Division of Enforcement, P.O. Box 8935, Madison, Wisconsin. The respondent appeared in person and by her attorney, Clark Dempsey, 144 West Main Street, Whitewater, Wisconsin 53190.

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

FINDINGS OF FACT

1. Mary Freitag Meyer, hereinafter referred to as respondent, was at all times material to this proceeding licensed as a practical nurse in the State of Wisconsin. This license was issued on June 3, 1977. Respondent has a mailing address of P.O. Box 2435, Cody, Wyoming 82414.

2. At all times relevant to this proceeding, respondent was working as a licensed practical nurse at Fairhaven Home for Senior Citizens, 435 Starin Road, Whitewater, Wisconsin.

3. During the time period from January 15, 1982, through May 11, 1982, respondent diverted approximately 10 units of Tylenol #3 from patient supplies at Fairhaven Home. Tylenol #3 contains codeine, a controlled substance.

4. There is not clear and convincing evidence that respondent diverted any Empirin #3 from patient supplies at Fairhaven Home between January 15, 1982, and May 11, 1982.

5. There is not clear and convincing evidence that respondent diverted two tablets of Tylenol #3 from patient B.L.'s supplies at Fairhaven Home on or about June 15, 1983.

6. There is not clear and convincing evidence that respondent attempted to substitute a plain Tylenol tablet for Tylenol #3 in her administration of medications to patient W.L. at Fairhaven Home on or about October 27, 1983.

CONCLUSIONS OF LAW

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

2. In diverting Tylenol #3 from patient supplies while working as a licensed practical nurse at Fairhaven Home for Senior Citizens, as found in paragraph 3 of the Findings of Fact, respondent acted in violation of Wis. Stats. sec. 441.07(1)(d), and Secs. N 11.03(3)(b) and N 11.04(1), Wis. Adm. Code (1980).

3. There is no clear and convincing evidence that respondent diverted Tylenol #3 on or about June 15, 1983, or that she attempted to substitute plain Tylenol for Tylenol #3 in administering medications to a patient on or about October 27, 1983.

ORDER

NOW, THEREFORE, IT IS ORDERED that Mary Freitag Meyer, L.P.N., shall be and hereby is, reprimanded.

OPINION

The respondent, Mary Freitag Meyer, was charged with two counts of unprofessional conduct regarding her practice as a licensed practical nurse while employed at the Fairhaven Home for Senior Citizens. The first count alleges that she diverted an unknown quantity of Tylenol #3 and Empirin #3 from patient supplies between January 15, 1982, and May 11, 1982. The second count involves two instances of alleged misconduct; the first alleging the diversion of Tylenol #3 from patient supplies on or about June 15, 1983, and the second concerning an alleged attempt to improperly substitute plain Tylenol for Tylenol #3 in administering to a patient on approximately October 27, 1983.

On April 29, 1982, the consulting pharmacist for Fairhaven Home, Mr. James Underwood, conducted an inventory of controlled substances at the home. Among his findings were that 47 units of Empirin #3 and that 103 units of Tylenol #3 were not accounted for. Subsequently, between April 30 and May 11, the home conducted daily counts of medications. Although the daily counts did not employ the use of patients' charts, personnel at the home noted shortages of Empirin #3 and Tylenol #4 during

this time period. It was also observed that shortages did not appear to occur when Ms. Meyer was not working and that the only person consistently performing duties when shortages were found was Ms. Meyer.

Upon being confronted with the foregoing circumstantial evidence, Ms. Meyer subsequently admitted to a police investigator that she had, in fact, diverted 4 units of Tylenol #3 on May 11, 1982, and that she had diverted perhaps as many as 10 throughout the course of the previous few months. She adamantly denied additional diversions of Tylenol #3 and denied any diversion of the unaccounted for Empirin #3. In explanation for her conduct, Ms. Meyer testified that commencing in January of 1982 she had suffered from a kidney infection which caused her to take extended sick leave from work on occasion, and had been receiving prescriptions for antibodies and Tylenol #3 as pain medication. She indicated that she had diverted the Tylenol #3 from patient supplies at Fairhaven only on those days when shehad forgotten to bring her own supply from home. The fact that an inventory indicated additional shortages of mediations than to which Ms. Meyer admitted does not, in my opinion, clearly and convincingly establish that she was responsible for them.

Following her admission of diverting Tylenol #3, Ms. Meyer was suspended for a period of time from Fairhaven. The second count of the Complaint in this case involves instances of alleged diversion and attempted diversion of Tylenol #3 subsequent to Ms. Meyer's return to employment.

On June 15, 1983, one of Ms. Meyer's co-workers at Fairhaven, Carol Cosgrove, a registered nurse, received a delivery of a bottle of Tylenol #3 from Underwood Pharmacy. She did not count the number of units in the bottle at that time. Ms. Cosgrove placed the bottle in a medicine cabinet. She testified that she left the cabinet unlocked because of a malfunction with the lock, but that she believed she locked the door to the room in which the cabinet was maintained. She then went to dinner, which lasted approximately 15-20 minutes, during which time she had Ms. Meyer cover for her. When Ms. Cosgrove returned she testified that the medicine cabinet was locked. She then removed the bottle of Tylenol #3, counted the units, and found the bottle to be two units short from the amount stated on the label. Ms. Meyer denies having diverted the Tylenol #3 from the medication cabinet.

This allegation stems from the circumstantial evdience presented, which tends to infer that diversion by Ms. Meyer is the only reasonable explanation for the missing two units of Tylenol #3. It is argued that this inference should be drawn, especially in light of Ms. Meyer's conduct of a year previous, which was discussed above. However, in order to find a professional violation, the evidence must be clear and convincing. In my opinion, it is not.

There is no evidence indicating that significant shortages of Tylenol #3 had been recurring since May of 1982 which might tend to show that Ms. Meyer was continuing to engage in her previous conduct. Furthermore, the two-unit shortage is conceivably a dispensing error which may have occurred at the pharmacy upon preparation. Such errors are not so uncommon in generally known experience to effectively eliminate such a

mistake as reason for the shortage in this instance. This is especially true in a case such as this where the units contained in the bottle were not counted prior to the alleged incident. Finally, Ms. Cosgrove testified that she left the medication cabinet unlocked, although she believes she did lock the door to the room. The easy access to an unlocked medication cabinet, especially in the event Ms. Cosgrove's recollection of the locked room door were faulty, does not leave Ms. Meyer as the only reasonable explanation for the Tylenol #3 shortage.

In my opinion, the inferences which may be drawn from the testimony in this case are not sufficiently strong to clearly and convincingly establish that Ms. Meyer's diverted the two unaccounted for Tylenol #3 on June 15, 1983.

The second allegation contained within count two of the Complaint charges that on or about October 27, 1983, the respondent attempted to substitute a plain Tylenol tablet for Tylenol #3 in her administration of medication to a patient. The patient involved was to receive either two plain Tylenol or one Tylenol #3 in the evening, according to her medication plan, depending upon the patient's pain. Ms. Meyer was responsible for administering the patient's medication the evening of October 27, 1983. According to Ms. Meyer, the physician's orders were to give the patient the plain Tylenol whenever possible and, accordingly, she took both the plain Tylenol and the Tylenol #3 to the patient with the intent of administering the form of medication deemed appropriate by her assessment. Ms. Meyer further testified that she gave the patient one plain Tylenol tablet after her assessment and that she intended to return the Tylenol #3 to the medication bottle later.

The registered nurse on duty at the time, Carol Cosgrove, stated she checked upon the medication given to the patient immediately after Ms. Meyer's administration and discovered that plain Tylenol had been given. Ms. Cosgrove then checked the Tylenol #3 supply, noted that one unit was apparently missing, and confronted Ms. Meyer. Ms. Meyer claimed she had made a mistake and placed the Tylenol #3 tablet in her nursing uniform and had not yet replaced it in the bottle.

In my opinion, although Ms. Meyer's conduct with regard to administering plain Tylenol rather than Tylenol #3 to the patient and then placing the Tylenol #3 in her uniform pocket was not the appropriate procedure to employ, I do not believe that it has been established clearly and convincingly that she intended to divert the Tylenol #3 to her own use. Ms. Meyer indicated that she was aware that Ms. Cosgrove was closely monitoring her performance, especially in the area of diversion of Tylenol #3. Such monitoring could well be expected in light of Ms. Meyer's previous diversion and the suspicions held concerning the incident of June 15, 1983, discussed above. Given the awareness of the close scrutiny of her conduct by staff, it would seem unlikely that Ms. Meyer would have placed the Tylenol #3 tablet in her uniform pocket, due to possible discovery, if in fact she intended to divert the substance. Rather, it would seem more likely that she would have ingested the "evidence" immediately. Furthermore, again, there is no indication that the home was experiencing suspicious shortages of Tylenol #3 upon Ms. Meyer's return to employment. Although the circumstances surrounding the administration of

plain Tylenol to a patient appear suspicious, in my opinion it is reasonable to conclude that Ms. Meyer's conduct may have more likely involved inadvertent negligence that an intent to divert Tylenol #3. In any event, in my opinion, the factual inferences which may be drawn from Ms. Meyer's conduct the evening of October 27th are not sufficiently strong to constitute clear and convincing evidence of diversion.

DISCIPLINE

The final issue in this case is the appropriate discipline, if any, which should be imposed in light of Ms. Meyer's diversion of Tylenol #3, as found in count one of the Complaint. It is my recommendation that Ms. Meyer be reprimanded. Her stated purpose for the diversion of Tylenol #3 -- that she had failed to bring her prescription to work with her on those occasions -- mitigates against the imposition of stronger discipline. Furthermore, there is no evidence to suggest that she was selling the medications or that patients were not receiving their required allotments. Under the circumstances present, I believe that a reprimand of Ms. Meyer is appropriate discipline.

Dated at Madison, Wisconsin, this 25th day of April, 1986.

Respectfully submitted,

Donald R. Rittel

Donald R. Rittel
Hearing Examiner

DRR:rjt
886-028