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STATE OF WISCONSIN
BEFORE THE NURSING HOME ADMINISTRATORS EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
SANDRA O'NEIL, RESPONDENT.	:	Case No. LS9108092NHA

The parties to this proceeding for the purposes of Wis. Stats. sec. 227.53, are:

Sandra O'Neil
Route #4, Lot 24
Crivitz, WI 54114

Nursing Home Administrators Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708

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

The rights of a party aggrieved by this decision to petition for rehearing and to petition for judicial review are set forth in the attached "Notice of Appeal Information".

A disciplinary hearing was held in the above-captioned matter on March 18, 1992. The respondent, Sandra O'Neil, appeared personally and by her attorney, John C. Gower, ESLIEN, WOODS AND GOWER, Attorneys and Counselors, 400 E. Highland Drive, P.O. Box 39, Oconto Falls, Wisconsin 54154. The complainant appeared by attorney, Gilbert C. Lubcke, Department of Regulation and Licensing, Division of Enforcement, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708. A transcript of the hearing was received on May 18, 1992.

The disciplinary hearing was conducted in closed session, pursuant to an order of the Nursing Home Administrators Examining Board dated August 15, 1991. Prior to that hearing, the parties entered into a stipulation resolving the factual and legal issues to be heard, thus limiting the purpose of the hearing to a determination of what discipline, if any, should be imposed.

Also by virtue of an order under date of August 15, 1991, the Nursing Home Administrators Examining Board provided that the decision herein is to be the final decision in this matter, pursuant to Wis. Stats. sec. 227.46(3)(a). Based upon the entire record in this case, the administrative law judge makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Sandra O'Neil, respondent herein, Route #4, Lot 24, Crivitz, Wisconsin 54114, is licensed as nursing home administrator in the state of Wisconsin, license #1632, and has been so licensed since October 20, 1980.

2. Sandra O'Neil was the nursing home administrator at the Greenview Health Center, 620 Harper Avenue, Peshtigo, Wisconsin, on April 13, 1989 and continued to serve in this capacity at this nursing home until June, 1989. As nursing home administrator, Ms. O'Neil was responsible for all aspects of the operation of the Greenview Health Center, except for financial matters. Ms. O'Neil was responsible for patient care, including the investigation of any allegations of patient abuse. Ms. O'Neil was responsible for acting on the findings of the investigations. Ms. O'Neil had joint responsibility with Shirley Huss, the owner of Greenview Health Center, for the employment and the suspension or termination of employment of personnel at the facility.

3. Janet Hausfeld has been licensed as a registered nurse in the state of Wisconsin since August 21, 1984.

4. Janet Hausfeld was employed as the Director of Nurses at Greenview Health Center on April 13, 1989 and continued to be employed in this position until May 9, 1989.

5. E.A. was a resident at the Greenview Health Center on April 13, 1989 and continued to reside at this facility at all times thereafter relevant to this proceeding.

6. On April 13, 1989, Sandra O'Neil was present at Greenview Health Center, acting in her capacity as the nursing home administrator. At approximately 10:00 a.m. on April 13, 1989, Carol Boucher, a registered nurse employed at the Greenview Health Center, came to Ms. O'Neil's office and reported an incident of patient abuse to Ms. O'Neil. She reported that E.A. had been in the recreation room in an agitated state. Ms. Boucher and Ms. Hausfeld had attempted to place a vest restraint on E.A. and Ms. Hausfeld had made the decision to give E.A. an IM injection of Thorazine. While Ms. Boucher was in the medication room, which looked out into the recreation room, she observed Ms. Hausfeld strike E.A. on the forehead with her fist. In response to Ms. O'Neil's inquiry, Ms. Boucher reported that John Hilton, Ella Pinkowsky, and Marcey Carron, who were also residents of the facility, were present in the recreation room when this event occurred.

7. Immediately after Ms. O'Neil received this report from Ms. Boucher, Ms. O'Neil went to E.A.'s room and examined E.A. in the head, neck and shoulder areas. She did not observe any bruises or other marks on the resident. Ms. O'Neil attempted to ask E.A. questions concerning the reported incident, but the resident could not respond appropriately. Ms. O'Neil knew that E.A. was not mentally competent and she did not expect meaningful responses to her questions.

8. After Ms. O'Neil examined E.A., she spoke with Mr. Hilton in his room. This conversation occurred sometime between 11:00 a.m. and 1:00 p.m. on April 13, 1989. Mr. Hilton told Ms. O'Neil that he had observed Ms. Hausfeld and Ms. Boucher attempting to put a restraint on E.A. who was flinging her arms about. He saw Ms. Hausfeld hit E.A. twice in the head.

9. After Ms. O'Neil left Mr. Hilton's room, she went to talk with Ella Pinkowsky and Marcey Carron. Both of the residents indicated that they saw E.A.'s arms flying about while Ms. Hausfeld and Ms. Boucher were attempting to apply a restraint. Neither of these residents observed Ms. Hausfeld strike E.A.

10. After Ms. O'Neil spoke with Ella Pinkowsky and Marcey Carron, she met with Shirley Huss, the owner of Greenview Health Center. She informed Ms. Huss that Ms. Boucher and Mr. Hilton had reported to her that they had observed Ms. Hausfeld strike E.A. in the head. Ms. Huss questioned whether Ms. Hausfeld's employment should be terminated immediately. Ms. O'Neil advised that they complete the investigation before taking any action regarding Ms. Hausfeld's employment. Ms. Huss conducted an independent investigation, but did not report the results of the investigation to Ms. O'Neil.

11. When Ms. O'Neil returned to her office, Donald Jahnke, the maintenance supervisor at Greenview Health Center, was in her office. He told her that they had trouble. He reported that while he was mopping the floor, he saw Ms. Hausfeld stomping on E.A.'s feet.

12. After talking with Mr. Jahnke, Ms. O'Neil went to E.A.'s room and examined her feet. She did not observe any bruising.

13. Later on the afternoon of April 13, 1989, Ms. Boucher returned to Ms. O'Neil's office. Ms. Boucher was excited. Ms. Boucher said she saw arms flailing. She said she did not mean to get any of her peers in trouble. Ms. O'Neil told Ms. Boucher not to worry about it. She advised Ms. Boucher to tell the truth whether they were her peers or not. Ms. Boucher then left Ms. O'Neil's office without further discussion of the incident.

14. Ms. O'Neil was of the opinion after her second conversation with Ms. Boucher on April 13, 1989 that this incident required further investigation and that she should talk to Ms. Hausfeld about the allegations.

15. Ms. O'Neil spoke with Ms. Hausfeld about the allegations for the first time on the morning of April 14, 1989. Ms. Hausfeld denied the allegations. Ms. Hausfeld further indicated to Ms. O'Neil during this conversation that she would be terminating her employment with Greenview Health Center in approximately 30 days.

16. Following her conversation with Ms. Hausfeld on April 14, 1989, Ms. O'Neil had not reached any conclusions from her investigation except that her problems arising out of this incident were over as a result of Ms. Hausfeld's notification of her intention to terminate her employment with Greenview Health Center.

17. The investigation of this incident continued and, after a period of weeks, the State of Wisconsin Department of Health and Social Services, Division of Health, Bureau of Quality Compliance became involved. No further incidents of patient abuse, alleged or in fact, occurred at Greenview Health Center between April 13, 1989 and May 9, 1989, or at any time thereafter, relevant hereto.

18. Ms. Hausfeld continued uninterrupted in her employment as Director of Nurses at the Greenview Health Center from April 13, 1989 until her termination on May 9, 1989.

19. The standard of care ordinarily exercised by a nursing home administrator under the circumstances set forth above requires that the nursing home administrator suspend from employment the person against whom allegations of physical abuse of a resident have been made pending completion of an investigation of the alleged incident.

20. Sandra O'Neil did not take action on April 13, 1989 or at any time thereafter to suspend Janet Hausfeld from her employment to protect the health, welfare and safety of the residents of Greenview Health Center during the pendency of the investigation.

21. Sandra O'Neil's failure to conform her conduct to the standard of care set forth above, thereby permitting continued and uninterrupted interaction between Janet Hausfeld and the residents of the facility during the pendency of the investigation, created unacceptable risks of harm to E.A. and other residents of the facility.

22. Every resident in the nursing home has the right to be free from physical abuse pursuant to Wis. Stats. sec. 50.09(1)(k).

23. Sandra O'Neil, as nursing home administrator for the Greenview Health Center, had the authority to act on behalf of the facility to promptly report to the Wisconsin Board of Nursing the allegations that Janet Hausfeld, a licensee of the Board of Nursing, had violated E.A.'s right to be free from physical abuse, as required by Wis. Stats. sec. 50.09(6)(b).

24. Wis. Stats. secs. 50.09(1)(k) and 50.09(6)(b), are laws substantially related to the practice of nursing home administration.

25. Sandra O'Neil failed to report these allegations of physical abuse to the Board of Nursing until June 26, 1989, after the facility's failure to make this report had been identified as the result of an investigation of this incident conducted by the Department of Health and Social Services, Bureau of Quality Compliance.

CONCLUSIONS OF LAW

1. The Nursing Home Administrators Examining Board has jurisdiction in this matter, pursuant to Wis. Stats. sec. 456.10.

2. The Administrative Law Judge has the authority to issue the Final Decision and Order herein, as provided by the Order of the Nursing Home Administrators Examining Board dated August 15, 1991, pursuant to Wis. Stats. sec. 227.46(3)(a).

3. Sandra O'Neil's conduct as herein described was contrary to Wis. Stats. sec. 456.10(1)(a), and Wis. Adm. Code sec. NHA 5.02(2), in that she demonstrated unfitness to practice as a nursing home administrator by practicing in a manner which substantially departed from the standard of care ordinarily exercised by a nursing home administrator and, thereby, created an unacceptable risk of harm to the residents of the facility.

4. Sandra O'Neil's conduct as herein described was contrary to Wis. Stats. secs. 456.10(1)(a), 50.09(1)(k) and 50.09(6)(b), and Wis. Adm. Code sec. NHA 5.02(1), in that she demonstrated unfitness to practice as a nursing home administrator by failing to promptly report allegations of physical abuse of a resident to the Board of Nursing as required by Wis. Stats. sec. 50.09(6)(b).

ORDER

IT IS HEREBY ORDERED that the license of Sandra O'Neil to practice as a nursing home administrator is suspended for three (3) months, effective 30 days after the date of this Final Decision and Order.

IT IS FURTHER ORDERED that Sandra O'Neil, pursuant to the authority of Wis. Stats. sec. 440.22, shall pay costs in this proceeding in the amount of $434.00 to the Department of Regulation and Licensing within 30 days after the date of this Final Decision and Order.

IT IS FURTHER ORDERED that Count III of the Complaint is dismissed.

OPINION

The Findings of Fact and Conclusions of Law, as well as the last two provisions in the Order, are based upon a stipulation between the parties. (Exhibit 1). Accordingly, the issue addressed in this decision, as it was at the hearing, is the discipline to be imposed upon Sandra O'Neil, if any.

The resolution of the this issue must take into consideration that the interrelated purposes for applying disciplinary measures are to promote the rehabilitation of the licensee, protect the public and deter other licensees from engaging in similar misconduct. State v. Aldrich, 71 Wis. 2d 206, 209 (1976). Punishment of the licensee is not an appropriate consideration. State v. MacIntyre, 41 Wis. 2d 481, 485 (1969). In this case the parties

agree that Ms. O'Neil demonstrated unfitness to practice as a nursing home administrator, within the meaning of Wis. Stats. sec. 456.10(1)(a), by:

1. Substantially departing from the standard of care expected of a nursing home administrator, by failing to suspend Janet Hausfeld from her employment in order to assure against possible harm to patients during the pendency of the investigation, contrary to NHA 5.02(2), and,

2. Failing to promptly report the allegations of abuse to the Board of Nursing, contrary to Wis. Stats. sec. 50.09(6)(b).

However, the parties disagree as to the discipline which would be appropriate for these violations. Complainant argues that the facts underlying the misconduct require that a sanction tending toward the "revocation end of the spectrum" is necessary. Respondent, conversely, points to several facts mitigating against such a harsh result, and contends that a reprimand is sufficient.

The pertinent circumstances in this case are those which deal not with whether patient abuse actually occurred, but the appropriate professional reaction of a nursing home administrator when presented with allegations of such abuse. Within a few hours on April 13, 1989, Ms. O'Neil received information from three separate individuals that the Director of Nurses at the nursing home, Janet Hausfeld, had abused a patient on that day. The first came from a nurse in the facility, Carol Boucher, who reported that Ms. Hausfeld had struck a patient and further informed her that three other patients had observed the conduct. One of the patients corroborated the allegation that the patient was struck by Ms. Hausfeld, but the other two could only attest to the fact that "arms were flying about". Later in the day, a maintenance supervisor informed Ms. O'Neil that he had observed Ms. Hausfeld stomping on the patient's feet. Ms. O'Neil examined the patient involved after both reports, but did not find any bruises or other physical manifestation of abuse.

Despite the above reports, Ms. O'Neil did not confront Janet Hausfeld the day of the incident. She did talk to the owner of the nursing home and advise that no action be taken with respect to Ms. Hausfeld's employment until after the completion of an investigation. After Ms. O'Neil advised caution to the owner, Ms. Boucher revisited Ms. O'Neil and gave her the impression that she was having second thoughts about reporting the incident, since she did not want to get anyone in trouble.

As indicated, Ms. O'Neil did not confront Ms. Hausfeld until the following day. At that time Ms. Hausfeld denied the incident, but informed Ms. O'Neil that she intended to terminate her employment at the nursing home within 30 days. As stipulated between the parties, Ms. O'Neil felt that she no longer needed to address the issue of whether or not to suspend Ms. Hausfeld in light of her intent to leave the nursing home. This explanation clearly does not exonerate Ms. O'Neil from her inaction. In fact, it could have led to even

more difficult employment problems. For example, one can reasonably envision a situation in which a manipulative employee might choose not to voluntarily leave a nursing home in the event no immediate personnel action were taken, despite a stated intent to do so.

Ms. O'Neil testified at the hearing that another reason for not taking action to suspend Ms. Hausfeld was that the work schedule at the nursing home was set up in such a manner that Ms. Hausfeld would not be working alone with patients. The contention here is that the presence of other staff would serve to assure that Ms. Hausfeld did not engage in additional patient abuse. However, the presence of other staff had not been sufficient to protect a patient from such reported conduct previously. There would appear to be no good basis for assuming that staff presence would assure restraint by Ms. Hausfeld in the future.

There can be no question but that discipline must be imposed in this matter. The parties agree that Ms. O'Neil had a duty to suspend Ms. Hausfeld from employment and promptly report the matter to the Board of Nursing, but failed to do so. Given that the primary purpose behind these duties evolve from the basic philosophy that the concept of protecting patient health, welfare and safety includes an assurance of a patient's right to be free from physical abuse, the discipline imposed must be strong. Thus, the sanction must serve to emphasize the protection of the public and deterrence of other licensees from failing to meet their responsibilities in similar situations.

However, discipline must also recognize the unique facts presented in any given case. It should be considered that Ms. O'Neil did affirmatively respond to the initial allegation by immediately talking with the three witnesses who were residents of the facility; one of which confirmed the allegation of abuse, while the other two could not. She did check the patient involved twice, once after Ms.Boucher's report and again after that of the maintenance supervisor, only to find no physical manifestation of the alleged abuse. She also notified and conferred with the owner of the facility. Had Ms. O'Neil taken none of these actions, thereby essentially ignoring or dismissing the reported abuse, a revocation of licensure would clearly and necessarily be in order.

The stipulated facts do indicate that Ms. O'Neil failed to fulfill her professional and legal responsibilities in not suspending the Director of Nurses at the nursing home and in not promptly reporting the incident to the Board of Nursing. However, they also demonstrate a recognition of an obligation to immediately assess the veracity of the reported abuse. She did this. It appears that the combination of a lack of unequivocal proof of abuse, combined with the nurse's promise to leave employment, led Ms. O'Neil into making a very poor decision. Nevertheless, although this case demonstrates a lack of judgement, it does not establish that type of disregard for patient safety or welfare which should lead to the imposition of a license revocation.

It is ordered that the license of Ms. O'Neil to practice as a nursing home administrator be suspended for a period of three months, given the circumstances of this case. In my opinion, this suspension serves to recognize and enunciate the importance of taking immediate employment actions toward individuals who become the subject of allegations of patient abuse and for reporting those allegations to the Board of Nursing when required, while at the same time appropriately tailoring the suspension's length in recognition of the specific actions and inactions of Ms. O'Neil in this case.

Dated this 21st day of May, 1992.

Donald R. Rittel

Donald R. Rittel
Administrative Law Judge

BDLS2-1587

NOTICE OF APPEAL INFORMATION

(Notice of Rights for Rehearing or Judicial Review, the times allowed for each, and the identification of the party to be named as respondent)

The following notice is served on you as part of the final decision:

1. Rehearing.

Any person aggrieved by this order may petition for a rehearing within 20 days of the service of this decision, as provided in section 227.49 of the Wisconsin Statutes, a copy of which is attached. The 20 day period commences the day after personal service or mailing of this decisi n. (The date of mailing of this decision is shown below.) The petition for rehearing should be filed with the State of Wisconsin Nursing Home Administrators Examining Board.

A petition for rehearing is not a prerequisite for appeal directly t circuit court through a petition for judicial review.

2. Judicial Review.

Any person aggrieved by this decision has a right to petition for judicial review of this decision as provided in section 227.53 of the Wisconsin Statutes, a copy of which is attached. The petition should be filed in circuit court and served upon the State of Wisconsin Nursing Home Administrators Examining Board

within 30 days of service of this decision if there has been no petiti n for rehearing, or within 30 days of service of the order finally disposing of the petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30 day period commences the day after personal service or mailing of the decision or order, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing of this decision is shown below.) A petition for judicial review should be served upon, and name as the respondent, the following: the State of Wisconsin Nursing Home Administrators Examining Board.

The date of mailing of this decision is MAY 21, 1992.