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STATE OF WISCONSIN
BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
MARY ALBERTZ, R.N.,and L.P.N., RESPONDENT.	:	LS9504171NUR

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

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Board of Nursing.

The Division of Enforcement and Administrative Law Judge are hereby directed to file their affidavits of costs, and mail a copy thereof to respondent or his or her representative, within 15 days of this decision.

Respondent or his or her representative shall mail any objections to the affidavit of costs filed pursuant to the foregoing paragraph within 30 days of this decision, and mail a copy thereof to the Division of Enforcement and Administrative Law Judge.

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

Dated this 3 day of November, 1995.

Pamela A. Mapson RN

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

PROPOSED DECISION
Case No. LS-9504171-NUR

MARY ALBERTZ, R.N. AND L.P.N.,
RESPONDENT.

PARTIES

The parties in this matter under § 227.44, Stats., and for purposes of review under § 227.53, Stats., are:

Mary Albertz
P.O. Box 83
Butternut, WI 54514

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

Department of Regulation & Licensing
Division of Enforcement
P.O. Box 8935
Madison, Wisconsin 53708

This matter was commenced by the filing of a Notice of Hearing on April 17, 1995. A hearing was held in the above-captioned matter on June 21, 1995. Atty. James W. Harris appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. The respondent, Mary Albertz did not appear at the hearing.

Based upon the record herein, the Administrative Law Judge 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 Albertz (dob, 10/14/54), P.O. Box 83, Butternut, WI, is licensed as a registered nurse in the State of Wisconsin, license #110282, first granted on 8/14/92. Respondent also holds an expired license as a licensed practical nurse, license #30580, first granted on 2/6/91.

2. On June 3, 1994, the Minnesota Board of Nursing issued a disciplinary order placing the nursing licenses (R.N., and L.P.N.) of respondent in a limited and conditional status based upon facts stipulated to by the respondent.

3. On April 6, 1995, the Minnesota Board of Nursing issued an order accepting the voluntary surrender of respondent's registration certificates to practice professional and practical nursing in the State of Minnesota. The Board's order is based upon a Stipulation and Consent Order signed by the respondent on February 10, 1995. The findings set forth in the Stipulation and Consent Order include, but are not limited to, the following:

> 11. Licensee admits the facts referred to below and grants that the Board may, for the purpose of reviewing the record in paragraph 9 above, consider the following as true without prejudice to her in any current or future proceeding of the Board with regard to these or other allegations.
>
> As discussed at a conference on May 5, 1994 with the Board Review Panel, the following occurred while Licensee was employed as a professional nurse at Moose Lake Regional Treatment Center, Moose Lake, Minnesota:
>
> a. Licensee's employment began on March 16, 1992, and she was temporarily assigned to the mental illness unit on April 13, 1992. Licensee expressed concern that she could not handle the admission unit and did not know nursing diagnosis. On April 27, 1992, Licensee was transferred to the developmental disability unit;
>
> b. Licensee had a hard time focusing on a task and had extreme difficulty retaining what she had been told. Licensee required multiple repetitions of instructions and still was not able to learn or retain the information. Examples included the following:
>
> > 1) On April 30, 1992, Licensee was told that she should read the social history, physician's assessment and nursing assessment before starting on the form for patient SC's annual. Licensee immediately started completing the form and kept asking questions. Licensee again was told to read the assessments. Licensee shrugged and continued. In her written response to the Board, Licensee admitted this allegation was true but stated she personally found it worked well for her to gather information about patients through verbal communication with other staff.
> >
> > 2) On May 12, 1992, Licensee was told that the physician had been informed of a patient's seizure activity and that there was concern about a second seizure occurring. Ten minutes later Licensee asked if the physician was around because Licensee wanted to make sure that the physician had been informed of the patient's seizure activity. In her written response to the Board, Licensee explained she merely wanted to double check on the situation;

3) On May 14, 1992, a physician ordered a topical medication for a patient. Licensee wanted to update the necessary forms without knowing what forms need to be updated. It was explained to Licensee three times that morning that the primary nurse would take care of it when she arrived and that the entire discharge process would be explained to Licensee at another time. In her written response to the Board, Licensee admitted this allegation was true but stated she was just eager to help in any way she could;

4) After working on the DD unit for three months, Licensee could not remember staff names and titles. In her written response, Licensee admitted this allegation but stated she was expected to know the names of staff who worked evenings and nights even though she worked on the day shift;

5) On May 27, 1992, Licensee asked employee LS what finger was the index finger. Licensee stated in her written response that she does not recall this incident and that she does know which is the index finger;

6) On May 27 and 28, 1992, Licensee approved a PRN medication after being told that she could not do this while still being on orientation. Licensee stated in her written response that this patient was complaining of a severe headache. She checked with a nurse who frequently cared for the patient and the other nurse recommended a pain medication which had frequently been effective for that patient in the past. It was the lunch hour so her preceptor was unavailable. Licensee decided quick pain relief was important for the patient so took the other nurse's recommendation and administered the pain medication;

7) On June 2, 1992, it took Licensee one hour to gather two charts and to check on two patients. Licensee had written nothing in the rounds book. When told that she needed to write in the book, Licensee asked, "What?" Licensee had to be reminded again at 11:00 a.m. to write in the rounds book.

c. Licensee's communication with physicians was fragmented and not always adequate or accurate regarding client needs. Examples included the following:

1) On May 20, 1992, Licensee was asked to get information from a physician regarding the use of a knee immobilizer for a patient. After seven hours of going back and forth with the order and the physician, the information Licensee had obtained was not yet clear. In her written response, Licensee admitted this allegation but explained that the delay occurred because two physicians had conflicting opinions about the best way to care for this patient;

2) On June 1, 1992, Licensee needed to be reminded to give all the information to the physicians as to what needed to be done. Licensee admitted that, as a new R.N., she needed guidance in the area of presenting information to a physician.

3) On July 7, 1992, Licensee was instructed to add a sedation order to the rounds book. Licensee failed to record the order. In addition, Licensee failed to make a copy of a UGI referral for the rounds book.

d. Licensee's documentation was often inaccurate. Examples included the following:

1) Licensee charted on July 8, 1992, that a patient named "Don" would see "Dr. Stevens." In fact the patient's last name was "Stevens" and the physician's name was "Nelson";

2) On June 17, 1992, Licensee incorrectly recorded eight of 47 weights that she had collected and recorded in the weight book. During a discussion on the inaccuracies, Licensee stated that the week had been difficult for her and she was not able to focus. In her written response, Licensee admitted this allegation and stated she did have difficulty focusing on tasks because she had been told by her co-workers that her performance was being watched, which caused her significant anxiety;

3) On July 6, 1992, Licensee had made and recorded three weight calculation errors. Licensee requested a calculator to perform the calculations.

e. Licensee had problems completing medication check off return and made errors in transcribing and administering medications. Examples included the following:

1) On May 28, 1992, Licensee put patient Karen's name on patient Dennis' medication card;

2) On June 24, 1992, Licensee failed the a.m. unit medication check off after the following occurred:

a) Licensee left the control drawer open and the medication cart open while checking on a tube feeding drip rate;
b) Licensee used the night bottle of Ibuprofen in setting up NF's a.m. dose, which indicated that Licensee had not read the label carefully;
c) After dropping a medication on the floor, Licensee thought the correct way to dispose of the medication was to throw it in the garbage instead of flushing the medication;

d) Licensee put one patient's topical acne medication on the wrong patient;

e) Patients did not begin to receive their 8:00 a.m. medications until 9:00 a.m.;

f) Licensee charted that she had held patient TH's Sorbitol when, in fact, Licensee had held KN's Sorbitol due to loose stools;

g) Licensee stated that she had given a patient all of his medications before he left for school. After the patient left the medications were found on top of the medication cart. The medications included Dilantin, Folic Acid and Benztropine.

f. On June 13, 1992, Licensee was doing the Heimlich Maneuver on patient WN, who was choking on a meatball. Licensee was not successful in removing the obstruction and refused assistance from another employee. When asked why she had refused to let another employee assist her, Licensee replied, "If you think you're going to use me as a scapegoat in this -- think again." At the conference, Licensee stated that she believed the patient would be able to expel the meatball on her own, which she did. Licensee described signs of an obstructed airway as becoming blue or cyanotic;

g. Licensee frequently dozed off, including while being oriented with two other employees, while shadowing L.P.N.s, while doing diet reviews, and while reading policies;

h. During a mid-probationary period performance review on June 6, 1992, Licensee stated that she had some medical issues and increased symptoms since February, 1992, that may be contributing to some of the concerns addressed in the review. Recommendations for corrective action included the following:

1) Licensee's probationary period would be extended for two months;
2) Licensee would not be tardy;
3) Licensee would have no more than two medication/transcription errors during the next three months;
4) Licensee would be required to identify all employees and their titles on the DD unit;
5) Licensee would not fall asleep while on duty.

i. On July 9, 1992, Licensee was terminated.

12. In September 1994, Licensee notified the Board she had been hospitalized for depression. A review of records received in response to the Board's request for additional information revealed the following:

a. On October 23, 1989, Licensee was hospitalized for depression with suicidal ideation. She did well in the hospital setting, was started on Prozac, and was discharged on October 30, 1989 with a guarded prognosis.

b. During an office visit with her psychiatrist on April 5, 1990, Licensee demonstrated symptoms of a thought disorder. Licensee indicated she had been scattered and indicated she had suffered a "religious setback." The psychiatrist indicated that medication may help her to reorganize her thinking but Licensee refused to try medication.

c. A psychiatric assessment completed on May 27, 1994 indicated Licensee was suffering from severe depression with mood incongruent psychotic features. Licensee reported inability to function at work. She indicated she was unable to concentrate or focus, her memory was bad and she felt suicidal. She stated she did not hear voices, but indicated that during her hospitalization she did "receive messages from people and warnings from God." Weekly therapy was recommended.

d. On September 8, 1994, Licensee was admitted to St. Luke's Hospital, Duluth, Minnesota for escalating depressive symptomology. She was discharged on September 19, 1994, with diagnoses of probable bipolar disease, atypical with current depression and personality disorder with borderline features. Discharge medications included Navane, Artane, and Effexor.

e. In an office visit to her psychiatrist on September 27, 1994, Licensee appeared to be improved and stable. Licensee indicates some reluctance to continue taking Navane. Her psychiatrist advised her that during her hospitalization she was quite disorganized and encouraged her to continue taking her medication to prevent recurrence of those symptoms.

13. Licensee admits and acknowledges that the facts and conduct specified in paragraphs 11 and 12 above constitute a violation of Minn. Stats. s. 148.261 (1994) and justify disciplinary action against her licenses and constitute a reasonable basis in law and fact to justify the disciplinary action provided for in the order.

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this matter pursuant to s. 441.07 (1), Stats., and ch. N 7, Wis. Adm. Code.

2. By having engaged in conduct as described in Findings of Fact 2 and 3, herein, respondent violated s. 441.07 (1) (b), (c) and (d), Stats., and s. N 7.03 (1) (a), (b), (c), N 7.03 (3) and N 7.04 (7) and (15), Wis. Adm. Code.

3. By failing to file an Answer to the Complaint and failing to appear at the hearing held in this matter, respondent is in default under s. RL 2.14 Wis. Adm. Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Mary Albertz to practice as a registered nurse and as a licensed practical nurse be, and hereby is, SUSPENDED for an INDEFINITE PERIOD of time.

IT IS FURTHER ORDERED that:

(1) **Petition for Stay**. Ms. Albertz may petition the Board at any time for a stay of the suspension of her licensure. In conjunction with such petition, Ms. Albertz shall submit documentation of an evaluation performed by a health care provider acceptable to the Board of her psychological status. The assessor shall submit a written report of his or her findings directly to the Board, including: 1) a diagnosis of Ms. Albertz's condition; 2) recommendations (if any) for treatment; 3) an evaluation of Ms. Albertz's level of cooperation in the assessment process; 4) work restriction recommendations, and 4) Ms. Albertz's prognosis. The report shall include a certification stating that Ms. Albertz is fit to safely and competently return to the active practice of nursing. The assessment shall occur within thirty (30) days prior to the date of its submission and reflect the fact that the person (s) performing the assessment received a copy of this Order.

(2) **Board Action.** Upon its determination that Ms. Albertz can safely and competently return to the active practice of nursing, the Board may stay the suspension for a period of three (3) months, conditioned upon compliance with the conditions and limitations set forth in paragraph (3).

(a) Respondent may apply for consecutive three (3) months extensions of the stay of suspension, which shall be granted upon acceptable demonstration of compliance with the conditions and limitations imposed upon respondent's practice during the prior three (3) month period.

(b) If the Board denies the petition by respondent for an extension, the Board shall afford an opportunity for hearing in accordance with the procedures set forth in ch. RL 1, Wis. Adm. Code, upon timely receipt of a request for a hearing.

(c) Upon a showing by respondent of complete, successful and continuous compliance for a period of two (2) year with the terms of paragraph (3), below, the Board may grant a petition by respondent for return of full licensure if it determines that respondent may safely and competently engage in practice as a registered nurse and/or licensed practical nurse.

(3) **Conditions of Stay**

(a) If the assessment report referred to in paragraph (1) above recommends continued therapy, respondent shall maintain successful participation in a program of treatment at a health care facility acceptable to the Board. As a part of treatment, respondent must attend therapy on a schedule as recommended by her therapist; the Board may, however, in its discretion establish a minimum number of therapy sessions per month.

(b) If continued therapy is required under the stay Order, respondent shall arrange for submission of quarterly reports to the Board from her therapist evaluating her attendance and progress in therapy. If the assessment recommends work restrictions, respondent shall comply with all restrictions recommended.

(c) Respondent shall provide the Board with current releases complying with state and federal laws, authorizing release and access to the records of the health care provider(s) performing her assessment.

(d) Respondent shall be responsible for all costs associated with the assessment referred to in paragraph (1) above, and for all treatment, education and reporting required under the terms of the stay Order.

(e) Within six (6) months of the date of the initial Board Order granting stay of suspension, respondent shall certify to the Board of Nursing the successful completion of an approved course of education in medication administration and documentation and a course in medical record documentation. Respondent shall submit course outlines for approval by a Board designee within two (2) months of the date of the stay Order. The course outlines shall include the name of the institution providing the instruction, the name of the instructor, and the course content. Until filing of certification of successful completion of the required training, respondent shall not engage in medication administration except under the direct supervision of another registered nurse.

(f) Respondent shall provide all current and prospective nursing employers with a copy of this Final Decision and Order and any subsequent stay Orders; arrange for submission of quarterly reports to the Board of Nursing from her nursing employer(s) reporting the terms and conditions of her employment and evaluating her work performance, and report to the Board any change in her employment status within five (5) days of such change.

(4) **Petition for Modification of Terms**

Respondent may petition the Board in conjunction with any application for an additional stay to revise or eliminate any of the above conditions. Denial in whole or in part of a petition under this paragraph shall not constitute denial of a license and shall not give rise to a contested case within the meaning of Wis. Stats. S. 227.01 (3) and 227.42.

IT IS FURTHER ORDERED that pursuant to s. 440.22, Wis. Stats., the cost of this proceeding shall be assessed against respondent, and shall be payable to the Department of Regulation and Licensing.

This order is effective on the date on which it is signed by a designee of the Board of Nursing.

OPINION

This matter was commenced by the filing of a Notice of Hearing on April 17, 1995. A hearing was held on June 21, 1995. Atty. James W. Harris appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. The respondent, Mary Albertz, did not file an Answer to the Complaint filed in this matter and did not appear at the hearing.

The evidence presented in this case establishes that the respondent violated numerous provisions of ch. 441, Stats., and ch. N 7 Wis. Adm. Code. Having found that Ms. Albertz violated laws governing the practice of nursing in Wisconsin, a determination must be made regarding whether discipline should be imposed, and if so, what discipline is appropriate.

The Board of Nursing is authorized under s. 441.07 (1), Stats., to reprimand registered nurses and licensed practical nurses or limit, suspend or revoke the licenses of registered nurses and licensed practical nurses if it finds that the licensees have violated ch. 441, Stats., or any rule adopted by the Board under the statutes.

The purposes of discipline by occupational licensing boards are to protect the public, deter other licensees from engaging in similar misconduct and to promote the rehabilitation of the licensee. *State v. Aldrich*, 71 Wis. 2d 206 (1976). Punishment of the licensee is not a proper consideration. *State v. McIntyre*, 41 Wis. 2d 481 (1969).

The Administrative Law Judge recommends that Ms. Albertz's license to practice as a registered nurse and as a licensed practical nurse be suspended for an indefinite period of time such to the right to petition for a stay of the suspension as set forth in the proposed Order. This measure is designed primarily to assure protection of the public.

Ms. Albertz was first granted a license to practice as a licensed practical nurse in Wisconsin in February, 1991, and a license to practice as a registered nurse in August, 1992. In June, 1994, the Minnesota Board of Nursing issued a disciplinary order placing her R.N., and L.P.N., licenses in a limited and conditional status. In April, 1995, the Minnesota Board issued another order accepting the voluntary surrender of her registration certificates to practice professional and practical nurses. Both of the Orders issued by the Minnesota Board are based upon Stipulations signed by Ms. Albertz in which she admitted specific facts, and consented to determinations relating to violations and imposition of discipline. Some of the findings contained in the Minnesota Board Orders are set forth herein in the proposed Findings of Fact (Findings #2 and #3). Based upon these findings, the evidence establishes that Ms. Albertz is not capable of practicing as a nurse in a manner which safeguards the interests of the public.

Upon receipt of a petition for a stay of the order of suspension and documentation from a Board approved health care professional certifying that Ms. Albertz is fit to practice in a safe and competent manner, it is recommended that she be permitted to return to the active practice of nursing subject to compliance with certain conditions as set forth in the proposed Order. An additional safeguard include a requirement that she complete educational coursework in medication administration and documentation and in medical record documentation prior to being allowed to return to full licensure.

Based upon the record herein, the Administrative Law Judge recommends that the Board of Nursing adopt as its final decision in this matter, the proposed Findings of Fact, Conclusions of Law and Order as set forth herein.

Dated at Madison, Wisconsin this 21st day of August, 1995

Respectfully submitted,

Ruby Jefferson-Moore

Ruby Jefferson-Moore
Administrative Law Judge

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

AFFIDAVIT OF COSTS
LS9504171NUR

MARY ALBERTZ, RN., and L.P.N.,
RESPONDENT.

STATE OF WISCONSIN
COUNTY OF DANE

Ruby Jefferson-Moore, being first duly sworn on oath deposes and states:

1. That affiant is an attorney licensed to practice law in the State of Wisconsin, and is employed by the Wisconsin Department of Regulation and Licensing, Office of Board Legal Services.

2. That in the course of affiant's employment she was appointed administrative law judge in the above-captioned matter. That to the best of affiant's knowledge and belief, the costs for services provided by affiant are as follows:

ACTIVITY	DATE	TIME
Preparation and Hearing	06/21/95	1 hr.
Review record/law/draft decision	08/16/95	1 hr.
Draft decision	08/21/95	2 hrs.

Total costs for Administrative Law Judge: $108.00.

3. That upon information and belief, the total cost for court reporting services provided by Magne-Script is as follows: N/A

Total costs for Office of Board Legal Services: $108.00.

Ruby Jefferson-Moore
Administrative Law Judge

Sworn to and subscribed to before me
this 17th day of November, 1995

Notary Public
My Commission: is Permanent

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST MARY ALBERTZ, R.N. and L.P.N., RESPONDENT.	:	AFFIDAVIT OF COSTS LS9504171NUR

STATE OF WISCONSIN)
) ss.
COUNTY OF DANE)

James W. Harris, being duly sworn, deposes and states as follows:

1. That I am an attorney licensed in the state of Wisconsin and am employed by the Wisconsin Department of Regulation and Licensing, Division of Enforcement:

2. That in the course of those duties I was assigned as a prosecutor in the above-captioned matter; and

3. That set out below are the costs of the proceeding accrued to the Division of Enforcement in this matter, based upon Division of Enforcement records compiled in the regular course of agency business in the above-captioned matter.

PROSECUTING ATTORNEY EXPENSE

Date	Activity	Time Spent
2/05/95	file review/fact prep	2.0
2/07/95	letter to Respondent	0.3
2/24/95	prep stipulation/letter Respondent	1.0
4/06/95	prep complaint & notice; transmittal	2.0
6/20/95	prep for hearing	2.0
6/21/95	prep and hearing	0.5
6/22/95	prep supplemental exhibit/record check	0.5
11/08/95	prep affidavit/transmittal	0.5
TOTAL HOURS		8.8 hours

Total attorney expense
8.8 hours and minutes at $41.00 per hour
(based upon average salary and benefits
for Division of Enforcement attorneys) equals: $360.80

INVESTIGATOR EXPENSE

Date	Activity	Time Spent
1/30/95	license status check	0.25
2/03/95	file 94/199 prep	1.0
2/10/95	consult Minn Board of Nursing	1.0
2/11/95	file 94/109 prep	1.0
2/11/95	consult board advisor	0.5
2/13/95	PIC files	0.75
	TOTAL HOURS	4.3 hours

Total investigator expense
4.3 hours and minutes at $20.00 per hour
(based upon average salary and benefits
for Division of Enforcement investigators) equals: $ 86.00

TOTAL ASSESSABLE COSTS: $ 446.80

James W. Harris, Attorney
Division of Enforcement

Subscribed and sworn to before me
this 8th day of November, 1995.

Notary Public, my commission permanent

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.

Serve Petition for Rehearing or Judicial Review on:

STATE OF WISCONSIN BOARD OF NURSING

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

The Date of Mailing this Decision is:

November 7, 1995

1. REHEARING

Any person aggrieved by this order may file a written petition for rehearing within 20 days after service of this order, as provided in sec. 227.49 of the *Wisconsin Statutes*, a copy of which is reprinted on side two of this sheet. The 20 day period commences the day of personal service or mailing of this decision. (The date of mailing this decision is shown above.)

A petition for rehearing should name as respondent and be filed with the party identified in the box above.

A petition for rehearing is not a prerequisite for appeal or review.

2. JUDICIAL REVIEW.

Any person aggrieved by this decision may petition for judicial review as specified in sec. 227.53, *Wisconsin Statutes* a copy of which is reprinted on side two of this sheet. By law, a petition for review must be filed in circuit court and should name as the respondent the party listed in the box above. A copy of the petition for judicial review should be served upon the party listed in the box above.

A petition must be filed within 30 days after service of this decision if there is no petition for rehearing, or within 30 days after service of the order finally disposing of a petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30-day period for serving and filing a petition commences on the day after personal service or mailing of the decision by the agency, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing this decision is shown above.)