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STATE OF WISCOSNIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY

PROCEEDINGS AGAINST

TODD C. GROHALL, R.N.	**FINAL DECISION AND ORDER**
RESPONDENT	**LS0001251NUR**

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 with the Department General Counsel within 15 days of this decision. The Department General Counsel shall mail a copy thereof to respondent or his or her representative.

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 7th day of July, 2000

Ann Brewer, R.N.

A Member of the Board

STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST

TODD C. GROHALL, RN,	**PROPOSED DECISION**
RESPONDENT	**Case No. LS-0001251-NUR**

PARTIES

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

Todd C. Grohall

3018 South 90th Street

West Allis, Wisconsin 53227

Board of Nursing

P.O. Box 8935

Madison, WI 53708-8935

Department of Regulation & Licensing

Division of Enforcement

P.O. Box 8935

Madison, Wisconsin 53708-8935

The Board of Nursing issued an Order of Summary Suspension on January 19, 2000. This proceeding was commenced by the filing of a Notice of Hearing and Complaint on January 27, 2000. A hearing was held on March 8, 2000. Atty. James W. Harris appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. The respondent, Todd C. Grohall, appeared at the hearing in person and without legal counsel.

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. The respondent, Todd C. Grohall (d.o.b. 12/3/69) is duly licensed in the state of Wisconsin to practice as a registered nurse (license #128479). Respondent's license was first granted on February 5, 1998.

2. Respondent's latest address on file with the Department of Regulation and Licensing is 3018 South 90th Street, West Allis, Wisconsin 53227.

3. Respondent was convicted on June 20, 1988 in Milwaukee County Circuit Court, case #239360, of the misdemeanor offense of possession of a controlled substance (marijuana).

4. Respondent was convicted on July 16, 1993, in Milwaukee County Circuit Court, case #93-CF-931215, of the misdemeanor offense of possession of a controlled substance (marijuana).

5. On December 16, 1997 respondent signed an "Application for Licensure as a Professional Nurse by Examination", in which he answered NO to the following question: "13. Have you ever been convicted of any offense or are you subject to a pending charge?". Respondent filed the application with the Board of Nursing on December 26, 1997.

6. On December 7, 1999, while employed as a registered nurse at Cameo Care Center, Milwaukee, Wisconsin, respondent entered the room of resident BB after the resident had requested examination of an ingrown toenail. Without authorization, respondent removed a Duragesic [50-microgram- per-hour] patch from the back of the resident and left the room with the patch in his possession. Resident BB had a physician order for Duragesic for relief of pain.

7. Upon confrontation, respondent admitted to facility staff that he had removed the Duragesic patch from the body of resident BB for his personal use.

8. In November 1999, while employed as a registered nurse at Hales Corners Care Center, respondent made the following medication errors:

(a) On November 16, 1999, and on November 17, 1999, Mr. Grohall placed a 100 -microgram Duragesic patch on a resident. Respondent did not document the reason for the replacement or disposal of the patch.

(b) On November 17, 1999, Mr. Grohall signed out hydrocodone for a resident who was "basically comatose". Hydrocodone had been ordered for the resident prior to her hospitalization. The resident did not require hydrocodone after her hospitalization because she did not indicate that she was in significant pain and she did not have a physician's order for it.

(c) On November 23, 1999, Mr. Grohall recorded in the Medication Administration Record ("MAR") that a Duragesic patch "fell off" a resident. On November 24, 1999, and on November 25, 1999, Mr. Grohall signed out on the MAR that a Duragesic patch was placed on the resident. The physician's order required that the Duragesic patch for the resident be changed ever three days. Respondent did not document the reason for the replacement or disposal of the patch.

(d) On November 24, 1999, Mr. Grohall signed out hydrocodone at 19:00 hours and at 21:00 hours to administer to a resident. Respondent did not document administration of the dose at 21:00 hours. The physician's order for the resident was for "prn" every 6 hours.

(e) On November 24, 1999, Mr. Grohall signed out propoxyphene ("Propoxy -N/Acetaminophen 100-65") for a resident after the medication order had been canceled and after the cancellation had been posted on the MAR. Mr. Grohall administered the propoxyphene for complaints of increased leg pain. The physician's order indicated that the propoxyphene had been ordered for back pain and that the resident had not required it since September 20, 1999, when the resident experienced an acute episode of back pain.

(f) On November 24, 1999, Mr. Grohall administered a scheduled dose of Xanax to a resident and then administered a second dose within 30 minutes.

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 engaging in conduct as described in Findings of Fact 3, 4 and 5 herein, respondent violated s. 441.07 (1) (a), (b), and (d), Stats., and s. N 7.04 (1) and (15), Code.

3. By engaging in conduct as described in Findings of Fact 6 and 7 herein, respondent violated s. 441.07 (1) (b), (c) and (d), Stats.; s. N 7.03 (1) (a) and (b), and s. N 7.04 (2), (4) and (15), Code.

4. By engaging in conduct as described in Findings of Fact 8 herein, respondent violated s. 441.07 (1) (b), (c) and (d), Stats.; s. N 7.03 (1) (a) and (b), and s. N 7.04 (2), (4) and (15), Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Todd C. Grohall be, and hereby is, SUSPENDED for an INDEFINITE PERIOD of time.

IT IS FURTHER ORDERED that:

(1) Petition for Stay. Mr. Grohall may petition the Board at any time for a stay of the suspension of his license. In conjunction with such petition, Mr. Grohall shall submit documentation of an evaluation performed by a health care provider acceptable to the Board of his current use and/or dependence on controlled substances. The assessor shall submit a written report of his or her findings directly to the Board, including: 1) a diagnosis of Mr. Grohall's condition; 2) recommendations (if any) for treatment; 3) an evaluation of Mr. Grohall's level of cooperation in the assessment process; 4) work restriction recommendations, and 5) Mr. Grohall's prognosis. The report shall include a certification stating that Mr. Grohall 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 Mr. Grohall 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) Upon a showing by respondent of complete, successful andcontinuous compliance for a period of four (4) years 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.

(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 part of treatment, respondent must attend therapy on a schedule as recommended by his 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 his therapist evaluating his 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 his 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 his nursing employer(s) reporting the terms and conditions of his employment and evaluating his work performance, and report to the Board any change in his 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.

(5) Costs: 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

The Division of Enforcement alleges in its Complaint that Mr. Grohall's conduct, as described therein, constitutes a violation of s. 441.07 (1) (a), (b), (c) and (d), Stats., and s. N 7.03 (1) (a) and (b) and s. N 7.04 (1), (2), (4) and (15), Code.

I. Violations

The evidence presented establishes that Mr. Grohall violated numerous laws relating to the practice of professional nursing.

(A) Application for Licensure

The Complainant alleges in its Complaint that Mr. Grohall violated s. 441.07 (1) (a), Stats., by filing an application for licensure with the Board of Nursing in which he indicated that he had not been convicted of an offense, when in fact was convicted of a misdemeanor on June 20, 1988 and of a felony on July 16, 1993 for manufacture of a controlled substance. [Exhibit 10]

Section 441.07 (1) (a), Stats., states, in part, that the Board may discipline a registered nurse if it finds that the nurse has committed "fraud in the procuring or renewal of the certificate or license".

The evidence presented establishes that Mr. Grohall committed fraud in the procuring of his license by indicating on his application for licensure that he had not been convicted of an offense.

Mr. Grohall was convicted in a Milwaukee County Circuit Court on June 20, 1988 and on July 16, 1993 of the misdemeanor offense of possession of a controlled substance (marijuana). Mr. Grohall admitted in his Answer that he was convicted of these offenses. *Respondent's Answer, par. 3 and 4.* [1.]

On December 16, 1997 Mr. Grohall signed an "Application for Licensure as a Professional Nurse by Examination", in which he answered "NO" to the following question: "have you ever been convicted of any offense or are you subject to a pending charge?". He filed the application with the Board of Nursing on December 26, 1997. He was granted a license to practice as a registered nurse on February 5, 1998.

Mr. Grohall admits that he indicated "No" to the question on his application for licensure relating to whether he had ever been convicted of an offense. He said that he answered "No" to the question of whether he had ever being convicted of any offense only after consulting with an instructor at Milwaukee Area Technical Schools where he received his degree. He said that based upon his discussion with his instructor, it was his understanding that he was to answer "Yes" to that question only if he was convicted of a felony charge or a felony charge was pending against him. *Answer, par. 5; Tr. p. 51, 54-55.*

1. The Complainant alleges that Mr. Grohall was convicted of the felony offense of manufacture of a controlled

substance; however, no evidence was offered to establish that fact.

Mr. Grohall's explanation of why he indicated on his application for licensure that he had not been convicted on an offense is not credible. He was convicted of possession of controlled substances on two occasions; therefore, it can be concluded that he has some knowledge of the criminal justice system and what it means to be convicted of a crime. Also, in my opinion, it is unlikely that a student would discuss a criminal conviction with an instructor, especially with a focus on how to avoid being truthful when providing information to a licensing authority. At no time did Mr. Grohall contact the Board office regarding its interpretation of the language in the application. Finally, it should be noted that Mr. Grohall also indicated on his applications for employment that he submitted to Cameo Care Center and Hales Corners Care Center in November of 1999 that he had not been convicted of any crime. *Ex. 2, p. 2; Ex. 3, p. 6.*

(B) <u>Cameo Care Center</u>

The complainant alleges in paragraph 6 of its Complaint that on December 7, 1999, Mr. Grohall, while employed as a registered nurse at Cameo Care Center in Milwaukee, entered the room of resident BB after the resident had requested examination of an ingrown toenail. Without authorization, respondent removed a Duragesic patch from the back of the resident and left the room with the patch in his possession. Resident BB had a physician order for Duragesic for relief of pain. In addition, the complainant alleges in paragraph 7 of its Complaint that "upon confrontation", Mr. Grohall admitted to the facility staff that he had removed the Duragesic patch from the body of resident BB for his personal use.

Mr. Grohall stated in his Answer that he recalls moving resident BB to her room, per her request, after she complained of pain in her feet. He said that he removed only the resident's shoes and socks and that he never removed a Duragesic patch from her. He said that on December 8, 1999, the Director of Nursing called him at home and insisted that he come to the facility to talk about the alleged incident. When he arrived other staff members were present. He said that he never admitted to the staff that he removed resident BB's Duragesic patch for his personal use. He said that "under pressure" he was forced to talk to Lynn from the Impaired Professional Program regarding his alleged behavior. Finally, Mr. Grohall stated that due to the unethical tactics and administrative harassment, he resigned from Cameo Care Center.

Mr. Grohall testified at the hearing that when he was told that the patch was missing he searched the patient's room and found it under the plastic trash bag in the wastebasket. *Tr. p. 51.*

Mr. Grohall's response to the allegations contained in paragraph 6 and 7 of the Complaint is not credible.

Based upon a statement given by resident BB on December 9, 1999, she was in her room when she asked the "doctor" to come into her room to look at her ingrown toenail. She said that she believed that Mr. Grohall was a doctor because "he looked like a doctor". She said that when he came into her room she addressed her toe, he looked at it and said, "there was no help for an in-grown toe nail". She said that he "then began to monkey around with my back and remove the patch". She asked him what he was doing, but he did not respond. She said that she hollered "leave me alone". "What are you doing?" He said nothing and did not stop until he had it (the patch) removed. Then he left the room. Resident BB said that she was upset and crying. She told a nurse who replaced the patch and told her not be upset. *Exhibit 1*.

Sally Beland, a registered nurse at Cameo Care Center, testified at a deposition held on February 23, 2000 that she put a Duragesic patch on resident BB's right shoulder the morning of December 7, 1999. She said that she placed the patch on the right scapular area and secured it with a bioclusive dressing and put a date on it. *Exhibit 6, p. 7.*

Nicole Savage, a medical technician on duty at the time of the incident testified at the hearing held in this matter that Sally Beland informed her around 3:00 p.m., that she had put a new patch on resident BB. Ms. Savage noted that information in her "24-hour report sheet" so that the information would be available for the next shift. Ms. Savage further testified that she was standing at her cart when resident BB said that she needed to "see the doctor". She said that resident BB said "there's the doctor right there", referring to Todd Grohall who was wearing a white lab coat. Resident BB then went over to Mr. Grohall and said "doctor, doctor, could you look at my foot? It's hurting". According to Mr. Savage, Todd Grohall said "okay"; jumped off the table he was sitting on and pushed resident BB in her room and closed the door. She said later Mr. Grohall pushed resident BB out of her room and said, "Blanche, is your foot okay?" According to Ms. Savage, resident BB was "flabbergasted" and "astounded". She said that resident BB told her that the doctor pulled her patch off. Resident BB said in a real loud voice, "why did he take my patch off my back? I want it back on". Ms. Savage said that she took resident BB to her room and looked at her back found that the patch had been "ripped off" and that the area where the patch had been placed was "just completely red". Ms. Savage said that resident BB told her that the doctor never looked at her foot. *Tr. p. 33-35.*

Ms. Savage further testified that when she discovered that the patch had been removed from resident BB's back, she immediately called Sally Beland, who was the first shift supervisor, and told her that she wanted her "down here right now". When Ms. Beland arrived she and Ms. Savage searched resident BB's clothing and also did a complete search of the resident's room. Ms. Savage said that she emptied the resident's garbage completely;

emptied the resident's roommate's garbage and searched the bathrooms. They did not find the patch. *Tr., p. 35; Exhibit 6, p. 8.*

Ms. Savage said that at some point in time, after Mr. Grohall was paged throughout the facility, he came back to the first floor and asked her why they were saying that resident BB's patch was gone. He said he wanted to talk to resident BB. He went into the resident's room and closed the door. According to Ms. Savage, when Mr. Grohall came out of the resident's room he said "see, I found the patch right here. It was in the garbage". *Tr., p. 36, 51; Exhibit 6, p. 9-10.*

Vincent W. Bergstrom, the Director of Nursing at Cameo Care Center at the time of the incident testified at a deposition taken on February 22, 2000, that he met with Mr. Grohall immediately after the incident was reported to him. He said that Mr. Grohall initially denied that he removed the patch from resident BB. After they discussed the fact that it would be considered a criminal act; that it would be reported to the Board of Nursing and that the Center wanted Mr. Grohall to get help, Mr. Grohall admitted that he took the patch for his own use. *Exhibit 7, p. 11-12; 14-15.*

In reference to whether Mr. Grohall's conduct in removing the patch from the resident without a physician's order constitutes conduct below the minimum acceptable standards of practice of a registered nurse, Mr. Bergstrom testified that in his opinion such conduct is below the minimum standard. *Exhibit 7, p. 17-18.*

Finally, Nanette Guehlstorf, a certified social worker employed at Cameo Care Center since July 1999, testified at a deposition taken on February 22, 2000, that she obtained a statement from resident BB regarding the removal of the patch. She prepared the statement and the resident signed it. Ms. Guehlstorf testified that in her opinion, the conduct of removing the Duragesic patch from the back of resident BB constituted abuse of the resident based on the fact that it was intentionally removed from the resident when the resident need it for her own comfort. *Exhibit 1; Exhibit 5, p. 12-14.*

(C) <u>Hales Corners Care Center</u>

The complainant alleges in paragraph 8 of its Complaint that in November 1999, Mr. Grohall made the following medication errors:

a. On November 16, 1999, respondent placed a Duragesic patch on a resident when the resident had no complaint of pain. Respondent did not document justification for the use of the medication.

[Mr. Grohall stated in his Answer that he would never place a Duragesic patch on any resident without a doctor's authorization.]

b. On November 17, 1999, respondent signed out hydrocodone for a comatose resident.

[Mr. Grohall stated in his Answer that the resident was not comatose as because at bedtime the resident complained of pain. The resident's chart listed hydrocodone as "prn" pain medication.]

c. On November 22, 1999, respondent claimed that a Duragesic patch "fell off" a resident. Respondent placed a new Duragesic patch on the resident without appropriate documentation.

[Mr. Grohall stated in his Answer that his recollection is that the Duragesic patch was not on the resident and was no where to be found, so a new patch was given to insure the resident of optimal benefit of pain relief. This procedures was reported to the RN supervisor, who never mentioned at that time the necessity for documentation.]

d. On November 24, 1999, respondent signed out hydrocodone at 18:00 hours and at 21:00 hours for a resident, but failed to document administration of the second dose. The physician order for the patient was for "prn" every 6 hours.

[Mr. Grohall stated in his Answer that if this in fact did occur, it was probably due to his confusing standard time with military time. If, in fact, if he did administer hydrocodone to the resident, he suspect he accidentally misrepresented the time when signing the medication out.]

e. On November 24, 1999, respondent signed out propoxyphene for a resident after the medication order had been canceled and after the cancellation had been posted on the Medical Administration Record ("MAR").

[Mr. Grohall stated in his Answer that he did not recall seeing a cancellation of propoxyphene on the MAR, otherwise he would have followed the order.]

f. On November 24, 1999, respondent administered a scheduled dose of Xanax to a resident and then administered a second dose within 30 minutes.

[In his Answer, Mr. Grohall said that he did not recall this allegation, but in his defense he said that he knows

that Xanax is a tranquilizer and he knows that a second dose is usually administered several hours after the first.]

At the hearing, Mr. Grohall testified as follows [Tr. p. 52]:

> MR. GROHALL: Actually, I'll take one -- for one thing, I was never counseled regarding my medication errors at Hales Corners Care Center. I was basically thrown out in the floor with minimal supervision. As far as the controlled substances being dispensed, I usually -- in fact, always -- asked the patient if they're having pain, which is why I -- I administer medications to people, even if they are not comatose but semi- -- semi-alert. My philosophy is that nursing is a profession in which people deserve good pain control, and if patches did in fact come off of people it necessitated re -- replacement for their optimal benefit and relief, because that does happen, not on an often basis but occasionally it does. Let's see.
> As far as administering Xanax, my -- my error possibly could have occurred from confusing military time with standard time, because I'm used to standard time, and sometimes I get confused as to which is which, so if there was an error with that, that -- that's most likely why.

Doriann Schell, the Director of Nursing at Hales Corners Care Center at the time the medication errors occurred, testified at a deposition held on February 23, 2000 that medication errors were documented during the time period Mr. Grohall was employed at the Center. At the request of the Division of Enforcement, she compiled information concerning those medical administration errors in a packet. *Exhibit 8, p. 12; Exhibit 4.*

According to Ms. Schell, the Medication Administration Record ("MAR") reflects that the following medication errors occurred: **2**

(a) On November 16, 1999, and on November 17, 1999, Mr. Grohall placed a 100 -microgram Duragesic patch on a resident. There is no documentation of disposal of the patch or reason for replacement. Ms. Schell testified that good nursing procedure requires that the disposition of a Duragesic patch be documented. *Exhibit 4; Exhibit 8, p. 14, 18.*

(b) On November 17, 1999, Mr. Grohall signed out hydrocodone for a resident who was "basically comatose".

Hydrocodone had been ordered for the resident prior to her hospitalization. The resident did not require hydrocodone after her hospitalization because she did not indicate that she was in significant pain and she did not have a physician's order for it. *Exhibit 4; Exhibit 8, p. 28.*

(c) On November 23, 1999, Mr. Grohall recorded in the MAR that a Duragesic patch "fell off" a resident without documenting the disposal of the patch. Ms. Schell testified that the protocol for the disposal of a class C drug required the signature of two nurses. On November 24, 1999, and on November 25, 1999, Mr. Grohall signed out on the MAR that a Duragesic patch was placed on the resident. According to Ms. Schell, the physician's order indicated that the patch should be changed ever three days. Ms. Schell testified that since Mr. Grohall was not in the facility on November 25, 1999, the entry on the MAR was a false entry. *Exhibit 4; Exhibit 8, p. 15-17.*

(d) On November 24, 1999, Mr. Grohall signed out hydrocodone at 19:00 hours and at 21:00 hours to administer to a resident. The physician's order for the patient was for "prn" every 6 hours. There is no documentation of administration of the dose at 21:00 hours. Ms. Schell testified that Mr. Grohall's failure to document administration of the 21:00 does that he signed out for is contrary to good nursing practice. In reference to pain medication, Ms. Schell stated that Mr. Grohall failed to document the need for the drug and the effect of the drug on the patient. *Exhibit 4; Exhibit 8, p. 21-26.*

(e) On November 24, 1999, Mr. Grohall signed out propoxyphene ("Propoxy-N/Acetaminophen 100-65") for a resident after the medication order had been canceled and after the cancellation had been posted on the MAR. According to Ms. Schell, Mr. Grohall held the resident's Tylenol extra strength and administered the propoxyphene for complaints of increased leg pain. Ms. Schell said that the physician's order indicated that the propoxyphene had been ordered for back pain and that the resident had not required it since September 20, 1999 when the resident experienced an acute episode of back pain. *Exhibit 4; Exhibit 8, p. 19-21.*

2. Ms. Schell also identified several other errors; however, those errors were not alleged in the Complaint as violations.

(f) On November 24, 1999, Mr. Grohall administered a dose of Xanax to a resident and then administered a second dose within 30 minutes. According to Ms. Schell, Mr. Grohall administered a schedule dose of Xanax, 0.25 milligrams, at 2100 hours. At 2130 hours, he administered a p.r.n. dose of Xanax, .5 milligrams for complaints of increased anxiety. Ms. Schell testified that Mr. Grohall also signed out on the narcotics sign-out sheet for oxycodone at 2100 hours. He documented on the MAR that the medication was given at 2115. Ms. Schell said that after reviewing the incident, she found that the resident did have a history of having Xanax and oxycodone at the same time. She said that it is unusual to administer a second dose of Xanax within 30 minutes of the first dose, along with the oxycodone. She said that in good nursing practice that is not done. *Exhibit 4; Exhibit 8, p. 20-31; Exhibit 9, p. 10-12.*

(D) <u>Sunrise Care Center</u>

The Complainant alleges in paragraph 9 of its Complaint that on November 6, 1999, while on duty as a registered nurse at Sunrise Care Center, Milwaukee, Wisconsin, Mr. Grohall exited a washroom with blood on his uniform. A nurse immediately entered the washroom and found warm, wet syringes tinged in blood and wrapped in a paper towel. Staff noted that Mr. Grohall acted disoriented after he existed the washroom.

Mr. Grohall stated in his Answer that while employed as a registered nurse by Sunrise Care Center he often used the washroom referred to in the allegation, along with all of the other employees at Sunrise and any visitors who might be in the facility. He said that while in the washroom and before exiting the washroom on November 6, 1999, he did not dispose of any syringes. He also said that he did not have any recollection of having blood on his uniform.

At the hearing, Mr. Grohall testified as follows regarding the allegation [Tr., p. 52]:

> As far as blood on my uniform at Sunrise Care Center,
>
> I don't recall having any on my uniform, and if there
>
> was, that bathroom is a public bathroom in which there
>
> are many employees that do go in there, and they either
>
> smoke cigarettes or, you know, spend periods of time in
>
> there, so I just thought I'd like to mention that as
>
> well. That's about it.

The evidence presented does not establish that a violation occurred.

Three witnesses testified at the hearing regarding this allegation, Sharon Sass, Laura Redd and Walter Vine. Mr. Vine, the Director of Nursing at Sunrise, did not have any direct knowledge of the facts surrounding the allegation. He was not present when the incident occurred.

Ms. Sass, a registered nurse employed at Sunrise at the time of the incident, testified that on November 5, 1999, that Mr. Grohall came out of the bathroom, stood with his arms folded way up on his chest with his arms on his shoulders. She said that she noticed some blood on his uniform that looked fresh, and that was an area between one-and-a- half to three inches. She said that his speech was different than what it normally was and that it "kind of sounded a little spacy". His gait was "kind of jerky and unsteady". She also testified that she asked Mr. Grohall how he got the blood on his uniform. She said that Mr. Grohall told her that "he had done it when he did a finger stick". *Tr. p.8-12.*

Ms. Redd, a registered nurse employed at Sunrise at the time of the incident, testified that

on November 6, 1999, she observed Mr. Grohall coming out of the washroom and that his smock was "soaked in water, really wet". She went into the washroom immediately after Mr. Grohall came out of the washroom. While in the washroom, Ms. Redd noticed that there was water on the floor and what "appeared to be blood" on the floor. She said that she "trailed the blood" over to the garbage can. She looked in the garbage and saw "rolls of paper towels that was really soaked and balled up in a knot". She shook the paper towels and about three needles fell out. She said that the syringes appeared to contain medication, "red liquid, like a clear liquid, and one of them could have been like an orange liquid, like thick ... vitamins". *Tr. p. 12-19.*

As Mr. Grohall testified, other employees at Sunrise as well as the public had access to the washroom that day. There is no direct evidence, such as fingerprints, that he is the person who handled the syringes. There is also no evidence regarding what was in the syringes. The evidence only establishes that Mr. Grohall had what appeared to be blood on his uniform; that his uniform was wet; that he was in the washroom that day, and that syringes had been placed in the garbage can.

II. Discipline

The evidence presented in this case establishes that the Mr. Grohall violated s. 441.07 (1) (a), (b), (c) and (d), Stats.; s. N 7.03 (1) (a) and (b) and s. N 7.04 (1), (2), (4) and (15), Code. Having found that Mr. Grohall violated laws governing the practice of a registered nurse 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 a registered nurse or limit, suspend or revoke the license of a registered nurse if it finds that the individual has 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 Complainant argues that a loss of license in one form or another is required.

Mr. Grohall did not offer an opinion regarding this issue, except to say that he feels the field of nursing is really not his desired profession and the he is "just not cut out for it". He said that his intentions are to get into another field of work. *Tr. p. 65-66*.

The Administrative Law Judge recommends that Mr. Grohall's license to practice as a registered nurse be suspended for an indefinite period of time. This measure is designed primarily to assure protection of the public.

Based upon the evidence presented, Mr. Grohall is not capable of practicing as a registered nurse in a manner that safeguards the interests of the public. Upon receipt of a petition for a stay of the order of suspension and documentation of fitness to safely and competently resume practice as a registered nurse, it is recommended that Mr. Grohall be permitted to return to active practice subject to compliance with certain conditions as set forth in the proposed Order. The requirement that he complete educational course work in medication administration and documentation prior to being allowed to return to full licensure is designed to provide an additional measure of protection to the public.

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 25th day of May, 2000

Respectfully submitted,

Ruby Jefferson-Moore

Administrative Law Judge