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STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	FINAL DECISION
	:	AND ORDER
KRISTI MINOR, L.P.N,	:	LS0204261NUR
RESPONDENT.	:	

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 5th day of December, 2002.

Linda M. Sanner, RN

Chairperson

Board of Nursing

STATE OF WISCONSIN

BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST **PROPOSED DECISION**

LS0204261NUR

KRISTI L. MINOR, L.P.N.,

RESPONDENT.

PARTIES

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

Kristi L. Minor

2514 North View Court

Green Bay, Wisconsin 54303

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

This proceeding was commenced by the filing of a Notice of Hearing and Complaint on April 26, 2002. Ms. Minor did not file an Answer to the Compliant. A hearing was held on August 20, 2002. Atty. James W. Harris appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Ms. Minor did not appear at the hearing. The hearing transcript was filed on September 10, 2002.

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, Kristi L. Minor (d.o.b. 09/19/69) is duly licensed in the state of Wisconsin to practice as a licensed practical nurse (license #32795). Respondent's license was first granted on October 28, 1994.

2. Respondent's most recent address on file with the Department of Regulation and Licensing is 2514 North View Court, Green Bay, Wisconsin, 54303.

3. In January 2000 respondent worked as a licensed practical nurse at Woodland Health Center, Brookfield, Wisconsin. Respondent diverted 29 doses of Percocet from the medication cart at Woodland on January 17, 2000, and 15 doses of Percocet from the medication cart on January 19, 2000 for her own personal use.

4. On March 22, 2000, respondent was on duty as a licensed practical nurse at Shorehaven Care Center as an agency nurse for Top Tech. On March 22, 2000, respondent diverted a Duragesic patch from the medication cart at Shorehaven for her own personal use.

Patient EZ had a physician order for a Duragesic 50 mcg patch to be applied every three days. A patch had been applied to the patient's upper left back on March 21st. On March 22nd, respondent signed out a Duragesic 50 mcg patch for patient EZ on the MAR. The MAR documentation was "3/00-1600 given". An inspection of the patient revealed the March 21st patch in place, and no other patch applied to the patient's body. Replacement of the existing patch was not scheduled for 2 days. Respondent could not account for signing out the patch incorrectly or failing to properly document the disposition of the controlled substance.

5. On October 12, 2000, respondent was on duty as a licensed practical nurse at the Lutheran Home, Wauwatosa, Wisconsin. On October 12, 2000, respondent divert 8 Roxicet tablets from the medication cart at Lutheran Home. Respondent was responsible on her duty shift for the security of controlled substances. At the end of her shift, respondent signed off on the drug inventory. It was then determined that 8 Roxicet tablets were missing.

6. On February 28, 2001, respondent was convicted in Milwaukee County Circuit Court of knowingly violating a domestic abuse order in violation of s. 813.12 (8) (a), Stats. Respondent was placed on probation for 18 months and ordered to successfully complete "Batterer's Intervention" counseling and continued programming. Respondent was also ordered to participate in Alcohol and Drug Assessment and successfully complete recommended treatment including random urine screens, successfully complete any other counseling and/or treatment deemed appropriate and to refrain from making contact with the victim.

7. On July 19, 2001, respondent was convicted in Waukesha County Circuit Court of misdemeanor theft, in violation of s. 943.20 (1) (a), Stats. The theft, which occurred on March 22, 2000 at Shorehaven Care Center, involved the theft of a Duragesic patch from a patient. As a result of the conviction, respondent was placed on probation for a period of 18 months. Among the conditions of probation, respondent may not possess or consume drugs, unless prescribed by a physician, may not possess or consume alcohol and must engage in AODA

treatment.

8. Respondent did not file an Answer to the Complaint filed in this matter.

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 3-5 herein, respondent violated s. 441.07 (1) (b) (c) and (d), Stats., ss. N 7.03 (1) (a) and (b) and N 7.04 (2) and (15), Code.

3. By having been convicted of crimes substantially related to the practice of practical nursing, as described in Findings of Fact 6 and 7 herein, respondent violated s. 441.07 (1) (b) and (d), Stats., and s. N 7.04 (1) and (15), Code.

4. Respondent, by failing to file an Answer to the Complaint filed in this matter, is in default under s. RL 2.14, Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that the license (#32795) of Kristi L. Minor to practice 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. Minor may petition the Board at any time for a stay of the suspension of her license. In conjunction with such petition, Ms. Minor shall submit documentation of an evaluation performed by a health care provider acceptable to the Board of respondent's drug and/or alcohol dependency as well as her abstinence from the use of drugs and alcohol. The assessor shall submit a written report of his or her findings directly to the Board, including: 1) a diagnosis of Ms. Minor's condition; 2) recommendations for treatment (if any); 3) an evaluation of Ms. Minor's level of cooperation in the assessment process; 4) work restriction recommendations, and

5) the prognosis. The report shall include a certification stating that Ms. Minor is fit to safely and competently return to the active practice of nursing. The assessment shall occur within (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. Minor 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 and continuous compliance for a period of five (5) 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 licensed practical nurse.

(3) Conditions of Stay

(a) If the assessment report referred to in paragraph (1) above recommends continued treatment for drug and/or alcohol dependency, 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 her therapist; the Board may, however, in its discretion establish a minimum number of therapy sessions per month.

(b) If the assessment report referred to in paragraph (1) above recommends continued treatment for drug and/or alcohol dependency, respondent shall: 1) abstain from all personal use of drugs and/or alcohol; 2) attend Narcotics Anonymous and/or Alcoholic Anonymous meetings upon a frequency as recommended by his therapist, but not less than one meeting per week, and 3) enroll in and participate in a drug and/or alcohol monitoring program as outlined in paragraph (4) below.

(c) 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 assessor recommends work restrictions, respondent shall comply with all restrictions, as recommended.

(d) 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.

(e) 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.

(f) Within six (6) months of the date of the initial Board Order granting stay of suspension, respondent shall certify to the Board the successful completion of an approved course of education relating to the maintenance and documentation of medication administration records. Respondent shall submit course outlines for approval by a Board designee within 45 days 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.

(g) Respondent shall not practice nursing, except under the direct supervision of a registered nurse or, if approved by the Board, some other health care provider.

(h) 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) <u>Drug and Alcohol Monitoring Program</u>

Within thirty (30) days from the date of the initial Board Order granting stay of suspension, Respondent shall enroll and begin participation in a drug and alcohol monitoring program which is approved by the Department of Regulation and Licensing pursuant to Wis. Admin. Code § RL 7.11, ("Approved Program").

(a) The Department Monitor, Board or Board designee shall provide to the Respondent a list of Approved Programs; however, the Respondent is solely responsible for timely enrollment in any such Approved Program.

(b) Unless otherwise ordered by the Board, the Approved Program shall require the testing of urine specimens at a frequency of not less than 52 times each year.

(c) The Department Monitor, Board or Board designee shall determine the tests to be performed upon the urine specimens.

(d) The Respondent shall comply with all requirements for participation in drug and alcohol monitoring established by the Approved Program, including but not limited to; (1) contact with the Approved Program as directed on a daily basis, including weekends and holidays, and; (2) production of a urine specimen at a collection site designated by the Approved Program within five (5) hours of notification of a test.

(e) The Board in its discretion without a hearing and without further notice to the Respondent may modify this Order to require the submission of hair or breath specimens or that any urine or hair specimen be furnished in a directly witnessed manner.

(f) All expenses of enrollment and participation in the Approved Program shall be borne by the Respondent. The Respondent shall keep any account for such payments current in all respects.

(g) For purposes of further Board action under this Order it is rebuttably presumed that all confirmed positive test results are valid. Respondent has the burden of proof to establish by a preponderance of the evidence an error in collection, testing or other fault in the chain of custody which causes an invalid confirmed positive test result.

(5) 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.

(6) Department Monitor

The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with the terms of this Order, including receiving and coordinating all reports and petitions, and requesting additional monitoring and surveillance. The Department Monitor may be reached as follows:

Department Monitor

Department of Regulation & Licensing, Division of Enforcement

P.O. Box 8935

Madison, WI 53708-8935

FAX (608) 266-2264

TEL. (608) 267-3817

(7) 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 a representative of the Board of Nursing

signs it.

OPINION

The Division of Enforcement alleges in its Complaint amended, that Ms. Minor's conduct, as described therein, constitutes a violation of s. 441.07 (1) (b), (c) and (d), Stats., and

s. N 7.03 (1) (a) and (b) and N 7.04 (1), (2) and (15), Code.

I. Applicable Law

441.07 Revocation.

(1) The board may, after disciplinary proceedings conducted in accordance with rules promulgated under s. 440.03 (1), revoke, limit, suspend or deny renewal of a license of a registered nurse, a nurse-midwife or a licensed practical nurse, may revoke, limit, suspend or deny renewal of a certificate to prescribe drugs or devices granted under s. 441.16, or may reprimand a registered nurse, nurse-midwife or licensed practical nurse, if the board finds that the person committed any of the following:

(b) One or more violations of this chapter or any rule adopted by the board under the authority of this chapter.

(c) Acts which show the registered nurse, nurse-midwife or licensed practical nurse to be unfit or incompetent by reason of negligence, abuse of alcohol or other drugs or mental incompetency.

(d) Misconduct or unprofessional conduct.

N 7.03 Negligence, abuse of alcohol or other drugs or mental incompetency.

(1) As used in s. 441.07 (1) (c), Stats., "negligence" means a substantial departure from the standard of care ordinarily exercised by a competent licensee. "Negligence" includes but is not limited to the following conduct:

(a) Violating any of the standards of practice set forth in ch. N6.

(b) An act or omission demonstrating a failure to maintain competency in practice and methods of nursing care.

N 7.04 Misconduct or unprofessional conduct.

As used in s. 441.07 (1) (d), Stats., "misconduct or unprofessional conduct" means any practice or behavior which violates the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient or the public. "Misconduct or unprofessional conduct" includes, but is not limited to, the following:

(1) Violating, or aiding and abetting a violation of any law substantially related to the practice of professional or practical nursing. A certified copy of a judgment of conviction is prima facie evidence of a violation;

(2) Administering, supplying or obtaining any drug other than in the course of legitimate practice or as otherwise prohibited by law;

(15) Violating any rule of the board.

RL 2.14 Default.

If the respondent fails to answer as required by s. RL 2.09 or fails to appear at the hearing at the time fixed therefor, the respondent is in default and the disciplinary authority may make findings and enter an order on the basis of the complaint and other evidence. The disciplinary authority may, for good cause, relieve the respondent from the effect of such findings and permit the respondent to answer and defend at any time before the disciplinary authority enters an order or within a reasonable time thereafter.

II. Violations

A. In General

The evidence presented establishes that Ms. Minor violated numerous laws relating to the practice of a licensed practical nurse.

Section RL 2.14, Code, states that if the respondent fails to answer as required by s. RL 2.09 or fails to appear at the hearing at the time fixed therefore, the respondent is in default and the disciplinary authority may make findings and enter an order on the basis of the complaint and other evidence. The disciplinary authority may, for good cause, relieve the respondent from the effect of such findings and permit the respondent to answer and defend at any time before the disciplinary authority enters an order or within a

reasonable time thereafter.

In this case, since Ms. Minor did not file an Answer to the Complaint, she is in default under s. RL 2.14, Code. Therefore, the Administrative Law Judge recommends that the Board of Nursing make findings and enter an order on the basis of the Complaint and other evidence. Based upon the facts presented, the evidence establishes that Ms. Minor violated laws governing the practice of a licensed practical nurse, as alleged in the Complaint.

B. Evidence Presented

(1) Diversion of Drugs

(a) Woodland Health Center

Patricia Panter testified at the hearing at the request of the Division of Enforcement. Ms. Panter is a registered nurse. She graduated with an associate degree at MATC in 1980. She worked at the Milwaukee Jewish Home first as a shift nurse, then as a shift supervisor and then she worked her way up to assistant director of nursing. She worked there for seven and a half years in various capacities. Then, she transferred and became the assistant director of nursing at Clearview, which was formerly the Dodge County Health Facilities. She worked at Clearview as the assistant director of nursing for six and a half years and thereafter as the director of nursing. She was offered a position at Woodland Health Care Center, in Brookfield, Wisconsin, and was the director of nursing there for almost two years. She now works at Lakewood Health and Rehab doing the "Medicare kind of oversight" and managing the care of 60 patients on the second floor there.

According to Ms. Panter, the average census at Woodland Health Center was well over 200. They had four units, one unit had 40 beds, and the other three had 60 plus beds. The 40-bed unit had one nurse, two of the units had three nurses on the a.m. and p.m. shift, and one of the other units had two nurses. They had a nurse manager for each unit. The largest unit, 2 West, had 66 beds and because of the number of residents they almost always had three nurses on the day shift and three nurses on the p.m. shift. Also, that unit was probably a little more medical with a mix of Alzheimer's. There was a combination of patients there, but more long-term. Typically, residents on that unit required the administration of medications including controlled substances.

In reference to management of narcotic medications, Ms. Panter said that they were generally dispensed in unit dose. They were bubble packed. So each medication had a numbered slot on a card and it came with a sign-out sheet so that each dose of medication used was signed for and then it moved to the next number in the sequence. Each card, when it was delivered to the facility from the pharmacy, came with a sign-out sheet that was generally rubber banded to the pack of medications. At the beginning and end of each shift, the nurses counted the medications to make sure that all of the narcotics were accounted for and to verify that none of the medication had been diverted. *Tr. p. 18-19*.

In reference to her role as the director of nursing at Woodland, Ms. Panter testified that her job was really to oversee the medical care, manage the nurse managers, assist them, help to develop policies, deal with any state issues, teach the staff and deal with any issues that came up. She was also the liaison with the pharmacy and the lab.

In reference to her contacts with Ms. Minor, Ms. Panter testified that in her capacity as director of nursing at Woodland Health Center she became acquainted with Kristi Minor. She said that Ms. Minor was the "third" day shift nurse on 2 West in January, 2000.

Ms. Panter further testified that on January 17, 2000, they determined that a card of Percocet, with 29 doses, as well as the sign-out sheet that the nurses were using, and the copy of the sign-out sheet kept in the nurse manager's office were missing. The nurse on the p.m. shift on the 17th reported the theft. She had

actually used the first medication off the cart the night before. She recognized that the card should have been there. She had seen it the day before and it wasn't there. Ms. Panter said that when they started to put things together "it kind of looked like maybe Kristi" was responsible. Ms. Panter said that after the theft was reported all of the supervisors, the nurse managers, and the shift supervisors were at heightened awareness of where the narcotics were, making sure that the copies got into safe places.

On January 19, 2000, Ms. Minor worked the p.m., shift on "another unit". On January 20, 2000, at some point in time during the day, the p.m. supervisor informed Ms. Panter that 15 Percocet were missing on "another unit". They determined that Ms. Minor had worked the p.m. shift on that unit on January 19th. Ms. Minor initially denied having access to the medication, but later admitted that she did have the keys for just a short period of time and that she had dispensed medication to someone. *Tr. p. 23-24*.

Later during the week, Ms. Panter, and Mary Boatwright, the assistant director of nursing at that time, met with Ms. Minor. During the meeting, Ms. Minor denied taking the medications and asked if they wanted her to take a drug test. Ms. Panter testified that based upon their investigation, Ms. Minor was suspended from her nursing duties.

According to Ms. Panter, after she informed Ms. Minor that her duties were suspended, she learned that the nursing staff could not locate the keys to the narcotics storage cabinet. Ms. Minor initially denied having the keys, but later said that maybe they were in her car. She went to her car and returned with the keys. Ms. Panter said that it is not unusual and it is not unheard of for a nurse to carry the keys off in their pocket, but it is highly unusual for them to ever take those keys out of their pocket and leave them lay anywhere. Because they do have narcotic keys and a lot of very sensitive keys on them and so they generally don't leave them lay, but generally they do leave them on the unit with the nurse then when they leave.

After Ms. Minor left the facility, they did a survey of the controlled substances. They discovered that, in addition to the missing medications that they questioned Ms. Minor about, there were a number of medications that were not signed out appropriately. Ms. Panter said that, in the case of one resident, there should have been five Darvocet pills left, but only three were left. In other instances, there should have been five doses of Ativan, but only four were left; 18 doses of Darvocet, but only 17 were left and 12 doses of Tylenol No. 3, but only 11 were left. Ms. Panter said that in those four instances the medications were not signed off on the sign-out sheets and they were not signed off on the medication book. They were just not there. Ms. Panter said that Ms. Minor had control of the keys to the storage cabinet where those narcotics were kept.

Finally, Ms. Panter testified that in her professional opinion Ms. Minor's conduct in all aspects related to these issues is far below the standard of practice for a nurse.

(b) <u>Shorehaven Care Center</u>

Elizabeth Hennes testified at the request of the Division of Enforcement. Her testimony was given at a deposition held on July 30, 2002. Ms. Hennes has been employed at Shorehaven (Lutheran Homes Of Oconomowoc) since 1994. She graduated from Moraine College of Fond du Lac and has been licensed as a registered nurse since 1987. Her duties at Shorehaven include managing the care of the residents that is provided by the nursing assistants and the team leaders, any change in condition of a resident, updating families and doctors, assessing, and "doing thorough assessments on residents to be able to give the doctors a detailed description about what is going on with the resident so that the doctors can make a diagnosis over the telephone". *Exhibit 4.*

In reference to her contact with Ms. Minor, Ms. Hennes testified that Ms. Minor worked at Shorehaven as an agency or pool nurse. Ms. Hennes said that during the month of March 2000, Ms. Minor was scheduled to work on the 8, 11, 12, 15, 22, 26, and 28th. According to Ms. Hennes, during the time period that Ms. Minor worked at Shorehaven, some of the narcotic records showed that someone signed out a Duragesic transdermal patch one day after another patch was put on a patient. Ms. Hennes said that in most cases a Duragesic patch is changed

every 72 hours. S said that she reviewed the work schedule and determined the patches were signed out on the days that Ms. Minor worked. She said that they investigated "who was on what cart what days" and as a result of their investigation, Ms. Minor's name was "the only one that was a common name". *Exhibit 4, p. 8, 9, 12*.

Ms. Hennes further testified that on March 21, 2000, the narcotic record for resident Patient EZ showed that a Duragesic patch was signed out for 1600. That patch was applied to Patient EZ. On March 22, someone signed out another patch and wrote "3/00 – 16". Ms. Hennes said that the signature on the record was difficult to read. However, Ms. Minor was the only one that had a key to the medication cart that day.

Ms. Hennes further testified on March 22, 2000, sometime around 2:30 p.m., she asked Ms. Minor to come down to the director of nursing office with her. They questioned her at that time about the entry in the records. At some point in time during the meeting, Ms. Hennes obtained the key to the medication cart from Ms. Minor. Ms. Hennes checked the medication cart and found that there were only four patches left when there should have been five left. When they questioned her about the missing patch, Ms. Minor said that she could not find a patch on Patient EZ so she put a new patch on his arm. Ms. Hennes said that she then checked Patient EZ's room, in the wastebasket, the bed, the wheelchair and she crawled on the floor, but could not find a discarded patch or anything. She said that that the only patch that she found was the one on Patient EZ's back and it was dated 3/21 with the initials of the nurse that put it on. She could not find the patch that Ms. Minor said that she put on Patient EZ. Ms. Hennes said that Ms. Minor did not explain why the record reflected that the patch was signed out for 4:00 p.m., that day when their interview of her was being conducted around 2:30 p.m., that day. *Ex. 4, p. 17-20-25*.

(c) <u>Lutheran Home</u>

Margaret Skocir testified at the request of the Division of Enforcement. Her testimony was given at a deposition held on July 30, 2002. Ms. Skocir is a registered nurse. She received a bachelor's degree in nursing from Marian College in Fond du Lac and a master's degree in nursing administration from Marquette University. She is a Nurse Fellow of the Wharton School of Business and she is a licensed nursing home administrator. She has practiced as a nurse since 1968 and has worked in nursing homes since 1989. *Exhibit #3.*

On October 12, 2000, Ms. Skocir was the director or resident services at Lutheran Home in Wauwatosa, Wisconsin. She was responsible for the administration and coordination of all aspects of the nursing department, hiring of nursing staff, monitoring and maintaining a budget and performing a variety of administrative duties. Lutheran Home provided long-term care services to residents who required custodial support as well as nursing monitoring. At least in October, 2000, the facility had 313 skilled nursing beds. *Exhibit 3*.

Ms. Skocir testified that the nursing department was organized with nurse managers on the units who were responsible for the activities on the units. Unit 2 West, a 31-bed unit, was staffed with one nurse, either a LPN or a RN, during the day and during the evening shift. In addition, several nursing assistants provided direct hands-on care to the residents. When a nurse reported for duty at the beginning of a shift, he or she received a report from the nurse who worked the previous shift. Information about any significant events that may have occurred to the residents during the preceding shift was provided to the nurse reporting for duty. In addition, the "on-coming" nurse and the "off-going" nurse were required to perform a narcotic count. Keys to the medication carts and to the medication room, which permitted access to narcotics, were provided to the "on-coming" nurse. The "on-coming" nurse is responsible for passing medications based upon the medication administration records on the units.

Ms. Skocir further testified that on October 12, 2000, the respondent, Kristi Minor was assigned to work at Lutheran Home as a nurse on 2 West during the day shift. Ms. Minor was a staff agency nurse hired to fill staffing needs at the facility.

Ms. Skocir testified that on the morning of October 12, 2000, Ms. Minor provided nursing care to resident MS. Resident MS had a physician order for Roxicet, a controlled substance, to be administered as needed. Roxicet is a pain reliever and is an addictive drug. Ms. Minor administered one dose of Roxicet to resident MS on the morning of October 12, 2000. After that administration, 8 doses of Roxicet remained. Based upon the medication policy at Lutheran Home, since there were only 8 doses remaining, Ms. Minor was responsible for reordering the medication. At some point in time during the first shift, Ms. Minor submitted a reorder form for

Roxicet to Alliance Pharmacy. In general, the pharmacy delivered drugs to the facility between 6:00 and 7:00 p.m.

According to Ms. Skocir, when drugs are delivered by the pharmacy, they are delivered with a sheet of paper called a proof-of-use sheet that is wrapped around it. When a drug is removed and administered, the date, time and dosage are recorded on the "proof-of-use" form. The form also includes an inventory of the amount of drugs used, the amount remaining and the initial of the nurse making the entry. *Exhibit #3, p. 14-15.*

Ms. Skocir further testified that after Ms. Minor gave the initial administration of the Roxicet on the morning of October 12, 2000, it was determined later that day that 8 Roxicet tablets were missing, along with the "proof-of-use sheet". Ms. Skocir testified that Ms. Minor was responsible for the security and accounting for the 8 Roxicet tablets. *Exhibit 3*.

Finally, Ms. Skocir testified that in her opinion, Ms. Minor's failure to account for the accuracy of the drugs and her diversion of the 8 Roxicet tablets is conduct below the minimal standards of acceptable conduct of a nurse in Wisconsin. *Exhibit 3*, *p. 16*.

(2). Criminal Convictions

(a) Domestic Abuse

The evidence presented establishes that Ms. Minor was convicted on February 28, 2001, of knowingly violating a domestic abuse order in violation of s. 813.12 (8) (a), Stats., and that the crime substantially relate to the practice of a licensed practical nurse. Ms. Minor was placed on probation for 18 months and ordered to successfully complete "Batterer's Intervention" counseling and continued programming. Respondent was also ordered to participate in Alcohol and Drug Assessment and successfully complete recommended treatment including random urine screens, successfully complete any other counseling and/or treatment deemed appropriate and to refrain from making contact with the victim. *Exhibit 1.*

(b) Misdemeanor Theft

The evidence presented establishes that Ms. Minor was convicted on July 19, 2001, of misdemeanor theft, in violation of s. 943.20 (1) (a), Stats., and that the crime substantial relate to the practice of a licensed practical nurse. The theft, which occurred on March 22, 2000 at Shorehaven Care Center, involved the theft of a Duragesic patch from a patient. As a result of the conviction, respondent was placed on probation for a period of 18 months. Among the conditions of probation, respondent may not possess or consume drugs, unless prescribed by a physician, may not possess or consume alcohol and must engage in AODA treatment. *Exhibit 2.*

III. Discipline

The evidence presented in this case establishes that Ms. Minor violated s. 441.07 (1) (b) (c) and (d), Stats., and ss. N 7.03 (1) (a) and (b) and N 7.04 (1) (2) and (15), Code. Having found that Ms. Minor violated laws governing the practice of a licensed practical 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 licensed practical nurse or limit, suspend or revoke the license of a licensed practical 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).

In summary, the Division of Enforcement recommends that Ms. Minor's license be suspended for at 5 years, that certain conditions be satisfied, including the she be required to submit to an AODA evaluation by a specialist in addiction medicine and to follow any recommendations of that evaluator with respect to treatment.

The Administrative Law Judge recommends that Ms. Minor's license to practice as a licensed practical nurse be suspended for an indefinite period of time as set forth in the proposed Order. This measure is designed primarily to assure protection of the public and to promote Ms. Minor's rehabilitation. 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 licensed practical nurse, it is recommended that Ms. Minor be permitted to return to active practice subject to compliance with certain conditions as set forth in the proposed Order. The assessment is being recommended so that the Board will have access to more current information regard Ms. Minor's drug and/or alcohol dependency. The requirement that Ms. Minor complete appropriate education prior to being allowed to return to active practice is designed to provide an additional measure of protection to the public.

IV. Costs of the Proceeding

Section 440.22 (2), Stats., provides in relevant part as follows:

> In any disciplinary proceeding against a holder of a credential in which the department or an examining board, affiliated credentialing board or board in the department orders suspension, limitation or revocation of the credential or reprimands the holder, the department, examining board, affiliated credentialing board or board may, in addition to imposing discipline, assess all or part of the costs of the proceeding against the holder. Costs assessed under this subsection are payable to the department.

The presence of the word "may" in the statute is a clear indication that the decision whether to assess the costs of this disciplinary proceeding against the respondent is a discretionary decision on the part of the Board, and that the Board's discretion extends to the decision whether to assess the full costs or only a portion of the costs. The Administrative Law Judge's recommendation that the full costs of the proceeding be assessed is based primarily on fairness to other members of the profession.

The Department of Regulation and Licensing is a "program revenue" agency, which means that the costs of its operations are funded by the revenue received from its licensees. Moreover, licensing fees are calculated based upon costs attributable to the regulation of each of the licensed professions, and are proportionate to those costs. This budget structure means that the costs of prosecuting cases for a particular licensed profession will be borne by the licensed members of that profession. It is fundamentally unfair to impose the costs of prosecuting a few members of the profession on the vast majority of the licensees who have not engaged in misconduct. Rather, to the extent that misconduct by a licensee is found to have occurred following a full evidentiary hearing, that licensee should bear the costs of the proceeding.

This approach to the imposition of costs is supported by the practice of the Wisconsin Supreme Court, which is granted similar discretionary authority by SCR 22.24 to impose costs in attorney disciplinary hearings. The Court acknowledges the logic of imposing the cost of discipline on the offender rather than on the profession as a whole, and routinely imposes costs on disciplined respondents unless exceptional circumstances exist. In the Matter of Disciplinary Proceedings against M. Joanne Wolf, 165 Wis. 2d 1, 12, 476 N.W. 2d 878 (1991); In the Matter of Disciplinary Proceedings against Willis B. Swartwout, III, 116 Wis. 2d 380, 385, 342 N.W. 2d 406 (1984).

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 18th day of October, 2002.

Respectfully submitted,

Ruby Jefferson-Moore

Administrative Law Judge