WISCONSIN DEPARTMENT OF REGULATION & LICENSING

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
TERRY J. COTTS, R.N., RESPONDENT	:	LS0702022NUR

[Division of Enforcement Case # 02 NUR 025]

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Terry J. Cotts, R.N.
5030 South Maple Drive Road
Eau Claire, WI 54701

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

Board of Nursing
Department of Regulation & Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

This is a disciplinary action against Respondent Terry J. Cotts, R.N. A Complaint and Notice of Hearing was filed on February 2, 2007 and the same was served on the Respondent by ordinary mail. An evidentiary hearing was scheduled for June 13, 2007. The Respondent has failed to file an answer or other responsive pleading. A hearing in the above-captioned matter was held on June 13, 2007 before Administrative Law Judge Dennis C. Schuh. The Division of Enforcement appeared by Attorney Pamela Stach. Respondent Terry J. Cotts failed to appear in person or by her attorney.

The Board of Nursing reviewed the Proposed Decision and Order at its meeting on July 26, 2007, and directed counsel to amend the Order and include an Explanation of Variance. Based upon the evidence submitted at the hearing, the Board of Nursing adopts as its Final Decision and Order the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Terry J. Cotts, Respondent herein, whose date of birth is June 22, 1954, is currently licensed to practice as a registered nurse in the State of Wisconsin pursuant to license number 93046 which was first granted on March 26, 1986.

2. Respondent's last known address reported to the Department of Regulation and Licensing is S5030 Maple Dr. Rd., Eau Claire, WI 54701.

3. At all times relevant hereto, Respondent was employed as a registered nurse at the Dove Health Care, a 140 bed skilled nursing home, located in Eau Claire, Wisconsin.

4. On September 7, 2001, a 58 year old female resident was admitted to Dove Health Care with a diagnosis of

progressive multiple sclerosis.

5. On October 16, 2001, the patient was transferred to Luther Hospital where she was diagnosed with a cerebrovascular accident and urinary tract infection.

6. On October 19, 2001, the patient was transferred back to Dove Health Care.

7. On October 22, 2001, Respondent worked from 2:45 p.m. through the end of the evening shift.

8. Respondent assessed the patient between 3:45 p.m. and 4:00 p.m. on October 22, 2001.

9. According to Respondent, the patient was afebrile, stated "hi" when addressed, shook her head "no" in response to questioning whether she was in pain and the patient's eyes appeared hazy.

10. Respondent did not chart her findings on assessment of the patient.

11. Respondent did not take any vital signs of the patient during her assessment with the exception that Respondent took the temperature of the patient.

12. Respondent believed that the patient's condition declined from the start of her shift until the patient was prepared for transport at approximately 5:00 p.m. on October 22, 2001, for a previously scheduled physician's appointment.

13. Respondent did not notify the physician of the patient's declining condition.

14. The patient was transferred to the physician's office at approximately 5:00 p.m. on October 22, 2001 and immediately transferred to Luther Hospital.

15. The patient was readmitted to Luther Hospital on October 22, 2001, and died on October 27, 2001 of acute staph aureus endocarditis leading to emboli to both sides of the brain with a right sided stroke.

16. The Wisconsin Department of Regulation and Licensing has not received an answer or other responsive pleading from Terry J. Cotts.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction to act in this matter, pursuant to Wis. Stat. § 440.03 (1) and 441.07.

2. By failing to file an Answer as required by Wis. Admin. Code § RL 2.09, respondent is in default under Wis. Admin. Code § 2.14, and the facts stated in the Complaint are admitted.

3. The Respondent has received proper notice of this action from the Department of Regulation and Licensing when it mailed a copy of the Notice of Hearing and Complaint to the Respondent's last known address.

4. Respondent's conduct set out in paragraphs 10, 11 and 13 of the Findings of Fact, is a violation of Wis. Stat. § 441.07 (1) (c) and Wis. Admin. Code § 7.03 (1) (c), which subjects Respondent to discipline pursuant to Wis. Stat. § 441.07 (1) (d).

5. The conduct described in the findings of fact constitutes an agency finding within the meaning of Wis. Stats. §50.065 and §146.40.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Terry J. Cotts, R.N. is **REVOKED.**

2. The license of Terry J. Cotts, R.N. to practice nursing in the State of Wisconsin, and her privilege to practice pursuant to the Multi-State Nursing Compact, shall not be reinstated until such time as she has successfully completed the following:

(a) Respondent, at her own expense, shall complete six hours of pre-approved continuing education in nursing ethics, six hours of pre-approved continuing education in nursing documentation and six hours of pre-approved continuing education in nursing assessment. Respondent is responsible for finding an appropriate course and submitting the course information to the Board for approval prior to taking the course and in sufficient time to obtain board approval, taking into account the board's meeting schedule. Upon submission of satisfactory proof of completion of the required course, Respondent may petition for reinstatement of her nursing license.

(b) Pursuant to Uniform Nursing Licensure Compact regulations, Respondent's nursing practice shall be restricted until her license is unconditionally reinstated.

3. Respondent shall, within ninety (90) days from the date of this Order, pay the assessable costs of this proceeding. Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817
Fax (608) 266-2264

4. This Order is effective on the date of its signing.

EXPLANATION OF VARIANCE

Based upon the entire record, and the reasons set forth herein, the Board of Nursing has varied the recommendations for discipline in the Proposed Decision because it did not believe that a reprimand, continuing education and costs was a sufficient means of discipline in this case. These recommendations were weighted primarily toward a presumption of rehabilitation. While this approach has been acceptable to the Board in other cases, there is little, if any, indication in the record here that the Respondent is genuinely interested in her own rehabilitation. Instead, the Board finds it more appropriate to revoke the Respondent's license until such time as she has completed the required education to ensure the protection of the public and to promote deterrence.

Applicable Law

Wisconsin Statutes §441.07 provides in part;

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:

…

(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.

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:

…

(c) Failing to observe the conditions, signs and symptoms of a patient, record them, or report significant changes to the appropriate person;

RL 2.09 **Answer.**

(1) An answer to a complaint shall state in short and plain terms the defenses to each cause asserted and shall admit or deny the allegations upon which the complainant relies. If the respondent is without knowledge or information sufficient to form a belief as to the truth of the allegation, the respondent shall so state and this has the effect of a denial. Denials shall fairly meet the substance of the allegations denied. The respondent shall make denials as specific denials of designated allegations or paragraphs but if the respondent intends in good faith to deny only a part or a qualification of an allegation, the respondent shall specify so much of it as true and material and shall deny only the remainder.

(2) The respondent shall set forth affirmatively in the answer any matter constituting an affirmative defense.

(3) Allegations in a complaint are admitted when not denied in the answer.

(4) An answer to a complaint shall be filed within 20 days from the date of service of the complaint.

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.

The Respondent voluntarily chose not to appear at the hearing and did not present any evidence from which the Board could determine that she is willing and able to conform her conduct to the required standards of safe nursing practice. As a result of the Respondent's non-appearance and non-cooperation, there is nothing in the record from which the Board could determine that the Respondent has accepted responsibility for the wrongfulness of her acts or is remorseful for the potential harm to the patient. Rather, the evidence in the record suggests that the Respondent does not take the regulatory authority of the Board or the disciplinary process seriously. When confronted with the prospect of formal disciplinary action against her license, the Respondent failed to submit an answer to the formal complaint or to appear at the hearing, despite having received adequate notice of the proceeding. The record evidence shows that the Notice of Hearing and Complaint were mailed to the last-known address of the Respondent as indicated in the records of the department and the returned certified mail records shows that delivery was accepted and signed for by the Respondent.

The Board is unwilling to presume that the continued or future licensing of the Respondent would be compatible with the protection of the public safety, health and welfare, given her inaction and non-cooperation in the disciplinary process.

The Respondent's conduct at issue created a risk to the health, safety and welfare of her patient. The first risk created is

that the failure to record observations creates circumstances in which health care providers who subsequently come in contact with the patient are deprived of information that is important and sometimes vital to appropriate determination of health care services. The second risk is that the failure to notify the physician of noted decline in a patient deprives the patient of the possibility of prompt responsive care and treatment. Many maladies require prompt response for effective treatment and successful resolution. Delays in such treatment can create substantial risk to patients.

Furthermore, if the Board were to adopt the recommendations for a reprimand, education and costs, the Respondent would gain the same result as others who have cooperated with the Board in the disciplinary process. This would send the wrong message not only to the Respondent, but to other licensees, thereby destroying any incentive for them to cooperate with the Board or to take personal responsibility for their misconduct. It is necessary to send a strong message to deter the Respondent and others who may be tempted to ignore or avoid the disciplinary process from engaging in similar conduct.

STATE OF WISCONSIN
BOARD OF NURSING

Marilyn Kaufmann, RN, PhD 8/30/07
Chair

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