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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	FINAL DECISION
	:	AND ORDER
DONNA JEAN FROEMMING, L.P.N.,	:	LS0702082NUR
RESPONDENT.	:	

Division of Enforcement Case No. 04NUR023

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 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 19th day of April, 2007.

Marilyn Kaufmann
Member of the Board
Board of Nursing

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST DONNA JEAN FROEMMING, L.P.N., RESPONDENT.

Case No. LS-0702082-NUR

PROPOSED FINAL DECISION AND ORDER

[Division of Enforcement Case No. 04 NUR 023]

PARTIES

The parties in this matter for purposes of Wis. Stat. § 227.53 are:

Complainant:
Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Ave.
Madison, WI 53708-8935

Respondent:
Donna Jean Froemming L.P.N.
430 First Street
Delavan, WI 53115

Disciplinary Authority:
Board of Nursing
1400 East Washington Ave.
Madison, WI 53703

PROCEDURAL HISTORY

This is a disciplinary action against Respondent Donna Jean Froemming, L.P.N. A Complaint and Notice of Hearing was filed on February 8, 2007 and was served on the Respondent by ordinary mail. An evidentiary hearing was scheduled for March 20, 2007. The Respondent has failed to file an answer or other responsive pleading. An evidentiary hearing was held on March 20, 2007 before Administrative Law Judge Dennis C. Schuh. The Division of Enforcement appeared by Attorney Sandra L. Nowack. The respondent failed to appear.

FINDINGS OF FACT

1. Donna Jean Froemming, L.P.N., Respondent, date of birth December 5, 1951, is licensed by the Wisconsin Board of Nursing as a licensed practical nurse in the state of Wisconsin pursuant to license number 12441, which was first granted May 25, 1972.

2. Respondent's address of record with the Department of Regulation and Licensing is 430 First Street, Delavan, WI 53115.

3. At the time of the events relevant to this proceeding, Respondent was practicing as a licensed practical nurse at Williams Bay Care Center in Williams Bay, Wisconsin.

4. On January 15, 2004, at approximately 4:10 a.m., staff at Williams Bay Care Center found Patient HC (DOB 08/26/1906) on the floor after Patient HC apparently fell from her bed. Patient HC incurred bruises on her right elbow and on her right knee. CNA Wendy Knight reported the incident to Respondent. Respondent told Knight to put Patient HC back in her bed.

5. On January 19, 2004, Respondent failed to report for work as scheduled, claiming she was ill. On that date, Kathy Smith, RN, Director of Nursing at Williams Bay Care Center, and Lucy Knull, Nursing Home Administrator, interviewed Respondent by telephone. Respondent admitted that on January 15, 2004, she failed to assess Patient HC after her fall. Respondent later explained that she "forgot" to do the assessment.

6. Williams Bay Care Center's written policy concerning patient falls required nurses to complete a fall assessment, to document the results of the assessment and to indicate whenever an assessment occurred more than 15 minutes after the patient fell.

7. On January 16, 2004, Patient HC was ill and vomited twice. During midnight rounds, staff observed that Patient HC's ear was bleeding. Staff reported Patient HC's condition to Respondent who checked Patient HC at approximately midnight.

8. Patient HC vomited again at 2:30 a.m. and at 3:30 a.m. Each time staff went to report the events to Respondent; they found Respondent in a chair in the television room, apparently sleeping. Respondent did not check on Patient HC after the 2:30 a.m. and 3:30 a.m. episodes.

9. Respondent's notes concerning Patient HC for the early hours of January 16, 2004 indicate that Patient HC vomited twice "early shift," as opposed to the four times observed and reported by CNA staff.

10. On January 19, 2004, Respondent admitted to Smith and Knull that on January 16, 2004, between 2:30 a.m. and 4:00 a.m., she sat in a chair in the television room. Respondent explained that she had a migraine, but denied she was asleep. Respondent was the only nurse on duty at the time.

11. On January 16, 2004, Respondent made an entry in the facility's narcotic log, indicating that at 6:00 a.m., she had removed 40 mg of OxyContin for Patient MW. Respondent made a notation indicating "error" but did not explain what was meant by the notation. Patient MW was to receive OxyContin at 8:00 a.m., and at 4:00 p.m.; there was no dose scheduled for 6:00 a.m. OxyContin is a schedule II controlled substance containing oxycodone.

12. During the January 19, 2004 telephone interview with Smith and Knull, Respondent explained that she discovered she had removed medication for the wrong patient and then, without a witness, threw the OxyContin down a sink.

13. Williams Bay Care Center's written policy concerning wasted controlled substances required documentation within the narcotic record that the substance was "wasted." The destruction of the substance was required to be witnessed by two nurses and the destruction was also to have been documented by two nurses.

14. Wisconsin Admin. Code § HFS 132.65(6)(c)2., concerning destruction of medications, requires that "a record of destruction shall be witnessed, signed and dated by 2 or more personnel licensed or registered in the health field."

15. Patient KP was prescribed a daily nitroglycerin patch to be applied in the morning and removed at bedtime. On January 16, 2004, staff at Williams Bay Care Center found three nitroglycerin patches on Patient KP's body.

16. During the January 19, 2004 telephone interview with Smith and Knull, Respondent admitted that on January 15 & 16, 2004, she neglected to remove Patient KP's nitroglycerin patches as ordered.

17. Documents mailed by the Department of Regulation and Licensing on September 24, 2004 and May 12, 2005 to Respondent at her address of record, 430 First Street, Delavan, Wisconsin, were returned unclaimed. On July 26, 2005, the postmaster in Delavan, Wisconsin indicated that Respondent lived at the address of record but Respondent "doesn't pick up her mail. It goes back unclaimed."

18. On November 13, 2006, the postmaster in Palmyra, Wisconsin informed Consumer Protection Investigator Linda Nicholls that Respondent receives mail at W1310 S. Shore Drive, Palmyra, WI 53156.

19. On September 21, 2006, Investigator Nicholls mailed a certified letter to Respondent at W1310 S. Shore Drive, Palmyra, WI 53156. Records of the United States Postal Service indicate that the letter was delivered on October 2, 2006. A second certified letter, mailed on October 12, 2006, was returned unclaimed.

20. On November 7, 2006, Investigator Nicholls spoke with George Holzbauer of Palmyra, Wisconsin, who

confirmed that he owned the property located at W1310 S. Shore Drive, Palmyra, Wisconsin, and that he is Respondent's landlord.

21. Respondent has not notified the Department of Regulation and Licensing that her address is any other than 430 First Street, Delavan, Wisconsin.

22. Wisconsin Stat. § 440.11(1) requires licensees, including nurses, who have moved to notify the Department of Regulation and Licensing of their new address within thirty days.

CONCLUSIONS OF LAW

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

2. By failing to file an Answer as required by Wis. Admin. Code § RL 2.09, and by failing to appear at the hearing Respondent is in default under Wis. Admin. Code § RL 2.14, and the Board of Nursing may make findings and enter an orde on the basis of the Complaint and the evidence presented at the hearing.

3. Respondent, by engaging in the conduct as set out in paragraphs 4-6, above, has engaged in conduct which fails to constitute basic nursing care, and which tends to constitute a danger to the health, welfare, or safety of a patient, which is unprofessional conduct as defined by Wis. Admin. Code §§ N 6.04(1) (b) and 7.04(intro). Respondent is therefore subject to discipline pursuant to Wis. Stat. § 441.07(1) (d).

4. Respondent, by engaging in the conduct as set out in paragraphs 7-10, above, has engaged in conduct which fails to constitute basic nursing care, and which tends to constitute a danger to the health, welfare, or safety of a patient, which is unprofessional conduct as defined by Wis. Admin. Code §§ N 6.04(1) (b) and 7.04(intro). Respondent is therefore subject to discipline pursuant to Wis. Stat. § 441.07(1) (d).

5. Respondent, by engaging in the conduct as set out in paragraphs 11-14, above, has engaged in conduct whicl constitutes a violation of a law substantially related to the practice of nursing, which is unprofessional conduct as defined b Wis. Admin. Code § N 7.04(1). Respondent is therefore subject to discipline pursuant to Wis. Stat. § 441.07(1) (d).

6. Respondent, by engaging in the conduct as set out in paragraphs 15-16, above, has engaged in conduct whicl fails to constitute basic nursing care, and which tends to constitute a danger to the health, welfare, or safety of a patient, which i unprofessional conduct as defined by Wis. Admin. Code §§ N 6.04(1) (b) and 7.04(intro). Respondent is therefore subject t discipline pursuant to Wis. Stat. § 441.07(1) (d).

7. Respondent, by engaging in the conduct as set out in paragraphs 2, and 17-20, has failed, within thirty days, t notify the Department of Regulation and Licensing of a change of mailing address, which is in violation of Wis. Stat. § 440.11(1), which is a law substantially related to the practice of nursing. Respondent is therefore subject to a forfeiture pursuan to Wis. Stat. § 440.11(3), and discipline pursuant to Wis. Admin. Code § N 7.04(1).

8. The Findings of Fact set forth above constitute an agency finding within the meaning of sections 48.685 (4m) and 50.065 Wis. Stats.

ORDER

THEREFORE, IT IS ORDERED that effective on the date of this Order, the license of Respondent Donna Jean Froemming to practice as a Licensed Practical Nurse in the State of Wisconsin is **REVOKED.**

IT IS FURTHER ORDERED that Respondent Donna Jean Froemming pay the costs of this proceeding, as authorized b sec. 440.22 (2), Stats., and sec. RL 2.18, Wis. Admin. Code. Payment shall be made payable to the Wisconsin Department o 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

IT IS FURTHER ORDERED that this Order is effective on the date of its signing.

OPINION

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: (d) Misconduct or unprofessional conduct.

440.11 **Change of name or address.**

(1) An applicant for or recipient of a credential who changes his or her name or moves from the last address provided to the department shall notify the department of his or her new name or address within 30 days of the change in writing or in accordance with other notification procedures approved by the department.

(2) The department or any examining board, affiliated credentialing board or board in the department may serve any process, notice or demand on the holder of any credential by mailing it to the last-known address of the holder as indicated in the records of the department, examining board, affiliated credentialing board or board.

(3) Any person who fails to comply with sub. (1) shall be subject to a forfeiture of $50.

N 6.04 **Standards of practice for licensed practical nurses.**

(1) PERFORMANCE OF ACTS IN BASIC PATIENT SITUATIONS. In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a physician, podiatrist, dentist or optometrist:

…

(b) provide basic 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;

The Notice of Hearing and Complaint in this matter were served by mail upon the respondent on February 8, 2007. The respondent failed to respond. No answer or other responsive pleading was received.

On March 20, 2007, complainant made a Motion for Default at the hearing scheduled in this matter. Testimony and evidence supporting the motion was presented.

Section RL 2.14 of the Wisconsin Administrative Code provides that a respondent who fails to answer a complaint or fails to appear at a hearing is in default. If found to be in default, the disciplinary authority may make findings and enter an order based on the complaint and other evidence against the respondent. In this case, the respondent did not file an answer to the above-captioned complaint nor did she appear at the scheduled hearing.

Section RL 2.09(3) of the Wisconsin Administrative Code provides that allegations in a complaint are admitted when not denied in an answer. Therefore, the Board of Nursing can deem the allegations of the complaint against the respondent as admitted based upon the failure to answer.

The complainant introduced evidence showing 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 at another address believed to be occupied by the respondent. (Exhibit #1) The complainant introduced as Exhibit #3 and #4, the returned certified mail records showing that delivery was refused or unable to be completed.

The complainant requested a default be granted, that the respondent's license to practice nursing be revoked and imposition of costs. The complainant's motion for default is granted and the relief requested is granted.

Revocation of the respondent's license has been recommended. It is well established that the objectives of professional discipline include the following: (1) to promote the rehabilitation of the licensee; (2) to protect the public; and (3) to deter other licensees from engaging in similar conduct. *State v. Aldrich*, 71 Wis. 2d 206, 209 (1976). Punishment of the licensee is not an appropriate consideration. *State v. McIntyre*. 41 Wis. 2d 481, 485 (1969).

The state's purpose in licensing professionals is to protect its citizens. *Strigenz,* 103 Wis.2d at 286, 307 N.W.2d at 667. License revocation is the ultimate means of protecting the public short of fining or imprisonment. *Strigenz v. Department of Regulation and Licensing*, 103 Wis.2d 281, 287, 307 N.W.2d 664 (1981)

The practice of professional nursing involves a unique combination of duties and patient trust. The allegations proven in this case establish that the respondent violated both her duties and the trust of her patients. Protection of the public requires that those who engage in the nursing profession behave in a manner consistent with that vocation.

There is nothing in the record to suggest that imposing any discipline short of revocation would have a rehabilitative effect on the respondent or that she is even interested in being rehabilitated. The conduct proven demonstrates an indifference to the health, safety and welfare of patients and the public. The failure of the respondent to answer or otherwise participate in this proceeding indicates that least severe avenues that rely upon the participation and cooperation of the respondent will not be useful. Considering her lack of cooperation thus far as an indication of future action, it is unlikely that the respondent will actively engage in other rehabilitative options.

Imposing any discipline less severe than revocation would also wrongly signal others to engage in similar conduct without consequence, thus not constituting proper deterrence. Revocation will therefore act to safeguard the public and deter such conduct by other practitioners.

<u>Costs</u>

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 of Nursing, and that the board's discretion extends to the decision whether to assess the full costs or only a portion of the costs.

The ALJ's recommendation that the full costs of the proceeding be assessed is based on two factors. First, 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 an evidentiary or default hearing, that licensee should bear the costs of the proceeding.

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".

Dated this ____ day of March, 2007

Respectfully Submitted

____

Dennis C. Schuh

Administrative Law Judge