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Before The
State Of Wisconsin
Board of Nursing

In the Matter of the Disciplinary Proceedings
Against **CHERYL J. HALVERSON, R.N.,**
Respondent

FINAL DECISION AND ORDER
Order 0000030

Division of Enforcement Case No. 09 NUR 149

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, make 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 at Madison, Wisconsin on 1-27-11.

Member
Board of Nursing

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Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings
Against **CHERYL J. HALVERSON, R.N.**,
Respondent

PROPOSED DECISION AND ORDER

DHA Case No. DRL-10-0039

Division of Enforcement Case No. 09 NUR 149

The parties to this proceeding for purposes of Wis. Stat §§ 227.47(1) and 227.53 are:

Cheryl J. Halverson, R.N.
E9642 Lyster Road
Readstown, Wisconsin 54652

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

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

PROCEDURAL HISTORY

The Department of Regulation and Licensing, Division of Enforcement (the "Division") filed a formal Complaint against Respondent Cheryl J. Halverson, R.N. on or about June 9, 2010, alleging that: (1) while formerly licensed as a Nursing Home Administrator at the Tomah Healthcare Center in 2006, Respondent Halverson falsified documents claiming that fire drills had been conducted, when they had not in fact occurred, in violation of Wis. Admin. Code §§ N 7.03(1) and 7.04(1); (2) Respondent Halverson continued to work as a nurse in DHS-licensed nursing homes without first passing a Rehabilitation Review, even though she had entered into a stipulation with respect to the above allegation surrendering her Nursing Home Administrator License, which provided that "should [she] wish to work in a Wisconsin DHFS-licensed facility, she [would] need to pass a Rehabilitation Review through DHFS prior to the commencement of such employment," in violation of Wis. Admin. Code § N 7.07(1), and implicating that (3) Respondent Halverson had stolen narcotics from her employer, (Sannes Skogdalen Heim), as she

had (a) tested positive for Darvocet, (Schedule II narcotic), after another nurse that worked at Sannes Skogdalen Heim noted that three of a resident's morphine tablets, (Schedule III narcotic), had been replaced by Proscar pills, (b) worked at another nursing home at which there was both missing Proscar pills and other narcotics during this same time period, and (c) been prescribed narcotics for pain, of which there were treatment notes that documented concern over her usage during this same time period, including a note that indicated that she was warned that any additional episodes of lost or misplaced medication would result in her physician refusing to continue to prescribe narcotics.

On or about June 30, 2009, Respondent Halverson filed an Answer asserting that she had no basis for admitting or denying any of the Division's allegations against her at that time.

A Prehearing Conference was held by telephone on July 20, 2010, and then again on August 5, 2010, Amanda Tollefsen, administrative law judge, presiding. At the second of these conferences, Respondent Halverson indicated that she intended to deny all allegations against her, and that she therefore did not wish to enter into any stipulation.

A contested case hearing was thereafter set for November 9, 2010, at the Department of Regulation and Licensing.

FINDINGS OF FACT

On the evidence presented, the undersigned ALJ makes the following findings of fact:

1. Cheryl J. Halverson, R.N., Respondent, date of birth May 26, 1970, is licensed by the Wisconsin Board of Nursing as a registered nurse in the State of Wisconsin pursuant to license number 126685. This license was granted on July 11, 1997.

2. Respondent Halverson's address of record with the Department of Regulation and Licensing is 9570 Lyster Road, Readstown, WI, 54652.

3. Respondent Halverson was formerly licensed as a Nursing Home Administrator. On August 7, 2008, the Nursing Home Administrator Examining Board issued an order accepting the surrender of Respondent Halverson's license as a nursing home administrator, pursuant to allegations that she sent documents to DHFS claiming that fire drills had been conducted, when they had not in fact occurred. (DOE Exhibit 1A[1]).

4. The stipulation for the surrender of Respondent Halverson's license as a nursing home administrator contained the following provision:

[1] DOE Exhibit 1A includes a copy of the signed stipulation from Respondent Halverson. DOE Exhibit 1, presented at hearing, included an unsigned copy of the stipulation.

Respondent is further informed that should the Board adopt this Stipulation, the Board's Final Decision and Order would constitute an agency finding within the meaning of Wis. Stats. §§ 48.685 and 50.065[2]. Should Respondent wish to work in a Wisconsin DHFS-licensed facility, she will need to pass a Rehabilitation Review through DHFS prior to commencement of such employment.

(DOE Exhibit 1A) (emphasis added).

5. Despite signing this stipulation, Respondent Halverson did not contact DHFS (now DHS) and did not pass a Rehabilitation Review.[3] Tr. p. 39, ll. 10-12, *see also* DOE Exhibit 2, Affidavit of Patricia Lynch). She continued to work as a nurse in nursing homes, which are DHS-licensed facilities, until May of 2009, and has continued to work as a nurse for Star One Staffing and Focus Corp.,[4] even after being informed by Attorney Lytle that the above-referenced stipulation applied to her nursing license as well as her nursing administrator license. (Tr. p. 35, ll. 5-21; p. 34, ll. 12-20, pp. 40-41).

6. On or about May 8, 2009, another nurse working with Respondent Halverson at Sannes Skogdalen Heim noted that a resident's medication card of morphine sulfate 15 mg tablets, (Schedule III narcotic), had been tampered with. (Tr. pp. 70-71; *see also* DOE Exhibit 3). Inspection of the medication card revealed that at least four[5] of the morphine sulfate tablets had been punched out and replaced with Proscar, a mediation used for the treatment of an enlarged prostate, and that the card had been taped over to disguise that tablets had been taken, making it difficult to manipulate. (Tr. pp. 70-71, pp. 83-84; *see also* DOE Exhibits 3, Caregiver Misconduct Insert Reprt, and 4). The nurse who detected this recalled that the medication card for the same resident from previous night had also been difficult to work with. (Tr. p. 70, ll. 21-23).

7. Proscar looks very similar to morphine sulfate tablets, except that the writing or numbers on the Proscar tablets are different from the writing or numbers on the morphine sulfate tablets. (Tr. pp. 74, ll. 1-6). It was not prescribed to any resident at Sannes Skogdalen Heim. (Tr. p. 71, ll. 16-18).

8. As part of the investigation of the missing morphine sulfate tablets, three nurses, including Respondent Halverson, were asked to take drug tests on May 8, 2009. (Tr. p. 72., ll. 2-15). These three nurses were all new employees – no one else was tested at this point because Sannes Skogdalen Heim had no prior incidents of narcotics diversion, and, with the exception of the three nurses tested, its licensed staff had all worked there for a very long time. (*Id.*).

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[2] Wis. Stat. § 50.655 is commonly referred to as the "caregiver law." It prohibits individuals who have been found to have abused, neglected, or misappropriated patient property from working in any facility licensed by the Department of Health Services (DHS) unless and until they have demonstrated successful rehabilitation. *See id.* at (4m)-(5). *See also* Transcript, pages 21-22, 38, 68-69, 114.

[3] Respondent Halverson did not initially believe the stipulation applied to her nursing license. (Tr. pp. 35-43).

[4] It is unclear whether these are DHS facilities.

[5] Two of the morphine tablets had already been distributed. (*See* DOE Exhibit 4, Medication Card of patient R.O.).

9. The other two nurses' drug tests were negative. (Tr. p. 72, ll. 21-23). Respondent Halverson's drug test was positive for Proxyphene (Darvocet), a schedule II narcotic. (Tr. pp. 54-55; DOE Exhibit 5). She did not have a prescription to explain the positive test results.[6]

10. Respondent Halverson was further interviewed as a part of Sannes Skogdalen Heim's investigation. Though she denied any involvement with respect to the missing morphine, she demonstrated very poor eye contact throughout her interview. (Tr. P. 75, ll. 13-19).

11. Upon testing positive for Darvocet, Respondent Halverson was terminated from Sannes Skogdalen Heim. (Tr. p. 73, ll. 9-12).

12. Since Respondent Halverson's termination, there have been no further instances of missing narcotics. (Tr. p. 73, ll. 13-15). Additionally, there was no problem of missing narcotics before she commenced her employment. (Tr. pp. 69-70, 72).

13. Respondent Halverson also worked at another nursing home (Schmitt Woodland Hills), at the time that the morphine tablets went missing from Sannes Skogdalen Heim, as a fill-in employee. (Tr. p. 33, ll. 12). Upon a phone call from Sannes Skogdalen Heim, informing them of the above situation, Schmitt Woodland Hills conducted a check and noted that three Proscar pills had been punched out from three different resident's medication cards. (Tr. pp. 74-75, 76, 93, 96). Respondent Halverson was the only employee of Sannes Skogdalen who worked at another facility.[7]

14. No formal investigation was conducted with respect to the missing Proscar, (Tr. p. 98, ll. 20), and it was never determined who was responsible for its diversion. (Tr. p. 93, ll. 20-22; p. 98, ll. 16-20).

15. Schmitt Woodland Hills was also missing narcotic medications during the time that Respondent Halverson worked there. Specifically, in March of 2009, there were two instances where the pharmacy that provided Schmitt Woodland Hill's medications (Pinnacle Pharmacy) notified the nursing home that medications, (including oxycodone and morphine, but not Darvocet), had been missing from the "contingency box."[8] (Tr., p. 92, ll. 16-22). No investigation was conducted (Tr. p. 97, ll. 6-23).

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[6] Respondent Halverson testified that she must have accidentally taken her daughter's pills, which sat next to hers in a locked medicine cabinet, as she was prescribed a stronger pain medication (hydrocodone), and thus had no need to take Darvocet, which she claimed made her pain worse. (Tr. pp. 55-57).

[7] The investigation into the missing morphine tablets at Sannes Skogdalen Heim apparently concluded upon this information. No further nurses were tested or interviewed.

[8] Schmitt Woodland Hills experienced a similar problem in January of 2009, however, an investigation was conducted, and Pinnacle Pharmacy terminated one of its employees in relation to the missing medications. (Tr., p. 92, ll. 9-15).

16. No medications have gone missing since Respondent Halverson stopped working at Schmitt Woodland Hills. (Tr. pp. 92-93). 2009 was the only time period in which Schmitt Woodland Hills had problems with missing narcotics. (Tr. pp. 91-93).

17. Respondent Halverson has chronic pain. (Tr. p. 43, ll. 23-24).

18. Respondent Halverson was prescribed narcotics at the time the morphine tablets went missing from Sannes Skogdalen Heim, including hydrocodone and OxyContin, for pain. (DOE Exhibit 7, p. 25; *see also* Tr. p. 44). Her treatment records document requests for early refills and one instance of lost medication. (DOE Exhibit 7). Specifically, an April 14, 2009 entry indicates that Respondent Halverson was warned that any additional episodes of lost or misplaced medication would result in the physician refusing to continue to prescribe narcotics. (DOE Exhibit 7, p. 26; *see also* Tr. pp. 53-54).

19. Respondent Halverson's treating physician (Dr. Duane Koons) testified,[9] that the reason for Respondent Halverson's' early refills, etc, was that they were trying to get her symptoms under control and the medication regimen at that time was not achieving that, and that he had no concerns that she was overusing or misusing any of her medications. (Tr., pp. 102, ll. 8-14).

20. Respondent Halverson demonstrated good job performance throughout the relevant time period. (Tr. p. 90, ll. 7-11; p. 94, ll. 5-11).

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. §§ 441.07 and 441.50(3)(b).

2. The burden of proof in disciplinary proceedings before the department or any examining board, affiliated credentialing board or board in the department is a preponderance of the evidence. Wis. Stat. § 440.20(3). *See also*, Wis. Admin. Code HA 1.17(2), ("[u]nless the law provides for a different standard, the quantum of evidence for a hearing decision shall be by the preponderance of the evidence.").

3. "Preponderance of the evidence" is defined as the greater weight of the credible evidence. Wis. Admin. Code § HA 1.01(9). Stated otherwise, is it more likely than not that the alleged events occurred.

[9] DOE prosecutor Jeanette Lytle objected to testimony by this witness at hearing, as Respondent Halverson did not identify him as a witness on a witness list, and she did not have the opportunity to depose him. (*See* Tr. p. 101). Because Attorney Lytle identified Dr. Koons as a witness on the Division's witness list, the undersigned administrative law judge has allowed his testimony.

4. Pursuant to Wis. Stat. § 441.07(1)(c), the Board of Nursing has authority to "revoke, limit, suspend or deny renewal of a license of a registered nurse...or may reprimand a registered nurse...," if the board finds that the registered nurse has engaged in "acts which show the registered nurse... to be unfit or incompetent by reason of negligence...."

5. Pursuant to Wis. Stat. § 441.07(1)(d), the Board of Nursing further has authority to "revoke, limit, suspend or deny renewal of a license of a registered nurse...or may reprimand a registered nurse...," if the board finds that the registered nurse committed misconduct or unprofessional conduct.

6. Wis. Admin. Code § N 7.03(1) defines "negligence" as "a substantial departure from the standard of care ordinarily exercised by a competent licensee."

7. Wis. Admin. Code § N 7.04(1) defines "misconduct or unprofessional conduct" to include "[v]iolating, or aiding and abetting a violation of any law substantially related to the practice of professional or practical nursing."

8. Wis. Admin. Code § N 7.04(14) further defines "misconduct or unprofessional conduct to include "[v]iolating any term, provision or condition of any order of the board."

9. Wis. Admin. Code § N 7.04(2) further defines "misconduct or unprofessional conduct to include "[a]dministering, supplying or obtaining any drug other than in the course of legitimate practice or as otherwise prohibited by law."

10. The conduct described in paragraph 3 of the Findings of Fact, above, constitutes a violation of Wis. Admin. Code §§ N 7.03(1) and 7.04(1), and thereby subjects Respondent Halverson to discipline pursuant to Wis. Stat. §§ 441.07(1)(c) and (d).

11. The conduct described in paragraphs 4-5 of the Findings of Fact, above, constitutes a violation of Wis. Admin. Code § N 7.04(14), and thereby subjects Respondent Halverson to discipline pursuant to Wis. Stat. § 441.07(1)(d).

12. The conduct described in paragraph 9 of the Findings of Fact, constitutes a violation of Wis. Admin. Code § N 7.04(2), and thereby subjects Respondent Halverson to discipline pursuant to Wis. Stat. § 441.07(1)(d).

13. The Division has proven, by the greater weight of the evidence described in ¶¶ 6-20 of the Findings of Fact, that Respondent Halverson diverted morphine from Sannes Skogdalen Heim, in violation of Wis. Admin. Code § N 7.04(2), thereby subjecting her to discipline pursuant to Wis. Stat. § 441.07(1)(d).

DISCUSSION

Violations of Statutes and Administrative Code:

The burden of proof in this case was on the Division. This means that the Division had to prove, by the greater weight of the credible evidence, that Respondent Halverson: (1) while formerly employed as a nursing home administrator at the Tomah Healthcare Center in 2006, "falsified documents" claiming that fire drills had been conducted in the previous calendar year, when they had not in fact occurred; (2) continued to work as a nurse in DHS-licensed nursing homes without first passing a Rehabilitation Review, even though she had entered into a stipulation with respect to the previous allegation that required that she do so; (3) tested positive for a narcotic (Darvocet) not prescribed to her while employed at Sannes Skogdalen Heim in May of 2009; and (4) diverted morphine from Sannes Skogdalen Heim while employed there in May of 2009.

Falsification of Documents and Non-compliance with Rehabilitation Review:

Despite alleging that Respondent Halverson "falsified documents" claiming that fire drills had been conducted at the Tomah Healthcare Center, when they in fact had not occurred, the Division presented no evidence to confirm this allegation at hearing. The only testimony on this point came in Respondent Halverson's opening statement, in which she stated that she "didn't personally falsify anything." (Tr. p. 27, ll. 5-6). Additionally, DOE Exhibit 1A (Final Decision and Order in DOE Case # 07 NHA 003), to which the Division pointed to in support of its allegation that Respondent Halverson falsified documents (*See* Tr. p. 119-120), asserts only that Respondent Halverson faxed documentation to DHFS identifying that four fire drills had been conducted, when further investigation revealed that these fire drills never occurred, and includes no accusations of any forgery on the part of the respondent. (*See* DOE Exhibit 1A).

Regardless of whether the respondent falsified any documents, the undersigned administrative law judge is convinced there was at least some negligence on Respondent Halverson's part in connection with the fire drills that did not occur – as she was the administrator of the nursing home at the time.[10] More importantly, Respondent Halverson signed a stipulation admitting wrongdoing, surrendering her nursing home administrator license *and agreeing that if she "wish[ed] to work in a Wisconsin DHS-licensed facility, she [would] need to pass a Rehabilitation Review through DHFS prior to commencement of such employment."* (DOE Exhibit 1A, Final Decision and Order in DOE Case # 07 NHA 003 and attached stipulation) (emphasis added). Respondent Halverson's claim that she did not understand that this stipulation applied to her nursing license, in addition to her nursing home

[10] The undersigned administrative law judge finds Respondent Halverson's testimony that she "never saw these fire drill documents," and has "no idea what they are," (Tr. P. 27, ll. 3-5), totally incredulous in light of the stipulation she signed. (*See* DOE Exhibit 1A).

administrator license, is unavailing. Even if true, it was her burden to understand the terms, and effect, of the stipulation she was signing.

In light of the above, the undersigned administrative law judge finds that Respondent Halverson engaged in acts which show her to be incompetent by reason of negligence, subjecting her to discipline under Wis. Stat. § 441.07(1)(c). She further finds that the respondent violated the terms of her stipulation, (accepted as the Board's Final Decision and Order in DOE case # 07 NHA 003), which mandated that before Respondent Halverson could work in any DHFS (DHS) facility, she had pass a Rehabilitation Review. Though the undersigned administrative law judge is hard pressed to see how this violates Wis. Admin. Code § 7.04(1), which pertains to violation of any law substantially related to the practice of professional nursing, it is clear that Respondent Halverson's conduct violated a term, provision or condition of a Board order, in violation of Wis. Admin. Code § 7.04(14), and subjecting her to discipline pursuant to Wis. Stat. § 441.07(1)(c).

Non-prescribed Narcotic (Darvocet):

It is undisputed that Respondent Halverson tested positive for Darvocet, a Schedule II narcotic, in an urinanalysis conducted on May 8, 2009. Such conduct clearly violates Wis. Admin. Code § N 7.04(1)(d), which defines "misconduct or unprofessional conduct" to include "[a]dministering, supplying or *obtaining* any drug other than in the course of legitimate practice or as otherwise prohibited by law." *Id.* (emphasis added). Respondent Halverson is thus subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

Diversion of Morphine:

This was a somewhat difficult determination for the undersigned administrative law judge to make, as there is credible evidence in the record that both suggests that Respondent Halverson diverted morphine tablets from Sannes Skogdalen Heim, and replaced them with Darvocet tablets, and contradicts this finding as well.

Evidence in the record that supports that Respondent Halverson diverted the morphine tablets include the facts that: (1) the morphine tablets that were diverted from Sannes Skogdalen Heim had been replaced with Proscar tablets; (2) Proscar was not prescribed to any resident at Sannes Skogdalen Heim; (3) Respondent Halverson worked at another nursing home (Schmitt Woodland Hills) at the time the morphine tablets were diverted from Sannes Skogdalen Heim, where Proscar was prescribed to at least three residents; (4) Respondent Halverson was the only employee at Sannes Skogdalen Heim to work at another facility; (5) after being informed that morphine tablets had been diverted from Sannes Skogdalen Heim, and replaced with Proscar tablets, Schmitt Woodland Hills conducted a check and found that at least three Proscar tablets had been punched out of three different resident's medication cards early; (6) Schmitt Woodland Hills was also missing other narcotic medications during the time Respondent Halverson worked there (specifically, in March 2009); (7) Schmitt Woodland Hills has not had any problems with missing narcotics since Respondent Halverson stopped working there in May 2009; (8) Sannes

Skogdalen Heim has not had any problems with missing narcotics since Respondent Halverson stopped working there in May 2009; (9) neither facility had problems with missing narcotics before Respondent Halverson worked for them; (10) Respondent Halverson tested positive for Darvocet, a schedule II narcotic she did not have a prescription for, in a reasonable suspicion drug test conducted by Sannes Skogdalen Heim as part of their investigation into the missing morphine tablets; (11) Respondent Halverson was further interviewed with respect to the missing morphine tablets, and though she denied any involvement, had very poor eye contact[11]; and finally, (12) Respondent Halverson suffered from chronic pain, for which her and her doctor were having difficulty finding adequate treatment.

Evidence in the record that contradicts that Respondent Halverson diverted the morphine tablets include the facts that: (1) she did not test positive for morphine in her reasonable suspicion drug test; (2) only three nurses were tested and interviewed with respect to the missing morphine tablets, even though none of them tested positive for morphine; (3) the amount of Proscar that went missing at Schmitt Woodland Hills (3 tablets) was less then the amount used to replace the missing morphine tablets at Sannes Skogdalen Heim (at least four tablets)[12]; (4) no determination was ever made as to who diverted the missing Proscar pills (or other missing narcotics) at Schmitt Woodland Hills; (5) Respondent Halverson was working with a doctor who prescribed her narcotics for her pain, and who testified that he had no concerns over drug misuse; and (6) Respondent Halverson demonstrated good work performance throughout during the relevant time period at both Sannes Skogdalen Heim and Schmitt Woodland Hills.

Considering all the above evidence, the undersigned administrative law judge is convinced it is more likely than not that Respondent Halverson diverted the missing morphine tablets from Sannes Skogdalen Heim, and replaced them with Proscar tablets she diverted from Schmitt Woodland Hills. Although the investigation conducted by Sannes Skogdalen Heim could have been more complete[13], the facts that (1) Sannes Skogdalen Heim had housed no residents who were prescribed Proscar, (2) Respondent Halverson worked at another facility (and was the only employee at Sannes Skogdalen Heim to work at another facility) that did house patients who were prescribed Proscar, and (3) that Proscar went missing at that facility at about the same time that it was discovered at Sannes Skogdalen Heim are too connected to be coincidental.

[11] Respondent Halverson demonstrated a similar demeanor at hearing.
[12] And possibly more, as the nurse that discovered that the morphine had been diverted from a resident's medication card, and replaced with Proscar, recalls that the same resident's medication card had been difficult to work with the prior evening, suggesting that this medication card may also have been tampered with.
[13] Only three of fifty-plus nurses were tested for narcotics.

Discipline:

Falsification of Documents and Non-compliance with Rehabilitation Review:

As discipline for the above-referenced violations, the Division recommends that Respondent Halverson go through the Board-ordered Rehabilitation Review. (*See* Exhibit 1A). The undersigned administrative law judge agrees with this recommendation.

The purpose of discipline is to: (1) to promote the rehabilitation of the licensee; (2) to protect the public from other instances of misconduct; and (3) to deter other licensees from engaging in similar contact. *State v. Aldrich*, 71 Wis. 2d 206 (1976). Respondent Halverson's negligence in performing four required fire drills while administrator at the Tomah Healthcare Center posed a significant danger to the residents, for which rehabilitation was not only warranted, but ordered. Her failure to go through this Rehabilitation Review, even after being informed by Attorney Lytle that such was required for her to practice as a nurse (and not just as an administrator), shows that the relief requested by the Division is not only appropriate, but necessary to ensure Respondent Halverson's rehabilitation, and, hence, the protection of the public.

Narcotics Violations

The Division requests that Respondent Halverson receive the same discipline the Nursing Board found appropriate *In the Matter of Disciplinary Proceedings against Kimberly K. Krueger, R.N.* (DOE # 10 NUR 064), namely, suspension for an indefinite period with the possibility of a stay after three months upon proof of compliance with treatment, drug and alcohol screenings, and practice limitations, except that it recommends that her suspension be stayed for a period of six months instead of three. (Tr., p. 117-118). In support of this recommendation, the Division argues that this is the typical order in impairment cases, and that a six month stay is appropriate given the possibility that patients did not get their medications. (*Id.*).

For her part, Respondent Halverson maintains that she did not divert any drugs, that the Darvocet that was found in her system was most likely her daughter's, and must have been taken by accident, as she kept it next to her own prescription of hydrocodone in a locked medicine cabinet, that her treating physician had no concerns over her narcotic usage, and that her job performance throughout the alleged events was good.

A review of both the *Krueger* decision (in which the respondent nurse admitted to diverting one of thirteen Vicodin® that went missing on her shifts), and the case at hand leads the undersigned ALJ to believe that the misconduct involved in both is similar, and that the discipline ordered in Krueger, including a three months of suspension with no stay, is justified in the instant case as well. Indeed, Respondent Halverson's actions posed a serious risk to her patients, and her diversion of narcotics indicates a drug problem. Though the Division argues

that the order should include an additional three months of suspension without stay, because of the possibility that patients did not receive their narcotics, they did not provide any evidence to suggest that any of the residents were harmed or deprived of their pain medication. (*Compare to Krueger*, DOE case # 10 NUR 064, p. 2, Finding of Fact ¶ 6). Moreover, Respondent Halverson did not demonstrate an inability to perform her duties in a satisfactory manner at the time of the diversion – indeed; there was no trace of morphine even found in her system. The undersigned administrative law judge thus finds that the discipline ordered in Krueger is sufficient to address the three goals of discipline stated above.

Assessment of Costs

The ALJ's recommendation and the Board's decision as to whether the full costs of the proceeding should be assessed against the credential holder are based on the consideration of several factors, including:

1) The number of counts charged, contested, and proven;
2) The nature and seriousness of the misconduct;
3) The level of discipline sought by the parties
4) The respondents cooperation with the disciplinary process;
5) Prior discipline, if any;
6) The fact that the Department of Regulation and Licensing is a "program revenue" agency, whose operating costs are funded by the revenue received from licenses, and the fairness of imposing the costs of disciplining a few members of the profession on the vast majority of the licensees who have not engaged in misconduct;

See In the Matter of Disciplinary Proceedings against Elizabeth Buenzli-Fritz (LS 0802183 CHI).

Respondent Halverson cooperated in these disciplinary proceedings. Nevertheless, she was found to have diverted morphine and Proscar tablets, allegations she continually denied.

Balancing these factors with the number of counts proven and the seriousness of her misconduct, the undersigned administrative law judge finds that the respondent should pay all of the costs involved in investigating and prosecuting this matter.

ORDER

IT IS THUS ORDERED, effective the date of this Order:

REHABILITATION REVIEW

Should Respondent wish to work in a Wisconsin DHFS-licensed facility, she will need to pass a Rehabilitation Review through DHFS prior to commencement of such employment.

SUSPENSION

A.1. The license of Cheryl J. Halverson, R.N., to practice as a licensed practical nurse in the State of Wisconsin is SUSPENDED for an indefinite period.

A.2. The privilege of Cheryl J. Halverson, R.N. to practice as a licensed practical nurse in the State of Wisconsin under the authority of another state's license pursuant to the Nurse Licensure Compact is also SUSPENDED for an indefinite period.

A.3. During the pendency of this Order and any subsequent related orders, Respondent may not practice in another state pursuant to the Nurse Licensure Compact under the authority of the Wisconsin license, unless Respondent receives prior written authorization to do so from both the Wisconsin Board of Nursing and the regulatory board in the other state.

A.4. Respondent shall mail or physically deliver all indicia of Wisconsin nursing licensure to the Department Monitor within 14 days of the effective date of this order. Limited credentials can be printed from the Department of Regulation and Licensing website at http://drl.wi.gov/index.htm.

A.5. Upon a showing by Respondent Halverson of continuous, successful compliance for a period of at least five (5) years with the terms of this Order, the Board shall grant a petition by the Respondent under paragraph D.6. for return of full Wisconsin licensure. The Board may, on its own motion or at the request of the Department monitor, grant full Wisconsin licensure at any time.

STAY OF SUSPENSION

B.1. The suspension shall not be stayed for the first three (3) months, but any time after three (3) months, the suspension shall be stayed upon Respondent's providing proof, which is determined by the Board or its designee to be sufficient, that Respondent has been in compliance with the provisions of Sections C and D of this Order for the most recent three (3) consecutive months.

B.2. The Board or its designee may, without hearing, remove the stay upon receipt of information that Respondent is in substantial or repeated violation of any provision of Sections C or D of this Order. Repeated violation is defined as the multiple violation of the same provision or violation of more than one provision. The Board may, in conjunction with any removal of any stay, prohibit Respondent for a specified period of time from seeking a reinstatement of the stay under paragraph B.4.

B.3. This suspension becomes reinstated immediately upon notice of the removal of the stay being provided to Respondent either by:
(a) Mailing to Respondent's last-known address provided to the Department of Regulation and Licensing pursuant to Wis. Stat. § 440.11; or
(b) Actual notice to Respondent.

B.4. The Board or its designee may reinstate the stay if provided with sufficient information that Respondent is in compliance with the Order and that it is appropriate for the stay to be reinstated. Whether to reinstate the stay shall be wholly in the discretion of the Board or its designee.

B.5. If Respondent Halverson requests a hearing on the removal of the stay, a hearing shall be held using the procedures set forth in Wis. Admin. Code ch. RL 2. The hearing shall be held in a timely manner with the evidentiary portion of the hearing being completed within 60 days of receipt of Respondent's request, unless waived by Respondent. Requesting a hearing does not stay the suspension during the pendency of the hearing process.

CONDITIONS AND LIMITATIONS

Treatment Required

C.1. Respondent Halverson shall enter into and continue in a drug treatment program at a treatment facility (Treater) acceptable to the Board or its designee. Respondent shall participate in, cooperate with, and follow all treatment recommended by the Treater.

C.2. Respondent Halverson shall immediately provide the Treater with a copy of this Final Decision and Order and all other subsequent orders.

C.3. The Treater shall be responsible for coordinating Respondent Halverson's rehabilitation, drug monitoring and treatment program as required under the terms of this Order, and shall immediately report any relapse, violation of any of the terms and conditions of this Order, and any suspected unprofessional conduct, to the Department Monitor (See D.1., below). If the Treater is unable or unwilling to serve as the Treater, Respondent shall immediately seek approval of a successor Treater by the Board or its designee.

C.4. The rehabilitation program shall include individual and/or group therapy sessions at a frequency to be determined by the Treater. Therapy may end only with the approval of the Board or its designee, after receiving a petition for modification as required by D.4, below.

C.5. The Treater shall submit formal written reports to the Department Monitor on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent Halverson's progress in the drug treatment program. The Treater shall report immediately to the Department Monitor any violation or suspected violation of this Order.

Releases

C.6. Respondent Halverson shall provide and keep on file with the Treater, all treatment facilities and personnel, laboratories, and collection sites current releases complying with state and federal laws. The releases shall allow the Board, its designee, and any employee of the Department of Regulation and Licensing, Division of Enforcement to: (a) obtain all urine, blood and hair specimen screen results and patient health care and treatment records and reports, and (b) discuss

the progress of Respondent's treatment and rehabilitation. Copies of these releases shall immediately be filed with the Department Monitor.

NA Meetings/AA Meetings

C.7 Respondent Halverson shall attend Narcotics Anonymous and/or Alcoholics Anonymous Meetings or an equivalent program for recovering professionals, at the frequency recommended by the Treater. Attendance of Respondent at such meetings shall be verified and reported quarterly to the Treater and the Department Monitor.

Sobriety

C.8. Respondent Halverson shall abstain from all personal use of controlled substances as defined in Wis. Stat. § 961.01(4), except when prescribed, dispensed or administered by a practitioner for a legitimate medical condition. Respondent Halverson shall disclose Respondent's drug and alcohol history and the existence and nature of this Order to the practitioner prior to the practitioner ordering the controlled substance. Respondent Halverson shall at the time the controlled substance is ordered immediately sign a release in compliance with state and federal laws authorizing the practitioner to discuss Respondent's treatment with, and provide copies of treatment records to the Treater and the Board or its designee. Copies of those releases shall immediately be filed with the Department Monitor.

C.9. Respondent Halverson shall abstain from all use of over-the-counter medications or other substances which may mask consumption of controlled substances, create false positive screening results, or interfere with Respondent's treatment and rehabilitation.

C.10. Respondent Halverson shall report to the Treater and the Department Monitor all medications and drugs, over-the-counter or prescription, taken by Respondent. Reports must be received within 24 hours of ingestion or administration, and shall identify the person or persons who prescribed, dispensed, administered or ordered said medications or drugs. Each time the prescription is filled or refilled, Respondent shall immediately arrange for the prescriber or pharmacy to fax and mail copies of all prescriptions to the Department Monitor.

Drug and Alcohol Screens

C.11. Respondent Halverson shall enroll and begin participation in a drug and alcohol monitoring program which is approved by the Department ("Approved Program"). A list of Approved Programs is available from the Department Monitor.

C.12. At the time Respondent Halverson enrolls in the Approved Program, Respondent shall review all of the rules and procedures made available by the Approved Program. Failure to comply with all requirements for participation in drug monitoring established by the Approved Program is a substantial violation of this Order. The requirements shall include:
(a.) Contact with the Approved Program as directed.
(b.) Production of a urine, blood, sweat, hair, saliva or other specimen at a collection site designated by the Approved Program within five (5) hours of notification of a test.

C.13. The Approved Program shall require the testing of urine specimens at a frequency of not less than forty-nine (49) times per year, for the first year of this Order. After the first year, Respondent may petition the Board on an annual basis for a modification of the frequency of tests. The Board may adjust the frequency of testing on its own initiative at any time.

C.14. If any urine, blood, sweat, fingernail, hair, saliva or other specimen is positive or suspected positive for any controlled substances, Respondent Halverson shall promptly submit to additional tests or examinations as the Treater or the Board or its designee shall determine to be appropriate to clarify or confirm the positive or suspected positive test results.

C.15. In addition to any requirement of the Approved Program, the Board or its designee may require Respondent Halverson to do any or all of the following: (a) submit additional specimens, (b) furnish any specimen in a directly witnessed manner; or (c) submit specimens on a more frequent basis.

C.16. All confirmed positive test results shall be presumed to be valid. Respondent Halverson must prove by a preponderance of the evidence an error in collection, testing, fault in the chain of custody or other valid defense.

C.17. The Approved Program shall submit information and reports to the Department Monitor as directed.

Practice Limitations

C.18. Respondent Halverson shall not work as a nurse or other health care provider in a setting in which Respondent has direct access to controlled substances.

C.19. Respondent Halverson shall practice only under the direct supervision of a licensed nurse or other licensed health care professional approved by the Board or its designee and only in a work setting pre-approved by the Board or its designee. Respondent may not work in a home health care, hospice, pool nursing, or agency setting.

C.20. Respondent Halverson shall provide a copy of this Final Decision and Order and all other subsequent orders immediately to supervisory personnel at all settings where Respondent works as a nurse or care giver or provides health care, currently or in the future.

C.21. It is Respondent Halverson's responsibility to arrange for written reports from supervisors to be provided to the Department Monitor on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent's work performance, and shall include the number of hours of active nursing practice worked during that quarter.

C.22. Respondent Halverson shall report to the Board any change of employment status, residence, address or telephone number within five (5) days of the date of a change.

MISCELLANEOUS

Department Monitor

D.1. Any requests, petitions, reports and other information required by this Order shall be mailed, e-mailed, faxed or delivered to:

Department Monitor
Wisconsin Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax: (608) 266-2264
Telephone: (608) 267-3817

Required Reporting by Respondent

D.2. Respondent Halverson is responsible for compliance with all of the terms and conditions of this Order, including the timely submission of reports by others. Respondent shall promptly notify the Department Monitor of any failures of the Treater, treatment facility, Approved Program or collection sites to conform to the terms and conditions of this Order. Respondent shall promptly notify the Department Monitor of any violations of any of the terms and conditions of this Order by Respondent. Additionally, every three (3) months the Respondent shall notify the Department Monitor of the Respondent's compliance with the terms and conditions of the Order, and shall provide the Department Monitor with a current address and home telephone number.

Change of Treater or Approved Program by Board

D.3. If the Board or its designee determines the Treater or Approved Program has performed inadequately or has failed to satisfy the terms and conditions of this Order, the Board or its designee may direct that Respondent Halverson continue treatment and rehabilitation under the direction of another Treater or Approved Program.

Petitions for Modification of Limitations or Termination of Order

D.4. Respondent Halverson may petition the Board for modification of the terms of this Order or termination, however no such petition for modification shall occur earlier than one (1) year from the date of this Order. Any such petition for modification shall be accompanied by a written recommendation from Respondent's Treater expressly supporting the specific modifications sought. Denial of a petition in whole or in part shall not be considered a denial of a license within the meaning of Wis. Stat. § 227.01(3)(a), and Respondent shall not have a right to any further hearings or proceedings on the denial.

D.5 Respondent may petition the Board for termination of this Order anytime after five years form the date of this order. However, no petition for termination shall be considered without a showing of continuous, successful compliance with the terms of the Order, for at least five years.

Costs of Compliance

D.6. Respondent Halverson shall be responsible for all costs and expenses incurred in conjunction with the monitoring, screening, supervision and any other expenses associated with compliance with the terms of this Order. Being dropped from a program for non-payment is a violation of this Order.

Costs of Proceeding

D.7. Respondent shall pay all recoverable costs in this matter in an amount to be established pursuant to Wis. Admin. Code § RL 2.18. After the amount is established, payment shall be made by certified check or money order payable to the Wisconsin Department of Regulation and Licensing and sent to:

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

within one hundred eighty (180) days of this Order. In the event Respondent fails to timely submit any payment of costs, the Respondent's license (# 30-140147) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

Additional Discipline

D.8. In addition to any other action authorized by this Order or law, violation of any term of this Order may be the basis for a separate disciplinary action pursuant to Wis. Stat. § 441.07.

IT IS FURTHER ORDERED that the above-captioned matter be and hereby is closed as to Respondent Cheryl J. Halverson.

Dated at Madison, Wisconsin on December 9, 2010.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
5005 University Avenue, Suite 201
Madison, Wisconsin 53705
Telephone: (608) 266-7709
FAX: (608) 264-9885

By: 

Amanda Tollefsen
Administrative Law Judge

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