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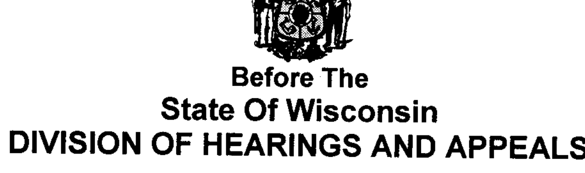

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings Against **CHRISTELE WILLIAMS, R.N.**, Respondent	FINAL DECISION AND ORDER DHA Case No. DRL-10-0040 ORDER0000892

Division of Enforcement Case No. 09 NUR 217

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

Christele Williams, R.N.
4436 North 92nd Street, #3
Milwaukee, Wisconsin 53225

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

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

PROCEDURAL HISTORY

The procedural matters leading up to this hearing are as follows:

On or about June 9, 2010, the Department of Regulation and Licensing, Division of Enforcement filed a formal Complaint against Respondent Christele Williams, implicating that Respondent Williams was responsible for ten duragesic patches that went missing at her place of employment in March and April of 2009, and alleging that respondent (1) was found sleeping on the job in May 2009, (2) took several narcotic medications for back pain over the years which she did not report to her employer until asked to take a drug test, contrary to workplace policy, and, (3) was non-compliant with her physician's requirements for pain management with narcotics, including, but not limited to, testing positive for non-prescribed narcotics, and a refusing to take a drug test. The Complaint contends that such conduct violates Wis. Admin Code §§ N 7.04(2) (unprofessional conduct) and 7.03(2) (negligence by use of alcohol or other drug(s)), subjecting her to discipline pursuant to Wis. Stat. § 441.07(1)(c).

On or about June 14, 2010, Respondent Williams filed an Answer denying all allegations of misconduct against her, and affirmatively alleging that her employer's claims against her were an act of retaliation for filing unemployment benefits. A Prehearing Conference was held by telephone on July 28, 2010, Amanda Tollefsen, administrative law judge, presiding. Respondent Williams reiterated that all allegations against her were false, and that she therefore did not wish to enter into any stipulation. A contested case hearing was thereafter set by the ALJ for Wednesday October 20, 2010, at the Department of Regulation and Licensing. Because the Division did not have sufficient time to complete its cross examination of Respondent Williams on that date, the hearing was continued to Tuesday, November 16, 2010, with the respondent appearing by telephone.

Upon conclusion of the hearing, the ALJ prepared a Proposed Decision containing Findings of Fact, Conclusions of Law and Order which was submitted to the parties and the Board of Nursing for possible adoption as the Final Decision and Order in this matter. Objections to the Proposed Decision were submitted by the Division and Respondent Williams.

On June 2, 2011, the Board reviewed the Proposed Decision submitted by the ALJ and the Objections to the Proposed Decision submitted by the parties. The Board did not find the arguments and objections of Respondent Williams persuasive or supported by the evidence in the record. However, the Board determined that it was necessary to vary the ALJ's recommendations for discipline, based upon the concerns raised in the objections by the Division. The Board's modifications to the Proposed Decision are described in the Explanation of Variance and Order which is contained herein.

FINDINGS OF FACT

1. Christele Williams, R.N., date of birth November 7, 1954, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 99320, which was first granted April 1, 1988.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 4436 N. 92nd Street # 3, Milwaukee, WI 53225.

3. In 1995, Respondent signed a stipulation with the Department of Regulation and Licensing admitting that she had obtained Roxicet[1] for her own personal use by forging prescriptions on six different occasions. (State's Exhibit 2). As part of this stipulation, Respondent's license was indefinitely suspended; however, the suspension could be stayed every three months conditioned upon Respondent's compliance with numerous conditions and limitations. (*Id.*). Among other conditions, Respondent agreed to enter into drug treatment, to maintain sobriety, and to be drug tested on a random basis. (*See Id.*).

[1] A brief Google search revealed that Roxicet is a narcotic pain reliever comprised of oxycodone and acetaminophen. (*See also*, Tr. 1 p. 51).

4. As part of her Board-ordered drug and alcohol assessments, Respondent was diagnosed with narcotic addiction. (*See* Transcript from October 10, 2010 Hearing, ("Tr. 1"), pp. 74-75).

5. Respondent's suspension was stayed at times, but at other times, her stay was terminated for "failure to *submit documentation* of participation in therapy and maintenance of sobriety." (*See* State's Exs. 1, 3, 4, and 5, Tr. 1 p. 68[2]).

6. Respondent admits she was not able to maintain sobriety from drugs and alcohol at the outset of her suspension, asserting that "… I had some times that I did and sometimes I didn't. And that's when [sic] some of the times the order was stayed and sometimes the order wasn't…." (*See* Tr. 1 pp. 65-66). Respondent's attempts to back away from this statement in later testimony are not credible. (*See* Tr. 1 pp. 68, 71) (Respondent states that she does not recall whether she was able to maintain sobriety, and then states she was "clean" throughout the entire process).

7. Respondent denies that she was ever addicted to narcotics, but admits that she "abused" Roxicet during the events that led to the above-referenced stipulation. (*See* Tr. 1 pp. 66). The ALJ finds this distinction unconvincing, and finds that Respondent was addicted to narcotics.

8. Respondent was eventually granted full nursing licensure on September 8, 2000, five years after the date she entered into the stipulation suspending her license. (Ex. 6; *see also* State's Exs. 1 and 2). It appears her indefinite suspension was limited to a period of five years, though the ALJ could find no evidence of this within the stipulation and order. (*See* State's Ex. 2).

9. Even after she obtained full licensure, Respondent continued taking narcotics. Her medical records show that she routinely received prescriptions for fentynal[3] and Percocet[4]. (State's Exs. 8-12 (showing Respondent was prescribed duragesic patches (fentanyl) and Percocet on: December 6, 2005 (and prior), January 25, 2006, February 23, 2006 (fentanyl only), June 24, 2006 August 4, 2006, July 17, 2007 (fentanyl only), 9/30/08, (and while in North Carolina the preceding year), November 7, 2008, December 8, 2008, December 20, 2008, April 29, 2009, June 30, 2009, July 20, 2009, August 19, 2009, September 9, 2009, October 15, 2009, November 12, 2009, December 11, 2009, January 15, 2010 (Percocet only), and January 21, 2010 (Percocet only); and was prescribed oxycodone on January 7, 2010)).

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[2] Respondent admits that she had a difficult time complying with the terms of her suspension because she was not working, and thus could not afford treatment and drug screens.
[3] A brief Google search revealed that fentanyl is an opiod narcotic.
[4] A brief Google search revealed that Percocet is a narcotic pain reliever comprised of oxycodone and acetaminophen.

10. Taking narcotics for pain after abusing narcotics is not necessarily a problem. Addicts can have pain too, which needs to be treated. (Tr. 1 pp. 179-180).

11. Nevertheless, an addict needs to be very careful, and work very collaboratively with her physician when taking narcotics. (*Id.*).

12. While continuing to take narcotics after she obtained full licensure, Respondent:

a. did not divulge her history of narcotic addiction/abuse to at least three of her physicians, (Tr. 1 pp. 75-76, State's Ex. 8 p. 35; Tr. 1 p. 87, State's Ex. 11 p. 109; Tr. 1 p. 88, State's Ex. 11 p. 130), and one ER physician (Tr. 1 p. 84, State's Ex. 10, p. 83);

b. lied to another physician about not having taken any pain medications for two months until confronted with a positive urine screen (Tr. 1 pp. 76-77, State's Ex. 9, p. 61);

c. took Percocet and Vicodin from relatives (Tr. 1 p. 77, State's Ex. 9 p. 63; Tr. 1 p. 91, State's Ex. 11 p. 155);

d. got narcotics from emergency rooms (Tr. 1 p. 84, State's Ex. 10 p. 83; Ex. 11 p. 130);

e. refused a drug test by a physician (Tr. 1 p. 88, State's Ex. 11 p. 134);

f. did not call at least one physician with respect to her tolerance of fentanyl, as requested, and missed at least one appointment. (Tr. 1 pp. 80-81, State's Ex. 10 p. 79); and

g. discharged her physicians on at least two occasions, citing her dislike of them. (*See* Tr. 1 pp. 53-54, 89, and 103-105; State's Ex. 10 p. 88).

13. Respondent additionally received several warnings from her physicians with respect to her narcotic management:

a. On January 25, 2006 Dr. Schatzman noted "I reviewed with [Respondent] her noncompliance and told her in blunt terms that, if she is not compliant with showing up for appointments and following my recommendations, she will be terminated from the clinic." (Tr. 1 p. 81, State's Ex. 10 p. 79).

b. On February 23, 2006 Dr. Schatzman noted "I emphasized the need to take Percocet only PRN and not scheduled." (Tr. 1 p. 83, State's Ex. 10 p. 82).[5]

c. On September 11, 20090, Dr. Thomas-King noted, "the patient refused to undergo an opiod urine toxicology screen today... She was informed that this was a violation of the opiod contract, and, therefore this clinic could not treat her." (Tr. 1 pp. 88-89, State's Ex. 11 p. 134).

14. Prior to regaining full licensure in 2000, Respondent had worked as a nurse at Bellevue, a facility for people with addictions. (Tr. 1 pp. 180-181). She should have been well-versed in addiction and treatment from a clinical perspective. (*Id.*).

15. Respondent began working at Cameo Care Center (again) in October of 2008. (Ex. 14 p. 191, Ex. 15). Respondent had worked there on previous occasions. (State's Ex. 15, Christele Williams' Resume).

16. In March and April of 2009, Duragesic patches began to go missing from residents at Cameo Care Center. (*See* Tr. 1 pp. 96, 175-76; State's Ex. 14 p. 191). Patches were noted to have gone missing on the following dates: **3/28/2009, 3/29/2009, 4/3/2009, 4/6/2009, 4/8/2009, 4/10/09, 4/16/2009, 4/17/2009, 4/20/2009 and 4/26/09.** (*Id.*, *see also* Respondent's Exhibits 106, 107, 108, 111, 112, 113, 114, 115, and 116 (Investigation Summary Reports). Respondent worked on or about all these dates. (*See infra* at ¶ 26).

17. In at least two instances, no "visual patch checks" were made with respect to the missing fentanyl patches during the shift prior to Respondent's, making it possible that patch disappeared on a previous shift.[6] (Tr. 1 pp. 112-117, 150-151; Respondent's Exs. 111 (Incident Report, 4/3/09), 117 (Jermaine Statement, 4/8/09), 123 (Casarez Statement, 4/16/09), 148 (Hopple Statement, 4/7/09), 149 (Otto Statement, undated), 150 (Hopple Statement, 4/6/09), 151 (Otto Statement, 4/6/09), 152 (Williams Statement, 3/27/09)).[7] It is also possible that the patch disappeared on Respondent's shift.

18. In four other instances, the patches were later found, but were found off the resident, or at a different location on the resident. (Tr. 1 pp. 127 – 131, 137-144, 176; Respondent's Exs.

[5] Interestingly, in July of 2006, Respondent reported that she had not been getting much relief from the fentanyl patches. (Ex. 10, p. 86).

[6] Generally, a visual patch count is done between each shift. (Tr. 1 pp. 142-143).

[7] Unfortunately, documentation noting that a visual patch check was not done between shifts was not always included in the Investigative Summary Reports, and staff statements did not always reference the incident date, making it difficult to determine for certain on which dates and shifts visual patch counts were not done. Such is compounded by Respondent's inability to properly identify and/or reference her exhibits (*see infra*), and to properly match the Investigation Summary Reports with the correct witness statements. (*See generally*, Respondent's Exhibits and testimony as identified in chart at p. 4 of State's brief-in-chief; Tr. 1 pp. 150-151 (statements 114, 115 and 116 "all talking about same patch"); Tr. 2. pp. 167-168). Nonetheless, a review of the above exhibits evinces that visual patch counts did not occur between the p.m. and night shifts on 4/3/09 and on 4/6/09.

113[8], 110[9], 106, 112 (Investigation Summary Reports for 4/17/09, 4/16/09, 4/8/09 and 4/10/09, respectively); 147 (Investigation Summary Report for 4/26/09), 122, 125, 132, 135, 145, 146, 137, 138, 130[10] (Witness Statements)). On three of these occasions, Respondent found the missing patches when other nurses had searched the same area and not found them, twice on the floor (*See* Tr. 1 pp. 139-140; Respondent Exs. 106, 137, 138 and 147), and once underneath the patient. (Respondent's Exs. 112, 130). In one instance, the ADON (acting director of nursing) noted that it was believed that the patient whom the patch went missing from "scratches," and in doing so, removed the patch. (Respondent's Ex. 112).

19. In one other incident, Respondent, as nursing supervisor, was given a patch to put on a patient by a nurse from the previous shift. She gave the patch to another nurse to put on the patient. At least two witnesses saw the second nurse take the patch into the patient's room. The patch was noted to be missing three days later. (*See* Tr. 118-127, Respondent's Exs. 107, 140-143).

20. No notations indicating that Cameo Care Center believed Respondent was responsible for the missing fentanyl patches were made in the Investigative Summary Reports. (*See* Tr. pp. 129, 152 (If Cameo Care Center thought Respondent was stealing, there should have been notice of it in the Investigation reports").

21. Respondent generally searched for missing patches with other staff members (*See* Tr. 1, p. 126), however, in at least one instance, Respondent conducted the search alone. (*See* Respondent's Ex. 136 (Cohill Statement, 4/10/09)).

22. Patches do come off of patients, when they perspire heavily, come into contact with water, or rub it or take it off themselves. (Tr. 1 pp. 114, 188-189, 208, 215; Respondent's Ex. 130). It is not a common occurrence, however, and patients who take their patches off are given other medicine. (*See Id.* at pp. 188-89, 208, 215)

23. It is more common for addicts to take fentanyl patches off of patients, remove the medicine, and then put the patch in the patient's sheets or wastebasket and let someone else discover it. (Tr. 1 p. 176), Thus, the fact that a missing patch is later found does not mean that the narcotic was not tampered with.[11] (*Id.*).

24. Some of the patches that went missing had been on patient for several days. (Tr. p. 130, 145-146).

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[8] Respondent incorrectly identified this Investigation Summary Report as Exhibit 114. (*See* Tr. 1. pp. 127-131, *compare* Respondent's Exs. 113, 114 and 147).

[9] Respondent incorrectly identified this Investigation Summary Report as Exhibit 111. (*See* Tr. 1, p. 137-139, *compare* Respondent's Exs. 110, 111, 122, 125, 132, 135, 145, and 146).

[10] Respondent incorrectly associates this Statement with the Investigation Summary Report for 4/8/09 (Respondent's Ex. 106). A review of Respondent's exhibits demonstrates that this statement corresponds to the Investigation Summary Report for 4/10/09. (Respondent's Ex. 112).

[11] Unfortunately, there is nothing in the record to confirm whether such investigations were made into the patches that were later found.

25. Fentanyl Patches still contain some active ingredient even after 72 hours. (Tr. 1 p. 168).

26. Regardless of whether "visual patch checks," were conducted or whether the missing patches were later found, fentanyl patches only went missing from residents on the days Respondent was working (Tr. 1 pp. 196, 204, Tr. 2 p. 257, *see also generally*, Respondent Exs. 106-155), and the patches stopped going missing when she quit in May of 2009. (Tr. 1 p. 176; Tr. 2, p. 253).

27. During this same time period, Respondent was having performance issues at work:

a. On March 22, 2009, Respondent was written up for failing to document her assessment after a patient fell. (Tr. 1 p. 95; Tr. 2, pp. 181-182; Respondent's Ex. 14 pp. 201-206).

b. On March 25, 2009, Respondent was written up for incomplete assessments and treatment related to a new admission. (Tr. 1 pp. 95-96; State's Ex. 14 pp. 207-211).

c. On May 2, 2009, Respondent was written up for falling asleep on the job. (Tr. 2., pp. 183-184, State's Ex. 14 p. 344).[12]

28. Respondent's testimony that these events did not occur as alleged, and that the only reason she was written up for each was because she did not "see eye to eye" with her supervisor is not credible. (Tr. 1 pp. 94-96, 157-158, State's Ex. 14 pp. 201-211, 344)

29. Respondent's medical records note that on March 10, 2009, Dr. Sadeghi gave Respondent 10 patches of fentanyl, to be applied every 72 hours. (Tr. p. 97, State's Ex. 11 pp. 147-148). If taken as directed, Respondent's patches would have run out on or about April 9, 2009. (*Id*). Respondent's next appointment with Dr. Sadeghi was not until April 29, 2009. (*Id*).

30. Respondent's testimony that she took her fentanyl patches only as needed, (Tr. 1 p. 109), and not as directed is not credible. Fentanyl patches are not generally prescribed as needed, and were not prescribed to Respondent that way.[13] (Tr. 1 p. 169; State's Ex. 10 pp. 147-148).

31. In connection to the missing fentanyl patches, eight nurses, including Respondent, were asked to take drug tests. (Tr. pp. 176-177). All nurses who worked shifts during which the patches went missing, and had access to narcotics were tested. (*Id., see also* Tr. 2 p. 253).

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[12] These were the only performance-related write-ups Respondent received while working at Cameo Care Center.

[13] Indeed, it is easy to imagine that this could lead to overdose.

32. All but Respondent complied, and tested negative. (Tr. 1 pp. 176-177). Respondent first refused the drug test, then agreed to take the drug test, but could not produce a sample. (*Id.*, Tr. 1 pp. 155-157; Tr. 2 pp. 296-297; State's Ex. 14 p. 191). She did not return to work after the second attempted drug test (May 2, 2009). (*Id.*)

33. It is possible that any staff member or family member who had contact with a patient from whom a fentanyl patch went missing could have taken that patient's patch, however, the patches were placed under the patients' clothing, thus, the offender would have had to know that a patient was wearing a patch with respect to all of the patients' whose patches went missing. (Tr. 2 pp. 254-256).

34. Despite testifying that she did not know which patients wore patches at Cameo Care Center, (Tr. 1 p. 125), Respondent had access to the medical records, and could easily find out who had a patch. (Tr. 1 p. 205).

35. Cameo Care Center had a policy that all nurses report any narcotic medications taken. (Tr. 1 pp. 177-178). Nonetheless, they were not made aware that Respondent had a prescription for fentanyl patches until after they asked Respondent to undergo a drug test. Had they known Respondent was taking fentanyl, they would not have allowed her to practice without medical clearance. (Tr. 1 pp. 178-179; Tr. 2 pp. 249-250).

36. Respondent's testimony that she never took pain medications while at work is not credible. (*See* Tr. 1 p. 109). Respondent's fentanyl patches were prescribed to be worn for a period of 72 hours, and then replaced with another patch. (*See* Tr. 1 p. 97, State's Ex. 11 pp. 147-148). Even if Respondent had only worn her patches while at home, as claimed, and removed her patches before each shift, there would likely have been some medication in her system while at work.

37. Respondent filed for unemployment benefits in June of 2009. (Tr. 1 pp. 153-154, Respondent's Ex. 104). The circumstances of how she became unemployed, (whether she failed to return to Cameo Care after being asked to take a drug test or was not called to return after May 2, 2009) are unclear. (*See* Tr. 1 pp. 155). Respondent's testimony that she did not return to work because she was overworked, and felt that her environment was unsafe (Tr. 1 157-160), and her further testimony that she did not know that there was an investigation into whether she diverted the missing fentanyl patches until after she filed for unemployment benefits, is not credible. (*See* Tr. 1, pp. 153-158, 160; Tr. 2, pp. 296-298).

38. Respondent received some unemployment benefit payments before her claim was contested. (Tr. 1 p. 158).

39. Cameo Care Center DON, Vincent Bergstrom, filed a complaint regarding Respondent's above nursing practices with the Department of Regulation and Licensing on July 9, 2009. (State's Exhibit 13 p. 191). In reaching his conclusion that Respondent was responsible

for the missing patches, Mr. Bergstrom took into account the facts that: (1) all of the patches in question went missing on shifts Respondent was working, (2) no patches went missing after Respondent quit working, and (3) the drug tests for all the other nurses that worked on shifts that the patches went missing were negative. (Tr. 1 p. 196).

40. Respondent's daughters (Crystal Williams and Tatanesha Gray) do not *believe* Respondent abuses her pain medications. (Tr. 1 pp. 225-226, 235-236).

41. Respondent's daughters further confirmed that Respondent struggles with pain regularly and needs her pain medications. (Tr. 1 pp. 226, 232).

42. Respondent was extremely defensive and even defiant during these proceedings, testified contrary to the record on many occasions[14], and made excuses for any behavior that could be seen negatively. She furthermore made many unpersuasive and completely self-serving statements that (1) she did not need to steal from patients, as she had other ways of obtaining narcotics, and (2) that if she had a drug problem, she would admit it and get help for it as she did before.

43. The ALJ is convinced that that Respondent lied to both the Department and the tribunal about diverting the missing fentanyl patches, and is lying to herself, her doctors and her daughters about her present abuse of narcotics.

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.

4. Pursuant to Wis. Stat. § 441.07(1)(d), the Board of Nursing has authority to "revoke, limit, suspend or deny renewal of a license of a registered nurse... or may reprimand a

[14] Respondent denied numerous statements contributed to her in both the Investigative Summary Reports. (*See* Tr. 1 p. 122; Respondent's Exhibit 142), and the medical records

registered nurse...," if the board finds that the registered nurse committed "misconduct or unprofessional conduct."

5. 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... abuse of alcohol or other drugs...."

6. Wis. Admin. Code § N 7.04(2) 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." (emphasis added).

7. Wis. Admin. Code § N 7.03(2) defines "abuse of alcohol or other drugs negligence" as "the use of alcohol or any drug to the extent that such use impairs the ability of the licensee to safely or reliability practice."

8. The conduct described in paragraphs 16 - 42 of the Findings of Fact, above, constitutes a violation of Wis. Admin. Code §§ N 7.04(2), and thereby subjects Respondent Williams to discipline pursuant to Wis. Stat. §§ 441.07(1)(d).

9. The conduct described in paragraphs 26 and 34 - 35 of the Findings of Fact, above, constitutes a violation of Wis. Admin. Code § N 7.04(14), and thereby subjects Respondent Williams to discipline pursuant to Wis. Stat. § 441.07(1)(c).

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 Williams (1) obtained a drug, (specifically, fentanyl patches), other than in the course of legitimate practice or as otherwise prohibited by law, and (2) abused that drug to such an extent that that it impaired her ability to safely and reliably practice.

Diversion of Fentanyl Patches:

This was a somewhat difficult determination for the ALJ to make, as there is evidence in the record that both supports that Respondent Williams diverted the fentanyl patches that went missing at Cameo Care Center during the spring of 2009 (i.e. she was the only nurse to refuse a drug test), and that contradicts it (i.e. she already had a prescription for fentanyl).

After weighing all of the evidence in this case, however, the ALJ finds that it is more likely than not that Respondent Williams diverted the missing fentanyl patches:

Not only did all the patches go missing (or possibly go missing) on shifts that Respondent Williams was working[15], she was the only nurse of those asked to take a drug test to refuse. While Respondent Williams very well could have tested positive for fentanyl regardless of whether she diverted it, as she was prescribed this medication, her refusal to cooperate with her employer, and the fact that all of the other nurses tested negative, suggests guilt. When one combines these facts with Respondent Williams' (1) history of narcotic abuse and misuse, even after having had her license suspended; (2) daily struggle with pain; (3) need for a refill of prescription fentanyl patches at about the same time they began to go missing from her employer; (4) lies to the tribunal about being prescribed fentanyl patches "as needed;" (5) lies to her employer about being prescribed narcotics at all; (6) performance issues, (including falling asleep on the job), at the same time that fentanyl patches began to go missing from her employer; (7) attempts to blame these deficiencies on a supervisor not liking her; (8) fortuitous finding of several of the patches that went missing, even when other nurses could not find them; (9) general defensiveness throughout these proceedings, and, perhaps most importantly, the fact that (10) the patches stopped disappearing when she stopped working, it seems clear that Respondent Williams not only diverted the missing fentanyl patches, but that she has a problem with narcotics that she refuses to admit.

Respondent Williams' attempts to demonstrate, on a patch by patch basis, why the Division failed to prove that she was responsible for each missing fentanyl patch are unavailing. (*See* Respondent's brief pp. 4-8). While it is true that when one considers the evidence as it relates to each missing patch separately, it is difficult to link Respondent Williams, and Respondent Williams alone, to at least some of the missing patches; when one considers all the evidence together, it becomes evident that Respondent Williams is the responsible party.

Respondent Williams' further attempt to suggest that the Division's case against her is nothing more that a ruse to avoid paying unemployment insurance benefits, as evidenced by the two plus months it took Cameo Care Center to implicate her beginning its initial investigation, are not convincing. (*See Id.* at p. 3). While the timing of Vincent Bergstrom's complaint to the Department of Regulation and Licensing is somewhat suspicious, when compared to all of the above evidence, and Respondent's general lack of credibility, it does little to change the balance.

Finally, Respondent Williams' argument that by not calling her treating physicians to testify, the Division was being less than forthcoming with respect to her narcotic use, is absurd. (*See Id.* at pp. 2-3). If Respondent wanted her physicians to testify to her narcotic practices, it was her obligation to produce them.

The greater weight of the evidence shows that Respondent Williams stole fentanyl patches and/or their medication from patients at Cameo Care Center, in violation of Wis. Admin. Code § N 7.04(2), and is thus subject to discipline pursuant to Wis. Stat. § 441.07(1)(c).

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[15] Respondent Williams' attempts to argue that she was not on shift when at least one of the patches went missing (*See* Respondent Brief, p. 7) is not supported by the record.

Abuse of Narcotics:

Even if Respondent Williams hadn't diverted fentanyl patches from patients at Cameo Care Center, the ALJ still believes that the evidence shows that Respondent abused drugs to such an extent that her use impaired her ability to safely and reliably practice, in violation of Wis. Admin. Code § N 703(2). Indeed, unbeknownst to her employer, Respondent was taking two powerful narcotics, one of which was a patch that continuously released fentanyl. During this same period of time, Respondent was having performance issues at work, including falling asleep, and incomplete documentation. Though Respondent tries to blame her overwhelming work load, the ALJ believes it is more likely than not that it was narcotic use that led to these problems.

As it is though, Respondent Williams use and abuse of narcotic pain killers led her to steal medication from patients who needed it. The ALJ cannot imagine a clearer example of drug abuse leading to impaired practice.

In light of her above violations, Respondent Williams is subject to further discipline pursuant Wis. Stat. § 441.07(1)(c).

Appropriate Discipline:

As discipline for the above-referenced violations, the Division recommends that Respondent Williams' license to practice nursing be suspended for an indefinite period of time, with the opportunity for a stay of suspension after she has been assessed by a pain management specialist approved in advance by the board for fitness to practice, and after she has shown at least six months of compliance with drug treatment, testing, and counseling.[16] (Division's brief-in-chief p. 10). It further advises that her practice should be restricted so that she has no access to narcotics, she is subject to direct supervision, and her employers and treaters provide work reports on a quarterly basis. (*Id.*). In support of this recommendation, the Divisions notes that this is how the Nursing Board has historically assessed discipline in cases where a nurse has diverted medications or is found unable to safely or reliably practice. (*Id., citing In re Disciplinary Proceedings Against Kimberly Krueger (at https://online.drl.wi.gov/decisions/2010/ORDER0000526-00005455.pdf), In re Disciplinary Proceedings against Michele Basiks (at https://online.drl.wi.gov/decisions/2010/ORDER0000531-00005460.pdf) In re Disciplinary Proceedings Against Lolita Sharpe (at https://online.drl.wi.gov/decisions/2010/ORDER0000456-00005372.pdf), In re Disciplinary proceedings Against Pamela Divine (at https://online.drl.wi.gov/decisions/2010/ls0710122NUR--00005499.pdf*)).

Respondent Williams makes no recommendation as to discipline, assumedly because she denied all charges of wrong-doing.

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[16] The Division makes no recommendation as to whether the indefinite suspension is to be limited after a certain number of years.

Unfortunately, neither party addresses the three purposes of discipline as addressed in *State v. Aldrich*, 71 Wis. 2d 206 (1976). After reviewing the facts of this case, and the discipline previously imposed by the Board in the cases cited by the Division, however, the undersigned administrative law judge agrees that an indefinite suspension with the opportunity to stay that suspension if and when certain conditions are met accomplishes the three goals of discipline as set out in *Aldrich*. The three goals of discipline are 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 Williams' conduct in (1) diverting fentanyl patches from patients, (2) hiding her legitimate narcotic prescriptions from her employer and (3) working while impaired evinces that she still suffers from addictions, and thus is very much a danger to patients. Her inability to accept she has a problem only strengthens that concern. The relief requested by the Division is thus appropriate and even necessary to protect the public from future instances of misconduct by the respondent.

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).

Though Respondent Williams participated in these disciplinary proceedings, she was at times less that cooperative.[17] Moreover, she was found to have diverted fentanyl patches from patients at the Cameo Care Center, allegations she continually denied.

Balancing these factors with the number of counts proven, the seriousness of her misconduct, and the fact that this is her second offense, the undersigned administrative law judge

[17] Indeed, Respondent's lack of preparation at hearing caused a great deal of delay and effort on the part of both the Division and the ALJ.

finds that the respondent should pay all of the costs involved in investigating and prosecuting this matter.

EXPLANATION OF VARIANCE

Upon review of the Divisions' Objections to the Proposed Decision, the Board of Nursing determined that the ALJ's recommendations for discipline should be varied to include the terms and conditions contained in state's Exhibit A. The requirements set forth in Exhibit A reflect the standard disciplinary terms consistently utilized by the Board in cases involving drug and alcohol abuse, chemical dependency and diversion of controlled substances. Although the ALJ's factual and legal findings are adopted and deemed sufficient to sustain imposition of the standard impairment limitations, the actual disciplinary terms were lacking in the detail and specificity for adequate monitoring, treatment and compliance necessary to protect the public. These terms are necessary should a stay of suspension be granted to the Respondent in the future which allows her to return to practice as a registered nurse It appears that the ALJ recognized this as she stated on page 14 of her decision that "any further details associated with these limitations are to be determined by the Board."

This variance fulfills the requirements of Wis. Stat. § 227.46(4), which provides that in any case which is a Class 2 disciplinary proceeding, the hearing examiner shall prepare a proposed decision, which includes findings of fact, conclusions of law, order and opinion, in a form that may be adopted as the final decision in the case. Ultimately, the Board of Nursing, as the regulatory authority and final decision maker, is authorized to make modifications as necessary to the proposed decision. Accordingly the Board has adjusted the order to now include the terms and conditions necessary to fulfill the requirements of the law:

ORDER

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

SUSPENSION

A.1. The license of Christele Williams, R.N., to practice as a nurse in the State of Wisconsin is SUSPENDED for an indefinite period.

A.2. The privilege of Christele Williams, R.N. to practice as a 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 a 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 of continuous, successful compliance for a period of at least five (5) years with the terms of this Order, including at least 600 hours of active nursing for every year the suspension is stayed, the Board may 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 six (6) months, but any time after six (6) months the suspension may be stayed upon Respondent providing proof, which is determined by the Board or its designee to be sufficient, that: (1) Respondent has been assessed as safe to practice by a qualified pain management specialist who has been approved in advance by the board; and (2) Respondent has been in compliance with the provisions of Sections C and D of this Order for the most recent six (6) 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. A substantial violation includes, but is not limited to, a positive drug or alcohol screen. A 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 the 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 or Respondent's attorney.

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 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 shall enter into, and shall continue, drug and alcohol treatment with a treater acceptable to the Board or its designee ("Treater"). Respondent shall participate in, cooperate with, and follow all treatment recommended by Treater.

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

C.3. Treater shall be responsible for coordinating Respondent's rehabilitation and treatment 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 Treater is unable or unwilling to serve as required by this Order, 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 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. 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's progress in drug and alcohol treatment. Treater shall report immediately to the Department Monitor any violation or suspected violation of this Order.

Releases

C.6. Respondent shall provide and keep on file with Treater, all treatment facilities and personnel, laboratories and collections 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 specimen screen results and patient health care and treatment records and reports, and (b) discuss the progress of Respondent's treatment and rehabilitation with Treater and treatment facilities and personnel, laboratories and collection sites. Copies of these releases shall immediately be filed with the Department Monitor.

AA/NA Meetings

C.7. Respondent shall attend Narcotics Anonymous and/or Alcoholics Anonymous meetings or an equivalent program for recovering professionals, at the frequency recommended by Treater, but no less than twice per week. Attendance of Respondent at such meetings shall be verified and reported quarterly to Treater and the Department Monitor.

Sobriety

C.8. Respondent shall abstain from all personal use of alcohol.

C.9. Respondent 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 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 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, Treater and the Board or its designee. Copies of these releases shall immediately be filed with the Department Monitor.

C.10. Respondent shall abstain from all use of over-the-counter medications or other substances (including but not limited to natural substances such as poppy seeds) which may mask consumption of controlled substances or of alcohol, create false positive screening results, or interfere with Respondent's treatment and rehabilitation. It is Respondent's responsibility to educate himself or herself about the medications and substances which may violate this paragraph, and to avoid those medications and substances.

C.11. Respondent shall report to Treater and the Department Monitor all prescription medications and drugs taken by Respondent. Reports must be received within 24 hours of ingestion or administration of the medication or drug, 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.

C.12. Respondent shall provide the Department Monitor with a list of over-the-counter medications and drugs that they may take from time to time. Over-the-counter medications and drugs that mask the consumption of controlled substances or of alcohol, create false positive screening results, or interfere with Respondent's treatment and rehabilitation, shall not be taken unless ordered by a physician and approved by Treater, in which case the drug must be reported as described in paragraph C.11.

<u>Drug and Alcohol Screens</u>

C.13. Respondent shall enroll and begin participation in a drug and alcohol monitoring program which is approved by the Department ("Approved Program").

C.14. At the time Respondent 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 and alcohol 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 on a daily basis, including vacations, weekends and holidays.

(b.) Production of a urine, blood, sweat, fingernail, hair, saliva or other specimen at a collection site designated by the Approved Program within five (5) hours of notification of a test.

C.15. The Approved Program shall require the testing of specimens at a frequency of not less than 22 times per year, (4 of which must be hair tests) 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.16. If any urine, blood, sweat, fingernail, hair, saliva or other specimen is positive or suspected positive for any controlled substances or alcohol, Respondent shall promptly submit to additional tests or examinations as the Board or its designee shall determine to be appropriate to clarify or confirm the positive or suspected positive test results.

C.17. In addition to any requirement of the Approved Program, the Board or its designee may require Respondent 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.18. All confirmed positive test results shall be presumed to be valid. Respondent must prove by a preponderance of the evidence an error in collection, testing, fault in the chain of custody or other valid defense.

C.19. The Approved Program shall submit information and reports to the Department Monitor as directed.

Practice Limitations

C.20. Respondent shall not work as a nurse or other health care provider in a setting in which Respondent has access to controlled substances.

C.21. Respondent shall practice only under the direct supervision of a licensed nurse or other licensed health care professional approved by the Board or its designee.

C.22. Respondent shall practice only in a work setting pre-approved by the Board or its designee.

C.23. Respondent may not work in a home health care, hospice, pool nursing, or agency setting.

C.24. Respondent 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.25. It is Respondent'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. If a report indicates poor performance, the Board may institute appropriate corrective limitations, or may revoke a stay of the suspension, in its discretion.

C.26. Respondent 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 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.

D.3. 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.4. 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 continue treatment and rehabilitation under the direction of another Treater or Approved Program.

Petitions for Modification of Limitations or Termination of Order

D.5. Respondent may petition the Board on an annual basis for modification of the terms of this Order, however no such petition for modification shall occur earlier than one year from the date of the initial stay of the suspension. Any 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.6. Respondent may petition the Board for termination of this Order anytime after five years from the date of the initial stay of the suspension. 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.7. Respondent 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.8. Respondent shall pay the full costs of this proceeding, in an amount to be determined by subsequent order of the board, within ninety (90) days of the date of the subsequent Order. Payment shall be made to the Department of Regulation and Licensing, Payment should be directed to the attention of the Department Monitor at the address in paragraph D.1., above. In the event Respondent fails to timely submit any payment of costs, the Respondent's license (#30-99320) may, in the discretion of the Board or its designee, be or remain SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

Additional Discipline

D.9. 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.

Dated at Madison, Wisconsin on June 3, 2011.

Wisconsin Board of Nursing

By:____
Kathleen Sullivan,
Chair