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Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings
Against **ZETISHA B. KAYDE, R.N.**, Respondent

FINAL DECISION AND ORDER
DHA Case No. DRL-10-0042
ORDER 0000893

Division of Enforcement Case No. 08 NUR 102

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

Zetisha B. Kayde, R.N.
2520 North 40th Street
Milwaukee, Wisconsin 53210

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 14th, 2010, the Department of Regulation and Licensing, Division of Enforcement filed a formal Complaint against Respondent Zetisha B. Kayde, alleging that Respondent Kayde was responsible for 90 oxycodone pills that went missing from one of her patient's supplies in February of 2008, in violation of Wis. Admin Code §§ N 7.04(1) and 7.04(2) (unprofessional conduct by means of violating law/obtaining drugs other than in the course of business), and subjecting her to discipline pursuant to Wis. Stat. § 441.07(1)(d).

On or about June 14, 2010, Respondent Kayde filed an Answer denying all allegations of misconduct against her, and affirmatively alleging that though she ordered additional narcotics for the aforementioned patient, she did so because the patient was experiencing increased pain. A Prehearing Conference was held by telephone on July 26, 2010, Amanda Tollefsen, administrative law judge, presiding. The Division, (by Attorney Jeanette Lytle), was present,

however, Respondent Kayde did not make herself available for this telephone conference. Because Respondent Kayde had filed an Answer, and was thereby assumed to have some interest in participating in the disciplinary proceedings against her, the administrative law judge continued the prehearing conference until August 10, 2010. The continued prehearing conference was held as scheduled on August 10, 2010. While the Division was (again) present for the prehearing conference, Respondent Kayde again did not make herself available. As such, the conference proceeded without her. Because Respondent Kayde had filed an Answer to the Division's Complaint, a contested case hearing was scheduled for October 12, 2010.

On October 4, 2010, the ALJ received an e-mail from Division Attorney Jeanette Lytle indicating that Respondent Kayde had told Attorney Lytle that she mailed the latter a signed stipulation on October 2, 2010. The hearing scheduled for October 12, 2010 was thus cancelled. On October 15, 2010, however, the ALJ received information from Attorney Lytle that she had yet to receive a signed stipulation from Respondent Kayde. Upon this information, the ALJ scheduled a prehearing conference for November 8, 2010. Respondent Kayde once again did not make herself available for the November 8, 2010, prehearing conference. The Division was present, and the prehearing conference once again proceeded without Respondent Kayde's participation. The contested case hearing rescheduled for January 5, 2011. Both Respondent Kayde, and the Division were present for the January 5, 2011, contested case hearing. 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.

On June 2, 2011, the Board reviewed the Proposed Decision submitted by the ALJ. The Board also reviewed the Objections to the decision submitted by the Division. Based upon the validity of the arguments and objections raised by the Division, the Board has varied the ALJ's recommendations for disciplinary terms as described in the Explanation of Variance and Order contained herein.

FINDINGS OF FACT

1. Zetisha B. Kayde, R.N., Respondent, date of birth December 4, 1973, is licensed by the Wisconsin Board of Nursing as a registered nurse in the State of Wisconsin pursuant to license number 160993, which was first granted December 6, 2007.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 2520 North 40th Street, Milwaukee, Wisconsin, 53210.

Heritage Nursing Home

3. Respondent's first nursing job was at Heritage Nursing Home in Port Washington, where she worked as a graduate nurse under a temporary license. (Transcript of January 5, 2011 Proceedings ("Tr."), p. 21). She worked there two to three months. (*Id.*).

4. After what appears to be a few weeks on the job, a patient who had previously been a nurse at this facility (L. D.) accused Respondent of failing to administer PRN oxycodone that Respondent claimed to have given her. (Tr. pp. 22-23, 75-78, 149-150). Upon this patient's return home from the nursing home, she noted that she had been charged for 24 pills when she had only received one (1). (Tr. p. 149).

5. After a six to seven week investigation into the above accusation[1], the nursing home administrator for Heritage Home told Respondent that he was no longer comfortable with her working there and let her go. (*See* Tr. pp. 21-22).

6. Respondent's claims that: (1) Patient L.D. fabricated the above accusation because she was friends with nurses and administrators who did not care for Respondent and, in fact, racially harassed her; (2) Patient L.D's story changed three times, until she came up with one that implicated Respondent[2]; and (3) she was let go for giving her keys to someone else to return after accidentally taking them home (*see* Tr. pp. 22-23, 168-169), are not credible, and not supported by any independent evidence.

7. Respondent's further claims that she was let go *because* she complained to the Assistant Director of Nursing (ADON) and Director of Nursing (DON) about being racially harassed, and because she would have been entitled to back pay from the period she was under investigation, are equally incredible and not supported by the transcript or any other part of the record. (*See* Respondent's Closing Argument, p. 1).[3]

Mary Jude Nursing Home

8. Respondent next recalls working at Mary Jude Nursing Home. (Tr. p. 33). She began working there in December of 2007, and worked there just a few months, before being terminated on February 28, 2008. (Tr. p. 33, *see also* Tr. p. 88).

9. During her employment at Mary Jude, Respondent was counseled by Mary Jude's Nursing Home Administrator, Michael Frisby, about medication administration and documentation. (Tr. pp. 88-89; Exhibit 3 pp. 42-43; *see also* Tr. pp. 33-35).

10. Respondent had documented giving PRN narcotics (specifically OxyContin) more frequently than they were ordered to be given to patient E. S., and more often then other nurses

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[1] It does appear that Respondent worked during this investigation. (*See* Tr. p. 167).

[2] Respondent claimed that she had evidence of this, and of the fact that she gave patient L.D. the oxycodone patient L.D. claimed not to have received (in the form of witness statements) with her attorney in the criminal case has been brought against her as a result of her conduct. (Tr. pp. 167, 188-196). She failed, however, to produce any of these statements or witnesses at hearing, and failed to produce the statements when the ALJ gave her a second opportunity to do so. (*See Id.*). Regardless of whether such evidence exists, the ALJ is convinced that Respondent diverted oxycodone from patient L.D.

[3] Respondent's Closing Argument makes references to many "facts" not introduced at the hearing. To the extent that they violate Wis. Stat. § 227.44(9), ("the factual basis of the decision shall be solely the evidence and the matters officially noticed"), they will not be considered.

were giving them to her. (Tr. pp. 88, 92-93, Exhibit 3 p. 44 (Controlled Drug Use Record)). She admits that she gave narcotics to patient E.S. too frequently. (*See* Tr. p. 169).

11. Despite being counseled, Respondent continued having problems with medication administration and documentation:

12. On or about February 26 of 2008, the facility discovered it was missing a card of OxyContin. (*See* Tr. p. 97). The signature sheet, indicating that the narcotic had been received by the pharmacy (*see* Tr. p. 99), was missing as well. (*Id.*).

13. Mr. Frisby's investigation revealed that Respondent had not documented giving out scheduled medications to many residents on February 26, 2008 on the medication administration (MAR) reports, against Mary Jude policy.[4] (Tr. pp. 98, 104, State's Exhibit 3 p. 45). (Upon questioning by Mr. Frisby, Respondent said that she'd given the medications, but did not document that they had been given. (*Id.*))

14. Further investigation revealed that on three different occasions, (including the one referenced above), Respondent ordered narcotics (specifically OxyContin[5]) during the day shift, worked a double shift, and signed for the narcotics when they arrived in the evening shift. (Tr. pp. 98 - 103). Later on, the narcotics were unaccounted for. (*Id.*). They were not signed out on either the narcotic count sheets, (showing that narcotics had been removed from the narcotic drawer), or the medication administration records, (showing that medications had been administered to a patient).[6] (*See* Tr. pp. 100, 101).

15. All of the above-referenced OxyContin was for patient E.S., the only patient on the first floor (where Respondent worked) to receive a PRN medication. (Tr. p. 105)).

16. In fact, Respondent had been ordering refills for PRN OxyContin for patient E.S., before she could have possibly finished this medication. (Tr. pp. 102-103; *see also* Tr. pp. 141-142). (Respondent was also prescribed a scheduled narcotic that was much stronger than the OxyContin at issue, which was merely for breakthrough pain. (Tr. pp. 93; Exhibit 7 pp. 107-110, Tr. p. 14)).

17. Patient E.S. had told other nurses that she had not received the PRN OxyContin that Respondent signed out for her. (Ex. 7 pp. 107-110; Tr. pp. 99 139 – 141). Mr. Frisby, however,

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[4] Although Mr. Frisby initially testified that the MAR reports he initially looked at to determine this did not include information as to whether the medications were narcotics, it appears it was later determined that the MAR reports for February 26, 2007 did not document that any narcotics had been administered to patient Sundemeyer (*See* Tr. p. 100). Unfortunately, the MAR sheets for the relevant time period were not made part of the record.

[5] a.k.a. oxycodone

[6] The signature sheets indicating that narcotics had been received, MAR reports and narcotic count sheets have not been made part of the record.

did not receive any allegations from patient E.S. that she was not receiving her medications. (Tr. p. 123).

18. Patient E.S. was usually about 80% on target in terms of her cognition. (Tr. pp. 126-127).

19. Respondent denies any knowledge that any medications had been unaccounted for at Mary Jude. (Tr. pp. 35-36). She claims she was terminated for improper charting, (specifically, she claims she did not realize she had to chart pain scales), but alleges she had done everything she was trained to do. (Tr. pp. 33-34). She further admits that she had been associated with three missing narcotic signature sheets that, two of which she claims were found. (Tr. pp. 36-37).

20. Nurses are taught how to administer medications and document medication administration in nursing school. (Tr. pp. 89-90).

21. Respondent was also trained during orientation, a process that lasted about a week. (*Id.*).

22. Mr. Frisby counseled her about her shortcomings during her employment, and also gave her written information on the standards of nursing practice for medication administration. (Tr. pp. 94-95, Ex. 3 p. 025). Respondent denies ever receiving the written information. (Tr. p. 172).

23. Nursing home policies with respect to control of narcotics are standard. (Tr. pp. 96, 121).

24. Respondent was terminated from Mary Jude on February 28, 2008 for failing to following their medication administration policy and for not signing out medications. (Tr. p. 106).

25. On March 6, 2008, Mr. Frisby filed a Caregiver Misconduct Incident Report with the Department of Health and Family Services. (Tr. pp. 106-107, Exhibit 1). Although he could not prove any misappropriation of patient Sundemeyer's medication (*see* Tr. p. 115), he believed that Respondent had taken her OxyContin, and wanted to "get this [information] into the system." (*Id.*)

26. Respondent's claims that she was never made aware that any medication was missing (Tr. 33-36?), and that she ordered more OxyContin for patient E.S. because she was experiencing more pain, a fact she claims she shared with the DON, are not credible and not supported by the record. (*See* Tr. pp. 109-11, 119).

27. Her further claims that patient E.S. was interviewed and stated that she did not recall that any of her medications went missing (*see* Respondent Closing Argument, pp. 1-2), is not supported by the record. (*See* footnote # 2).

Golden Living Center

28. Respondent worked at Golden Living Center from March 5, 2008 to May 6, 2008. (Tr. pp. 41-42).

29. Respondent was terminated after an incident involving missing narcotic count sheet. (Tr. pp. 42-44):

30. Specifically, on or about May 1, 2008, there was an incident in which Respondent (who was the acting p.m. shift supervisor) tried to avoid conducting a medication count with the oncoming nurse (Joyce Stuart, the acting night shift supervisor), claiming she did not want to miss her ride home. (Tr. pp. 144-145, Ex. 7 p. 98). Respondent reluctantly agreed to stay and do the count. (Tr. p. 145, Ex. 7 p. 98). It is unclear who counted the medications in the contingency box, and who wrote the count down on the proper form. (*Compare* Tr. p. 145 to Ex. 7 p. 98). Later on during Nurse Stuart's shift, another nurse who Nurse Stuart had given the contingency key to discovered that the amount of oxycodone in the contingency box did not correspond to the number written in the log. (*Id.*) The pharmacy "med sheet" was also discovered missing. (Ex. 7 p. 98) No one had been in the contingency box since Respondent and Nurse Stuart – an L.P.N with 44 years of experience. (Tr. p. 145). Indeed, shift supervisors are the only nurses who have keys to the contingency boxes. (Ex. 7 p. 98).

31. Respondent's claims that she (1) properly counted the above medications with Nurse Stuart nurse, and (2) signed the [pharmacy med] sheet, only to find out on her next shift that the sheet was no longer there[7], and (3) was terminated after that shift without an investigation, (Tr. p. 42), are not credible.

32. Respondent's further implication that it was the nurse whom Nurse Stuart gave the contingency key to that was responsible for the oxycodone count being off is equally unconvincing. (*See* Tr. p. 177-178). While it may have been inappropriate for Nurse Stuart to hand the keys to this nurse, the preponderance of the evidence demonstrates that Respondent was responsible party.

Allis Care Center

33. Respondent worked at Allis Care center from June 4, 2008 to October 13, 2008. (Tr. p. 44).

[7] Respondent appears to suggest that the sheet was intentionally discarded by others. (*See* Tr. p. 42).

34. She was trained initially, and then trained again after being out ill.[8] (Tr. p. 143).

35. Prior to being trained a second time, Respondent was counseled about improper documentation of medications. (Tr. pp. 45-47, Exhibit 7 p. 103). Specifically, Respondent was not properly documenting oxycodone administration on all necessary forms, and not documenting pain scales in patient notes. (Tr. pp. 47, 144, Exhibit 7 p. 103-104).

36. Additionally, a patient had claimed that she had not gotten (or even asked for) her medications (Percocet).[9] (Tr. p. 46 Ex. 7 p. 104). Respondent claims, unconvincingly, that she merely did not give the patient her medication on time.

37. Respondent was eventually terminated for continued non-documentation of narcotics. (Tr. pp. 45-46, 142, Exhibit 7 p. 104). Respondent admits this, and that she should have been documenting correctly. (Tr. p. 176). The DON stated that she had no reason to suspect Respondent of diverting narcotics, however, as all medications were accounted for every shift Respondent was associated with. (Exhibit 7 p. 104).

Menomonee Falls Healthcare Center

38. Respondent worked at Menomonee Falls Healthcare Center from November 20, 2008 to December 18, 2008. (Tr. p. 48).

39. On or about December 12 or 13, 2008, 10 pills (eight Vicoden tablets and two Ambien tablets) went missing from the contingency box in the medication room. This was less than one week after eight oxycodone pills went missing from the same place. (Exhibit 6 pp. 56, 58, *see also* Tr. pp. 48-52[10], 147).

40. After an investigation by both Menomonee Falls Healthcare Center and the Menomonee Falls Police Department, Respondent was issued a citation for the theft of the 10 missing pills that went missing on or about December 13, 2008, from the Menomonee Falls Police Department.[11] (Tr. p. 55; Ex. 6). She was furthermore terminated.

41. Respondent was one of only two employees who had access to the medication room during the time frame from which the medication went missing. (Ex. 6 p. 56). After the first theft, Menomonee Falls Healthcare Center had changed their procedure as to how medications were handled so that (1) only one nurse (the nurse supervisor) had access to the contingency box key during a shift, and (2) the nurse supervisor from the outgoing shift was required to go over

[8] Respondent passed out at work and was taken to West Allis Memorial Hospital shortly after beginning her employment, on or about June 14, 2008. (Tr. p. 143). She did not return to work until August 12, 2008.
[9] Unfortunately, this condition deteriorated before Mr. Gutierrez could confirm this information. (Ex. 7 pp. 103-104).
[10] In is unclear whether Respondent's testimony is in reference to the first or second alleged theft. It appears it is in reference to the first. (*See* Tr. pp. 48-56, compare with Exhibit 6).
[11] Despite numerous employee interviews, the perpetrator could not be identified. (Exhibit 6,p. 58).

and verify the medications that were in the medication room with the oncoming nurse supervisor. (Exhibit 6 pp. 58 and 65, *see also* Tr. pp. 53-54).

42. Respondent was the nurse supervisor for the p.m. shift on the evening before the discovery of the missing Vicodin and Ambien pills (December 12, 2008). (Ex. 6 p. 58).

43. The count at the time she arrived at work was normal. (*Id.* at pp. 58, 66).

44. Respondent was asked to inform the oncoming nurse (Nurse Carr) about a change in policy requiring both nursing supervisors to count medications, as the nurse for the next shift only worked weekends, and was not yet made aware of the new policy. (Ex. 6 pp. 65-66).

45. She did not do so, and no count was done. (Ex. 6, p. 72).

46. The count was off when Nurse Carr counted the medications with the oncoming nurse for the next shift. (*Id.*)

47. Respondent's claims that she: (1) did not inform Nurse Carr of the new count procedure because she was never informed of it; (2) told Nurse Carr to read the new policy regarding med counts; (3) assumed that Nurse Carr knew the new policy; (4) did not know anything about the second theft (Vicodin and Ambien); (5) that the reason she was issued a citation for the second theft was because she could not make it to a "meeting" regarding this theft, as she had been in a car accident, and was "walking around in a daze," (*see* Tr. pp. 53-56, 181-182), and (6) that Nurse Carr was associated with missing narcotics at another facility, are not credible and not supported by any independent evidence.

48. Her further claims that: (1) five nurses had access to the contingency box during the timeframe from which the medications went missing – of which she was not the last to have the contingency box key; (2) on the morning that it was realized that the 10 pills of Vicodin and Ambien was missing, she saw a nurse pull these same medications out of her pocket; and, (3) nothing ever came of her citation because she did not do anything are not supported by the record, and indeed, contradict some of her earlier testimony. (*See* footnote # 2).

Alexian Brothers

49. Respondent worked at Alexian Brother's Nursing Home one (1) day. (Tr. pp. 26-27, 32-22). Though Mr. Gutierrez's records identify this date at November 3, 2007, the date that Respondent worked at Alexian Brothers was actually November 3, 2008. (*See* Ex. 7 p. 101).

50. On November 4, 2008, a longtime L.P.N. at this facility (Nancy Reimer) was looking through the "Controlled Drug Use" sheets and noticed that resident B.K. was given two pills of oxycodone on November 3, 2008, at 16:00 and 21:00, by Respondent. Nurse Reimer looked at the "Nurse's Medication Notes" and observed no documentation that these four pills

were given to resident B.K. on November 3, 2008 by Respondent. Nurse Reimer was not aware of any change in resident B.K.'s condition to warrant the four pills of oxycodone given by Respondent. Since September 8, 2008, (55 days), the Controlled Drug Use form showed that resident B.K. had only received 17 doses of oxycodone total. (B.K.'s prescription stated, "Take (2) tabs by mouth every four hours as needed for breakthrough pain...."). Nurse Reimer saw no indication that resident B.K needed or asked for the pills from Respondent. (Exhibit 7 p. 101).

51. Nurse Reimer also noticed that the Controlled Drug Use form for another resident[12] noted that Respondent had had given this resident one (1) tablet of oxycodone twice in a row at 20:00 on November 3, 2010. At the bottom of this sheet was a notation that one of these doses had been wasted. (*Id.*)

52. Nurse Reimer immediately notified the Assistant Director of Nursing of the two instances. (*Id.*).

53. Respondent recalls giving two doses of pain pills at the first resident's request, but testified that she "thought" she documented the resident's pain. (Tr. pp. 30-31). Her claim is unconvincing.

54. Respondent further recalls dropping the second resident's pill, and not being able to find it. (Tr. pp. 28-29, *see also* Exhibit 7 at p. 102). She claims she did not know how to document this occurrence, and that there was no supervisor on duty to let her know. (*Id.*)

55. Thereafter, Alexian Brothers informed Respondent they had no more work for her. (Tr. pp. 31-32).

56. Respondent's claim that she was not given any more work with Alexian Brothers because Mr. Gutierrez (*see below*) called the facility and alerted it that he was investigating her (*see* Tr. pp. 31-32) is not credible.

57. Respondent's claim that the resident B.K. came to her and asked her for two [doses] of pain pills, and that she gave them to her as that was the correct amount to be given is equally unconvincing.

Mount Carmel

58. Respondent worked at Mount Carmel Nursing Home from January 8, 2009 through January 29, 2009. (Tr. p. 57).

59. After three weeks, she was told her services were no longer needed. (Tr. pp. 57-58).

[12] Unfortunately, neither of the above-referenced "Controlled Drug Use" sheets were put into evidence.

60. There were no claims of missing oxycodone from this facility.

Bel Air

61. Ms. Kayde worked at Bel Air nursing home for six to seven weeks, sometime after being asked to leave Mount Carmel and starting at St. Ann's. (Tr. pp. 59-61).

62. She was terminated for not disclosing all of the facilities at which she had worked. (Tr. pp. 59-61).

63. Respondent's claim that she did not do so because (1) there was not enough room on the application, and (2) the receptionist told her not to worry about adding a second sheet, as [Bel Air] never looked at all of the employers anyway (Tr. pp. 59-60)," is unconvincing.

St. Ann's

64. Respondent worked for St. Ann's beginning in June of 2009. (Tr. pp. 58-59, 63).

65. She was off some time due to an illness. (*Id*).

66. When she tried to come back to work in November of 2009, she was told she was suspended. (*Id*).

67. Respondent claims that she was not asked back because Mr. Gutierrez called this facility and alerted them to his investigation. (Tr. pp. 63).

Gutierrez Investigation

68. Detective Alfredo Gutierrez, a Medicaid fraud investigator, was alerted to Respondent's questionable work history by the Department of Health Services. (Tr. pp. 132-133). He began investigating.

69. Mr. Gutierrez spoke to Respondent's previous employers, documented each conversation, (Exs. 4 and 7), and prepared a summary of his conversations. (Tr. p. 133-139; Ex. 4 p. 51).

70. He noted that each time Respondent was employed, she was terminated after a short time amidst allegations of missing or non-documented medications, most specifically oxycodone. (*See* Ex. 4, p. 51).

71. Mr. Gutierrez further discovered that Respondent has had health problems, beginning with a botched gastric bypass in 2004. (Tr. pp. 152-154; Ex. 4; *see also* Tr. pp. 65 and 67 (Respondent admits to health problems stemming from gastric bypass surgery)).

72. Respondent admitted that she was on oxycodone during the time frame of May 4, 2007 to September 14, 2007, when she was working at Heritage of Port Washington. (Tr. p. 66). She has continued to take oxycodone to this day. (Tr. p. 67).

73. Mr. Gutierrez noted that when Respondent was working at Heritage Nursing Home of Port Washington, her prescription records show she was paying cash for her oxycodone pills. (Ex. 4; Ex. 5; *see also* Tr. p. 68). She was paying about $100 per month for her oxycodone. (Ex. 5).

74. Mr. Gutierrez confronted Respondent when she appeared at the Menomonee Falls Municipal Court with respect to her above-referenced citation (March 11, 2009). (Tr. p. 15; Ex. 4). He interviewed her at that time, and then again on March 12, 2009. (Tr. pp. 154-155; Ex. 4). During the second interview, Respondent confessed to taking oxycodone from several of her employers. (*Id.*). Mr. Gutierrez quoted Respondent as stating: "I only took a few, some pills of oxycodone from a few of the facilities." (*Id.*). Upon further questioning, Respondent admitted to stealing oxycodone from Heritage Nursing Home of Port Washington, Mary Jude Nursing Home, and Allis Care Center. (*Id.*).

75. At hearing, Respondent denied confessing to Mr. Gutierrez. (Tr. pp. 69-70). She claimed he told her to confess to taking the oxycodone but to blame her pain, so that the authorities would go easy on her. (*Id.*). Her claim is unconvincing.

76. Mr. Gutierrez testified that at no time did he suggest that Respondent confess to something she did not do. (Tr. p. 156). He told her to tell the truth. (*Id.*).

77. Respondent's claims that Mr. Gutierrez (1) calls facilities after Respondent is hired in order to have her terminated, and (2) based his determination that she was an addict on her size (*see* Respondent's Closing Argument, pp. 4-5), are not supported by the record. (*See* Footnote # 2).

78. On the above evidence, the administrative law judge finds that Respondent diverted narcotic medications from many of her past places of employment including Heritage Nursing Home, Mary Jude Nursing Home, Golden Living Center, Allis Living Center, Menomonee Falls Healthcare Center and Alexian Brothers. (*See above*). In addition to the plethora of evidence that indicates she did so, Respondent's testimony was defensive, full of excuses, contradictory, and completely disingenuous.

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 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.

5. 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."

6. 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."

7. The conduct described in paragraphs 3-75 of the Findings of Fact, above, constitutes a violation of Wis. Admin. Code §§ N 7.04(1) and 7.04(2), and thereby subjects Respondent to discipline pursuant to Wis. Stat. §§ 441.07(1)(c) and (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 Kayde (1) obtained a drug, other than in the course of legitimate practice or as otherwise prohibited by law, and (2) in doing so, violated a law substantially related to the practice of nursing. (*See* Wis. Admin, Code §§ N. 7.04(1) and (2). The Division has met its burden. Indeed, the record is replete with evidence that demonstrates that Respondent stole narcotics from numerous of her nursing home employers, in violation of N. 7.04(1)[13] and (2):

[13] Because stealing is against the law (*see* Wis Stat. § 943.20), and stealing narcotics is undeniably related to the practice of nursing, Respondent's conduct violates N. 7.04(1).

Since receiving her R.N. license in December 2007, Respondent has worked at least nine (9) different nursing homes. She was continually "let go" from these facilities for improper documentation of narcotics, and amidst allegations of theft. Three different patients of Respondent's have claimed that they did not receive narcotics Respondent claimed to have given them, and in more than one work setting, Respondent frequently administered PRN narcotics to patients who previously rarely received them. In most these instances, the narcotic involved was oxycodone (OxyContin), a narcotic pain reliever Respondent herself has been prescribed since 2004, and has had to pay cash for. Most significantly, Respondent confessed to having taken narcotics from several of the facilities at which she worked.

Respondent's attempts to (1) recant from this confession at hearing, and (2) suggest that *Mr. Gutierrez* was responsible for her inability to retain employment by "black-balling" her, were thoroughly unconvincing. Respondent has provided no reason to explain why Mr. Gutierrez would lie about Respondent's confession to him and/or purposely attempt to prevent her from gaining employment. Moreover, many of Respondent's numerous terminations occurred before Mr. Gutierrez' investigation began.

Respondents additional attempt to blame her tumultuous work history on being new, busy, and improperly trained, was equally incredulous. The evidence against her is just too great and too repetitive to be coincidental. In fact, it shows a very clear pattern of narcotic, and particularly oxycodone, theft.

Appropriate Discipline:

As discipline for the above-referenced violations, the Division recommends that Respondent Kayde's license to practice nursing be suspended for an indefinite period of time, with the opportunity for a stay of suspension after she has shown at least six months of compliance with drug treatment, testing, and counseling.[14] (Division's Closing Argument p. 9). 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.*). Finally, the Division requests that Respondent be required to take additional courses in the documentation of controlled substances, to ensure against the possibility that she truly does not understand the requirements. In support of its recommendation, the Divisions notes that this is how the Nursing Board has historically assessed discipline in cases where a nurse has diverted medications (*Id., see also 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).*

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

[14] 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 Kayde's conduct in (1) stealing narcotics from patients, and (2) trying to lay the blame elsewhere evinces that she has not yet been rehabilitated, and that she is still 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 Kayde ultimately participated in these disciplinary proceedings, she was at times less that cooperative, failing to appear for several prehearing conferences. Moreover, she was found to have diverted narcotics from numerous nursing homes, 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.

EXPLANATION OF VARIANCE

Upon review of the Divisions' Objections to the Proposed Decision, the Board accepts the Findings of Fact and Conclusions of Law but has determined that the ALJ's recommendations for discipline should be varied. The variance is specifically to include the terms and conditions contained in state's Exhibit A. The requirements set forth in Exhibit A reflect the standard disciplinary terms utilized on a consistent basis by the Board in cases involving drug and alcohol abuse and diversion of controlled substances by a nurse. Although the ALJ's factual and legal findings were sufficient to warrant inclusion of the standard impairment terms and conditions, the proposed order was vague and incomplete. The additional terms contained in Exhibit A provide the details necessary to protect the public by providing for specific monitoring and treatment requirements should Respondent be allowed to return to nursing practice in the future. It appears that the ALJ recognized that the Board would need to take such action as she stated on page 16 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

For the reasons set forth above, IT IS FURTHER ORDERED, effective the date of this Order:

SUSPENSION

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

A.2. The privilege of Zetisha B. Kayde, 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;

(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; and

(3) Respondent shall have completed at least three (3) hours of preapproved continuing education in Medication Administration and three (3) hours of preapproved continuing education in Documentation of controlled substances.

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.

Drug and Alcohol Screens

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 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.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.

IT IS FURTHER ORDERED that Respondent Kayde 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

Dated at Madison, Wisconsin on June 3, 2011.

Wisconsin Board of Nursing

By: _____
Kathleen Sullivan,
Chair