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Before The
State Of Wisconsin
Board of Nursing

In the Matter of the Disciplinary Proceedings
Against **DIANE C. WALTERS, R.N.,**
Respondent

FINAL DECISION AND ORDER
Order No. _____
ORDER 0001239

Division of Enforcement Case No. 09 NUR 290

The State of Wisconsin, Board of Nursing, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, make the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Board of Nursing.

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

Dated at Madison, Wisconsin on the 1 day of Dec, 2011.

Member
Board of Nursing

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings Against **DIANE C. WALTERS, R.N.**, Respondent	DHA Case No. SPS-10-0095

Division of Enforcement Case No. 09 NUR 290

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

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PROCEDURAL HISTORY

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

On or about December 3, 2010, the Department of Safety and Professional Services (formerly known ad the Department of Regulation and Licensing), Division of Enforcement ("Division") filed a formal Complaint against Respondent Diane Walters, alleging that while employed as a home health nurse in a home with seven special needs children during the weekend of July 25-26, 2009, a bottle of Roxicet (liquid Oxycodone with acetaminophen) in the home was tampered with, and diluted. The Complaint further alleged that: (1) Respondent was one of eight nurses who cared for the children that weekend; (2) that the seven other nurses who

worked in the home that weekend all voluntarily completed drug tests, and tested negative for Roxicet; (3) that Respondent refused to complete a drug test; and (4) that a review of Respondent's medical records showed that Respondent's physician had expressed concerns regarding Respondent's use of pain medications as Respondent had (a) asked for additional pain medications, (b) asked for early refills of her pain medications, (c) took more pills than were prescribed, (d) claimed that her husband had taken her pain medications and that her dog had eaten her pain medications, and (e) went through withdrawal due to taking more pain medications than prescribed, and running out early. The Complaint alleged that such conduct violated Wis. Admin. Code §§ N 7.04(2)(misconduct by administering, supplying or obtaining any drug other than in the course of legitimate practice or as otherwise prohibited by law) and N 7.03(2) (abuse of alcohol or other drugs to any extent that it impairs the ability of the licensee to safely or reliably practice), thus subjecting her to discipline pursuant to Wis. Stat. §§ 441.07(1)(c) and (d).

Respondent Walters filed an Answer to the Division's Complaint on or about December 16, 2010, denying all allegations against her, and affirmatively alleging (1) that she had no duty or obligation under state or federal laws to submit herself or her person to any drug test(s) demanded by the state or its administrative agencies and cannot be disciplined for seeking to protect her rights and immunities, and (2) that her medical records obtained without her consent, in violation of the physician-patient privilege and HIPAA. She alternatively moved the ALJ to dismiss that part of the Complaint alleging a violation of Wis. Admin. Code § N 7.04(2), for failure of the Complaint to allege grounds sufficient for discipline.

Following a prehearing conference held on January 12, 2011, and at the undersigned administrative law judge's request, the Division filed an Amended Complaint on or about January 19, 2011, noting that: (1) only six other nurses (and not seven) were present in the home where the Roxicet went missing on the weekend of July 25-25, 2009; (2) the only other person in the house that weekend capable of reaching the Roxicet was the children's father, who voluntarily complied with a drug test and tested negative for Roxicet; (3) while Respondent came to the hospital as requested, she appeared nervous, drank a great deal of water, went to the bathroom several times, and then ultimately refused to take the drug test. The Amended Complaint alleged that the afore-mentioned evidence was sufficient to prove, by a preponderance of the evidence, that it was Respondent Walters who tampered with and diluted the Roxicet.

On or about January 21, 2011, Respondent Walters filed an Answer to the Division's Amended Complaint again denying all of the above allegations, and again affirmatively alleging that she had no duty under state or federal law to submit herself to any drug test(s) demanded by the state, and cannot be disciplined for seeking to protect her rights

Respondent Walters further filed a Motion *In Limine* requesting that this administrative law judge (ALJ) exclude from evidence: any and all medical records of the respondent, as obtained from Aurora Advanced Health Care and Shopko Pharmacy, by the State of Wisconsin, its Department of Safety and Professional Services or its Division of Enforcement.

Though Respondent initially cited several grounds for her request, after a prehearing conference that took place on January 31, 2011, she withdrew all grounds for her motion except Wis. Stat. § 905.04 (physician-patient privilege).

This administrative law judge denied Respondent's motion in an Order issued on April 29, 2011, finding that Wis. Stat. § 146.82(2), allowing patient health care records to be released without informed consent in response to a written request by any state governmental agency to perform a legally authorized function, provides an exception to the general rule of confidentiality.

Pursuant to due Notice, the hearing in this matter was held on Monday, May 9, 2011, at 9:30 a.m.

Briefing was thereafter ordered, and received.

FINDINGS OF FACT

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

1. Diane C. Walters, R.N., (DOB 03/06/1966) is licensed as a professional nurse in the State of Wisconsin (license #30-104872). This license was first granted on September 9, 1990.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 832 Delaware Ave, Apt. C, Grafton, WI 53024.

3. For approximately four (4) months, (from approximately March of 2009, until July 27, 2009, when she was terminated), Respondent was employed by Gail Urbina to provide in-home care to Molly and Ebony Urbina. (Transcript of May 9, 2011, Hearing ("Tr."), pp. 142-143).

4. Respondent was one of several home health care nurses employed by Gail Urbina. (*See* Tr. pp. 30-31; Division's Exhibit 2, p. 005, Sheboygan Police Department Incident Reports for 6/22/2009 and 7/27/2009[1]; Amended Complaint ¶ 3, Answer to Amended Complaint, ¶ 3).

[1] Despite referencing this exhibit at hearing, and throughout her written closing argument, (*see* Tr. pp. 222-224; July 19, 2011, Closing Argument of Respondent), Respondent objected to the introduction of this exhibit at the time of the hearing, alleging it contained "nothing but hearsay," in violation of Wis. Stat. § 908.02, and furthermore was not signed by the reporting police officers, or submitted under seal of the Sheboygan Police Department, assumedly in violation of Wis. Stat. § 909.02. (Tr. p. 218). As Respondent was instructed at the outset of this hearing, "[hearing examiners are] not bound by common law or statutory rules of evidence, but shall admit all testimony having a reasonable, probative value." (Tr. pp. 13-14; *see also* Wis. Stat. § 227.45). Though unsubstantiated hearsay evidence may not be relied upon as the sole basis for a finding of fact, when corroborated, hearsay evidence is admissible. (*See* Tr. p. 14; *Gehin v. Wisconsin Group Ins. Bd.*, 2005 WI 16, ¶¶ 53-56, 58, 278 Wis. 2d 111, 692 N.W.2d 572). Because the Sheboygan Police Department Incident Reports (Division's Exhibit 2) are corroborated by several witnesses; because hearing examiners are not bound by Wis. Stat. § 909.02 – or virtually any other statutory rule of evidence; because Respondent has provided the ALJ no reason to believe that the Sheboygan Police

5. Molly and Ebony Urbina are two of seven adopted foster children that Gail Urbina and her husband Luis Urbina (now divorced) adopted. (Tr. pp. 58-59).[2] Gail Urbina also has two grown biological daughters, Crystal and Melissa. (*Id.*)[3]

6. Respondent primarily worked the night shift (approximately 7 or 8 p.m. until 7 a.m.). (*See* Tr. p. 142). Though she routinely worked every other Sunday, she would pick up shifts, and admittedly worked approximately two to four times per month. (Tr. pp. 142-143, 220, *see also*, Division's Exhibit 2, p. 006).

7. Respondent's attempt to assert that she only picked up additional *Sunday* shifts (Tr. p. 143) is not credible in light of: (1) her own contradictory testimony (Tr. pp. 142, 200); (2) testimony from Nurse Tammy Korman indicating that Respondent worked Saturday evenings from 5:00 p.m. to 9:00 p.m. (*see* Tr. pp. 37-40; *see also* Tr. pp. 91-90); (3) testimony from other witnesses that Respondent worked the weekend the medications went missing (*see infra*); and (4) her obvious interest in defending herself.

8. When Respondent worked the night shift, she would work alone. (Tr. p. 142).

9. The majority of the children in the Urbina house have special needs.[4] (*See* Tr. pp. 60-61, 107-112). Many take prescription medications, and from time to time, have taken narcotics. (*See* Tr. pp. 60-61, 107-112).

10. While caring for Molly and Ebony Urbina, Respondent was responsible for giving them their medications. (Tr. p. 143).

11. Molly, Ebony, and all of the other Urbina children's medications, (including narcotic medications), were kept in two unlocked kitchen cabinets. (Tr. pp. 112-113, 209). Respondent thus had access to all of the children's narcotic medications, as did all other nurses employed in the Urbina home. (*See Id.*).

12. While working for the Urbina's, other nurses in the home noted that Respondent was "high strung," "always on the go," "hyper," "loud," "boisterous," excessively "outgoing" and that she talked a lot. (Tr. pp. 34-35, 41, 123, 129). Nurse Bushek-Greve further testified that she was very up and bubbly at times, and at other times seemed ready to sleep. (Tr. p. 129).

Department Incident Reports are somehow fraudulent; and because Respondent herself relied on said police reports to the extent it helped her case, the Division's Exhibit 2 has been accepted into evidence, and considered by the ALJ.

[2] Six of these seven children lived with Gail Urbina while Respondent worked for her. (*Id.*).

[3] Though neither of Gail Urbina's biological children lived with her at the time Respondent worked for her, Crystal would stay with Gail Urbina on occasion. (Tr. pp. 59-60).

[4] Molly and Ebony had the most serious of those special needs: Molly, as a result of being shaken as an infant, was not able to walk, speak, control her bodily functions or eat. Ebony, as a result of being thrown from a third story window as a toddler, likewise could not walk, speak, control her bodily functions or eat. Indeed, she had a "trach," and was virtually bed-bound. (*See* Tr. pp. 31-32, 60-61, 107-112).

13. Shortly after Respondent started working at the Urbina household, Nurse Tammy Korman noticed that the Urbina children's medications, (particularly, Molly's Roxicet), were going down. (Tr. p. 50, *see also* Tr. pp. 32-33, 38-39, 50; Division's Exhibit 2, p. 009). Nurse Korman was initially surprised to find that Molly's Roxicet was down from where it had been, as Molly had not needed that medication for at least two months. (Tr. p. 32). She thus informed Nurses Jenna Peterson and Barbara Bushek-Greve and Gail Urbina of her findings, and began to keep an eye on Molly's Roxicet bottle. (Tr. p. 33). She noticed that the medication levels would fluctuate up and down too much in light of Molly's limited use of it. (*Id.*). She further noted that the bottle appeared tampered with after Respondent worked a shift. (Tr. p. 51).

14. Around the same time, Gail Urbina and Nurse Barbara Bushek-Greve (Molly and Ebony Urbina's case manager) also began to notice problems with the Urbina children's narcotic medications:

15. The first discrepancy the women appear to have noted was that Molly's Roxicet was being refilled more frequently than it should be based on documented use. (Tr. pp. 113-114; *compare* Tr. pp. 32-33, 38-39, 50).[5] Nurse Bushek-Greve further testified that some of Ebony's medication "seemed" to have been given without being recorded. (Tr. pp. 113-14).

16. Shortly thereafter, the Urbina children's other case manager (Nurse Peterson) informed Nurse Bushek-Greve that Respondent had spilled a dose or two [of Molly's medicine] without documenting it. (Tr. p. 115, *see also* Division's Exhibit 2, p. 006).

17. Respondent admitted to spilling at least one dose of medication. (Tr. pp. 143-144).

18. Nurse Bushek-Greve was further informed, by other LPNs working in the Urbina household, that Molly was only getting her PRN Roxicet when Respondent was working (Tr. pp. 115, *see also* Division's Exhibit 2, p. 006).

19. Then, in approximately mid-late June of 2009, Gail Urbina noticed that her son Jerry Urbina did not seem to get any relief from his narcotic pain relievers after having back surgery. (Tr. p. 62). Luis Urbina also noticed that Jerry was in a lot of discomfort after his surgery. (Tr. p. 93).

20. Gail Urbina brought this to Nurse Bushek-Greve's attention. (Tr. p. 62). The two checked the children's medications, and noticed that some of them were discolored. (*Id.*). They took the medications to Walgreens, who confirmed the medications were discolored and looked tampered with. (Tr. p. 63, 115, Division's Exhibit 2, p. 005). Gail Urbina called the police, who

[5] It is unclear whether Nurse Korman brought this to their attention, (*see above* at ¶ 13), or whether they noticed this on their own.

suggested several ways to control the children's medication supply, but did not take immediate action. (Tr. p. 64; *see also* Division's Exhibit 2, p. 006).

21. Gail Urbina and her two case managers, (Nurse Bushek-Greve and Nurse Peterson), began marking the children's medication bottles at this point. (Tr. pp. 64, 115-116)

22. Sometime thereafter, on a particular evening while Nurse Bushek-Greve and Nurse Peterson were preparing the "last doses" of the night before their shifts ended, Nurse Peterson noted that one bottle of medication looked fuller than it had. (Tr. p. 116). Respondent, who was the above nurses' "reliever," told them that this was because she spilled some of the medication, and added water so that it would not run out. (*Id.*).

23. No competent nurse would dilute medication after a spill. (Tr. p. 116). Such changes the quality of the medication. (*Id.*).

24. Finally, during the weekend of July 24-26, 2009, a bottle of Roxicet in the Urbina home was tampered with, and diluted:

25. Per a court ordered custody arrangement, this was Luis Urbina's weekend to be with the children. (Tr. pp. 88-89, 92).

26. As was always the case when it was Luis Urbina's weekend with the children, Gail Urbina planned to be away from the house. (*See* Tr. pp. 64, 65, 74, 119).

27. Prior to leaving the house, Gail Urbina and Nurse Bushek-Greve jointly marked the level in the narcotic medication bottle. (Tr. p. 64, 118)[6] Luis Urbina was unaware that the bottle had been marked, and, indeed, did not even know there was a problem with the narcotic counts in his children's home. (Tr. p. 93).

28. The only people in the Urbina household for the weekend (July 24-26), after the medication bottle was marked, were Luis Urbina, the younger Urbina children,[7] and the nurses on duty. (Tr. p. 89). (The incident report from the Sheboygan Police Department has identified

[6] Nurse Bushek-Greve recalls that Nurse Jenna Peterson was also present when the above-referenced bottle of medication was marked, and that she was "there for the evening." (Tr. pp. 118-119). While it is not clear from the record whether Nurse Peterson was present at the time the bottle was marked (Compare Tr. p. 64 to Tr. p. 118-119), the record does not support that she worked after the time the bottle was marked on the weekend of July 24-26, 2009. Indeed, the record is clear that Gail Urbina and Nurse Bushek-Greve requested all nurses that were on duty during the weekend of July 24-26, 2009, (and Luis Urbina) to take drug tests, and that all but one submitted. (*See* Tr. pp. 67, 120-121, Division's Exhibit 2, pp. 007 – 010, Closing Argument of Respondent, p. 2). Those nurses have been identified as Barbara Bushek-Greve, Rose A. Simon, Tammy Korman, Marsha Buevid, Dena A. Parker, Marsha S. Muensch, and Diane C. Walters. Even if Nurse Peterson did work, however, there is still little doubt that Respondent was the offending party. *See infra.*

[7] Indeed, Becky Urbina, was spending the weekend at her grandparents' house, and Crystal Urbina, who had no reason to stay at her mother's residence when she was not there, left with her mother. (Tr. pp. 64-65, p. 76). Both daughters were furthermore in Gail Urbina's car at the time she marked the medicine bottle. (*Id.*).

these nurses as: Barbara Bushek-Greve, Rose A. Simon, Tammy Korman, Marsha Buevid, Dena A. Parker, Marsha S. Muensch, and Diane C. Walters. (Division's Exhibit 2, pp. 008-012)).

29. None of the children who were home could have reached the medications. (Tr. pp. 64-65, 113, 121). The two children who could reach the medication, (Becky and Crystal) were gone for the weekend. (*See* footnote 11). Moreover, Becky Urbina had been drug tested by Gail in the past, and the tests were negative. (Tr. pp. 47-48, 72-73; *see also* Division's Exhibit 2, p. 005).

30. When Gail Urbina returned home at the end of the weekend, she checked the narcotic medication, and found that the levels had gone down and the medication appeared to have been tampered with. (Tr. pp. 65-66).[8] It is unclear from the record whether Ms. Urbina made this discovery late Sunday evening, or early Monday. (*Compare* Tr. p. 65 to Division's Exhibit 2, p. 007-008). *Id.*

31. There is further evidence in the record that Nurse Korman noted that the level of the Roxicet bottle was "missing quite a bit" at 9:30 p.m. on what appears to be Saturday, July 25, 2009. (*See* Tr. pp. 38-39). Both Nurse Korman and Luis Urbina confirmed that Respondent sometimes worked Saturdays, and even Respondent admitted that she would pick up shifts. (Tr. pp. 37-40, 90-01, 142-143).

32. Gail Urbina had her adult daughter, Crystal, take the bottle to a Walgreens Pharmacy, at which it was confirmed that the medication bottle was diluted in comparison to a bottle of stock Roxicet. (Tr. p. 67, 94-96, 99).[9] She then called the police, who recommended that everyone with access to the medications be drug-tested. (Tr. p. 67).

33. Nurse Bushek-Greve contacted all the nurses who had worked in the Urbina home on the above-referenced weekend, and Luis Urbina, and asked them to submit to drug-testing. (Tr. pp. 120-121). She informed them that they were being asked to take this drug test because they had worked during the weekend of July 25-26. No other information was provided to them, including what they were being tested for, or what medication had gone missing. (*See* Tr. p. 122).

34. Respondent asserts that she did not work on the above-referenced weekend until Sunday, July 26, 2009, at 8:00 or 9:00 p.m. (Tr. p. 200; *see also* Division's Exhibit 2, p. 010). Others have provided testimony suggesting that Respondent may also have worked at the Urbina home on Saturday, July 25, 2011, as well, and in any event, worked before the drugs were noted

[8] There is some confusion as to which child's Roxicet this was. (*Compare* Tr. p. 38 , Tr. p. 66 and Tr. p. 120). Regardless, none of these children would have needed it during this time frame. (*See Id.*).

[9] Respondent attempts to suggest that because Gail Urbina herself did not take the bottle to Walgreens, there is a chain of custody problem, and no way of ruling out that Crystal diverted and diluted the Roxicet on the way to the pharmacy. (Respondent's Closing Argument, p. 19). As there is evidence in the record to show that the Roxicet was noted to be reduced and diluted before Crystal handled it, her claim does not hold water.

to be missing. (*See* Tr. pp. 36, 39-40, 80, 91-92). While none of the witnesses could recall exactly when Respondent worked on the weekend of July 24-26 (*see generally*, Transcript)[10], it is clear that she did work, and that at the time of the incident, she was identified as someone who had been on duty when the drugs went missing, and thus, who needed to take a drug test. (*See* Tr. pp. 70, 120-121).

35. The six other nurses who worked that weekend, and Luis Urbina, all voluntarily completed drug tests. All were negative for Roxicet. (Amended Complaint, ¶ 5, Answer to Amended Complaint, ¶ 5).

36. While Respondent came to the hospital as requested, while waiting, she appeared nervous, drank a great deal of water, and went to the bathroom several times. (*See* Tr. pp. 35 68, 122). She further seemed hesitant in wanting to give a urine sample, had several questions about the drug test, (*i.e.* what drug had gone missing, what drug the nurses were being tested for, what was going to happen to the person found to be guilty of taking the medication, who the other nurses believed took the medication, and whether she could return to take the drug test the following morning), and made several phone calls to her husband and attorney. (*See* Tr. pp. 34, 68, 207; Division's Exhibit 2, pp. 011-012). She ultimately refused to complete the drug test, asserting that her husband and lawyer had told her not to because she was on some [prescription] medications that could result in a false positive. (*See* Tr. p. 123; Division's Exhibit 2, p. 012; *see also* Tr. p. 213.

37. There is no law in Wisconsin that requires nurses to submit to drug tests.

38. The Sheboygan Police Department made it known that none of the nurses or Luis Urbina had to subject themselves to the urine drug screens and that they were free to leave the hospital at any time. (Tr. pp. 205 - 206; Division's Exhibit 2, pp. 007-008).

39. Nevertheless, Gail Urbina told Respondent that if she did not take the drug test, she would be terminated from her employment at the Urbina household. (Tr. p. 68; Division's Exhibit 2, p. 12; *see also*, Tr. p. 124).

40. Respondent was further told that if she tested positive for a medication, but had a prescription for it, there would be no negative consequences. (*See* Tr. pp. 68, 123-124; *see also* Tr. pp. 206-208).

41. Respondent was terminated for failing to take the requested drug test. There have been no problems with missing narcotics in the Urbina home since Respondent's termination. Moreover, there were no problems before she began working there. (Tr. pp. 54, 71, 126).

[10] Unfortunately, and inexplicably, there are no records to confirm the nurses work schedules for the weekend of July 24-26, 2011.

42. Respondent's medical records were thereafter obtained. (*See* Division's Exhibits 4 and 5).

43. Respondent has chronic pain. At various times, she has complained of back pain, neck pain, shoulder pain, arm pain, leg pain, elbow pain and post-accident whiplash pain. (Tr. pp. 145, 151, 156, 158-161, 173, 179, 192).

44. She regularly takes Tramadol (non-narcotic) for her pain[11], and sometimes takes the narcotics Percocet (fairly often) or Opana (much more rarely). (Tr. pp. 147-148, 163-164, 170-172, 180, 196, and generally; *see also* Division's Exhibits 4 and 5).

45. Respondent also routinely requests and receives Tussionex, a narcotic medication, for sinus infections and smoking-intensified bronchial inflammation. (*See* Tr. pp. 147-148, 155, 161, 162, 168, 169, 171, 172, 175, 176, 177, 179, 180, 182, 186, 190, 195; *see also* Division's Exhibits 4 and 5). Indeed, the record reflects that Respondent was prescribed Tussionex on the following dates from January 2008 until May of 2010: 1/3/08 (Division's Exhibit 4, p. 021); 4/26/08 (*Id.* at p. 045); 6/2/08 (*Id.* at p. 061); 7/28/08 (*Id.* at p. 069); 10/18/08 (*Id.* at p. 77); 10/23/08 (Division's Exhibit 5, p. 231); 12/15/08 (Division's Exhibit 4, p. 086); 2/15/09 (*Id.* at p. 112); 3/5/09 (*Id.* at p. 117); 4/6/09 (*Id.* at p. 120); **5/20/09 (*Id.* at p. 126); 8/21/09 (*Id.* at p. 144);** 9/1/09 (*Id.* at p. 149); 11/20/09 (*Id.* at p. 160); 12/31/09 (*Id.* at p. 174); 5/14/09 (*Id.* at p. 194)). The dose ordered was always one teaspoon (5 ml) every 12 hours. (*See citations, above*).

46. Respondent's physician has expressed concerns regarding Respondent's use of pain medications. (Tr. p. 183, 192-193; Division's Exhibit 4, pp. 153, 182).

47. Despite testifying that she always takes her medications as scheduled, Respondent has asked for additional pain medications, asked for early refills, and taken more pills than prescribed. (*See* Tr. pp. 150-151, 160, 170, 174, 181-182; *see also* Division's Exhibit 4 pp. 039, 071-072, 090, 146, 152-153, 167).

48. She was not always accurate in her reports to physicians about her pain medication use. (*See* Tr. pp. 166-168).

49. Often, her requests and/or prescriptions for narcotic medications were during urgent care visits, as opposed to visits with her regular physician. (*See* Tr. pp. 161, 186-187, 190, 195; *see also* Division's Exhibit 4, pp. 043-044, 066-069, 075-077, 084-086, 110-112, 118-120, 124-126, 142-144, 197-199).

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[11] The Division requested that the ALJ take judicial notice of information it obtained from the U.S. Department of Justice, Drug Enforcement Administration website, suggesting that Tramadol can be abused, and is controlled as a narcotic in two states. The ALJ does not believe it is appropriate to take judicial notice of such information per Wis. Stat. § 227.45 (3) and (4).

50. She claimed that her husband had taken her pain medications, and that the dog had eaten her medications. (*See* Tr. pp. 150-151, 189, 191-193; *see also* Division's Exhibit 4 pp. 167, 177). (Interestingly, Respondent first claimed that her dogs knocked over her bottle of Tussionex, but when presented with the record, testified that they knocked over and ate her Tramadol, thinking it was "treats.")

51. She went through withdrawal due to taking more medications than prescribed and running out early. (Tr. pp. 191-192; *see also* Division's Exhibit 4, pp. 177, 181-182).

52. There is a gap in Respondent's narcotics prescriptions between 5/20/09 and 8/21/09, during which time she was working at the Urbina home. (*See* Division's Exhibit 5, p. 232).

53. Respondent also requested Zolfran on a frequent and regular basis. (Tr. p. 175; *see also* Division's Exhibit 4). (Zolfran is an anti-nausea medicine. (Tr. p. 149)).

54. Narcotic medications can, and are known to cause nausea. (Tr. pp. 144-145, 178-179).

55. Other known side effect of narcotics, per Respondent, are mood swings and lethargy. (Tr. p. 145). She demonstrated some of these characteristics as well. (See ¶ 12, above).

56. Respondent was extremely defensive and even defiant during these proceedings, testified contrary to the record, until presented with it, in at least one instance (*see* ¶ 46, *above*), and made excuses for any behavior that could be seen negatively. She furthermore seemed to change her story to make it appear less and less likely that she was in the Urbina home at the time she perceived the Roxicet to have been tampered with during the weekend of July 24-26, 2009. (*See* ¶ 7, *above*). Finally, she appeared wired, as if she were on something.

57. In light of all the above findings, the ALJ is convinced that that Respondent lied to both the Department and the tribunal, and that she diverted, and diluted, Roxicet from the Urbina home, not only on the weekend of July 24-26, 2009, but on several prior occasions as well.

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 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. Wisconsin 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. Wisconsin 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. Respondent's conduct in diverting Roxicet from the Urbina home, and then diluting it to appear full, (*see above*), constitutes a violation of Wis. Admin. Code § N 7.04(2), and thereby subjects Respondent to discipline pursuant to Wis. Stat. §§ 441.07(1)(d).

9. Respondent's conduct in diverting and diluting the Urbina children's Roxicet, so that that the quality of the medication they were receiving was changed, further constitutes a violation of Wis. Admin. Code § N 7.03(2), and thereby subjects Respondent 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. As such, the Division had to prove, by the greater weight of the credible evidence, that Respondent Walters: (1) obtained a drug, (specifically, Roxicet, a narcotic), other than in the course of legitimate practice or as otherwise prohibited by law, in violation of Wis. Admin. Code § N 7.04(2); and (2) abused drugs to such an extent that that it impaired her ability to safely and reliably practice, in violation of Wis. Admin. Code § N 7.03(2).

Diversion of Roxicet:

Respondent argues that because the Division failed to conclusively show that she worked prior to the time that Nurse Korman believes she noticed that the much discussed bottle of Roxicet was tampered with on the weekend of July 24-26, 2009[12], it has failed to meet its burden in proving that she is the one responsible for diverting said Roxicet. (*See* Closing Argument of Respondent, pp.1, 2-6).

While the Division may not have produced a work schedule or other documentary evidence directly linking Respondent to the Urbina home prior to the time that Nurse Korman, (or even Gail Urbina), discovered that the bottle of Roxicet had been tampered with and diluted on the weekend of July 24-26, 2009[13], the preponderance of the evidence that was presented at hearing leaves little doubt that Respondent diverted and diluted Roxicet from the Urbina home, both on, and before, this weekend.

Weekend of July 24-26, 2009

This evidence shows that it is more likely than not that Respondent worked in the Urbina home prior to the time that the Roxicet bottle was discovered to have been tampered with on the weekend of July 24-26, 2009. Indeed, Respondent admittedly worked that Sunday July 26, 2009; others placed her in the Urbina home as early as Saturday July 25, 2009; Respondent was known to work Saturdays by both Nurse Korman and Luis Urbina and admittedly picked up shifts; regardless of Respondent's schedule, Nurse Korman is certain Respondent worked before her on the weekend of July 24-26, 2009, and before she noticed that the Roxicet level was down; Gail Urbina may not have confirmed that the bottle of Roxicet that she had marked had been tampered with until early Monday – well after Respondent's Sunday night shift has commenced, and, finally; at the time of the incident, when memories were clear, Respondent was identified as someone who had been on duty when the drugs went missing. (*See* Findings of Fact ¶ 34).

Other Evidence of Diversion

When one combines this evidence, with the facts that: (1) Respondent was the only person of those identified as having access to the Roxicet during the weekend of July 24-26, 2009, to refuse a drug test; (2) everyone else's tests were negative for Roxicet; (3) while waiting to take the drug test, Respondent appeared nervous, drank a great deal of water, asked if she could return the next day, and called her lawyer; (4) Respondent was noted to be very "up and down," and even "hyper" while at work, concerning other nurses; (5) Respondent admittedly spilled at least one dose of Roxicet, and when a bottle of medication was noted to be fuller than it had been Respondent told Nurse Bushek-Greve that this was because she had spilled some of the medication, and added water so that it would not run out; (6) Respondent has chronic pain, and

[12] 9:30 p.m. on Saturday, July 25th, 2009. *See* Findings of Fact ¶ 31.
[13] As identified in Finding of Fact ¶ 30, is not clear whether Gail Urbina made this discovery was on Sunday evening, July 26, 2009, or early Monday, July 27, 2009.

was almost continuously prescribed the narcotic Tussionex; (7) Respondent overused and exhibited other concerning behavior with respect to her pain medications, including obtaining narcotics at urgent care visits, claiming that her husband had taken them and that her dog had eaten them, and going through withdrawal symptoms when not prescribed; (8) Respondent's medical records reflect a gap in her prescription of narcotic medications from 5/20/09 to 8/21, during which time she was working at the Urbina home, and, most significantly; (9) there were other problems with missing and diluted narcotics while Respondent was working at the Urbina home, and (10), there were no problems with missing narcotics before Respondent began working for them, or after she was terminated – it is clear that Respondent was illegitimately diverting Roxicet from the Urbina home. (*See* Findings of Fact ¶¶ 12, 17, 22, 35-36, 45-50, 52; Wis. Admin Code § N 7.04(2)).

Respondent is thus subject to discipline pursuant to Wis. Stat. § 441.07(1)(d)

Impaired Ability to Safely and Reliably Practice:

This was a much more difficult determination for the ALJ, as the Division did not produce much in the way of evidence showing that Respondent cared for either Molly or Ebony Urbina while in an impaired state.

Nevertheless, there is credible evidence from at least two witnesses that Respondent was excessively "up" while at work and that more than one nurse was concerned about her behavior. There is further credible testimony that while Respondent was extremely bubbly and happy at times, within a short period of time, she would be down, like she was ready to sleep. Such "up and down" behavior while at work indicates impaired practice. (*See* Findings of Fact, ¶ 55).

Even more importantly, however, the preponderance of the evidence shows that Respondent abused pain medications to the extent that she diverted Roxicet from severely disabled children, diluting whatever remained so that the bottle would appear full. In the process, she changed the medications' properties, and assumedly, effectiveness. (Findings of Fact, ¶ 23). The ALJ cannot imagine a clearer example of drug abuse leading to an impaired ability to safely and reliably practice. (*See* Wis. Admin. Code § N 7.03(2).

In light of her above conduct, Respondent Walters 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 Walter's 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 twelve months of compliance with drug treatment, testing, and counseling. (Division's

Closing Argument, pp. 11-12). 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 Division 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 due to drug use, and there is cause to be concerned about a nurses' fitness to practice. (*Id., citing In re Disciplinary Proceedings Against Christele Williams* (*at https://ice/enforcement/orders/OrderViewDoc.aspx?orderID=6094, In re Disciplinary Proceedings against Zetisha Kayde (at https://ice/enforcement/orders/OrderViewDoc.aspx?orderID=6095), In re Disciplinary Proceedings Against Lolita Sharpe (at https://online.drl.wi.gov.decisions/2010/ORDER0000465-00005372.pdf), In re Disciplinary proceedings Against Pamela Divine (at https://online.drl.wi.gov/decisions/2010/LS0710122NUR--00005499.pdf*[14])).

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

As identified in *State v. Aldrich*, 71 Wis. 2d 206 (1976), the three goals of discipline are to: (1) promote the rehabilitation of the licensee; (2) protect the public from other instances of misconduct; and (3) deter other licensees from engaging in similar contact. *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, the ALJ 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*. Respondent Walter's conduct in (1) diverting Roxicet from severely disabled children, (2) diluting the remainder to cover her tracks, and (3) continuously taking, overusing, and "losing," prescribed pain medications evinces that she has serious drug-abuse problem that requires rehabilitation, without with she is very much a danger to her patients and the public. Her inability to accept that she has a problem only strengthens that concern. Finally, her continued need for narcotics and other pain killers, due to chronic pain, raises concern about her ability to practice. The relief requested by the Division is thus appropriate, and even necessary, to ensure rehabilitation and to protect the public from future instances of misconduct by the respondent – with one exception.

The ALJ sees no reason to require Respondent to show *at least twelve months* of compliance with drug treatment, testing, and counseling before she may request a stay of her suspension. The Division provides no reason for this extensive requirement, and such is at odds with the decisions it cites above. Consistent with the *Williams* and *Kayde* decisions, the ALJ believes that the Respondent need only show six months of compliance with drug treatment, testing, before she may request a stay.

[14] This citation references an Order Denying Request for Stay of Suspension.

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 Safety and Professional Services 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;
7) Any other relevant circumstances

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

Though Respondent Walters participated in these disciplinary proceedings, she was at times less that cooperative, fighting hard to keep her medical records out of evidence, and failing to initially present herself at the hearing, even though she was at the Department of Regulation and Licenses' Offices, because she had not been formally subpoenaed.

Balancing these factors with the counts proven, the seriousness of her misconduct (stealing pain medications from special needs children), and the "program revenue" nature of the Department of Safety and Professional Services, the ALJ finds that the respondent should pay all of the costs involved in investigating and prosecuting this matter.

ORDER

For the reasons set forth above, IT IS ORDERED that the license of the Respondent Diane C. Walters to practice nursing in the State of Wisconsin be and is hereby **SUSPENDED FOR AN INDEFINITE PERIOD OF TIME.**

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

SUSPENSION

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

A.2. The privilege of Diane Walters, 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 Safety and Professional Services 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 Safety and Professional Services 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 Safety and Professional Services, 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 Safety and Professional Services
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 Safety and Professional Services, 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 Williams 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 Safety and Professional Services and sent to:

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

IT IS FURTHER ORDERED that the above-captioned matter be and hereby is closed as to Respondent Diane C. Walters.

Dated at Madison, Wisconsin on September 23, 2011.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
5005 University Avenue, Suite 201
Madison, Wisconsin 53705-5400
Telephone: (608) 266-7644
FAX: (608) 264-9885

By: Amanda Tollefsen
Administrative Law Judge

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