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Before The
State Of Wisconsin
BOARD OF NURSING

In the Matter of the Disciplinary Proceedings
Against **JOHANNA R. EDWARDS, R.N.,**
Respondent

FINAL DECISION AND ORDER
WITH VARIANCE

DHA Case No. SPS-11-0060

ORDER 0001589

Division of Enforcement Case No. 09 NUR 382

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

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PROCEDURAL HISTORY

These proceedings were initiated when the Department of Safety and Professional Services, Division of Enforcement (the Division), filed a formal Complaint against Respondent Johanna R. Edwards on June 27, 2011, alleging violations of Wis. Stat. § 441.07(1)(d), and Wis. Admin. Code § N 7.04 (intro), (1), (2) and (6). A prehearing conference was held on August 15, 2011, and a hearing was held before the undersigned Administrative Law Judge (ALJ) on November 8, 2011. Post-hearing briefing was completed on February 9, 2012. After conclusion of the hearing process, the ALJ prepared a Proposed Decision and Order which included findings of fact, conclusions of law and disciplinary recommendations.

On April 12, 2012, the Board of Nursing reviewed the ALJ's Proposed Decision and Order. Based upon its review of the proposed decision, the board voted to adopt the findings of fact and conclusions of law in the proposed decision and to issue a variance to the disciplinary recommendations. The basis for the variance is set forth in the section of this Final Decision and Order titled Explanation of Variance.

FINDINGS OF FACT

1. Johanna R. Edwards, R.N., is licensed as a professional nurse in the State of Wisconsin (License No. 152335). This license was first granted on August 26, 2005.

2. During the events that gave rise to this disciplinary matter, Ms. Edwards was employed as a professional nurse at Aurora Visiting Nurse Association (VNA) in Oshkosh, Wisconsin, where she had been employed since 2007. Ms. Edwards worked as a hospice nurse and also became lead nurse supervising approximately ten other nurses involved in hospice, palliative care and home care (Tr., pp. 43-44, 197-98).[1]

3. On September 23, 2009, a letter was received by the Wisconsin Department of Health Services (DHS), which is signed, "A very concern [sic] citizen and Medical Professional," and which states, in relevant part: "Just recently Johanna [Edwards], a Hospice Nurse from the Aurora VNA was in our facility seeing a patient of ours when she received a phone call from another Aurora VNA nurse. Johanna informed the person on the other end that if they needed any liquid Morphine they could go into the bottom drawer of her desk and take a vile that she had saved from a patient that had passed away." The letter also includes complaints about Ms. Edwards' documentation and lack of follow-through. It further states: "I have also heard that the working conditions are horrible. The management is threatening and very harassing to the employees there. The office has had staff quit because the working conditions are not good. If the moral[e] of the staff and the treatment from the Management team are poor, what kind of care is the patient's receiving?" [sic] (Exh. 5, p. 11).

[1] In this Proposed Decision, the transcript of the November 8, 2011 hearing is referenced as "Tr." and the exhibits as "Exh."

4. DHS's State Surveyor met with the VNA's Director of Clinical Services, and after reviewing the letter from DHS, met with Ms. Edwards at her desk on October 19, 2009 to conduct a search of Ms. Edwards' desk drawers (Exh. 5, p. 1; Tr., p. 140).

5. The following items were found in Ms. Edwards' unlocked desk drawers: one sealed full bottle (30 ml.) (a total of 600 mg.) of liquid morphine sulfate, a Schedule II controlled substance, 6 Compro® (prochlorperazine) suppositories and 6 acetaminophen suppositories. The Compro was in a different drawer than the morphine (Tr., pp. 141-146).

6. When the medications were found in Ms. Edwards' drawer, Ms. Edwards was immediately placed on an investigative suspension at the VNA (Exh. 5, p. 1).

7. The box found in Ms. Edwards' desk drawer containing the morphine has a pharmacy prescription label which, although partially torn off, has the name, "Avis" on it. The prescription label is for Avis Hazen, a patient who died in her home on January 23, 2009. The bottle of morphine itself does not contain Ms. Hazen's name or a prescription pharmacy label. However, the lot number and expiration date on the box are the same as the lot number and expiration date on the bottle. Both the acetaminophen and Compro suppositories are inside plastic bags, which have prescription labels with Ms. Hazen's name on them. Inside the plastic bags is packaging which directly encases the suppositories and which is not labeled with Ms. Hazen's name (Tr., pp. 31, 156-157; Exhs. 2, 3 and 5, pp. 2-3, 12-14).

8. The morphine, acetaminophen and Compro were picked up at Aurora pharmacy on January 22, 2009 by Ms. Hazen's son, Daryl Hazen (Exh. 4; Exh. 5, p. 19; Tr., pp. 144-145).

9. Ms. Edwards and her nurse colleague, Nikki Ryberg, responded to a "death call" to Ms. Hazen's home on January 23, 2009, during which they retrieved medications from Ms. Hazen's home.

10. Ms. Edwards, with Ms. Ryberg as a witness, signed a document dated January 23, 2009, attesting to the destruction of certain medications found at Ms. Hazen's home. The document begins, "The following controlled drugs have been disposed of on this date: 1/23/09" and then lists a series of medications. The list includes 20 ml. of morphine but does not include 30 ml. of morphine. The list does not contain any acetaminophen and contains 2 entries of Compazine, one for "1 tab" (25 mg.) and the other for "6 supp" (25 mg.) (Exh. 5, p. 18).

11. Robert Solie testified that he had been the manager of Loss Prevention Services at Aurora Healthcare for the past 33 years and that he was assigned to investigate Ms. Edwards' conduct for Aurora. In interviewing Ms. Edwards' colleagues, many of them described Ms. Edwards as a very caring nurse (Tr., pp. 139-40, 168).

12. According to Mr. Solie's Case Report Narrative (the Report) (Exh. 5, pp.1-10), Mr. Solie met with Ms. Edwards on October 20, 2009. Immediately into the interview, Ms. Edwards told Mr. Solie that the medications found in her desk were nothing more than a set-up by someone who was out to get her. Mr. Solie asked her if she suspected anyone who may have planted the medications in her desk and she was unable to offer the identity of a possible suspect (Exh. 5, p. 4).

13. The Report further indicates that Ms. Edwards stated that the Aurora VNA policy was that unused medication be destroyed at the patient's home and that she had never transported any medications from a patient's home to the VNA office but that she was aware that other nurses had done so (Exh. 5, p. 5).

14. The Report states that Mr. Solie explained to Ms. Edwards that, in cross-referencing Ms. Hazen's name with the expiration date and lot number of the morphine found in Ms. Edwards' drawer, it was determined that Ms. Hazen's relative had purchased the medication on January 22, 2009. He further informed Ms. Edwards that, according to Ms. Hazen's medical records, Ms. Edwards had performed a "death call" at Ms. Hazen's residence on January 23, 2009. He also indicated to Ms. Edwards that the medical records further showed that no other VNA employee had been at the Hazen residence prior to January 20, 2009, which led him to believe that Ms. Edwards had access to the morphine found in her desk (Exh. 5, pp. 6-7).

15. According to the Report, Ms. Edwards told Mr. Solie that VNA nurses often visit the patients' homes following the death to see how the family is doing. According to the Report, Mr. Solie then "interjected and asked Ms. Edwards if she expected [him] to believe that a VNA Nurse visited the home of patient Haze[n], after her death, obtained medications that she (Edwards) should have collected on her 'death call visit,' kept the medication in their [sic] possession for 9-plus months, and then planted it in her desk drawer?" According to the Report, Ms. Edwards "thought momentarily, then stated, 'I guess that would be stretching it.'" The Report further states that Ms. Edwards then "admitted that she might have inadvertently placed the medications in her desk drawer." Mr. Solie asked Ms. Edwards if she had ever discussed with a co-worker having morphine in her desk drawer in case a patient needs it for pain control, and Ms. Edwards responded that she had not and could not think of any reason why a co-worker would say that because it was not true (Exh. 5, p. 6).

16. The Report further states that Ms. Edwards agreed to provide a written statement to Mr. Solie. Mr. Solie asked her if he had in any way threatened her or made any promises to her during the interview and Ms. Edwards replied that he had not. He asked Ms. Edwards to indicate that fact in the beginning of her statement (Exh. 5, p. 6).

17. Ms. Edwards' written statement dated October 20, 2009 states, in pertinent part: "I have no honest recollection of knowingly putting Morphine, Acetaminopen, or Compazine in my desk drawer. As these were found in my unlocked drawer, I could have not remembered placing them there. It could be a possibility I did place them there. There is no criminal intent for these findings in my unlocked desk drawer." (Exh. 5, p. 20).

18. Ms. Edwards testified that what she put in her written statement were not her "own thoughts." She stated that after writing the section about not having any recollection of placing the medications in her unlocked drawer, she stopped writing and was very tearful and told Mr. Solie that she did not know what else to write. She testified that Mr. Solie suggested cooperating with him and that "I wanted to save my job so I listened to him." (Tr., p. 207-208).

19. Mr. Solie testified that he did not dictate portions of Ms. Edwards' written statement. He stated he asks individuals if he ever made any threats or promises to them and he asks them to include that in the report. His recollection was as follows: "[S]he would say, 'What do you want me to write,' and I would just say, 'Write what you told me. Did you say blah blah blah?' And she would say, 'Yes.' I said, 'Well, then that's how you should write it in your own words.'" When asked if he made any statement to her to the effect that if she cooperated, she would keep her job, he responded, "Absolutely not." When asked if it was his suggestion to Ms. Edwards that she put the items in her drawer, he stated, "I wouldn't make the suggestion. I would say, 'Are you sure? Is there any reason why those could have gotten in your drawer? Do you have any explanation for it?'" (Tr., pp. 150-151, 154).

20. Nikki Ryberg testified that her recollection was that during the Hazen death call she performed with Ms. Edwards, the family members gathered the medications. She stated that although the usual policy is to destroy the medications by flushing them down the toilet at the patient's home, that was not done in this case because a family member was in the shower. According to Ms. Ryberg, all of the medications were placed in a large bag in the trunk of Ms. Edwards' car. However, Ms. Ryberg could not say that she watched the trunk being opened when she and Ms. Edwards returned to the VNA (Tr., pp. 180-184, 189).

21. Ms. Ryberg further testified that the normal procedure was to peel the labels, or at least the name of the patients, off of the boxes, and throw the boxes away in a garbage can in the office, and that anyone who is in the VNA office would have access to the garbage cans where the boxes were thrown away (Tr., pp. 184-185).

22. Mr. Ryberg testified that bottles of morphine come in 30 ml. bottles; therefore, the 20 ml. of morphine listed on the controlled drug disposal form as being destroyed would have been opened and partially used. She stated that she and Ms. Edwards did not inventory the acetaminophen and Compro suppositories contained in Exhibits and 2 and 3. She did not

remember where they put the emptied morphine bottle or the labels; they could have been placed in a biohazard container to which any VNA employee would have access (Exh. 5, p. 18; Tr., pp. 185-86, 193-96).

23. Ms. Ryberg testified that at no point after the Hazen death call did Ms. Edwards tell her that she had morphine in her desk drawer. She did not see Ms. Edwards put any morphine in her drawer and she never heard anyone else telling people that Ms. Edwards had morphine in her drawer. She stated that it was not common knowledge at the VNA that Ms. Edwards had morphine in her drawer (Tr., p. 186).

24. Ms. Ryberg also testified that the process for getting morphine for a patient, from the time the family requested it to the time it was available to pick up from the pharmacy, usually took a couple hours and that she never had any trouble obtaining morphine for a patient on a weekend or at night. She stated that if a doctor was not available to fax or phone in the prescription to the pharmacy, the nurses could call the medical director who was readily available. She also agreed, however, that 2-3 hours was an eternity for someone who was in pain (Tr., pp. 187-190).

25. Lynda DeDee testified that she had been a nurse for about 27 years and had a Masters degree and PhD in nursing. Ms. DeDee worked as a staff nurse in hospice and palliative care at the Aurora VNA in Oshkosh from October 2007 through June of 2009. She quit working at the VNA because she was not happy with the management situation. She had some issues with Ms. Edwards' management style. According to Ms. DeDee, Ms. Edwards seemed "angry with people or bossy, not very trustful, demanding." She stated that she believed other staff had problems with Ms. Edwards as well, and that the "general view" "was not very favorable." (Tr., pp. 53-57).

26. Regarding the procedures for getting medication such as morphine for a patient, Ms. DeDee testified that the procedure was that they had to get in touch with a physician, who would then call the prescription into the pharmacy. She stated that during the time period involved, there was an issue with obtaining morphine. Sometimes, the pharmacy would not have any and it would not be available until the next day. She stated that from her perspective, "it didn't seem right not to have morphine available for people who were in pain." (Tr., p. 50).

27. Ms. DeDee described an instance on a Saturday night in either the Fall of 2008 or the Spring of 2009, at around 10:00 p.m. when a patient's wife called and said that she was afraid the patient was going to run out of morphine before the weekend was over. Ms. DeDee attempted to call the physician and did not get an answer so she then called Ms. Edwards. She did so not only because Ms. Edwards was the lead nurse and was good at solving problems but also because Ms. Edwards had told Ms. DeDee earlier than she had some morphine in her desk

drawer in case of an emergency. Ms. DeDee did not want the patient to go without pain medication so she asked Ms. Edwards if the morphine was still in her desk, and Ms. Edwards told her that it wasn't any longer there and that she had it at home. Ms. DeDee then made arrangements with Ms. Edwards to drive halfway between Ms. Edwards' home and Oshkosh. The two women met at a gas station and Ms. Edwards gave Ms. DeDee two vials of morphine in a little cloth bag, which Ms. DeDee took. On the way home, Ms. DeDee decided she should again attempt to follow the correct procedures so she phoned the doctor again and the doctor responded and called the prescription into the pharmacy. The vials Ms. DeDee obtained from Ms. Edwards remained unused. The following Monday morning, Ms. DeDee called Ms. Edwards' cell phone and left a message telling her that she was putting the morphine back on her desk, and Ms. Edwards called Ms. DeDee back and told her to put the morphine in her desk drawer, which Ms. DeDee did (Tr., pp. 48-50).

28. Ms. DeDee stated that Exhibit 1, which was a plastic bottle of morphine, differed from what Ms. Edwards gave her that evening because what she obtained from Ms. Edwards was not liquid and was in a glass vial with a metal top (Tr., p. 49, 66).

29. Ms. DeDee testified regarding an incident in which she came back to the VNA after visiting a patient, and the volunteer coordinator, Jayne, was telling others, "Look what I found in Johanna's desk" and asking why it was there or how it got there. She testified that the bag Jayne was showing people was the same one Ms. DeDee had put in Ms. Edwards' drawer and that it was "a bright color, maybe lime green with some other colors. It was bright, very bright colored bag." Ms. DeDee said, "Well, I know how it got there. Johanna said that she had it there." She then related the story about meeting Ms. Edwards at the gas station and informed Jayne that "Johanna asked me to put it back in the desk drawer and I did." Other nurses were there at the time of the conversation, including, she believed, Roberta Gasper and Marlene Roberts. She testified that this conversation occurred about a month before she left employment with the VNA, and that it was "common knowledge" that Ms. Edwards had a stash of morphine for emergency use. (Tr., pp. 51-52, 68).

30. Ms. DeDee testified that she never reported to anyone that there was morphine in Ms. Edward's desk drawer because Ms. Edwards was the person she went to and was in charge. She stated that sometime prior to her meeting with Ms. Edwards to obtain the morphine, she told Ms. Edwards the morphine should not be in her drawer (Tr., p. 58).

31. Ms. DeDee testified she did not write the letter to DHS regarding Ms. Edwards and did not know who did (Tr., p. 55).

32. Ms. DeDee was interviewed by Mr. Solie. According to Mr. Solie's Report, Ms. DeDee did not mention her meeting with Ms. Edwards at the gas station. Rather, she stated that

she recalled an incident in which she had a patient with extreme pain issues and she was unable to obtain morphine to help control the patient's pain. She stated that Ms. Edwards told her that she had morphine in her desk drawer and that Ms. DeDee should go in her drawer and get if for her patient. Ms. DeDee stated that she never took the morphine out of Ms. Edwards' desk because she was able to get the doctor to order it at the last minute (Exh. 5, p. 8).

33. Debra Diaz testified she has been a registered nurse for 24 years and worked at the Aurora VNA in Oshkosh for nine years, leaving in August of 2009. Ms. Edwards was her supervisor. She was fired from the VNA by Peggy DeWane, who was the manager. She testified that she thought VNA management was threatening and harassing, and that by "management," she meant Ms. DeWane and not Ms. Edwards. However, she admitted that she "probably" told the attorney for the Division during an interview that she did not care for Ms. Edwards. She stated that she did not write the letter to DHS regarding Ms. Edwards (Tr., pp. 79, 86-90).

34. Ms. Diaz testified that she heard a conversation in the office in which Ms. Edwards told another nurse, Marlene Roberts, that there was an emergency supply of morphine in case it was needed. She stated it was common knowledge during the Summer of 2009 that Ms. Edwards had an emergency supply of morphine available. She knew that one of the nurses, Roberta Gasper, knew about the morphine. Ms. Diaz was standing by Ms. Gasper one day and Ms. Edwards opened the drawer of her desk and Ms. Diaz observed a colorful bag (Tr., pp. 80-81, 85, 87-88).

35. Jayne Syrjamaki testified that she has been the Volunteer Coordinator at Aurora Hospice for the past 6 years (Tr., p. 92). At some point in the Spring of 2009, she was part of a conversation which included Lynda DeDee and Roberta Gasper, among others, during which Ms. DeDee mentioned that Ms. Edwards had offered her some morphine to take to a patient's home. Ms. Syrjamaki further testified: "Apparently, there was some kind of morphine shortage at the time . . . and [Ms. Edwards] had kept some in her drawer in case they needed it for another patient; and . . . [Ms. DeDee] had said that [Ms. Edwards] had told her she had it. Someone opened up Ms. Edwards' desk drawer and said 'It's in that bag.'" She testified it was an earth-toned, brown striped bag, although she did not remember the exact details of the colors. She did not see the contents of the bag until DHS came in and pulled out that same bag from Ms. Edwards' drawer on October 19, 2009 (Tr., pp. 92-99).

36. Ms. Syrjamaki also testified that generally, nurses had their own cubicles and desks and that it was rare for someone else to use a desk that was assigned to a particular nurse (Tr., pp. 98-99).

37. Roberta Gasper testified that she had been a Registered Nurse for 21 years and had been employed at Aurora VNA from February 2008 through August 2009. In the Spring of 2009, Ms. Gasper heard rumors that Ms. Edwards had morphine in her desk drawer. At that time, there were a lot of management changes occurring in the office, some of it was "not so good," and there were rumors of people getting fired or walking out. She said there was anger with the management team and people were "getting walked out for various ridiculous reasons" and someone said, "management should start looking at themselves; and . . . the comment was made about the morphine being in the drawer." The anger at the management team from the hospice nurses extended to Ms. Edwards. They had lost a director that they all regarded quite highly and when the new manager came, "it just seemed like Johanna [Ms. Edwards] had kind of slipped away from the rest of us, and this new manager was not very nice, and I think we were all afraid that Johanna was turning away from us toward her; which, you know, Johanna used to be – at least with me she was quite approachable. And I looked up to her, you know, as a good resource person. So I think . . . I think when the changes were coming, everybody got a little paranoid about everybody." (Tr., pp. 103-106, 109-110).

38. Johanna Edwards testified that in the course of her employment, she had done approximately 120 death calls. With respect to the death call at Ms. Hazen's home, Ms. Edwards testified that there were no drugs from the Hazen home that remained after she and Ms. Ryberg flushed the drugs down the toilet at the VNA. She testified that she did not recall seeing medication inside a paper pharmacy bag, that Ms. Ryberg was with her the entire time the medications were in her possession, and that she did not remove any of the Hazen medications and put them in a desk drawer. Ms. Edwards stated that she has never placed any patient's medicine in a desk drawer, never told anyone she had morphine available, and never met with a nurse to provide her with morphine. Ms. Edwards testified that she frequently had to get in touch with a doctor in order to obtain pain medication and that she never had any problems reaching the doctor and was not aware of any shortage of morphine. Prior to the morphine being discovered in her desk in October of 2009, she had never seen the morphine in her desk (Tr., pp. 198, 201-206).

39. Ms. Edwards further testified that anyone could sit at anyone else's open cubicle, that it happened on more than one occasion and that she had used someone else's desk in the past. Because of a problem with thefts in the office, she did not keep her purse in her desk drawer, but instead, kept in in her locked car (Tr., p. 209).

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 is on the Division to show by a preponderance of the evidence that the events constituting the alleged violations occurred. Wis. Stat. § 440.20(3).

3. The Division has met its burden of establishing that Ms. Edwards' conduct constitutes misconduct or unprofessional conduct pursuant to Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04 (intro), (1) and (2).

4. The Division has not met its burden of establishing that Ms. Edwards' conduct constitutes misconduct or unprofessional conduct pursuant to Wis. Admin. Code § N 7.04(6).

5. As a result of Ms. Edwards' violations, she is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04 (intro), (1) and (2).

ALJ's DISCUSSION

Burden of Proof

The burden of proof in disciplinary proceedings is on the Division to show by a preponderance of the evidence that the events constituting the alleged violations occurred. Wis. Stat. § 440.20(3). To prove by a preponderance of the evidence means that it is "more likely than not" that the examined action occurred. *See State v. Rodriguez*, 306 Wis. 2d. 129, 141-142, 743 N.W.2d 460 (Ct. App. 2007), citing *United States v. Saulter,* 60 F.3d 270, 280 (7th Cir. 1995).

Credibility Determinations

The testimony portrayed two competing and mutually exclusive versions of the events in question. Ms. Edwards asserts that she never placed the morphine in her desk drawer and does not know how it got there, whereas several of her colleagues, testifying for the Division, report either hearing first-hand from Ms. Edwards or indirectly through co-workers that Ms. Edwards intentionally kept morphine in her drawer for use in emergency situations. Based on all of the evidence presented in this case, and under the preponderance of the evidence standard, Ms. Edwards' version of events is less credible than the version presented by the Division.

Notably, although Ms. Edwards testified at hearing that she definitely did not ever place morphine in her desk drawer and initially indicated the same to Mr. Solie, she eventually stated both to Mr. Solie and in her written statement that she may have inadvertently placed the morphine there. In her written statement, Ms. Edwards stated, "As these were found in my unlocked drawer, I could have not remembered placing them there. It could be a possibility I did place them there. There is no criminal intent for these findings in my unlocked desk drawer." Although Ms. Edwards suggested in her testimony that these statements are the result of her attempting to keep her job by cooperating with Mr. Solie, it strains credulity to believe that, in order to keep her job, Ms. Edwards would admit that she may have put the morphine in her desk drawer. Nor is there sufficient evidence to indicate that Ms. Edwards was coerced into making such a statement. In addition, the written statement itself, even without the contrary hearing

testimony, undermines Ms. Edwards' credibility in that it is highly unlikely that one would not remember whether or not she placed a medication like morphine, a Schedule II controlled substance, into an unlocked drawer.

In addition, both Ms. Diaz and Ms. DeDee testified that they heard Ms. Edwards state that she had morphine available in her desk in the event a nurse needed it for a patient. Other VNA staff were also generally aware that this was the case.

Further, crediting Ms. Edwards' assertion that she did not place the morphine in her desk drawer would necessarily mean that another person or persons did so and then contacted DHS in an attempt to get Ms. Edwards into trouble. If this is true, then it necessarily follows that one of the following also occurred. Either someone with access to Ms. Edwards' drawer obtained the medications marked with Ms. Hazen's pharmacy labels and placed them in Ms. Edwards' drawer or, alternatively, someone retrieved the morphine box from Ms. Hazen and a bottle from another source containing the exact same lot number and expiration date as the box.

As indicated by the Division, whoever was involved in setting up Ms. Edwards in one of these ways would have had to rely heavily on luck because that person could not know whether the medications would be discovered and removed after the anonymous letter was received by DHS on September 23, 2009 but before authorities arrived to search the drawer on October 9, 2009. (Notably, two nurses who testified they heard Ms. Edwards say she had morphine available left the VNA months before the morphine was discovered on October 19, 2009 – Ms. DeDee in June 2009 and Ms. Diaz in August 2009.)

More likely than any of these scenarios is that Ms. Edwards placed the morphine and other medications in her desk drawer herself.

In support of her position, Ms. Edwards points to various discrepancies in the record, such as some of the witnesses' conflicting descriptions of the bag containing the medications found in Ms. Edwards' drawer and the version of events Ms. DeDee conveyed to Mr. Solie compared to that testified to at hearing. However, such discrepancies do not outweigh the evidence, and inferences to be drawn therefrom, indicating that it is more likely than not that Ms. Edwards withheld Ms. Hazen's morphine from the items to be destroyed, placed the morphine in her desk drawer, and offered it to other nurses to provide for patients who needed it.

Violations of Wisconsin Statute and Administrative Code

Wisconsin Stat. § 441.07(1)(d), states, in relevant part:

> **Revocation.**
> **(1)** The board may, after disciplinary proceedings conducted in accordance with rules promulgated under s. 440.03 (1), revoke, limit, suspend or deny renewal of a license of a registered nurse, a nurse-midwife or a licensed practical nurse, may revoke, limit, suspend or deny renewal of a certificate to prescribe drugs or devices granted under s. 441.16, or may reprimand a registered nurse,

nurse-midwife or licensed practical nurse, if the board finds that the person committed any of the following:

(d) Misconduct or unprofessional conduct.

As used in Wis. Stat. § 441.07(1)(d), "misconduct or unprofessional conduct" is defined as "any practice or behavior which violates the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient or the public." Wis. Admin. Code § N 7.04 (intro). Misconduct or unprofessional conduct includes, *inter alia*, "[v]iolating, or aiding and abetting a violation of any law substantially related to the practice of professional or practical nursing," Wis. Admin. Code § N 7.04(1); "[a]dministering, supplying or obtaining any drug other than in the course of legitimate practice or as otherwise prohibited by law," Wis. Admin. Code § N 7.04(2); and "[f]alsifying or inappropriately altering patient records." Wis. Admin. Code § N 7.04(6). The Division asserts that Ms. Edwards' conduct constituted misconduct or unprofessional conduct as specified in the introduction of Wis. Admin. Code § N 7.04 as well as in subsections (1), (2) and (6) of that provision. As discussed below, the Division has shown by a preponderance of the evidence that Ms. Edwards' conduct constituted misconduct or unprofessional conduct as alleged by the Division, with the exception of Wis. Admin. Code § N 7.04(6).

First, Ms. Edwards engaged in misconduct or unprofessional conduct as that term is defined in the introduction of Wis. Admin. Code § N 7.04. By placing and maintaining morphine, a Schedule II controlled substance, in her unlocked desk drawer, and making it accessible to others in the workplace and available for use by those without an authorized prescription, Ms. Edwards "violated the minimum standards of the profession necessary for the protection of the health, safety or welfare of patients and the public."

Ms. Edwards' conduct also constitutes misconduct or unprofessional conduct under Wis. Admin. Code § N 7.04(1), which prohibits "[v]iolating, or aiding and abetting a violation of any law substantially related to the practice of professional or practical nursing."[2] The "law substantially related to" nursing which the Division showed by a preponderance of evidence that Ms. Edwards violated is Wis. Stat. § 961.41(3g), which states: "No person may possess or attempt to possess a controlled substance . . . unless the person obtains the substance . . . directly from, or pursuant to a valid prescription or order of, a practitioner who is acting in the course of his or her professional practice, or unless the person is otherwise authorized by this chapter to possess the substance . . ."

Although there was a "valid prescription" for the morphine, that prescription was not for Ms. Edwards, nor does it allow her to retain the morphine for anyone other than the patient for whom it is prescribed. Likewise, Chapter 961 of the criminal code does not "otherwise authorize[]" Ms. Edwards to possess morphine for anyone other than the patient for whom it is prescribed.[3] Thus, the Division met its burden of establishing that Ms. Edwards violated Wis.

[2] The Division's Complaint does not state which "law substantially related to" nursing was violated. Based on the record in this matter, it appears that the specific laws alleged to have been violated were first set forth in the Divisions' post-hearing brief-in-chief. Because Ms. Edwards' attorney does not raise any challenge with regard to this issue, this decision does not address it.

[3] The Division also states that Ms. Edwards' conduct violated another law "substantially related to the practice of" nursing, namely, Wis. Stat. § 450.11(h). This subsection is in a statute entitled, "Prescription drugs and prescription

Stat. § 961.41(3g), which is a law "substantially related" to the practice of nursing. As a result, Ms. Edwards engaged in misconduct or unprofessional conduct under Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(1).

Ms. Edwards' conduct also constitutes misconduct or unprofessional conduct because it entailed "[a]dministering, supplying or obtaining any drug other than in the course of legitimate practice." Wis. Admin. Code § N 7.04(2). By placing and keeping the morphine for purposes other than those related to the patient for whom it was prescribed, Ms. Edwards "obtain[ed]" the morphine "other than in the course of legitimate practice." By offering the morphine to others to use for patients for whom it was not prescribed, Ms. Edwards was "supplying" the morphine "other than in the course of legitimate practice."

The Division also asserts that Ms. Edwards' conduct constituted misconduct or unprofessional conduct because it involved "[f]alsifying or inappropriately altering patient records." Wis. Admin. Code § N 7.04(6). The Division has not proved this particular form of misconduct or unprofessional conduct by a preponderance of the evidence. Assuming the Controlled Drug Disposal Form constitutes a "patient record," under Wis. Admin. Code § N 7.04(6), there is insufficient evidence of "falsifying" or "inappropriately altering" this document. Nowhere does the Form state the items listed constitute all of the controlled substances retrieved from Ms. Hazen's house. The Form simply lists Ms. Hazen's name and date of discharge, states that "the following controlled drugs have been disposed of on this date 1/23/09," and then lists the items destroyed. Although a 20 ml. container of morphine appears on the list, the record demonstrates that the unopened 30 ml. bottle of morphine and the Compro and acetaminophen suppositories found in Ms. Edwards' desk drawer do not appear on this list. Indeed, the Division's theory is that the substances which were found in Ms. Edwards' drawer were ones which Ms. Edwards held back from the items which she and Ms. Ryberg destroyed. (Division's Reply Brief, p. 2).

Accordingly, it has not been demonstrated that Ms. Edwards falsified or inappropriately altered patient records.

Nonetheless, based on the misconduct or unprofessional conduct the Division has proven in this matter, Ms. Edwards is subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

ALJ's Recommendation for Appropriate Discipline

The three purposes of discipline are: (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 conduct. *State v. Aldrich*, 71 Wis. 2d 206, 237 N.W.2d 689 (1976). The Division recommends that Ms. Edwards be reprimanded for retaining medications and that her

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devices," and states, "No person may possess a prescription drug unless the prescription drug is obtained in compliance with this section." Wis. Stat. § 450.11(h). The Division does not explain how Ms. Edwards' obtaining the morphine was not "in compliance" with the "section" (i.e., Wis. Stat. § 450.11), nor does the Division otherwise develop its argument that Ms. Edwards' conduct violated this provision. Therefore, and in light of the conclusion that Ms. Edwards' conduct violated Wis. Stat. § 961.41(3g), this decision does not address whether a violation of Wis. Stat. § 450.11 occurred.

license be suspended for a period of 30-60 days for untruthfulness to the Board during the investigation and hearing. The record demonstrates that a reprimand and 30-day suspension is appropriate.

Ms. Edwards engaged in misconduct or unprofessional conduct by retaining morphine, a Schedule II controlled substance, in her unlocked drawer for what appears to be a substantial period of time, where it could have been accessed by anyone at the VNA. This posed a threat to the public, as does administering morphine to a patient for whom it is not prescribed, which was Ms. Edwards' intent in retaining the morphine.

However, Ms. Edwards did so out of concern for patients. As stated by the Division's attorney in his opening statement: "We don't claim that respondent was motivated by anything other than the comfort of patients who are in hospice care. This is not a case where we think she is using it herself or diverting it for some other purpose. This is a case of a nurse who with only noble motives broke a rule and the law." (Tr., p. 37). In addition, as stated by Mr. Solie, many of Ms. Edwards' colleagues, despite other issues they may have had with Ms. Edwards, told him that she was a very caring nurse.

A reprimand and 30-day suspension promotes the protection of the public and rehabilitation of Ms. Edwards in that it requires her to take accountability for, and hopefully learn from, her behavior while also providing an avenue for her to eventually continue practicing nursing in a safe and responsible manner. It also deters other licensees from engaging in similar misconduct, as it is a discipline reportable to the public.

Costs

The Division requests that Ms. Edwards be ordered to pay the full costs of its investigation and of these proceedings.

In *In the Matter of Disciplinary Proceedings against Elizabeth Buenzli-Fritz* (LS 0802183 CHI), the Chiropractic Examining Board stated:

> 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..., is 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 respondent's 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.

Considering the factors delineated in the *Buenzli-Fritz* decision, Ms. Edwards should be assessed seventy-five percent of the recoverable costs. Although Ms. Edwards' conduct is serious, it was also borne of concern for patients' suffering. Ms. Edwards does not have any prior disciplinary actions taken against her, and the level of discipline recommended by the Division is on the lower end of the options available.

On the other hand, despite strong evidence against her, Ms. Edwards apparently rejected a settlement offer and required the Division to expend substantial resources in proving its case. In addition, there is no argument that certain factual findings were investigated and litigated unnecessarily and, given the program revenue nature of the Department of Safety and Professional Services, fairness dictates imposing the costs of these disciplinary proceedings on Ms. Edwards, and not on fellow members of the nursing profession who have not engaged in such conduct.

Based on the foregoing, it is appropriate to require Ms. Edwards to pay seventy-five percent of the costs incurred in this matter.

If the Board assesses costs against Respondent, the amounts of costs will be determined pursuant to Wis. Admin. Code § SPS 2.18.

EXPLANATION OF BOARD'S VARIANCE

The ALJ's recommendation for discipline consisted of a thirty (30) day suspension of Ms. Edwards' nursing license and imposition of seventy-five (75) percent of costs in this matter. The Board finds that additional disciplinary terms and conditions are warranted given the nature of her unprofessional conduct. Specifically, the Board varies from the ALJ decision to require that Ms. Edwards shall complete continuing education in the topics of nursing leadership and safe medication handling and management prior to the termination of her suspension. In addition, upon completion of the suspension, Ms. Edwards shall be required to practice under direct supervision in a pre-approved work-setting with quarterly work reports from her employer. Finally, Ms. Edwards shall be required to provide a copy of this decision to her current or prospective employer.

The primary concern of the Board of Nursing and its reason for imposing additional disciplinary terms and conditions upon Ms. Edwards license is that her misconduct occurred in her capacity and role as a lead nurse supervisor. In her supervisory capacity, she was not only

accountable for her own actions but responsible for ensuring that she did not create unsafe conditions for the nurses and the patients who were cared for by the nursing staff whom she supervised. Ms. Edwards' apparent careless disregard for handling narcotics could have placed other nurses and the patients of those nurses in jeopardy. The required continuing education and work restrictions will ensure that Ms. Edwards fully appreciates the significance of her actions and that she will practice in a safe manner in the future.

Finally, the Board has determined that the full costs of the proceeding shall be assessed against Ms. Edwards due to the nature of her misconduct and the unfairness of imposing these costs on the fellow members of the nursing profession who have not engaged in such conduct. Ms. Edwards was an experienced nurse, in a management position, who was well aware of the importance of safe medication handling and therefore should bear the full responsibility of her actions including the costs of this proceeding.

ORDER

For the reasons set forth above, IT IS ORDERED that the Respondent Johanna R. Edwards shall be and hereby is **REPRIMANDED.**

IT IS FURTHER ORDERED that the registered nurse license of Ms. Edwards shall be and hereby is **SUSPENDED** for a period of thirty **(30) days,** or completion of the required continuing education whichever is greater, with the period of suspension to begin five **(5)** days from the effective date of this order.

IT IS FURTHER ORDERED that Respondent's nursing license shall be LIMITED as follows:

1. Ms. Edwards shall, at her own expense, complete six **(6)** hours of board pre-approved continuing education in the topic of leadership in nursing and four **(4)** hours in safe medication handling and management. The continuing education shall be completed prior to the termination of her suspension.

2. For a period of at least two **(2)** years from the date of this Order, Ms. Edwards shall arrange for quarterly reports from her nursing employer(s) in a Board pre-approved work setting with direct supervision. The quarterly work reports shall address the terms and conditions of Ms. Edwards' employment and evaluate her work performance. Ms. Edwards shall also provide a copy of this Order to her employer/and or immediate supervisor.

3. After two **(2)** years from the date of this Order, Ms. Edwards may petition the board for termination of this requirement. The Board may grant or deny the petition, it is discretion, or may modify this Order within its discretion.

IT IS FURTHER ORDERED that Ms. Edwards shall pay the full costs of the recoverable costs in this matter in an amount to be established pursuant to Wis. Admin. Code § SPS 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) 266-226

This Order is effective on the date signed below.

Dated at Madison, Wisconsin on May 22nd, 2012.

WISCONSIN BOARD OF NURSING

By: Lou Ann Weix
Lou Ann Weix, APNP
Chair

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