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Before The
State Of Wisconsin
BOARD OF NURSING

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

FINAL DECISION AND ORDER
WITH VARIANCE
ORDER NO _____
ORDER 0002470

Division of Legal Services and Compliance[1] Case No. 11 NUR 370

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

Diane Zakopyko, by:

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Department of Safety and Professional Services, Division of Legal Services and Compliance, by:

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This case is before the undersigned administrative law judge (ALJ) following a Notice of Default issued on February 7, 2013 and the ALJ's receipt of the Recommendation for Discipline filed by the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division) on February 19, 2013. Respondent did not file a response to

[1] The Division of Legal Services and Compliance was formerly known as the Division of Enforcement.

the Division's February 19, 2013 submission. The ALJ issued a Proposed Decision and Order in this matter on March 22, 2013.

On May 9, 2013, the Wisconsin Board of Nursing (Board) reviewed the Proposed Decision and Order of the ALJ. No objections to the proposed decision and order were received from either party, and neither party appeared before the Board. Upon considering the ALJ's proposed decision and disciplinary recommendations, the Board of Nursing adopts the proposed Findings of Fact, Conclusions of Law, and determination of Costs, but varies the Order as set forth below.

FINDINGS OF FACT

Facts Related to the Alleged Violation

Findings of Fact 1-20 are taken from the Division's Complaint against Respondent filed in this matter.

1. Diane T. Zakopyko, R.N., ("Respondent") was born on May 11, 1961 and is licensed to practice as a professional nurse in the State of Wisconsin (license no. 138948-30). This license was first granted on July 2, 2001 and is current through February 28, 2014.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing (Board) is 2948 W. Frank Street, Eau Claire, Wisconsin.

3. At all times relevant, Respondent was an employee of Medical Staffing Solutions and worked as a contracted Travel Nurse at Mercy Medical Center ("Mercy"), located in Oshkosh, Wisconsin.

4. On July 6, 2011, Respondent removed narcotics from the Pyxis dispensing system at 7:35 a.m. in preparation for an 8:00 a.m. surgery. Respondent left the room with the narcotics at 7:45 a.m. and did not return until 8:15 a.m.

5. When Respondent returned to the room, the doctor ordered administration of 1 milligram of Versed and 50 micrograms of Fentanyl to the patient undergoing surgery. Nurse A

witnessed Respondent remove two unlabeled syringes from her pocket, which she used to administer the ordered medication.

6. Approximately 10 minutes after the administration of medication, the patient denied feeling any effect from the medication. Another 1 milligram of Versed and 50 microgram of Fentanyl were ordered. Radiology Technician B (Tech B) witnessed Respondent administer medication from an unlabeled, capped syringe Respondent carried in her pocket. Tech B did not witness the administration of the first round of medication.

7. After administration of the second round of medication, Tech B witnessed Respondent starting to open a 19-gauge needle, taken from her pocket. Respondent stopped opening the package when she noticed Tech B watching her.

8. Tech B then turned away but continued to watch Respondent. Respondent then attached the needle to the emptied syringe she just used to administer the medication and drew up a clear liquid from a different syringe than the one used when Respondent administered the second round of medication. Tech B then witnessed Respondent waste this liquid as the leftover Versed with Nurse A.

9. At approximately the same time, Tech C witnessed Respondent draw 3 milliliters of saline solution into the empty 5 milliliter syringe. Respondent set the syringe containing 3 milliliters of saline solution on the counter. After the procedure concluded, Tech C witnessed Respondent waste the saline solution with Nurse A, holding the saline solution out to be the leftover Versed.

10. At approximately 9:00 a.m., Respondent, Nurse A, Tech B and Tech C attended to a second procedure. Respondent approached Tech B and requested that Tech B waste the medication with her later, as Nurse A asked several questions when verifying the previous waste, which made Respondent uncomfortable. Tech B agreed to waste the medication with Respondent.

11. During the second procedure, Tech B and Tech C witnessed Respondent administer medication from appropriately labeled vials. The second patient felt the effect of the medication.

12. Following the procedure, Respondent did not waste the excess medication with Tech B. Respondent stated that she was going to the library and left the room.

13. Nurse A, Tech B and Tech C reported Respondent's suspicious behavior.

14. At approximately 3:00 p.m., three individuals of Mercy's management interviewed Respondent regarding her possible diversion of narcotics earlier in the day.

15. Throughout the meeting, Respondent made inconsistent statements, changing her story several times, often after confronted with proof of the incorrectness of her statement. The inconsistent statements included when she returned to the procedure room, when Respondent dispensed the medication, when she recorded a time out, indicating she left the procedure room, whether she informed the operating doctor of the first patient's abnormal lab results, and whether she wasted the excess medication from the second procedure.

16. Regarding the excess medication from the second procedure, Respondent at first stated she had not yet wasted the medication because she was waiting for Tech C. When confronted with how much time had passed since the procedure, Respondent then stated that she did waste the medication with Tech D, but that after she discharged the medication, Tech D informed Respondent that she did not have access in the Pyxis system to document the waste.

17. Respondent was asked to submit to a 10-panel drug test, which Respondent strongly protested. When told a cab will take her to the drug screen, Respondent insisted that she cannot leave her car at Mercy. Respondent was informed several times that a cab will bring her back to Mercy.

18. At approximately 3:20 p.m., Respondent agreed to the drug screen and left the meeting to retrieve her purse. Respondent did not return.

19. Around 3:55 p.m., Respondent called two of the three individuals who had interviewed her, thanking them for their understanding and kindness during her employment at Mercy. At 4:50 p.m. that afternoon and 5:30 a.m. the next day, Respondent left two messages, apologizing and indicating she planned on completing the drug screen.

20. Respondent did not complete the drug screen. Respondent did not return to Mercy.

Facts Related to Default

21. The Complaint and Notice of Hearing in this matter were served on Respondent and her attorney by both certified and regular mail at her address on file with the Department of Safety and Professional Services and were served by regular mail on Respondent's attorney on December 11, 2012, consistent with Wis. Admin. Code § SPS 2.08.

22. Neither Respondent nor Respondent's counsel has filed an Answer to the Complaint as required by Wis. Admin. Code § SPS 2.09(4). At a prehearing conference held on January 17, 2013, Respondent's counsel indicated that Respondent had not authorized him to file an Answer and had not communicated with counsel since June of 2012, despite counsel's repeated efforts to attempt to contact her.

23. By Notice dated January 18, 2013, the ALJ set an additional status conference for February 7, 2013, providing Respondent with another opportunity to communicate with her attorney and avoid default in this matter.

24. At the status conference on February 7, 2013, Respondent's counsel's paralegal indicated that counsel had sent the January 18, 2013 Notice to Respondent at two separate addresses but that the correspondence was returned as undeliverable and that counsel had not received any further communication from Respondent. As a result, the ALJ granted the Division's motion for default.

25. On February 7, 2013, the ALJ issued a Notice of Default to the parties informing them that Respondent had been determined to be in default. The Notice required the Division to

file a recommended proposed decision no later than February 21, 2013 and provided Respondent's counsel with the opportunity to file a response to the Division's submission no later than March 7, 2013.

26. On February 19, 2013, the Division filed a Recommendation for Discipline (rather than a recommended proposed decision). Respondent did not file a response.

CONCLUSIONS OF LAW AND DISCUSSION

Default and Violation of Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(2)

Wisconsin Admin. Code § SPS 2.14 provides that "[i]f the respondent fails to answer as required by s. SPS 2.09 . . ., the respondent is in default and the disciplinary authority may make findings and enter an order on the basis of the complaint and other evidence." An Answer to a Complaint must be filed within 20 days of service of the Complaint. *See* Wis. Admin. Code § SPS 2.09(4). Service of the Complaint may be made by mailing a copy of the complaint to the respondent at his last known address. *See* Wis. Stat. § 440.11(2); Wis. Admin. Code § SPS 2.08(1). "Service by mail is complete upon mailing." Wis. Admin. Code § SPS 2.08(1).

On December 11, 2012, the Division served Respondent with the Complaint by mailing a copy of the Notice of Hearing and Complaint by both regular and certified mail to her most recent address on file with the Department and by mailing a copy to her attorney. Pursuant to Wis. Admin. Code §§ SPS 2.08(1) and 2.09(4), Respondent was required to file an Answer within 20 days but failed to do so. Accordingly, Respondent is in default and an order may be entered against Respondent on the basis of the Complaint and other evidence. *See* Wis. Admin. Code § SPS 2.14.

Wisconsin Stat. § 441.07(1)(d) provides that the Board may "revoke, limit, suspend or deny renewal of a license of a registered nurse . . . may reprimand a registered nurse. . . the board finds that the person committed. . .[m]isconduct or unprofessional conduct." Wisconsin Admin.

Code § N 7.04(2) defines misconduct or unprofessional conduct 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" and includes "(a)dministering, supplying or obtaining any drug other than in the course of legitimate practice or as otherwise prohibited by law."

As a result of Respondent's default, the facts set forth above taken from the Complaint are undisputed. These facts establish by a preponderance of the evidence that Respondent committed misconduct or unprofessional conduct as defined by Wis. Admin. Code § N 7.04(2). It is undisputed that on July 6, 2011, while Respondent was working for a medical staffing agency as a contracted travel nurse, three co-workers witnessed Respondent divert controlled medication during two separate medical procedures. The three individuals reported Respondent's behavior to the medical center's management. When management personnel interviewed Respondent regarding the alleged diversion of narcotics, Respondent made inconsistent statements, changing her story when confronted with adverse facts. For a length of time, Respondent refused to take a 10-panel drug test, claiming hardship with leaving her car at the medical center despite management's reassurances that she would be brought back to the medical center by a cab after the test. Eventually, Respondent agreed to take the test, only to leave without a word. Several times after Respondent left, Respondent called the individuals who had interviewed her to apologize and to state that she would complete the drug screen. However, Respondent never completed the drug screen and never returned to work at the medical center.

The conduct alleged in the Complaint and accepted as true establishes that Respondent "(a)dminister[ed], suppl[ied] or obtain[ed] any drug other than in the course of legitimate practice or as otherwise prohibited by law," in violation of Wis. Admin. Code § N 7.04(2). Respondent is therefore subject to discipline pursuant to Wis. Stat. § 441.07(1)(d).

ALJ'S RECOMMENDED 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. *See State v. Aldrich*, 71 Wis. 2d 206, 209, 237 N.W.2d 689 (1976).

The Division requests that Respondent's license be revoked. The Division also requests the imposition of terms and conditions, specified in the Order section below, that Respondent must satisfy in order to re-apply for a license and resume the practice of nursing. Based on the factors set forth in *Aldrich* and the facts of this case, the ALJ concluded that such discipline is warranted.

Respondent appears to have a very serious drug problem, as evidenced by the tremendous and foolish risks she took while on the job in order to procure unauthorized narcotics. She risked not only her continued employment and possible criminal proceedings against her, but also put patients at risk by evidently having controlled substances in her system while on duty as a nurse and apparently taking for herself the medication intended for patient use. She is unsafe to practice until she fully addresses her problem. Moreover, she has failed to take these proceedings seriously as evidenced by her complete abandonment of this case.

Revocation of Respondent's license to practice nursing and imposition of the terms and conditions for resuming her nursing practice set forth below are appropriate in this matter and will serve to protect the public and ensure that Respondent only practices when she is safe to do so. The discipline imposed will also serve to promote Respondent's rehabilitation and deter others from engaging in such conduct.

COSTS

The Board of Nursing has the authority to assess costs pursuant to Wis. Stat. § 440.22. The factors to be considered in assessing costs are: (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 prosecutor; (4) the respondent's cooperation with the disciplinary process; (5) prior discipline, if any; (6) the fact that the Department 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; and (7) any other relevant circumstances. *See In the Matter of Disciplinary Proceedings Against Elizabeth Buenzli-Fritz*, LS0802183CHI (Aug. 14, 2008).

The Division requests that Respondent be ordered to pay the full costs of its investigation and of these proceedings. Based on the factors set forth above, the Division's request is appropriate. The Division has proven the conduct alleged, and the conduct is quite serious. Respondent has not participated in any manner in these proceedings, demonstrating either indifference to the proceedings' seriousness or the great magnitude of her drug problem. Finally, it would be unfair to impose the costs of pursuing discipline in this matter on those licensees who have not engaged in misconduct.

EXPLANATION OF VARIANCE

As the regulatory authority and final decision-maker in this Class 2 proceeding, the Board of Nursing may modify the ALJ's proposed decision. *See* Wis. Stat. § 227.46(2). The Board must provide reasons for any such modifications. *Id.* Here, the Board adopts as its own the findings of fact, conclusions of law and discussion of the ALJ as incorporated herein. The Board also adopts the ALJ's determination of costs. However, the Board modifies the ALJ's proposed order as set forth below.

The Board agrees with the recommended revocation of Respondent's nursing license, but believes it premature at this juncture to impose specific conditions upon any future petition for relicensure. While the recommended pre-licensure educational requirement and the limitations

after any resumption of practice proposed by the ALJ may be appropriate if and when Respondent reapplies, the Board could find other requirements more appropriate, depending on then-existing circumstances. The Board must have the discretion to request information that will permit an accurate contemporaneous assessment of Respondent's fitness to practice without risk of harm to those in her care and to impose conditions which will ensure protection of the patients and public in the event any petition for relicensure from Respondent is granted.

ORDER

Accordingly, IT IS ORDERED that:

1. Respondent Diane Zakopyko's license to practice as a practical nurse in the State of Wisconsin is hereby REVOKED.

2. In the event Respondent Diane Zakopyko ever reapplies for any credential to practice as a nurse in the State of Wisconsin, Respondent shall appear before the Board at the time of application to satisfy the Board as to her competence and fitness to engage in such practice. The Board may request from the Respondent any information necessary to make this determination. The Board may grant or deny the request for licensure or may offer a limited license with terms and conditions to be determined by the Board to address any perceived deficiencies in Respondent's competence or fitness to practice as a nurse at the time of any petition from Respondent.

3. Respondent shall pay all 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 Legal Services and Compliance
P.O. Box 8935
Madison, WI 53708-8935

4. The terms of this Order are effective the date the Final Decision and Order is signed by the Board.

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

Dated at Madison, Wisconsin on June 12th, 2013.

Wisconsin Board of Nursing

By: Julia Nelson (DW)

Julia Nelson, R.N.
Chair of the Board of Nursing