WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	ORDER DESIGNATING HEARING OFFICIAL
DEBORAH J. MISHLER, L.P.N., RESPONDENT.	:	ORDER 0002531

Division of Legal Services and Compliance[1] Case No. 12 NUR 020

The Wisconsin Board of Nursing, having considered the Petition for Designation of Hearing Official, dated July 8, 2013, and having heard the presentation of Attorney Sandra L. Nowack, hereby grants the petition and orders that, pursuant to the authority of Wis. Stat. § 227.46(1), and Wis. Admin. Code § SPS 6.09, an appropriate attorney of the Department of Safety and Professional Services, is designated as the hearing official to preside over the Hearing to Show Cause, if any, and that at the conclusion of the hearing, to make findings and an order as to whether the Order of Summary Suspension, dated July 11, 2013, should be continued.

Wisconsin Board of Nursing

By: Julia Nelson (DW) 7/15/13
A Member of the Board Date

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

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	DLSC Case No. 12 NUR 020
DEBORAH J. MISHLER, L.P.N. RESPONDENT.	:	

ORDER OF SUMMARY SUSPENSION

The Petition for Summary Suspension of July 3, 2013, was noticed to be presented at 8:00 a.m., or as soon thereafter as the matter could be heard, on July 11, 2013. At that time, Attorney Sandra L. Nowack appeared for the Petitioner, Department of Safety and Professional Services, Division of Legal Services and Compliance. Respondent did not appear and did not have counsel appear on her behalf.

The Wisconsin Board of Nursing considered the sworn July 3, 2013 Petition for Summary Suspension of Sandra Nowack, the July 9, 2013 Affidavit of Mitali Chatterjee certifying that service was attempted to Respondent's last known address on the Department's records by Federal Express overnight mail, for Respondent to be personally served true and accurate copies of the Notice and Petition for Summary Suspension of Sandra Nowack, and Petition for Designation of Hearing Official dated July 9, 2013, the affidavit of Tara Albedyll, the Affidavit of Adrian Perez, and the testimony of Tara Albedyll. Having considered this Petition, affidavits and testimony and having heard the argument of counsel, the Board of Nursing hereby makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Respondent Deborah J. Mishler, L.P.N., (dob December 14, 1957), is licensed in the State of Wisconsin as a licensed practical nurse, having license number 32519-31, first issued on June 21, 1994 and expired as of May 1, 2013. Respondent retains the right to automatically renew her license through April 30, 2018. Deborah Mishler's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 6484 N. 58th Street, Milwaukee, Wisconsin 53223

2. On January 18, 2012, Respondent contacted the Department by telephone and left a message indicating that "she had gotten into trouble" and asked that someone from the department call her back.

3. When Department staff returned the call, Respondent stated that her boyfriend and daughter believed that she was mentally ill and sent her to a behavioral health facility. She

said she was not allowed to leave for 3 days. Respondent also stated that the doctor misdiagnosed her and determined that she was incompetent.

4. Department staff noted that Respondent seemed "disconnected," and unable to understand the conversation and what was being said. Respondent would raise her voice and talk over the staff member. Based on the conversation, the staff member, who has experience dealing with impaired individuals, believed Respondent seemed unstable.

5. The staff member's report of the phone call led the Department to open an investigation based on Respondent's apparent impairment and a concern for imminent risk of harm to patients or the public.

6. On January 31, 2012, a Department investigator spoke to Respondent, with the following result:

a. The investigator asked why Respondent had left a message indicating that she is "in trouble." Respondent could not remember making the phone call. Respondent stated that, since 2007, after conducting an illegal search and seizure, the City of Milwaukee had taken her to a mental hospital three times. She reported that, against her will, a doctor injected her with psychotherapy drugs, but that she was unsure of what those drugs were.
b. The investigator informed Respondent that since she had disclosed that a doctor had diagnosed her as incompetent, a fitness to practice and psychological evaluation would be recommended to determine whether or not Respondent was safe to practice as a nurse.
c. Respondent then became angry and denied she had been diagnosed as incompetent.
d. The investigator tried several times to explain the reason for her call, but Respondent would talk over the investigator, so she ended the call.
e. Following the call, Respondent contacted other members of the Department, including the Division of Legal Services and Compliance Division Administrator, wanting to know why we were jeopardizing her license. Respondent was angry and hostile during these calls, interrupting and talking over to the staff member. Respondent also requested the name and phone number of the staff person she had talked to originally.

7. On February 8, 2012, Respondent called asking why the Department was investigating her for an incident that happened in 2007. The investigator explained that her diagnosis of incompetency had prompted the investigation, and Respondent again denied she been diagnosed as incompetent.

8. Respondent did not participate in a mental health evaluation or assessment. She continued to call the Department periodically, speaking to various staff members. Respondent appeared agitated and angry. At one point, Respondent admitted that she had had problems with nursing employment since 2008. She feels she is being "blackballed" whenever she applies for a nursing position.

9. Department staff, as part of the investigation, conducted an inquiry into the Respondent's employment history which revealed that Respondent has been fired or suspended from a number of nursing jobs.

a. In June 2010, her then-employer, Eastside Health and Rehabilitation Center, suspended Respondent for 3 days. The suspension was due to Respondent's failure to follow specific directions regarding care of a resident.
b. On July 10, 2010, Respondent's employer at Eastside Health and Rehabilitation Center attempted to counsel Respondent regarding her failure to complete nursing assignments, to comply with nursing protocols, and her resisting direction from her superiors. Respondent refused to sign documentation of the employee counseling. On the same date she called the employer, and quit without advance notice.
c. On September 29, 2010, Respondent was terminated from her employment as a licensed practical nurse at Linden Grove, a long term care facility, for improper administration of insulin. Respondent had been given prior verbal warnings for failure to complete duties during assigned shifts and inappropriate interaction with co-workers. Respondent had worked for less than 3 months at Linden Grove, and did not complete her probationary period.
d. On October 7, 2010, Respondent was hired as a licensed practical nurse by Mount Carmel Health and Rehabilitation Center. Respondent was fired after 6 days due to her inability to follow directions from the RN supervisor or unit nurse. The employer's notes indicate that Respondent was escorted off the premises.

10. Department staff, as part of the investigation, conducted an inquiry into the Respondent's arrest and conviction history. Milwaukee Police Department records indicate that Respondent was taken into protective custody on February 20, 2011 for an emergency mental health detention. (Case No. 07ED0860.) According to court documents, Respondent had threatened to kill a family member and was making delusional statements. The police report stated that Respondent's daughter had filed the complaint, because Respondent had made threats to kill her daughter and had also made other delusional statements. The daughter advised that Respondent had not slept in 4 days, was barely eating, was not bathing, was making statements about "walking into the light and not coming back."

11. Further, according to her daughter, Respondent had reportedly become severely depressed when she broke up with a boyfriend. Her daughter stated that Respondent had had a "nervous breakdown," and that her behavior was getting worse every day. Her daughter also indicated that Respondent was diagnosed as bi-polar in 2007, and has never taken her prescribed medication, Risperdol.

12. Since the opening of the investigation, Respondent has periodically contacted the Department by telephone or letter. When doing so, Respondent was excessively argumentative, hostile, and uncooperative, making communication with her difficult. When Division staff would attempt to find out whether Respondent is receiving treatment from health care providers,

Respondent would become extremely angry, and claim that she does not need to see any doctors, or take any medication.

13. Respondent has refused to sign authorizations for release of medical or mental health treatment records or to provide any information regarding her mental health status or treatment.

14. On July 3, 2013, a representative from the Department contacted Respondent, and informed her of the proceedings before the Board of Nursing. She indicated that she has not had a mental health assessment as requested, nor is she receiving any treatment for mental health issues, asking why she would do that. She is not on medications, then asked, "Who are you?" despite having been told. Although she had been told that the proceeding would be before the Board of Nursing she continued question the representative, asking: "Who are you people and why are you harassing me?" She said she is not currently working. Respondent could not or would not participate in a conversation.

CONCLUSIONS OF LAW

1. Sufficient notice of this proceeding has been given to Respondent Deborah J. Mishler, L.P.N., as required by Wis. Admin. Code § SPS 6.05.

2. The Board of Nursing is authorized, pursuant to Wis. Sta. §§ 227.51(3) and Wis. Admin. Code § SPS 6.03(4) to summarily suspend Respondent's right to renew her nursing license upon probable cause to believe that the public health, safety, or welfare imperatively requires emergency action.

3. There is probable cause to believe that Respondent has violated Wis. Stat. § 441.07 and Wis. Admin. Code § N 7.03(3) by conduct which reflects an impaired ability of the Respondent to safely or reliably perform as a practical nurse.

4. The public health, safety or welfare imperatively requires emergency suspension of Respondent's right to renew her license to practice as practical nurse in the State of Wisconsin, including the multi-state privilege to practice under the Nurse Licensure Compact set forth in Wis. Stat. sec. 441.50.

ORDER

1. The right to renew the license to practice nursing in the State of Wisconsin, and the privilege to practice nursing in Wisconsin pursuant to the Nurse Licensure Compact of Respondent Deborah J. Mishler, L.P.N., is SUMMARILY SUSPENDED until the effective date of a final decision and order issued in the disciplinary proceeding against Respondent Deborah J. Mishler, L.P.N., unless otherwise ordered by the Board.

2. A notice of hearing commencing disciplinary proceedings under Wis. Admin. Code § SPS 2.06 against Respondent Deborah J. Mishler L.P.N. shall be filed within ten (10) days of the date of this Order by the Department of Safety and Professional Services, Division of

Legal Services and Compliance with the Division of Hearing and Appeals or this Order shall lapse on the tenth day following the date this Order was signed.

3. Respondent Deborah J. Mishler, L.P.N., is hereby notified of her right, pursuant to Wis. Admin. Code § SPS 6.09, to request a hearing to show cause why this summary suspension order should not be continued. Respondent is further notified that any request for a hearing to show cause should be filed with the Wisconsin Board of Nursing, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

4. In the event that Respondent Deborah J. Mishler, L.P.N., requests a hearing to show cause why the summary suspension should not be continued, that hearing shall be scheduled to be heard on a date within 20 days of receipt by the Board of Respondent's request for hearing, unless Respondent requests or agrees to a later time for the hearing.

WISCONSIN BOARD OF NURSING

By: Julia Nelson DW
A Member of the Board

7/15/13
Date