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Before The
State Of Wisconsin
BOARD OF NURSING

In the Matter of the Disciplinary Proceedings
Against **CHERYL SMOKOWICZ SALCEDA, R.N.**, Respondent

FINAL DECISION AND ORDER
Order No. 0003025

Division of Legal Services and Compliance Case No. 10 NUR 239

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 13 day of February, 2014.

Julia Nelson, RN
Member
Board of Nursing

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings
Against **CHERYL SMOKOWICZ SALCEDA, R.N.**, Respondent

PROPOSED DECISION AND ORDER
DHA Case No. SPS-12-0079

Division of Legal Services and Compliance Case No. 10 NUR 239

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

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PROCEDURAL SUMMARY

These proceedings were initiated on December 18, 2012, when the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), served a formal Complaint upon Respondent Cheryl Smokowicz Salceda, alleging that Ms.

Salceda's[1] nursing license was subject to disciplinary action pursuant to Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(6) and (13) due to Ms. Salceda's falsifying visit records for Patient A and forging Patient A's signature on the records from May 19-22, 2010. Ms. Salceda filed an Answer on January 9, 2013. Following a telephone prehearing conference on January 17, 2013, the parties filed a Stipulation of Facts on March 6, 2013, and on April 17, 2013, a hearing on discipline and costs was held. Following the hearing, the parties contacted the undersigned administrative law judge (ALJ) requesting a stay in the proceedings to allow the parties additional time to attempt to reach a settlement. The parties subsequently informed the ALJ that they were unable to resolve the matter. Post-hearing briefs were submitted, with the last brief received on October 9, 2013 and a delayed exhibit (Respondent's Exhibit 7) received on October 22, 2013.

FINDINGS OF FACT

Findings of Fact 1-8 are taken from the parties' Stipulation of Facts. Findings of Fact 9-20 are based on the evidence presented at the April 17, 2013 hearing.

1. Respondent Salceda (DOB October 18, 1967) is licensed in the State of Wisconsin as a professional nurse, having license number 30-105517, first issued on September 9, 1990 and current through February 28, 2014.

2. Ms. Salceda's most recent address on file with the Department is N11 W29938 Saint James Way, Waukesha, Wisconsin 53188.

3. At all times relevant to this proceeding, Ms. Salceda was employed as an in-home professional nurse at Quality Assurance Home Health, located in Milwaukee, Wisconsin.

[1] Ms. Salceda indicated at the April 17, 2013 hearing that she generally uses the last name Salceda rather than Smokowicz.

4. Ms. Salceda completed and submitted to her supervisor visit records for Patient A for May 19, 20, 21 and 22, 2010. The visit records included a full assessment of Patient A and the patient's signature.

5. On May 27, 2010, Ms. Salceda's supervisor received a call from Patient A's caregiver, who reported that Patient A was admitted to the hospital on May 19, 2010 and was in the hospital during the period of time Ms. Salceda claimed to have assessed the patient.

6. Upon review of Patient A's records, it was discovered that Ms. Salceda submitted falsified visit records and forged Patient A's signature on the records.

7. At the time Ms. Salceda submitted the falsified visit records, she was unaware that Patient A had been admitted to the hospital.

8. There was no negative outcome or harm to Patient A resulting from the falsified records.

9. The visits on May 19, 20, 21 and 22, 2010 were scheduled visits, meaning that Ms. Salceda was expected to see Patient A on those dates. (Hrg. Trans., p. 49)

10. Ms. Salceda testified that on May 19, 2010, she went to Patient A's home and rang the buzzer and called Patient A to ask where she was. She further testified that Patient A lived in a retirement community and had an aide service for bathing purposes. (Hrg. Trans., pp. 49-50)

11. At the time of the hearing, Ms. Salceda had been a nurse for over 22 years. (Hrg. Trans., pp. 15-16)

12. Ms. Salceda had never been the subject of disciplinary proceedings by the Wisconsin Board of Nursing prior to the events at issue in this case, nor has she been involved in any disciplinary proceeding following these events. The conduct involved in this case was her first and only instance of misconduct. (Resp. Ex. 1; Hrg. Trans., p. 27-28)

13. Law enforcement did not become involved as a result of Ms. Salceda's conduct on May 19-22, 2010. (Hrg. Trans., p. 27)

14. At the time of her May 2010 misconduct and at the time of the April 17, 2013 hearing, Ms. Salceda also worked at Metro Home Health Services, Inc. (Metro). Ms. Salceda introduced into evidence five employee evaluations conducted by Metro, from April 2, 2007 through May 30, 2012. The 2007-2011 evaluations contain three categories under the heading, "Overall Rating of the Employee:" "Above Average," "Average," and "Below Average." With the possible exception of the April 22, 2010 evaluation, which cannot be discerned, in each of these evaluations, "Average" is checked. The May 30, 2012 evaluation contains a rating scale of 1-3: 1 is "Does not meet standards;" 2 is "Meets standards;" and 3 is "Exceeds standards." For those that are checked, 2's are marked in each of the performance responsibilities, with the exception of the category for "responsibility of ensuring safe delivery of home health care services," for which a 2-3 is checked. (Resp. Ex. 6)

15. In Ms. Salceda's April 2, 2007 employee evaluation, the evaluator states that Ms. Salceda is "very experienced with Home Care Services," that she "[e]xercises appropriate judgment with handling/providing care to clients," that her "[d]ocument and [c]are provision is according to expectations," and that she is "[v]ery motivated and eager to work." It further states that "[t]imeliness of documentation is a concern" and requests her to "show improvements in this area." (Resp. Ex. 2) Ms. Salceda's employee evaluation from Metro on April 28, 2008 makes similar comments, also adding that Ms. Salceda "[s]ees a large volume of clients." (Resp. Ex. 3)

16. Metro's employee evaluation on April 22, 2010, during the time period of the incidents at issue, makes similar comments about Ms. Salceda, stating, "Documentation is complete, however lacks timely submission. This has been a serious ongoing issue that has

improved in intervals, but lacks consistency and requires ongoing attention and work." The evaluation further notes: "Cheryl has experienced some personal challenges recently which have seemed to impact the overall performance; however there have been recent noted strides to address some of the areas that feedback has been given in." (Resp. Ex. 4)

17. Metro's May 30, 2012 evaluation contains similar comments to those in 2007 and 2008. In addition, the General Comments section includes the following: "Cheryl is a dependable, hard working individual who tries to maintain a full-time equivalent caseload. Cheryl is extremely competent in the provision of wound cares to her clients as well as those she sees for other staff. Generally maintains good communication with supervisors regarding client status." However, the General Comments section notes her timeliness issues and also states, "Has been counseled in the past regarding demeanor when interacting with clients, community staff (group home, CSP, other agencies) and seems to be making an effort to improve." (Resp. Ex. 6; Hrg. Trans., pp. 25-26)

18. Ms. Salceda has bilateral hearing loss which makes it difficult or impractical for her to practice in some nursing areas, such as intensive care units, surgical units or busy hospitals because of background noise and due to the masks worn by healthcare providers in these settings which prevents Ms. Salceda from being able to read lips. As a result, in-home nursing is preferable for Ms. Salceda because she can more easily communicate with patients and other caretakers in a quieter, more controlled environment. (Hrg. Trans., pp. 18-20)

19. Ms. Salceda is currently employed full-time with Metro as a case manager. At the time of the April 17, 2013 hearing, she had been employed there for seven years. In that position, she conducts assessments of, and provides care to, patients at home. She also works part-time for Alliance Services, Incorporated, a staffing agency which provides nurses for

hospitals when they are short-staffed. She has worked for Alliance Services for over seven years and is more comfortable working the night shift because there is less noise. (Hrg. Trans., pp. 16-17)

20. At the time of the 2010 incidents at issue, Ms. Salceda was going through a divorce and bankruptcy, losing her house, and trying to keep her five children emotionally stable during these difficulties. (Hrg. Trans., p. 24)

DISCUSSION

Violation of Wis. Stat. § 441.07 and Wis. Admin. Code § N 7.04

Wisconsin Stat. § 441.07(d) states that Wisconsin Board of Nursing (Board) may revoke, limit, suspend or deny renewal of a license of a licensed practical nurse or may reprimand a licensed practical nurse, if the Board finds that the person committed, *inter alia*, "[m]isconduct or unprofessional conduct." Wisconsin Admin. Code § N 7.04 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 "(6) Falsifying or inappropriately altering patient records" and "(13) Obtaining or attempting to obtain any compensation by fraud, misrepresentation, deceit or undue influence in the course of nursing practice."

In the instant case, Ms. Salceda stipulated at hearing that the conduct described in the Stipulation of Facts constituted violations of Wis. Stat. § 441.07(d) and Wis. Admin Code § NUR 7.04(6) and (13). (Hrg. Trans., pp. 4-5) Therefore, the only issues in dispute are the issues of discipline and costs.

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 requests that Ms. Salceda's license be suspended for 60 days and that she be required to complete six hours of education in ethics, six hours of education in professional accountability for nurses and three hours of education in recordkeeping. The Division further requests that Ms. Salceda's license be limited for a period of two years to require the following: (1) that she provide a copy of the Final Decision and Order immediately to supervisory personnel at all settings where she works as a nurse or caregiver or provides health care; (2) that she practice only under direct supervision and only in a work setting pre-approved by the Board or its designee and be prohibited from working in a home health care, hospice, pool nursing, assisted living or agency setting; (3) that Ms. Salceda's supervisor(s) provide written reports on Ms. Salceda's work performance to the Department Monitor on a quarterly basis, as directed by the Department Monitor, with the first report due 90 days from the date of the Final Decision and Order, and that it be Ms. Salceda's responsibility to ensure that the reports are made in a timely manner; (4) that she notify the Department Monitor of any change of nursing employment within 15 days of a change of employment and that the notification include an explanation of the reasons for the change; (5) that her nursing practice be limited to Wisconsin during the pendency of these limitations, with this requirement waived only upon the prior written authorization of both the Wisconsin Board and the regulatory authority of the state in which Ms. Salceda seeks to practice, and that she pay the board in the state in which she seeks to practice; and (6) that after

two years from the date of the Final Decision and Order, Ms. Salceda should be permitted to petition the Board for modification or termination of one or more of the limitations.

Ms. Salceda argues that the circumstances of this case warrant an administrative warning, and, if necessary, some continuing education credits. Her opposition to the Division's recommendation is mainly to the Division's request for suspension, the requirement that she work only under direct supervision and the prohibition of in-home care. She emphasizes that during the four days at issue, she was a single mother of five children in the midst of going through a divorce, losing her house, filing for bankruptcy and caring for her children. She further emphasizes that she has been a registered nurse since 1990, has never previously been the subject of a disciplinary proceeding and has not been since the incidents three years ago, has had many positive reviews from superiors, colleagues and patients, is a compassionate and dedicated nurse, and that she took ownership of her misconduct in this matter by stipulating to the facts that form the basis of the violations and to the violations themselves. She further states that the conduct did not result in harm to the patient and that the recommended discipline would also undermine her entire career, particularly in view of her hearing disability which restricts her ability to practice in many other non-home-care environments. She further states that to require her to practice nursing only under direct supervision would also have a disparate impact on her because in-home care is a setting which accommodates her hearing disability and direct supervision in a home care setting is impractical. Finally, she argues that the Division's proposed sanctions are inconsistent with the level of discipline imposed in other Board decisions with similar facts.

For the reasons set forth below, I conclude that suspension is not warranted, nor is a prohibition on in-home care or a requirement that Ms. Salceda be directly supervised, to the

extent that by the phrase "direct supervision," the Division means that a supervisor must be on location with Ms. Salceda at all times. I further conclude that a reprimand is appropriate as are the other recommendations from the Division.

Ms. Salceda is correct that the discipline requested by the Division in this case is inconsistent with that ordered by the Board under similar circumstances. One of these prior decisions, *In the Matter of Disciplinary Proceedings Against Shelly L. Lato*, Case No. 09-NUR-028 (January 27, 2011), involved a registered nurse, Shelly Lato, who had been licensed as a nurse in Wisconsin for less than four years at the time of the decision and who, like Ms. Salceda, reported home visits and assessments even though such visits and assessments never occurred. Also like Ms. Salceda, Ms. Lato forged signatures on visit notes and did not inform the physician of any missed cares. Unlike Ms. Salceda, who committed misconduct with only one patient over a consecutive four-day period, Ms. Lato committed her misconduct with five patients, presumably over a longer period of time.[2] In addition, although Ms. Lato entered into a stipulation for purposes of resolving the matter without further expense, Ms. Lato "denie[d] the allegations although she d[id] admit that the record keeping during the employment at issue could have been better." Here, Ms. Salceda takes responsibility for her conduct, admitting not only the conduct at issue but also that the conduct constitutes the violations alleged.

Despite Ms. Lato's very similar conduct involving five patients and Ms. Lato's failure to admit her misconduct, Ms. Lato received a lesser discipline than that recommended by the Division in the instant case. Instead of a suspension as recommended here, Ms. Lato received: (1) a reprimand; (2) a requirement to complete, within 90 days, six hours of pre-approved

[2] Although Ms. Salceda emphasizes that Ms. Lato's conduct occurred over a longer period of time than Ms. Salceda's conduct, the decision is actually silent on that issue. It is not unreasonable to assume, however, that given the number of patients involved, Ms. Lato's conduct occurred over a time period longer than the four-day period at issue here.

continuing education in nursing education and six hours of pre-approved continuing education in record-keeping; (3) a limitation to work only under direct supervision and only in a work setting approved by the Board; (4) a two-year prohibition from working in a home health, agency or pool position, although she was allowed to keep her then-current position at Hospice Advantage; (5) two years of quarterly reporting from her employer(s); (6) a two-year requirement of notifying the Department of any change in employment; (7) a limitation to practice nursing only in Wisconsin. In addition, Ms. Lato was required to pay costs in the amount of $1,000. The decision in *Lato* was issued on January 27, 2011, less than a year after Ms. Salceda's conduct in this case.

Another case, *In the Matter of Disciplinary Proceedings Against Wendi J. Mueller*, Case No. 06-NUR 018 (November 5, 2009), also suggests that the discipline recommended by the Division in this case is inconsistent with prior Board decisions. In that case, Wendi Mueller, a registered nurse, was charged with making false claims of providing home health care nursing services that were not actually provided. Ms. Mueller submitted false claims to the Wisconsin Medicaid program. At the time of the misconduct, Ms. Mueller had been a nurse for just over three years. The misconduct occurred over a five-month period, between March 12, 2004 and August 12, 2004. Ms. Mueller was charged criminally, found guilty of three criminal misdemeanor counts and sentenced to two years of probation and restitution payments of $7,375. During her probation she was not permitted to work in any position of employment where she would be participating in direct billing to Medicare or Medicaid. At the time of the final order, Ms. Mueller had successfully completed her probation. Ms. Mueller entered into a stipulation with respect to the violations and the discipline and costs imposed. As a result, she received a reprimand and was required to pay costs of $1,305.80 within 90 days, failing which her license

would be suspended until she complied with the Order. Despite the similar conduct, which resulted in criminal conviction and involved a five-month period of misconduct rather than the four consecutive days at issue here, the discipline involved no suspension of Ms. Mueller's license, no requirement for direct supervision, and no prohibition on in-home care. The date of the *Mueller* decision was November 5, 2009, approximately six months prior to Ms. Salceda's misconduct.

Ms. Salceda also cites *In the Matter of the Disciplinary Proceedings Against Judith A. Mueller*, Case No. 09-NUR-109 (July 23, 2009), a case not equally comparable but nonetheless relevant. In that case, Judith Mueller, a registered nurse, was intoxicated on the job. After experiencing health problems during a shift, she was taken to the emergency room. Although she had already worked for a few hours, her blood alcohol concentration was determined to be .19. This incident was in addition to a previous incident which occurred the prior year, when she overdosed on narcotics. At the time of the July 23, 2009 Final Decision and Order in that case, Ms. Mueller reported that had not consumed alcohol since March of 2009. At the time of the decision, she was still employed as a registered nurse at a hospital. Although a suspension was imposed indefinitely, it was immediately stayed subject to certain conditions such as attending an alcohol treatment facility and attending Narcotics Anonymous and Alcoholics Anonymous meetings.[3]

At hearing, the Division acknowledged that prior orders may not be consistent[4] but stated that "this is a different Board from past Boards," that the Board "has changed dramatically," and

[3] Ms. Salceda also discusses *Noesen v. Dep't of Reg. and Lic.*, 2008 WI App 52, 311 Wis. 2d 237, 751 N.W.2d 385. However, because that case involved a decision by the Pharmacy Examining Board rather than the Board of Nursing, it is not considered here.

[4] In its brief-in-chief, with different counsel, the Division states that it does not concede that the prior cases are inconsistent with the discipline recommended here. (Division's Brief, pp. 10-12)

that the current Board views this type of fraud more seriously than did past Boards. (Hrg. Trans., pp. 38-39) In its brief-in-chief, the Division further states:

> Additionally, the Board is an administrative body, consisting of politically appointed members. Administrative bodies do not have or create precedent the same way that circuit courts do. While a range of consistency is appropriate, the Board is reasonably endowed with more discretion to divert from its past practices than a circuit court, for example. Administrative bodies need to respond to changing demands of the public and the profession.

(Division's Brief, p. 12)

The Division has cited no authority for these assertions, nor are they convincing.[5] In fact, "[a]dministrative agencies are designed to provide uniformity and consistency in the fields of their specialized knowledge." *Brookfield v. Milwaukee Metro Sewerage Dist.*, 171 Wis. 2d 400, 421, 491 N.W.2d 400 (1992). While agency (including Board) decisions are not necessarily legally binding precedent, particularly with respect to higher courts, it has long been the practice for administrative law judges to follow the final decisions of administrative agencies, for agencies to follow their own final decisions, and for parties, including Division attorneys, to rely on prior agency decisions in support of their positions. Fairness demands no less. Those who are regulated by the Board have the right to expect consistency and uniformity in the application of the laws rather than be subject to the whim of particular personalities or political trends.[6] The three goals of discipline – rehabilitation, protection of the public and deterrence – remain the same regardless of the composition of the Board, and licensees should be disciplined based on these goals and the particular facts of their cases. While no two cases will be factually identical, decision-makers have an obligation to treat similarly situated licensees similarly, barring

[5] Although not relevant to this case, I note that the Division is incorrect that circuit court decisions are precedential. *See* Kuhn v. Allstate Ins. Co., 181 Wis. 2d 453, 468, 510 N.W.2d 826 (Ct.App.1993) ("[A] circuit court decision is neither precedent nor authority upon which this court may base its decision.").

[6] Indeed, one of the axioms of American democracy, which includes our justice system, is that we are a government of laws, not of men.

evidence or a compelling argument that past practices were somehow unsound. There is no suggestion here that these decisions from just a few years ago (and very close to the time period in which Ms. Salceda's May 2010 conduct occurred), were unprincipled or in error.

The Division asserts that the current Board's view is reflected in *In the Matter of Disciplinary Proceedings Against Samantha S. Connaughty*, Case No. 11-NUR-586 (June 7, 2012), decided more than two years after Ms. Salceda's conduct, and that the *Connaughty* case is more analogous to the instant case. Ms. Connaughty, a professional nurse, committed insurance fraud, was criminally convicted of three counts of misdemeanor fraudulent insurance claim, was ordered to six months in jail and had to pay restitution of $37,890.32. The convictions were based on Ms. Connaughty having made false statements on applications for payments for hours she claimed to have worked as a nurse for a patient who was covered by the Medicaid Program, between January 1, 2009 and November 25, 2010, almost a two-year period. Ms. Connaughty entered into a stipulation admitting the violations and agreeing to the discipline imposed, but claimed to have been suffering from an illness which made her unable to work. She claimed she filed the fraudulent claims to help support her family.

The Board ordered that Ms. Connaughty's license be suspended for 90 days. In addition, she had to complete four hours of pre-approved continuing education in ethics and four pre-approved hours of continuing education in proper billing practices; was required to provide her nursing employers with a copy of the Order before engaging in any nursing employment; and for two years from the date of the Order, was permitted to work only under direct supervision in a work setting pre-approved by the Board. Although the Board ordered that Ms. Connaughty could not work in a home health, agency or pool position, her current position with a home care provider was nevertheless approved. She was also required to submit quarterly work reports to

the Board, was prohibited from working in any state but Wisconsin and had to notify the Department Monitor of any change in nursing employment during the time the Order was in effect. She was also ordered to pay $400 in costs.

I agree with Ms. Salceda that the facts in the *Connaughty* case are more egregious than those here. Unlike Ms. Salceda's conduct, Ms. Connaughty's conduct occurred for almost a two-year period in contrast to the four consecutive days at issue here, involved nearly $38,000 in fraudulent claims, and resulted in criminal convictions and jail time. I am not persuaded by the Division's assertion that Ms. Connaughty's conduct was less serious than Ms. Salceda's because Ms. Connaughty's patients "still received the care they needed" whereas Ms. Salceda's patient did not. (Division's Brief, p. 11) The *Connaughty* decision does not indicate that the patients received the care they needed; rather, it states that Ms. Connaughty "made false statements on applications for payment for hours she claimed to have worked as a nurse for a patient," which suggests that the care was actually *not* provided to the patient, similar to the situation here.

Ms. Salceda's case is much more similar to the *Lato* and *Mueller* record falsification cases where no suspensions were imposed even though the behavior conduct in *Lato* and *Mueller* was somewhat more egregious than Ms. Salceda's conduct.

I conclude that based on the three purposes of discipline in *Aldrich*, the facts of this case and the cases cited above, suspension of Ms. Salceda's license is not warranted. Ms. Salceda has been a nurse for approximately 22 years and this is the only instance of misconduct. The misconduct occurred during a four-day period during a time period in which Ms. Salceda was going through a divorce, bankruptcy, and losing her home, all while trying to keep her five children stable. No additional misconduct has occurred in the three years following the 2010 incidents. It also appears unlikely that such an incident will occur again given her multiple years

of practice without incident, her continued employment, and her generally positive employment reviews.

The Division emphasizes that Ms. Salceda violated two provisions, one for falsifying patient records and another for obtaining or attempting to obtain compensation for work she did not do. The Division also argues that Ms. Salceda abandoned Patient A: after knocking on her door and not getting an answer, Ms. Salceda failed to contact anyone or get Patient A any help. Instead, she falsified Patient A's record for that day and for the three days that followed, not knowing that Patient A had been taken to the hospital. The Division states that for all Ms. Salceda knew at the time, Patient A could have been lying injured or unconscious. Ms. Salceda's behavior created the risk that Patient A would go without needed help and that the physicians' orders would not be carried out by anyone. The Division further notes that Ms. Salceda was caught shortly after her conduct and suggests that she may have continued her dishonest conduct had Patient A's caregiver not informed Ms. Salceda's employer of Patient A's hospitalization.

The Division's arguments are well-taken. However, such risks to the patients presumably existed in the *Lato* and *Wendi Mueller* cases too, with more patients and/or for a longer time periods, yet no suspension was imposed. In addition, unlike nurses Lato and Wendi Mueller, both of whom had been nurses for under five years at the time of their misconduct, Ms. Salceda had been practicing as a nurse for approximately 20 years at the time the misconduct occurred, with no other misconduct before or since. I also note that Ms. Salceda admitted the conduct and violations early on in these proceedings, thereby taking responsibility for her conduct, and that the conduct occurred during an extremely stressful time in Ms. Salceda's life.

The Division also argues that between 2007 and 2012, the timeliness of Ms. Salceda's nursing records had been an ongoing problem and that her documentation issues persisted even two years after her 2010 misconduct. The Division asserts that "late documentation could mean that in the future Ms. Salceda will feel compelled to create documentation even if she does not remember the patient's contact." (Division's Brief, p. 7) This argument, based on conjecture, is not persuasive, as there is a big difference between untimeliness and falsifying records. In addition, Ms. Salceda's untimeliness was apparently never sufficiently significant to warrant discipline and despite this issue, all of her evaluations showed that she met her employer's expectations.

Based on the foregoing, I conclude that suspension is not warranted. However, I also reject Ms. Salceda's argument that an administrative warning is appropriate. Administrative warnings are governed by Wis. Admin. Code § SPS 8.03, which states:

> **8.03 Findings before issuance of an administrative warning.** Before issuance of an administrative warning, a disciplinary authority shall make all of the following findings:
> **(1)** That there is specific evidence of misconduct by the credential holder.
> **(2)** That the misconduct is a first occurrence for the credential holder.
> **(3)** That the misconduct is a minor violation of a statute or rule related to the profession or other conduct for discipline may be imposed.
> **(4)** That issuance of an administrative warning will adequately protect the public.

The term "minor violation" is defined by Wis. Admin. Code § SPS 8.02(6), which provides:

> **(6)** "Minor violation" means all of the following:
> **(a)** No significant harm was caused by misconduct of the credential holder.
> **(b)** Continued practice by the credential holder presents no immediate danger to the public.
> **(c)** If prosecuted, the likely result of prosecution would be a reprimand or a limitation requiring the credential holder to obtain additional education.
> **(d)** The complaint does not warrant use of prosecutorial resources.
> **(e)** The credential holder has not previously received an administrative warning.

I note that a reprimand was ordered in the *Lato* and *Wendi Mueller* cases for similar conduct. Although Ms. Salceda's conduct was somewhat less egregious than the conduct of the nurses in the *Lato* and *Wendi Mueller* cases, it was not sufficiently less egregious to warrant an administrative warning rather than a reprimand. Unlike a reprimand, an administrative warning is not published and the licensee is therefore not accountable to the public. (Hrg. Trans., p. 58) I cannot conclude that the issuance of an administrative warning will adequately protect the public or that the conduct meets the definition of "minor violation." The conduct posed a significant risk to Patient A, even if no harm ended up occurring to her, and it has not been shown that "[t]he complaint did not warrant the use of prosecutorial resources." Wis. Admin. Code. § SPS 8.02(6)(d). Obviously, the Division's prosecutorial resources were used in this disciplinary proceeding, and appropriately so as Ms. Salceda's conduct posed a risk to the patient and resulted in violations of two separate provisions defining professional misconduct.

Likewise unwarranted are the Division's recommendations that Ms. Salceda practice only under direct supervision in a work setting pre-approved by the Board, and that she be prohibited from working in a home health care, hospice, pool nursing, assisted living or agency setting. Ms. Salceda currently works for Metro, an in-home care provider, where she also worked at the time of the 2010 incidents. At the time of the hearing, she had provided in-home care for Metro for approximately seven years, for three years without incident following the misconduct and for four years without incident prior to the misconduct. I conclude that the other recommendations by the Division, with which I agree, are adequate to ensure that Ms. Salceda continue her in-home nursing practice without direct supervision in a safe and trustworthy manner. For example, Ms. Salceda is required to complete the recommended 15 hours of continuing education, is required to provide to the Department Monitor quarterly reports on her work performance from

her supervisors as requested by the Department, and is required to immediately provide a copy of the Final Decision and Order in this case to supervisory personnel at all settings where she works as a nurse or caregiver or provides health care. To further ensure her compliance and that she practice in a safe and reliable manner, I have added a further condition that if she fails to comply with any of the terms of the Order, the Board may, in its discretion, suspend her license until she complies with the orders.

Not imposing the direct supervision requirement and prohibition on in-home care is also consistent with prior Board decisions. The nurse in the *Wendi Mueller* case received only a reprimand and an order to pay costs. Ms. Mueller's discipline involved no requirement for direct supervision and no prohibition on in-home care. This was despite the fact that her misconduct continued over a five-month period rather than for four days and resulted in criminal conviction, and that Ms. Mueller had been in practice for only approximately three years when the misconduct occurred, as opposed to Ms. Salceda's 20 years of practice without incident.

In *Lato*, which involved five patients instead of one, a criminal conviction, and a nurse with under five years of nursing practice, the nurse was allowed to keep her position with a hospice care provider, despite the Board's two-year prohibition on working in a home health, agency or pool position and a limitation that she work only under direct supervision and only in a work setting approved by the Board. I also note that neither of the nurses in *Mueller* or *Lato* had a hearing disability or any other disability which placed limitations on the settings in which they could practice. Even the nurse in *Connaughty*, whose conduct was much more serious than Ms. Salceda's, was permitted to keep her job with an in-home care provider.

Based on the foregoing, I conclude that the discipline discussed above and outlined in more detail in the Order section below best serves the purposes of rehabilitation, protection of the public and deterrence.

Costs

The Department has the authority to assess costs pursuant to Wis. Stat. § 440.22. The Division requests that Ms. Salceda be ordered to pay the full costs of its investigation and of these proceedings. 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).

Regarding the first factor, Ms. Salceda admitted to the conduct and violations alleged and they were therefore proven by the Division. Further, the misconduct was serious but occurred over a very discreet amount of time (four days) during what was then a 20-year career and during a time period in which Ms. Salceda was experiencing an unusual amount of personal stress. With respect to the third factor, I note that the level of discipline sought by the Division – a 60-day suspension with license limitations -- is significant but not a very high level of discipline when compared to many other cases that come before this tribunal. I also note that the requested suspension was not ordered in this case, nor were some of the limitations recommended by the

Department, and that the parties expended resources arguing these points, both in the hearing and in post-hearing briefs. Regarding the fourth factor, Ms. Salceda has been very cooperative throughout the proceedings, taking ownership of her conduct while disputing the level of discipline and amount of costs which should be imposed. As previously noted, Ms. Salceda has had no prior or subsequent discipline against her. The only factor that unequivocally operates in favor of the Department, as it always does, is the fact that the Department is a "program revenue" agency, whose operating costs are funded by the revenue received from licenses, and it is unfair to impose the costs of disciplining Ms. Salceda on the vast majority of the licensees who have not engaged in misconduct.

I note that the cases discussed above are not instructive on the issue of costs as they provide a total amount of costs ordered without indicating what percentage of the total costs the imposed costs represent. Based on the factors above and the facts of this case, I conclude that it is appropriate to impose 50 percent of the costs of these disciplinary proceedings on Ms. Salceda.

CONCLUSIONS OF LAW

1. Ms. Salceda committed misconduct or unprofessional conduct in violation of Wis. Stat. § 441.07(d) and Wis. Admin Code § NUR 7.04(6) and (13).

2. The discipline set forth in the Order section below is appropriate under *State v. Aldrich*, 71 Wis. 2d 206, 237 N.W.2d 689 (1976).

3. Imposition of 50 percent of the costs on Ms. Salceda for these disciplinary proceedings is warranted under Wis. Stat. § 440.22 and *In the Matter of Disciplinary Proceedings Against Elizabeth Buenzli-Fritz*, LS0802183CHI (Aug. 14, 2008).

ORDER

Based on the foregoing, it is hereby ORDERED that:

1. Ms. Salceda is REPRIMANDED.

2. Within 90 days of the date of the Final Decision and Order in this matter, Ms. Salceda is required to complete six hours of education in ethics, six hours of education in professional accountability for nurses and three hours of education in recordkeeping.

3. Ms. Salceda's license shall be limited for two years from the date of the Final Decision and Order in this case, as follows:

a. Ms. Salceda shall provide a copy of the Final Decision and Order immediately to supervisory personnel at all settings where she works as a nurse or caregiver or provides health care.

b. Ms. Salceda shall provide timely written reports on her work performance from her supervisors to the Department Monitor on a quarterly basis, as directed by the Department Monitor, with the first report due 90 days from the date of the Final Decision and Order, and it shall be Ms. Salceda's responsibility to ensure that the reports are made in a timely manner.

c. Ms. Salceda shall notify the Department Monitor of any change of nursing employment during the time in which the Order is in effect. Notification shall occur within fifteen days of a change of employment and shall include an explanation of the reasons for the change.

d. Pursuant to Uniform Nurse Licensure Compact regulations, Ms. Salceda's nursing practice is limited to Wisconsin during the pendency of these limitations and this requirement may be waived only upon the prior written authorization of both the Wisconsin Board of Nursing and the regulatory authority of the state in which Ms. Salceda seeks to practice. Ms. Salceda must pay the board in the state in which she seeks to practice.

e. After two years from the date of the Final Decision and Order, Ms. Salceda may petition the Board for modification or termination of one or more of these limitations and the Board may, in its discretion, grant or deny the petition to modify the Final Decision and Order as it sees fit.

4. Fifty percent of the costs of these proceedings shall be assessed against Ms. Salceda in accordance with Wis. Stat. § 440.22 and Wis. Admin. Code § SPS 2.18.

5. Payment of costs shall be made payable to the Wisconsin Department of Safety and Professional Services and sent to the Department Monitor at the address below:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 8935
Madison, WI 53708-8935

6. If Ms. Salceda fails to comply with any of the terms of this Order, the Board, may, in its discretion, suspend her license until she complies with the Order.

7. 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 is hereby closed as to Respondent Cheryl Smokowicz Salceda.

Dated at Madison, Wisconsin on November 12, 2013.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
5005 University Avenue, Suite 201
Madison, Wisconsin 53705
Telephone: (608) 266-7709
FAX: (608) 264-9885

By: _____
Jennifer E. Nashold
Administrative Law Judge