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Before The
State Of Wisconsin
BOARD OF NURSING

In the Matter of the Disciplinary Proceedings
Against **SABRINA C.K. GILES, R.N.,**
Respondent

FINAL DECISION AND ORDER

Order No. 3144

Division of Legal Services and Compliance Case No. 13 NUR 059, 14 NUR 079

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 9th day of October, 2014.

Peggy A. McCue DNP, APNP
Member
Board of Nursing

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings
Against **SABRINA C.K. GILES, R.N.,**
Respondent

DHA Case No. SPS-14-0035
DLSC Case Nos. 13 NUR 059
14 NUR 079

ORDER 3144

PROPOSED DECISION AND ORDER

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

Sabrina C.K. Giles, R.N.
P.O. Box 294
Iron River, WI 54847

Wisconsin Board of Nursing
P.O. Box 8366
Madison, WI 53708-8366

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

Attorney Andrea E. Brauer
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

PROCEDURAL HISTORY

These proceedings were initiated when the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), filed a formal Notice of Hearing and Complaint against Respondent Sabrina C.K. Giles, R.N. The Complaint alleged that Respondent's license was subject to disciplinary action pursuant to Wis. Stat. § 441.07(1g)(b)–(e) because she: (1) committed unprofessional conduct as defined in Wis. Admin. Code § N 7.03(2) and Wis. Stat. § 441.50(5)(e) by being the subject of an adverse action taken against her privilege to practice nursing pursuant to the Nurse Licensure Compact by the Arizona State Board of Nursing; (2) was impaired and committed unprofessional conduct as defined in Wis. Admin. Code § N 7.03(2) by consuming controlled substances that rendered her unable to

safely or reliably practice nursing; (3) violated Wis. Admin. Code § N 7.04(2) by administering, supplying or obtaining a drug other than in the course of legitimate practice or as otherwise prohibited by law; (4) violated Wis. Stat. § 440.11(1) by failing to notify the Department of a new address within 30 days of the change; and (5) committed unprofessional conduct as defined in Wis. Admin. Code § N 7.04(1) by violating multiple laws substantially related to the practice of professional nursing.

The Division served Respondent on April 18, 2014 by sending a copy of the Notice of Hearing and Complaint to her address on file with the Department. Respondent failed to file an Answer to the Complaint, as required by Wis. Admin. Code § SPS 2.09, and failed to appear at the May 27, 2014 prehearing conference.

At the prehearing conference, the Division moved for default pursuant to Wis. Admin. Code § SPS 2.14 and Wis. Admin. Code § HA 1.07(3)(c). In light of Respondent's failure to file an Answer to the Complaint and failure to appear for the conference, the undersigned administrative law judge (ALJ) found Respondent to be in default. On May 28, 2014, the ALJ issued a Notice of Default against Respondent and ordered the Division to file a recommended proposed decision by June 10, 2014, which the Division timely filed. Respondent did not file a response to either the Notice of Default or to the Division's subsequent submission.

FINDINGS OF FACT

Facts Related to the Alleged Violations

Findings of Fact 1–34 are taken from the Division's Complaint against Respondent filed in this matter.

1. Respondent Sabrina C.K. Giles, R.N. (dob June 23, 1969) is licensed in the State of Wisconsin to practice professional nursing, having license number 144136-30, first issued on May 23, 2003 and current through February 29, 2016.

2. Respondent's address of record with the Department is P.O. Box 294, Iron River, Wisconsin 54847.

3. Respondent's actual address is 35552 County Road 3, Fairview, Montana 59221.

4. Respondent has never reported to the Department an address outside of Iron River, Wisconsin.

5. On December 21, 2009, in Bayfield County Wisconsin Circuit Court, Case Number 09TR2292, Respondent pled no contest to Operating with BAC of .10 or more (1st) in violation of Wis. Stat. § 346.63(1)(b).

6. On April 6, 2010, in Bayfield County Wisconsin Circuit Court Case Number 10CM005, Respondent was convicted of criminal damage to property in violation of Wis. Stat. § 943.01(1).

Adverse Action in Arizona

7. On March 20, 2013, the Arizona State Board of Nursing (Arizona Board) accepted Respondent's Voluntary Surrender of the privilege to practice nursing in Arizona under the multi-state compact.

8. The Arizona Board's Order reflects the following facts:

a. Between approximately August 27, 2012 and approximately December 14, 2012, Respondent worked as a nurse at Fort Defiance Indian Hospital in Fort Defiance, Arizona (Arizona employer) under her Wisconsin license, pursuant to the Nurse Licensure Compact.

b. Between August 2012 and October 2012, Respondent's Arizona employer found Respondent to be an exemplary nurse.

c. In October 2012, Respondent's quality of work deteriorated gradually.

d. On October 11, 2012, Respondent administered FluMist Quadrivalent, a nasal flu vaccine, to an asthmatic child.

e. A minimally competent nurse would not administer FluMist Quadrivalent to a child diagnosed with asthma.

f. Flumist Quadrivalent, when administered to a child with asthma, can trigger a severe and sustained asthmatic episode known as "status asthmaticus."

g. Respondent's action in administering Flumist Quadrivalent to a child with asthma under the circumstances of this case constituted a reckless violation of the standard of care in a nurse's assessment and vaccine administration in a child with asthma.

h. On October 26, 2012, Respondent attended an Advanced Cardiac Life Support (ACLS) class.

i. During a hands-on testing phase of the October 26, 2012 class, the instructor observed Respondent having slurred speech and falling asleep.

j. Due to slurred speech and falling asleep during the hands-on test, Respondent was removed from the ACLS class.

k. After Respondent was removed from the class, two witnesses observed that Respondent had slurred speech and pinpoint pupils, non-reactive to light.

l. Respondent did not believe she was impaired but acknowledged she took a controlled substance five hours before the class.

m. On October 30, 2012, staff observed Respondent falling asleep while on duty as a professional nurse. Respondent was asked to leave for a few hours.

n. On October 30, 2012, Respondent's employer verbally counseled her for failing to complete documentation of patient health care records.

o. Respondent's Arizona employer offered her an opportunity to participate in an employee assistance program. Respondent declined.

p. Between approximately January 14, 2013 and February 22, 2013, Respondent worked as a travel nurse in a pediatric unit at the University of New Mexico in Albuquerque, New Mexico (New Mexico employer) under her Wisconsin license, pursuant to the Nurse Licensure Compact.

q. On or about February 22, 2013, Respondent displayed behaviors consistent with impairment while on duty as a nurse at her New Mexico employer's pediatric unit.

r. Respondent's behaviors on or about February 22, 2013, included falling asleep while holding a child, exhibiting slurred and slow speech, and having difficulty maintaining consistent and stable gait/posture.

9. On or about February 27, 2013, Respondent submitted a written statement to the Arizona Board, which described Respondent's involvement in a car accident during October of 2012.

10. In her February 27, 2013, submissions, Respondent included a pharmacy profile for January 1, 2012 through December 31, 2012, reflecting the following:

a. Respondent purchased hydrocodone pursuant to a prescription on five occasions from October 1, 2012 to December 7, 2012;

b. Respondent purchased lorazepam pursuant to a prescription from April 12, 2012 to December 10, 2012;

c. Respondent purchased zolpidem pursuant to a prescription from April 12, 2012 to December 10, 2012;

d. Respondent purchased mirtazapine pursuant to a prescription on October 1, 2012 and October 26, 2012;

e. Respondent purchased promethazine pursuant to a prescription from April 12, 2012 to July 16, 2012;

f. Respondent purchased trazadone pursuant to a prescription from May 24, 2012 to November 17, 2012; and

g. Respondent purchased sertraline pursuant to a prescription from April 12, 2012 to November 17, 2012.

11. The medications set out in paragraph 10, above, when used alone or in any combination, are known to cause physical and mental impairment, and therefore reduced Respondent's ability to safely and reliably practice nursing.

12. The Arizona Board concluded that sufficient evidence existed to support the following conclusions of law:

a. Respondent engaged in conduct or practice that is or might be harmful or dangerous to the health of a patient or the public;

b. Respondent failed to take appropriate action to safeguard a patient's welfare or follow policies and procedures of the nurse's employer designed to safeguard the patient;

c. Respondent showed a pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice;

d. Respondent showed a pattern of using or being under the influence of alcohol, drugs, or a similar substance to the extent that judgment may be impaired and nursing practice detrimentally affected, or while on duty in any health care facility, school, institution, or other work location; and

e. Respondent practiced in a manner that gave the Arizona Board reasonable cause to believe the health of a patient or the public may have been harmed.

13. The Division first contacted Respondent on February 12, 2013, via certified mail to inform her of the investigation.

14. On March 1, 2013, Respondent initially responded to the Division's inquiries. She maintained communication with the Division via telephone calls and emails.

15. On or about May 16, 2013, the Department sent, via certified mail, correspondence to Respondent's address of record at P.O. Box 294, Iron River, Wisconsin 54847.

16. Respondent did not respond to the Division by the date specified within the May 16, 2013 correspondence.

Adverse Action in North Dakota

17. Between April 9, 2013 and February 24, 2014, Respondent worked as a registered nurse at Mercy Medical Center in Williston, North Dakota under her Wisconsin license, pursuant to the Nurse Licensure Compact.

18. On November 21, 2013, the Board of Nursing of the State of North Dakota issued an order (North Dakota Order) denying Respondent's application for licensure as a registered nurse by endorsement and ordering Respondent to cease and desist from the practice of nursing in the State of North Dakota, including pursuant to any multi-state nursing licensure compact with the Board.

19. The North Dakota Order found that Respondent attempted to obtain by fraud or deceit a license or registration to practice nursing, or submitted to the Board information that is fraudulent, deceitful or false.

20. The North Dakota Board based the legal conclusion set out in paragraph 19, above, on the following allegations, for which the Board determined there was credible evidence:

a. Respondent answered "no" to the question: "Has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?"

b. In fact, on or about March 20, 2013, Respondent signed a disciplinary Voluntary Surrender of Nurse Multi-State Licensure Privilege in Arizona for impairment issues at work.

c. Respondent answered "no" to the question: "Have you been investigated or are you presently being investigated by any other jurisdiction?"

d. In fact, the Wisconsin Board of Nursing had an open investigation against Respondent at the time.

e. Respondent answered "no" to the question: "Have you been terminated from a nursing related job due to conduct that may be grounds for disciplinary action?"

f. In fact, Respondent was terminated by her Arizona employer for failing to consistently demonstrate acceptable, professional behavior and safe nursing practice.

21. Between November 21, 2013, and February 13, 2014, Respondent continued to work as a registered nurse at Mercy Medical Center in North Dakota under her Wisconsin license in direct violation of the North Dakota Order.

22. Respondent did not inform Mercy Medical Center of the North Dakota Order.

23. Dr. K is a medical doctor at Mercy Medical Center in Williston, North Dakota, the same hospital where Respondent worked.

24. Between May 22, 2013, and February 10, 2014, Respondent obtained hydrocodone and zolpidem with prescription orders written on Dr. K's prescription pads and purportedly signed by Dr. K.

25. Between May 22, 2013, and February 10, 2014, Respondent's son obtained hydrocodone, zolpidem and cyclobenzaprine with prescription orders written on Dr. K's prescription pads and purportedly signed by Dr. K.

26. Dr. K never saw Respondent as a patient.

27. Dr. K never saw Respondent's son as a patient.

28. Dr. K did not prescribe any medications for Respondent.

29. Dr. K did not prescribe any medications for Respondent's son.

30. Because the prescription orders did not contain the signature of the practitioner who purportedly wrote the orders, they were illegally dispensed.

31. Respondent possessed prescription drugs that were not obtained in accordance with the law.

32. On February 13, 2014, Respondent consented to a drug screening, which was positive for alternate opiates, hydrocodone and hydromorphone, for which she had no prescription.

33. On February 24, 2014, Mercy Medical Center terminated Respondent's employment.

34. Respondent has not responded to the Division's attempts to contact her via telephone on February 21, 2014, or by telephone, email and regular mail on March 11, 2014.

Facts Related to Default

35. The Complaint and Notice of Hearing in this matter were served on Respondent on April 18, 2014 by both certified and regular mail consistent with Wis. Admin. Code § SPS 2.08. The Notice of Hearing advised Respondent: "If you do not provide a proper Answer within 20 days, you will be found to be in default and a default judgment may be entered against you on the basis of the Complaint and other evidence and the Wisconsin Board of Nursing may take disciplinary action against you and impose the costs of the investigation, prosecution and decision of this matter upon you without further notice or hearing."

36. Respondent failed to file an Answer as required by Wis. Admin. Code § SPS 2.09(4).

37. Following expiration of the 20-day time period to file an Answer, the ALJ scheduled a telephone prehearing conference for May 27, 2014. Notice of this prehearing conference was sent to both parties, with instructions that Respondent provide the ALJ with a telephone number

at which she could be reached no later than May 22, 2014. The Notice instructed Respondent: "A respondent's failure to appear at a scheduled conference or hearing may result in default judgment being entered against the respondent."

38. Respondent failed to provide a telephone number and could not be reached for the prehearing conference.

39. At the prehearing conference, the Division moved for default pursuant to Wis. Admin. Code § SPS 2.14 and Wis. Admin. Code § HA 1.07(3)(c).

40. On May 28, 2014, the ALJ issued a Notice of Default and Order, requiring the Division to serve no later than June 10, 2014 a recommended proposed decision.

41. The Division timely filed its recommended proposed decision.

DISCUSSION AND CONCLUSIONS OF LAW

Default

As stated in the May 28, 2014 Notice of Default and Order, Respondent is in default for failing to file an Answer to the Complaint and failing to appear at the prehearing conference held on May 27, 2014. Wisconsin Admin. Code § SPS 2.14 provides: "If the respondent fails to answer as required by s. SPS 2.09 or fails to appear at the hearing at the time fixed therefor, 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." Wisconsin Admin. Code § HA 1.07(3) states, in relevant part:

> (3) FAILURE TO APPEAR.
>
> . . .
>
> (b) If a respondent fails to appear, the administrative law judge may . . . take the allegations in an appeal as true as may be appropriate. . .
>
> (c) For a telephone or video hearing or prehearing, the administrative law judge may find a failure to appear grounds for default if any of the following conditions exist for more than ten minutes after the scheduled time for hearing or prehearing conference: (1) The failure to provide a telephone number to the division after it had been requested; (2) the failure to answer the telephone or videoconference line . . . (4) the failure to be ready to proceed with the hearing or prehearing conference as scheduled.

An Answer to a Complaint must be filed within 20 days of service of the Complaint. 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 the respondent's last known address. 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 April 18, 2014, 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. 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.

Because Respondent is in default for her failure to file an Answer and to appear at the prehearing conference, an order may be entered against her on the basis of the Complaint and other evidence.

Violations of Wisconsin Statute and Administrative Code

Respondent engaged in misconduct or unprofessional conduct in violation of Wis. Admin. Code § N 7.04(7)[1] and Wis. Stat. § 441.07(1)(b) and (d).[2]

Pursuant to Wis. Stat. § 441.07(1)(b) and (d), respectively, the Board may take disciplinary action against the license of a registered nurse when it finds that the licensee has committed "[o]ne or more violations of this subchapter or any rule adopted by the board under the authority of this subchapter" or has committed "[m]isconduct or unprofessional conduct." Misconduct or unprofessional conduct for purposes of Wis. Stat. § 441.07(1)(d) includes, among other things, "[h]aving disciplinary action through final board adjudication taken against one's license in another jurisdiction." Wis. Admin. Code § N 7.04(7).[3]

Both the Arizona and North Dakota Boards took disciplinary action against Respondent's license through final board adjudication. As a result, Respondent engaged in misconduct or unprofessional conduct in violation of Wis. Admin. Code § N 7.04(7) and Wis. Stat. § 441.07(1).

The Arizona Board's findings of fact show that on multiple dates between October 2012 and February 2013, Respondent consumed controlled substances that rendered her unable to safely or reliably practice nursing. The Arizona Board concluded that in October 2012, Respondent's quality of work deteriorated gradually and included administering a nasal flu vaccine to an asthmatic child which could have triggered a severe and sustained asthmatic episode in the child; being removed from an Advanced Cardiac Life Support class due to falling asleep in class and having slurred speech; falling asleep while on duty as a professional nurse, and failing to complete documentation of patient health care records. Between January 1, 2012 and December 31, 2012, Respondent purchased numerous controlled substances which cause physical and mental impairment, thereby reducing Respondent's ability to safely and reliably practice nursing. These substances included hydrocodone, lorazepam, zolpidem, mirtazapine, promethazine, trazadone and sertraline.

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[1] All references to provisions in Chapter N 7 of the Wisconsin Administrative Code are to the provisions as they existed during the time period in question. Substantial revisions were subsequently made to this Chapter, effective August 1, 2014. *See* Register July 2014 No. 703.

[2] The Division cites the current version of Wis. Stat. § 441.07, which was amended, effective December 21, 2013. *See* 2013 Wisconsin Act 114. However, the violations of Wis. Stat. § 441.07(1)(b) and (d) occurred prior to December 21, 2013. The statutory language at issue has not changed as a result of the amendments and continues to appear in the same subsections, (b) and (d), of the statute. This decision therefore uses the numbering of Wis. Stat. § 441.07 as it existed at the time of the conduct at issue.

[3] It is unclear why the Division does not rely on this provision, which is directly on point, but instead relies on Wis. Stat. § 441.50(5)(e) in conjunction with other statutory and administrative code provisions, which, as discussed in footnote 4, do not appear to be applicable in other jurisdictions. Because Respondent's conduct is so clearly a violation of Wis. Admin. Code § N 7.04(7), and application of this provision presents no due process concerns, I address Wis. Admin. Code § N 7.04(7) instead of those provisions relied upon by the Division.

The Arizona Board also noted that between approximately January 14, 2013 and February 22, 2013, while Respondent worked as a travel nurse in a pediatric unit at the University of New Mexico in Albuquerque, she displayed behaviors consistent with impairment while on duty as a nurse at her New Mexico employer's pediatric unit, which included falling asleep while holding a child, exhibiting slurred and slow speech, and having difficulty maintaining consistent and stable gait/posture. In addition, on or about February 27, 2013, Respondent submitted a written statement to the Arizona Board describing her involvement in a car accident during October of 2012.

On March 20, 2013, the Arizona Board accepted Respondent's Voluntary Surrender of the privilege to practice nursing in Arizona under the multi-state compact. By being the subject of a final disciplinary action taken against her privilege to practice nursing pursuant to the Nurse Licensure Compact by the Arizona Board, Respondent engaged in misconduct or unprofessional conduct in violation of Wis. Admin. Code § N 7.04(7) and Wis. Stat. § 441.07(1).

With respect to North Dakota, the facts show that between April 9, 2013, and February 24, 2014, while working as a registered nurse at Mercy Medical Center in Williston, North Dakota under her Wisconsin license, Respondent fraudulently represented to the North Dakota Board that she had not been terminated from employment, had not been disciplined by another jurisdiction, and was not being investigated by another jurisdiction, when in fact she had been terminated from employment in Arizona, had been disciplined by the Arizona Board, and was being investigated by the Wisconsin Board.

On November 21, 2013, the North Dakota Board issued an order denying Respondent's application for licensure as a registered nurse by endorsement and ordering Respondent to cease and desist from the practice of nursing in North Dakota, including pursuant to any multi-state nursing licensure compact with the Board. The North Dakota Order found that Respondent attempted to obtain by fraud or deceit a license or registration to practice nursing, or submitted to the Board information that is fraudulent, deceitful or false.

Despite the Board's cease and desist order, between November 21, 2013, and February 13, 2014, Respondent continued to work as a registered nurse at Mercy Medical Center in North Dakota under her Wisconsin license in direct violation of the North Dakota Order. During the time period between May 22, 2013 and February 10, 2014, Respondent and her son obtained numerous controlled substances using the prescription pads of Dr. K, a physician who also worked at Mercy Medical Center. Neither Respondent nor her son was Dr. K's patient, nor did Dr. K prescribe any medications for either of them. In addition, on February 13, 2014, Respondent consented to a drug screening, which was positive for alternate opiates, hydrocodone and hydromorphone, for which she had no prescription.

By having disciplinary action taken against her license through final adjudication of the North Dakota Board, Respondent engaged in misconduct or unprofessional conduct in violation

of Wis. Admin. Code § N 7.04(7) and Wis. Stat. § 441.07(1).[4] As a result of the above violations, Respondent is subject to discipline pursuant to Wis. Stat. § 441.07(1)(b) and (d).

Respondent violated Wis. Stat. § 441.50(3)(c).

By engaging in the conduct in North Dakota described above, Respondent violated N.D. Cent. Code § 43-12.1-14.4 for having obtained or attempted to obtain by fraud or deceit a license or registration to practice nursing, or for having submitted to the North Dakota Board any information that was fraudulent, deceitful, or false. She also violated N.D. Cent. Code § 43-12.1-03 by having practiced nursing without a current license or registration issued by the North Dakota Board. Wisconsin Stat. § 441.50(3)(c) provides:

> (c) Every nurse practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time care is rendered. In addition, the practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of a party state. The practice of nursing will subject a nurse to the jurisdiction of the nurse licensing board and the courts, as well as the laws, in that party state.

In failing to comply with the practice laws of the state in which the patient was located at the time care was rendered, Respondent violated Wis. Stat. § 441.50(3)(c).

Respondent violated Wis. Stat. § 440.11(1) by failing to notify the Department of a new address within 30 days of the change.

Wisconsin Stat. § 440.11(1) states: "An applicant for or recipient of a credential who changes his or her name or moves from the last address provided to the department shall notify the department of his or her new name or address within 30 days of the change in writing or in accordance with other notification procedures approved by the department."

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[4]The Division also asserts that Respondent's conduct in Arizona and North Dakota constituted misconduct or unprofessional conduct, in violation of Wis. Admin. Code § N 7.04(1) and (2), respectively, in that Respondent violated multiple laws substantially related to the practice of professional nursing; and administered, supplied or obtained a drug other than in the course of legitimate practice or as otherwise prohibited by law. The Division also asserts that, by consuming controlled substances which rendered her unable to safely or reliably practice nursing, Respondent engaged in "unprofessional conduct" under Wis. Admin. Code § N 7.03(2). With regard to the latter allegation, I note that § N 7.03(2) addresses negligence, not unprofessional conduct. More significantly, however, the Division has not shown how this tribunal may apply standards contained in these Wisconsin regulations to conduct which occurred in other jurisdictions. The same is true of Wisconsin statutes which the Division claims Respondent violated, such as Wis. Stat. § 450.11(7)(h) and Wis. Stat. § 450.11(1). While the Division has correctly established a violation of Wis. Admin. Code § N 7.04(7) and Wis. Stat. § 441.07(1) in that disciplinary action against Respondent's license was taken through final adjudication by the North Dakota and Arizona Boards, the Division has not provided any authority establishing that the other Wisconsin provisions upon which it relies are applicable in other jurisdictions. Indeed, Wis. Stat. § 441.50(3)(c) states that nurses practicing in a party state "must comply with the state practice laws of the state in which the patient is located at the time care is rendered" and that "[t]he practice of nursing will subject a nurse to the jurisdiction of the nurse licensing board and the courts, as well as the laws, in that party state." In any event, because I conclude that Respondent's conduct constitutes a violation of Wis. Admin. Code § N 7.04(7) and Wis. Stat. § 441.07(1), I need not address whether the same conduct establishes a violation of the other Wisconsin provisions the Division cites.

Respondent's address of record with the Department is P.O. Box 294, Iron River, Wisconsin 54847. Respondent's actual address at the time of the April 18, 2014 Complaint is 35552 County Road 3, Fairview, Montana 59221. Respondent has never reported to the Department an address outside of her Iron River, Wisconsin address. Consequently, Respondent violated Wis. Stat. § 440.11(1).

As a result of this violation, Respondent is subject to a forfeiture of $50. However, because the Division does not request a forfeiture in this case, I do not impose it.

Appropriate Discipline

The three purposes of discipline are: (1) to promote the rehabilitation of the Respondent; (2) to protect the public from other instances of misconduct; and (3) to deter other Respondents from engaging in similar conduct. *State v. Aldrich,* 71 Wis. 2d 206, 237 N.W.2d 689 (1976).

The Division recommends that the professional nursing license issued to Respondent be suspended under the conditions set forth in the Order section below, which include drug and alcohol treatment and screening, sobriety and education on ethics and medical errors.

The discipline sought by the Division is appropriate. As demonstrated by the facts stated above, Respondent has a serious substance abuse problem which poses a grave threat to patients. She is in dire need of rehabilitation, and the public needs to be protected from her conduct.

In addition, the recommended discipline is consistent with prior discipline imposed by the Board for conduct in which a nurse uses alcohol or any drug to the extent that such use impairs his or her ability to safely and reliably practice. In *In The Matter of Disciplinary Proceedings Against Brian J. Reynolds, R.N.*, Order No. 0002520 (July 11, 2013), the Board previously imposed an indefinite suspension of a credential holder's license where there was a finding that the credential holder was impaired in his ability to safely and reliably practice due to use of alcohol or drugs. As a condition of granting a stay of the suspension, the credential holder was required to demonstrate compliance with the conditions of a monitoring order which included entering into drug and alcohol treatment, attend and participate in AA/NA meetings, maintaining sobriety, and undergoing drug and alcohol screens not less than 49 times a year. *See* https://online.drl.wi.gov/decisions/2013/ORDER0002520-00008626.pdf.

In *In the Matter of Disciplinary Proceedings Against Shannon L. Deptula, R.N.*[5] (Jan. 26, 2006), the Board similarly suspended the license of the credential holder indefinitely until the credential holder had demonstrated compliance with conditions that included abstaining from the unauthorized use of controlled substances, submitting random drugs screens at a frequency to be determined by the Board or its designee, and providing proof that she was receiving psychological counseling and treatment. *See* http://online.drl.wi.gov/decisions/2006/agency-00004639.pdf.

[5] The Order No. is not provided on the on-line copy of this decision and the Division has not provided the ALJ with a hard copy.

The ordered education is also appropriate. By administering FluMist Quadrivalent to an asthmatic child and failing to complete documentation of patient records, Respondent showed a lack of competency in the practice of professional nursing, and education in the topic of medical errors is appropriate. Moreover, by continuing to practice nursing in North Dakota in direct violation of the North Dakota Board's Order, Respondent showed a complete lack of respect for the rules governing her profession and evinced unethical behavior. Therefore, education in the topic of ethics is appropriate.

Costs

The Department has the authority to assess costs pursuant to Wis. Stat. § 440.22. The Division requests that Respondent 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 parties; (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).

Based on the factors delineated in the *Buenzli-Fritz* decision and the facts of this case, Respondent should be assessed the full amount of recoverable costs in this case.

ORDER

Accordingly, IT IS ORDERED that the professional nursing license issued to Respondent Sabrina C.K. Giles, R.N. (license number 144136-30) is SUSPENDED, with the conditions and limitations set forth below.

SUSPENSION

A.1. The license of Sabrina C.K. Giles, R.N., (license number 144136-30) to practice as a nurse in the State of Wisconsin is SUSPENDED for an indefinite period.

A.2. The privilege of Respondent to practice as a nurse in the State of Wisconsin under the authority of another state's license pursuant to the Nurse Licensure Compact is also SUSPENDED for an indefinite period.

A.3. During the pendency of this Order and any subsequent related orders, Respondent may not practice in another state pursuant to the Nurse Licensure Compact under the authority of a Wisconsin license, unless Respondent receives prior written authorization to do so from both the Wisconsin Board of Nursing and the regulatory board in the other state.

A.4 Respondent shall mail or physically deliver all indicia of Wisconsin nursing licensure to the Department Monitor within 14 days of the effective date of this order. Limited credentials can be printed from the Department of Safety and Professional Services website at http://dsps.wi.gov/index.htm.

A.5. Upon a showing by Respondent of continuous, successful compliance for a period of at least five (5) years with the terms of this Order, including at least 600 hours of active nursing for every year the suspension is stayed, the Board may grant a petition by Respondent under paragraph D.6. for return of full Wisconsin licensure. The Board may, on its own motion or at the request of the Department Monitor, grant full Wisconsin licensure at any time.

STAY OF SUSPENSION

B.1. The suspension of Respondent's Wisconsin nursing license may not be stayed for a period of at least one year. After that time, the Board, in its discretion, may stay the suspension upon Respondent petitioning the Board and providing proof, which is determined by the Board or its designee to be sufficient, that Respondent is in compliance with the provisions of Sections C and D of this Order.

B.2. The Board or its designee may, without hearing, remove the stay upon receipt of information that Respondent is in substantial or repeated violation of any provision of Sections C or D of this Order. A substantial violation includes, but is not limited to, a positive drug or alcohol screen. A repeated violation is defined as the multiple violation of the same provision or violation of more than one provision. The Board may, in conjunction with any removal of any stay, prohibit Respondent for a specified period of time from seeking a reinstatement of the stay under paragraph B.4.

B.3. This suspension becomes reinstated immediately upon notice of the removal of the stay being provided to Respondent either by:

(a) Mailing to Respondent's last-known address provided to the Department of Safety and Professional Services pursuant to Wis. Stat. § 440.11; or
(b) Actual notice to Respondent or Respondent's attorney.

B.4. The Board or its designee may reinstate the stay if provided with sufficient information that Respondent is in compliance with the Order and that it is appropriate for the stay to be reinstated. Whether to reinstate the stay shall be wholly in the discretion of the Board or its designee.

B.5. If Respondent requests a hearing on the removal of the stay, a hearing shall be held using the procedures set forth in Wis. Admin. Code ch. SPS 2. The hearing shall be held in a timely manner with the evidentiary portion of the hearing being completed within 60 days of receipt of Respondent's request, unless waived by Respondent. Requesting a hearing does not stay the suspension during the pendency of the hearing process.

CONDITIONS AND LIMITATIONS

Treatment Required

C.1. Respondent shall enter into, and shall continue, drug and alcohol treatment with a treater acceptable to the Board or its designee (Treater). Respondent shall participate in, cooperate with, and follow all treatment recommended by Treater.

C.2. Respondent shall immediately provide Treater with a copy of this Final Decision and Order and all other subsequent orders.

C.3. Treater shall be responsible for coordinating Respondent's rehabilitation and treatment as required under the terms of this Order, and shall immediately report any relapse, violation of any of the terms and conditions of this Order, and any suspected unprofessional conduct, to the Department Monitor (See D.1., below). If Treater is unable or unwilling to serve as required by this Order, Respondent shall immediately seek approval of a successor Treater by the Board or its designee.

C.4. The rehabilitation program shall include individual and/or group therapy sessions at a frequency to be determined by Treater. Therapy may end only with the approval of the Board or its designee, after receiving a petition for modification as required by D.5., below.

C.5. Treater shall submit formal written reports to the Department Monitor on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent's progress in drug and alcohol treatment. Treater shall report immediately to the Department Monitor any violation or suspected violation of this Order.

Releases

C.6. Respondent shall provide and keep on file with Treater, all treatment facilities and personnel, laboratories and collections sites current releases complying with state and federal laws. The releases shall allow the Board, its designee, and any employee of the Department of Safety and Professional Services, Division of Legal Services and Compliance to: (a) obtain all specimen screen results and patient health care and treatment records and reports, and (b) discuss the progress of Respondent's treatment and rehabilitation with Treater and treatment facilities and personnel, laboratories and collection sites. Copies of these releases shall immediately be filed with the Department Monitor.

AA/NA Meetings

C.7. Respondent shall attend Narcotics Anonymous and/or Alcoholics Anonymous meetings or an equivalent program for recovering professionals, at the frequency recommended by Treater, but no less than twice per week. Attendance of Respondent at such meetings shall be verified and reported quarterly to Treater and the Department Monitor.

Sobriety

C.8. Respondent shall abstain from all personal use of alcohol.

C.9. Respondent shall abstain from all personal use of controlled substances as defined in Wis. Stat. § 961.01(4), except when prescribed, dispensed or administered by a practitioner for a legitimate medical condition. Respondent shall disclose Respondent's drug and alcohol history and the existence and nature of this Order to the practitioner prior to the practitioner ordering the controlled substance. Respondent shall at the time the controlled substance is ordered immediately sign a release in compliance with state and federal laws authorizing the practitioner to discuss Respondent's treatment with, and provide copies of treatment records to, Treater and the Board or its designee. Copies of these releases shall immediately be filed with the Department Monitor.

C.10. Respondent shall abstain from all use of over-the-counter medications or other substances (including but not limited to natural substances such as poppy seeds) which may mask consumption of controlled substances or of alcohol, create false positive screening results, or interfere with Respondent's treatment and rehabilitation. It is Respondent's responsibility to educate herself about the medications and substances which may violate this paragraph, and to avoid those medications and substances.

C.11. Respondent shall report to Treater and the Department Monitor all prescription medications and drugs taken by Respondent. Reports must be received within 24 hours of ingestion or administration of the medication or drug, and shall identify the person or persons who prescribed, dispensed, administered or ordered said medications or drugs. Each time the prescription is filled or refilled, Respondent shall immediately arrange for the prescriber or pharmacy to fax and mail copies of all prescriptions to the Department Monitor.

C.12. Respondent shall provide the Department Monitor with a list of over-the-counter medications and drugs that Respondent may take from time to time. Over-the-counter medications and drugs that mask the consumption of controlled substances or of alcohol, create false positive screening results, or interfere with Respondent's treatment and rehabilitation, shall not be taken unless ordered by a physician and approved by Treater, in which case the drug must be reported as described in paragraph C.11.

Drug and Alcohol Screens

C.13. Respondent shall enroll and begin participation in a drug and alcohol monitoring program which is approved by the Department (Approved Program).

C.14. At the time Respondent enrolls in the Approved Program, Respondent shall review all of the rules and procedures made available by the Approved Program. Failure to comply with all requirements for participation in drug and alcohol monitoring established by the

Approved Program is a substantial violation of this Order. The requirements shall include:

(a) Contact with the Approved Program as directed on a daily basis, including vacations, weekends and holidays.
(b) Production of a urine, blood, sweat, fingernail, hair, saliva or other specimen at a collection site designated by the Approved Program within five hours of notification of a test.

C.15. The Approved Program shall require the testing of specimens at a frequency of not less than 49 times per year, for the first year of this Order. After the first year, Respondent may petition the Board on an annual basis for a modification of the frequency of tests. The Board may adjust the frequency of testing on its own initiative at any time.

C.16. If any urine, blood, sweat, fingernail, hair, saliva or other specimen is positive or suspected positive for any controlled substances or alcohol, Respondent shall promptly submit to additional tests or examinations as the Board or its designee shall determine to be appropriate to clarify or confirm the positive or suspected positive test results.

C.17. In addition to any requirement of the Approved Program, the Board or its designee may require Respondent to do any or all of the following: (a) submit additional specimens; (b) furnish any specimen in a directly witnessed manner; or (c) submit specimens on a more frequent basis.

C.18. All confirmed positive test results shall be presumed to be valid. Respondent must prove by a preponderance of the evidence an error in collection, testing, fault in the chain of custody or other valid defense.

C.19. The Approved Program shall submit information and reports to the Department Monitor as directed.

Practice Limitations

C.20. Respondent may not work as a nurse or other health care provider in a setting in which Respondent has access to controlled substances. If Treater subsequently recommends restrictions on such access, the Board or its designee may impose such restrictions.

C.21. Respondent shall practice only under the direct supervision of a licensed nurse or other licensed health care professional approved by the Board or its designee.

C.22. Respondent shall practice only in a work setting pre-approved by the Board or its designee.

C.23. Respondent may not work in a home health care, hospice, pool nursing, assisted living, or agency setting.

C.24. Respondent shall provide a copy of this Final Decision and Order and all other subsequent orders immediately to supervisory personnel at all settings where Respondent works as a nurse or caregiver or provides health care, currently or in the future.

C.25. It is Respondent's responsibility to arrange for written reports from supervisors to be provided to the Department Monitor on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent's work performance, and shall include the number of hours of active nursing practice worked during that quarter. If a report indicates poor performance, the Board may institute appropriate corrective limitations, or may revoke a stay of the suspension, in its discretion.

C.26. Respondent shall report to the Board any change of employment status, residence, address or telephone number within five days of the date of a change.

Education

C.27. Respondent's suspension shall not be stayed or lifted until Respondent has submitted proof satisfactory to the Department of successful completion of the education as ordered in paragraphs (a) – (c), below.

(a) Within six months of the date of this Order, Respondent shall at Respondent's own expense take and successfully complete three hours of education in the topic of ethics and six hours of education in the topic of medical errors.

(b) Each course attended in satisfaction of this Order must be pre-approved by the Board or its designee. Respondent shall be responsible for locating course(s) satisfactory to the Board and for obtaining the required approval of the courses from the Board or its designee. Respondent must take and pass any exam offered for the course(s).

(c) Within 30 days of successful course completion, Respondent shall submit proof of successful completion of the education in the form of verification from the institution providing the education to the Department Monitor at the address stated above. None of the education completed pursuant to this requirement may be used to satisfy any continuing education requirements that have been or may be instituted by the Board or Department.

MISCELLANEOUS

Department Monitor

D.1. Any requests, petitions, reports, education and other information required by this Order shall be mailed, e-mailed, faxed or delivered to:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services

P.O. Box 7190, Madison, WI 53707-7190
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

Required Reporting by Respondent

D.2. Respondent is responsible for compliance with all of the terms and conditions of this Order, including the timely submission of reports by others and education as ordered in paragraph 2 below. Respondent shall promptly notify the Department Monitor of any failures of the Treater, treatment facility, Approved Program or collection sites to conform to the terms and conditions of this Order. Respondent shall promptly notify the Department Monitor of any violations of any of the terms and conditions of this Order by Respondent.

D.3. Every three (3) months Respondent shall notify the Department Monitor of Respondent's compliance with the terms and conditions of the Order, and shall provide the Department Monitor with a current address and home telephone number.

Change of Treater or Approved Program by Board

D.4. If the Board or its designee determines the Treater or Approved Program has performed inadequately or has failed to satisfy the terms and conditions of this Order, the Board or its designee may direct that Respondent continue treatment and rehabilitation under the direction of another Treater or Approved Program.

Petitions for Modification of Limitations or Termination of Order

D.5. Respondent may petition the Board on an annual basis for modification of the terms of this Order; however, no such petition for modification shall occur earlier than one year from the date of the initial stay of the suspension. Any petition for modification shall be accompanied by a written recommendation from Respondent's Treater expressly supporting the specific modifications sought. Denial of a petition in whole or in part shall not be considered a denial of a license within the meaning of Wis. Stat. § 227.01(3)(a), and Respondent shall not have a right to any further hearings or proceedings on the denial.

D.6. Respondent may petition the Board for termination of this Order any time after five years from the date of the initial stay of the suspension. However, no petition for termination shall be considered without a showing of continuous, successful compliance with the terms of the Order, for at least five years.

IT IS FURTHER ORDERED that 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 7190
Madison, WI 53707-7190

IT IS FURTHER ORDERED that the terms of this Order are effective the date the Final Decision and Order is signed by the Board.

Dated at Madison, Wisconsin on August 14, 2014.

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