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Before The
State Of Wisconsin
BOARD OF NURSING

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

FINAL DECISION AND ORDER
Order No. 0003278

Division of Legal Services and Compliance Case No. 12 NUR 019

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 12 day of June, 2014.

Julie Nelson RN
Member
Board of Nursing

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

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

PROPOSED DECISION AND ORDER
DHA Case No. SPS-13-0011
0003278

Division of Legal Services and Compliance Case No. 12 NUR 019

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

Diane L. Hiller, R.N.
7036 County Road MM
Larsen, WI 54947

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 Sandra L. Nowack
Department of Safety and Professional Services
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PROCEDURAL HISTORY

These proceedings were initiated when the Department of Safety and Professional Services, Division of Legal Services and Compliance (Division), filed and served a formal Complaint on Respondent Diane L. Hiller, R.N., alleging that Ms. Hiller engaged in misconduct or unprofessional conduct, in violation of Wis. Stat. § 441.07 and Wis. Admin. Code § N 7.04(1) and (2) by taking controlled substances for her own use from her patients, and that her use of these controlled substances impaired her ability to safely and reliably practice nursing, in violation of Wis. Stat. § 441.07 and Wis. Admin. Code § N 7.03(2).

The Division served Respondent on February 28, 2013 by sending a copy of the Notice of Hearing and Complaint to her last known address. Ms. Hiller filed an Answer to the Complaint on March 21, 2013, denying the allegations.

A prehearing conference was held before the undersigned administrative law judge (ALJ) on April 1, 2013. A Prehearing Conference Report and Scheduling Order was issued on April 1, 2013, scheduling a hearing for June 6, 2013 and establishing related deadlines.

On May 6, 2013, Ms. Hiller filed a letter requesting an extension of the deadline for filing exhibits, which was forwarded to the Division via email. On that same date, May 6, 2013, the Division informed the ALJ that it would be filing a Motion to Stay Scheduling Order based on the fact that prior Division counsel was retiring and new counsel was taking over the file. The motion was filed on May 9, 2013.

On May 8, 2013, the ALJ issued an order staying the scheduling order and setting a status conference for May 20, 2013. Ms. Hiller did not appear at the May 20, 2013 status conference, claiming not to have received the Notice, and the conference was rescheduled to June 20, 2013, and then again rescheduled to July 9, 2013.

At the July 9, 2013 conference, the Division indicated it would be filing a motion for partial summary judgment. A Briefing Order was issued on July 9, 2013, with the final submission to be filed on October 15, 2013.

On August 12, 2013, the Division informed the ALJ and Ms. Hiller that it would not be filing a motion for summary judgment and would like a hearing scheduled. A status conference was held on August 20, 2013, and a hearing date was set for November 12, 2013. Due to Ms. Hiller's not receiving certain documents from the Division because of her change of address, the hearing was subsequently postponed to December 2, 2013.

A hearing was held on December 2, 2013, after which the Division indicated it would seek to amend the Complaint to conform to the evidence presented at hearing. Following post-hearing submissions by the parties on the issue of amending the Complaint, the ALJ issued an Order Granting Motion to Amend Complaint and Briefing Order on December 19, 2013, with the Division's reply brief to be filed on March 3, 2014. On March 6, 2014, the Division informed the ALJ and Ms. Hiller by email that it would not be filing a reply brief.

FINDINGS OF FACT

1. Respondent Diane L. Hiller, R.N. (DOB September 9, 1961) is licensed in the State of Wisconsin as a professional nurse, having license number 110235-30, first issued on August 3, 1992.

2. On January 3, 2012, Ms. Hiller was terminated from employment as a home health care nurse with the Aurora Visiting Nurse Association (VNA), where she had been employed since March 2010. Ms. Hiller's termination was the result of Aurora's investigation into diversion of medications over the course of approximately 6 months, from June to December of 2011, from three patients: JG, SD and JW. (Ex. 10; Ex. 11; Hrg. Tr., p. 25)

3. Tina Kimps was Ms. Hiller's supervisor at Aurora. Ms. Kimps is a registered nurse and is a manager for the Aurora VNA, managing both in-home and hospice care. She has a bachelor's degree in nursing from the University of Wisconsin, Milwaukee, and has practiced nursing for more than twenty years in both Wisconsin and Florida. (Hrg. Tr., pp. 5-10, 13-14)

4. Ms. Kimps' role as a manager at Aurora and her work as a lead clinical nurse for several Green Bay area clinics have given her experience in reviewing the work of other nurses, including the nurses' documentation. Her professional training and experience has also given her expertise in evaluating whether or not a nurse had complied with legal requirements for dispensing controlled substances and in assessing competence in skilled nursing, including record keeping. She has witnessed nurses who have become addicted to or impaired by pain medications. (Hrg. Tr., pp. 15-20)

5. In her professional role, Ms. Kimps is entrusted with the responsibility of assisting the loss prevention officer with investigations of nursing misconduct, including medication and diversion issues. Ms. Kimps is further entrusted with ensuring that nursing staff under her supervision comply with policies and procedures of Aurora Health Care. (Hrg. Tr., pp. 15-16)

6. In the three years that Ms. Kimps worked at Aurora as the VNA manager, the only allegations she received concerning a home health care nurse's alleged diversion of controlled substances were the three separate complaints, from three different individuals, concerning Ms. Hiller. Ms. Hiller was responsible for more than half of medication discrepancies typically investigated by Aurora in an entire year. (Hrg. Tr., pp. 21-22, 139)

Patient JG

7. JG was a patient being seen for treatment with intravenous antibiotics and PICC line[1] care. She was not being seen for pain in particular. (Ex. 2, p. 11; Hrg. Tr., p. 50)

8. Ms. Hiller first saw JG as a patient on June 7, 2011 and recorded a current pain level of 6 and a pain level before intervention of 8. During her first visit, Ms. Hiller called a physician to increase JG's pain medications; however, the physician refused and instructed the patient to take the Vicodin as needed and to take Tylenol in between as needed. Ms. Hiller did not complete her charting regarding this visit until eight days after the visit, on June 15, 2011, and did not indicate which pain medication she attempted to have increased. (Ex. 6, p. 121; Hrg. Tr., pp. 32-34)

9. Aurora's policy is that for a start of care visit, nurses must complete charting within 48 hours and for a routine visit, must do so within 24 hours. (Hrg. Tr., pp. 34, 36)

10. Ms. Hiller had not had previous issues with documentation. (Hrg. Tr., p. 35)

11. Ms. Hiller next saw JG on Friday, June 10, 2011. She recorded a current pain level of 7 and a pain level before intervention of 10. On that day, she contacted Dr. Eric Gowing's office, requesting that Dr. Gowing increase JG's prescription of fentanyl patches from 25 mcg to 50 mcg. A nurse in Dr. Gowing's office informed Ms. Hiller that doubling the dose of fentanyl could result in potential overdose because JG was also taking Vicodin. Ms. Hiller did not complete her charting on that visit until five days after the visit, on June 15, 2011. (Ex. 6, p. 139; Ex. 11, p. 574; Ex. 13; Hrg. Tr. pp. 36, 40-41)

12. Ms. Hiller next visited JG on Monday, June 13, 2011. She recorded a current pain level of 6 and a pain level before intervention of 8. (Ex. 6, p. 145)

[1] A PICC line is an intravenous line that can remain in for an extended period of time. (Hrg. Tr., p. 29)

13. On June 13, 2011, Ms. Hiller went to Walgreen's pharmacy asking for an early refill of JG's fentanyl and Vicodin, representing that two fentanyl patches had fallen off of JG. As both refills were early, the pharmacist, Justin Mielke, contacted Dr. Gowing. Dr. Gowing reluctantly agreed to refill the fentanyl but declined to refill the Vicodin. The pharmacist then informed Dr. Gowing that Ms. Hiller had previously requested an early refill of fentanyl for another patient as well. The incident involving the other patient occurred in March or April of 2011. (Ex. 11, p. 575)

14. After Dr. Gowing's refusal to approve an early refill of JG's prescription for Vicodin, Ms. Hiller contacted another physician to have the prescription filled. She did not document having contacted another physician to obtain the refill. (Ex. 11, p. 574; Hrg. Tr., pp. 191, 208-209)

15. Because of Dr. Gowing's concern over Ms. Hiller's attempts to obtain additional fentanyl and Vicodin, Dr. Gowing asked JG to come into his office with her medications. He met with JG on June 16, 2011. During this appointment, Dr. Gowing observed that two fentanyl patches were missing and that someone had written on the package to reflect that the boxes contained only eight patches, rather than the ten that should have been there. He contacted the pharmacy and was informed that the pharmacy had not altered the number of patches on the fentanyl that Ms. Hiller picked up three days earlier and that JG should have received ten patches. JG also informed Dr. Gowing that 35 tablets of Vicodin were missing. (Ex. 2, p. 11; Hrg. Tr., pp. 27, 208)

16. Ms. Hiller did not document that any of JG's Vicodin was missing, nor did she inform Ms. Kimps that it was missing. Vicodin contains hydrocodone. It is a violation of Aurora's policies to fail to document that hydrocodone is missing and to fail to report it to a supervisor. (Hrg. Tr., pp. 23-24, 41-42, 156)

17. Dr. Gowing contacted Ms. Kimps on June 16, 2011 informing her of his belief that Ms. Hiller had diverted JG's medications. Dr. Gowing also indicated that JG should not have needed an early refill on either of her prescriptions because they had just recently been refilled. (Ex. 2, pp. 11-13; Ex. 11, p. 571; Hrg. Tr., pp. 26, 120, 178-79)

18. During the relevant time period, Ms. Hiller was the only VNA caregiver to visit JG. (Hrg. Tr., pp. 42, 572)

19. Following Dr. Gowing's call to Ms. Kimps, on June 16, 2011, Aurora placed Ms. Hiller on administrative suspension while Aurora investigated possible diversion of JG's medication by Ms. Hiller. The investigation was later found to be unsubstantiated, meaning that Aurora did not believe there was enough evidence to determine whether diversion had or had not occurred. (Hrg. Tr., pp. 43-45, 116)

20. Ms. Hiller did not complete charting of the June 13, 2011 visit until 15 days later, on June 28, 2011. (Hrg. Tr., pp. 41, 46)

21. Ms. Hiller violated Aurora's policies by transporting a prescription for JG's controlled substances to the pharmacy and then transporting the substances back to JG's home without contacting her supervisor and obtaining approval. (Hrg. Tr., pp. 39-40)

22. As part of Aurora's investigation, Ms. Hiller was interviewed on June 18, 2011 by Robert Solie, Aurora's manager of the Loss Prevention Services Department. When Mr. Solie asked Ms. Hiller why she picked up the prescription from the pharmacy herself, Ms. Hiller stated that JG told her that she had "absolutely no way" of getting to the pharmacy to pick up the prescription. In her Answer to the Complaint, Ms. Hiller stated that JG had "tearfully" told her that she had no way to pick up the prescription. At hearing, Ms. Hiller likewise testified that she picked up JG's medications because JG told her she had no way of getting the prescription. She also testified that at the time JG told her this on Friday, June 10, 2013, Ms. Hiller did not know JG's husband lived with her, but that when she brought the prescription to the home the following Monday, she observed that JG's husband had a toothache. (Answer, p. 2; Ex. 11, p. 573; Ex. 13; Hrg. Tr., pp. 191, 211-212)

23. Mr. Solie also interviewed JG on June 20, 2011. JG informed Mr. Solie that she never asked Ms. Hiller to go to the pharmacy to pick up her medications and that Ms. Hiller insisted on picking them up even though JG told Ms. Hiller that JG's husband could get them and that he had just picked up a prescription for her on June 2, 2011. JG also told Mr. Solie that Ms. Hiller was "very adamant" about getting JG on a higher dose of fentanyl patches and that JG did not understand why as her pain had not been that bad. JG told Mr. Solie that she told Ms. Hiller that on a scale of 1-10, she had rated her pain as a 5 or 6. When asked if she ever recalled telling Ms. Hiller that her pain level was 8, JG stated that she had not. (Ex. 11, p. 576)

24. JG also told Mr. Solie that when Ms. Hiller brought in the boxes of fentanyl patches, the seals had been ripped open and that she had no idea who crossed out the "10" and wrote an "8" on one of the boxes. She further stated that she had had no visitors at her home during the time period that Ms. Hiller was providing care, and that only she and her husband had been at the home. (Ex. 11, p. 576)

25. When interviewed by Mr. Solie on June 18, 2011, Ms. Hiller admitted that she wrote on the fentanyl box but contended that she only wrote the date of the next application. (Ex. 11, p. 573)

26. In JG's medical record, corroborated by Aurora's contemporaneous reports, the only notation written on JG's fentanyl packages were that the boxes contained only eight patches, rather than the ten which should have been present. (Ex. 2, p. 11; Hrg. Tr., pp. 165-167)

27. Ms. Hiller was interviewed again by Mr. Solie on June 21, 2011. Mr. Solie informed her that JG had stated that she had not asked Ms. Hiller to pick up medications and that Ms. Hiller had insisted on doing so even though JG told Ms. Hiller that her husband could do it. Ms. Hiller then stated to Mr. Solie that JG's husband had been suffering from a toothache and Ms. Hiller thought he could not drive. (Ex. 11, p. 577)

28. After Ms. Hiller was put on administrative leave, another nurse provided care to JG. She visited JG on June 16, 2011, charting that JG had no pain; visited her on June 20, 2011, charting that JG had a current pain level of 4, a before-intervention pain level of 7, and an after-intervention pain level of 2; and visited her on June 27, 2011, recording a current pain level of 2, a before-intervention pain level of 5 and an after-intervention pain level of 1. The charting indicates on June 20 and June 27, 2011 that the pain is "well controlled." (Ex. 6, pp. 151, 158, 164-165; Hrg. Tr., pp. 48-49)

29. At the June 18, 2011 interview, Ms. Hiller was asked if she was currently taking any type of pain medication. Ms. Hiller stated that she had had a recent issue with migraine headaches and neck pains and had been prescribed Prednisone as a result. She further stated that she had not taken any other medications. Mr. Solie asked if Ms. Hiller would be willing to have a drug screen and Ms. Hiller stated that she would. The drug screen was not conducted. (Ex. 11, p. 574)

30. During the June 21, 2011 interview, in explaining why she would not take medications from JG, Ms. Hiller informed Mr. Solie that her ex-husband and sister were drug addicts and that she had no desire to turn out like either of them. (Ex. 11, p. 577).

Patient SD

31. Patient SD was an end-stage cancer patient who took intravenous Dilaudid for pain. Ms. Hiller visited SD in SD's home for the purpose of administering medication and communicating with a pharmacist who controlled delivery of bags of diluted Dilaudid. (Hrg. Tr., pp. 51, 54, 190)

32. Ms. Hiller violated Aurora policy by repeatedly completing SD's charting in an untimely manner. Ms. Hiller first visited SD on November 1, 2011 and completed her charting of that visit four days later, on November 5, 2011. Visits by Ms. Hiller also included one on November 15, 2011, for which charting was completed on November 20, 2011; on November 21, 2011, for which charting was completed on November 26, 2011; and on November 28 and 29, 2011, for which charting was completed on December 4, 2011. (Ex. 8, pp. 302, 324, 336, 354, 359; Hrg. Tr., p. 62)

33. On December 18, 2011, a date on which Ms. Hiller visited SD, SD reported to Ms. Kimps that Ms. Hiller had left SD's home with bags of Dilaudid and that, unlike other nurses who had visited her, Ms. Hiller did not have SD witness and sign for medication. By Aurora policy, Dilaudid may never be taken from a patient's home and wasting of Dilaudid must be witnessed and documented. If a patient is in too much pain to witness and sign off on wasting and there is no other representative to do so, the nurse must make a note of these circumstances. (Ex. 9, p. 510; Hrg. Tr., pp. 50, 53, 56-57)

34. On December 20, 2011, Aurora again placed Ms. Hiller on an investigative suspension. (Hrg. Tr., p. 53)

35. Ms. Hiller's charting for her December 18, 2011 visit to SD was completed late, on December 21, 2011, after Ms. Hiller had been placed on an investigative detention. (Ex. 8, p. Hrg. Tr., pp. 62, 92)

36. Ms. Kimps had reviewed the wasting policy with Ms. Hiller just three weeks prior to receiving the complaint from SD because Ms. Hiller had reported that SD's puppy had chewed through the intravenous tubing and Ms. Hiller did not know how to dispose of the medication. During that conversation, Ms. Kimps had also given Ms. Hiller a copy of the VNA policy regarding wasting medications and a blank copy of the waste document. (Ex. 10, p. 525)

37. During a December 23, 2011 interview, Ms. Hiller informed Mr. Solie that SD had told her on December 14, 2011 that she could not locate her bottle of hydrocodone and insinuated that perhaps one of her children had taken it. Ms. Hiller further stated that on December 18, 2011, SD informed her that the medication was never found, that she had written a note to SD's physician requesting that he refill her prescription for hydrocodone, that SD's physician later contacted Ms. Hiller to ask if she thought SD may be diverting pain medication, and that Ms. Hiller told the physician that she thought SD had hidden the medication and could not recall where she had hidden it. (Ex. 10, p. 526; Hrg. Tr., pp. 140-141)

38. Ms. Hiller failed to document that the medication was missing, that she contacted the physician regarding the missing hydrocodone or that the physician contacted Ms. Hiller to ask about possible diversion. Aurora policy required documentation of such information and immediate notification to Ms. Kimps that medication was missing. (Ex. 10, p. 526; Hrg. Tr., pp. 23-24, 41-42, 139-141)

39. Toward the end of the December 23, 2011 interview, Mr. Solie asked Ms. Hiller why she had failed to report the missing hydrocodone to Ms. Kimps. For the first time, Ms. Hiller then indicated that she had in fact reported the missing hydrocodone to Ms. Kimps in a voicemail message she left for Ms. Kimps on Sunday, December 18, 2011. (Ex. 10, p. 527; Hrg. Tr., pp. 140-141)

40. Ms. Kimps credibly testified that she never received such a voicemail and was never told about the incident until after Ms. Hiller's suspension. (Hrg. Tr., pp. 66-67)

41. During the December 23, 2011 interview, Mr. Solie asked Ms. Hiller if she had documented the wasting of SD's Dilaudid. Ms. Hiller informed him that she had been provided with a policy and form by Ms. Kimps several weeks prior and that she had followed the procedure. Mr. Solie asked if Ms. Hiller had completed the form indicating her waste of the Dilaudid. Ms. Hiller stated that she had the form at home and because she only lived 10 minutes away, would go and get it. She returned approximately 20 minutes later and provided Mr. Solie with a document entitled, "Controlled Drug Disposal Form." (Ex. 10, p. 526; Hrg. Tr., p. 61)

42. The form included four dates in which Ms. Hiller indicated she had wasted Dilaudid in the presence of SD. Two of the wastes listed had SD's initials and two did not. Ms. Hiller told Mr. Solie that SD did not initial two of the wastes because SD was in a great deal of pain at the time. One entry that contained initials was initialed on a date that SD specifically informed Ms. Kimps was one of the dates on which Ms. Hiller had not asked SD to sign verification that the Dilaudid had been wasted. (*Id.*)

43. In her Answer, Ms. Hiller indicated that SD signed or initialed the medication disposal form each time Ms. Hiller wasted it. (Answer, p. 1; Hrg. Tr., pp. 215-216)

44. Ms. Kimps conducted an audit of the records of staff who had been seeing SD. After an analysis of all documentation from all nurses seeing SD during that time period, there were discrepancies in only Ms. Hiller's records. (Ex. 10, pp. 522-24; Hrg. Tr., pp. 61, 94-95)

45. Although Aurora originally believed three to four bags of Dilaudid were missing, upon further review, the audit revealed that two to three bags of Dilaudid were missing during

Ms. Hiller's care of SD. Ms. Kimps testified that she was certain that it was two to three bags which were missing. (Hrg. Tr., pp. 58-59, 91, 94)

Patient JW

46. Patient JW is an 88 year-old legally blind patient for whom Ms. Hiller provided in-home care through the VNA. (Ex. 7; Ex. 10, p. 518; Hrg. Tr., p. 76)

47. JW first started services with the VNA on May 23, 2011. When Ms. Hiller visited JW on May 24, 2011, she decided to change JW's treatment to fentanyl. (Ex. 10, p. 530)

48. On May 31, 2011, JW's dose of fentanyl was doubled by adding a second fentanyl patch. Under the circumstances, Ms. Hiller was required by Aurora's policies to contact the prescribing physician and to document the contact. There was no such contact or documentation. (Ex. 7, p. 204; Ex. 10, p. 530; Hrg. Tr., pp. 76, 78-79)

49. On June 3, 2011, Ms. Hiller documented that JW requested no visits while Ms. Hiller was on vacation. Pursuant to Aurora policies, the VNA nurses are to follow the ordered nursing strings; the patients do not decide when visits occur. (Ex. 10, p. 530; Hrg. Tr., pp. 75-76)

50. On June 13, 2011, Ms. Hiller provided service to JW and documented that she laid out the patches on an adhesive tape called Tagaderm for the patient to apply herself, despite the fact that JW was legally blind and, according to Ms. Kimps, could not have applied the patches herself. (*Id.*)

51. On June 22, 2011, a case manager other than Ms. Hiller visited JW and noted that there were no fentanyl patches on JW and no patches available in the home. The case manager believed the patient should be discharged in approximately three weeks. However, that did not occur and JW was not discharged as a patient until September 11, 2011. Ms. Hiller did not document why JW was seen for another three months rather than three weeks. (Ex. 10, pp. 518, 530; Hrg. Tr., pp. 76-77)

52. On or about January 2, 2012, during the time that Ms. Hiller was suspended for the events involving SD, Ms. Kimps received a call from a VNA nurse who was beginning services with JW at JW's home. JW had been receiving services from the VNA through Ms. Hiller, was discharged from service but then had been placed back in service. Ms. Hiller had been visiting JW from approximately September of 2011 to December 2011, during the time period that JW was discharged from service. During this time period, Ms. Hiller had been applying fentanyl patches, and some of the patches had gone missing. Ms. Hiller was on administrative suspension during at least part of the time that she made these visits. She had last visited JW a week before the report to Ms. Kimps. (Ex. 10, p. 518; Hrg. Tr., pp. 71-72, 75-76)

53. Between September 2011 and December 2011, when Ms. Hiller visited and changed JW's fentanyl patches, she failed to check JW's vital signs and did not document administration of a prescribed controlled substance. (Hrg. Tr., pp. 74, 87)

Ms. Hiller's Unauthorized Use of Oxycontin While Employed with ThedaCare

54. During an interview conducted on January 3, 2012, Ms. Hiller informed Mr. Solie that while working as a hospice nurse with her previous employer, ThedaCare, she developed an addiction to Oxycontin. She further informed Mr. Solie that her addiction to Oxycontin lasted for more than two years, and that she had stolen Oxycontin from the homes of deceased patients for her own use. Ms. Hiller also told Mr. Solie that when she left ThedaCare, she did not want to continue hospice care due to the temptation to steal patients' medications. (Ex. 10, p. 519; Hrg. Tr., pp. 82-85, 90)

55. The information regarding the two-year addiction to Oxycontin was repeated in front of Ms. Kimps and another Aurora employee. Ms. Kimps testified regarding this conversation, as did Mr. Solie, the latter of whom was "100 percent certain" that Ms. Hiller stated that her addiction lasted for two years while she was with ThedaCare. (Hrg. Tr., pp. 82-83, 127)

56. Ms. Hiller admits that she took and used Oxycontin intended for a hospice patient and that she became addicted to it, but now maintains that it was for a more limited period of time. In her March 21, 2013 Answer to the Complaint, she stated that she told Mr. Solie that she had taken the medication six years ago, two years prior to leaving ThedaCare, and that she had taken the Oxycontin for approximately one month. At hearing, she first stated that she told Mr. Solie she had taken the Oxycontin for a two-week period, but after being asked to read her Answer in which she stated it was for a one-month period and being asked if she recalled stating at a deposition that she took it for a little over a month, she testified she believed it was for a two to three week period. In her post-hearing brief, she states that she took the Oxycontin for three to four weeks. (Hrg. Tr., pp. 142, 189, 197, 223; Resp. Br., p. 3)

57. Ms. Hiller told a Department investigator in June of 2012 that everything that was said about her having a former addiction was a lie. (Hrg. Tr., p. 217)

58. By her own admission at hearing, at the time Ms. Hiller took the Oxycontin from the hospice patient(s), she knew it was illegal and contrary to her training and education as a nurse. Ms. Hiller also admitted that when a nurse steals controlled substances from a patient, she is not a reliable nurse. (Hrg. Tr., pp. 219, 221)

59. Ms. Hiller was terminated from employment with ThedaCare on October 16, 2009 for gross negligence. ThedaCare determined that between April and October 2009, while providing hospice care to patients, Ms. Hiller failed to document and respond to requests for services. (Ex. 12, pp. 582, 586)

60. The Termination Notice from ThedaCare which Ms. Hiller signed on October 16, 2009, states that she engaged in "gross negligence." A letter to Ms. Hiller from a Human Resources Consultant for ThedaCare in November 2009 likewise states that her conduct constituted "gross negligence." Ms. Hiller's Termination Notice further states that her "omission of patient documentation and failure to respond with necessary visits resulted in negative patient outcomes," and the November 2011 letter states that her "lack of documentation compromised patient safety." (Ex. 12, pp. 582, 586; Hrg. Tr., pp. 199-200)

61. Ms. Hiller was untruthful in testifying at hearing that during her last two years at ThedaCare, she did "no direct patient care," as evidenced by the fact that she was actually terminated for gross negligence in patient care. (Ex. 12, pp. 582, 586; Hrg. Tr., p. 188)

62. Ms. Hiller was also untruthful in her Answer in stating that in her years as a registered nurse, she has never had her behavior questioned, was untruthful when she testified at hearing that she was not terminated by ThedaCare in 2009 for gross negligence, was untruthful when she told the Division's attorney during a conversation on June 10, 2013 that she had never been disciplined professionally and that her care had never been questioned, and was untruthful with a Division investigator on February 14, 2012 when she denied, in writing, that she ever had an addiction issue. (Answer, p. 4; Hrg. Tr., pp. 213-215)

Ms. Hiller's Other Use of Controlled Substances

63. Ms. Hiller has previously stated that she would not take the medications she was accused of stealing from patients from June - December of 2011 because her ex-husband and sister were drug addicts, she herself had been addicted to Oxycontin, and she was afraid of becoming addicted to such substances. When Mr. Solie asked her during a June 18, 2011 interview if she was taking any pain medications, she stated that she had been prescribed Prednisone for headaches and neck pain but that she has not taken any other medications. (Answer, p. 3-4; Ex. 10, p. 519; Ex. 11, p. 577; Hrg. Tr., 179, 203)

64. A Walgreens Patient Profile for Ms. Hiller indicates that she was prescribed and had filled the following controlled substances:

- March 28, 2011: Generic Percocet (Oxycodone with Acetaminophen) - 15 tablets
- March 29, 2011: Generic Vicodin (Hydrocodone with Acetaminophen) - 20 tablets
- March 31, 2011: Generic Percocet (Oxycodone with Acetaminophen) - 15 tablets
- November 17, 2011: Generic Vicodin (Hydrocodone with Acetaminophen) - 16 tablets
- June 12, 2012: Generic Vicodin (Hydrocodone with Acetaminophen) - 16 tablets

(Ex. 1, pp. 1-6; Hrg. Tr., pp. 156-57, 173-175)

65. Ms. Hiller's medical records indicate that she went to the Aurora emergency room (ER) on March 27, 2011, complaining of a headache and pain in her ear. She was prescribed Percocet. (Ex. 5, pp. 77-82; Hrg. Tr., p. 206)

66. On March 31, 2011, Ms. Hiller again went to the ER complaining of a headache and neck pain. The medical records indicate that she was currently taking Vicodin and Percocet, that she was taking Vicodin four times a day, that her last Vicodin was taken at 7:00 that morning and that she was "out" of Percocet. As stated in Finding of Fact No. 64, Ms. Hiller had recently filled a prescription for Percocet on March 28, 2011 and had received 15 tablets. (Ex. 5, pp. 56, 60, 66; Hrg. Tr., p. 204)

67. According to the medical records, the March 31, 2011 visit was "her third visit for this headache in the last week." The records further state that she had earlier been seen in the walk-in clinic and was given an IV for morphine and that she stated that her headache returned right after she left urgent care. At the ER, she was given an IV for Dilaudid at 1312 and 1417

hours. She told medical staff that the Dilaudid did not relieve her headache. She was prescribed Percocet. (Ex. 5, pp. 58, 66-67; Hrg. Tr., p. 203-05)

68. Controlled substances such as fentanyl, Dilaudid, or Vicodin can be interchangeable for those who are addicted to them. (Hrg. Tr., p. 179, 203)

69. Ms. Hiller was untruthful when she told Mr. Solie she had not taken any medications besides Prednisone. Ms. Hiller was also untruthful with a Division investigator when she denied, in writing, use of, or current prescriptions for, narcotic medications. (Hrg. Tr., pp. 214-215)

Controlled Substances at Issue

70. Pursuant to Wis. Stat. § 961.16(3)(f), fentanyl is a Schedule II controlled substance, for which a prescription is required pursuant to Wis. Stat. § 961.38. (Hrg. Tr., pp. 151, 154)

71. Dilaudid is a brand name for hydromorphone. Pursuant to Wis. Stat. § 961.16(2)(a)8, hydromorphone is a Schedule II controlled substance for which a prescription is required pursuant to Wis. Stat. § 961.38. (Hrg. Tr., pp. 151-153)

72. Oxycontin is a form of oxycodone. Percocet also contains oxycodone. Pursuant to Wis. Stat. § 961.16(2)(a)11., oxycodone is a Schedule II controlled substance for which a prescription is required pursuant to Wis. Stat § 961.38. (Hrg. Tr., pp. 151, 157-158)

73. Vicodin contains hydrocodone. Pursuant to Wis. Stat. § 961.18(5)(c) and (d), hydrocodone is a Schedule III controlled substance for which a prescription is required under Wis. Stat. § 961.38. (Hrg. Tr., pp. 151, 155-156)

74. Schedule II and III controlled substances are subject to addiction and abuse, with Schedule II controlled substances generally having greater potential for abuse than Schedule III substances. (Hrg. Tr., pp. 152, 153, 179)

DISCUSSION

Burden of Proof

The burden of proof in disciplinary proceedings is on the Division to show by a preponderance of the evidence that the events constituting the alleged violations occurred. Wis. Stat. § 440.20(3); *see also* Wis. Admin. Code § HA 1.17(2). To prove by a preponderance of the evidence means that it is "more likely than not" that the examined action occurred. *See State v. Rodriguez*, 2007 WI App. 252, ¶ 18, 306 Wis. 2d. 129, 743 N.W.2d 460, citing *United States v. Saulter,* 60 F.3d 270, 280 (7th Cir. 1995).

Violations of Wisconsin Statute and Administrative Code

Following an investigation and disciplinary hearing, if the Board determines that a practical nurse is guilty of unprofessional conduct, it may revoke, limit, suspend, or deny renewal of a license of a registered nurse if that nurse committed acts which show the registered

nurse to be "unfit or incompetent by reason of negligence, abuse of alcohol or other drugs" or for "[m]isconduct or unprofessional conduct." Wis. Stat. § 441.07(1)(c) and (d) (2011-2012).[2]

The phrase "misconduct or unprofessional conduct" as used in Wis. Stat. § 441.07(1)(d) means "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 the following:

> (1) Violating, or aiding and abetting a violation of any law substantially related to the practice of professional or practical nursing. A certified copy of a judgment of conviction is prima facie evidence of a violation;
> (2) Administering, supplying or obtaining any drug other than in the course of legitimate practice or as otherwise prohibited by law[.]

Wis. Admin. Code § N 7.04(1) and (2).

Pursuant to Wis. Admin. Code § N 7.03(2) the phrase "abuse of alcohol or other drugs" as used in Wis. Stat. § 441.07(1)(c) means "the use of alcohol or any drug to an extent that such use impairs the ability of the licensee to safely or reliably practice."

In its Complaint and Amended Complaint, the Division generally alleged that Ms. Hiller's conduct violates the provisions set forth above. In its post-hearing brief, however, the Division specifies that with respect to patients JG, SD and JW, and with respect to the ThedaCare hospice patients, Ms. Hiller was unfit or incompetent by reason of abuse of drugs because such use impaired her ability to safely or reliably practice, in violation of Wis. Stat. § 441.07(1)(c) and Wis. Admin. Code § N 7.03(2).

The Division's brief also asserts that Ms. Hiller's conduct while at ThedaCare constituted misconduct or unprofessional conduct under Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(1) because she violated laws substantially related to the practice of nursing, namely, Wis. Stat. § 961.38(2) and Wis. Admin. Code § Phar 8.02(1).

The Division's brief does not address misconduct or unprofessional conduct as defined in Wis. Admin. Code § N 7.04(2), *i.e.*, "[a]dministering, supplying or obtaining any drug other than in the course of legitimate practice or as otherwise prohibited by law." However, because the Division alleged this violation in both its Complaint and Amended Complaint and evidence was presented on this issue at hearing, this violation is nevertheless addressed in this decision.

Credibility

Throughout these disciplinary proceedings, Ms. Hiller has maintained that she never took any controlled substances from the homes of JG, SD and JW. In light of the evidence presented by the Division, a determination must be made regarding whether Ms. Hiller's denial is credible or persuasive.

With respect to the remaining allegation, that Ms. Hiller took Oxycontin from hospice patients for her own use while working for ThedaCare, Ms. Hiller has admitted to that conduct,

[2] References to Wis. Stat. § 441.07 are to the statute as it existed at the time of the alleged conduct.

although she states that it was for a lesser period of time than alleged by the Division. Although the length of time that Ms. Hiller took Oxycontin from deceased patients is irrelevant in determining whether a violation occurred, the length of time may be relevant in determining whether it was more or less likely that she subsequently took medications from JG, SD and JW and may also be relevant to the issues of discipline and costs. I therefore make a credibility determination on this issue as well.

Issues of credibility must also be made with respect to several other instances in which Ms. Hiller's testimony and her statements to Mr. Solie directly contradicted testimony and other evidence presented by the Division.

As explained below, to the extent Ms. Hiller's statements contradicted those of Ms. Kimps and Mr. Solie, including their statements regarding what other people told them, I find Ms. Hiller's testimony less credible. I also do not find credible Ms. Hiller's denial that she took controlled substances from patients JG, SD and JW for her own use.

First, the Division has presented abundant and persuasive evidence of diversion. That evidence by itself is sufficient to negate Ms. Hiller's denial. In addition, no evidence was presented to suggest that either Ms. Kimps or Mr. Solie were biased against Ms. Hiller or that either of them had a motive to falsify testimony against her. Their testimony was consistent and credible. Nor has evidence been presented that there was a motive to fabricate on the part of the patients or others who provided Ms. Kimps and Ms. Solie with information regarding diversion. In contrast, Ms. Hiller had a motive to fabricate: namely, that she is potentially facing discipline, including potential revocation of her license, if she is found to have violated statutes or administrative rules governing the nursing profession.

Ms. Hiller is also less credible because during the course of these disciplinary proceedings, she has given contradictory and untruthful statements. For example, Ms. Hiller was dishonest in her Answer when she stated that in her years as a registered nurse, she has never had her behavior questioned, was dishonest when she testified at hearing that she was not terminated by ThedaCare in 2009 for gross negligence, was dishonest when told the Division's attorney during a conversation on June 10, 2013 that she had never been disciplined professionally and that her care had never been questioned, and was dishonest with a Division investigator on February 14, 2012 in denying, in writing, that she ever had an addiction issue or that she had current prescriptions for narcotic medications.

Ms. Hiller was also untruthful in testifying that during her last two years at ThedaCare, she did "no direct patient care," as evidenced by the fact that she was actually terminated for gross negligence in patient care.

Other instances of untruthfulness or contradictory statements are discussed below with respect to each of the particular patients.

In addition to the specific instances where Ms. Hiller was untruthful or inconsistent, I also note the following general facts which are applicable to all of the patients at issue and which further undermine Ms. Hiller's credibility.

First is the fact that the alleged conduct involved three separate patients during a short period of time, approximately six months. During that time period, three patients separately

reported that they were missing controlled substances while Ms. Hiller was caring for them. Ms. Hiller was responsible for more than half of medication discrepancies typically investigated by Aurora in an entire year, and in the three years that Ms. Kimps worked at Aurora as the VNA manager, the only allegations she received concerning a home health care nurse's alleged diversion of controlled substances were the three separate complaints related to Ms. Hiller.

In addition, during the time period that the patients' pain medications were missing, Ms. Hiller violated several Aurora policies and engaged in unreliable nursing practices, such as failing to document significant contacts with physicians and others, failing to document important events such as missing controlled substances, and consistently completing charting in an untimely manner, even completing one while on administrative suspension.

During this period of time, Ms. Hiller made repeated trips to the hospital, obtaining some of the same drugs which were missing from the patients' homes, such as Dilaudid and hydrocodone. Ms. Hiller's March 31, 2011 visit was her third visit for a headache within a week, and during that visit she was twice given intravenous Dilaudid and had earlier been given intravenous morphine.

Moreover, within a four day period, on March 28, 29 and 31, 2011, shortly before the conduct involving JG, Ms. Hiller received two prescriptions for Vicodin, which contains hydrocodone, and one for Percocet, which contains oxycodone. Oxycodone is the same substance contained in Oxycontin, to which Ms. Hiller had an addiction in the recent past. During one of the ER visits on March 31, 2011, Ms. Hiller stated that she was taking Vicodin four times a day, with the last one taken that morning. She stated she was out of Percocet on that day and was given another prescription for it, although she had just been given a prescription for Percocet a few days earlier, on March 28, 2011. In November of 2011, during the time of the allegations involving SD and JW, she again received a prescription for Vicodin. In December of 2011, fentanyl was missing from JW's home.

Both Ms. Hiller and Pharmacist Mielke testified that these controlled substances can be used interchangeably for those who are addicted to them.

Ms. Hiller was obtaining prescriptions for and receiving these drugs at the same time she was denying to Mr. Solie that she was taking anything but Prednisone and claiming that she would not take such drugs from patients because she was afraid of becoming addicted to them, that her ex-husband and sister were drug addicts and that she herself had been addicted to Oxycontin.

I also note that Ms. Hiller's conduct was such that Aurora saw fit to not only twice place her on administrative leave in order to investigate possible diversion but to ultimately terminate her employment. Ms. Hiller had previously been terminated from employment for gross negligence a few years prior to her employment with Aurora.

Ms. Hiller's testimony is also undermined by additional facts with respect to each particular allegation, as discussed below.

Patient JG

A preponderance of the evidence shows that Ms. Hiller diverted fentanyl and hydrocodone from JG's home.

JG was receiving in-home care, not for pain, but because she was receiving intravenous antibiotics. Ms. Hiller documented a pain rating higher than that documented by a subsequent nurse and, according to JG's statements to Mr. Solie, higher than JG herself had rated it. At her very first visit with JG and at her own initiative, Ms. Hiller attempted to increase JG's medications and at a subsequent visit shortly thereafter, attempted to double her dose of fentanyl. JG informed Mr. Solie that Ms. Hiller was "very adamant" about increasing her dosage, and that JG did not understand why because her pain was not that bad.

When Dr. Gowing refused to double the dosage of fentanyl, Ms. Hiller then attempted an early refill for both fentanyl and Vicodin. When she was unsuccessful with getting an early refill for Vicodin, she sought the early refill from another doctor, even though JG had recently had her prescription for Vicodin filled. These increases were attempted at Ms. Hiller's instigation, during a time period in which, as JG reported to Mr. Solie, JG's pain was not that bad.

The pharmacist, Mr. Mielke, who was aware that Ms. Hiller had recently attempted to increase another patient's prescription of fentanyl, was sufficiently concerned that he contacted JG's physician, Dr. Gowing. Dr. Gowing was sufficiently alarmed that he asked JG to come into his office so that he could determine whether she was missing any medications. After realizing that fentanyl and hydrocodone were missing and that someone had altered the box of fentanyl patches by indicating that the box contained eight rather than ten patches, he contacted Ms. Kimps to inform her of his belief that medications were being diverted. Ms. Kimps, in turn, placed Ms. Hiller on administrative leave and conducted an investigation. Ms. Hiller was the only nurse visiting JG while these drugs were determined to be missing and JG and her husband were the only people besides Ms. Hiller to be in the home during that time.

Ms. Hiller admitted that she wrote on the fentanyl box but contended that she only wrote the date of the next application. In JG's medical record, corroborated by Aurora's contemporaneous reports, the only notation on JG's fentanyl packages was that the boxes contained only eight patches, rather than the ten which should have been present.

Other evidence of diversion includes the fact that Ms. Hiller, who did not have previous problems with documentation, consistently completed her charting in an untimely manner, including one which was completed eight days following the visit, and another which was completed fifteen days after the visit. Her documentation did not include significant and required information, such as which pain medication she attempted to have increased on her initial visit or her contact with the other physician when Dr. Gowing refused to authorize an early refill of Vicodin on June 13, 2011. Contrary to Aurora's policies, Ms. Hiller also failed to document that JG's hydrocodone was missing and failed to report it to her supervisor as was required for a serious and unusual incident.

In addition, Ms. Hiller herself decided that she would pick up JG's prescription from the pharmacy, in violation of Aurora policy and without contacting or obtaining approval from Ms. Kimps, despite the fact that JG had told Ms. Hiller that JG's husband could pick up the prescription. I do not find credible Ms. Hiller's testimony and repeated assertions that JG told

her that she could not pick up the prescription or her suggestion that JG's husband could not do so because of a toothache.

Finally, as previously stated, it was around this time period, particularly in March of 2011, that Ms. Hiller was making repeated trips to the ER and obtaining and using various controlled substances, including hydrocodone and other substances which are interchangeable for those who are addicted. On June 18, 2011, Ms. Hiller lied to Mr. Solie, saying that she was not taking any such medications but was only taking Prednisone. She subsequently lied again when she denied any prescriptions or drug use to an investigator from the Department.

Although it is true that Aurora determined that the diversion from JG was unsubstantiated, this does not mean that diversion did not occur, only that at the time, Aurora believed it did not have sufficient evidence to prove it. Aurora's decision is not in any way binding on this tribunal, particularly as that investigation was prior to receiving information involving the other two patients and prior to receiving other information, such as Ms. Hiller's admitted addiction to Oxycontin while working at ThedaCare.

Based on the evidence presented, it is more likely than not that Ms. Hiller took fentanyl and hydrocodone, both of which are controlled substances requiring prescriptions, from JG's home for her own use. Such conduct constitutes misconduct or unprofessional conduct under Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(2) in that Ms. Hiller obtained drugs other than in the course of a legitimate practice.

Such conduct also establishes that Ms. Hiller was unfit by reason of abuse of alcohol or other drugs, in violation of Wis. Stat. § 441.07(1)(c) and Wis. Admin. Code § N 7.03(2), because her use of drugs impaired her ability to safely and reliably practice. This is evidenced by Ms. Hiller taking for her own use medications intended for a patient and by her unreliable nursing practices during the time period she obtained such drugs for her own use.

Patient SD

A preponderance of the evidence shows that Ms. Hiller diverted Dilaudid from SD's home for her own use.[3]

SD reported to Aurora that Ms. Hiller took bags of Dilaudid from SD's home. An audit conducted by Aurora indicated that two to three bags of Dilaudid were missing from SD's home during the time period that Ms. Hiller was providing care to SD.

No evidence has been presented that SD had any motive to fabricate her allegation that Ms. Hiller took Dilaudid from the home, nor was there evidence that any impairment would cause SD to perceive this incorrectly. Likewise, the record does not suggest any other explanation as to why the Dilaudid was missing. Ms. Hiller merely suggests that no Dilaudid was missing, but offers no contrary evidence to dispute the audit conducted by Aurora indicating that it was.

In addition, Ms. Hiller's lack of documentation with respect to wasting of Dilaudid strongly supports that she was diverting Dilaudid from SD's home. SD stated that she did not

[3] Although Ms. Hiller reported to Mr. Solie that SD was also missing hydrocodone, this allegation is not addressed as it was not alleged in the Amended Complaint or argued in the Division's brief.

sign or witness Dilaudid being wasted as she did with other nurses. The documentation of wasting that Ms. Hiller provided to Ms. Solie supports SD's statements. SD's signature is missing for two of the instances of wasting, with no explanation documented, and, contrary to Aurora's policy, which had recently been explained to Ms. Hiller. In addition, the two instances in which the initials for SD appear on the wasting form are suspect, particularly in light of SD's statements to Mr. Solie that Ms. Hiller did not have her witness the wasting and that Ms. Hiller was taking Dilaudid from the home. Indeed, one entry that was allegedly initialed was initialed on a date that SD specifically informed Ms. Kimps was one of the dates during which Ms. Hiller had not asked SD to sign verification that the Dilaudid had been wasted. The wasting form is also in conflict with Ms. Hiller's Answer, in which she indicated that SD signed or initialed the medication disposal form each time Ms. Hiller wasted it.

Further, as with the charting for JG, the charting for SD was routinely late, in violation of Aurora's policies. Charting from one of the visits was completed after Ms. Hiller was placed on an administrative suspension.

Finally, as noted above, around the same time period that the Dilaudid was missing from SD's home, Ms. Hiller was obtaining a variety of controlled substances, including Dilaudid, as a result of visits to the ER, while denying to Mr. Solie that she was taking any such medications and then subsequently lying again to an investigator from the Department regarding her prescriptions and use of drugs.

Based on the evidence presented, it is more likely than not that Ms. Hiller took Dilaudid, which is a controlled substance requiring a prescription, from SD's home for her own use. Such conduct constitutes misconduct or unprofessional conduct under Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(2) in that Ms. Hiller obtained drugs other than in the course of a legitimate practice.

Such conduct also establishes that Ms. Hiller was unfit by reason of abuse of alcohol or other drugs, in violation of Wis. Stat. § 441.07(1)(c) and Wis. Admin. Code § N 7.03(2), because her use of drugs impaired her ability to safely and reliably practice. This is evidenced by Ms. Hiller taking for her own use medications intended for a patient and by her unreliable nursing practices during the time period she obtained such drugs for her own use.

Patient JW

A preponderance of the evidence shows that Ms. Hiller diverted fentanyl from JW's home for her own use.

JW was a legally blind patient for whom Ms. Hiller was providing care. Within a few days after JW became an Aurora client, Ms. Hiller documented that JW had doubled the dose of fentanyl by putting on a second patch. Under the circumstances, Aurora's policies required that Ms. Hiller contact the prescribing physician and document that such communication occurred. Ms. Hiller failed to do so.

On one of the dates that Ms. Hiller provided service, she documented that she laid out the fentanyl patches on Tagaderm for JW to apply herself. Ms. Kimps testified that because JW was blind, she could not apply the patches herself.

On another occasion in June of 2011, a case manager other than Ms. Hiller visited JW and noted that there were no fentanyl patches on JW and no patches available in the home. The case manager also believed the patient should be discharged in approximately three weeks. However, that did not occur and JW was not discharged as a patient until September 11, 2011. Ms. Hiller did not document why JW was seen for another three months rather than three weeks.

It was later reported to Ms. Kimps that during a time period that JW was discharged from Aurora services, from approximately September through December, 2011, Ms. Hiller had been at JW's home, allegedly to help her put on fentanyl patches, with the last visit occurring approximately a week before this report. During at least part of the time that Ms. Hiller was visiting JW, she was on administrative suspension. At the time of Ms. Hiller's last visit, some fentanyl patches were discovered to be missing from JW's home. Ms. Hiller was the only caregiver seeing JW during this time.

It was only a few months before these events that Ms. Hiller had attempted to double JG's fentanyl and Vicodin, that fentanyl and Vicodin were missing from JG's home and that Dilaudid was missing from SD's home. It was also during this time that Ms. Hiller was making visits to the ER and receiving controlled substances which are interchangeable with fentanyl for one addicted to them.

Based on the evidence presented, it is more likely than not that Ms. Hiller took fentanyl, which is a controlled substance requiring a prescription, from JW's home for her own use. Such conduct constitutes misconduct or unprofessional conduct under Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(2) in that Ms. Hiller obtained drugs other than in the course of a legitimate practice.

Such conduct also establishes that Ms. Hiller was unfit by reason of abuse of alcohol or other drugs, in violation of Wis. Stat. § 441.07(1)(c) and Wis. Admin. Code § N 7.03(2), because her use of drugs impaired her ability to safely and reliably practice. This is evidenced by Ms. Hiller taking for her own use medications intended for a patient and by her unreliable nursing practices during the time period she obtained such drugs for her own use.

Ms. Hiller's Unauthorized Use of Oxycontin While Employed at ThedaCare

Ms. Hiller admitted at hearing that while employed as a hospice nurse at ThedaCare, she took Oxycontin from a hospice patient who had died and that she used it herself. She also admitted at hearing that at the time she took the Oxycontin from the hospice patient, she knew it was illegal and contrary to her training and education as a nurse. Ms. Hiller was fired from ThedaCare for gross negligence, based on her failure to document and attend to requests for her services.

Oxycontin is a form of oxycodone. Pursuant to Wis. Stat. § 961.16(2)(a)11., oxycodone is a Schedule II controlled substance for which, under the circumstances at issue, a prescription is required pursuant to Wis. Stat § 961.38. The Oxycontin which Ms. Hiller took was prescribed to the deceased patient or patients, not to Ms. Hiller.

The Division asserts that such conduct establishes that Ms. Hiller was unfit by reason of abuse of alcohol or other drugs, in violation of Wis. Stat. § 441.07(1)(c) and Wis. Admin. Code § N 7.03(2), because her use of drugs impaired her ability to safely and reliably practice. The

Division has established this violation by a preponderance of evidence. Ms. Hiller herself admitted that stealing Oxycontin intended for hospice patients was contrary to her training and education as a nurse. She also admitted that when a nurse steals controlled substances from a patient, she is not a reliable nurse. This is particularly true where the nurse is taking the controlled substances for her own use.

Moreover, at the time that Ms. Hiller was taking Oxycontin prescribed and intended for hospice patients, she engaged in a series of unreliable nursing practices at ThedaCare which resulted in her termination for gross negligence. Ms. Hiller failed to document and respond to requests for services on numerous occasions. ThedaCare determined that her "omission of patient documentation and failure to respond with necessary visits resulted in negative patient outcomes" and that her "lack of documentation compromised patient safety." Ms. Hiller's conduct at ThedaCare demonstrates that she was unfit by reason of abuse of alcohol or other drugs because her use of drugs impaired her ability to safely and reliably practice.

The Division also argues that Ms. Hiller's behavior constituted misconduct or unprofessional conduct under Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(1) because Ms. Hiller violated a law substantially related to the practice of nursing, namely, Wis. Stat. § 961.38(2) and Wis. Admin. Code § Phar 8.02(1).

Wisconsin Admin. Code § N 7.04(1) appears to address violations of criminal statutes, as evidenced by its inclusion of the following language: "A certified copy of a judgment of conviction is prima facie evidence of a violation," and "Violating, or *aiding and abetting* a violation of any law . . . ." The Division has not specified a criminal offense which has been committed in this case. With regard to Wis. Stat. § 961.38(2), this provision is found under Subchapter III of Chapter 961, which does not set forth criminal offenses pertaining to controlled substances. Rather, the offenses related to controlled substances are found in Chapter IV, entitled, "Offenses and Penalties." Likewise, Wis. Admin. § Phar 8.02, is not a criminal provision. Moreover, it pertains to "practitioners," and the Division has not provided any authority showing that a "practitioner" as used in the pharmacy regulations, includes registered nurses. Notably, the definition of "practitioner" in Wis. Stat. § 961.01(19) does not appear to include registered nurses.

Rather than determining whether Ms. Hiller committed misconduct or unprofessional conduct while ThedaCare by violating a law which substantially relates to the practice of nursing, I will address the far more obvious form of misconduct or unprofessional conduct which was alleged in both the Complaint and Amended Complaint and for which ample evidence was produced at hearing: namely, that while employed at ThedaCare, Ms. Hiller engaged in misconduct or unprofessional conduct by obtaining drugs other than in the course of her legitimate practice, in violation of Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(2).

Ms. Hiller's own admissions establish a violation of these provisions, although she currently maintains that she only took Oxycontin from one patient and ingested it for two to four weeks. Taking Oxycontin for her own use from one deceased hospice patient over a period of two to four weeks is sufficient to establish a violation of Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(2). However, I also conclude that based on the testimony and reports of Mr. Solie and Ms. Kimps, Ms. Hiller actually took Oxycontin from more than one deceased hospice patient over a period of approximately two years, which also establishes these violations.

Appropriate Discipline

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

The Division requests that Ms. Hiller's license to practice nursing be indefinitely suspended, in accordance with the Board's standard impairment order, with its requirements for treatment, practice limitations, random drug screens, work reports, and group support meetings. The Division's recommendation includes provisions allowing for a stay of the suspension upon Ms. Hiller having proven, to the satisfaction of the Board's Monitoring Liaison, that she has been in compliance with the terms of the impairment order.

The discipline recommended by the Division is warranted. First, the recommended discipline best promotes the disciplinary objectives set forth in *Aldrich*. Ms. Hiller is in need of rehabilitation, as evidenced by the fact that she took highly addictive controlled substances from three separate patients over a six-month period in 2011, after having taken Oxycontin from deceased hospice patients over a two-year period while employed at ThedaCare and becoming addicted to it.

Ms. Hiller has never received treatment for her addiction to controlled substances and the record speaks loudly of her need for such treatment. Her problem with controlled substances has resulted in her jeopardizing her decades-long career in nursing and placing her patients in harms' way. She has been untruthful to the Board, the Division and the ALJ. The public must be protected from Ms. Hiller's misconduct and other licensees must be deterred from engaging in such acts.

The terms of the requested impairment order adequately address public protection, while giving Ms. Hiller an opportunity to demonstrate rehabilitation over time. The impairment order, with its provisions for timely consequence of violations, also serves as additional motivation for Ms. Hiller's compliance with treatment and other provisions.

Based on the foregoing, it is appropriate to indefinitely suspend Ms. Hiller's license, with the conditions set forth below.

Costs

The Division has the authority to assess costs pursuant to Wis. Stat. § 440.22. The factors to be considered in assessing costs are: (1) the number of counts charged, contested and proven; (2) the nature and seriousness of the misconduct; (3) the level of discipline sought by the prosecutor; (4) the respondent's cooperation with the disciplinary process; (5) prior discipline, if any; (6) the fact that the Department is a "program revenue" agency, whose operating costs are funded by the revenue received from licenses, and the fairness of imposing the costs of disciplining a few members of the profession on the vast majority of the licensees who have not engaged in misconduct; and (7) any other relevant circumstances. *See In the Matter of Disciplinary Proceedings Against Elizabeth Buenzli-Fritz*, LS0802183CHI (Aug. 14, 2008).

The Division requests that the full costs of these proceedings be imposed on Ms. Hiller. Based on the factors delineated in the *Buenzli-Fritz* decision and the facts of this case, it is

appropriate to assess Ms. Hiller for the full amount of recoverable costs in this case. Ms. Hiller's conduct involved taking controlled substances from multiple home care patients, JG, SD and JW, as well as from ThedaCare hospice patients who were deceased. During the time that she took these substances from her Aurora patients, she did not comply with several of Aurora's policies, policies that are designed to ensure the safety and proper care of patients.

The Division has proven all of the conduct alleged. The conduct was serious, as it involved taking for Ms. Hiller's own use medications intended for vulnerable patients, medications which are highly addictive controlled substances. With regard to Ms. Hiller's participation in these proceedings, I note that she has participated fully, although she has also been untruthful at times with the Board, the Division and at hearing. I also note that while Ms. Hiller has not had previous discipline by the Board, she has previously been terminated from employment with ThedaCare based on gross negligence, and that while employed in that previous position, Ms. Hiller stole Oxycontin for her own use from deceased hospice patients over a two-year period.

Finally, it would be unfair to impose the costs of these proceedings on Ms. Hiller's fellow licensees who have not engaged in such misconduct. For the reasons set forth above, Ms. Hiller is assessed the full costs of these proceedings.

CONCLUSIONS OF LAW

1. The Division has met its burden of establishing by a preponderance of the evidence that Ms. Hiller engaged in misconduct or unprofessional conduct by obtaining drugs other than in the course of a legitimate practice in violation of Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04(2), with respect to Patients JG, SD and JW and with respect to ThedaCare hospice patients.

2. The Division has met its burden of establishing by a preponderance of the evidence that when obtaining controlled substances from Patients JG, SD and JW, and from ThedaCare hospice patients, Ms. Hiller was unfit to practice nursing by reason of abuse of drugs, in violation of Wis. Stat. § 441.07(1)(c) and Wis. Admin. Code § N 7.03(2), because her use of drugs impaired her ability to safely and reliably practice.

3. Applying the factors articulated in *Aldrich*, indefinite suspension of Ms. Hiller's nursing license is appropriate, as are the conditions set forth in the Order section below.

4. Pursuant to the factors delineated in *Buenzli-Fritz,* imposition of the costs of this proceeding on Ms. Hiller is warranted.

ORDER

Accordingly, IT IS HEREBY ORDERED:

SUSPENSION

A.1. The license of Diane L. Hiller, R.N., to practice as a nurse in the State of Wisconsin is SUSPENDED for an indefinite period.

A.2. The privilege of Ms. Hiller 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, Ms. Hiller may not practice in another state pursuant to the Nurse Licensure Compact under the authority of a Wisconsin license, unless she receives prior written authorization to do so from both the Wisconsin Board of Nursing and the regulatory board in the other state.

A.4 Ms. Hiller 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/Home.

A.5. Upon a showing by Ms. Hiller 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 Ms. Hiller 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 may be stayed upon Ms. Hiller petitioning the Board and providing proof, which is determined by the Board or its designee to be sufficient, that she has been 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 Ms. Hiller 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 Ms. Hiller 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 Ms. Hiller either by:

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

B.4. The Board or its designee may reinstate the stay if provided with sufficient information that Ms. Hiller 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 Ms. Hiller 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 Ms. Hiller's request, unless waived by Ms. Hiller. Requesting a hearing does not stay the suspension during the pendency of the hearing process.

CONDITIONS AND LIMITATIONS

Treatment Required

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

C.2. Ms. Hiller 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 Ms. Hiller'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, Ms. Hiller 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 Ms. Hiller'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. Ms. Hiller 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 Ms. Hiller'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. Ms. Hiller 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. Ms. Hiller's attendance at such meetings shall be verified and reported quarterly to Treater and the Department Monitor.

Sobriety

C.8. Ms. Hiller shall abstain from all personal use of alcohol.

C.9. Ms. Hiller 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. Ms. Hiller shall disclose her drug and alcohol history and the existence and nature of this Order to the practitioner prior to the practitioner ordering the controlled substance. Ms. Hiller 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 Ms. Hiller'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. Ms. Hiller 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 her treatment and rehabilitation. It is Ms. Hiller's responsibility to educate herself about the medications and substances which may violate this paragraph, and to avoid those medications and substances.

C.11. Ms. Hiller shall report to Treater and the Department Monitor all prescription medications and drugs taken by her. 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, Ms. Hiller shall immediately arrange for the prescriber or pharmacy to fax and mail copies of all prescriptions to the Department Monitor.

C.12. Ms. Hiller shall provide the Department Monitor with a list of over-the-counter medications and drugs that she 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 Ms. Hiller'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. Ms. Hiller 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 Ms. Hiller enrolls in the Approved Program, she 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 (5) 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, Ms. Hiller 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, Ms. Hiller 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 Ms. Hiller 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. Ms. Hiller 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. Ms. Hiller shall not work as a nurse or other health care provider in a setting in which she has access to controlled substances.

C.21. Ms. Hiller shall not work in a home health care, hospice, pool nursing, assisted living or agency setting.

C.22. Ms. Hiller shall provide a copy of this Final Decision and Order and all other subsequent orders immediately to supervisory personnel at all settings where she works as a nurse or care giver or provides health care, currently or in the future.

C.23. It is Ms. Hiller'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 Ms. Hiller'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.24. Ms. Hiller shall report to the Board any change of employment status, residence, address or telephone number within five days of the date of a change.

MISCELLANEOUS

Department Monitor

D.1. Any requests, petitions, reports and other information required by this Order shall be mailed, emailed, 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 Ms. Hiller

D.2. Ms. Hiller is responsible for compliance with all of the terms and conditions of this Order, including the timely submission of reports by others. Ms. Hiller 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. Ms. Hiller shall promptly notify the Department Monitor of any violations of any of the terms and conditions of this Order by Ms. Hiller.

D.3. Every three (3) months Ms. Hiller shall notify the Department Monitor of Ms. Hiller'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 Ms. Hiller continue treatment and rehabilitation under the direction of another Treater or Approved Program.

Petitions for Modification of Limitations or Termination of Order

D.5. Ms. Hiller 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 Ms. Hiller'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 Ms. Hiller shall not have a right to any further hearings or proceedings on the denial.

D.6. Ms. Hiller 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.

Costs of Compliance

D.7. Ms. Hiller shall be responsible for all costs and expenses incurred in conjunction with the monitoring, screening, supervision and any other expenses associated with compliance with the terms of this Order. Being dropped from a program for non-payment is a violation of this Order.

Costs of Proceeding

D.8. Respondent shall pay costs of the disciplinary proceedings within 120 days of this Order. Payment should be directed to the attention of the Department Monitor at the address in paragraph D.1., above. IN the event Ms. Hiller fails to timely submit any payment of costs, her license may, in the discretion of the Board or its designee, bye SUSPENDED, without further notice or hearing, until she has complied with the terms of this Order.

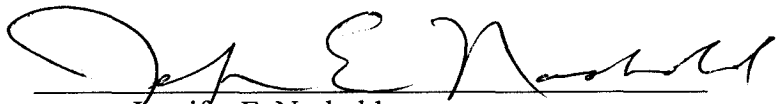
Additional Discipline

D.9. In addition to any other action authorized by this Order or law, violation of any term of this Order may be the basis for a separate disciplinary action pursuant to Wis. Stat. § 441.07.

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 April 10, 2014.

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

By: 

Jennifer E. Nashold
Administrative Law Judge

Diane L. Hilby
1317 Liberty St
Oshkosh WI 54901

Answer to complaint, case No. 12 NUR 019
Response to each allegation:

Allegation that A removed an IV Dilaudid medication bag from a patients home.
Fact: A never removed an IV bag from patients home. Every bag change A did was after direction from pharmacy, (pharmacist "Nancy"). Empty bags &/or bags with medication left were emptied in toilet & bags placed in patients trash. Patient signed or initialed form each time and this form was turned into manager. A Never Changed Dilaudid cassette without direction from pharmacist.
Allegation that there were missing Fentanyl patches from patients home after A applied patch to patient.
Fact: This patient was no longer on homecare services. I became close to person & would visit her on my own time. Patient lived alone & had several caregivers. When I would visit, at times She would ask me to change her Fentanyl patch because her vision was very poor. When patches reported missing, I had not seen this woman in at least 2 weeks.

cont'd

- Allegation - A called MD to request increase dose in Fentanyl and requested refill.

Fact: A did call to request increase and refill. This was my first home visit to this patient. Patient reported a pain level of > "6", (on 0-10 scale), when looking at medications for admission papers, patient had empty box of fentanyl patches. Patient told me she had to change them early because they had come off. Above info is documented in my charting from that visit. Doctors office said that they would not increase dose but would write prescription for refill that patient could pick up the following Monday. A relayed this information to the patient while on the phone with MD office. Patient tearfully said she had no way to get script or fill. A offered + did pick up script, had filled + brought to patient that Monday. A did not have patient sign form for delivery because at that time A didn't know there was a form. While A was on orientation, the nurse training me picked up several meds for patients and did not have them sign a form. This allegation was found "unsubstantiated" by loss/prevention dept and A was told by investigator that this patient had history of medication

abuse and financial issues. A recieved a disciplinary notice for this only for not getting form signed for picking up her medications.
- Allegation - that A admitted to Sonny 2 yr addiction to Oxycontin and stealing same from patient homes.
Fact: A never said A had a 2 yr addiction. What A said was that approximately 2 yrs before A left Theda Care at home, A did remove one bottle of Oxycontin from a patients home during a death visit. A admitted that during a very difficult time in my life, A had a ONE time very poor lapse in judgment & instead of flushing remaining pills, A took them. A admitted that the bottle had 20-30 pills which A did take for approximately 1 month. A told investigator that when they were gone A was shocked and terrified that A was experiencing withdrawl symptoms. A never did this again after this occurance or before.
The year and ½ before leaving Theda Care A was promoted to team leader so was not doing direct patient care on a regular/usual basis so wouldn't have had access to patient medications.

While A have major regret for my one lapse six yrs ago, A learned a valuable lesson. One of which was

how quickly addiction can happen. I have never done anything like this since or before.

I have never failed a drug test and appeared several times to take one at Aurora.

When I left Aurora I started new job within 1 mo where I was drug tested and passed. I have never been treated for addiction, have never had questionable doctor visits. In my 30+ years as an RN I have always had a good attendance record, have never had my behavior questioned.

I did nothing wrong while working at Aurora. My misconduct, which I deeply regret was 6 yrs ago.

Thank you for your time,

Diane Hing