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Before The
State Of Wisconsin
BOARD OF NURSING

In the Matter of the Disciplinary Proceedings Against **ROBIN J. STAVER, R.N.**, Respondent

FINAL DECISION AND ORDER

Order No. ORDER 0003723

Division of Legal Services and Compliance Case No. 13 NUR 307

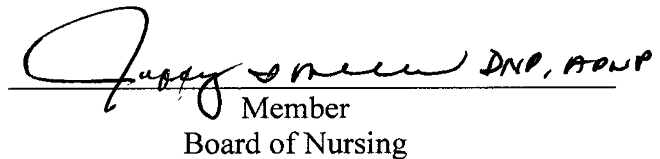
The State of Wisconsin, Board of Nursing, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, make the following:

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 12th day of February, 2015.



Member
Board of Nursing

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings Against **ROBIN J. STAVER, R.N.**, Respondent	DHA Case No. SPS-14-0039 DLSC Case No. 13 NUR 307

PROPOSED DECISION AND ORDER ORDER 0003723

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

Robin J. Staver, R.N.
1320 Central Avenue
Beloit, WI 53511

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 Kim M. Kluck
Department of Safety and Professional Services
Division of Legal Services and Compliance
P. O. Box 7190
Madison, WI 53707-7190

PROCEDURAL HISTORY

On April 30, 2014, the Department of Safety and Professional Services, Division of Legal Services and Compliance (Division) filed a formal complaint against Respondent Robin J. Staver, R.N., alleging that Staver engaged in one count of misconduct by obtaining any drug other than in the course of legitimate practice, in violation of Wis. Admin. Code § N 7.04(2),[1] and one count of negligence through an act or omission demonstrating a failure to maintain competency in practice and methods of nursing care, in violation of Wis. Admin. Code

[1] All references to Wis. Admin. Code §§ N 7.03 and 7.04 refer to the provisions as they existed at the time of the conduct alleged, prior to the August 1, 2014 amendments.

§ N 7.03(1)(b), and was therefore subject to discipline under Wis. Stat. § 441.07(b), (c), and (d) (2011-2012).[2]

On or about May 6, 2014, Staver filed an Answer to the Complaint in which she provided a general narrative which failed to address the specific allegations of the Complaint. On May 8, 2014, the Division filed a Motion to Strike Answer pursuant to Wis. Stat. § 802.06(6), on grounds that the Answer failed to set forth responses to each cause asserted and failed to admit or deny all allegations, as required by Wis. Admin. Code SPS § 2.09(1).

On May 27, 2014, a prehearing conference was held by telephone and the administrative law judge (ALJ) ordered that Staver was to file an Amended Answer to the Complaint by June 3, 2014 and that an additional prehearing conference would be held on June 10, 2014. Staver filed an Amended Answer on June 2, 2014 denying misconduct.

On June 10, 2014, the additional prehearing conference was held at which time the ALJ issued a Scheduling Order setting a hearing for September 4, 2014, and deadlines for witness disclosures and the filing and exchanging of exhibit lists and exhibits.

The hearing was held on September 4, 2014 in Madison, Wisconsin. At the close of hearing, the ALJ granted the Division's motion to amend the Complaint to conform to the evidence presented at hearing. The ALJ subsequently issued a briefing order setting the Division's deadline for filing its brief-in-chief by October 13, 2014; Staver's response brief by November 3, 2014; and the Division's reply brief by November 13, 2014.

FINDINGS OF FACT

1. Respondent Robin J. Staver, R.N. (D.O.B. March 10, 1965), is licensed in the State of Wisconsin as a professional nurse, having license number 125316-30, first issued on February 11, 1997, and current through February 29, 2016. (Complaint, ¶ 1; May 29, 2014 Answer, ¶ 1)

2. Staver's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 1320 Central Avenue, Beloit, Wisconsin 53511. (Complaint ¶ 2; May 29, 2014 Answer, ¶ 2)

3. At all times relevant to this proceeding, Staver was employed as a professional nurse at Select Specialty Hospital (Select Specialty), located in West Allis, Wisconsin. (Complaint, ¶ 3; May 29, 2014 Answer, ¶ 3)

4. Select Specialty is located on the second floor within the West Allis Memorial Hospital. The pharmacy at Select Specialty is located on the second floor as well. A number of security measures are in place at the pharmacy to safeguard the various medications and controlled substances stored there. Outside of the pharmacy door is a combination lock and only pharmacy employees know the combination to the lock. Inside the pharmacy is a narcotic key lockbox which can be accessed only by pharmacy employees who have the combination. The

[2] References to this statute are to the version as it existed at the time of the alleged conduct in 2013.

lockbox contains the keys to the cabinets where the narcotics are stored in the pharmacy. Just inside the pharmacy door is a security alarm which is set when pharmacy employees leave at night so that if the door is opened, security is notified. (Hrg. Trans., pp. 11, 33-34; Ex. 17)

5. Medications are delivered to Select Specialty by vendors and suppliers. Deliveries are tracked using a perpetual inventory log. The amount of medications contained in the pharmacy inventory is also maintained in the perpetual inventory log. The pharmacists perform audits of every controlled substance once a month at which time the auditing pharmacist verifies that every medication is accounted for in the appropriate quantity. (Hrg. Trans., pp. 62-63)

6. Select Specialty has two automated medication dispensing carts which both have a number of secure drawers where medications are stored, including schedule II, III and IV medications. Schedule III and IV medications can be stored together with other medications. Schedule II narcotic medications, which have the highest potential for abuse, are stored in separate drawers. (Hrg. Trans., pp. 36-37)

7. Access and entry to the medication cart is controlled by a computer. The operator is required to enter a password and provide a fingerprint scan before access is allowed. Every time that a medication dispense drawer is opened for a narcotic, the medication dispensing computer requires the operator to perform a manual count of the number of medication units contained in the drawer. (Hrg. Trans., p. 57)

8. The physical count is performed as a "blind count" which means that the computer does not prompt the operator as to what the count should be. The number from the manual count must be entered into the computer. If the number entered by the operator does not match the inventory number in the computer, the operator is given another opportunity to enter the correct amount. If there is still a discrepancy between the physical count and the computerized amount, the operator is not allowed to proceed. (Hrg. Trans., pp. 40, 57, 71-72, 84, 91-92)

9. The medication carts are re-stocked with controlled substances by either two pharmacists (on weekdays) or by a pharmacist and registered nurse (on weekends). It is not possible to re-stock a medication cart with a controlled substance with only one person because the computer requires two people to log in for the process. (Hrg. Trans., pp. 16-17, 40)

10. In the instant case, three pharmacists re-stocked controlled substances with Staver on five occasions. The three pharmacists followed the same procedure for re-stocking controlled substances in the medication carts. This procedure involved the following:

- The pharmacist requested Staver to assist with the re-stock. The pharmacist logged on to the computer using a password and fingerprint.

- The pharmacist then opened the re-stock screen on the computer and selected the medication that was to be re-stocked.

- Staver then countersigned by logging in to the computer with her password and fingerprint scan.

- At that point, the door to the selected medication drawer would pop open. The pharmacist and Staver then performed a physical count of the medications in the drawer and entered that amount into the computer.

- The pharmacist then physically placed the medication into the drawer and Staver entered the number added to the computer.

(Hrg. Trans., pp. 16, 37, 40-42, 46, 72)

11. A failure by the three pharmacists to maintain an accurate inventory and keep the medications secure could invite investigation by the federal government (DEA) and could result in consequences to the hospital and to the pharmacists' licenses. (Hrg. Trans., p. 33)

February 16, 2013 re-stock of hydrocodone-acetaminophen

12. On February 16, 2013, pharmacist Laura Schilling performed a re-stock of hydrocodone-acetaminophen in Cart 2 with Staver as the witness. Schilling first removed 20 tablets of hydrocodone-acetaminophen from the pharmacy and documented that transaction in the perpetual inventory log. An audit was later performed on February 26, 2013 at the pharmacy which confirmed the quantity of medication she removed from the pharmacy. (Hrg. Trans., pp. 15, 18-25; Exs. 6 and 11)

13. Schilling and Staver logged onto the medication dispensing machine also using the general procedure described above. That procedure involved verifying that the physical inventory (determined by the manual count) matched the computerized inventory amount. (Hrg. Trans., pp. 16-17)

14. The re-stock occurred at 11:27 a.m., at which time Schilling placed 20 tablets in the drawer and stated to Staver that she was placing 20 tablets in the drawer. Staver then entered a number into the computer; however, the number entered by Staver was 10, not 20. As a result, the physical inventory no longer matched the computerized inventory: there were ten additional physical tablets in the drawer following the re-stock that the amount reflected in the computer.[3] (Hrg. Trans., pp. 17-22; Ex. 11)

15. Had Schilling seen or recognized at the time that Staver entered a number which was incorrect, she would have re-accessed the drawer and fixed the count to accurately reflect what was actually added to the machine so that the count would be correct. (Hrg. Trans., p. 22)

16. Staver was the very next person to access that drawer for hydrocodone-acetaminophen. At 11:38 a.m. on that same date, only 11 minutes after the re-stock by Schilling and Staver, Staver accessed that same drawer in Cart 2 for hydrocodone-acetaminophen under Patient R.D.'s name. Staver had to perform a precount of the number of tablets in the drawer and enter the correct number into the computer. (Hrg. Trans., pp. 23-25, 71-72; Ex. 11)

[3] Prior to the re-stock, the beginning computer inventory was 17 units. After the re-stock, the computer inventory changed from 17 units to 27 units when, in fact, the ending count should have been 37. (Ex. 11)

17. The medication dispensing machine computer record reflects that Staver then canceled the open drawer without documenting that she removed any medication for Patient R.D. Staver did not immediately re-access the drawer under another patient's name. (Hrg. Trans., pp. 23-26; Ex. 11)

18. Staver was the only provider to access the hydrocodone-acetaminophen drawer during that shift before the end of shift count occurred. (Ex. 11)

19. An end of shift count is required by pharmacy policies and procedures at Select Specialty. The end of shift counts are performed by two nurses: the off-going charge nurse and the oncoming charge nurse. One nurse counts the physical medications in the drawer and provides that number to the other nurse who enters the number into the computer. Any discrepancies must be investigated and, if the discrepancy cannot be resolved, the nursing supervisor and the director of pharmacy are immediately involved. (Hrg. Trans., pp. 73-76; Ex. 3)

20. The end of shift count did not result in a discrepancy between the manual and computerized counts. (Ex. 11)

February 2, 2013 re-stock of oxycodone-acetaminophen[4]

21. On February 2, 2013, pharmacist Tim Nicksic performed a re-stock of oxycodone-acetaminophen in Cart 1 with Staver as the witness. Nicksic first removed 40 tablets of oxycodone-acetaminophen from the pharmacy and documented that transaction in the perpetual inventory log. (Hrg. Trans., pp. 39-40, 43-44; Exs. 9, 10)

22. Schilling and Staver logged onto the medication dispensing machine using the general procedure described above. That procedure involved verifying that the physical inventory (determined by the manual count) matched the computerized inventory amount.

23. The re-stock occurred at 10:59 a.m., at which time Nicksic placed 40 tablets in the drawer and stated to Staver that he was placing 40 tablets in the drawer. Staver then entered a number into the computer; however, the number entered by Staver was 30, not 40. As a result, the physical inventory no longer matched the computerized inventory. There were ten additional physical tablets in the drawer following the re-stock.[5] (Hrg. Trans., pp. 41-44; Ex.10)

24. Had Nicksic seen that Staver entered a number which was incorrect, he would have re-accessed the drawer and fixed the inventory count. (Hrg. Trans., pp. 44-45)

25. Staver was the very next person to access that drawer for oxycodone-acetaminophen. At 11:03 a.m. on that same date, only four minutes after the re-stock by Nicksic and Staver,

[4] Oxycodone-acetaminophen is generic Percocet, and is also called oxycodone APAP. APAP refers to acetaminophen. (Hrg. Trans. pp., 58, 82)

[5] Prior to the re-stock, the beginning computer inventory was 19. After the re-stock, the computer inventory changed from 19 units to 49 units when, in fact, the ending count should have been 59. (Ex. 10)

Staver accessed that same drawer in Cart 1 for oxycodone-acetaminophen under Patient P.A.'s name. Staver had to perform a precount of the number of tablets in the drawer and enter the correct number into the computer. (Hrg. Trans., pp. 45-46, 71-72; Ex. 10)

26. The medication dispensing machine computer record reflects that Staver then canceled the open drawer. Staver did not immediately re-access the drawer under another patient's name. (Hrg. Trans., pp. 45-46; Ex. 10)

27. The next provider to access the oxycodone-acetaminophen drawer before the end of shift count was Nurse Susan Bray, approximately six hours later, at 5:32 p.m. The physical count performed by Bray matched the computerized amount, indicating that there were not ten extra tablets in the drawer. (Hrg. Trans., p. 74; Ex. 10)

28. The end of shift count performed at 6:15 p.m. did not result in a discrepancy between the manual and computerized counts. (*Id.*)

April 27, 2013 re-stock of oxycodone

29. On April 27, 2013, pharmacist James Schmor performed a re-stock of oxycodone in Cart 1 with Staver as the witness. Schmor first removed 30 tablets of oxycodone from the pharmacy and documented that transaction in the perpetual inventory log. (Hrg. Trans., pp. 64-65, 69; Exs. 8, 12)

30. Schmor and Staver logged onto the medication dispensing machine computer using the general procedure described above. That procedure involved verifying that the physical inventory (determined by the manual count) matched the computerized inventory amount. (Hrg. Trans., pp. 66-68)

31. The re-stock occurred at 1:16 p.m., at which time Schmor placed 30 tablets in the drawer and, per his routine practice, stated to Staver that he was placing 30 tablets in the drawer. Staver then entered a number into the computer; however, the number entered by Staver was 20, not 30. As a result, the physical inventory no longer matched the computerized inventory. There were ten additional physical tablets in the drawer following the re-stock.[6] (Hrg. Trans., pp. 66-67, 69-70; Ex. 10)

32. Schmor did not watch Staver type in the number 20 when he put the tablets in the oxycodone drawer. Had Schmor seen that Staver entered a number which was incorrect, he would have re-accessed the drawer and fixed the inventory count. (Hrg. Trans., p. 70)

33. Staver was the very next person to access that drawer for oxycodone. At 1:23 p.m. on that same date, only seven minutes after the re-stock by Schmor and Staver, Staver accessed that same drawer in Cart 1 for oxycodone under Patient L.H.'s name. Staver had to perform a physical count of the number of tablets in the drawer and enter the correct number into the computer. The medication dispensing machine computer record reflects that Staver then removed

[6] Prior to the re-stock, the beginning computer inventory was 57 units. After the re-stock, the computer inventory changed from 57 units to 77 units when, in fact, the ending count should have been 87. (Ex. 10)

one tablet for the patient, and the inventory amount in the computer changed from 77 to 76. (Hrg. Trans., pp. 71-73; Ex. 12)

34. Staver was the last person to access the oxycodone drawer before the end of shift count at 6:19 p.m. The end of shift count did not result in a discrepancy between the manual and computerized counts. (Ex. 12)

April 28, 2013 re-stock of hydrocodone-acetaminophen

35. On April 28, 2013, pharmacist James Schmor performed a re-stock of hydrocodone-acetaminophen in Cart 1 with Staver as the witness. Schmor first removed 30 tablets of hydrocodone-acetaminophen from the pharmacy and documented that transaction in the perpetual inventory log. (Hrg. Trans., pp. 76-78, 81-82; Exs. 7, 13)

36. Schmor and Staver logged onto the medication dispensing machine computer using the general procedure described above. That procedure involved verifying that the physical inventory (determined by the physical/manual count) matched the computerized inventory amount. (Hrg. Trans., pp. 66-68)

37. The re-stock occurred at 1:14 p.m. at which time Schmor placed 30 tablets in the drawer and, per his routine practice, stated to Staver that he was placing 30 tablets in the drawer. Staver then entered a number into the computer; however, the number entered by Staver was 20, not 30. As a result, the physical inventory no longer matched the computerized inventory. There were ten additional physical tablets in the drawer following the re-stock.[7] (Hrg. Trans., p. 66-67, 77-79; Ex. 10)

38. Schmor did not watch Staver type in the number 20 when he put the tablets in the hydrocodone-acetaminophen 5/325 drawer. Had Schmor seen that Staver entered a number which was incorrect, he would have corrected her and had her enter the corrected quantity. (Hrg. Trans., p. 79)

39. Staver was the very next person to access that drawer for hydrocodone-acetaminophen. At 1:18 p.m. on that same date, only four minutes after the re-stock by Schmor and Staver, Staver accessed that same drawer in Cart 1 for hydrocodone-acetaminophen under Patient K.H.'s name. She then canceled the open drawer. Staver did not immediately re-access the drawer under another patient's name. Staver had to perform a physical count of the number of tablets in the drawer and enter the correct number into the computer. (Hrg. Trans., pp. 71-72, 79-80; Ex. 13)

40. Staver was the last person to access the hydrocodone-acetaminophen drawer before the end of shift count at 6:35 p.m. The end of shift count did not result in a discrepancy between the manual and computerized counts. (Hrg. Trans., p. 80; Ex. 13)

[7] Prior to the re-stock, the computer inventory was 16. After the re-stock, the computer inventory changed from 16 units to 36 units when, in fact, the ending count should have been 46. (Ex. 10)

April 28, 2013 re-stock of oxycodone-acetaminophen

41. On April 28, 2013, Schmor performed a re-stock of oxycodone-acetaminophen in Cart 1 with Staver as the witness. Schmor first removed 30 tablets of oxycodone-acetaminophen from the pharmacy and documented that transaction in the perpetual inventory log. (Hrg. Trans., pp. 81-82; Exs. 9, 14)

42. Schmor and Staver logged onto the medication dispensing machine computer using the general procedure described above. That procedure involved verifying that the physical inventory (determined by the manual count) matched the computerized inventory amount. (Hrg. Trans., pp. 66-68, 82)

43. The re-stock occurred at 1:16 p.m. at which time Schmor placed 30 tablets in the drawer and, per his routine practice, would have stated to Staver that he was placing 30 tablets in the drawer. Staver then entered a number into the computer; however, the number entered by Staver was 20, not 30. As a result, the physical inventory no longer matched the computerized inventory. There were ten additional physical tablets in the drawer following the re-stock.[8] (Hrg. Trans., pp. 66-67, 82-83; Ex. 14)

44. Schmor did not watch Staver type in the number 20 when he put the tablets in the oxycodone/acetaminophen drawer. Had Schmor seen that Staver entered a number which was incorrect, he would have stopped her and had her enter the correct amount. (Hrg. Trans., p. 83)

45. Staver was the very next person to access that drawer for oxycodone-acetaminophen. At 1:17 p.m. on that same date, only one minute after the re-stock by Schmor and Staver, Staver accessed that same drawer in Cart 1 for oxycodone-acetaminophen under Patient L.A.'s name. Staver had to perform a physical count of the number of tablets in the drawer and enter the correct number into the computer. The medication dispensing computer record reflects that Staver then removed one tablet for the patient and the inventory amount in the computer changed from 29 to 28.[9] (Hrg. Trans., p. 71-72, 83-84; Ex. 12)

46. Staver was the last person to access the oxycodone-acetaminophen drawer before the end of shift count at 6:19 p.m. The end of shift count did not result in a discrepancy between the manual and computerized counts. (Ex. 12)

Failure to properly waste and/or document the wasting of a controlled substance

47. Jennifer Reuter is the chief nursing officer at Select Specialty. Her duties include maintaining hospital policy and procedure records. Reuter has been a nurse for 22 years, holding various positions in a supervisory role and as a charge nurse. She has experience in administering and wasting controlled substances. (Hrg. Trans., pp. 93, 97-98)

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[8] Prior to the re-stock, the beginning computer inventory was 9. After the re-stock, the computer inventory changed from 9 units to 29 units when, in fact, the ending count should have been 39. (Ex. 14)

[9] In fact, the physical inventory was changing from 39 to 28. Therefore, Staver removed 11 tablets, not 1 tablet.

48. At Select Specialty, the hospital policy requires that controlled substances which are not administered must be wasted or returned to the medication dispensing machine. When injectable medications are dispensed and later determined not to be needed by the patient, the injectable medication cannot be returned to the machine. It must be wasted with a second nurse as a witness. (Hrg. Trans., pp. 99-101; Exs. 1, 5)

49. Reuter testified that this policy also represents what the standard of care requires of nurses. (Hrg. Trans., p. 104)

50. Hydromorphone (brand name Dilaudid) is an injectable medication and was available in a two mg. dose at Select Specialty. There are two mg. of medication in one ml. of injectable liquid. In order to administer 0.5 mg. of hydromorphone to a patient, a provider would be required to waste 0.75 ml. of liquid medication. When a provider wastes a portion of an injectable medication, the wasting is recorded in the medication dispensing machine as a "WST" entry. (Hrg. Trans., pp. 107, 109-110; Ex. 21)

51. On March 2, 2013, Staver removed two mg. of hydromorphone from medication dispense Cart 1 for Patient H.J. Staver then administered 0.5 mg. of the hydromorphone to Patient H.J. as documented in the patient's medical records. Staver should have wasted the remaining 0.75 ml. of hydromorphone, but there is no indication that she either wasted or returned the remaining amount of hydromorphone. (Hrg. Trans., pp. 110-113; Ex. 19, p. 33; Ex. 21, p. 4 of 35)

52. On March 3, 2013, Staver removed two mg. of hydromorphone from medication dispense Cart 1 for Patient H.J. Staver did not document that she administered any hydromorphone to Patient H.J. Staver should have wasted the entire amount of hydromorphone, but there is no indication that she did so. (Hrg. Trans., pp. 114-115, Ex. 19, pp. 39-40; Ex. 21, p. 6 of 35)

53. On March 28, 2013, Staver removed two mg. of hydromorphone from medication dispense Cart 2 for Patient T.S. Staver then administered 0.5 mg. of the hydromorphone to Patient T.S. as documented in the patient's medical records. Staver should have wasted the remaining 0.75 ml. of hydromorphone, but there is no indication that she either wasted or returned the remaining amount of hydromorphone. (Ex. 19, p. 30; Ex. 21, p. 14 of 15; Hrg. Trans., pp. 116-117)

54. Reuter testified that with respect to each of these occurrences involving hydromorphone, Staver's failure to properly waste the remaining medication, or her failure to document if she did waste the remainder, is a departure from the standard of care for a registered nurse. (Hrg. Trans., pp. 113-114, 115, 117)

Controlled substances at issue

55. Pursuant to Wis. Stat. § 961.16(2)(a)11. (2011-2012), oxycodone is a schedule II controlled substance for which, under the circumstances at issue, a prescription is required pursuant to Wis. Stat. § 961.38.

56. Pursuant to Wis. Stat. § 961.18(5)(c) and (d) (2011-2012), hydrocodone is a schedule III controlled substance[10] for which, under the circumstances at issue, a prescription is required pursuant to Wis. Stat. § 961.38.

57. Pursuant to Wis. Stat. § 961.16(2)(a)8. (2011-2012), hydromorphone is a schedule II controlled substance for which, under the circumstances at issue, a prescriptions is required under Wis. Stat. § 961.38.

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).

Violation of Wis. Stat. § 441.07(1)(c) and (d) and Wis. Admin. Code §§ N 7.04(2) and 7.03(1)(b)

Pursuant to Wis. Stat. § 441.07(1), the Board may take disciplinary action against a registered nurse if the Board determines that the registered nurse has committed "[a]cts which show the registered nurse . . . to be unfit or incompetent by reason of negligence," Wis. Stat. § 441.07(1)(c), or "[m]isconduct or unprofessional conduct." Wis. Stat. § 441.07(1)(d). In the instant case, the Division alleges both "misconduct or unprofessional conduct" and negligence.

Misconduct or Unprofessional Conduct

Wisconsin Admin. Code § N 7.04 defines "misconduct or unprofessional conduct" as "any practice or behavior which violations the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient or the public," and includes "[a]dministering, supplying or obtaining any drug other than in the course of legitimate practice or as otherwise prohibited by law."

A preponderance of the evidence shows that Staver obtained drugs other than in the course of legitimate practice or as otherwise prohibited by law.

The evidence shows that Staver removed controlled substance medications from a medication dispensing machine on five occasions without a legitimate reason for doing so. Each

[10] In some circumstances, hydrocodone can also be a schedule II controlled substance. *See* Wis. Stat. § 961.16(2)(a)7. However, the testimony at hearing was that the substance at issue here was a schedule III controlled substance, but that by federal law, all hydrocodone was being moved to a schedule II controlled substance a month from hearing. (Hrg. Trans., p. 12)

of those five occasions was immediately preceded by a re-stocking of the same medications and by Staver entering the wrong count into the computer.

In all five of the re-stock transactions, ten units of medication were diverted. Staver was the person responsible for typing in the number of medication units being added to the drawer and, in all five transactions, she typed in a number that was exactly ten units less than what the pharmacists communicated to her. The pharmacists' testimony regarding the amounts they communicated to Staver was confirmed by the perpetual inventory log, in which the pharmacists entered the number they communicated to Staver, an amount exactly ten more than that which Staver entered into the computer. Monthly audits also confirmed the amounts of controlled substances the pharmacists testified they removed from the pharmacy, which they documented in the perpetual inventory log and communicated to Staver.

Following all five transactions, Staver was the very next provider to access the medication drawer for which she had entered the incorrect number. On all five occasions, Staver re-accessed the drawers within a few minutes. Notably, Staver was required to perform a physical count to access the drawers and was the only person who knew that the physical count in the drawer was ten more than what was in the computer inventory. She was the only person to know that the number to enter into the computer for the precount was not the number of physical units in the drawer; rather, it was exactly ten less than that physical number in the drawer.

Moreover, on several of those occasions when Staver accessed the drawers, she just canceled the open drawers. Staver did not immediately re-access the drawers under another patient's name, which would have been expected had she accidentally accessed the drawers under the wrong patient's name. Only Staver had the knowledge which allowed her to re-access the drawers and remove the ten extra tablets, leaving a physical inventory count that would match the computer inventory and not alert anyone to a discrepancy.

All of the evidence leads to the conclusion that on each of these occasions, Staver took ten units of controlled substances for an unauthorized purpose. Staver presented no evidence or credible argument rebutting the substantial and credible evidence presented by the Division. No evidence was presented indicating that anyone else diverted these medications, nor did Staver present any other explanation for the discrepancies between the amounts entered into the perpetual inventory log and the amounts she entered into the computer while assisting with re-stocking.

The evidence pointing to Staver's diversion of these substances is further supported by the security protocols which were in place at Select Specialty to ensure that an accurate inventory of controlled substances is maintained by the pharmacy. A failure by the three pharmacists to maintain and accurate inventory and keep the medications secure could invite investigation by the federal government (DEA) and could result in consequences to the hospital and to the pharmacists themselves, who each hold a professional license in Wisconsin. The professionalism of the pharmacists was evident during their testimony, as was their credibility.

All three pharmacists adhered to the policies and procedures for removing medications from the pharmacy inventory and re-stocking the medication carts.

It logically flows from the abundance of evidence that Staver diverted oxycodone and hydrocodone, schedule II and III controlled substances, for which a prescription is required. Such diversion was not within the course of legitimate practice and therefore constituted "misconduct or unprofessional conduct" pursuant to Wis. Stat. § 441.07(1)(d) and Wis. Admin. Code § N 7.04.

Negligence

Wisconsin Admin Code § N 7.03(1)(b) defines negligence as used in Wis. Stat. § 441.07(1)(c) as "a substantial departure from the standard of care ordinarily exercised by a competent licensee," and includes "[a]n act or omission demonstrating a failure to maintain competency in practice and methods of nursing care."

A preponderance of the evidence shows that on three occasions in March of 2013, Staver either failed to waste hydromorphone or failed to document that she had wasted it. I find persuasive Nurse Reuter's testimony that either of these actions is below the standard of care required of registered nurses. Hydromorphone is a schedule II controlled substance and is highly addictive. Select Specialty had appropriate policies in place to ensure that only those authorized to use such a substance could do so and that any unused amounts would be wasted and thereby inaccessible. Failing to do so or failing to document when one has done so is below the standard of minimal competency for a registered nurse.

Discipline

Because Staver has engaged in negligence and misconduct or unprofessional conduct, she is subject to discipline pursuant to Wis. Stat. § 441.07(1).

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).

Staver's conduct in this case demonstrates a clever scheme to divert medications. She attempted to divert by entering false information into the computer database regarding the number of medication units in the drawer. Although there was no evidence presented at trial to show either that Staver was impaired or that she was taking the medications herself, the evidence clearly showed that Staver was the person who diverted the medications. Diverting medications violates a fundamental duty with which every nurse is entrusted: the responsible handling of controlled substances that they have access to by virtue of their professional licenses. Regardless of whether Staver diverted the medications for her personal use, for the use of family members or friends or for selling on the street, she has demonstrated that she cannot be trusted with the privilege of handling these medications.

In addition, despite her acumen in deceiving the medication dispensing machine computer, Staver failed to demonstrate even the most basic level of competency in keeping track of the proper wasting of controlled substances in the medication dispensing machine. On three occasions, Staver removed two mg. of injectable hydromorphone from the medication dispensing machine and then failed to either properly waste the medication or failed to properly document in the medication dispensing computer that she had properly wasted the hydromorphone.

The Division requests that an order be issued reprimanding Staver and limiting her license for a two-year period, as set forth more fully in the Order section below, to require drug monitoring; abstention from controlled substances; a prohibition on work in settings where Staver would have access to controlled substances; and education courses on documentation, medication errors, and professionalism and ethics.

Under the circumstances set forth above and applying the *Aldrich* factors, I adopt the Division's recommendation. This discipline serves to rehabilitate Staver, protects patients and other members of the public from unauthorized diversion and mishandling of controlled substances and deters others from engaging in such conduct.

Costs

The Division has the authority to assess costs pursuant to Wis. Stat. § 440.22. With respect to imposition of costs, factors to consider include: (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 cooperation of the Staver; (5) any prior discipline; and (6) the fact that the Department is a program revenue agency, funded by other licensees. *See In the Matter of Disciplinary Proceedings against Elizabeth Buenzli-Fritz,* Order No. LS0802183CHI (Aug. 14, 2008).

The Division has requested imposition of the full costs of these disciplinary proceedings on Staver. However, under application of the factors set forth in *Buenzli-Fritz*, imposition of 80 percent of the costs on Staver is warranted.

With regard to the first factor, two counts were charged, contested and proven. These charges were extremely serious and involved a deliberate, intentional and somewhat intricate plan to divert highly addictive controlled substances from an employer on multiple occasions. In addition, on several occasions, Staver also failed to waste another highly addictive controlled substance, hydromorphone, or she failed to document that she did so.

The level of discipline sought by the Division is a reprimand, on the lower end of the discipline spectrum, although the recommended limitations on Staver's license, and adopted in this case, are rigorous. Regarding the fourth and fifth factors, Staver has cooperated fully in these proceedings and has no prior discipline. Operating in the Division's favor, however, is the fact that any costs which Staver does not pay for these proceedings will be indirectly imposed on nurses who have not engaged in such negligence and misconduct.

Based on the foregoing, Staver is required to pay 80 percent of the costs of these disciplinary proceedings.

CONCLUSIONS OF LAW

1. The Division met its burden of establishing by a preponderance of the evidence that Staver engaged in negligence and misconduct or unprofessional conduct, in violation of Wis. Stat. § Wis. Stat. § 441.07(1)(c) and (d) and Wis. Admin. Code §§ N 7.03(1)(b) and 7.04(2).

2. The discipline set forth in the Order section below is warranted pursuant to the facts of record and the factors delineated in *Aldrich.*

3. Imposition of 80 percent of the costs of these proceedings on Staver is warranted under the Department's prior decision in *Buenzli-Fritz*.

ORDER

For the reasons set forth above, IT IS ORDERED that:

1. Respondent Robin J. Staver, R.N., is REPRIMANDED.

2. The professional nursing license issued to Robin J. Staver, R.N. (license number 125316-30) to practice nursing in the State of Wisconsin, and her privilege to practice in Wisconsin pursuant to the Nurse Licensure Compact, is LIMITED as follows:

a. For a period of at least two years from the date of this Order:

i. Staver shall enroll and participate in a drug monitoring program which is approved by the Department (Approved Program).

ii. At the time Staver enrolls in the Approved Program, Staver shall review all of the rules and procedures made available by the Approved Program. Failure to comply with all requirements for participation in drug monitoring established by the Approved Program is a substantial violation of this Order. The requirements shall include:

1. Contact with the Approved Program as directed on a daily basis, including vacations, weekends and holidays.

2. 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.

3. 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, Staver 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.

iii. Staver 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. Staver shall disclose her drug history and the existence and nature of this Order to the practitioner prior to the practitioner ordering the controlled substance. Staver 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 Staver's treatment with, and provide copies of treatment records to, the Board or its designee. Copies of these releases shall immediately be filed with the Department Monitor.

iv. Staver shall report to 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, Staver shall immediately arrange for the prescriber or pharmacy to fax and mail copies of all prescriptions to the Department Monitor.

v. Staver 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, create false positive screening results, or interfere with Staver's treatment and rehabilitation, shall not be taken unless ordered by a physician, in which case the drug must be reported as described in the paragraph 2(a)iv.

vi. All positive test results are presumed valid and may result in automatic suspension of licensure by the Board or the Board's designee. Staver must prove by a preponderance of

the evidence an error in collection, testing, fault in the chain of custody or other valid defense.

vii. If any urine, blood, sweat, fingernail, hair, saliva or other specimen is positive or suspected positive for any controlled substances or alcohol, Staver 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. Staver shall provide her nursing employer with a copy of this Order before engaging in any nursing employment.

viii. Staver shall not work as a nurse or other health care provider in a setting in which she has access to controlled substances.

3. Pursuant to Uniform Nurse Licensure Compact regulations, Staver's nursing practice is limited to Wisconsin during the pendency of this limitation. This requirement may be waived only upon the prior written authorization of both the Wisconsin Board of Nursing and the regulatory board in the state in which Staver proposes to practice.

4. The Board or its designee may, without hearing, suspend Staver's nursing license upon receipt of information that Staver is in substantial or repeated violation of any provision 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 violations of the same provision or violation of more than one provision.

5. Staver shall provide her nursing employer with a copy of this Order before engaging in any nursing employment.

6. After two years from the date of this Order, Staver may petition the Board for the modification or termination of this limitation. The Board may grant or deny the petition, in its discretion, or may modify this Order as it sees fit.

7. Staver's license and her privilege to practice in Wisconsin pursuant to the Nurse Licensure Compact are further LIMITED as follows:

a. Within 90 days of the date of this Order, Staver shall at her own expense, successfully complete five hours of education on the topic of documentation; six hours of education on medication errors; and three hours on the topic of professionalism and ethics in nursing offered by a provider pre-approved by the Board's monitoring liaison, including taking and passing any exam offered for the courses.

b. Staver 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 below. 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, and also may not be used in future attempts to upgrade a credential in Wisconsin.

c. This limitation shall be removed from Staver's license after satisfying the Board or its designee that she has successfully completed all of the ordered education.

8. Request of approval of courses and proof of successful course completion shall be sent by Staver to the Department Monitor at the address below:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190
Madison, WI 53707-7190

9. Staver shall pay 80 percent of the 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 the address set forth in the preceding paragraph.

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

Dated at Madison, Wisconsin on December 18, 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