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Before the
State Of Wisconsin
Board of Nursing

In the Matter of Disciplinary Proceedings Against
Nicole A. Hunt, R.N., Respondent

FINAL DECISION AND ORDER

Order No. 0004125

Division of Legal Services and Compliance Case No. 15 NUR 276

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 8th day of October, 2015.

Cheryl Krause
Member
Board of Nursing

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against Nicole A. Hunt, R.N., Respondent	DHA Case No. SPS-15-0064 DLSC Case No. 15 NUR 276

PROPOSED DECISION AND ORDER

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

Nicole A. Hunt, R.N.
625 South 15th Street
Sheboygan, WI 53081

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

These proceedings were initiated when the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), filed a formal Complaint against Respondent Nicole A. Hunt, R.N. (Respondent), alleging that Respondent had engaged in five counts of negligence and misconduct or unprofessional conduct.[1] Respondent did not file an Answer to the Complaint.

[1] The five counts are as follows: (1) Engaging in negligence by "a substantial departure from the standard of care ordinarily exercised by a competent licensee," Wis. Admin. Code § N 7.03(1); (2) Engaging in negligence by "[a]n act or omission demonstrating a failure to maintain competency in practice and methods of nursing care," Wis. Admin. Code § N 7.03(1)(b); (3) "[P]racticing nursing while under the influence of alcohol, illicit drugs, or while impaired by the use of legitimately prescribed pharmacological agents or medications," Wis. Admin. Code § N 7.03(6)(e); (4) "[A]fter a request of the board, failing to cooperate in a timely manner with the board's investigation of a complaint filed against a license holder," Wis. Admin. Code § N 7.03(1)(c); and (5) "[O]btaining, possessing or attempting to obtain or possess a drug without lawful authority," Wis. Admin. Code § N 7.03(8)(e). Counts one and two reference Wis. Admin. Code § 7.03 as it existed before August 1, 2014.

On August 6, 2015, the undersigned Administrative Law Judge (ALJ) issued a Notice of Telephone Prehearing Conference which set a telephone prehearing conference for August 18, 2015. Respondent failed to appear at the prehearing conference, whereupon the Division moved for default judgment based on Respondent's failure to appear and her failure to file an Answer to the Complaint.

On August 18, 2015, the ALJ issued a Notice of Default and Order against Respondent and ordered that the Division file a recommended proposed decision and order. On August 28, 2015, the Division timely filed its submission.

FINDINGS OF FACT

Facts Related to the Alleged Violations

Findings of Fact 1-19 are taken from the Division's Complaint against Respondent filed in this matter.[2]

1. Respondent Nicole A. Hunt, R.N. (D.O.B. May 8, 1982), is licensed in the State of Wisconsin as professional nurse, having license number 147603-30, first issued on June 17, 2004 and current through February 29, 2016.

2. Respondent's most recent address on file with the Department is 435 ½ East Main Street, Plymouth, Wisconsin 53073.

3. Patient B is a four year-old ventilator dependent child who was one of Respondent's pediatric patients in July 2014. Respondent provided in-home nursing care for Patient B in Fond Du Lac, Wisconsin.

4. On July 11, 2014, Respondent was in Patient B's home providing in-home nursing care while Patient B's mother was out of the home. The mother had to leave the home for a doctor's appointment and left her daughter alone with Respondent for one and a half hours, returning home around 3:30 p.m. When Patient B's mother returned, she found Respondent passed out on her couch, with her bra hanging over the chair and paperwork spread about. The mother was unable to wake Respondent and found her daughter sleeping in her room, not hooked up to her pulse oximeter. Patient B's mother made several attempts to wake Respondent, but was unsuccessful.

5. During this time, Patient B's mother had to suction her daughter. The noise from the suctioning did not wake Respondent. At approximately 6:30 p.m., Respondent finally woke up.

6. Patient A is a tracheostomy and ventilator dependent child who was one of Respondent's pediatric patients in February 2015. Respondent provided in-home nursing care for Patient A at the patient's residence in Little Chute, Wisconsin.

[2] The Findings of Fact in the Division's recommended proposed decision and order (PDO) do not entirely track the facts as set forth in its Complaint. Specifically, "Patient A" in the Complaint is "Patient B" in the recommended PDO and "Patient B" in the Complaint is "Patient A" in the recommended PDO. Also, paragraph 9 in the Complaint is paragraph 5 in the recommended PDO, which simply corrects a placement error in the Complaint. This decision refers to the two patients as they were referred to in the Complaint, moves paragraph 9 in the Complaint to paragraph 5, renumbers paragraphs 5-9 accordingly, and makes minor clarifying edits.

7. On February 7, 2015, Respondent presented to Patient A's residence to provide nursing cares while the patient's parents went to an appointment outside the home. A second professional nurse was in the home at the time, providing home nursing care for Patient A's sibling on that date.

8. Respondent told the second professional nurse that she was going to go outside to smoke a cigarette. When Respondent came back in a short time later, her eyes were "squinty and bloodshot." Respondent placed her bag on the table and when she moved the bag, the other professional nurse noticed a "skunky" odor from the bag. Respondent then proceeded to provide nursing care for Patient A until the parents returned approximately an hour later.

9. When Patient A's parents returned home, Respondent was trying to hide her eyes from the patient's mother and was talking slowly. The second professional nurse informed the patient's mother that during the time that the parents were absent from their home, Respondent smoked marijuana on the front porch and then returned to provide care for Patient A.

10. On May 21, 2015, Department Investigator Tiffany Brussow (Brussow), in the course of her duties as an investigator, contacted Respondent at the email address on file with the Department. In the email, she informed Respondent that she was an investigator with the Department and had been assigned on behalf of the Wisconsin Board of Nursing (Board) to investigate a complaint made against her by Patient A's mother. Brussow asked that Respondent provide a couple dates and times in the first two weeks in June that she could meet with Brussow at the Department for an interview.

11. As of the date of the Division's Complaint, Respondent had not replied to Brussow's email.

12. On May 22, 2015, Brussow attempted to contact Respondent at the phone number on file with the Department. Respondent did not answer the phone. The voicemail recording identified the number as belonging to "Nicole." Brussow left a voicemail for Respondent indicating that she was an investigator with the Department and had been assigned on behalf of the Board to investigate a complaint made against her. Brussow indicated that she had sent an email the previous day and needed to hear back from her regarding dates and times that she could present herself to the Department for an interview. Brussow informed Respondent that she would be out of the office the following week, but expected her to leave a voicemail or email with proposed dates by the time Brussow returned to the office on June 1, 2015.

13. As of the date of the Division's Complaint, Respondent had not returned Brussow's phone call.

14. On June 4, 2015, Brussow sent a subpoena via certified mail to Respondent's address on file with the Department. This subpoena was signed by Division Attorney, Kim Kluck, and required Respondent's appearance at the Department on June 15, 2015, at 10:30 a.m.

15. Respondent did not show up for the investigative interview on June 15, 2015 at the Department.

16. On June 17, 2015, Brussow attempted to contact Respondent at the phone number on file with the Department. Respondent did not pick up the phone. The voicemail recording identified the number as belonging to "Nicole." Brussow left a voicemail for Respondent indicating that she had attempted to reach her by phone and by email and had sent a subpoena to her address on file. Brussow informed her that she failed to show up to the Department for the subpoenaed interview. Brussow asked that she call her back and propose dates and times that she could present herself to the Department for an interview.

17. As of the date of the Division's Complaint, Respondent had not returned Brussow's call.

18. On October 9, 2014, in Sheboygan County, Wisconsin, a sheriff's deputy made contact with Respondent on State Highway 32. The deputy conducted a search of Respondent's vehicle which revealed a glass pipe which had the odor of burnt marijuana. Respondent was charged with possession of drug paraphernalia, in violation of Wis. Stat. § 961.573(1), in Sheboygan County case number 2014CM941.

19. On January 29, 2015, Respondent pled guilty to one count of possession of drug paraphernalia, in violation of Sheboygan County Ord. § 38.21, in Sheboygan County case number 2014CM941.

Facts Related to Default

20. The Complaint and Notice of Hearing in this matter were served on Respondent on July 17, 2015, by both certified and regular mail, consistent with Wis. Admin. Code § SPS 2.08. The Notice of Hearing instructed Respondent: "If you do not provide a proper Answer within 20 days, you will be found to be in default and a default judgment may be entered against you on the basis of the Complaint and other evidence. In addition, the Board may take disciplinary action against you and impose the costs of the investigation, prosecution and decision of this matter upon you without further notice or hearing."

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

22. Following expiration of the 20-day time period to file an Answer, the ALJ scheduled a telephone prehearing conference for August 18, 2015. Notice of this prehearing conference was sent to both parties, with instructions that Respondent provide the ALJ with a telephone number at which she could be reached for the conference no later than August 13, 2015. The Notice instructed Respondent: "The Respondent's failure to appear at a scheduled conference or hearing may result in default judgment being entered against the Respondent."

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

24. On August 18, 2015, the prehearing conference was held. Respondent did not appear. The Division moved for default pursuant to Wis. Admin. Code § SPS 2.14 and Wis. Admin. Code § HA 1.07(3)(c). The ALJ granted the motion for default.

25. On August 18, 2015, the ALJ issued a Notice of Default and Order which required the Division to file and serve no later than September 1, 2015 a recommended proposed decision and order.

26. The Division timely filed its recommended proposed decision and order.

27. Respondent did not file a response to the Notice of Default or to the Division's recommended proposed decision and order.

DISCUSSION AND CONCLUSIONS OF LAW

Default

As stated in the August 18, 2015 Notice of Default and Order, Respondent is in default for failing to file an Answer to the Complaint and failing to appear at the prehearing conference held on August 18, 2015. As a result, an order may be entered against her on the basis of the Complaint and other evidence. *See* Wis. Admin. Code § SPS 2.14; Wis. Admin. Code § HA 1.07(3)(b) and (c).

Violations of Wisconsin Statute and Administrative Code

Following an investigation and disciplinary hearing, the Wisconsin Board of Nursing (Board) may revoke, limit, or suspend the license of a registered nurse if the Board determines that the nurse has committed any of the following:

> . . .
>
> (b) One or more violations of this subchapter or any rule adopted by the board under the authority of this subchapter.
>
> (c) Acts which show the registered nurse . . . to be unfit or incompetent by reason of negligence, abuse of alcohol or other drugs or mental incompetency.
>
> (d) Misconduct or unprofessional conduct

Wis. Stat. § 441.07(1g)(b)(c) and (d) (formerly numbered as Wis. Stat. § 441.07(1)(b), (c) and (d) (2011-2012)).

Prior to amendments to Wis. Admin. Code § N 7.03(1) effective August 1, 2014, negligence was defined as "a substantial departure from the standard of care ordinarily exercised by a competent licensee," and included "[a]n act or omission demonstrating a failure to maintain competency in practice and methods of nursing care." Wis. Admin. Code § N 7.03(1)(b).

Respondent engaged in negligence as defined by Wis. Admin. Code § N 7.03(1)(b) on July 11, 2014, when she passed out on a sofa for approximately three hours while providing in-home nursing care to Patient B while Patient B's mother was out of the home; failed to hook up Patient B's pulse oximeter; and did not awaken, despite several attempts by Patient B's mother and despite the noise produced by the suctioning performed on Patient B by her mother.

As a result of this violation,[3] Respondent is subject to discipline pursuant to Wis. Stat. § 441.07(1)(c) and (d) (2011-2012).

Respondent also violated Wis. Admin. Code § N 7.03(6)(e), which prohibits "practicing nursing while under the influence of alcohol, illicit drugs, or while impaired by the use of legitimately prescribed pharmacological agents or medications."

On February 17, 2015, Respondent went to the home of another one of her patients, Patient A, who was a tracheostomy and ventilator dependent child, while Patient A's parents went to an appointment outside the home. A second professional nurse who was in the home at the time noticed that when Respondent returned from a purported cigarette break outside, her eyes were "squinty and bloodshot" and that a "skunky" odor came from Respondent's bag. Respondent then proceeded to provide nursing care for Patient A until the parents returned approximately an hour later. Respondent attempted to hide her eyes from the patient's mother and was talking slowly. The second professional nurse informed the patient's mother that Respondent had smoked marijuana on the front porch and then returned to provide care for Patient A.

Further, Respondent violated Wis. Admin. Code § N 7.03(1)(c), which prohibits "failing to cooperate in a timely manner with the board's investigation of a complaint filed against a license holder" after a request of the Board.

On numerous occasions from May 21 to June 17, 2015, Investigator Brussow contacted Respondent by email and telephone, informing Respondent that she was investigating a complaint made by Patient A's mother and that Respondent should contact her to set up a meeting. Investigator Brussow also sent a subpoena to Respondent, setting a meeting for June 15, 2015. Respondent did not contact Investigator Brussow and did not appear for the June 15, 2015 interview.

Finally, Respondent violated Wis. Admin. Code § N 7.03(8)(e), which prohibits; "obtaining, possessing or attempting to obtain or possess a drug without lawful authority," Not only did Respondent smoke marijuana while providing in-home care to Patient A in February of 2015, but she was also convicted on January 29, 2015 of possession of drug paraphernalia for possessing a marijuana pipe.

As a result of these violations, Respondent is also subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b), (c) and (d).

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).

[3] In its Complaint, the Division alleges that this conduct constitutes two violations, a violation of the general definition of negligence found in Wis. Admin. § N 7.03, and a violation of the more specific example contained in § N 7.03(1)(b). I conclude that this conduct may constitute only one violation, and that it falls within the description of negligence contained in Wis. Admin. Code § N 7.03(1)(b).

The Department requests imposition of the Board's standard impairment order, set forth in the Order section below, which includes an indefinite suspension of Respondent's license and a five-year period of monitoring and AODA treatment, following which the Board may grant a petition for a return of full licensure. The impairment order also prohibits working as a home-care nurse and in other settings where there is no supervision. It further provides the opportunity for a stay of the suspension after a period of time, if the Board, in its discretion, deems such action appropriate.

This discipline is consistent with prior discipline imposed by the Board for conduct in which a nurse engaged in the unauthorized use of drugs, or uses alcohol or drugs to the extent that such use impairs the ability to safely and reliably practice. *See e.g., In the Matter of Disciplinary Proceedings Against Brian J. Reynolds, R.N.*, Order No. 0002520 (July 11, 2013); *In the Matter of Disciplinary Proceedings Against Michael Duane Polivka, R.N.,* Order No. LS0702021NUR (April 19, 2007); *In the Matter of Disciplinary Proceedings Against Denise F. Linder, R.N.*, Order No. 0511141NUR (Mar. 9, 2006); *In the Matter of Disciplinary Proceedings Against Shannon L. Deptula, R.N.*, Order No. Unknown (Jan. 26, 2006).

Moreover, the discipline requested is appropriate here. The underlying conduct demonstrates that Respondent's use of illicit drugs has affected her ability to safely and reliably practice nursing, as evidenced by the fact that she was found non-responsive while working with a ventilator dependent child and used marijuana while working with another in-home patient. In addition, Respondent has been convicted of possession of drug paraphernalia for possessing a glass pipe which had the odor of burnt marijuana. Respondent's refusal to cooperate in the investigation and these proceedings demonstrates a lack of appreciation of her misconduct and a refusal to accept responsibility for her actions.

At this time, the only way to protect the public is by indefinitely suspending Respondent's license to practice and requiring her to undergo significant drug treatment and monitoring as outlined below. After three months of compliance with all terms of the order, Respondent can petition the Board for a stay of the suspension. This would serve to rehabilitate Respondent and show the Board that Respondent is working with substance abuse treaters and does not pose a risk to patients. Such discipline also serves to deter others from engaging in such unsafe nursing practices.

Costs

The Department has the authority to assess costs pursuant to Wis. Stat. § 440.22. *See also Noesen v. State Department of Regulation & Licensing, Pharmacy Examining Board.*, 2008 WI App 52, ¶¶ 30-32, 311 Wis. 2d 237, 751 N.W.2d 385 (Board may, in its discretion, "assess all or part of the costs of the proceeding" against licensee if Board takes disciplinary action). The factors to be considered in assessing full costs are: (1) the number of counts charged, contested, and proven; (2) the nature and seriousness of the misconduct; (3) the level of discipline sought by the parties; (4) the respondent's cooperation with the disciplinary process; (5) prior discipline, if any; (6) the fact that the department is a "program revenue" agency, whose operating costs are funded by the revenue received from credentials, and the fairness of imposing the costs of disciplining a few members of the profession on the vast majority of the credential holders 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 Respondent be ordered to pay the full costs of its investigation and of these proceedings. This outcome is appropriate. The factual allegations were deemed admitted and proven and there is no argument to apportion any counts that were unproven, or that certain factual findings were investigated and litigated that were unnecessary. Respondent's violations were serious. Her drug use and impaired behavior while working as a nurse demonstrate a total disregard for patient safety. Respondent's drug use has resulted not only in a failure to fulfill her nursing duties, but has also led to a criminal conviction. In addition, Respondent has failed to cooperate in any way with the Department's investigation or with these proceedings. Finally, given the fact that the Department is a "program revenue" agency, whose operating costs are funded by the revenue received from licensees, fairness dictates imposing the costs of disciplining Respondent upon Respondent and not fellow members of the nursing profession who have not engaged in such misconduct.

ORDER

Accordingly, IT IS ORDERED that the professional nursing license issued to Respondent Nicole A. Hunt, R.N. (license number 147603-30), is SUSPENDED as follows:

SUSPENSION

A.1. Respondent's license to practice as a nurse in the State of Wisconsin is SUSPENDED for an indefinite period.

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

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

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

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

STAY OF SUSPENSION

B.1. The suspension of Respondent's Wisconsin nursing license may not be stayed for a period of at least one year. After that time, the Board, in its discretion may stay the

suspension, upon Respondent petitioning the Board and providing proof, which is determined by the Board or its designee to be sufficient, that Respondent is in compliance with the provisions of Sections C and D of this Order.

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

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

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

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

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

CONDITIONS AND LIMITATIONS
Treatment Required

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

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

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

C.4. The rehabilitation program shall include individual and/or group therapy sessions at a frequency to be determined by Treater. Therapy may end only with the approval of the

Board or its designee, after receiving a petition for modification as required by D.5., below.

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

Releases

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

AA/NA Meetings

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

Sobriety

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

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

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

C.11. Respondent shall report to Treater and the Department Monitor all prescription medications and drugs taken by Respondent. Reports must be received within 24 hours

of ingestion or administration of the medication or drug, and shall identify the person or persons who prescribed, dispensed, administered or ordered said medications or drugs. Each time the prescription is filled or refilled, Respondent shall immediately arrange for the prescriber or pharmacy to fax and mail copies of all prescriptions to the Department Monitor.

C.12. Respondent shall provide the Department Monitor with a list of over-the-counter medications and drugs that 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 Respondent's treatment and rehabilitation, shall not be taken unless ordered by a physician and approved by Treater, in which case the drug must be reported as described in paragraph C.11.

Drug and Alcohol Screens

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

C.14. At the time Respondent enrolls in the Approved Program, Respondent shall review all of the rules and procedures made available by the Approved Program. Failure to comply with all requirements for participation in drug and alcohol monitoring established by the Approved Program is a substantial violation of this Order. The requirements shall include:

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

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

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

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

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

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

Practice Limitations

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

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

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

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

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

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

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

MISCELLANEOUS

Department Monitor

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

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190, Madison, WI 53707-7190
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

Required Reporting by Respondent

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

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

Change of Treater or Approved Program by Board

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

Petitions for Modification of Limitations or Termination of Order

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

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

IT IS FURTHER ORDERED that Respondent shall pay all recoverable costs in this matter in an amount to be established, pursuant to Wis. Admin. Code § SPS 2.18. After the amount is established, payment shall be made by certified check or money order payable to the Wisconsin Department of Safety and Professional Services and sent to:

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

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

Dated at Madison, Wisconsin on September 11, 2015.

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