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Before the
State Of Wisconsin
Board of Nursing

In the Matter of Disciplinary Proceedings Against
Jana L. Blair, R.N., Respondent

FINAL DECISION AND ORDER

Order No. 0004804

Division of Legal Services and Compliance Case No. 15 NUR 416

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 14th day of July, 2016.

Member
Board of Nursing

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against Jana L. Blair, R.N., Respondent	DHA Case No. SPS-16-0029 DLSC Case No. 15 NUR 416

PROPOSED DECISION AND ORDER

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

Jana L. Blair, R.N.
9567 Maple Way
Indianapolis, IN 46268-3280

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 Amanda L. Florek
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 Jana L. Blair, R.N., alleging that Respondent engaged in four counts of unprofessional conduct[1] and violated Wis. Stat. § 440.11(1) by failing to update her

[1] The four counts are as follows: (1) "[f]ailing to perform nursing with reasonable skill and safety," Wis. Admin. Code § N 7.03(6)(a); (2) "[d]eparting from or failing to conform to the minimal standards of acceptable nursing practice that may create unnecessary risk or danger to a patient's life, health, or safety," Wis. Admin. Code § N 7.03(6)(c); (3) "[a]busing a patient by a single or repeated act of force, violence, harassment, deprivation, neglect, or mental pressure which reasonably could cause physical pain, injury, mental anguish, or fear," Wis. Admin. Code § N 7.03(4)(c); (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).

address on file with the Department within 30 days. The Complaint and Notice of Hearing were served on Respondent by both certified and regular mail, consistent with Wis. Admin. Code § SPS 2.08. Respondent failed to file an Answer to the Division's Complaint.

On April 12, 2016, the undersigned Administrative Law Judge (ALJ) issued a Notice of Telephone Prehearing Conference which set a telephone hearing conference for April 21, 2016. Respondent failed to appear at the conference, whereupon the Division moved for default judgment based on Respondent's failure to appear and failure to file an Answer to the Complaint. On April 21, 2016, the ALJ issued a Notice of Default and Order against Respondent and ordered that the Division file a recommended proposed decision and order no later than May 13, 2016. The Division timely filed its submission.

FINDINGS OF FACT

Facts Related to the Alleged Violations

Findings of Fact 1-41 (with the exception of footnote 2) are taken from the Division's Complaint against Respondent filed in this matter.

1. Respondent Jana L. Blair, R.N., (D.O.B. October 13, 1969) is licensed in the State of Wisconsin as a professional nurse, having license number 141786-30, first issued on July 17, 2002.

2. Respondent's license expired on February 29, 2016 and has not been renewed.

3. Pursuant to Wis. Stat. § 440.08(3), Respondent has the right to renew her license upon payment of a fee until February 28, 2021.

4. Respondent's most recent address on file with the Department is 6441 Pizarro Circle, Madison, Wisconsin 53719.

5. Upon the Division's information and belief, Respondent's current address is 9567 Maple Way, Indianapolis, Indiana 46268-3280.[2]

6. Respondent failed to update her address with the Department within 30 days as required by Wis. Stat. § 440.11(1).

7. On June 23, 2015, Respondent was providing overnight in-home care to Patient A. The care took place in Wisconsin.

8. Patient A is paralyzed from the neck down due to muscular dystrophy.

9. Patient A requires regular oral suctioning to remove saliva from his mouth due to his impaired ability to swallow.

[2] The Division's information and belief are further supported by the facts contained in Finding of Fact 43.

10. Patient A also requires as-needed suctioning through his tracheostomy.

11. On June 24, 2015, at approximately 7:00 a.m., Nurse A arrived at Patient A's home to find his feeding pump beeping and his cheeks puffed out.

12. Respondent was not in Patient A's room.

13. Nurse A suctioned out copious amounts of saliva from Patient A's mouth.

14. Patient A informed Nurse A that Respondent had left him alone since approximately 3:00 a.m.

15. Patient A informed Nurse A that Respondent did not come to his aid, even after he called out to her several times.

16. After caring for Patient A, Nurse A found Respondent in a different bedroom asleep on the floor with a pillow and blanket.

17. Nurse A attempted to wake Respondent by calling her name, but Respondent did not respond.

18. Nurse A then touched Respondent; Respondent woke up and left without giving a report to Nurse A or completing her charting.

19. Respondent, by falling asleep and not suctioning out Patient A's mouth, created the unacceptable risk of harm or danger to Patient A's life, health and safety.

20. On June 30, 2015, Respondent sent a threatening Facebook chat message to Patient A which stated the following:

> I can't apologize enough for Tues. night. I take full responsibility for that. BUT--- why on earth are you suddenly slinging all kinds of stupid accusations at me??!! You know damn good & well...I sit next to you, watching movies, playing games...then you sleep. . .
>
> I fucked up on Tues. I left you vulnerable & in danger & I will have a rough time forgiving myself for that. I should have called for help, but I just did not feel physically bad when I came in. If you want to really go after people, I have a ton of scathing info on every nurse there. If you decide to report me, so be it. But, in turn, I will cough up all the info on all the other nurses & you will end up in a nursing home. . .
>
> I apologize one last time. But, you might want to think twice before you go bad-mouthing people who care about you.

21. Respondent, by sending threatening and intimidating messages to Patient A, caused Patient A to experience mental anguish and fear.

22. Approximately one week later, Nurse B texted Respondent to see if Respondent was going to come in and finish her charting for Patient A.

23. Respondent replied that she knew she was terminated and did not see the point.

24. Respondent's employment was terminated from the home health agency.

25. On July 31, 2015, the Department sent a letter to Respondent requesting a response to the allegations.

26. Respondent failed to respond to the letter.

27. On September 16, 2015, Respondent, in an email to a Department investigator, indicated she sent a response to the July 31, 2015 letter.

28. The Department did not receive Respondent's response.

29. Respondent did not provide proof that she sent the letter.

30. Respondent refused to send another response.

31. In the September 16, 2015 email, Respondent also refused to meet with the Department investigator for an interview.

32. On September 17, 2015, Respondent, in an email to a Department investigator, admitted to "lashing out via FB (Facebook) to someone I love."

33. In the September 17, 2015 email, Respondent stated, "Do whatever you feel necessary. Bring on the subpoena, I guess. This is silly. I see no reason for this to have gotten so blown out of proportion."

34. On September 18, 2015, Respondent, in an email to a Department investigator, stated the following:

> [she is] willing to cooperate. . . . But please understand I am also just going to be sure that the license I worked so hard for is not tainted because of a concussion & a bitter, bored, angry little man who has nothing better to do to amuse himself than stirring things up. . . I love him with all my heart, & his life situation is dreadful & so unfair.

35. On September 21, 2015, the Department subpoenaed Respondent to appear at the Department for an investigative interview on October 8, 2015, at 10:00 a.m.

36. On October 8, 2015, Respondent failed to appear for the investigative interview.

37. On October 8, 2015, at 2:35 p.m., Respondent sent an email to the Department investigator stating that she has "nothing more to say about [Patient A's] allegations than I already said."

38. In the October 8, 2015 email, Respondent admitted to falling asleep and to sending some "rotten, inappropriate messages" to Patient A.

39. In the October 8, 2015 email, Respondent further stated that she "saw no reason to waste gas [money] that I don't have to be put under a microscope for something that I have already admitted to."

40. Respondent failed to cooperate in a timely manner with the Board's investigation by failing to provide a written response to the July 31, 2015 letter.

41. Respondent failed to cooperate in a timely manner with the Board's investigation by failing to appear at the Department for an investigative interview pursuant to a subpoena.

Facts Related to Default

42. The Complaint and Notice of Hearing in this matter were served on Respondent on March 23, 2016, 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 twenty (20) days, you will be found 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."

43. The Division mailed the Complaint and Notice of Hearing to the address on file with the Department and 9567 Maple Way, Indianapolis, Indiana 46268-3280, via regular and certified mail. On March 26, 2016, Respondent signed for the Indiana certified mail. All written communications from the Department to Respondent's Madison, Wisconsin address have been returned to the Department by the U.S. Postal Service.[3]

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

45. Following expiration of the 20-day time period to file an Answer, the ALJ scheduled a telephone prehearing conference for April 21, 2016. 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 April 18, 2016. The Notice instructed Respondent: "The Respondent's failure to appear at the scheduled conference or hearing may result in default judgment being entered against the Respondent."

[3] The Division makes this assertion regarding returned mail and Respondent does not dispute it.

46. On April 19, 2016, Respondent provided a telephone number, as required by Wis. Admin. Code § HA 1.07(3)(c).

47. On April 21, 2016, the prehearing conference was held. The ALJ attempted to contact Respondent at the telephone number she had provided but received a recorded message. The ALJ left a voicemail for Respondent indicating that Respondent should contact the ALJ at the telephone number provided, failing which the ALJ would proceed with the conference without Respondent. Respondent did not contact the ALJ. The Division moved for default pursuant to Wis. Admin. Code § SPS 2.14 and Wis. Admin. Code § HA 1.07(3)(c).

48. On April 21, 2016, the ALJ issued a Notice of Default and Order which required the Division to file and serve no later than May 13, 2016, a recommended proposed decision and order.

49. The Division timely filed its recommended proposed decision and order. Respondent did not submit a response to either the ALJ's Notice of Default and Order or to the Division's submission.

DISCUSSION AND CONCLUSIONS OF LAW

Default

As stated in the April 21, 2016 Notice of Default and Order, Respondent is in default for failing to file an Answer to the Complaint and failing to appear at the telephone conference held on April 21 2016. 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, if the Board determines that a nurse has violated subchapter I of Chapter 441 of the Wisconsin Statutes or any rule adopted by the Board under the authority of that subchapter, or that the nurse has engaged in unprofessional conduct, it may reprimand the nurse or may revoke, limit, suspend or deny a renewal of the nurse's license. Wis. Stat. § 441.07(1g)(b) and (d). The phrase, "unprofessional conduct," is defined in Wis. Admin. Code § N 7.03.

Respondent engaged in unprofessional conduct as defined in Wis. Admin. Code § N 7.03(6)(a) by "[f]ailing to perform nursing with reasonable skill and safety." On June 23, 2015, Respondent was working in the home of Patient A, a paralyzed individual. She was the only nurse present during the overnight shift on that date. Respondent's duties included regular oral suctioning to remove saliva from Respondent's mouth due to his impaired ability to swallow. Respondent took a pillow and blanket into a spare room in Patient A's home and fell asleep. Patient A called out to Respondent several times but Respondent did not respond. By falling asleep while on duty as a nurse, Respondent failed to perform critical nursing functions. Furthermore, when Nurse A got to Patient A's home for her shift, she found Patient A with his

cheeks puffed out due to saliva build-up and his feeding pump beeping. Nurse A woke Respondent and Respondent left the home without providing any report or completing her charting. Change in shift reporting and charting are basic nursing functions required to provide continuous care to patients. When Respondent failed to perform these nursing functions, she failed to perform nursing with reasonable skill and safety. Respondent admitted in a message to Patient A that she left him vulnerable and in danger.

Respondent also engaged in unprofessional conduct as defined by Wis. Admin. Code § N 7.03(6)(c) by "[d]eparting from or failing to conform to the minimal standards of acceptable nursing practice that may create unnecessary risk or danger to a patient's life, health, or safety." When Respondent slept, she did not provide any nursing care to Patient A. This is less than minimal nursing care. When Respondent slept in lieu of caring for Patient A, Patient A's cheeks filled with copious amounts of saliva. Respondent did not come to Patient A's aid despite several attempts by Patient A to have Respondent assist him. Patient A experienced significant danger, including the risk of death, because he was reliant on Respondent for his care. Respondent created this risk of harm by her intentional act of going into another room and sleeping during the time she was supposed to provide critical nursing care to Patient A. By Respondent's own statements in messages to Patient A, she left him vulnerable and in danger.

Respondent also engaged in unprofessional conduct as defined by Wis. Admin. Code § N 7.03(4)(c) by "[a]busing a patient by a single or repeated act of force, violence, harassment, deprivation, neglect, or mental pressure which reasonably could cause physical pain, injury, mental anguish or fear." Respondent deprived Patient A of all nursing care during the time she slept, including feeding and suctioning. Patient A became fearful when he was not able to obtain Respondent's nursing assistance. Moreover, Respondent sent several threatening messages to Patient A which caused Patient A to experience anguish and fear. Some of these messages included threats such as, "you will end up in a nursing home."

Respondent further engaged in unprofessional conduct as defined by Wis. Admin. Code § N 7.03(1)(c) by "[a]fter a request of the Board, failing to cooperate in a timely manner, with the Board's investigation of a complaint against a license holder." There is a rebuttable presumption that a credential holder who takes longer with 30 days to respond to a request of the Board has failed to cooperate in a timely manner. *Id.* Respondent failed to respond to the letter for a written response and also failed to appear for a subpoenaed investigative interview at the Department. She even referred to the investigative interview as a waste of gas money, further showing her noncooperation with the investigation and the Board.

Respondent also violated Wis. Stat. § 440.11(1), which requires licensees to update their address within 30 days. The address on file is 6441 Pizzaro Circle, Madison, Wisconsin 53719. All written communications from the Department to the Madison, Wisconsin address have been returned to the Department by the U.S. Postal Service. Instead, Respondent claimed mail sent to Indiana, an address not on file with the Department. Therefore, Respondent failed to keep her address updated with the Department as required by Wis. Stat. § 440.11(1).

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 Department requests Respondent's right to renew her expired professional nursing license (license number 141786-30) and her privilege to practice nursing in Wisconsin pursuant to the Nurse Licensure Compact be revoked. For the reasons set forth below, the Division's recommendation is appropriate.

Respondent's conduct is so egregious that, based on this record, there is no indication that anything short of revocation will protect the public. Respondent has shown through her conduct that she cannot be trusted to care for a patient, which is the core purpose of nursing. Patients are vulnerable when they are in need of care, and Patient A was particularly vulnerable given his substantial physical limitations and health care needs. Despite Patient A's vulnerability, Respondent neglected and threatened Patient A. It also appears that Respondent has not learned from her serious mistakes or that she fully understands the harm caused by her message to Patient A. Notably, while purporting to apologize for her abhorrent threats to Patient A, she continued to make demeaning remarks about him, as reflected, for example, in her September 18, 2015 email to a Department investigator in which she refers to Patient A as "a bitter, bored, angry little man who has nothing better to do to amuse himself than stirring things up."

Respondent has also shown blatant disregard for the Board, as indicated by her statements that coming in for an investigative interview was not worth her time or gas money, and has shown disregard for these proceedings by failing to participate in them. The Board does not have any proof that Respondent is safe to practice, has been rehabilitated, or that she can be trusted. Finally, revoking Respondent's right to renew and privilege to practice nursing will deter other nurses from violating the law, placing patients in harm's way, and failing to comply with Board orders.

Costs

The Division has the authority to assess costs pursuant to Wis. Stat. § 440.22. The Division requests that Respondent be ordered to pay the full costs of this investigation and of these proceedings. Factors which may be considered in assessing costs 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 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, D.C.*, LS0802183CHI (Aug. 14, 2008). It is not mandatory that all or any of these factors be considered and it is within the Board's discretion to determine what weight, if any, to give any factors considered.

Particularly relevant are the following facts. The factual allegations were deemed admitted, the Division has proven all of the counts alleged and there is no argument that any factual findings or litigation were unnecessary. Respondent's conduct is extremely serious in nature and as a result, the Division sought, and was granted, revocation of Respondent's right to renew her license and her privilege to practice nursing under the Nurse Licensure Compact. Also, Respondent has failed to participate in this matter and has made no argument opposing the Division's request for imposition of full costs on her. Finally, it would be unfair to impose the costs of pursuing discipline in this matter on those licensees who have not engaged in misconduct. Therefore, it is appropriate for Respondent to pay the full costs of the investigation and of these proceedings.

ORDER

Accordingly, IT IS ORDERED that Respondent Jana L. Blair's right to renew her expired professional nursing license (license number 141786-30) and her privilege to practice nursing in the State of Wisconsin pursuant to the Nurse Licensure Compact are REVOKED as follows:

a. Respondent is on notice that she may not engage in the practice of nursing in the State of Wisconsin.

b. This revocation constitutes Respondent's permanent relinquishment of her license to practice nursing in the State of Wisconsin.

c. Respondent shall immediately return all indicia of Wisconsin licensure 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
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

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 of the Final Decision and Order in this matter is signed by the Board.

Dated at Madison, Wisconsin on May 19, 2016.

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