WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

Wisconsin Department of Safety and Professional Services
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Safety and Professional Services website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Safety and Professional Services from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Safety and Professional Services data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Safety and Professional Services, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Safety and Professional Services is shown on the Department's Web Site under "License Lookup."

  The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca

- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DSPS website: An individual who believes that information on the website is inaccurate may contact DSPS@wisconsin.gov

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	FINAL DECISION AND ORDER WITH VARIANCE
DEBORAH K. POLZIN, R.N., RESPONDENT.	DHA Case No. SPS-16-0037 DLSC Case No. 15 NUR 259

0005327

BACKGROUND

On April 6, 2017, Administrative Law Judge Jennifer Nashold (ALJ), Division of Hearings and Appeals, issued a Proposed Decision and Order (PDO) in the above-referenced matter. The PDO was mailed to all parties. The Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division) and Respondent both filed timely objections to the PDO and timely responses to each other's objections to the PDO. On May 11, 2017, the Board of Nursing (Board) met to consider the merits of the PDO, the partys' objections, and the responses to the objections. The Board voted to approve the PDO with a variance. The PDO is attached hereto and incorporated in its entirety into this Final Decision and Order with Variance (Order).

VARIANCE

Pursuant to Wis. Stat. §§ 440.035(1m) and 441.07, the Board is the regulatory authority and final decision maker governing disciplinary matters of those credentialed by the Board. The matter at hand is characterized as a class 2 proceeding pursuant to Wis. Stat. § 227.01(3). The Board may vary a PDO in a class 2 proceeding pursuant to Wis. Stat. § 227.46(2).

In the present case, the Board adopts the PDO in its entirety with the exception of a variance to the section titled, "**ORDER**" on pages 11-14 of the PDO. The Board also varies the section titled, **"Costs"** on pages 10-11. The Board issues the following variance to the PDO because it better protects public safety and assigns the appropriate weight due to each of the factors outlined *In the Matter of the Disciplinary Proceedings against Elizabeth Buenzli-Fritz*, LS 0802183 CHI (Aug. 14, 2008).

The section titled "ORDER" is varied as follows:

On page 13, following the paragraph titled "**ORDER**", paragraph 2(a)x is deleted and the following is substituted in its place:

> For a period of at least five (5) years while working at least half-time as a nurse, Respondent shall work only under direct supervision, and only in a work setting pre-approved by the Board. Respondent shall not work in a home health, assisted living, agency, pool or in a correctional setting.

On page 12, following the paragraph titled "**ORDER**", paragraph 2(a)viii is deleted (this deletion eliminates the redundancy with the variance to paragraph 2(a)x on page 13).

On page 14, first full paragraph, 80 percent is deleted and 100 percent is substituted in its place.

The section titled "Costs" is varied as follows:

On page 11, the first full sentence is deleted and the following is substituted in its place:

> Weighing all of these factors, and giving due weight to the nature and seriousness of the misconduct, Respondent's prior disciplinary history, and the fact that the Division proved every count it charged, it is appropriate for Respondent to pay 100 percent of the costs of these proceedings.

Dated at Madison, Wisconsin this 30 day of May, 2017.

By: Sheryl Kraus (DW)
A Member of the Board

Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against
Deborah A. Polzin, R.N., Respondent

DHA Case No. SPS-16-0037
DLSC Case No. 15 NUR 259

0005327

PROPOSED DECISION AND ORDER

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

Deborah A. Polzin, R.N., by

Attorney Stacie H. Rosenzweig
Halling & Cayo SC
320 E. Buffalo Street, Suite 700
Milwaukee, WI 53202-5837

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 SUMMARY

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 Deborah K. Polzin, R.N. (Respondent), alleging that Respondent engaged in two counts of unprofessional conduct.[1] The Division served Respondent on April 13,

[1] Specifically, the two counts alleged were that Respondent engaged in "[u]nsafe practice or substandard care" by: (1) "practicing nursing while under the influence of alcohol, illicit drugs, or while impaired by the use of legitimately prescribed pharmacological agents or medications," in violation of Wis. Admin. Code § N 7.03(6)(e), and (2) "being unable to practice safely by reason of alcohol or other substance use," in violation of Wis. Admin. Code § N 7.03(6)(f).

2016. Respondent filed an Answer to the Division's Complaint on April 29, 2015, denying unprofessional conduct.

Following several telephone prehearing conferences and the parties' attempts to resolve this matter, at a final telephone conference on July 19, 2016, the parties agreed to a hearing date. The hearing was held on November 16, 2016 in Madison, Wisconsin. Consistent with discussions held at the close of hearing, the parties submitted post-hearing briefs.

FINDINGS OF FACT

1. Respondent Deborah K. Polzin, R.N., is licensed in the State of Wisconsin as a professional nurse, having license number 95065-30, first issued on August 22, 1986 and current as of the date of the hearing.[2] (Complaint, ¶ 1; Answer, ¶ 1).

2. At all times relevant to this proceeding, Respondent was employed as a private duty nurse in a patient's home in Delavan, Wisconsin. The patient is referred to in these proceedings as Patient A. (Complaint, ¶ 3; Answer, ¶ 3)

3. Respondent was scheduled to work an overnight shift at Patient A's home from 7:00 p.m. on May 7, 2015 to 7:00 a.m. on May 8, 2015. (November 16, 2016 Hearing Transcript (Tr.), p. 63)

4. On May 8, 2015, at approximately 6:50 a.m., another private duty nurse (Nurse A)[3] presented to the apartment building where Patient A resides in order to take over cares for Patient A. Patient A is a ventilator-dependent quadriplegic. When Nurse A rang the apartment buzzer at the entrance to gain access to the building, Respondent did not buzz her in. Nurse A then walked around to the side of the building to look into Patient A's first floor apartment and did not see anyone. Nurse A was then let into the building by another resident. (Tr., pp. 21, 29-30)

5. When Nurse A entered Patient A's apartment, she found Respondent lying unconscious on the floor next to Patient A's bed. Nurse A grabbed Respondent by her shoulders to shake her and noticed that she felt cold. She found that Respondent had a weak pulse on her carotid artery and when Respondent did not awaken, Nurse A conducted a sternum rub on Respondent, which is meant to inflict pain, in order to arouse Respondent. Respondent woke up and Nurse A asked her if she was okay. Respondent said that she was "fine." Nurse A questioned Respondent and found that she was not oriented to person, time or place. (Tr., pp. 30-31)

---

[2] At the time of filing the Complaint, Respondent's license was expired. Pursuant to Wis. Stat. § 440.08(3), Respondent retained the right to renew upon payment of a fee until February 28, 2021. Respondent renewed her license since that time. Respondent's current licensure status can be verified online at https://app.wi.gov/LicenseSearch/IndividualLicense/SearchResultsSummary?chid=230365 through the Department's online license lookup.

[3] The parties refer to the nurse and doctor who testified at hearing by Nurse A and Physician A, respectively. Although no legal grounds have been offered for not using their actual names, because neither party objects, this decision likewise refers to them as Nurse A and Physician A.

6. Respondent stood up and stumbled as she walked, almost bumping into Patient A's ventilation tube. Respondent's speech was slurred and garbled and she was not making any sense when she spoke. Nurse A telephoned 911. (Tr., pp. 31-33)

7. Nurse A noticed that Respondent's eyeglasses were broken on the floor next to where she had been; Respondent's right sock and shoe were off and laying in the bathroom; and the baby monitor used for Patient A (which was usually on the table by the couch) was on the living room floor. On a tray next to the couch was a pile of 10-20 pills, some of which were on a napkin. Nurse A wrapped her arm around Respondent's lower back and walked her to the couch to sit Respondent down. (Tr., pp. 32-33)

8. When the paramedics arrived and assessed Respondent approximately 25 minutes later, her pupils were dilated and she had a sluggish response to light. A sluggish reaction to light indicates that there is a neurological issue such as a stroke or a medication overdose. (Tr., p. 35)

9. While the paramedics were assessing Respondent, Nurse A checked on Patient A. She performed a brief assessment, checked the ventilator to make sure that the settings were correct and drained the water in the ventilator tube collection cup. Nurses are required to perform ventilator checks every four hours and would routinely empty the collection cup. According to Patient A's nursing records, Respondent did not document that she performed a ventilator check at 3:00 a.m. which was when the last four-hour ventilator check should have occurred. Nurse A observed that the collection cup was full and was beginning to infiltrate the ventilator tubing. If the water had infiltrated high enough into the ventilator breathing tube, Patient A would not have been able to breathe. (Tr., pp. 23, 27, 34, 37-38)

10. Officer Jennifer Michalek-Milligan of the Delavan Police Department arrived at the residence and made contact with Respondent who was sitting on the couch. Officer Michalek-Milligan observed that Respondent's speech was slow and sluggish. When the officer asked Respondent what her name was, Respondent stated "Olsen." Officer Michalek-Milligan checked Respondent's purse for her driver's license which had the name Deborah K. Polzin on it and could not find any form of identification that had the name Olsen on it. When the officer asked Respondent if her name was Polzin, Respondent did not respond. The paramedics transported Respondent to the hospital. (Tr., pp. 45-47)

11. Nurse A then spoke with Patient A who was anxious, worried and upset about Respondent's loss of consciousness incident. Patient A told Nurse A that he called Respondent into his room and that she came in and fell down. (Tr., p. 36)

12. At a minimum, Respondent was unconscious and unable to provide cares to Patient A since 5:00 a.m. on May 8, 2015, which was two hours prior to the time that Nurse A was scheduled to take over cares. Respondent concedes that from 5:00 a.m. to 6:50 a.m., she was unable to perform her nursing duties for Patient A. Given that Respondent failed to chart that a ventilator check was performed at 3:00 a.m., it is likely that she was actually unconscious from 3:00 a.m. to 6:50 a.m. when Nurse A arrived for her shift. That is a period of almost four hours that Patient A did not receive nursing care. (Tr., pp. 38, 54, 96)

13. Patient A is not able to maintain his body temperature and is reliant on nurses to adjust his body temperature by adding or removing blankets or lowering the temperature in the

room. The nurses are required to take Patient A's temperature every hour to make sure his temperature is in an appropriate range. Respondent was unable to monitor Patient A's body temperature while unconscious. (Tr., p. 26)

14. At the time of the event on May 8. 2015, Respondent had been prescribed a muscle relaxant, methocarbamol (brand name Robaxin). She had also been prescribed diazepam (brand name Valium), which is a benzodiazepine, and hydrocodone, an opiate. These latter two medications can interact with methocarbamol and affect the sedation effect of methocarbamol. Respondent also had a prescription for primidone, a barbiturate. (Tr., pp. 8-10, 18, 60, 86)

15. Respondent testified that she had only been taking her Valium sporadically, approximately three to four times per week, and that during the past two years, the longest she went without taking Valium was a week to ten days. However, she reported to a nurse practitioner on May 15, 2015, that she had been taking Valium twice a day for the last five years. (Exhibit (Ex.) 2, p. 103; Tr., p. 100)

16. The hospital records from Respondent's admission on May 8, 2015, at 7:49 a.m., show that Respondent was "extremely uneasy on admission, requiring assistance of 2 for transfers," and that she reported to the emergency room physician that "she thinks she took too many muscle relaxants." The physician's primary assessment was "[A]ccidental medication overdose: patient admits to taking extra muscle relaxers this morning but doesn't recall how many." The physician additionally noted in the assessment that Respondent's medication trazadone would be discontinued because "it may worsen her oversedation." The medical records show that she had a negative head CT and that her urine was positive for benzodiazepines, barbiturates and opiates, all of which were medications prescribed to her. (Ex. 1, pp. 9, 19-20, 23)

17. Respondent is aware of the potential sedating effect of methocarbamol and has counselled her own patients on the importance of taking medications only as prescribed. Physician A also testified that sedation is a potential side effect of methocarbamol. Physician A routinely discussed with patients the potential side effects of prescribed medications and would have discussed with Respondent the potential effects of not taking methocarbamol as prescribed. (Tr., pp. 9, 90)

18. At hearing, Respondent claimed that she actually did not take too many muscle relaxants because she counted them within a week following the May 8 incident. Respondent testified that she kept her pills for each week in a seven-day pill box. She also kept a bottle of pills in her purse which she took with her. (Tr., pp. 95, 99-100)

19. At hearing, Respondent testified that, while at the emergency room on May 8, 2015, she felt scared and was "very quiet." The emergency room physician documented that Respondent was "extremely lethargic" and was able to answer some questions with one-word answers. Respondent testified that she felt "clear" approximately six hours after being brought to the emergency room. However, Respondent's husband observed that when he arrived at the hospital at 4:00 p.m., eight hours after admission, Respondent was still incoherent and confused. (Tr., pp. 77, 79, 106; Ex. 1, p. 19)

20. At hearing, Respondent claimed that she went home after she left the emergency room. Walgreens records show that Respondent's prescription for methocarbamol was filled on May 8, 2015. The prescription was given by the emergency room physician and was for 540 pills. (Tr., p. 80; Ex. 3, p. 9)

21. The May 8, 2015 prescription refill was approximately 24 days after Respondent had received 540 pills of methocarbamol pursuant to a prescription from her primary care physician (Physician A) on April 14, 2015. Respondent agreed that if she was taking her methocarbamol as prescribed, there is no reason that she would need a refill 24 days after she had obtained her last refill. (Tr., p. 96; Ex. 3, pp. 6, 9)

22. Physician A testified that 540 pills of methocarbamol should last 90 days if being taken as prescribed. As such, a refill of 540 pills of methocarbamol on April 14, 2015, should have lasted until mid-July 2015, as noted by Physician A in Respondent's medical chart, unless Respondent was not taking her methocarbamol as prescribed. (Tr., pp. 8-9, Ex. 2, p. 127)

23. The May 8, 2015 prescription refill was over two months before Respondent should have needed more methocarbamol. Early refills are an indication that a patient is not taking the medication as prescribed. Physician A testified that early refills would create a suspicion that the patient was abusing the medication or overdosing. A refill on a 90-day prescription that is a day early (day 89) would not be concerning, but a refill before 70 days would concern Physician A that a patient was taking more medications than prescribed. However, during cross-examination, Physician A also testified that methocarbamol is not a controlled substance, that he is not aware of it being taken recreationally, and that it is not a drug of abuse. (Tr., pp. 14-15)

24. On May 11, 2015, Department investigator Bill Searls interviewed Respondent about the incident on May 8, 2015. Respondent reported to Investigator Searls that the last thing she remembered was restocking at 5:00 a.m. Respondent told Investigator Searls that she may have been impaired and lost consciousness due to dehydration. There is no mention of dehydration in the physician's May 8, 2015 assessment. (Tr., pp. 54-55; Ex. 1, p. 19)

25. On May 15, 2015, Respondent presented to a nurse practitioner at her primary care clinic. On that date, her primary complaints were of vomiting, dizziness, chest pressure, palpitations and anxiety. Respondent reported to the nurse practitioner that she had stopped taking Valium a week previously because she had "lost" her Valium pills. Respondent reported not taking any Valium in the last week even though she had been taking that medication twice a day for the past five years. The nurse practitioner concluded that Respondent's symptoms were due to benzodiazepine withdrawal due to Respondent's sudden cessation of taking her Valium. During the visit, Respondent also told the nurse practitioner that she had been hospitalized a week previously for unintentional overdose of Robaxin. (Ex. 2, pp. 101, 103; Tr., p. 13)

26. On May 18, 2015, Respondent presented to Physician A at her primary care clinic for a post-hospitalization follow-up. Respondent reported that she "accidentally overdosed on muscle relaxers." Physician A asked Respondent "how exactly she could have overdosed accidentally," and Respondent said she did not know. Respondent also told Physician A that she lost her diazepam. (Ex. 2, p. 127; Tr., pp. 11-12)

27. Respondent testified at hearing that during her shift with Patient A, she took Vitamin C and valerian root but did not take methocarbamol, diazepam or pain medication. She also testified that at some point during her shift, she went into Patient A's bathroom to clean and restock supplies, that she closed the door of the bathroom so as not to disturb Patient A with the light, that it was warm and humid in the bathroom, that she used liquid bleach and Ajax powder to clean and that she spilled some bleach on her shoe, whereupon she took off her shoe and sock. At hearing, both Respondent and her husband suggested that Respondent's condition on May 8, 2015 may have been caused by her taking valerian root in combination with her other medications. However, Respondent made no reference to valerian root, liquid bleach or dehydration in her May 18, 2015 appointment with Physician A. (Ex. 2, p. 127; Tr., pp. 71-74, 81-82, 108-109, 111)

DISCUSSION

Burden of Proof

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

Violations

The Wisconsin Board of Nursing (Board) may revoke, limit, suspend or deny renewal of a license of a registered nurse if it finds that the licensee has engaged in "[o]ne or more violations of this subchapter or any rule adopted by the board under the authority of this subchapter" or in "[m]isconduct or unprofessional conduct." Wis. Stat. § 441.07(1g)(b) and (d), respectively.

The Division has alleged that Respondent practiced nursing while under the influence of alcohol or illicit drugs, or while impaired by the use of legitimately prescribed pharmacological agents or medications, in violation of Wis. Admin. Code § N 7.03(6)(e), and that she was unable to practice safely by reason of alcohol or other substance use, in violation of Wis. Admin. Code § N 7.03(6)(f).

The credible evidence establishes that Respondent took more methocarbamol than was prescribed to her. Respondent stated to the emergency room physician on May 8, 2015 that she took too many muscle relaxants. On May 15, 2015, Respondent reported to a nurse practitioner that she took too many muscle relaxants which led to her emergency room visit. On May 18, 2015, Respondent reported to Physician A that she took too many muscle relaxants and could not explain how it happened. Moreover, Respondent filled a prescription for 540 methocarbamol pills on May 8, 2015, from the emergency room physician when she should not have needed any until July 2015.

Respondent knew the dangers of taking too many muscle relaxants. She is aware of the potential sedating effect of the muscle relaxant methocarbamol. She is aware of the importance

of taking medications only as prescribed. Physician A testified that sedation is a potential side effect of methocarbamol. Physician A routinely discussed with patients the potential side effects of prescribed medications and would have discussed with Respondent the potential side effects of not taking methocarbamol as prescribed.

Respondent's hearing testimony as to the potential causes of her impaired condition is not credible. She testified at hearing that she did not take more muscle relaxants than her physician prescribed and counted her weekly pill box to verify the amounts. However, the evidence showed that she reported to Physician A on May 18, 2015, that she had taken too many muscle relaxants. This was *after* she purportedly counted her pills and verified she had not taken too many. If she had actually not taken too many pills, she would have known that when she spoke to Physician A on May 18, 2015, ten days following her hospitalization.

Respondent suggests that the herbal supplement valerian root had something to do with her impaired condition. However, Respondent failed to offer any credible medical or other evidence that this herbal supplement was the cause of her condition. Furthermore, Physician A testified that he did not recall her making any mention of valerian root at her appointment following the incident on May 8, 2015. Nor do the medical records support Respondent's suggestion that dehydration or bleach fumes were the cause of her impaired state. Instead, they show that Respondent repeatedly stated she had overdosed on Robaxin. Respondent's testimony was inconsistent on other matters as well. She testified, for example, that she had only been taking her Valium sporadically, approximately three to four times per week, and that during the past two years, the longest she went without taking Valium was a week to ten days. However, she reported to the nurse practitioner on May 15, 2015, that she had been taking Valium twice a day for the last five years.

In addition, in her brief, Respondent herself "concedes that an accidental medication overdose or interaction cannot be ruled out as the cause of her condition" and that "it is clear she became impaired while at work as a result of an unforeseen medical episode that may or may not have implicated methocarbamol." (Respondent's Brief, pp. 7, 8)

The Division has demonstrated by a preponderance of the evidence that Respondent has engaged in practicing nursing while under the influence of alcohol or illicit drugs, or while impaired by the use of legitimately prescribed pharmacological agents or medications, in violation of Wis. Admin. Code § N 7.03(6)(e); and that she was unable to practice safely by reason of alcohol or other substance use, in violation of Wis. Admin. Code § N 7.03(6)(f).

As a result of this conduct, she is subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b) and (c).

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).

As shown by Respondent's actions in this case and by her conduct in prior disciplinary actions, Respondent is in need of serious rehabilitation and the public needs to be protected from

her conduct. While being the sole medical professional responsible for Patient A's care, Respondent became unresponsive as a result of overdosing on prescribed medications. Patient A is an extremely vulnerable patient. He is a quadriplegic and is ventilator dependent. He is not able to breathe on his own and is not able to regulate his body temperature. Respondent's conduct placed Patient A at significant risk, including death. The collection cup attached to his ventilator tube had become full and the water was beginning to infiltrate the breathing tube itself. Had that breathing tube become completely occluded, Patient A would have been unable to breathe, with the potential for death by suffocation.

Respondent was found nonresponsive at 7:00 a.m. on May 8, 2015. Based on the fact that she did not perform a ventilator check when it was due at 3:00 a.m., Respondent could have become unconscious as early as 3:00 a.m. When her husband arrived at the hospital 9-13 hours later, at 4:00 p.m., Respondent was still incoherent. Given the magnitude of Respondent's impairment and that she has been a nurse for over 30 years who, by her own testimony, is aware of the potential sedating effect of methocarbamol and has counselled her own patients on the importance of taking medications only as prescribed, Respondent's argument that any overdose was "accidental," does not ring true.

Moreover, this is not the first time that Respondent has endangered patients due to her on-the-job impairment. On February 23, 2012, the Board issued an order imposing discipline on Respondent for reporting to work as a professional nurse at a residential facility while under the influence of alcohol. *In the Matter of Disciplinary Proceedings Against Deborah K. Polzin, R.N.*, Order No. 0001381 (Feb. 23, 2012).[4] As a result of Respondent's conduct, the Board reprimanded Respondent and placed limitations on her license requiring Respondent to submit to random urine drug screens for a period of two years and to arrange for quarterly work reports from her nursing employer(s).

After being reprimanded and having conditions placed on her license, Respondent then violated the Board's order. Specifically, in November 2012, Respondent interviewed with a case coordinator for a patient who was ventilator dependent and required skilled nursing care in a home health setting. *In the Matter of Disciplinary Proceedings Against Deborah K. Polzin, R.N.*, Order No. 0003380 (Sept. 11, 2014).[5] Respondent did not disclose the Board's order limiting her license, nor did she arrange to have work reports completed. She was hired as a professional nurse to care for the patient and provided care for approximately a year and a half, at which time the coordinator became aware of the Board order and terminated Respondent's employment. Work reports were never submitted to the Department during Respondent's employment. As a result of Respondent's conduct, the Board suspended her license for a period of 21 days.

Given Respondent's history and her conduct in this case, Respondent has shown that she cannot be trusted to provide unsupervised care to patients. Thus, instead of granting the Division's request to prohibit Respondent from having access to controlled substances (when there is no evidence that she has ever diverted anyone else's medications), Respondent is

[4]A copy of this order may be found online at https://online.drl.wi.gov/decisions/2012/ORDER0001381-00006893.pdf.

[5]A copy of this order may be found online at https://online.drl.wi.gov/decisions/2014/ORDER0003380-00010186.pdf.

prohibited from providing care to patients, including in-home care, unless she is accompanied by another medical professional.

In addition, Respondent needs an alcohol and other drug abuse (AODA) assessment to determine if she is abusing or dependent on drugs or alcohol, if she is abusing her prescription medications and if treatment is needed. If a treater determines drug treatment is needed, Respondent must comply with the treater's recommendations. Without this assessment, the Board is unable to be certain Respondent is receiving proper treatment to rehabilitate her.

In order to promote rehabilitation, the discipline imposed against Respondent must also include drug testing to ensure Respondent is not abusing prescribed medications, taking non-prescribed medications or other illegal drugs. Although there is no evidence in this case that Respondent took medications which were not prescribed to her, Respondent's conduct in this case of overdosing on prescribed medications, and her prior conduct of reporting to duty as a nurse while under the influence of alcohol, raises serious concerns about Respondent's willingness to overindulge in mind-altering substances, even when doing so affects her ability to safely perform her duties as a nurse. Drug testing is the only way that the Board will know if Respondent has ingested any medications that are not prescribed to her or are otherwise illegal. That testing should continue for a period of five years unless the Board, in its discretion, reduces the frequency of such testing. Respondent has previously been disciplined by the Board for being impaired in a work setting so an extended period of demonstrated compliance is required. I also agree with the Division that testing at a frequency of not less than 49 tests per year for at least the first year is appropriate, notwithstanding Respondent's arguments to the contrary.

In order to protect the public, Respondent is also required to provide the final decision and order in this matter to all employers to ensure she is adequately monitored and any usual behavior can be brought to the attention of the Board or its designee. Additionally, Respondent should be restricted to work in Wisconsin pursuant to the Nurse Licensure Compact during the pendency of the limitations because otherwise monitoring becomes too difficult.

Finally, Respondent will again be reprimanded, as she was in her first disciplinary proceeding in 2012. Because Respondent was evidently not sufficiently deterred by her prior reprimand or the 21-day suspension of her license, it is tempting to impose more than a reprimand in this case. However, because the Division has requested only a reprimand rather than any suspension, and the limitations on Respondent's license are more stringent than those imposed in her first case, a reprimand is imposed to deter others from engaging in similar conduct.

The discipline imposed here is consistent with the discipline imposed in other cases. For example, in one prior case, *In the Matter of Disciplinary Proceedings Against Nancy Brenden, R.N.*, Case No. 0004108 (June 19, 2015), a nurse was on her way to work to perform in-home care when she drove into a ditch. Police placed the nurse under arrest and she underwent a blood draw which revealed a blood alcohol concentration of 0.184 percent, over twice the legal limit. She was subsequently convicted of operating while intoxicated. The Board suspended her license to practice nursing indefinitely and the suspension could be stayed upon petition at any time after the entry of a final decision and order by the Board. The Board also imposed the following license limitations: treatment; providing signed releases to the Board or its designee for any treater; AA/NA meetings not less than twice a week; abstaining from alcohol and use of

controlled substances; drug and alcohol screens of not less than 49 times in the first year; no access to controlled substances; practicing only under direct supervision; a pre-approved work setting; no home health, hospice, pool, assisted living or agency nursing practice; showing a copy of the order and all subsequent orders immediately to supervisory personnel where she works as a nurse; and submission of work reports. Unlike Respondent, the nurse in *Brenden* had no prior discipline by the Board.

In another case, *In the Matter of the Disciplinary Proceedings Against Ericka J. Danforth,* Case No. 0003299 (July 10, 2014), a nurse diverted narcotic medications from two different facilities while on duty and was suspected to have taken them for personal use. The Board reprimanded the nurse in that case and limited her license for a period of at least two years. The limitations included were similar to those imposed here: an AODA assessment, drug and alcohol monitoring, including testing of specimens at a frequency of not less than 49 times per year for the first year of the order, and payment of costs. As with the *Brenden* case, the nurse in *Danforth* had no prior discipline, unlike Respondent.

Based on the factors set forth in *Aldrich*, the facts of this case, and prior Board orders, it is appropriate to impose the discipline summarized above and set forth in more detail in the Order section below.

Costs

The Department is vested with discretion concerning whether to assess all or part of the costs of this proceeding against Respondent. *See* Wis. Stat. § 440.22(2). In exercising such discretion, the Department must look at aggravating and mitigating facts of the case; it may not assess costs against a licensee based solely on a "rigid rule or invocation of an omnipresent policy," such as preventing those costs from being passed on to others. *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. The Department has also, in previous orders, considered many factors when determining if all or part of the costs should be assessed against a Respondent. Factors have included: (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 respondent; (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*, LS 0802183 CHI (Aug. 14, 2008). It is within the Department's discretion as to which, if any, of these factors to consider, whether other factors should be considered, and how much weight to give any factors considered.

In this case, the Division has proven the two counts alleged. In addition, Respondent's conduct was serious, leaving a ventilator dependent quadriplegic without care and endangering his life by her inexcusable overdose of medications. Moreover, Respondent has been disciplined by the Board twice before and nevertheless continued to engage in misconduct. Also, any costs not imposed on Respondent must be borne by those licensees who have not engaged in such misconduct. However, operating in Respondent's favor is the fact that she has been cooperative in these proceedings, including agreeing to undergo a medical and/or AODA assessment by a Board-approved treater and abide by any recommendations. Also, the Division in this case sought and was granted a reprimand with license limitations rather than a more severe form

discipline, such as a suspension or revocation. Weighing all of these factors, it is appropriate for Respondent to pay the 80 percent of the costs of these proceedings.

ORDER

Accordingly, IT IS HEREBY ORDERED:

1. Respondent Deborah K. Polzin is reprimanded.

2. The professional nursing license issued to Respondent to practice nursing in the State of Wisconsin, and her privilege to practice in Wisconsin pursuant to the Nurse Licensure Compact, are limited as follows:

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

i. Respondent shall enroll and participate in a drug and alcohol monitoring program which is approved by the Department (Approved Program). Enrollment shall occur within 30 calendar days from the date of this Order.

ii. 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 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 at least the first year of this Order. Thereafter, the Board may adjust the frequency of testing on its own initiative at any time.

iii. 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 her 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, the Board or its designee. Copies of these releases shall immediately be filed with the Department Monitor.

iv. Respondent shall report to 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.

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

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

ix. Respondent shall provide her nursing employer with a copy of this Order before engaging in any nursing employment. Respondent shall provide the Department Monitor with written acknowledgment from each nursing employer that a copy of this Order has been received. Such acknowledgment shall be provided to the Department Monitor within 14 days of beginning new employment and/or within fourteen 14 days of the date of this Order for employment current as of the date of this Order.

x. Respondent shall practice only while accompanied by a licensed nurse or other licensed health care professional.

3. Respondent's professional nursing license and her privilege to practice in Wisconsin pursuant to the Nurse Licensure Compact, is further LIMITED as follows:

a. Within 60 days from the date of this order, Respondent shall, at her own expense undergo an AODA assessment with a pre-approved treater.

b. Prior to assessment, Respondent shall provide a copy of this Final Decision and Order to the treater.

c. Respondent shall provide and keep on file with treater current releases complying with state and federal laws. The releases shall allow the Board, its designee, and any employee of the Department of Safety and Professional Services, Division of Legal Services and Compliance to obtain a copy of the assessment. Copies of these releases shall immediately be filed with the Department Monitor.

d. Respondent shall comply with treaters recommendations.

4. Pursuant to Uniform Nurse Licensure Compact regulations, Respondent'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 Respondent proposes to practice.

5. The Board or its designee may, without hearing, suspend Respondent's nursing license upon receipt of information that Respondent is in substantial or repeated violation of any provision of this Order. A substantial violation includes, but is not limited to, a positive drug screen. A repeated violation is defined as the multiple violations of the same provision or violation of more than one provision. The Board or its designee may, in conjunction with the suspension, prohibit Respondent from seeking termination of the suspension for a specified period of time.

6. The Board or its designee may terminate the suspension if provided with sufficient information that Respondent is in compliance with the Order and that it is appropriate for the suspension to be terminated. Whether to terminate the suspension shall be wholly in the discretion of the Board or its designee.

7. After the first year from the date of this Order, Respondent may petition the Board on an annual basis for a modification of the terms of this Order. After five consecutive years of successful compliance, Respondent may petition the Board for return of full licensure. The Board may grant or deny any petition, in its discretion, or may modify this Order as it sees fit.

8. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs as ordered, Respondent's license

may, in the discretion of the Board or its designee, be suspended, without further notice or hearing, until Respondent has complied with payment of costs.

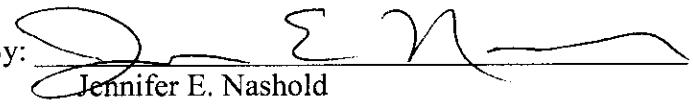
IT IS FURTHER ORDERED that Respondent shall pay 80 percent of the recoverable costs in this matter in an amount to be established, pursuant to Wis. Admin. Code § SPS 2.18. After the amount is established, payment shall be made by certified check or money order payable to the Wisconsin Department of Safety and Professional Services and sent to:

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 April 6, 2017.

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