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Before the
State of Wisconsin
Board of Nursing

In the Matter of Disciplinary Proceedings Against
Donna J. Klimek, R.N., Respondent

FINAL DECISION AND ORDER
Order No. 0005746

Division of Legal Services and Compliance Case No. 15 NUR 345

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 10 day of May, 2018.

Member
Board of Nursing

Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against Donna J. Klimek, R.N., Respondent	DHA Case No. SPS-17-0014 DLSC Case No. 15 NUR 345

PROPOSED DECISION AND ORDER

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

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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 Donna J. Klimek, R.N. (Respondent), alleging that Respondent engaged in unprofessional conduct by failing to perform nursing with reasonable skill and safety, in violation of Wis. Admin. Code § N 7.03(6)(a); by departing 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, in violation of Wis. Admin. Code § N 7.03(6)(c); by abusing 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, in violation of Wis. Admin. Code § N 7.03(4)(c); and by engaging in repeated or significant disruptive behavior or

interaction with health care personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered, in violation of Wis. Admin. Code § N 7.03(4)(d).

The Division served Respondent on June 29, 2017, by sending a copy of the Notice of Hearing and Complaint to her last known address on file with the Department and to Respondent's attorney (Marlene Garvis), via certified and regular mail. On July 12, 2017, Attorney Garvis filed an Answer on behalf of Respondent.

On July 18, 2017, the Administrative Law Judge (ALJ) issued a Notice of Telephone Prehearing Conference which set a telephone prehearing conference for July 27, 2017. On July 27, 2017, the ALJ held a telephone prehearing conference and issued a scheduling order setting a hearing date for November 16 and 17, 2017.

On October 24, 2017, the Division filed a motion in limine to preclude Respondent from introducing or referencing MP's health care records at hearing or in discovery depositions. On November 2, 2017, following briefing by the parties, the ALJ issued an order denying the Division's motion.

On November 6, 2017, Respondent filed a motion in limine seeking to exclude the testimony of the Division's identified expert, Olivia L. Schroeder, and a motion in limine to exclude the Division's Exhibit 4 and Exhibit 5 at hearing. On November 10, 2017, following briefing by the parties, the ALJ issued an order denying Respondent's motions.

The hearing was held on November 16 and 17, 2017, in Madison, Wisconsin, at which Respondent and her attorney appeared in person.

The ALJ subsequently issued a briefing order. The Division submitted its brief-in-chief on January 3, 2018; Respondent submitted her response on February 6, 2018; the Division submitted its reply on February 16, 2018; and Respondent submitted a response to the reply on February 19, 2018, which, over the Division's objection, the ALJ agreed to receive on February 20, 2018. On March 20-21, 2018, the ALJ requested clarification from the parties regarding Respondent's Exhibit 113, and received the parties' responses on those same dates.

FINDINGS OF FACT

1. Respondent Donna J. Klimek, R.N., is licensed in the State of Wisconsin to practice professional nursing, having license number 170023-30, first issued on September 23, 2009. At the time of the hearing, Respondent's license was current through February 28, 2018. (Complaint, ¶ 1; Answer, ¶ 2) As of the date of this decision, Respondent's license is current through February 28, 2020, according to the Department's website.

2. Our House is a memory care center and community based residential facility (CBRF). At all times relevant to these proceedings, approximately 20 residents with diagnoses of dementia, Alzheimer's and other cognitive conditions lived at Our House. (Transcript of Proceedings, Day 1,

November 16, 2017 ("Tr. 1"), p. 9); Transcript of Proceedings, Day 2, November 17, 2017 ("Tr. 2"), p. 258)

3. MP[1] and Mrs. P were married on June 23, 2005. In February of 2010, Mrs. P began to notice signs of memory problems in MP. He was forgetting things, and seemed to no longer enjoy activities that he had in the past, such as fishing, carpentry and yardwork. (Tr. 1, p. 88)

4. In approximately March of 2011, MP and Mrs. P traveled to the Mayo Clinic in Rochester, Minnesota, for MP to be evaluated. The physicians at Mayo diagnosed MP with frontotemporal dementia and Alzheimer's. MP was 57 years old. (Tr. 1, pp. 90-92)

5. At the time that MP was evaluated at the Mayo Clinic, he was no longer able to remember the name of the President of the United States, news events, the year, or how to tell time on a clock with an hour and minute hand. (Tr. 1, p. 103).

6. Following his diagnosis of dementia/Alzheimer's, MP continued to live at home with his wife for a short time, until it was suggested that he be placed in a residential facility for his own safety. In addition, Mrs. P eventually felt that she was unable to continue to provide the level of care that MP needed to remain in their home. (Tr. 1, pp. 93-94)

7. In January of 2012, Mrs. P admitted MP to a residential facility in Marshfield, Wisconsin. He remained there for approximately three months and then Mrs. P decided to place him at a second facility in Marshfield. He remained there for approximately a year and a half. (Tr. 1, pp. 95-97)

8. Mrs. P then moved MP to a facility in Dorcester, Wisconsin, where he remained for approximately three months. MP asked Mrs. P if he could live at home again, so she brought him home for approximately five months to live with her. (Tr. 1, pp. 98-99)

9. On January 23, 2015, MP moved into Our House. (Tr. 1, p. 101; Ex. 100)

10. Angelique Gukenberger (Gukengerber) is a certified nursing assistant (CNA) and worked as a resident care assistant (RCA) at Our House from 2012 until 2015. In June of 2015, Gukenberger worked the 7 a.m. to 3 p.m. shift at Our House. (Tr. 1, pp. 7-10)

11. For MP, Gukenberger performed skin and behavior assessments, took vital signs, maintained a toileting log and assisted with activities of daily living (ADLs) and self-cares. The ADLs with which Gukenberger assisted MP included being a standby assist in the shower, assisting with morning ADLs, providing reminders throughout the day, assisting with meals, and providing redirection. (Tr. 1, pp. 12-13)

12. Redirection is a technique used to guide a resident's negative behaviors to more appropriate behaviors. The goal of redirection is to keep the patients safe and to keep them calm.

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[1] To protect the privacy interests of the patient, the parties have intermittently referred to the patient as Patient A and Patient MP in these proceedings. He is referred to as MP in this decision and his wife is referred to as Mrs. P.

MP needed redirection at times because of memory issues caused by dementia. (Tr. 1, pp. 13-14; Tr. 2, p. 201)

13. The three redirection techniques Our House staff used with MP included talking to him about his job or about riding motorcycles, taking him for walks, and having him spend time with his cat that lived at Our House with him. (Tr. 1, pp. 5, 13, 15-16)

14. When the redirection techniques were not successful, Gukenberger would either contact MP's wife, take MP to see Respondent, or administer his anxiety medication. (Tr. 1, pp. 5, 13, 16-17, 41)

15. In working with dementia patients, Gukenberger was trained to speak slowly to the patients, to not argue with the patients due to their difficulties with comprehension, and to use redirection. (Tr. 1, p. 114)

16. Arguing with dementia patients can affect the patients emotionally, and cause their behaviors to become more severe. (Tr. 1, pp. 14-15)

17. During the time that MP lived at Our House, Gukenberger observed that his memory quickly declined. When he was first admitted to the facility, he was able to dress himself in the morning, brush his teeth, take a shower, make his bed, and remember when it was mealtime. As the year progressed, MP forgot to brush his teeth, had to be coached to sit and eat at the table, did not shower anymore, and did not make his bed. (Tr. 1, p. 18)

18. As MP's dementia progressed, Gukenberger noticed that his memory worsened and his tendency to wander or elope increased. His anger and frustration levels also increased. (Tr. 1, p. 42)

19. Due to MP's memory issues, there would be times when he would have a conversation with Gukenberger and then within minutes, be surprised to see her, not remembering that they had just spoken moments before. He would also forget that they had just gone for a walk together. (Tr. 1, pp. 18-19)

20. MP was aware that he had memory problems and that realization frustrated him and caused him to cry. He would cry when he realized that he had forgotten something and when staff had to explain why he had to stay at the facility. (Tr. 1, pp. 19-20)

21. Mrs. P visited MP frequently and would stay for hours with him. During her visits, Mrs. P would assist MP with ADLs such as showering, dressing, shaving and brushing his teeth. They would also go out to eat, take walks along the river, and go shopping. (Tr. 1, pp. 101–102)

22. Respondent became the residence director at Our House in April of 2015. Respondent's employment ended there on June 18, 2015. Respondent was Gukenberger's direct supervisor at Our House. (Tr. 1, p. 10; Tr. 2, p. 263; Ex. 101)

Name calling and vulgar language

23. Gukenberger observed occasions in which Respondent and MP would be in Respondent's office and both Respondent and MP would use cuss words in conversation. (Tr. 1, pp. 20-23, 78)

24. On occasions when Mrs. P and MP were in Respondent's office, Respondent would often swear at MP calling him "jackass," "donkey," the "f-word," and "arrogant." On one occasion, MP attempted to make a joke or say something funny and it did not make much sense. In response, Respondent told MP, "You are such a dumbass." (Tr. 1, pp. 108, 115)

25. Mrs. P questioned Respondent about why she talked that way to MP and Respondent said that Mrs. P needed to trust her and that it was the only way MP would learn. Respondent repeatedly told Mrs. P to trust her and that she would never lie to her. Mrs. P trusted Respondent for a time "because she was a nurse" and she thought she could trust her. (Tr. 1, pp. 115-116)

Reading time on the clock and vulgar language

26. Gukenberger observed an incident in which Respondent used inappropriate language toward MP. The incident occurred in Respondent's office while Gukenberger was present. Respondent asked MP what the time was on a clock on the wall. MP could not tell her because he had forgotten how to read the time. Respondent kept telling him that he could read the clock. Respondent also stated to MP, "You can read the fucking clock." MP continued to try to read the time on the clock after Respondent stated that, but he was unable to do so. (Tr. 1, pp. 20-21, 37)

27. Respondent repeatedly tried to get MP to tell time on the clock even though he was unable to do so. On one occasion, Mrs. P observed Respondent repeatedly ask MP what time it was on the clock and when he could not do so, Respondent stated that MP was just being stubborn and was being difficult because his wife was present. Respondent told Mrs. P that he could read the time when Mrs. P was not present. Respondent testified that being able to read the clock was an ability that could come and go. (Tr. 1, pp. 117-118; Tr. 2, pp. 249-250)

Calling names after eloping.

28. Gukenberger recalled other occasions at Our House during which Respondent told MP that he was a "little shit." Respondent called MP a "little shit" when he would elope or "exit seek" from the facility. Although Gukenberger could not recall other specific names that Respondent called MP, she remembered feeling that Respondent spoke to him in a degrading tone. These incidents occurred in May and June of 2015. (Tr. 1, pp. 31, 77-78)

Prohibiting visitation as punishment.

29. Respondent telephoned MP's wife late at night to talk about MP. (Tr. 1, p. 42)

30. Respondent told Mrs. P that she wanted to do intense psychotherapy with MP, which required spending a lot of time with him. Some of the staff at Our House told Mrs. P that MP was in Respondent's office quite often during the week. (Tr. 1, pp. 106-107)

31. Respondent also told Mrs. P on the telephone she shouldn't visit him so often and that MP would get used to living at Our House if Mrs. P did not visit him as much as she did. (Tr. 1, pp. 109-110)

32. Respondent and Mrs. P also had conversations in Respondent's office at Our House. During those conversations, Respondent told Mrs. P to not visit MP and to tell him that he was no longer allowed to come home because he was not behaving. In May of 2015, Mrs. P did what Respondent told her to do and told MP he could no longer come home. (Tr. 1, pp. 109-112)

33. A couple of weeks after that conversation, Respondent told Mrs. P that MP was still not behaving, and that if he did not start to behave or continued to elope, Mrs. P should tell MP that she was going to divorce him. Mrs. P had no intention of telling MP that she was going to divorce him and told Respondent she would not do that. MP's wife told Gukenberger about Respondent's comments to her. (Tr. 1, pp. 42, 112)

34. On or about June 2, 2015, Respondent telephoned Mrs. P and told her that she did not want her to visit MP for a week because he had been really misbehaving and she wanted time to work with him. Mrs. P recalled that June 2nd was a Tuesday. Mrs. P initially agreed not to see MP for a week. (Tr. 1, p. 113)

35. Mrs. P reported this to Gukenberger. Gukenberger recalled Mrs. P saying that Respondent did not want Mrs. P to visit MP at the facility for a week as a punishment for his attempts to elope from the facility. (Tr. 1, pp. 72-73, 77)

36. Later in the week, Mrs. P spoke to one of the staff at Our House. Staff told Mrs. P that MP was upset because she was not there to see him, then advised that she should come visit MP even if Respondent had said not to visit him. Mrs. P decided to visit MP on June 7, 2015, which was his birthday. (Tr. 1, pp. 112-114)

Repeated and challenging questions

37. On June 6, 2015, MP eloped from Our House. Only two RCAs were working at that time. One of the RCAs left the building to follow MP, leaving only one RCA in the building to take care of the other residents. The RCAs did not tell Respondent about the elopement because they were afraid they would get fired. However, Respondent found out about it the next day. (Tr. 1, p. 120; Tr. 2, pp. 312, 360)

38. On June 6, 2015, no entries were made on the resident log of MP's medical records regarding the elopement on that date. It was not until June 15, 2015, that a late entry was made in MP's records to reflect the elopement on June 6, 2015. (Ex. 100, June 15, 2015 note attached).

39. The late entry note reflects that MP had been upset because Mrs. P "hadn't come to see him in almost a week and that it wasn't like her." (*Id.*)

40. MP's birthday was on June 7, 2015, and a gathering of residents and family members was planned at Our House to recognize his birthday with cake and ice cream. Mrs. P brought MP's favorite food and an ice cream cake to Our House. She helped MP shower and he put on a new outfit that Mrs. P bought him for his birthday. Mrs. P and MP ate lunch and then spent time outside sitting by the flowerbeds that they had planted together. (Tr. 1, pp. 25-26, 118-119)

41. On June 7, 2015, Respondent found out about the elopement the day before and was not happy about it. Respondent attempted to call Mrs. P numerous times on her cellphone on that date to talk to her. (Tr. 1, p. 119)

42. Mrs. P believed it was approximately 3:00 p.m.[2] when Gukenberger came outside and told Mrs. P and MP that it was time for the birthday cake. Mrs. P and MP walked inside and Respondent called Mrs. P into her office. Respondent told her that MP had eloped the day before. (Tr. 1, p. 119)

43. Respondent stated to Mrs. P that had she known that MP ran away the day before, she never would have let MP's wife see him for his birthday or take him outside. (Tr. 1, p. 119)

44. Mrs. P went to get MP to bring him into Respondent's office because Respondent told her she wanted to "get to the bottom of this." The door to Respondent's office was closed during the meeting in which Respondent, Mrs. P and MP were present. Respondent asked MP why he ran away the day before and MP said that he didn't run away. Respondent replied that he had run away and asked him, "Why did you run away yesterday, you jackass?" MP said that he did not remember leaving the facility the day before, but Respondent kept asking him again and again why he ran away. Respondent was speaking in a very demanding tone. MP could not remember running away, and began crying hysterically after the repeated and challenging questioning by Respondent. MP had been happy before going into Respondent's office. (Tr. 1, pp. 119-123)

45. Gukenberger was scheduled to work until 3:00 p.m. that day but did not leave until 3:30 p.m. Before leaving for the day, Gukenberger observed MP and his wife enter Respondent's office. When Gukenberger left, MP and his wife had been in Respondent's office for approximately 10 to 15 minutes with the door closed. (Tr. 1, pp. 27-28)

46. Eventually, one of the staff knocked on the door to Respondent's office and asked if MP and Mrs. P could come out for MP's party. At that time, both Mrs. P and MP were upset and crying. By the time MP got to his party, the ice cream cake was melted. (Tr. 1, pp. 121, 123)

47. After Gukenberger left Our House that day, she received a telephone call from one of the other RCAs at Our House. The RCA reported to Gukenberger that MP and his wife were both crying during the party and that MP was crying when he blew out the candles on his cake. Both MP and his wife were upset when they walked out of Respondent's office. (Tr. 1, p. 28)

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[2] Gukenberger believed the birthday cake celebration was supposed to start at 2:30 p.m. because that is when they usually started. (Tr. 1, p. 28)

48. Later that night, Mrs. P returned to Respondent's office and informed Respondent that she thought it was unnecessary for Respondent to have questioned MP like she did, when it was obvious he could not remember why he ran away. Respondent told her that by the end of the night, he would tell her why he did it. Mrs. P told Respondent that she wanted her to leave MP alone for the night. Respondent told Mrs. P to trust her and attempted to hug her but Mrs. P just walked out of the room. (Tr. 1, p. 122; Ex. 1, p. 9)

49. On June 8, 2015, Mrs. P reported Respondent's conduct to Blanche Wellman, who was the area director and Respondent's immediate supervisor. Mrs. P was informed on that date that Respondent had been suspended. Following an investigation, ten days later, Mrs. P was informed that Respondent had been dismissed from Our House. Respondent testified that she resigned. (Tr. 1, pp. 124-125, 160; Tr. 2, pp. 254, 294)

50. Gukenberger did not complain to anyone about Respondent's conduct until June 2015. She did not feel comfortable confronting Respondent about her concerning behaviors with MP before then. (Tr. 1, pp. 43, 78)

Expert Testimony

51. Olivia Schroeder (Schroeder) testified as an expert in professional nursing. She is a registered nurse, licensed to practice in Wisconsin. Schroeder earned her master's degree as a nurse educator and is specialty-certified as a heart failure nurse. (Tr. 2, p. 174)

52. Schroeder's work experience as a nurse includes working as a triage nurse in internal medicine from 2008 to 2010 and working as a nurse case manager for a home health agency. In both positions, Schroeder provided direct patient care. Prior to professional nursing, she worked as a CNA at a residential facility where she worked with patients that suffered from cognitive impairments, including Alzheimer's. (Tr. 2, pp. 177-178, 186-187)

53. Schroeder is currently employed as a full-time nurse educator for the Madison Area Technical College (MATC). She teaches the following courses at MATC: fundamentals of nursing, introduction to clinical management, intermediate and advanced clinical, complex health alteration, and nursing management and professional concepts. Schroeder's course, Nursing Management and Professional Concepts, addresses areas such as scope of practice, legalities of nursing, ethics in nursing and communication in nursing. In addition, instruction on communication is woven into every nursing course she teaches. Communication is of paramount importance for a nurse, and three hours of instruction in the first-year fundamentals of nursing course is devoted to communication. The instruction that she provides on communication is evidence-based which means that the practices are based on, and substantiated by, current evidence. (Tr. 2, pp. 175, 179-181, 185)

54. In addition to classroom instruction, Schroeder is also involved in clinical instruction of nursing students in facilities at which the students provide nursing care to patients. The clinicals that she teaches require students to complete between 80 and 120 hours of clinical practice. During clinicals, Schroeder must directly observe and evaluate students' assessments and interactions with patients. She grades students on how well they employ the use of therapeutic communication

techniques with patients. It is also her responsibility in the clinical setting to make sure that the nursing students provide a minimally competent standard of treatment. (Tr. 2, pp. 182-183, 195, 205)

55. Schroeder has treated patients diagnosed with Alzheimer's and dementia. (Tr. 2, p. 192)

56. Although retained by the Division, Schroeder views her role as an independent expert to protect the public and patients. She does not view her role as advocating for a certain team to win. (Tr. 2, pp. 375-377)

57. Schroeder's opinions, set forth in paragraphs 58 -85, below, were based on her training, education and experience, and were held to a reasonable degree of professional certainty. (Tr. 2, pp. 207-208)

Dementia/Alzheimer's

58. Dementia is a general term used to describe conditions that impair memory. Alzheimer's is a neurodegenerative disease and is a type of dementia. The exact cause of Alzheimer's is not known but it is characterized by noticeable atrophy in the brain as well as plaques and tangles that disrupt normal brain function. The signs and symptoms of dementia include memory impairment (short and long-term), behavioral changes, personality changes, social withdrawal, and difficulty with tasks that involve sequencing. The condition will progress through stages, including limited abilities in walking and speaking, a decline in the understanding whether a person is thirsty or hungry, and eventually death. (Tr. 2, pp. 187-190)

Therapeutic Communication

59. Therapeutic communication is the type of communication used by nurses and healthcare professionals in interacting with patients. It is a technique of purposeful, planned communication that is meant to build trust and rapport with a patient. It is different than social communication in that therapeutic communication is always purposeful; there is a reason why the nurse is speaking with the patient and it is focused on the patient. (Tr. 2, pp. 195-196, 203-204)

60. Therapeutic communication is important to use with dementia and Alzheimer's patients. Patients with dementia and Alzheimer's constitute a special population and nurses should employ special considerations when communicating with them. They comprise a population which can be taken advantage of, abused and mistreated, so it is of paramount importance to treat Alzheimer's patients with dignity and respect. In communicating with Alzheimer's and dementia patients, the nurse must consider what their cognitive abilities and level of functioning are. Patients with higher levels of functioning are better able to benefit from education and may be involved in activities and procedures that patients in more advanced stages of Alzheimer's cannot. Nurses should also speak to dementia/Alzheimer's patients in very simple layman's terms. (Tr. 2, pp. 196-198)

61. Arguing and challenging patients with dementia and Alzheimer's is not therapeutic communication and is, in fact, a barrier to effective communication. Challenging a dementia or

Alzheimer's patient serves no purpose and can cause the patient to become frustrated. Speaking to a dementia or Alzheimer's patient in a demeaning manner or using vulgar language is never therapeutic communication. (Tr. 2, pp. 198-199, 204)

Failure to Perform Nursing with Reasonable Skill and Safety

62. Name calling and vulgar language. Calling MP a "jackass," "donkey," the "f-word" or "dumbass" does not meet the standard of performing nursing with reasonable skill and safety. Using vulgar language in a demeaning tone is likely to jeopardize the nurse-patient relationship and impact MP's willingness to speak to a nurse to share a care need. Failing to communicate a care need could potentially cause harm to MP. (Tr. 2, pp. 208-209)

63. Reading time on the clock and vulgar language. Stating to MP, "You can read the fucking time" when referring to his ability to read the clock does not meet the standard of performing nursing with reasonable skill and safety. It is never acceptable to swear at a patient. Using vulgar language with a patient is never therapeutic communication. (Tr. 2, pp. 204, 215-216)

64. Repeatedly challenging MP to read the time on the clock when he was unable to do so does not meet the standard of performing nursing with reasonable skill and safety. (Tr. 2, p. 227)

65. Calling names after eloping. Calling MP a "little shit" after he had eloped from the facility does not meet the standard of performing nursing with reasonable skill and safety. (Tr. 2, pp. 220-221)

66. Prohibiting Visitation as Punishment. Prohibiting MP's wife from visiting MP as punishment for eloping from the facility does not meet the standard of performing nursing with reasonable skill and safety. It is unacceptable for a nurse to punish a patient, particularly when the patient's conduct is a symptom of his disease. (Tr. 2, pp. 224-225; Ex. 100)

67. Repeated and challenging questions about events. Repeatedly asking MP why he had eloped from the facility when he could not remember does not meet the standard of performing nursing with reasonable skill and safety. (Tr. 1, p. 222)

Departing from or Failing to Conform to the Minimal Standards of Acceptable Nursing Practice that Created Unnecessary Risk or Danger to a Patient's Life, Health, or Safety

68. Name calling and vulgar language. Calling MP a "jackass," "donkey," "the f-word," or "dumbass" fails to conform to the minimal standards of acceptable nursing practice and created unnecessary risk or danger to the patient's life, health, or safety. The risk of harm to MP's health is that he may not come forth with his needs, which could place him in harm's way. In addition, he could experience emotional upset, as well as physiological changes that the emotional upset could produce, which could include elevated blood pressure and elevated cortisol levels. (Tr. 2, pp. 210-212)

69. Reading time on the clock and vulgar language. Stating to MP, "You can read the fucking time" when referring to his ability to read the clock failed to conform to the minimal standards of acceptable nursing practice and creates the unnecessary risk or danger to his life, health, or safety. The risk of harm to his health are that he will feel hopeless, and that it would be a barrier to effective communication. (Tr. 2, pp. 216-218)

70. Repeatedly challenging MP to read the time on the clock when he was unable to do so failed to conform to the minimal standards of acceptable nursing practice and created unnecessary risk or the danger to the patient's life, health, or safety. (Tr. 2, p. 227)

71. Calling names after eloping. Calling MP a "little shit" after he had eloped from the facility failed to conform to the minimal standards of acceptable nursing practice and created an unnecessary risk or danger to his life, health, or safety. The unnecessary risk of harm to his health was impairment of the patient's willingness to make their needs known to the healthcare professional. (Tr. 2, p. 220)

72. Prohibiting visitation as punishment. Prohibiting MP's wife from visiting MP as punishment for eloping from the facility fails to conform to the minimal standards of acceptable nursing practice and created the unnecessary risk or danger to the patient's life, health, or safety. (Tr. 2, p. 225)

73. Repeated and challenging questions about events. Repeatedly asking MP why he had eloped from the facility when he could not remember having done so failed to conform to the minimal standards of acceptable nursing practice and created unnecessary risk or danger to the patient's life, health, or safety. (Tr. 2, p. 223)

Abuse of 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

74. Name calling and vulgar language. When Respondent called MB, "jackass," "donkey," the "f-word" or "dumbass," she should have reasonably expected to cause physical pain, injury, mental anguish, or fear. Using such terms toward a patient is abusive. Calling a patient vulgar names can cause that person to have an acute emotional response which could produce physiological responses. (Tr. 2, pp. 212-214)

75. Reading time on the clock and vulgar language. When Respondent stated to MP, "You can read the fucking time" when he was unable to do so, she should have reasonably expected to cause physical pain, injury, mental anguish, or fear. Using language such as that could cause the patient to experience fear and mental anguish. (Tr. 2, p. 218)

76. Repeatedly challenging MP to read the time on the clock when he was unable to do so could reasonably be expected to cause mental anguish and or fear. (Tr. 2, pp. 227-228)

77. Calling names after eloping. Calling MP a "little shit" after he had eloped from the facility could reasonably be expected to cause fear and mental anguish. (Tr. 2, p. 221)

78. Prohibiting visitation as punishment. Prohibiting MP's wife from visiting MP as punishment for eloping from the facility could reasonably be expected to cause mental anguish and fear. (Tr. 2, pp. 225-226)

79. Repeated and challenging questions about events. Repeatedly asking MP why he had eloped from the facility when he could not remember having done so could reasonably be expected to cause mental anguish and fear. (Tr. 2, pp. 223-224)

Repeated or Significant Disruptive Behavior or Interaction with Health Care Personnel, Patients, Family Members, or Others That Could Interfere with a Patient's Care or Could Reasonably be Expected to Impact the Quality of Care Rendered

80. Name calling and vulgar language. Calling MP "jackass," "donkey," the f-word or "dumbass" could reasonably be expected to adversely impact patient care and the quality of that care. The quality of care would be affected because the nurse using that language is not in control emotionally and is exhibiting frustration, which impairs the nurse's ability to do her job. It could also affect the quality of care rendered by subordinates who hear the vulgar language directed at the patient and who then may treat the patient similarly. (Tr. 2, pp. 214-215)

81. Reading time on the clock and vulgar language. Stating to MP, "You can read the fucking time" when referring to his ability to read the clock is an interaction that could reasonably be expected to adversely impact the quality of care. It could affect care because the patient would not feel he could contact a trusted healthcare profession with his needs and that could delay or otherwise impede care. (Tr. 2, p. 219)

82. Repeatedly challenging MP to read the time on the clock when he was unable to do so could reasonably be expected to adversely impact the quality of care. (Tr. 2, p. 228)

83. Calling names after eloping. Calling MP a "little shit" after he had eloped from the facility could reasonably be expected to adversely impact the quality of care. (Tr. 2, p. 221)

84. Prohibiting visitation as punishment. Prohibiting MP's wife from visiting MP as punishment for eloping from the facility could reasonably be expected to adversely impact the quality of care. MP's wife was in a position to observe changes in MP's behavior and would be able to notice changes in his condition. Prohibiting MP's wife from seeing him would adversely impact the ability to note any changes which could warrant further investigation by a healthcare provider. (Tr. 2, p. 226)

85. Repeated and challenging questions. Repeatedly asking MP why he had eloped from the facility when he could not remember having done so is an interaction that could reasonably be expected to adversely impact the quality of care. (Tr. 2, p. 224)

Testimony of Michele M. Tessmer, R.N., regarding Respondent

86. Michele Tessmer (Tessmer), a registered nurse, was called as a witness for Respondent. She has been a nurse for 22 years. Prior to being a nurse, she was a CNA for approximately seven years. (Tr. 2, p. 414; Ex. 108)

87. At one point, Tessmer was the regional director of cares for Our House Senior Living, covering eight houses in Wisconsin. She then became the community director for two Our House facilities in Wisconsin Rapids. (Tr. 2, pp. 418-418, 424; Ex. 108)

88. Tessmer met Respondent in 2012, when Tessmer was a director of nursing at Marshfield Care Center. She interviewed Respondent for a charge nurse position and hired her on the spot during the interview. According to Tessmer, the interview revealed a nurse who cared about patients and patients' rights, and had that as a focus. (Tr. 2, pp. 432-433, 438)

89. According to Tessmer, Respondent immediately caught on to the job very well and became one of Tessmer's best nurses. Tessmer stated that Respondent's communication with patients, including dementia patients, was "outstanding" and that she never had any problems with Respondent's treatment of patients or their families. (Tr. 2, pp. 433-434, 438-439)

90. When Tessmer was asked to step into her community director role, she recommended Respondent as the "perfect nurse" for the regional director of cares. According to Tessmer, Respondent's skills and abilities in how to interact with patients are qualities that not many nurses have. Tessmer used Respondent as a resource if she was having problems interacting with patients. She also had other health care professionals train with Respondent so that Respondent could teach them her skills in interacting. Tessmer is one of Respondent's professional references. (Tr. 2, pp. 438, 440)

91. Tessmer has never heard Respondent swear, not even socially. Tessmer agrees that a nurse who swears at a patient is "unacceptable" and should not be working as a nurse. (Tr. 2, pp. 434, 442-443)

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

Pursuant to Wis. Stat. § 441.07(1g)(b) and (d), 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 "one or more violations of this subchapter [subchapter I] or any rule adopted by the board under the authority of this subchapter," or has engaged in "[m]isconduct or unprofessional conduct." The provisions of Wis. Admin. Code ch. N 7 are rules adopted by the Board under the authority of subchapter I of Wis. Stat. ch. 441.

Pursuant to Wis. Admin. Code § N 7.03, grounds for taking disciplinary action on a license or certificate include the following:

> (4) Misconduct or abuse, including any of the following:
>
> . . .
>
> (c) Abusing 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.
>
> (d) Engaging in repeated or significant disruptive behavior or interaction with health care personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered.
>
> . . .
>
> (6) Unsafe practice or substandard care, including any of the following:
>
> (a) Failing to perform nursing with reasonable skill and safety.
>
> . . .
>
> (c) Departing 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. Actual injury to a patient need not be established.

The Division has demonstrated by a preponderance of the evidence that Respondent has violated Wis. Admin. Code §§ N 7.03(4)(c), 7.03(4)(d), 7.03(6)(a), and 7.03(6)(c) by engaging in the following conduct:

a. Calling a patient "jackass," "donkey," the "f-word" or "dumbass;"
b. Stating to MP, "You can read the fucking time" when referring to his ability to read time on a clock;
c. Repeatedly asking MP in a challenging manner to read the time on the clock when he was unable to do so;
d. Calling MP a "little shit" after he had eloped from the facility;
e. Repeatedly asking MP why he had eloped from the facility when he could not remember; and
f. Prohibiting or attempting to prohibit family members from visiting MP as punishment for eloping from the facility.

The Division's expert, Olivia Schroeder, explained how this conduct constituted violations of these four separate code provisions. Her expert opinions were uncontroverted. Respondent does not dispute, and appears to concede, that the facts alleged, if true, constitute violations of these provisions. In fact, she stated that swearing at MP in the manner alleged would be "cruel," would

"damage" and "degrade" MP, and would be "counterintuitive to everything that I know as a nurse." (Tr., 2, p. 346) Likewise, her witness, Michele Tessmer, said that a nurse who swears at a patient should not be a nurse.

Respondent also does not argue that she made any of the vulgar comments alleged in jest or that she had a particular rapport and familiarity with MP (who also used curse words with Respondent) that made the language used acceptable. Instead, Respondent's entire argument in this case is that the conduct alleged did not occur, specifically, that she never swore at MP, never asked Mrs. P not to visit him, and never demanded that he read the clock or provide a reason for his elopement on his birthday.

Respondent attempts to undermine Gukenberger's and Mrs. P's credibility in various ways, none of which are significant or convincing. For example, she asserts their testimony that Mrs. P took MP home some weekends is contradicted by MP's medical records. Respondent is correct that MP's resident log shows that he did not have any weekend overnights outside of Our House for any weekends between January 23, 2015 (the date MP began residing at Our House) through June 30, 2015. (*See* Exhibit 100, resident log) However, the records do establish that during some weekends, MP did leave the premises with Mrs. P during the day. The records also indicate that after the events at issue in this case, Mrs. P did take MP home for overnights on weekends, particularly in September of 2015. (*See* Exhibit 100, attached note from Mrs. P, and MAR September 2015)

Gukenberger's and Mrs. P's credibility is not undermined by their testimony regarding weekends with Mrs. P. First, the testimony was ambiguous as to whether the weekend trips referred to by Mrs. P were overnight trips. Mrs. P's testimony on this point was as follows:

> Q Were there times where you would take [MP] home with you?
> A Yes.
> Q Would you have him for overnight or weekends?
> A I would take him home usually every weekend.
> . . .
> Q And it's your testimony that you did take him home on weekends?
> A Correct.

(Tr. 1, pp. 102-103, 136)

Gukenberger's testimony on this point was as follows:

> Q Do you recall if [Mrs. P] took MP home sometimes on the weekends from Our House?
> A Yes.
> Q How often would that happen?
> A When he first arrived at the home, he was going home frequently on the weekends, and that quit happening as frequent as his time there went on. She wasn't taking him home no longer as his disease progressed.

(Tr. 2, p. 455) Neither witness specifically testified that Mrs. P took MP home for overnights on the weekends.

However, even assuming that Gukenberger's and Mrs. P's testimony referred to *overnight* weekend trips rather than day trips, Mrs. P did not testify as to the time period in which MP went home with her. Thus, she could have been referring to the period after the events in question. Likewise, Gukenberger did not provide any dates for the weekend visits, but simply stated her belief, perhaps incorrect, that this occurred more frequently at the beginning of MP's residency at Our House rather than later. Further, to the extent that either Gukenberger or Mrs. P were inaccurate or incorrect in their testimony regarding weekend and/or overnight trips (trips that occurred more than two years prior to their testimony), this does not undermine their credibility regarding the essential and more memorable conduct in this case, namely, Respondent using vulgar, degrading or harassing language with MP, including on his birthday, and advising Mrs. P not to visit her husband and to threaten MP with divorce.

Respondent also asserts that Mrs. P's testimony is contradicted by the medical records in other ways. During cross-examination by Respondent's counsel, Mrs. P agreed that there were times that MP was very agitated, that there were circumstances under which he would yell at staff and other residents, and that he paced and eloped. (Tr. 2, pp. 160-16) However, when asked by Respondent's counsel whether she agreed that MP "told team member staff to move out of the way or he would punch them out," Mrs. P disagreed, and denied that she had ever been informed of such an incident. (Tr. 2, p. 161) Respondent asserts that Mrs. P's denial is contradicted by MP's medical records. However, this is not so. The part of MP's medical records upon which Respondent relies states:

> [MP] made it half way down the hallway and then started to proceed fast walking down the hallway towards the front door. Team member made it to the front door before [MP] could go out the door. [MP] began to tell team member that they better move out of the way before he punches right through the glass. Team member then decided to go for a small walk outside with [MP]. Team member was with [MP] at all times while outside. [MP] began to calm down and we headed back inside. Team member called [Mrs. P] (POA) for the 2nd time and left a message. [Mrs. P] (POA) called right back and calmed [MP] down and apologized to the team about his behaviors.

(Ex. 100, February 22, 2015 Resident Log Entry) Nowhere in this excerpt does it state that MP threatened to punch out staff members as characterized by Respondent's counsel in her questioning of Mrs. P. Rather, MP threatened to break through glass, presumably the door. Thus, Respondent's attempt to undermine Mrs. P's credibility on this point is unavailing.

Respondent also stresses that staff did not document any verbal abuse by Respondent in MP's records. However, as noted by the Division, the handwritten charting by the RCAs was kept *in Respondent's office*. (Tr. 2, pp. 301-302). Furthermore, Respondent reviewed *all* of the notes and initialed the pages after she reviewed them. (Tr. 2, p. 309). It is not surprising that, under these watchful circumstances, staff members did not document this conduct by Respondent, their

supervisor, particularly when Respondent had been involved in the termination of other Our House employees. (Tr. 2, p. 360)

Respondent has not demonstrated that there would be any motivation for either Gukenberger or Mrs. P to make up these allegations against Respondent. Respondent's suggestion that Mrs. P was emotionally unstable is not convincing, nor was Respondent's testimony that staff generally did not receive her well because she implemented accountability at Our House. (Tr. 2, pp. 274, 299-300) Mrs. P's testimony was credible and believable. Her emotions were appropriate to the situation and to the testimony she was providing. It was apparent that Mrs. P believed that she had not protected MP for allowing Respondent to speak to MP in a demeaning way. She made the statement several times in her testimony (*Id.* Tr. 1, pp. 115, 121) It was evident that regret still weighed on her heavily.

All of Respondent's attempts to undermine Mrs. P's and Gukenberger's credibility are unpersuasive. Moreover, Mrs. P's and Gukenberger's testimony is substantially consistent with regard to the underlying allegations at issue in this case. In addition, Mrs. P's testimony is substantially consistent with her complaint to the Department and written statements to Our House regarding the events at issue, both of which she made closer in time to the events. I also note that Gukenberger credibly testified to the facts, regardless of whether they were favorable to Respondent or not. She acknowledged, for example, that Respondent had an open door policy and that when she could not calm a patient down, she could bring the patient to Respondent's office and Respondent would be successful in calming the patient down. She further stated that staff often brought MP to Respondent's office to calm him down and that most to the time, he would be calm when he left. (Tr., 1, pp. 47-48, 53-54)

Respondent, facing disciplinary action, has more of a motivation to falsely deny the allegations at issue. Based on the record, her denials are not persuasive. Not only are the denials negated by credible evidence to the contrary, but her own statements undermine her credibility. For example, both Mrs. P and Respondent acknowledge that after MP's birthday party on June 7, 2015, Mrs. P came back to Respondent's office because she was upset about the discussion on MP's birthday related to MP's elopement the previous day. In addition, Respondent acknowledged that when she called Mrs. P later that night, Mrs. P was still crying. This supports the allegations in this case regarding what occurred in Respondent's office just prior to the party. (Tr., 1, pp. 122; Tr. 2, pp. 323-333, 328; Ex. 102, p. 9)

Also, Respondent admits in her response to Mrs. P's complaint that on MP's birthday, she attempted to get MP to recall eloping the day before and to make him and Mrs. P realize how detrimental such action was to the facility. (Ex. 102) In Respondent's resident log for April 7, 2015, Respondent acknowledges that MP "states he does not recall any events from yesterday." (Ex. 100, June 7, 2017 Resident Log entry by Respondent) During her testimony, Respondent stated that she did not attempt to get Respondent to remember "why he eloped" but that she attempted to get MP to remember the events just prior to the elopement that triggered the elopement, a distinction which makes little sense. (Tr. 2, pp. 347-348) Respondent was very concerned about the fact that one of her staff left the building, leaving only one person in the building to care for patients. It is clear that Respondent felt MP was responsible for the fact that a

staff member left the building and caused a staffing issue. When describing the staffing issue, Respondent stated the following:

> And I was concerned for his safety and more concerned for the safety of the rest of the house, because this time when the staff member went out, she left the house with only one caregiver there for 18 other residents.
> . . .
> And that put the rest of the facility at great risk, and that is a huge problem for me as the nurse in charge. That's a huge problem for the safety of those residents, and it was something that *I needed to make sure [MP] understood.*

(Tr. 2, p. 312) (emphasis added) It is clear from Respondent's testimony that when she pulled MP and Mrs. P into her office on June 7, 2015 to discuss the elopement, she was intent on making MP understand that his behavior was problematic. She stated as follows:

> And MP was very smart.
> ...
> So if I could get him to understand when he does that - - I need him to recognize that when he's getting angry, there has to be another alternative. Because when you leave, if someone has to go after you, it can't be at the expense of everyone else.

(Tr. 2, p. 312) Despite all her training and experience with Alzheimer's and dementia patients, and despite MP suffering from severe dementia to the extent that he often could not remember having a conversation with someone just minutes before, Respondent expected MP to understand that if he has an emotional feeling and leaves the building, a staff member may follow him outside, which would leave only one person in the building, and having only one staff member in the building can be dangerous for everyone else.

Further, although Respondent testified at hearing she could not remember if MP or Mrs. P cried during the conversation in her office on June 7, 2015, in her August 4, 2015 response to Mrs. P's complaint, she states: "Cindy and Mark both cried during the conversation" but that "[n]obody sobbed uncontrollably during this conversation." (Tr. 2, pp. 314, 317, Ex. 102, pp. 8-9) That they were both crying indicates that the conversation was unpleasant. And although it was not extremely unusual for MP to cry, Mrs. P described MP's crying during that conversation as extreme: "And she just kept it up and up and just kept asking him. And MP just started crying hysterically, I mean, just – I have never ever seen him cry like he cried that day, and I just sat in the chair like a dummy just listening to her." (Tr. 1, p. 121) This description was corroborated by Gukenberger, who testified that another Our House employee told her that P and Mrs. P were upset when they left Respondent's office and that MP was still crying as he blew out the candles on his birthday cake.

Significantly, nowhere in Respondent's resident log entry following the June 7, 2015 meeting does she mention the fact that both MP and Mrs. P were crying. (Ex. 100) Respondent's own witness Michele Tessmer testified that it was very important to properly document a patient's psychological status in the resident log. (Tr. 2, 427) She also testified that if a patient is "upset, that needs to be something that's documented, and for whatever reason that is." (Tr. 2, p. 429)

That Respondent did not document this information further calls into question her characterization about what actually occurred during the meeting.

Also supporting Mrs. P's and Gukenberger's version of events is that management at Our House conducted an investigation into the matter, and based on Respondent's dismissal or resignation ten days later, evidently concluded that Mrs. P's allegations were true.

Based on the evidence of record, the Division has established by a preponderance of the credible evidence that Respondent failed to perform nursing with reasonable skill and safety, in violation of Wis. Admin. Code § N 7.03(6)(a); departed from or failed 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, in violation of Wis. Admin. Code § N 7.03(6)(c); abused 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, in violation of Wis. Admin. Code § N 7.03(4)(c); and engaged in repeated or significant disruptive behavior or interaction with health care personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered, in violation of Wis. Admin. Code § N 7.03(4)(d).

As a result, Respondent is subject to discipline pursuant to § 441.07(1g)(b) and (d), and Wis. Admin. Code § N 7.03.

Discipline

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

The Division requests that Respondent be reprimanded and that she be required to take three hours on education on the topic of patient rights, three hours of education on the topic of stress management, and three hours of education on ethics and professionalism. The Division further requests that Respondent's license be limited for a period of at least two years so that she work only under direct supervision; only in a work setting pre-approved by the Board; and not in a home health, assisted living, agency, pool or as a nurse in a correctional setting or setting in which she is the only RN on duty. The Division's recommendations also include a requirement that Respondent provide a copy of this decision to nursing employer(s) and that she arrange for her nursing employer(s) to send to the Department Monitor quarterly reports, reporting the terms and conditions of her employment and evaluating her work performance, and that her practice be limited to Wisconsin. The Division's recommendations, as set forth in more detail in the order section below, are appropriate.[3]

[3] However, this tribunal does not adopt the following order term suggested by the Division: "This Order constitutes an agency finding of abuse or neglect within the meaning of Wis. Stat. §§ 48.685 and 50.065. Should Respondent wish to work in a Wisconsin DHS-licensed facility in any role, Respondent will need to pass a Rehabilitation Review through DHS prior to commencement of such employment." (Division's recommended Proposed Decision and Order, p. 35) Notably, this was not a case brought by DHS, nor did the Division's Complaint allege violations of Wis. Stat. §§ 48.685 and 50.065. Likewise, these issues were not argued at hearing or briefed post-hearing. As a result, this tribunal does not address them.

Respondent's conduct in verbally abusing MP on multiple occasions and prohibiting or attempting to prohibit Mrs. P from visiting him is very serious conduct. Particularly aggravating is that MP suffered from dementia and was vulnerable. In fact, dementia patients are particularly vulnerable in that some may not be able to remember the abusive behavior to report it.

In order to promote rehabilitation, the discipline imposed against Respondent should include education on patient rights, stress management, ethics and professionalism. Further, in order to protect the public, Respondent should not be allowed to work in an unsupervised setting and should not be the only RN on duty during her shifts. Respondent engaged in verbal abuse with MP with impunity, in part, because her subordinate staff members did not feel comfortable confronting her. Subordinate staff members did not speak out about Respondent's conduct until an internal investigation was conducted and Respondent was under suspension.

Also, Respondent should be required to provide the order in this matter to all employers. Doing so ensures that she will be adequately monitored and that 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.

Prior Board decisions are instructive as to the appropriate discipline in this case. For example, in *In the Matter of Disciplinary Proceedings Against Peggy Karr, L.P.N.,* LS9604033NUR (Sept 12, 1996),[4] Peggy Karr, a licensed practical nurse, scolded a patient until the patient cried and instructed staff to ignore the patient's call light. The Board revoked her license, noting that protection of the public was of paramount importance in determining the level of discipline, and explaining the need for revocation as follows:

> . . . Ms. Karr's violations were not simply of unintentional omission or neglect, but were intentional and aggravated by her interference and obstruction of the provision of care by other nursing staff, and motivated by a prejudice toward and intolerance of the conditions of the patient under her care. Ms. Karr's conduct evidenced a callous disregard of the principles of providing care and comfort to the ill in a manner that is conducive to the patient's health and well being, which are fundamental to the practice of the nursing profession. Revocation of license is the only appropriate discipline to protect the public and similarly disabled patients from the type of unacceptable conduct Ms. Karr displayed in this matter.

Further, in *In the Matter of the Disciplinary Proceedings Against Robin J. Staver, R.N.,* 0003797 (March 12, 2015),[5] a patient at a residential facility refused to take a shower. Robin Staver, a registered nurse, attempted to physically force the patient out of bed which resulted in the patient and Staver falling on the floor. The patient cried as a result. The Board suspended her license indefinitely until she could provide proof of completion of education on the topics of patient rights, ethics and professionalism.

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[4] A copy of this decision can be found at https://online.drl.wi.gov/decisions/1996/ls9604033nur-00075827.pdf.
[5] A copy of this decision can be found at https://online.drl.wi.gov/decisions/2015/ORDER0003797-00010983.pdf.

In *In the Matter of the Disciplinary Proceedings Against Jane C. Arps-Johnson, R.N.,* LS0407291NUR (July 29, 2004),[6] a dementia patient in the intensive care unit at a facility had activated her nurse call light multiple times, so the registered nurse, Jane Arps-Johnson, placed the call light out of reach. Arps-Johnson also temporarily left the unit without securing proper nursing coverage. The Board reprimanded Arps-Johnson and placed the following limitations on her license: working only under the direct supervision of another professional nurse and no working independently as a nurse for a minimum of two years; completing education on the topics of anger and stress management, patient rights and ethics; submitting quarterly work reports from nursing employers for a minimum of two years; notifying the Department Monitor of any change of employment during the time the order was in effect; and providing a copy of the order to current or prospective employers.

In the present case, Respondent's conduct includes multiple instances of vulgar and demeaning language toward MP, ridiculing and berating comments about his inability to remember how to tell time and to remember events from the previous day, and punishment for behaviors that MP was not able to control. Based on the foregoing, the discipline recommended by the Division is reasonable and necessary.

Costs

The Board 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 Board 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.

In previous orders, many factors have been considered when determining if all or part of the costs should be assessed against a Respondent. These 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 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 within the Board'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.

The Division requests that the full costs of this proceeding be borne by Respondent. Based on the factors set forth above, I conclude that imposition of 80 percent of the costs on Respondent is appropriate. The Division has proven all of the violations alleged, although all of the violations stem from the same underlying conduct. In addition, Respondent's conduct was intentional and serious, and violated a nurse's fundamental duty to provide care and comfort to a vulnerable

[6]A copy of this decision can be found at https://online.drl.wi.gov/decisions/2004/ls0407291nur-00068564.pdf.

patient. In analyzing the factors above, I give the greatest weight to the egregiousness of Respondent's conduct. As was evident from Michelle Tessmer's testimony, however, Respondent has also exhibited commendable nursing qualities with other patients. She also has no prior disciplinary history in her career as a nurse. Further, the level of discipline sought by the Division is a reprimand with educational requirements and specified license limitations. While certainly serious to Respondent, the discipline sought and imposed in this case is on the lower end of the spectrum in terms of severity. In addition, Respondent has cooperated throughout these proceedings, although her hearing testimony on the conduct alleged was ultimately not found to be credible. Finally, I note that any costs not borne by Respondent will have to be absorbed by other licensees who have not engaged in misconduct.

Based on the foregoing, it is appropriate for Respondent to pay 80 percent of the investigation and of these proceedings.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter pursuant to Wis. Stat. § 441.07.

2. The Division has established by a preponderance of the credible evidence that Respondent violated Wis. Admin. Code § N 7.03(4)(c), Wis. Admin. Code § N 7.03(4)(d), Wis. Admin. Code § N 7.03(6)(a), and Wis. Admin. Code § N 7.03(6)(c).

3. As a result of these violations, Respondent is subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b) and (c), and Wis. Admin. Code § N 7.03.

4. The discipline contained in the Order section below is warranted under Wis. Stat. § 441.07, Wis. Admin. Code § N 7.03, the facts of record in this case, and the criteria set forth in *Aldrich*.

5. Under Wis. Stat. § 440.22(2) and the facts of this case, Respondent imposition of 80 percent of the costs of this proceeding on Respondent is reasonable and appropriate.

ORDER

Accordingly, IT IS HEREBY ORDERED:

1. Respondent Donna J. Klimek, R.N., is REPRIMANDED.

2. The professional nursing license issued to Respondent (license number 170023-30), and her privilege to practice in Wisconsin pursuant to the Nurse Licensure Compact, are LIMITED as follows:

   a. Within 90 days of the date of this Order, Respondent, at her own expense, shall complete three hours of education on the topic of patient rights, three hours of education on the topic of stress management, and three hours of education on ethics and professionalism. Respondent is responsible for finding appropriate courses and submitting the course information to the Board or its designee for approval prior to

taking the courses and in sufficient time to obtain Board approval within the 90-day time frame, taking into account the Board's meeting schedule. Respondent shall provide proof of completion of the education to the Department Monitor.

b. 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 14 days of the date of this Order for employment current as of the date of this Order.

c. For a period of at least two 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 as a nurse in a correctional setting. Respondent is prohibited from being the only RN on duty on any shift when she is working as an RN.

d. For a period of at least two years while working at least half-time as a nurse, Respondent shall arrange for her nursing employer(s) to send to the Department Monitor quarterly reports, reporting the terms and conditions of Respondent's employment and evaluating her work performance.

e. Pursuant to Nurse Licensure Compact regulations, Respondent's nursing practice is limited to Wisconsin during the pendency of these limitations. 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.

f. Respondent shall notify the Department Monitor of any change of nursing employment during the time in which the Order is in effect. Notification shall occur within 15 days of a change of employment and shall include an explanation of the reasons for the change.

g. After two years of working at least half-time as a nurse, Respondent may petition the Board for the modification or termination of the limitation. The Board may grant or deny the petition, in its discretion, or may modify this Order as it sees fit.

3. Request for approval of courses, proof of successful course completion and payment of costs (made payable to the Wisconsin Department of Safety and Professional Services) shall be sent by Respondent 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

5. In the event Respondent violates any term of this Order, Respondent's license or Respondent's right to renew her license, may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of the Order. The Board may, in addition and/or in the alternative refer any violation of this Order to the Division for further investigation and action.

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 March 26, 2018.

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