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
MICHAEL HARASYMIW, R.N., RESPONDENT. [redacted]6032	DHA Case No. SPS-18-0007 DLSC Case No. 16 NUR 421

BACKGROUND

On November 21, 2018, 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. On January 10, 2019, the Board of Nursing (Board) met to consider the merits of the PDO. The Board voted to approve the PDO with variance. The PDO is attached hereto and incorporated into this Final Decision and Order with Variance.

VARIANCE

Pursuant to Wis. Stat. §§ 440.035(1m) and 441.07(1g), 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)(b). The Board may make modifications to a PDO, in a class 2 proceeding, pursuant to Wis. Stat. § 227.46(2), provided the Board's decision includes an explanation of the basis for each variance.

In the present case, the Board adopts the PDO in its entirety with the following variance:

1. Respondent held a Wisconsin home state multistate license on the effective date of the Enhanced Nurse Licensure Compact (eNLC), July 20, 2017. Respondent retained and was able to renew the multistate license pursuant to Wis. Stat. § 441.51(3)(g).

2. The limitations of this Order are encumbrances as defined in Wis. Stat. § 441.51(2)(e).

3. Pursuant to the eNLC, a nurse who fails to satisfy the multistate licensure requirements in Wis. Stat. § 441.51(3)(c), due to a disqualifying event occurring after the eNLC's effective date, shall be ineligible to retain or renew a multistate license, and the nurse's multistate license shall be deactivated. Wis. Stat. § 441.51(3)(g)2.

4. Respondent no longer meets the requirements of Wis. Stat. § 441.51(3)(c)5. as the limitations of this Order are an encumbrance upon his license.

5. As a result, Respondent's nursing practice is limited to the State of Wisconsin during the pendency of this Order.

ORDER

Accordingly, IT IS ORDERED that:

1. Respondent Michael T. Harasymiw, R.N., is REPRIMANDED.

2. The Registered Nurse license issued to Michael T. Harasymiw, R.N., (license number 105066-30) and his privilege to practice in Wisconsin pursuant to the Enhanced Nurse Licensure Compact, are LIMITED as follows:

    a. Respondent shall provide his current nursing employer with a copy of this Order. He shall also provide any other nursing employer with a copy of this Order before engaging in any nursing employment. Respondent shall provide the Department of Safety and Professional Services Monitor (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 fourteen (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.

    b. Respondent shall obtain preapproval by the Board prior to any change of nursing employment while this Order is in effect.

    c. For a period of at least two (2) years while working at least half-time as a nurse, Respondent shall arrange for his nursing employer(s) to send to the Department Monitor quarterly reports, reporting the terms and conditions of Respondent's employment and evaluating his work performance.

    d. After two (2) years of working at least half-time as a nurse, Respondent may petition the Board for modification or termination of the limitations. The Board may grant or deny the petition, in its discretion, or may modify this order as it sees fit.

3. Pursuant to the eNLC, Respondent's multistate license is deactivated. Respondent's nursing practice is limited to the State of Wisconsin during the pendency of this Order.

4. Respondent shall pay fifty percent (50%) of recoverable costs in this matter in an amount to be established, pursuant to Wis. Admin. Code § SPS 2.18. After the amount is establishes, 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
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

Respondent may also submit information online via DSPS' Monitoring Case Management System, here:

https://app.wi.gov/DSPSMonitoring

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

Dated at Madison, Wisconsin this 11th day of February, 2019.

By: Pam White,
A Member of the Board

Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against Michael T. Harasymiw, R.N. Respondent	DHA Case No. SPS-18-0007 DLSC Case No. 16 NUR 421

PROPOSED DECISION AND ORDER

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

Michael T. Harasymiw, R.N., by

Attorney Robert Ruth
Robert T. Ruth Law Offices, S.C.
7 North Pinckney, Suite 240
Madison, WI 53703

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

PROCEDURAL HISTORY

This proceeding was initiated by the filing of a formal Complaint by the Department of Safety and Professional Services ("Department"), Division of Legal Services and Compliance ("Division"), on January 18, 2018, against Respondent Michael T. Harasymiw ("Respondent").

On February 7, 2018, the undersigned administrative law judge ("ALJ") issued a Notice of Telephone Prehearing Conference scheduling a prehearing conference for February 20, 2018. At the Division's request, the February 20, 2018 conference was rescheduled to May 7, 2018. At

the May 7, 2018 conference, counsel for Respondent indicted that Respondent did not dispute the facts or violations alleged. On that same date, the ALJ issued a Notice scheduling the matter for a telephone status conference on June 19, 2018 to allow Respondent to file an Answer to the Complaint and to determine whether he would call witnesses at a hearing on discipline and costs. On May 10, 2018, Respondent filed an Answer to the Complaint, wherein he admitted some, but not all, of the Division's allegations.

A telephone conference was held on June 19, 2018, during which counsel for Respondent agreed that the remaining issues in this matter could be resolved through a stipulation of facts and written arguments. A Briefing Order was issued the same date. Pursuant to a joint request of the parties, an Amended Briefing Order was issued on August 15, 2018, whereby the Division was to file its brief-in-chief by August 30, 2018, Respondent would file a response by September 28, 2018, and any reply would be filed by October 11, 2018. As part of the Briefing Order, the parties were to file a stipulation of facts, which occurred on July 19, 2018. At the request of the Division, and with Respondent's agreement, on August 24, 2018, the ALJ issued a two-week extension of the filing deadlines.

Following the completion of briefing on October 12, 2018, on October 25, 2018, the ALJ sought clarification from Respondent's counsel regarding his argument related to discipline. On October 29, 2018, Respondent filed a clarification letter. The Division did not submit a response or request to do so.

FINDINGS OF FACT

The following facts are taken from the parties' Stipulated Facts filed in this matter.[1]

1. Respondent Michael T. Harasymiw is licensed in the State of Wisconsin as a professional nurse, having license number 105066-30, first issued on September 9, 1990, and current through today's date.

2. At all times relevant to this proceeding, Respondent was employed as a professional nurse at a skilled nursing facility in Iowa, practicing under his Wisconsin nursing license pursuant to the Nurse Licensure Compact.

[1]This case is decided based solely on the stipulated facts of the parties. Although the parties attempt to insert additional facts into the case, none of these additional factual assertions have been proven in any respect and will therefore not be considered. For example, Respondent's brief asserts that he was overworked on the night in question. This assertion is not in the form of an affidavit or testimony under oath. The Division asserts that Respondent failed to assess the patient after the fall; however, this assertion is taken from a charging document in the Iowa criminal case for a charge to which Respondent did not plead guilty and from the Iowa Board's charging document. The Iowa Board's Settlement Agreement and Final Order does not find the allegations contained in its charging document to be true, but instead only states, "Respondent acknowledges that the allegations contained in the Statement of Charges, if proven in a contested case proceeding, would constitute grounds for the discipline agreed to in this Order." (Division's brief-in-chief, McGowan Affidavit, Ex. B) The Division also asserts that the patient suffered a broken hip. This information is contained in the charging document for the criminal charge of tampering with records. Although Respondent did plead guilty to the tampering charge, the patient's broken hip would not be part of a tampering offense or plea. The Division also asserts that after the fall, Respondent left the facility. It is not clear what the source of that assertion is.

3. On July 18, 2016, Respondent pleaded guilty to one count of tampering with records in violation of Iowa Code § 715A.5 (misdemeanor), in Hardin County District Court case number FECR309579. The charge was based on the following conduct:

> On or about February 12, 2015, Respondent incorrectly documented in the resident's chart that he had contacted the resident's physician about the resident's fall.

4. The Hardin County Court entered a Deferred Judgment Order placing Respondent on informal probation for a period of two years and requiring him to pay a civil penalty, a law initiative surcharge, court costs, court appointed attorney fees and any restitution.

5. Respondent completed the two years of informal probation in the Hardin County case on July 18, 2018. All costs and surcharges have been paid in the Hardin County case. No restitution was requested or imposed.

6. The Iowa Board of Nursing ("Iowa Board") filed a Notice of Hearing and Statement of Charges on January 12, 2017, based on the above-described Harden County incident. On April 19, 2017, Respondent and the Iowa Board entered into a settlement agreement in that matter whereby Respondent agreed to complete 60 hours of continuing education on ethics and assessment and the Iowa Board of Nursing agreed that the order was the final resolution of a contested case.

7. On September 5, 2017, Respondent completed the education hours required under the order.

8. By the conduct described above, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § N 7.03(2), in that he violated a law substantially related to the practice of nursing.

DISCUSSION

Violations

Respondent concedes that he engaged in unprofessional conduct as defined by Wis. Admin. Code § N 7.03(2) by violating a law substantially related to the practice of nursing and that he violated Wis. Admin. Code § N 7.03(1)(b) by "[h]aving a license to practice nursing or a nurse licensure compact privilege to practice denied, revoked, suspended, limited, or having the credential holder otherwise disciplined in another state, territory, or country." He also agrees that a reprimand is appropriate in this case. Thus, the only disputes in this matter are with respect to the issues of license limitations and costs.

Discipline

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. Because Respondent violated Wis. Admin. Code § N 7.03(1)(b) and (2), he may be disciplined pursuant to Wis. Stat. § 441.07(1g)(b) and (d).

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 the Wisconsin Board of Nursing ("Board") impose the following limitations on his license: (1) Respondent must provide his nursing employer with a copy of this Order before engaging in any nursing employment; (2) for a two-year period while working at least half-time as nurse, Respondent must work only under direct supervision in a work setting preapproved by the Board, and not work in a home health, assisted living, agency, or pool setting or as a nurse in a correctional setting; (3) Respondent must submit quarterly reports from his nursing employer for a two-year period; and (4) Respondent must notify the Department of any change of nursing employment within 15 days of such change, along with an explanation of the reasons for the change.

Respondent agrees to the reprimand but objects to the Division's recommended limitation prohibiting him from working as a pool nurse.[2] Respondent states that he currently works as a pool nurse, that this is the only nursing work that he can find, and that if he cannot practice as a pool nurse, for all practical purposes, he would not be able to practice his profession. Also, because working as a pool nurse does not necessarily involve working under direct supervision, Respondent also objects to the recommendation requiring direct supervision and to the requirement that he obtain preapproval from the Board if such preapproval prevents him from working as a pool nurse. Respondent also objects to the limitation of his practice to Wisconsin, stating that he works as a pool nurse throughout the country.

As agreed to by the parties, a reprimand is appropriate. Regarding its proposed license limitations, the Division states that Respondent cannot be trusted to provide nursing care in a setting where he is unsupervised. The Division does not provide a rationale for limiting Respondent's practice to Wisconsin.

The Division has not shown that it is necessary to prohibit Respondent from working as a pool nurse and only under direct supervision in Wisconsin -- limitations that would evidently require him to quit his current job as a pool nurse and seek other employment, possibly resulting in unemployment. Likewise, it has not shown that Respondent should be restricted from working in a home health, assisted living, or agency setting, or as a nurse in a correctional setting. As noted by Respondent, the conduct at issue occurred in 2015 and was one incident in an otherwise unblemished 28-year nursing career. Respondent has been practicing for three years since the

[2] Neither party has provided a definition of "pool nurse." In its Reply Brief, the Division describes a pool nurse as "in and out of various facilities, with no direct supervision." (Reply Brief, p. 4) According to an on-line dictionary, a pool nurse is a nurse who is "an employee of the hospital who is not assigned to a specific patient care unit and is available to work in (float to) units with the greatest need." *See* https://medical-dictionary.thefreedictionary.com.

2015 incident, including as a pool nurse, without further incident. Neither the Iowa Board nor the Iowa criminal court deemed it necessary to place any restrictions on his nursing license. The Iowa criminal court saw fit to enter a Deferred Judgement Order placing Respondent on informal probation for a period of two years and requiring him to pay a civil penalty, court costs and other fees. Respondent successfully completed the two years of informal probation on July 18, 2018, with all required costs and fees paid. In addition, the incident in 2015 occurred in a skilled nursing facility, which presumably had other nursing staff, including supervisory staff, present. The Division therefore has not shown why the limitations at issue are necessary to ensure the safety of others.

The prior Board decisions relied on by the Division do not support these limitations. The Division cites *In the Matter of Disciplinary Proceedings Against Kawana Hickman, L.P.N.*, Order No. 0002526 (July 11, 2013), in which a nurse was convicted of three counts of misdemeanor theft by false representation. The nurse engaged in a series of transactions which occurred over a period of a year and a half, in which she intentionally deceived a Medicaid recipient and obtained over $4,000 in fraudulent Medicaid payments. The Board reprimanded the nurse and limited her license. The limitations included no work in a home health, assisted living, agency or pool position; quarterly reports from her nursing employers; and limitation of her nursing practice to Wisconsin. She was also ordered to complete four hours of education on the ethics of nursing and five hours of education on professional and legal accountability. *Hickman* is distinguishable from the instant case in that it involved repeated acts of fraud over a period of a year and a half, whereas this case involves one discrete act of falsifying contact with a physician.

The Division also relies on *In the Matter of Disciplinary Proceedings Against Theodore C. Alexander, L.P.N.*, Order No. 0001990 (Aug. 16, 2012). In that case, a nurse working with a quadriplegic patient walked away from the massage table where the patient was propped up, and the patient fell. The nurse immediately placed the patient back on the table and failed to thoroughly assess the patient after the fall. He also failed to notify the oncoming nurse or the patient's mother of the fall as required by protocol, although he did inform the patient's father, who was at home at the time of the fall. The patient was taken to the hospital for x-rays the next day and it was revealed that he had a fractured femur. Following surgery to repair the femur, the patient suffered complications and ultimately died. The Board suspended the nurse's license for a minimum of 180 days, with the suspension immediately stayed as long as he completed a preapproved licensed practical nurse refresher course within 180 days, which was to include no less than 30 hours of theory and no less than 10 hours of laboratory. In addition, the nurse's license was limited for two years to require him to work only under direct supervision and only in a work setting approved by the Board, which was not to include work in a home health, agency or pool position. He was limited to practice only in Wisconsin and was required to notify the Department Monitor of any change of employment and include an explanation of reasons for the change.

This case is similar to *Alexander* in that they both involve issues of patient safety. However, this case is distinguishable from *Alexander* in that there is no finding here that Respondent failed to assess the patient after the fall.[3] Moreover, the nurse in *Alexander* did not

[3] See footnote 1.

make any notation in the record of the fall, nor did he inform the oncoming care nurse that the fall had occurred. Thus, oncoming providers were in the dark that the patient had fallen. Here, Respondent did make note of the fall in the patient's record but falsely stated that a physician had been contacted. Another distinction is that at the time the discipline was imposed in *Alexander*, the nurse had only been licensed for six years, unlike in the instant case where Respondent has practiced for 28 years as a nurse, with no disciplinary action other than the instant case.

Hickman and *Alexander* are also distinguishable in that, unlike the nurses in those cases, Respondent has already been professionally disciplined for his conduct, by both an Iowa criminal court and the Iowa Board of Nursing, neither of which imposed restrictions on Respondent's ability to practice nursing in Iowa. The Iowa Board imposed 60 hours of continuing education on ethics and assessment, which Respondent completed. Further, unlike in *Hickman*, the instant case involved a deferred judgment, in which Respondent satisfied the terms of the agreement, resulting in no conviction on his record.

Respondent argues that this case is more like *In the Matter of Disciplinary Proceedings Against Laura L. Spring, R.N.*, Order No. 0005507 (Nov. 9, 2017), in which a nurse was disciplined by the Alaska Board of Nursing for writing her own name on a patient's prescription for Percocet and then having the prescription filled at a pharmacy. There was no evidence that the nurse in that case had a substance abuse disorder. The Alaska Board of Nursing reprimanded her and required her to complete 15 hours of education on ethics and critical thinking and pay a fine of $1,500. The Wisconsin Board likewise reprimanded her and ordered her to pay costs in the amount of $215 but did not restrict her license in any way.

I agree with the Division that the circumstances in this case are different from those in *Spring* because patient safety is more of a concern here. However, it is nevertheless significant that in *Spring*, neither the Wisconsin Board nor the Alaska Board imposed any of the license limitations the Division seeks here, and that the Wisconsin Board actually imposed less discipline than that imposed by the Alaska Board, with only 15 hours of educational requirements compared to the 60 hours imposed by the Alaska Board.

Based on the record in this case, the Division has not shown that the license limitations related to Respondent's work setting are necessary or appropriate for Respondent's rehabilitation, the protection of the public or to deter others from engaging in similar conduct. Therefore, they will not be imposed here. However, because there were serious issues of patient safety involved with respect to Respondent's conduct, it is necessary and appropriate under the factors set forth in *Aldrich* to require preapproval by the Board of any change in Respondent's current employment so that the Board may assess patient safety issues prior to Respondent's new employment. In addition, patient safety requires Respondent to show current and future employers a copy of this Order and to arrange for his employer to provide quarterly reports to the Department Monitor, as set forth below.

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. Imposition of full costs is unwarranted here. First, although the Division has proven the two counts alleged, it did so through the cooperation of Respondent, who conceded that the violations occurred. Second, the conduct found in this case – falsely documenting that a physician had been contacted after a patient fell – is serious; however, it is less serious than in many cases which come before this tribunal. Also, Respondent has already been disciplined twice for the conduct, by the Iowa Board and by an Iowa criminal court. Third, the discipline sought by the Division, a reprimand and license limitations, is on the less serious end of available discipline. More significantly, Respondent prevailed on the few issues he disputed in this matter, namely, the Division's recommendation that he be prohibited from working as a pool nurse, that his license be limited to require direct supervision and that he only perform nursing work in Wisconsin. That said, however, Respondent must seek preapproval from the Board in order to change his current employment as a pool nurse. Fourth, Respondent has cooperated in this proceeding by agreeing to stipulated facts and briefing and by conceding the violations, thereby making a hearing unnecessary. Fifth, Respondent has no previous discipline in his 28 years as a nurse. Finally, it is Respondent, through his misconduct, who has made these proceedings necessary, and it would be unfair to impose all of the costs of this proceeding on members of the nursing profession who have not engaged in such misconduct. As a result, imposition of 50 percent of the costs on Respondent is appropriate.

CONCLUSIONS OF LAW

1. Respondent engaged in unprofessional conduct pursuant to Wis. Admin. Code § N 7.03(2) by violating a law substantially related to the practice of nursing.

2. Respondent violated Wis. Admin. Code § N 7.03(1)(b) by having discipline imposed upon him by the Iowa Board.

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

4. A reprimand and the license limitations set forth in the Order section below are 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, imposition of 50 percent of the costs of this proceeding on Respondent is reasonable and appropriate.

ORDER

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

1. Respondent Micahel T. Harasymiw is REPRIMANDED.

2. The professional nursing license issued to Respondent (license number 105066-30) and his privilege to practice in Wisconsin pursuant to the Nurse Licensure Compact, are LIMITED as follows:

a. Respondent shall provide his current nursing employer with a copy of this Order. He shall also provide any other 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.

b. Respondent shall obtain preapproval by the Board prior to any change of nursing employment while this order is in effect.

c. 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 his work performance.

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

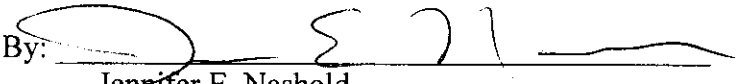
3. Respondent shall pay 50 percent of recoverable costs in this matter in an amount to be established, pursuant to Wis. Admin. Code § SPS 2.18. After the amount is established, payment shall be made by certified check or money order payable to the Wisconsin Department of Safety and Professional Services 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

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

Dated at Madison, Wisconsin on November 21, 2018.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
4822 Madison Yards Way, 5th Floor North
Madison, Wisconsin 53705
Telephone: (608) 266-7709
FAX: (608) 264-9885

By: 

Jennifer E. Nashold
Administrative Law Judge