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Before the
State of Wisconsin
Board of Nursing

In the Matter of Disciplinary Proceedings Against
Jamie L. Soteropoulos, Respondent

FINAL DECISION AND ORDER

Order No. **ORDER 0006273**

**Division of Legal Services and Compliance Case Nos. 17 NUR 127, 18 NUR 254 and
18 NUR 270**

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 11 day of July, 2019.

Member
Board of Nursing

XXXXXXXXXXXX



Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against
Jamie L. Soteropoulos, R.N., Respondent

DHA Case No. SPS-19-0012
DLSC Case Nos. 17 NUR 127
18 NUR 254
18 NUR 270

PROPOSED DECISION AND ORDER

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

Jamie L. Soteropoulos, R.N.
N51W22239 Lisbon Rd
Sussex, WI 53089

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

PROCEDURAL HISTORY

These proceedings were initiated on February 18, 2019, when the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), filed a formal Complaint against Respondent Jamie L. Soteropoulos, R.N. (Respondent), alleging that Respondent engaged in unprofessional conduct by violating a law substantially related to the practice of nursing or being convicted of any crime substantially related to the practice of nursing, in violation of Wis. Admin. Code § N 7.03(2); 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); and by obtaining, possessing or attempting to obtain or possess a drug without lawful authority, in violation of Wis. Admin. Code § N 7.03(8)(e).

The Division served Respondent on February 18, 2019, by sending a copy of the Notice of Hearing and Complaint to N51W22239 Lisbon Road, Sussex, Wisconsin 53089, via certified and regular mail. Respondent failed to file an Answer to the Complaint.

At the expiration of the 20-day time period to file an Answer, the Administrative Law Judge (ALJ) scheduled a telephone prehearing conference for April 3, 2019. Notice of the prehearing conference was mailed to the Respondent on March 11, 2019, instructing her to provide the ALJ a telephone number at which she could be reached for the conference no later than April 1, 2019. Respondent failed to provide a telephone number and could not be reached for the conference. The Division moved for default based on Respondent's failure to file an Answer and failure to appear, pursuant to Wis. Admin. Code § SPS 2.14 and § HA 1.07(3).

On April 3, 2019, the ALJ issued a Notice of Default and Order against Respondent, which ordered the Division to file a recommended proposed decision and order by May 3, 2019. The Division timely filed its submission.

FINDINGS OF FACT

Facts Related to the Alleged Violations

Findings of Facts 1-25 are set forth in the Division's Complaint against Respondent filed in this matter.

1. Respondent Jamie L. Soteropoulos, R.N., is licensed in the State of Wisconsin as a registered nurse, having license number 161544-30, first issued on March 19, 2008, and current through February 28, 2020.

17 NUR 127

2. At all times relevant to this case number, Respondent was employed as a registered nurse at a hospital (Hospital), located in Milwaukee, Wisconsin.

3. On January 23, 2017, at 3:44 a.m., Respondent removed a vial containing 100 mcg of fentanyl from the automated medication dispensing cabinet (Medselect) for Patient A.

4. At 3:50 a.m., Respondent documented that she administered 50 mcg to Patient A. Respondent failed to waste the remaining 50 mcg of fentanyl and put the vial in her pocket.

5. At 4:55 a.m., Respondent left the Hospital, stating she was not feeling well. She took the fentanyl vial home with her and did not return it to the Hospital.

6. On January 26, 2017, at 6:00 a.m., Respondent documented that she administered 50 mcg of fentanyl to Patient B.

7. At 6:03 a.m., Respondent removed a vial containing 100 mcg of fentanyl from the Medselect for Patient B.

8. Respondent failed to waste, and/or failed to document the waste of, the remaining 50 mcg of fentanyl after she documented that she had administered 50 mcg to Patient B.

18 NUR 254

9. At all times relevant to this case number, Respondent was employed as a registered nurse at a home health care agency (Agency), located in Waukesha, Wisconsin. Respondent's role at that time was primarily in-office intake and completion of outstanding documentation. Respondent was instructed not to do any independent work.

10. On March 24, 2018, at 11:53 a.m., Respondent called Patient C and requested a visit to retrieve unsigned paperwork. This call was placed from Respondent's cell phone.

11. Respondent arrived at Patient C's home approximately 35 minutes later and requested Patient C's Medicare card for the paperwork. Respondent stated she needed to do a medication check.

12. Patient C's daughter left Respondent alone with Patient C's medication for approximately ten minutes while she went to get Patient C's Medicare card. It was later discovered that a copy of the Medicare card had been in Patient C's file and there was no documentation that was missing Patient C's signature.

13. On March 25, 2018, at approximately 8:30 a.m., Patient C's daughter and granddaughter were going over Patient C's care plan for the day, as Patient C's granddaughter would be providing care.

14. In reviewing Patient C's medication, Patient C's daughter noticed that Patient C's bottle of hydrocodone was missing a significant number of pills. After counting the medication, Patient C's daughter discovered 35 pills were missing.

15. Patient C's daughter locked up the remaining hydrocodone.

16. At approximately 5:45 p.m. the same day, Respondent returned to Patient C's residence, stating she needed paperwork signed. After retrieving the signature, Respondent stated she needed to conduct a medication check and began looking at the bottles of medication on the counter.

17. Patient C's granddaughter informed Respondent that Patient C's pain medication was locked up and not on the counter. According to the granddaughter, Respondent immediately discontinued her review of the medication on the counter after only looking at two bottles.

18 NUR 270

18. On April 25, 2018, a United States Postal Inspector obtained search warrants for two packages addressed to Respondent. The Inspector arranged for the Waukesha County Metro Drug Enforcement Group to be present during the search.

19. The search found that the first package contained ten tablets of oxycodone and the second package contained eight tablets of oxycodone. Postal records indicated that Respondent had received 640 packages of unknown contents in the last two years.

20. Arrangements were made to deliver the packages to Respondent at the Village of Pewaukee Post Office. After Respondent claimed the packages, she was arrested and consented to a search of her vehicle and residence, as well as a download of her electronics.

21. During the vehicle search, detectives found 20 tramadol 50 mg tablets in a prescription bottle labeled with Respondent's father's name. Detectives also found a pill grinder as well as cut up straws.

22. A search of Respondent's residence uncovered seven tapentadol 100 mg pills, a silver grinder, three glass pipes, and a pill bottle containing 5.1 g of THC.

23. During an interview, Respondent admitted to purchasing controlled substances off of the internet.

24. On September 26, 2018, Respondent pled guilty in Waukesha County Circuit Court case number 2018CF653 to two counts of possession of narcotic drugs, a class I felony, in violation of Wis. Stat. § 961.41(3g)(am).

25. On November 14, 2018, Respondent was sentenced in Waukesha County Circuit Court case number 2018CF653 to 18 months of initial confinement, two years of extended supervision on both counts, to run concurrent, but stayed, and three years of probation. Conditions of probation include an alcohol and other drug assessment and treatment, absolute sobriety, and random drug testing.

Facts Related to Default

26. The Notice of Hearing and Complaint in this matter were served on Respondent on February 18, 2019, by both certified and regular mail, consistent with Wis. Admin. Code § SPS 2.08. The Notice of Hearing instructed Respondent: "If you do not provide a proper Answer within 20 days, you will be found to be in default and a default judgment may be entered against you on the basis of the Complaint and other evidence. In addition, the Board may take disciplinary action against you and impose the costs of the investigation, prosecution and decision of this matter upon you without further notice or hearing."

27. On March 14, 2019, the Division provided a copy of the certified mail return receipt to the ALJ. This receipt is signed and a box is checked indicating it was signed by the addressee.

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

29. Following expiration of the 20-day time period to file an Answer, the ALJ scheduled a telephone prehearing conference for April 3, 2019. Notice of this prehearing conference was sent to both parties, with instructions that Respondent provide the ALJ with a telephone number at which she could be reached for the conference. The Notice instructed Respondent: "The

Respondent's failure to appear at a scheduled conference or hearing may result in default judgment being entered against the Respondent."

30. Respondent failed to provide a telephone number. During the conference on April 3, 2019, the Division provided a telephone number for Respondent, at which the ALJ left a message allowing Respondent 15 minutes to return the ALJ's call. Respondent failed to contact the ALJ. The ALJ therefore granted the Division's motion for default based on failure to file an Answer and failure to appear.

31. On April 3, 2019, the ALJ issued a Notice of Default and Order which required the Division to file and serve, no later than May 3, 2019, a recommended proposed decision and order.

32. On May 2, 2019, the Division filed its recommended proposed decision and order.

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

DISCUSSION AND CONCLUSIONS OF LAW

Default

As stated in the April 3, 2019, Notice of Default and Order, Respondent is in default for failing to file an answer to the Complaint and failing to appear at the telephone conference held on April 3, 2019. *See* Wis. Admin. Code § SPS 2.14; Wis. Admin. Code § HA 1.07(3). Accordingly, an order may be entered against Respondent on the basis of the Complaint and other evidence. *Id.*

Violations

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

The Division alleges that Respondent is subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b) and (d),¹ for violating Wis. Admin. Code § N 7.03(2), 7.03(6)(c), and 7.03(8)(e). The Division has proved these violations.

The undisputed facts establish that on January 23, 2017, Respondent removed a vial containing 100 mcg of fentanyl from the Medselect for Patient A and documented that she administered 50 mcg to Patient A. Respondent failed to waste the remaining 50 mcg of fentanyl

¹ The Division also asserts in its recommended proposed decision and order that Respondent is in violation of Wis. Stat. § 441.07(1g)(c) by committing acts which show Respondent is unfit or incompetent by reasons of abuse of alcohol or other drugs. This allegation was not alleged in the Complaint and is not developed by the Division or supported by the record. It is therefore not considered.

and put the vial in her pocket. Shortly after, Respondent left the Hospital, stating she was not feeling well. She took the fentanyl vial home with her and did not return it to the Hospital.

On January 26, 2017, Respondent removed a vial containing 100 mcg of fentanyl from the Medselect for Patient B and documented that she administered 50 mcg of fentanyl to Patient B. Respondent failed to waste, and/or failed to document the waste of, the remaining 50 mcg of fentanyl after she documented that she had administered 50 mcg to Patient B.

On March 24, 2018, Respondent visited Patient C, ostensibly to retrieve unsigned paperwork. Patient C's daughter left Respondent alone with Patient C's medication for approximately ten minutes while she went to get Patient C's Medicare card. It was later discovered that a copy of the Medicare card had been in Patient C's file and there was no documentation that was missing Patient C's signature. The following day, Patient C's daughter counted Patient C's hydrocodone pills and discovered that 35 pills were missing. Patient C's daughter locked up the remaining hydrocodone. That evening, Respondent returned to Patient C's residence, stating she needed paperwork signed. After retrieving the signature, Respondent stated she needed to conduct a medication check and began looking at the bottles of medication on the counter but when informed that the pain medication was locked up, Respondent immediately discontinued her review of the medication on the counter after only looking at two bottles.

In addition, pursuant to a search warrant on April 25, 2018, two packages delivered to Respondent were found to contain a total of 18 tablets of oxycodone. Postal records indicated that Respondent had received 640 packages of unknown contents in the last two years. Following Respondent's arrest, a vehicle search revealed 20 tramadol 50 mg tablets in a prescription bottle labeled with Respondent's father's name, a pill grinder, and cut up straws. A search of Respondent's residence uncovered seven tapentadol 100 mg pills, a silver grinder, three glass pipes, and a pill bottle containing 5.1 g of THC. During an interview, Respondent admitted to purchasing controlled substances off of the internet.

On September 26, 2018, Respondent pled guilty in Waukesha County Circuit Court case number 2018CF653 to two counts of possession of narcotic drugs, a class I felony, in violation of Wis. Stat. § 961.41(3g)(am). On November 14, 2018, Respondent was sentenced in Waukesha County Circuit Court case number 2018CF653 to 18 months of initial confinement, two years of extended supervision on both counts, to run concurrently, but stayed, and three years of probation. Conditions of probation include an alcohol and other drug assessment and treatment, absolute sobriety, and random drug testing.

Based on the facts above and Respondent's failure to make any argument to the contrary, Respondent violated a law substantially related to the practice of nursing and was convicted of any crime substantially related to the practice of nursing, in violation of Wis. Admin. Code § N 7.03(2); 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); and obtained, possessed or attempted to obtain or possess a drug without lawful authority, in violation of Wis. Admin. Code § N 7.03(8)(e).

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

Appropriate Discipline

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

The Division recommends that Respondent's nursing license and her privilege to practice under the Enhanced Nurse Licensure Compact be revoked. The recommended discipline is consistent with the purposes articulated in *Aldrich* and the facts of this case. Promoting rehabilitation is one of the purposes of discipline; however, rehabilitation is unlikely in this case, as Respondent has refused to cooperate or participate in these proceedings. Having obtained no information from Respondent during the investigation or in these proceedings, the Board cannot ascertain whether rehabilitative measures will be effective. "Protection of the public is the purpose of requiring a license." *State ex rel. Green v. Clark*, 235 Wis. 628, 631, 294 N.W. 25 (1940). When a license is granted to an individual, Wisconsin is assuring the public that the licensed individual is competent in his or her profession. *Stringez v. Dep't of Regulation & Licensing Dentistry Examining Bd.*, 103 Wis. 2d 281, 287, 307 N.W.2d 664 (1981). It follows that if the state cannot assure the public of the licensee's competence to practice the profession, then revocation is appropriate. *Gilbert v. State Medical Examining Bd.*, 119 Wis. 2d 168, 189-190, 349 N.W.2d 68 (1984).

Revocation of Respondent's license and privilege to practice nursing are necessary to protect the public from other instances of misconduct. Registered nurses are licensed to care for the sick and injured. These duties necessitate a considerable amount of caring and responsibility. Contrary to this, Respondent disregarded the public's trust and disregarded her responsibilities to her patients. She also disregarded the law. Imposing anything less than revocation would not promote deterrence but may instead wrongly encourage others to engage in similar conduct.

Diversion of controlled substances and illegally obtaining controlled substances are serious offenses. Further, Respondent refused to cooperate with the Board as it relates to a disciplinary matter. Licensees need to know this conduct will not be tolerated. Respondent has demonstrated a lack of respect for the Board's authority, and because of her lack of cooperation, the Board cannot assure the public of Respondent's competency or fitness to practice as a registered nurse. Therefore, revocation of Respondent's right to renew her license is an appropriate response to her disrespect for the law, the public welfare, and the licensing authority governing her profession.

The recommended discipline is also consistent with prior Board decisions. *See e.g., In the Matter of Disciplinary Proceedings Against Kelly L. Kowalkowski, R.N.*, Order No. 0004613 (March 18, 2016) (Board revoked nurse's right to renew license and privilege to practice nursing pursuant to Nurse Licensure Compact where nurse was charged with several drug-related offenses, failed to cooperate with Board's investigation, and failed to file an Answer or appear at a prehearing conference); *In the Matter of Disciplinary Proceedings Against Regina M. Fabian*,

R.N., Order No. LS0710234NUR (Feb. 28, 2008) (Board revoked license of nurse who diverted controlled substances intended for patient use and who was in default for failure to file an Answer or appear at the hearing); *In the Matter of Disciplinary Proceedings Against Diane Zakopyko, R.N.*, Order No. 0002470 (June 12, 2013), (Board revoked license of nurse who diverted controlled substances intended for patient use and who was in default for failure to file an Answer to the Complaint or participate in disciplinary proceedings).²

In light of the facts of this case, the factors set forth in *Aldrich*, and prior Board cases, revocation of Respondent's license and privilege to practice nursing in Wisconsin under the Enhanced Nurse Licensure Compact is warranted.

Costs

As a result of revocation, 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. The Department and professional boards have also, in previous orders, considered the following factors when determining if all or part of the costs should be assessed against a Respondent: (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*, Order 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 following facts are particularly relevant to the instant case. First, by virtue of Respondent's default, the factual allegations were deemed admitted in this matter, the Division has proven all counts alleged, and there is no argument to indicate any litigation in this proceeding was unnecessary. Second, Respondent's conduct that led to these disciplinary proceedings was serious. Respondent illegally diverted controlled substances from patients and illegally purchased controlled substances over the internet. Third, as a result of Respondent's serious conduct, the Division sought to revoke Respondent's license and privilege to practice pursuant to the Enhanced Nurse Licensure Compact. The level of discipline sought is significant and was imposed in this case. Fourth, Respondent failed to cooperate in any manner in these proceedings. Fifth, the Department is a program revenue agency whose operating costs are funded by the revenue received from credential holders. As such, fairness weighs heavily in

² The decisions in this paragraph are attached to the Division's recommended proposed decision and order and are also available on the Department's website.

requiring Respondent to pay the costs of this proceeding which resulted in significant discipline, rather than spreading the costs among all Board of Nursing licensees in Wisconsin. Finally, Respondent made no argument contrary to the Division's request for imposition of full costs.

Based on the foregoing, all of the costs of this proceeding should be assessed against Respondent in an amount to be determined pursuant to Wis. Admin. Code § SPS 2.18.

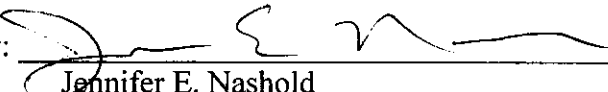
ORDER

Accordingly, it is hereby ORDERED that the license of Jamie L. Soteropoulos, R.N., to practice nursing (license number 161544-30) and her privilege to practice as a nurse in the State of Wisconsin under the Enhanced Nurse Licensure Compact are REVOKED, effective on the date the final decision is signed by the Board.

IT IS FURTHER ORDERED that Respondent shall pay all recoverable costs in this matter in an amount to be established, pursuant to Wis. Admin. Code § SPS 2.18.

Dated at Madison, Wisconsin on June 5, 2019.

STATE OF WISCONSIN
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By: 

Jennifer E. Nashold
Administrative Law Judge