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Before the
State of Wisconsin
Board of Nursing

In the Matter of Disciplinary Proceedings Against
Janelle F. Biegert, L.P.N., Respondent

FINAL DECISION AND ORDER

Order No. ORDER0006646

Division of Legal Services and Compliance Case No. 18 NUR 235, 18 NUR 293, 18 NUR 459, and 18 NUR 693

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 13 day of Feb, 2020.

Member
Board of Nursing

Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against
Janelle F. Biegert, L.P.N., Respondent

DHA Case No. SPS-19-0043
DLSC Case Nos. 18 NUR 235,
18 NUR 293, 18 NUR 459,
and 18 NUR 693

PROPOSED DECISION AND ORDER

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

Janelle F. Biegert
3500 Andalusia Court, Apt. 214
Green Bay, WI 54301

Wisconsin Board of Nursing
P.O. Box 8366
Madison, WI 53707-8366

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 August 16, 2019, when the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), filed a formal Complaint against Respondent Janelle F. Biegert, L.P.N. The Complaint alleged that Respondent was subject to disciplinary action, pursuant to Wis. Stat. § 441.07(1g)(b) and (d) as the result of having engaged in unprofessional conduct, in violation of Wis. Admin. Code § N 7.03(4)(c), 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 practicing nursing while under the influence of alcohol, illicit drugs, or while impaired by the use of legitimately prescribed

pharmacological agents or medications, in violation of Wis. Admin. Code § N 7.03(6)(e), by being unable to practice safely by reason of alcohol or other substance use in violation of Wis. Admin. Code § N 7.03(6)(f), 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 August 16, 2019, by sending a copy of the Notice of Hearing and Complaint to Respondent's address on file with the Department, via certified and regular mail, pursuant to Wis. Admin. Code § SPS 2.08. Respondent was allowed 20 days from the date of service to file an Answer. Respondent failed to file an Answer.

At the expiration of the 20-day time period to file an Answer, the Administrative Law Judge (ALJ) scheduled a telephone prehearing conference for September 16, 2019. On September 16, 2019, the ALJ was not able to reach either party by telephone, so the prehearing conference was rescheduled for September 27, 2019. The ALJ sent notice of the rescheduled prehearing conference by electronic mail and U.S. mail to Respondent and to Respondent's attorney, Cole White. The ALJ was unable to reach Attorney Cole White on September 27, 2019. Consequently, the ALJ again rescheduled the telephone prehearing conference to October 8, 2019 and sent written notice of the rescheduled prehearing conference to both Respondent and Attorney White. The notice stated that if Respondent or her attorney failed to appear at the rescheduled telephone prehearing conference, default judgment may be entered against Respondent.

At the prehearing conference held on October 8, 2019, the ALJ attempted to contact Attorney White, but the call did not go through, and the ALJ was unable to leave a voice mail message. The ALJ then attempted to contact the Respondent at the number on file with the Department, but Respondent did not answer the telephone. The ALJ left a voice mail message allowing Respondent 15 minutes to call back. Consequently, the prehearing conference reconvened without Respondent, and the Division moved for default, pursuant to Wis. Admin. Code § SPS 2.14 and Wis. Admin. Code § HA 1.07(3)(c). The ALJ granted the Division's motion and issued a Notice of Default.

On October 10, 2019, Respondent contacted the ALJ by electronic mail, acknowledging that she missed the prehearing conference and stating that she had believed that Attorney White would be handling the matter on her behalf. Accordingly, the ALJ rescinded the Notice of Default and once again rescheduled the telephone prehearing conference to October 24, 2019.

On October 11, 2019, the ALJ sent written notice of the rescheduled telephone prehearing conference to Respondent by mail, as well as by electronic mail, with a detailed message ordering Respondent to file an Answer by October 21, 2019 and informing her that if she failed to file an Answer by October 21, 2019 or failed to appear at the telephone prehearing conference on October 24, 2019, she may be found in default. Respondent failed to file an Answer.

At the telephone prehearing conference on October 24, 2019, Respondent claimed she did not know she needed to file an Answer; however, she acknowledged that she had received and

read the Notice and Order from the ALJ dated October 11, 2019. The Division again moved for default, pursuant to Wis. Admin. Code § SPS 2.14. In light of Respondent's continued failure to file an Answer to the Complaint, despite being given an extended period of time to do so, the ALJ found Respondent in default. Wisconsin Admin. Code § SPS 2.14 provides that when a Respondent is in default, "the disciplinary authority may make findings and enter an order on the basis of the complaint and other evidence."

The ALJ issued a Notice of Default and Order on October 24, 2019 and ordered the Division to file a recommended proposed decision and order by November 25, 2019. The Division timely filed its submission.

On November 12, 2019, the ALJ received a lengthy letter from Respondent, which was also copied to the Division, in which Respondent discussed the allegations against her and requested that the ALJ reconvene the "proceedings" after Respondent's Brown County Circuit Court criminal hearing scheduled on December 6, 2019. The ALJ did not schedule further prehearing conferences in this matter.

FINDINGS OF FACT

Facts Related to the Alleged Violations

1. Respondent Janelle F. Biegert is licensed in the state of Wisconsin to practice practical nursing, having license number 315385-31, first issued on February 24, 2012, and current through April 30, 2021.

2. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is 3500 Andalusia Court, Apt. 214, Green Bay, Wisconsin 54301.

Facts Related to Case No. 18 NUR 235

3. At all times relevant to the following facts, Respondent was employed as a licensed practical nurse at a community-based residential facility (Facility), located in De Pere, Wisconsin.

4. On March 9, 2018, Respondent was scheduled to work from 6:00 p.m. until 6:00 a.m.

5. Shortly after 6:00 p.m., certified nursing assistants (C.N.A.) A and B called Respondent to assess Resident C, age 82, who fell. Respondent did not respond, even though, as the only practical nurse on duty, it was Respondent's responsibility to respond.

6. At approximately 7:00 p.m., Respondent arrived in Resident C's room but did not assess Resident C. Respondent assisted C.N.A. D in repositioning Resident C so C.N.A. D could administer medication.

7. While repositioning Resident C, C.N.A. D smelled alcohol on Respondent's breath.

8. Additionally, at approximately 7:00 p.m., Resident E, age 82, fell. Resident E's husband reported that Resident E hit her head during the fall. Respondent never conducted an assessment on Resident E.

9. C.N.A. B and C.N.A. D contacted multiple supervisors to report the situation. Facility Assistant Director F arrived at the Facility at approximately 7:50 p.m.

10. Assistant Director F observed Respondent having difficulty walking and that Respondent's eyes were bloodshot and watery.

11. Assistant Director F asked Respondent to submit to a reasonable suspicion drug and alcohol test, but Respondent refused.

12. Assistant Director F called the police because Respondent was going to drive home. Respondent agreed to get a ride home from the police but wanted her phone from inside the Facility.

13. Assistant Director F went inside the Facility to retrieve Respondent's phone and staff also gave her a 32-ounce clear water bottle that contained a raspberry-colored liquid that belonged to Respondent. Assistant Director F smelled the liquid, and it smelled like alcohol.

14. Respondent denied administering any medication during her shift on March 9, 2018; however, Respondent forced Resident G, age 87, to take morphine and diazepam on March 9, 2018.

15. On June 26, 2018, Respondent was charged in Brown County Circuit Court case 18CM895 with one count of recklessly abusing patients-bodily harm, a class A misdemeanor, in violation of Wis. Stat. § 940.295(3)(a)2.

Facts Related to Case No. 18 NUR 293

16. At all times relevant to the following facts, Respondent was employed by a staffing agency (Agency) to work as a licensed practical nurse at a community treatment center (Center), located in Green Bay, Wisconsin.

17. On April 20, 2018, Respondent worked from 3:00 p.m. to 11:00 p.m.

18. Respondent was the only person with access to the medication cart during her shift.

19. At the end of Respondent's shift, she conducted a narcotic count with the on-coming nurse, Registered Nurse (R.N.) A.

20. The narcotic count showed discrepancies with three separate bottles of liquid morphine sulfate. Respondent acknowledged the discrepancies and signed off on the narcotic count.

21. The Agency required Respondent to take a urine drug test, which was negative for benzodiazepines, opioids, and oxycodone.

22. The Center reported the missing narcotics to the police, who interviewed Respondent.

23. During the police interview, Respondent denied diverting the morphine but admitted to abusing prescription and illicit drugs in the past.

24. On May 20, 2019, Respondent was charged in Brown County Circuit Court case 19CF708 with one count of possession of narcotic drugs, a class I felony, in violation of Wis. Stat. § 961.41(3g)(am), and two counts of theft of movable property, less than or equal to $2,500, a class A misdemeanor, in violation of Wis. Stat. § 943.20(1)(a).

Facts Related to Case No. 18 NUR 459

25. At all times relevant to the following facts, Respondent was an agency nurse, working as a licensed practical nurse, at a rehabilitation center located in Manitowoc, Wisconsin.

26. On May 30, 2018, Resident A fell, and Respondent did not obtain Resident A's vitals following the fall.

27. On May 30, 2018, Respondent yelled and displayed rude behavior with Residents.

28. On May 30, 2018, Resident B was sitting in a chair in the lounge area and began spitting on the floor. Respondent pushed Resident B's chair, which struck the leg of Resident C.

Facts Related to Case No. 18 NUR 693

29. At all times relevant to the following facts, Respondent was employed as a licensed practical nurse at a rehabilitation facility (Facility), located in Appleton, Wisconsin.

30. On September 30, 2018, Resident A requested assistance from Respondent to help find something in her room.

31. A short time later, two staff members heard yelling coming from Resident A's room. Respondent exited the room and Resident A followed with an empty coffee cup, throwing it at Respondent.

32. The Facility concluded that Resident A may have contributed to Respondent's yelling; however, Respondent did not respond in the appropriate manner to diffuse the situation.

33. Respondent was terminated from the Facility.

Facts Related to Default

34. The Notice of Hearing and Complaint were served on Respondent on August 16, 2019, by certified and first-class 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."

35. Respondent failed to file an Answer to the Complaint.

36. At the expiration of the 20-day time period to file an Answer, the ALJ scheduled a telephone prehearing conference for September 16, 2019. On September 16, 2019, the ALJ was not able to contact either party, and the prehearing conference was rescheduled for September 27, 2019. The ALJ sent notice by electronic mail and U.S. mail to Respondent and to Attorney Cole White regarding the rescheduled prehearing conference.

37. On September 27, 2019, the ALJ was unable to reach Attorney Cole White. The ALJ rescheduled the telephone prehearing conference to October 8, 2019 and sent written notice to Respondent and Attorney White. The notice stated that if Respondent or her attorney failed to appear, default judgment may be entered against Respondent.

38. At the telephone prehearing conference held on October 8, 2019, the ALJ attempted to contact Attorney White, but the call did not go through, and the ALJ was unable to leave a voice mail message. The ALJ then attempted to contact the Respondent at the number provided by the Department, but Respondent did not answer. The ALJ left a voice mail message allowing Respondent 15 minutes to call her back, but Respondent did not return the call. Consequently, the prehearing conference reconvened without Respondent, and the Division moved for default, pursuant to Wis. Admin. Code § SPS 2.14 and Wis. Admin. Code § HA 1.07(3)(c). The ALJ granted the Division's motion and issued a Notice of Default.

39. On October 10, 2019, Respondent contacted the ALJ by electronic mail, acknowledging that she missed the pre-hearing conference and stating that she believed Attorney White would be handling the matter on her behalf. Accordingly, the ALJ rescinded the Notice of Default and rescheduled the telephone prehearing conference to October 24, 2019.

40. On October 11, 2019, the ALJ sent written notice of the rescheduled prehearing conference to Respondent by mail, as well as by electronic mail, with a detailed message ordering Respondent to file an Answer by October 21, 2019 and informing Respondent that she may be found in default if she failed to file an Answer by October 21, 2019 or failed to appear at the rescheduled prehearing conference. Respondent failed to file an Answer.

41. At the prehearing conference on October 24, 2019, Respondent claimed that she did not know she needed to file an Answer; however, she acknowledged that she had received and read the Notice from the ALJ dated October 11, 2019. The Division moved for default, pursuant to Wis. Admin. Code § SPS 2.14. In light of Respondent's continued failure to file an Answer to the Complaint, despite being given an extended period of time to do so, the ALJ found Respondent to be in default.

42. On October 24, 2019, the ALJ issued a Notice of Default and ordered the Division to file and serve a recommended proposed decision and order by November 25, 2019. The Division timely filed its recommended proposed decision and order.

DISCUSSION AND CONCLUSIONS OF LAW

Jurisdictional Authority

Pursuant to Wis. Admin. Code § SPS 2.10(2), the undersigned ALJ has authority to preside over this disciplinary proceeding in accordance with Wis. Stat. § 227.46(1).

Default

By failing to file an answer to the complaint, Respondent violated Wis. Admin. Code § SPS 2.09(4). As stated in the Notice of Default and Order dated October 24, 2019, Respondent is in default for failing to file an answer by the October 21, 2019 deadline, which was an extended deadline well past the 20-day deadline by which Respondent should have filed an Answer. *See* Wis. Admin. Code § SPS 2.14. Accordingly, an order may be entered against Respondent on the basis of the Complaint and other evidence. *See* Wis. Admin. Code § SPS 2.14.

Violations

Pursuant to Wis. Stat. §§ 441.07(1g)(b) and (d), the Wisconsin Board of Nursing (Board) possesses the authority to discipline any licensee or license holder for violating the standards of conduct established by the examining board under Wis. Stat. § 440.03(1) and for engaging in unprofessional conduct under Wis. Admin. Code § N 7.03(4)(c), 7.03(6)(a), 7.03(6)(c), 7.03(6)(e), 7.03(6)(f), and 7.03(8)(e).

Because Respondent failed to file an Answer to the Complaint, Respondent is in default, and the ALJ may take the allegations in the Complaint as true and enter an order on the basis of the Complaint. *See* Wis. Admin. Code § SPS 2.14.

The undisputed facts in this matter are as set forth in the Complaint and in the Findings of Fact contained herein. With regard to DLSC case 18 NUR 235, on March 9, 2018, Respondent did not respond to a call that a facility's elderly resident had fallen and did not assess that resident or another elderly resident who had also fallen. The facility's director and another employee believed Respondent had been drinking alcohol, based upon her odor of alcohol, unsteady walking and watery, bloodshot eyes. In addition, although Respondent denied administering any medication during her shift on March 9, 2018, she forced an elderly resident to take morphine and diazepam. On June 26, 2018, Respondent was charged in Brown County Circuit Court case 18 CM 895 with one count of recklessly abusing patients-bodily harm, a class A misdemeanor, in violation of Wis. Stat. § 940.295(3)(a)2.

As to DLSC case 18 NUR 293, on April 20, 2018, after having been the only employee with access to the medication cart, the narcotic count showed discrepancies with three separate bottles of liquid morphine sulfate. Respondent acknowledged the discrepancies and signed off on the narcotic count. The center reported the missing narcotics to the police, who interviewed Respondent. During the police interview, Respondent denied diverting the morphine but admitted to abusing prescription and illicit drugs in the past. On May 20, 2019, Respondent was charged in Brown County Circuit Court case 19CF708 with one count of possession of narcotic drugs, a class I felony, in violation of Wis. Stat. § 961.41(3g)(am), and two counts of theft of

movable property, less than or equal to $2,500, a class A misdemeanor, in violation of Wis. Stat. § 943.20(1)(a).

Regarding DLSC case 18 NUR 459, on May 30, 2018, Respondent did not obtain a resident's vitals following a fall, yelled at and displayed rude behavior towards the facility's residents, and pushed a chair that a patient was seated in, causing it to strike another patient

Finally, with regard to DLSC case 18 NUR 693, on September 30, 2018, two facility staff members heard yelling coming from a resident's room. The facility concluded that the resident may have contributed to Respondent's yelling but that Respondent did not respond in the appropriate manner to diffuse the situation. Consequently, Respondent was terminated from facility.

By the conduct described above, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § N 7.03(4)(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. Respondent also engaged in unprofessional conduct pursuant to Wis. Admin. Code § N 7.03(6)(a) by failing to perform nursing with reasonable skill and safety. Further, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § N 7.03(6)(c, 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 addition, Respondent engaged in unprofessional conduct under Wis. Admin. Code § N 7.03(6)(e) by practicing nursing while under the influence of alcohol, illicit drugs, or while impaired by the use of legitimately prescribed pharmacological agents or medications and under Wis. Admin. Code § N 7.03(6)(f) by being unable to practice safely by reason of alcohol or other substance use. Finally, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § N 7.03(8)(e) by obtaining, possessing, or attempting to obtain or possess a drug without lawful authority.

As a result of the above conduct, 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 the license of Respondent and privilege to practice under the Enhanced Nurse Licensure Compact be suspended pursuant to the terms and conditions of the Order section below.

The recommended discipline is consistent with the purposes articulated in *Aldrich.* Promoting rehabilitation is one of the purposes of discipline. Respondent worked with elderly residents while under the influence of alcohol and did not provide appropriate care to the residents during that time period. Additionally, Respondent admitted to abusing prescription and illicit drugs in the past. Finally, Respondent engaged in disruptive and inappropriate behavior with patients. Requiring supervision and monitoring will allow Respondent to maintain her

license while she gets the necessary treatment to overcome these personal and professional issues.

"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, the Board 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 Board, via the Department, cannot assure the public of the licensee's competence to practice the profession, then suspension is appropriate. *Gilbert v. State Medical Examining Bd.*, 119 Wis. 2d 168, 189–90, 349 N.W.2d 68 (1984). In the instant case, the Board cannot assure the public that an individual who works while intoxicated is competent or safe to practice. The Board cannot ensure that Respondent will practice nursing safely if she is not monitored and required to participate in a treatment program.

Suspension of Respondent's license and privilege to practice nursing are necessary to protect the public from other instances of misconduct. Respondent's misconduct was serious. Working while under the influence of alcohol and abusing prescription and illicit drugs show that Respondent is not safe or competent to practice nursing. While criminal charges were pending, Respondent still engaged in appropriate and disruptive conduct towards residents in another facility. Respondent disregarded the public's trust, her responsibilities to her patients, and the law. Imposing anything less than suspension would not aid in deterrence but could imply that such conduct by a licensed nurse is tolerable. Accordingly, suspension of Respondent's license and privilege to practice under the Enhanced Nurse Licensure Compact are necessary to deter other licensees from engaging in similar conduct and is the only appropriate way in which to safeguard the public.

The recommended discipline is also consistent with Board precedent. *See In the Matter of Disciplinary Proceedings Against Jennifer Civitarese, R.N.,* Order Number 0005586 (January 11, 2018) (nurse who smelled of alcohol at work and had a blood alcohol concentration of 0.28 had license suspended by Board and was allowed to petition for a stay of the suspension after three months upon providing proof to the Board that she was in compliance with conditions and limitations placed on her license).[1] *See also In the Matter of Disciplinary Proceedings Against Kristin L. Feltz, R.N.,* Order Number 0005430 (September 14, 2017) (nurse convicted of causing injury while operating under the influence of an intoxicant in 2015, and in 2016, was intoxicated at work with an alcohol level of 0.226, was diagnosed with alcohol use disorder, had license suspended by the Board, and was allowed to petition for a stay of the suspension after three months upon providing proof to the Board that she was in compliance with conditions and limitations placed on her license).[2] *See also In the Matter of Disciplinary Proceedings Against Elizabeth M Krajewski, R.N.,* Order Number 0004648 (April 14, 2016) (nurse who smelled of alcohol at work had license suspended by Board and was allowed to petition for a stay of suspension upon providing proof to the Board that she was in compliance with conditions and limitations placed on her license).[3] *See also In the Matter of Disciplinary Proceedings Against Terry L. Hensel, R.N.,* Order Number 0004806 (July 14, 2016) (nurse who smelled of alcohol and had a blood alcohol concentration of 0.08 at work and on a separate date was arrested and subsequently convicted of operating a motor vehicle while intoxicated (4th) had license

[1] This decision is available online at: https://online.drl.wi.gov/decisions/2018/ORDER0005586-00014312.pdf
[2] This decision is available online at: https://online.drl.wi.gov/decisions/2017/ORDER0005430-00014009.pdf
[3] This decision is available online at: https://online.drl.wi.gov/decisions/2016/ORDER0004648-00012558.pdf

suspended by Board and was allowed to petition for a stay of suspension upon providing proof to the Board that she was in compliance with conditions and limitations placed on her license).[4]

Based upon the facts of this case and the factors set forth in *Aldrich,* I find that suspension of Respondent's license and privilege to practice practical nursing in Wisconsin under the Enhanced Nurse Licensure Compact, as well as the conditions and limitations of the Order section below, are warranted.

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. *Noesenv. 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, Boards considered the following factors when determining if all or part of the costs should be assessed against the 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,* 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.

Here, in light of Respondent's default, the factual allegations were deemed admitted, and the Division proved all counts alleged. Respondent's conduct was serious. While under the influence of alcohol at work, Respondent neglected patients and provided inappropriate care. She also admitted abusing prescription and illicit drugs. Despite facing criminal charges, Respondent continued to act inappropriately at work by pushing a chair that a patient was seated in, causing it to strike another patient. In addition, Respondent failed to file an Answer to the Complaint. Neither she or her attorney appeared at the first two prehearing conferences. At the prehearing conference on October 24, 2019, Respondent claimed she did not know she needed to file an Answer; however, she acknowledged that she had received and read the Notice from the ALJ dated October 11, 2019. Respondent did not offer any reasonable or plausible justification for her failure to file an Answer.

Another factor to consider in this case is that 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 requiring Respondent to pay the costs of this proceeding which resulted in significant discipline, rather than spreading the costs among all Board licensees in Wisconsin. Accordingly, it is appropriate for Respondent to pay the full costs of the investigation and this proceeding, as determined pursuant to Wis. Admin. Code § SPS 2.18.

[4] This decision is available online at: https://online.drl.wi.gov/decisions/2016/ORDER0004806-00012844.pdf

ORDER

For the reasons set forth above, IT IS ORDERED that the license and privilege of Respondent Janelle F. Biegert (license number 315385-31) to practice as a nurse in the State of Wisconsin under the Enhanced Nurse Licensure Compact are suspended and limited as follows:

SUSPENSION

A.1. The license of Respondent (license number 315385-31) to practice as a nurse in the State of Wisconsin is SUSPENDED for an indefinite period.

A.2. The privilege of Respondent to practice as a nurse in the State of Wisconsin under the authority of another state's license, pursuant to the Enhanced Nurse Licensure Compact, is also SUSPENDED for an indefinite period.

STAY OF SUSPENSION

B.1. The suspension shall not be stayed for the first three months, but any time after three months, the suspension may be stayed upon Respondent providing proof that is determined by the Board or its designee to be sufficient to show that Respondent has been in compliance with the provisions of Sections C and D of this Order for the most recent three consecutive months.

B.2. The Board or its designee may, without hearing, remove the stay upon receipt of information that Respondent is in violation of any provision of this Order. The Board or its designee may, in conjunction with any removal of any stay, prohibit the Respondent for a specified period of time from seeking a reinstatement of the stay under paragraph B.4.

B.3. This suspension becomes reinstated immediately upon notice of the removal of the stay being provided to Respondent either by:

(a) Mailing to Respondent's last-known address provided to the Department of Safety and Professional Services (Department) pursuant to Wis. Stat. § 440.11; or

(b) Actual notice to Respondent or Respondent's attorney.

B.4. The Board or its designee may reinstate the stay if provided with sufficient information that Respondent is in compliance with the Order and that it is appropriate for the stay to be reinstated. Whether to reinstate the stay shall be wholly in the discretion of the Board or its designee.

CONDITIONS AND LIMITATIONS

Treatment Required

C.1. Respondent shall enter into, and shall continue, drug and alcohol treatment with a treater acceptable to the Board or its designee (Treater). Respondent shall participate in, cooperate with, and follow all treatment recommended by Treater.

C.2. Respondent shall immediately provide Treater with a copy of this Final Decision and Order and all other subsequent orders.

C.3. Treater shall be responsible for coordinating Respondent's rehabilitation and treatment as required under the terms of this Order, and shall immediately report any relapse, violation of any of the terms and conditions of this Order, and any suspected unprofessional conduct, to the Department Monitor (See D.1., below). If Treater is unable or unwilling to serve as required by this Order, Respondent shall immediately seek approval of a successor Treater by the Board or its designee.

C.4. The rehabilitation program shall include individual and/or group therapy sessions at a frequency to be determined by Treater. Therapy may end only with the approval of the Board or its designee after receiving a petition for modification as required by D.5., below.

C.5. Treater shall submit formal written reports to the Department Monitor on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent's progress in drug and alcohol treatment.

Releases

C.6. Respondent shall provide and keep on file with Treater, all treatment facilities and personnel, laboratories and collection sites, current releases complying with state and federal laws. The releases shall allow the Board, its designee, and any employee of the Department to: (a) obtain all specimen screen results and patient health care and treatment records and reports, and (b) discuss the progress of Respondent's treatment and rehabilitation with Treater, treatment facilities and personnel, laboratories and collection sites. Copies of these releases shall immediately be filed with the Department Monitor.

AA/NA Meetings

C.7. Respondent shall attend Narcotics Anonymous and/or Alcoholics Anonymous meetings or an approved equivalent program for recovering professionals, at the frequency recommended by Treater, but no less than twice per week. Attendance of Respondent at such meetings shall be verified by the speaker or chair and reported quarterly to Treater and the Department Monitor.

Sobriety

C.8. Respondent shall abstain from all use of alcohol.

C.9. Respondent shall abstain from all use of controlled substances as defined in Wis. Stat. § 961.01(4), except when prescribed, dispensed or administered by a practitioner for a legitimate medical condition. Respondent shall disclose Respondent's drug and alcohol history and the existence and nature of this Order to the practitioner prior to the practitioner prescribing the controlled substance. Respondent shall, at the time the controlled substance is prescribed, immediately sign a release in compliance with state and federal laws authorizing the practitioner to discuss Respondent's treatment with, and provide copies of treatment records to, Treater and the Board or its designee. Copies of these releases shall immediately be filed with the Department Monitor. Respondent shall disclose the name and address of such practitioner to the Department Monitor within five business days of receipt of a prescription for controlled substances.

C.10. Respondent shall provide the Department Monitor with a list of over-the-counter medications and drugs that they may take from time to time. Respondent shall abstain from all use of over-the-counter medications, products, or other substances (including but not limited to natural substances, such as poppy seeds or any products containing alcohol) which may mask consumption of controlled substances or alcohol, create false positive screening results, or otherwise interfere with Respondent's test results, treatment or rehabilitation, unless ordered by a physician and approved by Treater, in which case the drug must be reported as described in paragraph C.11. It is Respondent's responsibility to educate herself about the medications and substances which may violate this paragraph, and to avoid those medications and substances.

C.11. Respondent shall report to Treater and the Department Monitor all prescription medications and drugs taken by Respondent. Reports must be received within 24 hours of administration, fill, or refill of the medication or drug, and shall identify the person or persons who prescribed, dispensed, administered, or ordered said medications or drugs. Each time the prescription is filled or refilled, Respondent shall immediately arrange for the prescriber or pharmacy to fax and mail copies of the prescription to the Department Monitor.

Drug and Alcohol Screens

C.12. Respondent shall enroll and begin participation in a drug and alcohol monitoring program which is approved by the Department (Approved Program).

C.13. At the time Respondent enrolls in the Approved Program, Respondent shall review all rules and procedures made available by the Approved Program. Failure to comply with all requirements for participation in drug and alcohol monitoring established by the Approved Program is a violation of this Order. The requirements shall include:

(a) Contact with the Approved Program as directed on a daily basis, including vacations, weekends, and holidays.

(b) Production of a urine, blood, sweat, nail, hair, saliva, or other specimen at a collection site designated by the Approved Program within five hours of notification of a test.

C.14. The Approved Program shall require the testing of specimens at a frequency of not less than 49 times per year (one of which must be a hair test), for at least the first year of this Order. Thereafter, the board may adjust the frequency of testing on its own initiative at any time, and/or Respondent may petition for modification of testing frequency per paragraph D.5.

C.15. If any urine, blood, sweat, nail, hair, saliva, or other specimen is positive or suspected positive for any controlled substances or alcohol, Respondent shall promptly submit to additional tests or examinations, as the Board or its designee shall determine to be appropriate, to clarify or confirm the positive or suspected positive test results.

C.16. In addition to any requirement of the Approved Program, the Board or its designee may require Respondent to do any or all of the following: (a) submit additional specimens; (b) furnish any specimen in a directly witnessed manner; or (c) submit specimens on a more frequent basis.

C.17. All confirmed positive test results shall be presumed valid. Respondent must prove, by a preponderance of the evidence, an error in collection, testing, fault in the chain of custody, or other valid defense.

C.18. The Approved Program shall submit information and reports to the Department Monitor as directed.

Practice Limitations

C.19. Respondent shall not work as a nurse or other health care provider in a setting in which Respondent has access to controlled substances.

C.20. Respondent shall practice only under the direct supervision of a licensed nurse or other licensed health care professional, approved by the Board or its designee, who has received a copy of this Order.

C.21. Respondent shall practice only in a work setting pre-approved by the Board or its designee. Requests for pre-approval must be accompanied by a current job description, name and contact information of the direct supervisor, and written acknowledgment from the employer that a copy of this Order has been received and that the restrictions will be accommodated.

C.22. Respondent may not work in a home health care, hospice, pool nursing, assisted living, agency, or as a nurse in a correctional setting.

C.23. Prior to commencing practice, Respondent shall provide a copy of this Order, and all other subsequent orders, immediately to supervisory personnel at all settings where Respondent works as a nurse, caregiver or provides health care currently or in the future.

C.24. It is Respondent's responsibility to arrange for quarterly written reports to be submitted to the Department Monitor from his or her supervisor at each setting in which Respondent practiced nursing in the previous quarter. These reports shall be submitted as

directed by the Department Monitor, and shall assess Respondent's work performance, and shall include the number of hours of active nursing practice worked during that quarter. If a report indicates poor performance, the Board may institute appropriate corrective limitations, or may revoke a stay of the suspension, in its discretion.

C.25. Respondent shall report to the Board any change of employment status, residence, address, or telephone number within five days of the date of a change. This report shall not be considered formal change of address notification pursuant to Wis. Stat. § 440.11.

MISCELLANEOUS

Department Monitor

D.1. Any requests, petitions, reports, and other information required by this Order shall be mailed, e-mailed, faxed, or delivered 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

You may also submit this information online via DSPS' Monitoring Case Management System at www.dspsmonitoring.wi.gov.

Required Reporting by Respondent

D.2. Respondent is responsible for compliance with all terms and conditions of this Order, including the timely submission of reports by others. Respondent shall promptly notify the Department Monitor of any failures of the Treater, treatment facility, Approved Program, or collection sites to conform to the terms and conditions of this Order. Respondent shall promptly notify the Department Monitor of any violations of any of the terms and conditions of this Order by Respondent.

D.3. Respondent shall submit self-reports to the Department Monitor on a quarterly basis, as directed by the Department Monitor. The reports shall include a summary of Respondent's compliance with the terms and conditions of the Order in the previous quarter, Respondent's current address, and home telephone number. The self-report shall not be considered formal change of address notification pursuant to Wis. Stat. § 440.11.

Change of Treater or Approved Program by Board

D.4. If the Board, or its designee, determines the Treater or Approved Program has performed inadequately or has failed to satisfy the terms and conditions of this Order, the Board, or its designee, may direct that Respondent continue treatment and rehabilitation under the direction of another Treater or Approved Program.

Petitions for Modification of Limitations or Termination of Order

D.5. Respondent may petition the Board on an annual basis for modification of the terms of this Order; however, no such petition for modification shall occur earlier than one year from the date of the initial stay of the suspension. Any petition for modification shall be accompanied by a written recommendation from Respondent's Treater expressly supporting the specific modifications sought. Denial of a petition in whole or in part shall not be considered a denial of a license within the meaning of Wis. Stat. § 227.01(3)(a), and Respondent shall not have a right to any further hearings or proceedings on the denial.

D.6. Respondent may petition the Board for termination of this Order after demonstrating five years of successful compliance with all terms, including at least 600 hours of approved nursing practice each year. The Board may, on its own motion, grant full Wisconsin licensure at any time.

Costs of Compliance

D.7. Respondent shall be responsible for all costs and expenses incurred in conjunction with the monitoring, screening, supervision, and any other expenses associated with compliance with the terms of this Order. Being dropped from a program for non-payment is a violation of this Order.

Additional Discipline

D.8. In addition to any other action authorized by this Order or law, the Board, in its discretion, may impose additional limitations or pursue separate disciplinary action for violation of any term of this Order.

IT IS FURTHER ORDERED that Respondent pay all recoverable costs in this matter in an amount to be established, pursuant to Wis. Admin. Code § SPS 2.18. After the amount is established, payment shall be made by certified check or money order payable to the Department of Safety and Professional Services and sent to the address listed in paragraph D.1. above.

IT IS FURTHER ORDERED that the terms of the Order are effective the date the Final Decision and Order in this matter is signed by the Board.

Dated at Madison, Wisconsin, on 17 of December, 2019.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
4822 Madison Yards Way, 5th Floor North
Madison, Wisconsin 53705
Tel. (608) 267-2745
Email: Sally.Pederson@wisconsin.gov

By: _____

Sally Pederson
Administrative Law Judge