

## WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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STATE OF WISCONSIN  
BEFORE THE BOARD OF NURSING

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IN THE MATTER OF DISCIPLINARY  
PROCEEDINGS AGAINST

ADAM E. BONDY, R.N.  
RESPONDENT.

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FINAL DECISION AND ORDER

**ORDER 0006711**

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Division of Legal Services and Compliance Case Nos. 17 NUR 609 and 18 NUR 130

The parties to this action for the purpose of Wis. Stat. § 227.53 are:

Adam E. Bondy, R.N.  
Appleton, WI 54915

Wisconsin Board of Nursing  
P.O. Box 8366  
Madison, WI 53708-8366

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

The parties in these matters agree to the terms and conditions of the attached Stipulation as the final disposition of the above referenced matters, subject to the approval of the Wisconsin Board of Nursing (Board). The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Respondent Adam E. Bondy, R.N., (DOB XX-XX-1984) is licensed in the state of Wisconsin as a Registered Nurse (R.N.), having license number 198050-30, first issued on October 15, 2013. Respondent's R.N. license is currently suspended.

2. Respondent was also licensed in the state of Wisconsin as a Licensed Practical Nurse (L.P.N.), having license number 310199-31, first issued on July 2, 2008. That license was revoked by Board Order number 5620 (DLSC Case No. 16 NUR 254) on February 8, 2018.

3. On February 8, 2018, Respondent was reprimanded by the Board and limitations were placed on his registered nursing license (license number 198050-30) pursuant to Board Order number 5620 (DLSC Case No. 16 NUR 254). The limitations included successful completion of

thirteen (13) hours of education and showing the Order to any nursing employer for at least two (2) years from the date of the Order. On June 6, 2018, the Board suspended Respondent's registered nursing license (license number 198050-30) due to Respondent's failure to comply with the education requirements of Order number 5620.

#### 17 NUR 609

4. At all times relevant to this matter, Respondent was employed as a registered nurse at a senior living community-based residential facility (Facility), located in Appleton, Wisconsin.

5. A care manager at the Facility visiting two (2) of her clients observed Respondent give Resident A a hug and kiss on top of the head. Resident A kissed Respondent somewhere on the face, which Respondent allowed.

6. On or about October 12, 2017, the Facility discovered two (2) residents' fentanyl prescriptions were not in the narcotic box. When asked about the medications, Respondent admitted to taking the fentanyl patches home because he did not trust the Certified Nursing Assistant (C.N.A.) or caregiver. Respondent was told all medications must remain in the Facility per federal guidelines.

7. Respondent went home to get the fentanyl patches and the narcotic tracking sheet. The fentanyl patches were not in the original packaging when Respondent brought them back to the Facility. Both residents' patches were mixed together and had a handwritten date on the pouch. Respondent stated he knew which prescription belonged to which resident based on the dosage. Respondent was told the fentanyl patches must remain in the lock box and two (2) people must be present when the patch is administered to a resident.

8. On or about October 14, 2017, Respondent administered a fentanyl patch to a resident, observed by the Facility's administrator. Afterwards, Respondent proceeded to put the remaining medication into the closet in Respondent's office. Respondent was told again that the fentanyl patches must remain in the locked narcotic box.

9. On or about October 20, 2017, the Facility administrator followed up with Respondent to ensure he was properly storing the residents' fentanyl patches, but they were not in the narcotic box. Respondent was instructed to put the fentanyl patches in the narcotic box immediately, which Respondent did. When Respondent returned them to the box, the fentanyl patches appeared dusty. Respondent stated they were still alright to use because the gel is still on the patch. Later that day, Respondent sent an email resigning from his position.

#### 18 NUR 130

10. At all times relevant to this matter, Respondent was employed as a registered nurse at a nursing and rehabilitation center (Center), located in Ripon, Wisconsin.

11. On or about February 15, 2018, Respondent was seen on video taking approximately four (4) pills out of his pocket and setting them on the counter of the medication room of the Center. Respondent split the pills into two (2) piles, covered one (1) pile with a small plastic bag, and crushed the pills using a glass vial that was on the counter. Respondent then used

a credit card or identification card to line the powder up and used a straw to snort the powder up his nose. Respondent then repeated these actions with the second pile of pills.

12. Respondent admitted to the police to crushing and snorting loratadine and 1 (one) oxycodone, which Respondent stated he had an old prescription for. He stated to the police that he was unsure if he had any oxycodone left from his prescription but admitted to having an addiction.

13. Additionally, Respondent failed to provide his nursing supervisor at the Center with a copy of Order number 5620.

#### As to all matters

14. On May 14, 2019, a Department investigator attempted to call Respondent at the phone numbers on file with the Department. The phone numbers were no longer in service. The investigator checked Lexis Nexis® and found an additional phone number. The investigator called the number and left a voicemail for Respondent to call the Department.

15. On May 14, 2019, a Department investigator sent a letter to Respondent at Respondent's most recent address on file with the Department informing Respondent that the Department wished to schedule a time to meet in person regarding these matters. Respondent was asked to contact the Department investigator no later than Friday, May 24, 2019.

16. On May 29, 2019, a Department investigator sent an email to Respondent at Respondent's email address on file with the Department requesting to schedule an interview with Respondent.

17. The Department never received a response from Respondent.

18. In resolution of these matters, Respondent consents to the entry of the following Conclusions of Law and Order.

#### CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction to act in this matter pursuant to Wis. Stat. § 441.07 and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

2. By the conduct described in paragraph 5 in the Findings of Fact above, Respondent Adam E. Bondy, R.N., violated Wis. Admin. Code § N 7.03(4)(e)1.a., by failing to establish, maintain, or communicate professional boundaries with the patient.

3. By the conduct described in paragraphs 6 through 9 and 11 and 12 in the Findings of Fact above, Respondent Adam E. Bondy, R.N., violated 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.

4. By the conduct described in paragraphs 11 and 12 in the Findings of Fact above, Respondent Adam E. Bondy, R.N., violated Wis. Admin. Code § N 7.03(8)(e), by obtaining, possessing or attempting to obtain or possess a drug without lawful authority.

5. By the conduct described in paragraph 12 in the Findings of Fact above, Respondent Adam E. Bondy, R.N., violated Wis. Stat. § 441.07(1g)(c), by engaging in acts which show Respondent to be unfit or incompetent by reason of negligence, abuse of alcohol or other drugs or mental incompetency.

6. By the conduct described in paragraph 13 in the Findings of Fact above, Respondent Adam E. Bondy, R.N., violated Wis. Admin. Code § N 7.03(1)(g), by violating any term, provision, or condition of any order of the Board.

7. By the conduct described in paragraphs 14 through 17 in the Findings of Fact above, Respondent Adam E. Bondy, R.N., violated Wis. Admin. Code § N 7.03(1)(c), by failing to cooperate in a timely manner with the Board's investigation of these matters.

8. As a result of the above conduct, Adam E. Bondy, R.N., is subject to discipline pursuant to Wis. Stat. §§ 441.07(1g)(b), (c), and (d).

#### ORDER

1. The attached Stipulation is accepted.

2. The VOLUNTARY SURRENDER of the license and privilege of Adam E. Bondy, R.N., to practice as a registered nurse (license no. 198050-30) in the State of Wisconsin or under another state license pursuant to the Enhanced Nurse Licensure Compact is hereby accepted.

3. After a period of three (3) years, Respondent may petition for reinstatement, under the following conditions:

a. Within three (3) months prior to filing a petition, Respondent shall have, at his own expense, undergone a fitness to practice evaluation with a pre-approved psychiatrist or psychologist experienced in evaluating health care practitioners' fitness for duty.

i. The provider performing the evaluation must not have treated Respondent and shall have been approved by the Board or its designee, with the opportunity for the Division of Legal Services and Compliance to make its recommendation, prior to the evaluation being performed; and

ii. Within fifteen (15) days of the completion of the assessment, a written report regarding the results of the assessment shall be submitted to the Department Monitor at the address below. The report shall address whether Respondent suffers from any condition(s) that may interfere with his or her ability to practice safely and, if so, shall provide any recommended limitations for safe practice.

b. Within three (3) months prior to filing a petition, Respondent shall have, at his own expense, undergone an Alcohol and Other Drug Abuse (AODA) assessment with an evaluator, pre-approved by the Board or its designee, who has experience conducting evaluating health care professional with substance abuse disorders.

i. This assessment must be completed by a licensed mental health professional that has never treated nor had a professional or personal relationship with Respondent.

ii. Within fifteen (15) days of the completion of the assessment, a written report regarding the results of the assessment shall be submitted to the Department Monitor at the address below. The report shall address whether Respondent suffers from any condition(s) that may interfere with his or her ability to practice safely and, if so, shall provide any recommended limitations for safe practice.

c. Prior to the evaluations, Respondent shall provide a copy of this Final Decision and Order to the health care provider.

d. Respondent shall execute necessary documents authorizing the Division to obtain records of evaluation, and to discuss Respondent and his case with the evaluator. Respondent shall execute all releases necessary to permit disclosure of the final evaluation report to the Board or its designee. Certified copies of the final evaluation report shall be admissible in any future proceeding before the Board.

e. Respondent shall comply with any and all reasonable requests by the evaluator for purposes of scheduling and completing the evaluation, including additional testing the examiner deems helpful. Any lack of reasonable and timely cooperation, as determined by the examiner, may constitute a violation of an order of the Board.

f. Respondent is responsible for timely payment of the costs of the examination. Payment shall be made directly to the evaluator.

g. Respondent must provide proof sufficient to convince the Board that Respondent is able to practice with reasonable skill and safety of patients and the public and does not suffer from any condition which prevents Respondent from practicing in that manner.

h. If the Board determines that Respondent is fit to practice, the Board may nonetheless limit Respondent's license in a manner to address any concerns the Board has as a result of the conduct set out in the Findings of Fact and to address any recommendations resulting from the assessment, including, but not limited to:

i. Psychotherapy, at Respondent's expense, by a therapist approved by the Board or its designee, to address specific treatment goals, with periodic reports to the Board by the therapist.

ii. Additional professional education in any identified areas of deficiency.

iii. Restrictions on the nature of practice or practice setting or requirements for supervision of practice, by a professional approved by the Board, with periodic reports to the Board by the supervisor.

i. If the Board determines that Respondent is not fit to practice, the Board may deny Respondent's reinstatement until Respondent provides proof sufficient to convince the Board that Respondent is able to practice with reasonable skill and safety of patients and the public and does not suffer from any condition which prevents Respondent from practicing in that manner.

4. In the event Respondent petitions the Board for reinstatement of his license to practice as a Registered Nurse in the state of Wisconsin, or applies for another credential with the Department, Respondent shall pay the costs of these matters in the amount of \$3,000.00, before any application is considered.

5. If applicable, payment of costs (made payable to the Wisconsin Department of Safety and Professional Services) shall be sent by Respondent to the Department Monitor at the address below:

Department Monitor  
Division of Legal Services and Compliance  
Department of Safety and Professional Services  
P.O. Box 7190, Madison, WI 53707-7190  
Telephone (608) 267-3817; Fax (608) 266-2264  
DSPSMonitoring@wisconsin.gov


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

<https://dspsmonitoring.wi.gov>.

6. This Order is effective on the date of its signing.

WISCONSIN BOARD OF NURSING

by:

  
A Member of the Board

3/18/2020  
Date

RECEIVED

FEB 20 2020

STATE OF WISCONSIN  
BEFORE THE BOARD OF NURSING

DIV LEGAL SERVICES & COMPLIANCE  
DEPT SAFETY & PROFESSIONAL SERVICES

IN THE MATTER OF DISCIPLINARY  
PROCEEDINGS AGAINST

ADAM E. BONDY, R.N.,  
RESPONDENT.

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STIPULATION

ORDER 00067 11

Division of Legal Services and Compliance Case Nos. 17 NUR 609 and 18 NUR 130

Respondent Adam E. Bondy, R.N., and the Division of Legal Services and Compliance, Department of Safety and Professional Services stipulate as follows:

1. This Stipulation is entered into as a result of two (2) pending investigations by the Division of Legal Services and Compliance. Respondent consents to the resolution of these investigations by Stipulation.

2. Respondent understands that by signing this Stipulation, Respondent voluntarily and knowingly waives the following rights:

- the right to a hearing on the allegations against Respondent, at which time the State has the burden of proving those allegations by a preponderance of the evidence;
- the right to confront and cross-examine the witnesses against Respondent;
- the right to call witnesses on Respondent's behalf and to compel their attendance by subpoena;
- the right to testify on Respondent's own behalf;
- the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision;
- the right to petition for rehearing; and
- all other applicable rights afforded to Respondent under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and other provisions of state or federal law.

3. Respondent is aware of Respondent's right to seek legal representation and has been provided an opportunity to obtain legal counsel before signing this Stipulation.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Wisconsin Board of Nursing (Board). The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall then be returned to the Division

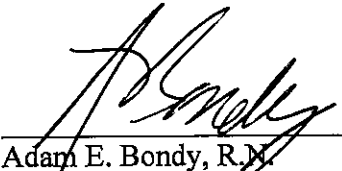


of Legal Services and Compliance for further proceedings. In the event that the Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

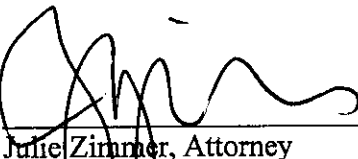
6. The parties to this Stipulation agree that the attorney or other agent for the Division of Legal Services and Compliance and any member of the Board ever assigned as an advisor in these investigations may appear before the Board in open or closed session, without the presence of Respondent, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with deliberations on the Stipulation. Additionally, any such advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

7. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

8. The Division of Legal Services and Compliance joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.

  
\_\_\_\_\_  
Adam E. Bondy, R.M.  
License No. 198050-30

02/17/2020  
Date

  
\_\_\_\_\_  
Julie Zimmer, Attorney  
Department of Safety and Professional Services  
Division of Legal Services and Compliance  
P.O. Box 7190  
Madison WI 53707-7190

02/21/2020  
Date