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Before the
State of Wisconsin
Board of Nursing

In the Matter of the Disciplinary Proceedings
Against Amanda R. Nieuwenhuis, R.N.

FINAL DECISION AND ORDER

Order No. ORDER 0007150

Division of Legal Services and Compliance Case No. 17 NUR 346 and 18 NUR 750

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 14th day of January, 2021.

Member
Board of Nursing

Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against AMANDA R. NIEUWENHUIS, R.N., Respondent	DHA Case No. SPS-20-0022 DLSC Case Nos. 17 NUR 346 and 18 NUR 750

PROPOSED DECISION AND ORDER

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

Amanda R. Nieuwenhuis, R.N.
P.O. Box 432
Darien, WI 53114

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

PROCEDURAL HISTORY

The proceedings were initiated on August 24, 2020, when the Department of Safety and Professional Services (Department), by the Division of Legal Services and Compliance (Division), filed a formal complaint against Respondent Amanda R. Nieuwenhuis, R.N. (Respondent), alleging that Respondent engaged in unprofessional conduct by the following conduct: (1) failing to cooperate in a timely manner with the board's investigation, in violation of Wis. Admin. Code § N 7.03(1)(c); (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); (3) by practicing nursing while under the influence of 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); and (4) 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). Administrative Law Judge Kristin Fredrick (ALJ) was assigned to the matter.

On August 24, 2020 the Division served Respondent with a copy of a Notice of Hearing and Complaint, which was sent to Respondent's address on file with the Department via certified and regular first-class mail, pursuant to Wis. Admin. Code § SPS 2.08. On September 3, 2020, the Notice of Hearing and the Complaint sent to Respondent via certified mail were received and signed for by Respondent's agent.

Respondent was required to file an Answer twenty (20) days from the date of service, pursuant to Wis. Admin. Code § SPS 2.09(4); however, no Answer was filed. After the expiration of the 20-day time period to file an Answer, the ALJ scheduled a telephone prehearing conference for September 28, 2020. The ALJ sent notice of the conference by U.S. mail to Respondent. The notice ordered Respondent to contact the ALJ no later than September 25, 2020, to provide her current telephone number. The notice also stated that if Respondent failed to appear at the scheduled conference, default judgment may be entered against her.

Respondent failed to contact the ALJ by September 25, 2020 with her current telephone number. At the prehearing conference on September 28, 2020, Respondent failed to appear. The Division provided the ALJ with Respondent's telephone number on file with the Department. The ALJ left a voicemail message for Respondent that she should contact the ALJ or a default order may be entered against her. The ALJ also emailed Respondent and similarly advised her that a default order may be issued against her if she failed to contact the ALJ by close of business on September 28, 2020.

Respondent responded to the ALJ's email on September 28, 2020. The ALJ granted Respondent until the close of business on October 5, 2020 to file an Answer to the Complaint and provide her current address and telephone number. Respondent failed to file an Answer or provide her current contact information by October 5, 2020. Respondent emailed the ALJ on October 6, 2020 but did not provide an Answer or her current contact information. On October 6, 2020, the Division moved for default, pursuant to Wis. Admin. Code §§ SPS 2.14 and HA 1.07(3)(c).

On October 7, 2020, the ALJ issued a Notice of Default against Respondent and ordered that the Division file a recommended proposed decision and order by November 6, 2020. The Division timely filed its submission.

FINDINGS OF FACT

Facts Related to the Alleged Violations

1. Respondent Amanda R. Nieuwenhuis, R.N., is licensed in the state of Wisconsin to practice as a registered nurse, having license number 195769-30, first issued on June 5, 2013, and current through February 28, 2022. (Complaint ¶ 1).

2. Respondent's most recent address on file with the Department is Post Office Box 432, Darien, Wisconsin 53114. (Complaint ¶ 2).

17 NUR 346

3. At all times relevant to this proceeding, Respondent was employed as the Assistant Director of Nursing at a health and rehabilitation center located in Beloit, Wisconsin (Center). (Complaint ¶ 3).

4. On March 9, 2017, Resident A requested an immediate twenty-four (24) hour pass to leave the Center. Respondent offered to help get Resident A ready for her leave. (Complaint ¶ 4).

5. Nurse B gave Respondent the key to the medication cart to package Resident A's medications. Resident A had an order for one (1) tablet of oxycodone every six (6) hours as needed for a maximum of four (4) tablets per day. (Complaint ¶ 5).

6. Respondent signed out six (6) oxycodone 20 mg tablets for Resident A's twenty-four (24) hour pass. (Complaint ¶ 6).

7. Resident A left the Center for approximately two hours on March 9, 2017. (Complaint ¶ 7).

8. On March 10, 2017, Resident A returned the medication that was packaged for her 24-hour leave to Nurse C. Only two (2) tablets of oxycodone were in the package. (Complaint ¶ 8).

9. Resident A stated that she did not ingest any of the medication. (Complaint ¶ 9).

10. On March 10, 2017, Respondent submitted to a reasonable suspicion urine drug screen, the results of which were positive for buprenorphine, oxycodone, and hydrocodone. The only other person with access to the medication cart, Nurse B, tested negative. (Complaint ¶ 10).

11. On March 23, 2017, Respondent was terminated from the Center because she was unable to provide a valid prescription for oxycodone or hydrocodone. (Complaint ¶ 11).

12. On November 14, 2018, on behalf of the Board of Nursing, the Division investigator mailed a subpoena to Respondent's mailing address on file requiring her appearance for an interview with the Department. The subpoena was returned by the U.S. Postal Service as not deliverable as addressed. (Complaint ¶ 12).

13. On November 27, 2018, the Division investigator emailed the subpoena to Respondent's email address on file with the Department. Respondent failed to respond. (Complaint ¶ 13).

14. On December 6, 2018 and December 10, 2018, the Division investigator called Respondent at her phone number on file with the Department and left a voice mail message. Respondent failed to respond. (Complaint ¶ 14).

15. On December 18, 2018, Respondent emailed the Division investigator stating she received the subpoena but was unable to appear at the scheduled time. She requested a different interview date. The Division investigator asked Respondent to provide an alternative date, but Respondent never replied. (Complaint ¶ 15).

16. On January 14, 2019, the Division investigator emailed Respondent again to try to set up an interview. Respondent failed to respond. (Complaint ¶ 16).

17. On May 1, 2019, the Division received a voice mail message from Respondent. On May 6, 2019, the Division attorney emailed Respondent acknowledging receipt of the voice message and asking Respondent to contact her by May 15, 2019. (Complaint ¶ 17).

18. On May 14, 2019, Respondent emailed the Division with dates she was available for a phone call. The Division attorney tried to schedule a call with Respondent on May 20, 2019, but Respondent did not respond, nor did she answer when the Division attorney attempted to call her on May 20, 2019. (Complaint ¶ 18).

19. On May 21, 2019, Respondent emailed the Division attorney providing reasons she did not answer the Division's call on May 20, 2019. The Division attorney set up another call, but Respondent did not answer. (Complaint ¶ 19).

18 NUR 750

20. At all times relevant to this proceeding, Respondent was employed as a registered nurse at an acute care center in Williams Bay, Wisconsin (Facility). (Complaint ¶ 20).

21. On November 5, 2018, Resident B's narcotic card containing twenty-nine (29) tablets of Norco (hydrocodone-acetaminophen) and the corresponding narcotic count sheet went missing during the day shift. (Complaint ¶ 21).

22. Respondent was the nurse responsible for the medication cart during that shift. (Complaint ¶ 22).

23. After the missing narcotic card and count sheet were discovered missing on November 7, 2018, Respondent was suspended from the Facility pending an investigation and did not respond to the Facility after that day. (Complaint ¶ 23).

24. During the Facility investigation, the following additional medication discrepancies were discovered:

a. Resident C had an order for one (1) oxycodone 15 mg tablet every six (6) hours as needed for pain. On November 5, 2018, Respondent signed out two (2) tablets at 8:00 a.m. on the narcotic count sheet. Respondent did not document in the medication administration record (MAR) that she administered the medication to Resident C.

b. Resident D had an order for one (1) oxycodone-acetaminophen 10-325 mg tablet at bedtime and one (1) oxycodone-acetaminophen 10-325 mg tablet every six (6) hours as needed for pain. On November 5, 2018, Respondent signed out two (2) tablets at 7:30 a.m., 8:30 a.m., and 2:00 p.m., respectively. Respondent documented administration to Resident D in the MAR at 8:00 a.m. and 1:02 p.m.

c. On November 6, 2018, Respondent signed out two (2) tablets of oxycodone-acetaminophen 10-325 mg for Resident D at 3:00 p.m. Respondent did not document in the MAR that she administered the medication and Resident D claimed she never received it.

(Complaint ¶ 24).

25. On February 20, 2019, the Division intake coordinator emailed Respondent at her email address on file with the Department requesting a response to the complaint. Respondent failed to respond. (Complaint ¶ 25).

26. On April 12, 2019, the Division intake coordinator sent a letter to Respondent at the mailing address on file with the Department requesting a response to the complaint. Respondent failed to respond. (Complaint ¶ 26).

27. On October 4, 2019, the Division attorney emailed Respondent again requesting a response to the complaint. Respondent failed to respond. (Complaint ¶ 27).

Facts Related to Default

28. The Notice of Hearing and Complaint were served on Respondent at her last known address on August 24, 2020, by both certified and first-class mail, pursuant to Wis. Admin. Code § SPS 2.08. (Affidavit of Service ¶¶ 3-4).

29. The Division also emailed a copy of the Notice of Hearing and Complaint to Respondent at her last known email address on August 24, 2020. (Affidavit of Service ¶ 5; Ex. 1).

30. On September 3, 2020, the Notice of Hearing and the Complaint were received and signed for by Respondent's agent. (Affidavit of Service ¶ 6; Ex. 2).

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

32. After the expiration of the 20-day time period to file an Answer, the ALJ scheduled a telephone prehearing conference for September 28, 2020. The ALJ sent notice of the conference by U.S. mail to Respondent. The notice ordered Respondent to contact the ALJ no later than September 25, 2020 to provide her current telephone number. The notice also stated that if Respondent failed to appear at the scheduled conference, default judgment may be entered against her.

33. Respondent failed to contact the ALJ by September 25, 2020 with her current telephone number.

34. At the prehearing conference on September 28, 2020, Respondent failed to appear. The Division provided the ALJ with Respondent's telephone number on file with the Department. The ALJ left a voicemail message for Respondent that she should contact the ALJ or a default order may be entered against her. The ALJ also emailed Respondent and similarly advised her that a default order may be issued against her if she failed to contact the ALJ by close of business on September 28, 2020.

35. Respondent responded to the ALJ's email on September 28, 2020. The ALJ granted Respondent until close of business on October 5, 2020 to file an Answer to the Complaint and provide her current address and telephone number. Respondent failed to file an Answer or provide her current contact information by October 5, 2020. Respondent emailed the ALJ on October 6, 2020 but did not provide an Answer or her current contact information.

36. On October 6, 2020, the Division moved for default, pursuant to Wis. Admin. Code §§ SPS 2.14 and HA 1.07(3)(c).

37. On October 7, 2020, the ALJ issued a Notice of Default and ordered that the Division file and serve a recommended proposed decision and order by November 6, 2020. According to the Notice, "[i]n light of Respondent's failure to file an Answer to the Complaint, failure to appear for the prehearing conference and failure to provide her updated contact information, the ALJ finds Respondent to be in default."

38. The Division timely filed its recommended proposed decision and order.

DISCUSSION

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

The Division properly served the Notice of Hearing and Complaint upon Respondent by mailing copies to her at her last known address. Service by mail is complete upon mailing. Wis. Admin. Code § SPS 2.08(1). Under Wis. Admin. Code § SPS 2.14, if a respondent "fails to answer as required by s. SPS 2.09 or fails to appear at the hearing at the time fixed therefor, the respondent is in default and the disciplinary authority may make findings and enter an order on the basis of the complaint and other evidence." *See also* Wis. Admin. Code § HA 1.07(3)(c).

Here, Respondent violated Wis. Admin. Code § SPS 2.09(4) by failing to file an Answer to the Complaint within 20 days from the date of service, or by the extended date ordered by the

ALJ. Respondent also failed to appear at the prehearing telephone conference on September 28, 2020 or provide updated contact information, as ordered by the ALJ. Therefore, Respondent is in default, and findings and an order may be entered on the basis of the Complaint.

Violations

The Wisconsin Board of Nursing (Board) has the authority to impose discipline against the Respondent pursuant to Wis. Stat. § 441.07. Following an investigation and disciplinary hearing, if the Board determines that a that a nurse has committed "[o]ne or more violations of this subchapter or any rule adopted by the board under the authority of this subchapter," or "[a]cts which show the registered nurse...to be unfit or incompetent by reason of negligence, abuse of alcohol or other drugs or mental incompetency," or has committed "[m]isconduct or unprofessional conduct," it may "revoke, limit, suspend or deny a renewal of a license of a registered nurse...." Wis. Stat. § 441.07(1g)(b), (c), and (d), respectively.

Pursuant to Wisconsin Administrative Code § N 7.03, the grounds for taking disciplinary action on a nursing license include the following:

> (1) Noncompliance with federal, jurisdictional, or reporting requirements including any of the following:
>
> ...
>
> (c) After a request of the board, failing to cooperate in a timely manner, with the board's investigation of a complaint filed against a license holder. There is a rebuttable presumption that a credential holder who takes longer than 30 days to respond to a request of the board has failed to cooperate in a timely manner.
>
> ...
>
> (6) Unsafe practice or substandard care, including any of the following:
>
> ...
>
> (c) Departing from or failing to conform to the minimal standards of acceptable nursing practice that may create unnecessary risk or danger to a patient's life, health, or safety. Actual injury to a patient need not be established.
>
> ...
>
> (e) Practicing nursing while under the influence of alcohol, illicit drugs, or while impaired by the use of legitimately prescribed pharmacological agents or medications.
>
> ...
>
> (8) Improper prescribing, dispensing, or administering medication or drug related offenses, including any of the following:
>
> ...

(e) Obtaining, possessing or attempting to obtain or possess a drug without lawful authority.

Respondent violated Wis. Admin. Code § N 7.03(1)(c) by failing to cooperate in a timely manner with the Board's investigation after a request by the Board. In case number 17 NUR 346, the Division issued a subpoena to Respondent who indicated she was unable to appear at the scheduled time. When asked to provide alternative dates, Respondent failed to respond. After eventually providing alternative dates, she did not appear or respond to the Division's two attempts to contact her. In case number 18 NUR 750, the Division requested Respondent's response to the complaint by sending emails to her email address on file with the Department on February 20, 2019 and October 4, 2019, and by sending a letter to her mailing address on file with the Department on April 12, 2019. Respondent failed to respond to all three requests for a response.

Respondent violated Wis. Admin. Code § N 7.03(6)(e) by practicing nursing while under the influence of illicit drugs or while impaired by the use of legitimately prescribed pharmacological agents or medications. On March 10, 2017, Respondent submitted to a reasonable suspicion urine drug screen while at work. The results of the drug screen were positive for buprenorphine, oxycodone, and hydrocodone. Respondent was unable to provide a valid prescription for oxycodone or hydrocodone. Pursuant to Wis. Stat. § 961.16(2)(a)7. and 11., respectively, hydrocodone and oxycodone are Schedule II controlled substances for which, under the circumstances at issue, a prescription is required pursuant to Wis. Stat. § 961.38(1r).

Finally, Respondent violated Wis. Admin. Code § N 7.03(6)(c) and (8)(e), 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, and obtaining, possessing, and attempting to obtain or possess a drug without lawful authority, respectively. In case number 17 NUR 346, Respondent signed out more oxycodone (six tablets) for Resident A's 24-hour leave than was ordered (four tablets); Resident A was only gone two hours and returned with two tablets, stating she did not ingest any medication while gone. Respondent tested positive for oxycodone and could not produce a valid prescription.

In case number 18 NUR 750, Resident B's narcotic card containing 29 tablets of Norco went missing on November 5, 2018 while Respondent was responsible for the medication cart. The Facility also found that Respondent signed out two oxycodone tablets at 8:00 a.m. on November 5, 2018 for Resident C when the order was for one tablet every six hours as needed. Respondent did not document administering the oxycodone to Resident C. Similarly, Respondent signed out two oxycodone-acetaminophen tablets for Resident D on November 5, 2018 at 7:30 a.m., 8:30 a.m., and 2:00 p.m. when the order called for one tablet every six hours as needed. Respondent only documented administering the medication to Resident D at 8:00 a.m. and 1:02 p.m. Finally, on November 6, 2018, Respondent signed out two tablets of oxycodone-acetaminophen for Resident D but did not document administration. Resident D claimed she never received it. Respondent failed to respond to the Facility after being suspended.

By violating these rules of professional conduct, Respondent is subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b), (c), and (d).

Discipline

The Division requests as discipline that the Respondent's registered nursing license be suspended indefinitely, with the opportunity to petition the Board for a stay of the suspension after providing sufficient proof Respondent is in compliance with drug treatment and monitoring for at least three (3) months. For the reasons set forth below, I agree with the Division's proposed discipline pursuant to the terms and conditions of the Order below.

The three purposes of discipline in a professional misconduct case 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, 209, 237 N.W.2d 689 (1976).

The recommended discipline is consistent with the purposes articulated in *Aldrich*. Respondent disregarded the public's trust and her responsibilities to her patients by testing positive at work for oxycodone and hydrocodone, two drugs for which she did not have a valid prescription. Respondent repeatedly signed out more oxycodone for patients than was ordered and failed to document its administration to those patients. Oxycodone went missing after being signed out by Respondent or under Respondent's watch. In addition, Respondent failed to cooperate with her employer's investigation and with the Division's investigations.

The recommended discipline protects the public by suspending Respondent's license indefinitely until she has entered into drug treatment with an approved treater, has verified attendance at Narcotics Anonymous, enrolled in an approved drug monitoring program, and can show compliance for at least three (3) months. "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). Respondent's suspension will also promote her rehabilitation and ensure she is successfully obtaining treatment before she is able to return to the practice of nursing.

The recommended discipline further protects the public and her patients by requiring that Respondent practice under direct supervision and in a Board-approved work setting. Respondent will not be allowed to work in home health care, hospice, pool nursing, an assisted living agency or a correctional setting because such settings will not provide adequate supervision. She will be required to provide a copy of this order to all her employers, and file quarterly work reports so her employer can report to the Board if she shows any negative behaviors.

Respondent repeatedly failed to cooperate with the Board's requests and impeded the Division's investigations of the complaints, thus putting public safety at risk. The Board cannot assure the public that the Respondent is competent or safe to practice nursing unless she is regularly monitored and required to participate in a treatment program. Requiring supervision and monitoring will allow Respondent to maintain her license and while she gets the necessary treatment to overcome these personal and professional issues.

Suspending Respondent's license indefinitely also deters other credential holders from engaging in similar conduct. Respondent has disregarded the Board's authority as well as the law in place to protect public health and welfare. Imposing anything less than a suspension would not deter other credential holders from engaging in similar conduct and could imply that such conduct by a licensed nurse is tolerable.

The recommended discipline is consistent with Board precedent. *See In the Matter of Disciplinary Proceedings Against Christine A. Hamilton, R.N.*, Order Number 0006579 (December 12, 2019) (nurse whose drug screen at work tested positive for fentanyl and norfentanyl had license suspended by Board and was allowed to petition for a stay of the suspension after three (3) months upon providing proof to the Board that she was in compliance with conditions and limitations placed on her license);[1] and, *In the Matter of Disciplinary Proceedings Against Jennifer Civitarese, R.N.*, Order Number 0005586 (January 11, 2018) (nurse was impaired and tested positive for alcohol at work, and failed to cooperate with the Division's investigation, had license suspended indefinitely and was allowed to petition for a stay of the suspension after three (3) months upon providing proof to the Board that she was in compliance with conditions and limitations placed on her license).[2]

Based upon the facts of this case and the factors set forth in *Aldrich,* I find that an indefinite suspension of Respondent's license, pursuant to the terms and conditions of the Order below, is reasonable and 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. *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, Boards have 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, funded by other licensees; 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 of these factors to consider, whether other factors should be considered, and how much weight to give any factors considered.

Considering the above factors, it is appropriate for Respondent to pay the full costs of the two investigations and of these proceedings. Respondent defaulted and the factual allegations

[1] This decision is available online at: https://online.drl.wi.gov/decisions/2019/ORDER0006579-00016242.pdf
[2] This decision is available online at: https://online.drl.wi.gov/decisions/2018/ORDER0005586-00014312.pdf

identified in this decision were deemed admitted. Respondent displayed dangerous behavior while practicing nursing that put herself, her patients, and the public at risk. She also failed to cooperate with the Department's investigations after repeated attempts to contact her. Finally, Respondent failed to provide current contact information to the ALJ, failed to appear at the prehearing conference, and failed to file an Answer to the Complaint or otherwise provide any argument regarding the allegations brought against her license to practice nursing.

The Department is a program revenue agency whose operating costs are funded by the revenue received from credential holders. It would be unfair to impose the costs of pursuing discipline in this matter on those licensees who have not engaged in misconduct. Therefore, 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.

ORDER

For the reasons set forth above, IT IS ORDERED that the license of Respondent Amanda R. Nieuwenhuis, R.N., License No. 195769-30, and her privilege to practice in Wisconsin under the Enhanced Nurse Licensure Compact, are suspended and limited as follows:

SUSPENSION

A.1. The license of Respondent, (license number 195769-30), 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 (3) months following the date of the final decision issued in this matter, but may be stayed at any time after three (3) months from the date of the final decision in this matter upon Respondent providing proof, that she has been in compliance with the provisions of Sections C and D of this Order for the most recent three (3) consecutive months. The Board or its designee will determine whether the Respondent's proof is sufficient.

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 shall be automatically 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 Decision and Order and all other subsequent orders.

C.3. Treater should coordinate Respondent's rehabilitation and treatment as required under the terms of this Order, and 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. The Respondent shall authorize and ensure that Treater submits 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 personal use of alcohol.

C.9. Respondent shall abstain from all personal 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 (5) 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 twenty-four (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 (5) hours of notification of a test.

C.14. The Approved Program shall require the testing of specimens at a frequency of not less than forty-nine (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 or care giver 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 (5) 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

Respondent may also submit this information online via DSPS' Monitoring Case Management System, here: https://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 Respondent's 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 (1) 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 (5) 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 Wisconsin 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 this 8th day of December, 2020.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
4822 Madison Yards Way, 5th Floor North
Madison, Wisconsin 53705
Tel. (608) 266-2447
Email: Kristin.Fredrick@wisconsin.gov

By: _____
Kristin P. Fredrick
Administrative Law Judge