

## 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

TIMOTHY J. HARRINGTON, R.N.,  
RESPONDENT.

:  
:  
: FINAL DECISION AND ORDER  
:  
: **ORDER 0007379**

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Division of Legal Services and Compliance Case Nos. 17 NUR 561,  
18 NUR 665, and 19 NUR 111

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

Timothy J. Harrington, R.N.  
Milwaukee, WI 53210

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 this matter agree to the terms and conditions of the attached Stipulation as the final disposition of this matter, 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 Timothy J. Harrington, R.N., (DOB XX-XX-1964) is licensed in the state of Wisconsin as a registered nurse, having license number 107175-30, first issued on July 19, 1991, and current through February 28, 2022. Respondent's most recent address of file with the Department of Safety and Professional Services (Department) is in Milwaukee, Wisconsin.

2. Upon information and belief, Respondent's current address is in West Yarmouth, Massachusetts 02673.

17 NUR 561

3. At all times relevant to this proceeding, Respondent was employed as a case manager at a hospital (Hospital), located in Wausau, Wisconsin.

4. On July 28, 2017, the Hospital opened an investigation into Respondent based on several individuals witnessing Respondent roughly handling Patient A.

5. Witness A stated that Respondent physically pinned Patient A down in order to draw blood. Witness A further stated that Respondent used excessive force with the needle during the draw and threatened Patient A with calling the police, stating that Patient A was responsible for her condition.

6. Witness B stated that Respondent, while performing the blood draw, roughly grabbed the syringe from out of her hand, and stated to Patient A, "You did this to yourself, you need to cooperate."

7. Witness C told Respondent she was uncomfortable drawing blood in the aggressive manner that Respondent was and Respondent stated, "Well if I wasn't here, would you just expect it to get done?" Witness C responded "yes, because that was their job."

#### 18 NUR 665

8. At all times relevant to this proceeding, Respondent was employed as a registered nurse at a medical center (Center), located in Ladysmith, Wisconsin.

9. On September 30, 2018, Respondent provided care to Patient D during the day shift.

10. Patient D's condition declined throughout the day.

11. Respondent failed to document Patient D's decline in the medical record and there was no documentation in the patient's file to show Respondent evaluated the patient.

12. Respondent reported that he notified the Advanced Practice Nurse Prescriber (APNP) throughout his shift regarding Patient D's change in condition.

13. Medical records show that Nurse F assessed Patient D at 4:45 p.m. and notified APNP E of a change in condition. The decision was made to transport Patient D to a higher level of care.

14. According to Nurse G, when she came on for evening shift, the APNP ordered IVs to be prepared for the Patient D's transport to another facility. Nurse G reported that Respondent told her on at least two (2) occasions to not prepare the IVs.

15. On October 3, 2018, Respondent was terminated for delaying treatment and ordering another nurse to delay treatment.

16. That evening, Respondent sent the following email to his employer: "I allowed someone to drowned [sic] in their own Fluids for twelve hours, gasping and struggling to keep their head above water, water we poured in them. No one to turn to. No clinical voice of Reason. Then to be forced into intubation. It should cost me my position. Not because of insubordination, but because I shrank from the from [sic] being a committed advocate fir [sic] those in my care."

#### 19 NUR 111

17. At all times relevant to this matter, Respondent was employed as a registered nurse, through a staffing agency, at a hospital (Hospital) located in Park Falls, Wisconsin.

18. On April 1, 2019, a Barron County Sheriff's Detective (Detective) received a report from a veterinary clinic regarding a female attempting to obtain significant amounts of tramadol. During his initial investigation, the Detective found that Respondent's name was on the utility bill of the female suspects residence. The Detective also discovered that the female suspect went by an alias using Respondent's surname.

19. After his initial investigation, the Detective obtained a search warrant for the female suspect's address.

20. During the execution of the search warrant, officers found several medications that can only be obtained by prescription, including carprofen (nonsteroidal anti-inflammatory drug (NSAID) used by veterinarians), ketorolac tromethamine injection (NSAID), orphenadrine citrate injection (muscle relaxer), lidocaine HCL 1% (anesthetic), tetracaine hydrochloride (anesthetic), and propranolol (beta-blocker). Marijuana paraphernalia was also found, which tested positive for the presence of marijuana.

21. Propranolol was found in a bag containing a barcode. The Hospital confirmed this medication came from their facility based on the barcode and how the facility labels and dates its medications. The Hospital also confirmed that they carry the same brand and dosage of the medication vials found and that those medications are only available to medical professionals.

22. Medical records were requested from the Hospital for the female suspect, to determine if she was prescribed any of these medications. No records could be found under her legal name or alias.

23. A text message on the female suspects phone from "Tim" stated, "I have long since stopped worrying about your tramadol use and have enjoyed it as well so I would have gone along with it." The Department confirmed that the phone number associated with this message matched a phone number associated with Respondent.

24. Paycheck stubs belonging to Respondent were found in the residence.

25. Respondent was immediately fired by the staffing agency.

26. In resolution of this matter, 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 the Findings of Fact, Respondent violated Wis. Admin. Code § N 7.03(4)(d), by engaging in repeated or significant disruptive behavior or interaction with health care personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered.

3. By the conduct described in the Findings of Fact, Respondent violated Wis. Admin. Code § N 7.03(6)(a), by failing to perform nursing with reasonable skill and safety.

4. By the conduct described in the Findings of Fact, Respondent violated Wis. Admin. Code § N 7.03(6)(b), by lacking knowledge, skill, or ability to discharge professional obligations within the scope of nursing practice.

5. By the conduct described in the Findings of Fact, Respondent 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. Actual injury to a patient need not be established.

6. By the conduct described in the Findings of Fact, Respondent violated Wis. Admin. Code § N 7.03(6)(p), by failing to observe the conditions, signs and symptoms of a patient, record them, or report significant changes to the appropriate person.

7. By the conduct described in the Findings of Fact, Respondent violated Wis. Admin. Code § N 7.03(8)(b), dispensing any drug other than in the course of legitimate practice or as otherwise prohibited by law.

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

### ORDER

1. The attached Stipulation is accepted.

2. Respondent Timothy J. Harrington, R.N., is REPRIMANDED.

3. The registered nurse license issued to Respondent, and Respondent's privilege to practice in Wisconsin under another state's license, are LIMITED as follows:

a. Within 90 days of the date of this Order, Respondent shall undergo, at his own expense, a fitness for practice evaluation with a pre-approved

psychiatrist or psychologist (Evaluator) who has not provided treatment to Respondent and is experienced in evaluating whether a health care professional is fit to practice:

- i. Prior to evaluation, Respondent shall provide a copy of this Final Decision and Order to the Evaluator.
- ii. Respondent shall identify and provide the Evaluator with authorizations to communicate with all physicians, mental health professionals, and facilities at which Respondent has been treated or evaluated.
- iii. Within fifteen (15) days of the completion of the evaluation, 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 her ability to practice safely and competently and, if so, shall provide any recommended limitations for safe and competent practice.
- iv. Respondent shall execute necessary documents authorizing the Division to obtain records of the evaluation, and to discuss Respondent and her 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.
- v. Respondent is responsible for ensuring that the results of the evaluation are sent to the Department Monitor at the address in paragraph 7 below.
- vi. If the Evaluator determines that Respondent is not fit to practice or is fit for practice with limitations, the Board or its designee may suspend Respondent's right to renew and/or his license until Respondent provides proof sufficient to convince the Board or its designee 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.
- vii. If the Evaluator determines that Respondent is fit to practice or is fit to practice with limitations, the Board or its designee may limit Respondent's right to renew and/or his license in a manner to address any concerns the Board or its designee has as a result of the conduct set out in the Findings of Fact and to address any

recommendations resulting from the evaluation, including, but not limited to:

- 1) Psychotherapy, at Respondent's expense, by a therapist approved by the Board or its designee, to address specific treatment goals, with quarterly reports to the Board by the therapist.
  - 2) Additional professional education in any identified areas of deficiency.
  - 3) Restrictions on the nature of practice, practice setting, or requirements for supervision of practice by a professional approved by the Board, with periodic reports to the Board by the supervisor.
- b. Within 90 days from the date of this Order, Respondent must undergo, at his own expense, an alcohol and other drug abuse (AODA) assessment with an evaluator pre-approved by the Board or its designee who has experience conducting these assessments.
- i. Prior to the assessment, Respondent shall provide a copy of this Order to the evaluator. Respondent shall provide the Department Monitor with written acknowledgment from the evaluator that a copy of this Order has been received by the evaluator. Such acknowledgment shall be provided to the Department Monitor prior to the assessment.
  - ii. Respondent shall provide and keep on file with the evaluator current releases complying with state and federal laws. The releases shall allow the Board, its designee, and any employee of the Department to obtain a copy of the assessment. Copies of these releases shall immediately be filed with the Department Monitor.
  - iii. Respondent shall identify and provide the evaluator with authorizations to communicate with all physicians, mental health professionals, and facilities at which Respondent has been treated or evaluated.
  - iv. The Board, or its designee, may impose additional limitations upon Respondent's right to renew and/or his license based on the results of the assessment and/or the evaluator's recommendations.
  - v. Respondent shall comply with the evaluator's recommendations.

- vi. Respondent is responsible for ensuring that the results of the evaluation are sent to the Department Monitor at the address in paragraph 7 below.

4. Within 90 days of the date of this Order, Respondent shall at his own expense, successfully complete five (5) hours of education on documentation; three (3) hours of education on the topic of patient abuse, and three (3) hours of education on patient rights offered by a provider pre-approved by the Board's monitoring liaison, including taking and passing any exam offered for the courses.

- a. Respondent shall submit proof of successful completion of the education in the form of verification from the institution providing the education to the Department Monitor at the address stated below. None of the education completed pursuant to this requirement may be used to satisfy any continuing education requirements that have been or may be instituted by the Board or Department, and also may not be used in future attempts to upgrade a credential in Wisconsin.
- b. This limitation shall be removed from Respondent's right to renew and/or his license after satisfying the Board or its designee that Respondent has successfully completed all of the ordered education.
- c. The Board's monitoring liaison may change the number of credit hours and/or education topics in response to a request from Respondent. The monitoring liaison may consider the topic availability and/or hours of education when determining if a change to the ordered education should occur.

5. Pursuant to the Enhanced Nurse Licensure Compact (Compact), Respondent may not practice in a Compact state, other than Wisconsin, while their license is encumbered by any term or restriction of this Order.

6. Within 180 days from the date of this Order, Respondent, shall pay COSTS of this matter in the amount of \$8,613.00.

7. Request for approval of courses, proof of successful course completion, evaluations, assessments, and 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) 266-2112; Fax (608) 266-2264  
[DSPSMonitoring@wisconsin.gov](mailto:DSPSMonitoring@wisconsin.gov)



Respondent may also submit this information online at: <https://dpsmonitoring.wi.gov>

8. In the event Respondent violates any term of this Order, Respondent's license (license no. 107175-30), or Respondent's right to renew his license, may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of the Order. The Board may, in addition and/or in the alternative refer any violation of this Order to the Division of Legal Services and Compliance for further investigation and action.

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

WISCONSIN BOARD OF NURSING

by:   
A Member of the Board

13 May 2021  
Date

STATE OF WISCONSIN  
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY  
PROCEEDINGS AGAINST

TIMOTHY J. HARRINGTON, R.N.,  
RESPONDENT.

STIPULATION

**ORDER 0007379**

Division of Legal Services and Compliance Case Nos. 17 NUR 561,  
18 NUR 665, and 19 NUR 111

Respondent Timothy J. Harrington, 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 a pending investigation by the Division of Legal Services and Compliance. Respondent consents to the resolution of this investigation 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. Respondent is represented by Attorney Basil Loeb.
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.

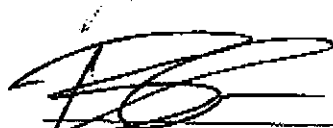
6. The parties to this Stipulation agree that the attorney or other agent for the Division of Legal Services and Compliance and any member of the Board ever assigned as an advisor in this investigation may appear before the Board in open or closed session, without the presence of Respondent, for purposes 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.

  
Timothy J. Harrington, R.N., Respondent  
Milwaukee, WI 53210  
License No. 107175-30

4/19/2021  
Date

  
Basil Loeb, Attorney for Respondent #1037772  
Schmidtkofer, Toth, Loeb & Drosen, L.L.C.  
949 Glen View Avenue  
Wauwatosa, WI 53213

4/19/2021  
Date

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

04/20/2021  
Date