WISCONSIN DEPARTMENT OF
SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
TABITHA D. MAJORS, R.N., RESPONDENT.	:	**ORDER 0007584**

Division of Legal Services and Compliance Case Nos.
19 NUR 142, 20 NUR 393 and 21 NUR 123

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

Tabitha D. Majors, R.N.
Edgerton, WI 53534

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 Tabitha D. Majors, R.N. (Year of Birth 1972), is licensed in the state of Wisconsin as a registered nurse with multistate privileges pursuant to the Enhanced Nurse Licensure Compact (Compact), having license number 224031-30, first issued on July 2, 2015, and current through February 28, 2022.

2. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is in Edgerton, Wisconsin 53534.

19 NUR 142

3. At all times relevant to this matter, Respondent was employed as a registered nurse at a nursing home located in Evansville, Wisconsin (Facility).

4. On April 3, 2019, Facility staff reported that Respondent appeared sleepy and was nodding off while charting during the night shift.

5. On the following day shift, a nurse reported that two Facility residents, Residents A and B, requested as needed (PRN) oxycodone and hydrocodone, respectively, during the morning pass but were denied because Respondent had documented administering those medications to them during the previous night shift. Residents A and B denied requesting or receiving any PRN medications during the night.

6. The Facility Director of Nursing (DON) reviewed Resident A and B's narcotic logs. Respondent documented administering oxycodone 10mg to Resident A at 2:00 a.m. and 6 a.m. on April 3, 2019. Respondent documented administering hydrocodone to Resident B at 4:30 a.m. on April 3, 2019.

7. Facility Resident C was a hospice patient with orders to receive morphine 15mg extended release in the morning and at bedtime, and morphine 15mg immediate release every two hours as needed at night. According to Resident C's narcotic log, Respondent documented giving Resident C thirty-three doses of PRN morphine between March 18 and April 2, 2019. Only five doses of PRN morphine were administered by other nurses to Resident C during that same period.

8. On April 3, 2019, Respondent was asked to take an on-site drug test and she stated it would be positive because she had ingested prescription medication. The DON and the charge nurse examined Respondent's test results, which were positive for oxycodone and morphine (opioid).

9. Respondent subsequently produced a prescription bottle in her name, dated July 26, 2018, for hydrocodone-acetaminophen 5-325mg tablets. Respondent failed to produce a prescription for morphine.

10. The Facility investigation also discovered that on three different residents' narcotic logs, Respondent filled in the date but failed to provide her signature on April 3, 2019.

11. Respondent's employment was terminated by the Facility.

20 NUR 393

12. At all times relevant to this matter, Respondent was employed as a registered nurse at a nursing home located in Edgerton, Wisconsin (Facility).

13. On September 17, 2019, after Facility staff reported concerns about Respondent's narcotic administration and documentation, Respondent was instructed to sign out narcotics in the

electronic medication administration record (EMAR) and on the narcotic sheet, complete a pain level assessment, and make a progress note supporting administration for every PRN narcotic.

14. In April 2020, Respondent was placed on a performance improvement plan by the Facility for inaccurate documentation. The following medication documentation errors were discovered regarding Facility Resident D:

a) On April 24, 2020, Respondent documented administration of Norco at 2:10 a.m. in the EMAR but did not document it in the progress notes.

b) On April 29, 2020, Respondent documented administration of Norco at 10:40 p.m. in the progress notes but did not document it in the EMAR.

c) On April 30, 2020, Respondent documented administration of Norco at 3:00 a.m. and 8:30 p.m. in the EMAR but did not document either in the progress notes.

15. On April 27, 2020, Respondent submitted to a six-panel drug screen at the Facility's request, the results of which were negative.

16. On June 24, 2020, Respondent was placed on another performance improvement plan by the Facility for failing to sign out narcotics in the EMAR and documenting administration in the progress notes. Respondent was suspended for two days and issued a warning for poor work quality.

17. On July 11, 2020, the Facility removed Respondent from the schedule after the DON was notified that she was behaving "unsafe" and "scattered." Respondent said she had been awake for more than 36 hours after leaving her husband. After her shift, Respondent left the Facility without completing any pain assessments.

18. On July 14, 2020, the DON took away Respondent's access to the narcotic box and told her she could no longer pass narcotic medications.

19. On July 24, 2020, Respondent informed the DON that it would be her last day.

<u>21 NUR 123</u>

20. At all times relevant to this matter, Respondent was employed as a registered nurse at a nursing home located in Fort Atkinson, Wisconsin (Facility).

21. On February 15, 2021, the Facility administrator was notified by a staff member that a pain pill was missing during transition of care from Respondent to the staff member.

22. The Facility requested an automated dispensing unit report for the period January 1 through February 15, 2021, and noted the following discrepancies:

a) Resident E had an order for hydrocodone-acetaminophen, every eight hours PRN. Respondent documented its administration to Resident E eighteen times in January, while other staff only documented administration four times.

b) Resident F had an order for hydrocodone-acetaminophen, every four hours PRN. Respondent documented its administration to Resident F eleven times in January, while other staff only documented administration five times. Respondent administered this medication to Resident F once in February but did not sign out the dose in the narcotic logbook.

c) Resident G had an order for hydrocodone-acetaminophen, every six hours PRN. Respondent documented its administration to Resident G nine times between February 1 through 13, 2021, while no other staff documented administration of this medication to Resident G during this period.

23. The Facility's investigation discovered fifty-nine hydrocodone APAPs, seven tramadol, and three Ritalin pills were missing and attributed to Respondent over a period of 45 days. Respondent said it was possible she forgot to sign out medications before the end of her shifts.

24. On February 16, 2021, Respondent submitted to a ten-panel drug screen at the Facility's request, the results of which were negative.

25. On March 8, 2021, the Facility terminated Respondent's employment for failure to adhere to its narcotics management and administration policies.

26. 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 these matters 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 departed from or failed to conform to the minimal standard of acceptable nursing practice that may have created unnecessary risk or danger to a patient's life, health, or safety, within the meaning of Wis. Admin. Code § N 7.03(6)(c).

3. By the conduct described in the Findings of Fact, Respondent committed errors in prescribing, dispensing, or administering medication, within the meaning of Wis. Admin. Code § N 7.03(8)(d).

4. 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 is REPRIMANDED.

3. Respondent's registered nurse license (license number 224031-30) is LIMITED as follows:

   a. Within ninety (90) days of the date of this Order, Respondent shall, at her own expense, successfully complete four (4) hours of education on proper medication administration, including taking and passing any exam offered for the course(s):

      i. Respondent shall be responsible for obtaining the course(s) required under this Order, for providing adequate course descriptions to the Department Monitor, and for obtaining pre-approval of the course(s) from the Board's monitoring liaison prior to commencement of the course(s).

      ii. 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.

      iii. 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.

      iv. 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.

      v. This limitation shall be removed from Respondent's license after satisfying the Board or its designee that Respondent has successfully completed all of the ordered education.

   b. Within ninety (90) days of the date of this Order, Respondent shall, at her own expense, undergo and complete an Alcohol and Other Drug Abuse (AODA) assessment with a certified substance abuse counselor (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 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 below.

4. Pursuant to the Enhanced Nurse Licensure Compact, Respondent may not practice in a Compact state, other than Wisconsin, during the pendency of these limitations.

5. Request for approval of courses and/or Evaluators, submission of any documents required by this Order, 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

Respondent may also submit this information online at: www.dspsmonitoring.wi.gov.

6. Within 120 days from the date of this Order, Respondent shall pay COSTS of these matters in the amount of $1,756.00.

7. In the event Respondent violates any term of this Order, Respondent's license (No. 224031-30), or Respondent's right to renew her 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.

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

WISCONSIN BOARD OF NURSING

By: ______________________________ 9/9/2021
A Member of the Board Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
TABITHA D. MAJORS, R.N., RESPONDENT.	:	STIPULATION **ORDER 0007584**

Division of Legal Services and Compliance Case Nos.
19 NUR 142, 20 NUR 393 and 21 NUR 123

Respondent Tabitha D. Majors, 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 three 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. Respondent is represented by Attorney Mario D. Mendoza.

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 or Respondent's attorney, 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.

08/11/2021

Tabitha D. Majors, R.N., Respondent
Edgerton, WI 53534
License No. 224031-30

Date

08/13/2021

Mario D. Mendoza, Attorney for Respondent
Murphy Desmond, S.C.
33 East Main St., Suite 500
Madison, WI 53703-3095

Date

8/13/2021

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

Date