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Before the
State Of Wisconsin
Board of Nursing

In the Matter of the Disciplinary Proceedings Against Latasha D. Brown, L.P.N., Respondent.	FINAL DECISION AND ORDER ORDER0007592 Order No. ______

Division of Legal Services and Compliance Case No. 19 NUR 555

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 9th day of September, 2021.

Member
Board of Nursing

Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against Latasha D. Brown, L.P.N., Respondent	DHA Case No. SPS-21-0038 DLSC Case No. 19 NUR 555

PROPOSED DECISION AND ORDER

The parties to this proceeding for purposes of sections 227.47(1) and 227.53 of the Wisconsin Statutes are:

Latasha D. Brown, L.P.N.
1500 Washington Ave., Apt. 1
Racine, WI 53403

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

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 Notice of Hearing and the Complaint in this matter were served on Latasha D. Brown, L.P.N., (Respondent), by the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), on May 5, 2021, by both certified and regular mail to the address that the Respondent has on file with the Department, pursuant to Wis. Admin. Code § SPS 2.08. A copy was also emailed to the email address that the Respondent has on file with the Department. An answer to a complaint must be filed within 20 days from the date of service of the complaint. Wis. Admin. Code § SPS 2.09(4). No answer was filed.

After the expiration of the 20-day period to file an answer, Administrative Law Judge Angela Chaput Foy (ALJ) scheduled a telephone prehearing conference for June 17, 2021.

Notice of this prehearing conference was sent to both parties. Attorney Julie Zimmer appeared on behalf of the Division. The Respondent did not appear.

Based on the Respondent's failure to file an answer to the Complaint and failure to appear at the prehearing telephone conference, the Division moved for a finding that the Respondent was in default pursuant to Wis. Admin. Code §§ SPS 2.14 and HA 1.07(3)(c).

On June 18, 2021, the ALJ issued a Notice of Default against the Respondent and ordered the Division to file a recommended proposed decision and order by July 19, 2021. The Division timely filed its recommended Proposed Decision and Order.

FINDINGS OF FACT

Facts Related to the Alleged Violations

Findings of Fact 1-13 are taken from the Division's Complaint filed against the Respondent in this matter.

1. The Respondent Latasha D. Brown, L.P.N., is licensed in the state of Wisconsin as a licensed practical nurse with multistate privileges pursuant to the Enhanced Nurse Licensure Compact (Compact), having license number 312082-31, first issued on November 18, 2009, and current through April 30, 2023.

2. The Respondent's most recent address on file with the Department is 1500 Washington Ave., Apt. 1, Racine, Wisconsin 53403.

3. At all times relevant to this proceeding, the Respondent was employed as a licensed practical nurse at a nursing home in Racine, Wisconsin (Facility).

4. On September 9, 2019, the Respondent was scheduled to work at the Facility from 7:00 a.m. to 3:30 p.m.

5. That morning at 8:35 a.m., the Respondent was observed sleeping in the Facility's breakroom. The Facility's Director of Nursing (DON) and office manager had to call the Respondent's name several times and shake her shoulder to wake her up.

6. The DON escorted the Respondent to her office. On the way, the Respondent's gait was staggered, and she mumbled her speech. The Respondent said she was just tired.

7. The Respondent agreed to take a reasonable suspicion drug and alcohol test but left the Facility before a test could be performed.

8. On September 9, 2019, the Facility terminated the Respondent's employment for refusing to cooperate in a company investigation by leaving the Facility.

9. On September 10, 2019, the Facility filed a complaint with the Division.

10. On November 7, 2019, the Division emailed the Respondent at her email address on file with the Department to request her response to the complaint. The Respondent did not respond.

11. On November 21, 2019, the Division sent a letter to the Respondent at her mailing address on file with the Department requesting her response to the complaint. The Respondent did not respond.

12. On March 8, 2021, the Division emailed the Respondent again at her email address on file with the Department and sent another letter to her at her mailing address on file with the Department to request her response to the complaint. The Respondent did not respond.

13. On March 22, 2021, a Division investigator called the Respondent at her telephone number on file with the Department. A message indicated that the number was temporarily not in use.

Facts Related to Default

14. On May 5, 2021, the Division served the Notice of Hearing and the Complaint on the Respondent at her address on file with the Department by both certified and regular first-class mail. The Division also emailed a copy to the Respondent at her email address on file with the Department.

15. On May 28, 2021, the U.S. Postal Service returned the Notice of Hearing and the Complaint sent to the Respondent via certified mail to the Division marked "Return to Sender" and "Unclaimed." The Notice of Hearing and the Complaint sent to the Respondent via regular, first-class mail and email were not returned to the Division.

16. The Respondent failed to file an answer to the Complaint.

17. After the expiration of the 20-day period to file an answer, the ALJ scheduled a telephone prehearing conference for June 17, 2021. The ALJ sent notice of the conference by U.S. mail to the Respondent. The notice ordered the Respondent to contact the ALJ no later than June 16, 2021, to provide her current telephone number. The notice also stated that if the Respondent failed to appear at the scheduled conference, default judgment may be entered against her.

18. The Respondent failed to contact the ALJ by June 16, 2021, with her current telephone number.

19. The Respondent failed to appear at the prehearing conference on June 17, 2021. The ALJ attempted to reach the Respondent at the telephone number that the Department had on file for her. The ALJ called the Respondent at that number three times, at 11:03 am, 11:15 am, and 11:20 am, but each time the line was busy and there was no ability to leave a voicemail message. The ALJ also emailed the Respondent at her email address on file with the Department and asked

her to respond or the ALJ would entertain the Department's motion for default. The Respondent failed to respond.

20. On June 17, 2021, the Division moved for a finding that the Respondent was in default based on the Respondent's failure to file an answer to the Complaint and failure to appear at the prehearing telephone conference, pursuant to Wis. Admin. Code §§ SPS 2.14 and HA 1.07(3)(c).

21. On June 18, 2021, the ALJ issued a Notice of Default against the Respondent and ordered the Division to file a recommended proposed decision and order by July 19, 2021.

22. The Division timely filed its recommended Proposed Decision and Order.

DISCUSSION

Jurisdictional Authority

The Wisconsin Board of Nursing (Board) has the authority to impose discipline against the Respondent. Wis. Stat. §§ 441.07(1c) and (1g). The undersigned ALJ has authority to preside over this disciplinary proceeding in accordance with Wis. Stat. § 227.46(1). Wis. Admin. Code § SPS 2.10(2).

Default

The Division properly served the Notice of Hearing and the Complaint on the Respondent by mailing a copy to her address on file with the Department. Service by mail is complete upon mailing. Wis. Admin. Code § SPS 2.08(1).

An answer to a complaint shall be filed within 20 days from the date of service of the complaint. Wis. Admin. Code § 2.09(4). 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." Wis. Admin. Code § SPS 2.14.

For a telephone prehearing, the administrative law judge may find a failure to appear grounds for default if any of the following conditions exist for more than ten minutes after the scheduled time for prehearing conference: (1) the failure to provide a telephone number to the ALJ after it had been requested; (2) the failure to answer the telephone; (3) the failure to free the line for the proceeding; and (4) the failure to be ready to proceed with the prehearing conference as scheduled. Wis. Admin. Code § HA 1.07(3)(c).

Here, the Respondent failed to file an answer to the Complaint, failed to appear at the prehearing telephone conference on June 17, 2021, failed to provide a telephone number to the ALJ after it had been requested, failed to answer the telephone when the ALJ called, and failed

to be ready to proceed with the prehearing conference as scheduled. Therefore, the Respondent is in default, and findings may be made, and an order may be entered, based on the Complaint.

Violations

Following an investigation, if the Board determines that a nurse has committed one or more violations of the Wisconsin Statutes or administrative rules adopted by the Board, or if the Board finds that a nurse has committed misconduct or unprofessional conduct, it may "revoke, limit, suspend or deny a renewal of a license" of that registered nurse. Wis. Stat. §§ 441.07(1g)(b) and (d).

Wisconsin Administrative Code § N 7.03 sets out the grounds for taking disciplinary action against a nurse. The grounds include:

> (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:
>
> > (d) Failing to report to or leaving a nursing assignment without properly notifying appropriate supervisory personnel and ensuring the safety and welfare of the patient or client.
> >
> > . . .
> >
> > (h) Unable to practice safely by reason of physical illness or impairment.

The Respondent engaged in conduct qualifying as grounds for taking disciplinary action on her license by failing to cooperate in a timely manner with the Board's investigation of a complaint filed against her. *See* Wis. Admin. Code § N 7.03(1)(c). On November 7, 2019, the Division emailed the Respondent at her email address on file with the Department to request her response to the complaint filed against her by her former employer. She did not respond. On November 21, 2019, the Division sent a letter to the Respondent at her mailing address on file with the Department requesting her response to the complaint. She did not respond. On March 8, 2021, the Division emailed the Respondent again and sent another letter to her to request her response to the complaint. She did not respond. On March 22, 2021, a Division investigator called the Respondent at her telephone number on file with the Department. A message indicated that the number was temporarily not in use.

The Respondent engaged in conduct qualifying as grounds for taking disciplinary action on her license by leaving a nursing assignment without properly notifying appropriate

supervisory personnel and ensuring the safety and welfare of the patient or client, and being unable to practice safely by reason of physical illness or impairment, respectively. Wis. Admin. Code § N 7.03(6)(d) and (6)(h). On September 9, 2019, the Respondent was scheduled to work from 7:00 a.m. to 3:30 p.m. That morning at 8:35 a.m., the Respondent was observed sleeping in the breakroom. Staff had to call the Respondent's name several times and shake her shoulder to wake her up. As she was being escorted to the Director of Nursing's office, her gait was staggered and she mumbled her speech. She said she was just tired. The Respondent agreed to take a reasonable suspicion drug and alcohol test but left her nursing assignment before a test could be performed. The Respondent was terminated from her employment for refusing to cooperate in a company investigation by leaving.

By engaging in conduct qualifying as grounds for taking disciplinary action on her license, along with her failure to make any argument to the contrary, the Respondent is subject to discipline. Wis. Stat. §§ 441.07(1g)(b) and (d), and Wis. Admin. Code § N 7.03.

Discipline

The Division recommends that the Respondent be reprimanded and her license to practice limited until she completes an alcohol and other drug use (AODA) assessment within 90 days, pursuant to the terms and conditions of the Order below. In addition, the Division recommends that the Board should be authorized to impose any additional limitations upon the Respondent's license.

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).

Based on the purposes of discipline articulated in *Aldrich* and prior Board orders, I adopt the Division's proposal that the Respondent be reprimanded and that her license to practice be limited pursuant to the terms and conditions of the Order. Regarding the Board's authority to impose future limitations on the Respondent's license, the case law is clear that discipline must be responsive to the licensee's specific misconduct and warranted under the facts of the case. I therefore recommend that the order specify that the Board is authorized to limit Respondent's license only to the extent that the limitations are consistent with the purposes articulated in *Aldrich*. Any such limitation must be tailored to specifically address Respondent's violations – failing to cooperate with the Board's investigation, leaving a nursing assignment without properly notifying appropriate supervisory personnel and ensuring the safety and welfare of the patient or client, and being unable to practice safely by reason of physical illness or impairment.

The recommended discipline is consistent with the purposes articulated in *Aldrich*. The uncontroverted allegations in the complaint of sleeping on the job, showing signs of impairment, failing to submit to a drug and alcohol test, and leaving a nursing assignment without notifying her supervisor or ensuring the safety and welfare of her patients are serious ones. By failing to cooperate with the Board's investigation of those allegations, the Respondent impeded and delayed that investigation, thus putting public safety at risk.

The recommended discipline protects the public. "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). Reprimanding the Respondent will remind her of her duty to abide by the Board's rules of professional conduct, to timely respond to Board inquiries, and indicate to the Respondent that her actions have serious consequences for her licensure. The limitation placed on the Respondent's license of requiring completion of an AODA assessment within 90 days and giving the Board the ability to further limit her license based on the results, or suspend her license if she fails to comply, further protects the public by ensuring that if the Respondent has drug and alcohol issues, they are appropriately addressed by the Board.

The recommended discipline also deters other credential holders from engaging in similar conduct. The Respondent has not acted in the best interest of her patients and disregarded the Board's authority as well as the law in place to protect public health and welfare. Imposing anything less than a reprimand and an AODA requirement may not deter other credential holders from engaging in similar conduct and could imply that such conduct by a licensee is tolerable.

The recommended discipline is consistent with Board precedent. *See In the Matter of Disciplinary Proceedings Against Jaclyn M. Hebein, L.P.N.*, Order Number 0007377 (May 13, 2021) (nurse was reprimanded and her license limited until she completed an AODA assessment within 90 days for failing to conform to the minimal standard of acceptable nursing practice, failing to notify the Board of an OWI, and failing to cooperate with the Board's investigation);[1] *see also In the Matter of Disciplinary Proceedings Against Chad T. Lanoway, R.N.*, Order Number 0006227 (June 13, 2019) (nurse was reprimanded with the Board accepting the AODA assessment already completed as satisfying a requirement the Board would have ordered for submitting false information in the course of an investigation).[2]

Based upon the facts of this case and the factors set forth in *Aldrich*, issuing a reprimand to the Respondent, plus limiting her license to require completion of an AODA assessment, 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 the 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

[1] This decision is available online at: https://online.drl.wi.gov/decisions/2021/ORDER0007377-00017733.pdf
[2] This decision is available online at: https://online.drl.wi.gov/decisions/2019/ORDER0006227-00015565.pdf

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 the Respondent to pay the full costs of the investigation and prosecution of these proceedings. The Respondent defaulted and the factual allegations identified in the Complaint were deemed admitted. The Respondent failed to cooperate with the Board's investigation after repeated attempts to contact her. Finally, the 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 as a licensed practical nurse in Wisconsin.

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 the 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 Respondent Latasha D. Brown, L.P.N. (license number 312082-31), is REPRIMANDED.

IT IS FURTHER ORDERED that the Respondent's license to practice as a licensed practical nurse in the state of Wisconsin (license number 312082-31), and her privilege to practice in Wisconsin pursuant to the Compact, are LIMITED as follows:

a. Within 90 days the Respondent shall, at her own expense, undergo and complete 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 (AODA Evaluator). Requests for pre-approval may be submitted to the Department Monitor at the address below.

    i. Prior to the assessment, the Respondent shall provide a copy of this Order to the AODA Evaluator. The Respondent shall provide the Department Monitor with written acknowledgment from the AODA Evaluator that a copy of this Order has been received by the AODA Evaluator. Such acknowledgment shall be provided to the Department Monitor prior to the assessment.

    ii. The Respondent shall provide and keep on file with the AODA 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. The Respondent shall identify and provide the AODA Evaluator with authorizations to communicate with all physicians, mental health professionals, and facilities at which the Respondent has been treated or evaluated.

iv. The Board, or its designee, may impose additional limitations and/or restrictions upon the Respondent's license based on the results of the assessment and/or the AODA Evaluator's recommendations.

v. The Respondent shall comply with the AODA Evaluator's recommendations.

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

b. The Respondent shall report to the Board any change in employment status, residence, address, or telephone number within 10 days of the date of the change. This report shall not be considered formal change of address notification pursuant to Wis. Stat. § 440.11.

IT IS FURTHER ORDERED that in addition to any other action authorized by this Order or the law, the Board, in its discretion, may impose additional limitations or pursue separate disciplinary action for violation of any term of this Order. Any such limitation must serve the following purposes: promoting Respondent's rehabilitation, protecting the public from other instances of misconduct, and/or deterring other credential holders from engaging in similar conduct.

IT IS FURTHER ORDERED that the Respondent may not practice in any Compact state, other than Wisconsin, while the Respondent's license is encumbered by any term(s) or this Order.

IT IS FURTHER ORDERED that the 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 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

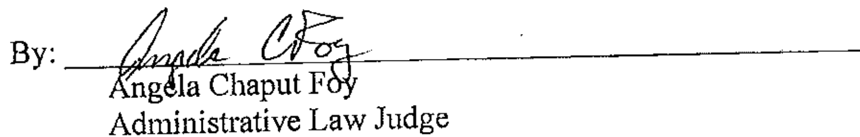
The Respondent may also submit this information online at: https://dspsmonitoring.wi.gov.

IT IS FURTHER ORDERED that in the event the Respondent violates any term of this Order, the Respondent's license (No. 312082-31), or the right to renew her license, may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until the 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.

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 July 26, 2021

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
4822 Madison Yards Way, 5th Floor North
Madison, Wisconsin 53705
Tel. (608) 266-7709
Email: Angela.ChaputFoy@wisconsin.gov

By: 
Angela Chaput Foy
Administrative Law Judge