STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	: :	
	:	FINAL DECISION AND ORDER
DELORES M. MOYER, R.N., RESPONDENT.	: :	LS# 0811101 NUR

Division of Enforcement Case Nos. 04 NUR 122, 06 NUR 215, 06 NUR 350, 06 NUR 417, 06 NUR 478, 07 NUR 026 and 08 NUR 401

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

Delores M. Moyer, R.N.
5001 Prairie Rose Court
Middleton, WI 53562

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Board of Nursing
Department of Regulation & Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

A disciplinary proceeding was commenced in this matter by the filing of a Notice of Hearing and Complaint with the Board of Nursing on November 10, 2008. Prior to the hearing on the Complaint, the parties in this matter agreed to the terms and conditions of the attached Stipulation as the final disposition of this matter, subject to the approval of the 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

1. Delores M. Moyer, R.N., (DOB 08/29/1946) is duly licensed as a registered nurse in the state of Wisconsin (license # 30-48003). This license was first granted on December 27, 1967.

2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 5001 Prairie Rose Court, Middleton, Wisconsin, 53562.

3. At all relevant times, Respondent was part-owner of a limited liability company that operated several community based residential facilities ("CBRFs") licensed by the Wisconsin Department of Health Services ("DHS") and located throughout Wisconsin ("Harbor House"). Harbor House was responsible for ensuring that the facilities and their operation complied with all laws governing CBRFs. Wis. Admin. Code § DHS 83.14(2).

4. DHS conducted inspections of the various Harbor House facilities between 2004 and 2006. Harbor House was issued several Statements of Deficiency, which alleged various violations of regulations relating to CBRF operations, including but not limited to the following:

(a) During an inspection of Harbor House I in De Forest, Wisconsin, ending on March 22, 2004, DHS alleged:

1. Harbor House failed to ensure that residents were free from physical restraints, in violation of Wis. Admin. Code § HFS 83.21(4)(n)4. DHS alleged that one resident used a Geri chair and lap tray, and one used a wheelchair belt, without physician orders.
2. Harbor House failed to ensure that the facility provided prompt and adequate treatment to a resident with Insulin Dependent Diabetes Mellitus, in violation of Wis. Admin. Code § HFS 83.21(4)(p). DHS alleged that the facility did not react in a timely manner when the resident had a low blood sugar, was unresponsive and failed to alert the resident's physician when his blood glucose readings were 38 and 48.
3. Respondent failed to ensure that the administration of insulin was properly delegated, in violation of Wis. Admin. Code § HFS 83.33(3)(e)2.b. DHS alleged that Respondent did not provide adequate delegation and supervision for three staff members that administered injections.
4. Harbor House failed to ensure that residents' individualized service plans reflected each of the resident's individual needs and services, in violation of Wis. Admin. Code § HFS 83.32(2)(a). DHS alleged

that ISPs did not reflect current orders for restraints and insulin regimes.

(b) During an inspection of Harbor House CBRF in Wausau, Wisconsin, ending on April 4, 2006, DHS alleged:

1. Harbor House failed to eliminate the existence or continuation of conditions creating a substantial risk to the health, safety or welfare of residents, in violation of Wis. Admin. Code §§ HFS 83.11(3)(h), failed to ensure that the facility prevented instances of resident to resident abuse, in violation of Wis. Admin. Code § HFS 83.21(4)(m), failed to ensure that the facility prevented harmful behavior patterns, in violation of Wis. Admin. Code § HFS 83.33(2)(a), failed to ensure that residents' individualized service plans addressed harmful behavior, in violation of Wis. Admin. Code § 83.32(2)(d) and 83.32(2)(a)5, failed to provide adequate supervision and to prevent resident to resident abuse in violation of Wis. Admin. Code § HFS 83.33(2)(a), and failed to ensure that the CBRF monitored the health of residents and made arrangements for needed health services, in violation of Wis. Admin. Code § HFS 83.33(2)(g)3. DHS alleged that between December 29, 2005 and March 18, 2006, there were noted 52 documented incidents of sexually inappropriate behavior or attempted sexual assault of female residents by a male resident. Medication adjustments were made and an alarm was placed on the male resident's door, but these interventions were insufficient to stop the behavior and no other interventions were implemented. In another example, a resident regularly washed his face in and drank from the toilet bowl. In another example, a resident with a history of suicide attempts attempted to cut his wrist with a piece of glass.

(c) During an inspection of Harbor House Merrill I in Merrill, Wisconsin, ending on June 23, 2006, DHS alleged:

1. Harbor House failed to ensure that individualized service plans were complete with current information about the residents' conditions, care needs and approaches and strategies to help the resident remain safe, well and independent, in violation of Wis. Admin. Code § HFS 83.32(2)(a). DHS alleged that the ISPs failed to address special diets, fall risks, current medical needs, and psychiatric needs.
2. Harbor House did not obtain required background checks in a timely manner, in violation of Wis. Admin. Code § HFS 50.065(2)(b)

(d) During an inspection of Harbor House II in De Pere, Wisconsin, ending on September 11, 2006, DHS alleged:

1. Respondent failed to comply with a DHFS order for staff training, in violation of Wis. Admin. Code § HFS 83.11(3)(a).
2. Harbor House failed to ensure that at least one qualified staff member was present in the facility, in violation of Wis. Admin. Code §HFS 83.15(1)(c)1. DHS alleged that a staff member was identified by DHFS in a previous survey as not qualified to work alone in the facility because she/he had not completed medication training. The staff member continued to work alone after that survey despite not receiving the required training.
3. Harbor House failed to ensure that all treatment records were kept confidential, in violation of Wis. Admin. Code § HFS 83.21(4)(i)1. DHS alleged that discharged resident records containing confidential medical information were placed in an unlocked activity room, accessible to the general public and residents.
4. Harbor House did not ensure that residents were free from physical and mental neglect, in violation of Wis. Admin. Code §HFS 83.21(4)(m). DHS alleged that a resident with a history of depression refused to eat or accept personal cares. The facility did not intervene until the resident's medical condition was compromised and she was hospitalized. During the time of the resident's refusal to eat and accept cares, the facility also neglected the resident's personal hygiene and the uncleanly condition of the resident's room was deemed a threat to the resident's health and safety.
5. Harbor House failed to ensure that the facility provided services at a level and frequency needed by the residents, in violation of Wis. Admin. Code § HFS 83.33(4). DHS alleged that a falls assessment and personal plan were not implemented for three residents.
6. Harbor House failed to ensure that rooms were clean and well-ventilated, in violation of Wis. Admin. Code § HFS 83.41(9).

(e) During an inspection of Harbor House III in De Pere, Wisconsin, ending on September 11, 2006, DHS alleged:

1. Harbor House failed to comply with DHS orders resulting from previous surveys, including orders to pay an imposed forfeiture, provide staff training and consultation, and maintain documentation of the training and consultation, in violation of Wis. Admin. Code § HFS 83.11(3)(a).
2. Harbor House failed to ensure that facility staff followed infection control standards, in violation of Wis. Admin. Code § HFS 83.13(5)(a).

3. Harbor House failed to ensure that the facility reviewed elements of care, treatment and service for a resident who fell and required therapy, in violation of Wis. Admin. Code § HFS 83.32(2)(d).

(f) During an inspection of Harbor House CBRF in Wausau, Wisconsin, ending on September 29, 2006, DHS alleged:

1. Harbor House failed to eliminate the existence and continuation of conditions of risk to the health, safety and welfare of other residents, in violation of Wis. Admin. Code §§ HFS 83.11(3)(h) and HFS 83.32(2)(a)5. DHS alleged the facility was unable to take aggressive enough measures to control a combative, antagonistic and disruptive resident who physically attacked other residents and staff on several occasions.
2. Harbor House failed to provide proof of care staff training on recognizing and responding to challenging behaviors within six months of initial employment, in violation of Wis. Admin. Code § HFS 83.14(1)(a).
3. Harbor House failed to provide training on determining dietary needs, menu planning, food preparation and sanitation within six months of initial employment, in violation of Wis. Admin. Code § HFS 83.14(2).
4. Harbor House failed to ensure that the facility delivered mail promptly to residents and their representatives, in violation of Wis. Admin. Code § HFS 83.21(4)(b).
5. Harbor House failed to ensure that residents who were incontinent were kept clean and dry, in violation of Wis. Admin. Code §§ HFS 83.21(4)(g) and HFS 83.33(2)(a). DHS alleged that several residents were observed in urine-soaked and soiled clothing. Harbor House failed to ensure that contaminated laundry was washed separately from resident clothing and face cloths, washer temperatures were not high enough to decontaminate, and staff was not permitted to use bleach on contaminated laundry, in violation of Wis. Admin. Code § HFS 83.21(4)(w).

(g) During an inspection of Harbor House, in Cottage Grove, Wisconsin, ending on October 4, 2006, DHS alleged:

1. Harbor House failed to ensure that the facility and its operation comply with all laws, in violation of Wis. Admin. Code § HFS 83.11(3)(a). DHS alleged that three of the citations received by Harbor House during this survey were repeat citations about which Respondent was previously warned: (1) failure to give prompt and adequate treatment; (2) failure to provide adequate staffing; and (3) failure to provide appropriate supervision and monitoring.

2. Harbor House failed to ensure that facility administrative staff supervised and monitored resident care and services, in violation of Wis. Admin. Code § HFS 83.12(5)(a). DHS alleged that staff did not call emergency medical services for a dying resident, although he did not have a Do-Not-Resuscitate directive in his file.
3. Harbor House failed to ensure that personnel records were available for review by DHFS, in violation of Wis. Admin. Code § HFS 83.13(7)(b). This was the facility's second citation of non-compliance.
4. Harbor House failed to ensure that at least one qualified staff person was on duty for fourteen shifts in the previous six weeks, in violation of Wis. Admin. Code § HFS 83.15(1)(c)1. Caregivers on duty during the survey were insufficiently trained.
5. Harbor House failed to ensure that the facility reported incidents involving two resident falls at the facility, in violation of Wis. Admin. Code § 83.19(3)(f). Both residents broke their hips.
6. Harbor House failed to ensure that the facility provided prompt and adequate treatment to a resident who fell and sustained a hip fracture, in violation of Wis. Admin. Code § HFS 83.21(4)(p). DHS alleges that the resident did not see a physician until five days after she fell.
7. Harbor House failed to ensure that a facility did not treat a resident as mentally incompetent without a court determination under Wis. Stat. Ch. 880, in violation of Wis. Admin. Code § HFS 83.21(4)(t).
8. Harbor House did not ensure that the facility reviewed the progress of each resident on their Individualized Service Plans every six months, in violation of Wis. Admin. Code § HFS 83.32(2)(d).

(h) During an inspection of Harbor House II, in De Pere, Wisconsin, ending on January 2, 2007, DHS alleged:

1. Harbor House failed to ensure that the facility complied with previous DHS orders, in violation of Wis. Admin. Code § HFS 83.11(3)(a). DHS alleges that the facility did not fully comply with orders to obtain professional consultations for its food service system and in pain assessment and management. It did not fully comply with orders to train employees.
2. Harbor House failed to supervise and monitor resident care and services in violation of Wis. Admin. Code § HFS 83.12(5)(a), failed to ensure that at least one qualified resident care staff member was present in the facility when residents were present, in violation of Wis. Admin. Code § HFA 83.15(1)(c)1, and failed to ensure that a resident received all prescribed medications in the dosage and intervals prescribed, in violation of Wis. Admin. Code § HFS 83.21(4)(o). DHS alleged that a certified nursing assistant (CNA) who had been employed by Harbor House II for two

months was given the duty to pass medications to residents. She had not administered medications in approximately three years and had not had a refresher course or competency testing in medication administration. The CNA committed a medication error.

3. Harbor House failed to ensure that the facility provided required annual pharmacy or physician on-site medication reviews, in violation of Wis. Admin. Code § HFA 83.33(3)(a)2.
4. Harbor House failed to ensure that medications were not administered without a written practitioner's order, in violation of Wis. Admin. Code § HFS 83.33(3)(e)2.a.
5. Harbor House failed to ensure that injections were administered under the supervision of a registered nurse, in violation of Wis. Admin. Code § HFS 833.33(3)(e)2.b.
6. Harbor House failed to ensure that services were provided at a level and frequency needed by residents to prevent falls and decrease potential for injury, in violation of Wis. Admin. Code § HFS 83.33(4).

CONCLUSIONS OF LAW

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

2. The conduct described above constitutes a violation of Wis. Admin. Code § N 7.04(1) and Wis. Stat. § 441.07(1)(d).

3. The conduct described above constitutes a violation of Wis. Admin. Code §§ N 6.03(3), N. 7.03(1)(a), and Wis. Stat. § 441.07(1)(c).

ORDER

IT IS ORDERED:

1. The license of Delores M. Moyer, R.N. to practice nursing in the State of Wisconsin, and her privilege to practice nursing in Wisconsin pursuant to the Nurse Licensing Compact, is indefinitely SUSPENDED.

2. The suspension of the license of Delores M. Moyer, R.N. to practice as a registered nurse in the State of Wisconsin is hereby STAYED and shall remain stayed so long as Respondent complies with the following conditions:

(a) AUDITS: Respondent shall, at her own expense, arrange for audits of the CBRF facilities that she owns in whole or in part by a registered nurse

approved in advance by the board or its designee at a frequency of 3 times per year (every 4 months). The auditor shall file written reports with the Board on an every-four month basis. In the event that the auditor reports a significant violation of applicable regulations that substantially relates to the practice of professional nursing, following Respondent's opportunity to appeal such findings as permitted by DHS and a DHS final determination of a significant violation of applicable regulations in the matter, or conduct below minimum standards for a registered nurse, the stay will be lifted and Respondent's license shall immediately return to suspended status, without notice or hearing. If Respondent requests a hearing on this action, a hearing shall be held using the procedures set forth in Wis. Admin. Code ch. RL 2. The hearing shall be held in a timely manner with the evidentiary portion of the hearing being completed within 60 days of receipt of Respondent's request, unless waived by Respondent. Requesting a hearing does not stay the suspension during the pendency of the hearing process.

(b) EDUCATION: Within one hundred eighty (180) days of the date of this Order, Respondent, at her own expense, shall complete 4 hours of pre-approved continuing education in supervision and delegation in nursing, 4 hours of pre-approved continuing education in challenging behaviors with assisted living residents, and 4 hours of continuing education in nursing issues affecting the elderly in assisted living. Respondent is responsible for finding an appropriate course and submitting the course information to the Board for approval prior to taking the course and in sufficient time to obtain board approval within the 180 day time frame, taking into account the board's meeting schedule.

3. Respondent may petition the board to end the suspension after two years from the date of this Order. The board may grant the request to end the suspension if Respondent shows, to the board's satisfaction, that: (1) no other regulatory authority has made a final determination of significant violations of any regulations that substantially relate to the practice of professional nursing and are applicable to the operation of a CBRF facility owned, in whole or in part, by Respondent, and no proceedings relating to allegations of significant violations are pending; and (2) the auditor referred to in paragraph 2(a) above has not reported any significant concerns or significant deficiencies in the operations of the CBRF facilities Respondent owns, in whole or in part.

4. Pursuant to Uniform Nursing Licensure Compact regulations, Respondent's nursing practice is limited to Wisconsin during the pendency of this suspension and any subsequent related limitations. This requirement may be waived only upon the prior written authorization of both the Wisconsin Board of Nursing and of the regulatory board in the state in which Respondent proposes to practice.

5. The Department Monitor is the individual designated by the Board as its agent to coordinate compliance with the terms of this Order, including receiving reports and coordinating all requests for approval of education or other petitions. The Department Monitor may be reached as follows:

Department Monitor
Division of Enforcement
PO Box 8935
Madison, WI 53708-8935
FAX (608) 266-2264

6. Respondent shall, within One Hundred Eighty (180) days from the date of this Order, pay costs of this proceeding in the amount of Six Thousand, Five Hundred Dollars ($6,500.00). Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817
Fax (608) 266-2264

7. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to pay costs as ordered or fails to comply with the ordered continuing education, the Respondent's license (#30-48003) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

8. This Order shall become effective upon the date of its signing.

Board of Nursing

By: Marilyn Kaufmann
A Member of the Board

9/3/09
Date

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	: :	
	:	STIPULATION
DELORES M. MOYER, R.N. RESPONDENT.	: :	LS# 0811101 NUR

Division of Enforcement Case Nos. 04 NUR 122, 06 NUR 215, 06 NUR 350, 06 NUR 417, 06 NUR 478, 07 NUR 026, 07 NUR 394 and 08 NUR 401

Delores M. Moyer, R.N., personally and by her attorney Robert Lightfoot; and Jeanette Lytle, attorney for the Department of Regulation and Licensing, Division of Enforcement, stipulate:

1. This Stipulation is entered into as a result of eight pending investigations of Respondent's licensure by the Division of Enforcement (case Nos. 04 NUR 122, 06 NUR 215, 06 NUR 350, 06 NUR 417, 06 NUR 478, 07 NUR 026 and 08 NUR 401). Respondent consents to the resolution of this investigation by stipulation.

2. Respondent understands that by signing this Stipulation she voluntarily and knowingly waives her rights, including: the right to a hearing on the allegations against her, 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 her; the right to call witnesses on her behalf and to compel their attendance by subpoena; the right to testify herself; 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 her under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and any other provisions of state or federal law.

3. Respondent has obtained the advice of legal counsel prior to signing this stipulation, and understands that signing this Stipulation is not an admission as to the truth or accuracy of the allegations claimed in the Final Decision and Order but is mutually entered into for, among other things, decreasing the further costs of this proceeding and to achieve a suitable closure.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Board of Nursing. 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 be returned to the Division of Enforcement for further proceedings. In the event that this 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 consideration of this attempted resolution.

6. The parties to this Stipulation agree that the attorney or other agent for the Division of Enforcement and any member of the Board of Nursing ever assigned as an advisor in this investigation may appear before the Board in open or closed session, without the presence of the Respondent or her attorney, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with the Board's deliberations on the Stipulation. Additionally, any such Board 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. Respondent is further informed that should the Board adopt this Stipulation, the Board's Final Decision and Order would constitute an agency finding within the meaning of Wis. Stats. §§ 48.685 and 50.065. Should Respondent wish to work in a Wisconsin DHFS-licensed facility, she will need to pass a Rehabilitation Review through DHFS prior to commencement of such employment.

9. The Division of Enforcement joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.

Delores M. Moyer, R.N. 5001 Prairie Rose Court Middleton, WI 53562	8-5-09 Date
Robert J. Lightfoot, II Murphy Desmond P.O. Box 2038 33 E. Main St., Ste 500 Madison, WI 53701-2038	8-5-09 Date
Jeanette Lytle, Attorney Division of Enforcement Wisconsin Department of Regulation and Licensing P.O. Box 8935 Madison, WI 53708-8935	8/6/09 Date