

# WISCONSIN DEPARTMENT OF REGULATION & LICENSING



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STATE OF WISCONSIN  
BEFORE THE BOARD OF NURSING

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IN THE MATTER OF DISCIPLINARY :  
PROCEEDINGS AGAINST : FINAL DECISION  
: AND ORDER  
KAREN CRESSY, LPN, :  
LS0204091NUR :  
RESPONDENT. :

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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, makes 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 Division of Enforcement and Administrative Law Judge are hereby directed to file their affidavits of costs with the Department General Counsel within 15 days of this decision. The Department General Counsel shall mail a copy thereof to respondent or his or her representative.

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 this 11<sup>th</sup> day of July, 2002.

Linda Sanner, Chairperson  
Board of Nursing

STATE OF WISCONSIN  
BEFORE THE BOARD OF NURSING

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IN THE MATTER OF :  
DISCIPLINARY PROCEEDINGS : PROPOSED FINAL DECISION  
AGAINST : AND ORDER  
KAREN CRESSY, LPN, :  
 : LS0204091NUR  
RESPONDENT. :

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Karen Cressy, LPN  
6435 W. Warnimont Ave  
Milwaukee, WI 53220

## **Karen Cressy, LPN**

3627 South 85<sup>th</sup> St.  
Milwaukee, WI 53228

James E. Polewski  
Division of Enforcement  
P. O. Box 8935  
Department of Regulation & Licensing  
Madison, WI 53708-8935

A hearing in this matter was held on May 7, 2002, at the department. Participating were Karen Cressy, the respondent, James E. Polewski, attorney for the complainant, and the undersigned administrative law judge. The respondent was not represented by an attorney. By agreement of the parties Ms. Cressy appeared telephonically.

## **Findings of Fact**

1. Karen Cressy, LPN, was born on February 28, 1955, and is a licensed practical nurse in the state of Wisconsin pursuant to

license number 21566, first granted on April 18, 1979. (Admitted in Answer)

2. By order of the Board of Nursing dated January 7, 2000, case number LS 0001071 NUR, the respondent was disciplined for continuing to practice nursing after the expiration of her registration on April 30, 1995, and continuing through July 19, 1999. (Admitted in Answer) (Exh. 1-Final Decision and Order – LS 0001071 NUR )

3. One term of the January 7, 2000, order required that, within ninety days of the signing of the order the respondent was to submit proof of conducting a presentation of a nursing staff in-service acceptable to the Board on the subject of the importance of maintaining current licensure, and the potential consequences of practice without current licensure registration. (Admitted in Answer) (Exh. 1-Final Decision and Order – LS 0001071 NUR )

4. The respondent did not comply with the January 7, 2000, order, and admitted to the department of regulation and licensing that someone forged written proof on her behalf from the human resources director for the respondent's employer that the respondent had completed the staff in-service as required by the January 7, 2000, order. (Exh. 1-Final Decision and Order – LS 01090662 NUR )

5. The forgery was discovered when the respondent's employer made inquiries to the Division of Enforcement, and the respondent admitted that the letter dated February 1, 2000, purporting to be from her employer was in fact a forgery submitted on her behalf. (Admitted in Answer) (Exh. 1 Final Decision and Order – LS 01090662 NUR- exhibit C )

6. The Board of Nursing issued an order dated September 6, 2001, suspending the respondent's license for her failure to comply with the January 7, 2000, order. The respondent was, in part, ordered to write a paper on the importance of being honest and trustworthy, addressing in particular the importance of honesty to the department of regulation and licensing. (Exh. 1 Final Decision and Order – LS 01090662 NUR)

7. In addition to the suspension of the respondent's license, the September 6, 2001 order required, in part, that, within ninety days from September 6, 2001, the respondent fulfill the original requirement of a nursing staff in-service about the importance of license renewal. (Exh. 1 Final Decision and Order – LS 01090662 NUR)

8. On or about December 21, 2001, the respondent reported that she had not conducted the required nursing staff in-service, and lied that she had scheduled the in-service, but that her grandmother had died and the funeral and related activities had conflicted with and pre-empted the in-service. (Admitted in Answer) (R.T. 11-12)

9. By letter dated February 15, 2002, the respondent reported that the in-service had been scheduled for December 4, 2001. (Admitted in Answer)

10. On April 2, 2002, the respondent telephoned Dawn Kalies, an investigator in the Division of Enforcement, in response to Ms. Kalies' request for information about the status of the respondent's complying with the September 6, 2001, order. During the conversation, the respondent told Ms. Kalies that the in-service had been scheduled for December 4, 2001, at West Allis Care Center, and that the West Allis Care Center had recently closed. (Admitted in Answer)

11. On April 3, 2002, Ms. Kalies called the West Allis Care Center and determined that the respondent had not scheduled any in-service, and that none had been held on the topic of the importance of maintaining current nursing license registration. (Admitted in Answer) (R.T. pp. 6-9)

12. The respondent's failure to comply with the terms of two separate disciplinary orders constitutes a violation of Wis. Admn. Code § N 7.04. (Admitted in Answer)

13. The respondent's attempt to deceive the Board about her non-compliance with the Board's order constitutes unprofessional conduct under Wis. Stats. § 441.07(1)(d). (Admitted in Answer)

## **Conclusions of Law**

1. The respondent's failure to comply with the terms of the September 6, 2001, disciplinary order constitutes a violation of Wis. Admn. Code § N 7.04 (14).

2. The respondent's attempt to deceive the Board about her non-compliance with the Board's September 6, 2001, order constitutes misconduct or unprofessional conduct under Wis. Stats. § 441.07(1)(d).

## **Order**

It is now therefore ordered:

1. That the respondent's license, number 21566, is revoked. The respondent may apply for reinstatement of her license pursuant to Wis. Stats. § 441.07(2).

2. Costs of the disciplinary proceedings are assessed against the respondent.

### Opinion

The respondent has admitted the allegations contained in the complaint and stipulated to the violations encompassed by the conclusions of law. Notwithstanding the respondent's admissions, but based upon an independent review of the agreed-to facts and applicable law, the undersigned also finds that the conclusions of law are supported by a preponderance of the evidence. Violating any order of the board is per se defined as misconduct or unprofessional conduct by Wis. Admn. Code § N 7.04 (14). By extension, such conduct also constitutes per se grounds for revocation as provided in Wis. Stats. § 441.07 (1) (d). Similarly, lack of candor to the board, as engaged in here by the respondent, places at risk the very object of credentialholder discipline in the first instance, namely, protection of the public. A board is hindered in carrying out its public protection task if it is misinformed, misled or deceived by a credentialholder. A board that is misled does not know if its orders are truly being adhered to. Such a result has ominous consequences where credentialholders do not comply with discipline designed to protect the public, yet aver that they have. For this reason, the respondent's attempt to deceive the board qualifies as misconduct or unprofessional conduct.

The respondent had initially offered the excuse that in some manner an in-service "scheduled" for December 4, 2001, was prevented by her grandmother dying on December 2, 2001. However, this was a lie because no in-service was ever scheduled in the first instance. (R.T. 11-12)

Dawn Kalies, an investigator with the department, testified that no one at the location where the in-service was purportedly scheduled had heard of the respondent:

Q. When did you start investigating a complaint --well, let me back up. What was the complaint about with Ms. Cressy?

A. A violation of a board order, that -- I understood that -- that one of her requirements was to give an in-service regarding licensing issues, and I was to verify that.

Q. And how did you go about verifying that?

A. I contacted Karen Cressy by phone and talked with her by phone, and I also talked with the facility that she said she had arranged an in-service with.

Q. What did you talk to -- what was your conversation with Ms. Cressy?

A. I -- I asked her what -- what the date was that she was supposed to be giving an in-service. She told me that date. And I asked her where that in-service was to be scheduled at, and she -- she told me that.

Q. Was the date that she told you the in-service was scheduled sometime in December 2001?

A. Yes, on December 4th, 2001.

Q. And where did she tell you she had scheduled this in-service?

A. At West Allis Care Center.

Q. Did Ms. Cressy tell you if she had done the in-service?

A. She told me that she could -- she could not do the in-service because her mother -- her grandmother had passed away two days before that and therefore she -- she could not do the in-service as it had been scheduled.

Q. Did Ms. Cressy tell you who she'd scheduled the in-service with?

A. I -- I asked her that, and she said she could not recall.

Q. How did you know that she was saying that it was at West Allis Care? Let me take -- did -- she told -- Ms. Cressy told you where the in-service was but not who she scheduled it with?

A. I asked her for the person's name, and she said she could not recall the person's name that she scheduled it through. She said that it was the in-service coordinator at that facility.

Q. And that facility is?

A. West Allis Care Center.

Q. What did you do then? Did you call West Allis Care Center?

A. Yes, I did. And I -- I called and I talked with the in-service coordinator there who also was the director of nursing. She told me that all of the in-services are scheduled through her and she tracks all of the in-services, and she told me that she had never heard of Karen Cressy.

Q. Did you talk to anyone else at West Allis Care Center?

A. Yes, I did. I talked with the administrator. I believe his name is John Winter. And he also did not schedule an in-service to be given by Karen. He also had never heard of her.

Q. Thank you. (R.T. pp.6-9)

The respondent admitted lying about the in-service being scheduled:

A. Well, I mean I did lie about that in-service.

Q. Is that the December 4, 2001 in-service?

A. Yeah.

Q. Yes?

A. Um --

Q. Is that a yes?

A. Yes. The only thing I can tell you, my grandmother did in fact die on December 2nd. When Dawn called me, at that time my husband was laid off, I was the only one that working. I guess I sort of panicked and made that up. And I mean I'm sorry I did that, but I'm not denying that I did.

Q. Have you done an in-service since then?

A. No, I haven't. (R.T. pp. 11-12)

The final issue here is the appropriate discipline for the respondent, keeping in mind the nature of the violations. It is well established that the objectives of professional discipline include the following: (1) to promote the rehabilitation of the licensee; (2) to protect the public; and (3) to deter other licensees from engaging in similar conduct. *State v. Aldrich*, 71 Wis. 2d 206, 209 (1976). Punishment of the licensee is not an appropriate consideration. *State v. McIntyre*. 41 Wis. 2d 481, 485 (1969).

It is clear from the agreed facts, testimony and the supporting exhibits that the respondent lied to the board in this instance. This lie regarding the completion of an in-service was made following and despite a reprimand and suspension in two previous disciplinary matters related to the same subject matter. The current order entered in LS 0109062 NUR allowed the respondent 90 days from September 6, 2001 to perform the in-service yet during that time she did not complete this requirement. Instead, she utilized her grandmother's purported death at the eleventh hour to support a lie as the reason for noncompliance with that order.

Therefore, it is clear that the respondent has not been responding to the lesser levels of discipline to promote her rehabilitation. Revocation is the remaining means to impress upon the respondent that she must comply with board orders and be truthful to the board. Therefore, revocation of the respondent's license will protect the public and deter other licensees from engaging in similar conduct. The public must have confidence that board orders are being followed. The board must have confidence that licensees are truthfully reporting compliance. Other licensees must be placed on notice that compliance and truthfulness are expected of them, and despite the board's possible forbearance in a given case, revocation exists as a potential outcome for those who choose to not comply.

## **Costs**

Section 440.22(2), Stats., provides in relevant part as follows:

In any disciplinary proceeding against a holder of a credential in which the department or an examining board, affiliated credentialing board or board in the department orders suspension, limitation or revocation of the credential or reprimands the holder, the department, examining board, affiliated credentialing board or board may, in addition to imposing discipline, assess all or part of the costs of the proceeding against the holder. Costs assessed under this subsection are payable to the department.

The presence of the word "may" in the statute is a clear indication that the decision whether to assess the costs of this disciplinary proceeding against the respondent is a discretionary decision on the part of the board, and that the board's discretion extends to the decision whether to assess the full costs or only a portion of the costs. The ALJ's recommendation that the full costs of the proceeding be assessed is based primarily on fairness to other members of the profession.

The Department of Regulation and Licensing is a "program revenue" agency, which means that the costs of its operations are funded by the revenue received from its licensees. Moreover, licensing fees are calculated based upon costs attributable to the regulation of each of the licensed professions, and are proportionate to those costs. This budget structure means that the costs of prosecuting cases for a particular licensed profession will be borne by the licensed members of that profession. It is fundamentally unfair to impose the costs of prosecuting a few members of the profession on the vast majority of the licensees who have not engaged in misconduct. Rather, to the extent that misconduct by a licensee is found to have occurred following a full evidentiary hearing, that licensee should bear the costs of the proceeding.

Dated: June 4, 2002

William Anderson Black

Administrative Law Judge