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Before The
State Of Wisconsin
Board of Nursing

In the Matter of the Disciplinary Proceedings
Against PENNY A. MCKNIGHT, R.N.,
Respondent

FINAL DECISION AND ORDER

~~ORDER 0000770~~

Division of Enforcement Case No. 09 NUR 103

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 24th day of March, 2011.

A handwritten signature in cursive script, appearing to read "Kathleen Smith".

Member
Board of Nursing



Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of the Disciplinary Proceedings
Against **PENNY A. MCKNIGHT, R.N.**,
Respondent

PROPOSED DECISION AND ORDER
DHA Case No. DRL-10-0082

Division of Enforcement Case No. 09 NUR 103

The parties to this proceeding for purposes of Wis. Stat §§ 227.47(1) and 227.53 are:

Penney A. McKnight, R.N.
P.O. Box 783
Lake Mills, WI 53551

Wisconsin Board of Nursing
P. O. Box 8935
Madison, WI 53708-8935

Department of Regulation and Licensing, Division of Enforcement, by

Attorney Jeanette Lytle
Department of Regulation
Division of Enforcement
P. O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

These proceedings were initiated when the Department of Regulation and Licensing, Division of Enforcement (the "Division") filed a formal Complaint against the Respondent, Penny McKnight. The Division filed said Complaint with the Division of Hearings and Appeals on November 4, 2010. On the same date, the Division sent a copy of the Complaint and a Notice of Hearing via certified and regular mail to Respondent McKnight at her most recent address on file with the Department of Regulation and Licensing; P.O. Box 783, Lake Mills, WI, 53551. The Notice of Hearing stated that Respondent McKnight was required to file a written Answer to the Complaint within 20 days, failing which "[she would] be found to be in default and a default judgment [could] be entered against [her] on the basis of the Complaint and other evidence and the Wisconsin Board of Nursing [could] take disciplinary action against [her] and impose the

costs of the investigation, prosecution and decision of this matter upon [her] without further notice or hearing.”

To date, no Answer has been filed.

On November 29, 2010, the undersigned Administrative Law Judge (ALJ) of the Division of Hearings and Appeals issued a Notice of Telephone Prehearing Conference that set a telephone conference with Respondent McKnight and Attorney Jeanette Lytle of the Division of Enforcement for December 15, 2010. This Notice instructed Respondent McKnight to contact the undersigned ALJ to provide the telephone number for which she could be reached for the December 15, 2010, telephone conference, and was sent to the address on file for Respondent McKnight, as provided above.

Respondent McKnight did not contact the undersigned ALJ with a telephone number that she could be reached at for the December 15, 2010, telephone conference, and the telephone conference that was conducted on that date was without her participation.

At the December 15, 2010, conference, Attorney Lytle made a motion for default pursuant to Wis. Admin. Code § RL 2.14. The undersigned ALJ summarily accepted Attorney Lytle’s default motion and issued a Notice of Default instructing Respondent McKnight that she was in default, and that findings would be made and an Order entered on the basis of the Complaint and other evidence. The Notice of Default further ordered Attorney Lytle to provide the undersigned ALJ with the Division’s written recommendations for discipline and the assessment of costs in this matter by January 7, 2011. It was mailed to Respondent McKnight at the last address on record for her, P.O. B0x 783, Lake Mills, WI, 53551. Attorney Lytle provided the undersigned ALJ with the Division’s written recommendations as to discipline and costs on or about December 21, 2010.

Respondent McKnight has failed to respond to either the Notice of Default issued against her, or the written recommendations provided by Attorney Lytle on December 21, 2010.

FINDINGS OF FACT

On the evidence presented, the undersigned ALJ makes the following findings of fact:

1. Penny A. McKnight, R.N., date of birth May 15, 1959, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 136515, which was first granted October 5, 2000.
2. Respondent McKnight’s last address reported to the Department of Regulation and Licensing is P.O. Box 783, Lake Mills, Wisconsin, 53551.

3. At the time of the events set out below, Respondent McKnight was employed as a registered nurse at Select Specialty Hospital, a Long Term Acute Care Hospital in Madison, Wisconsin.

4. On March 14, 2009, Respondent McKnight provided nursing care to five patients, including Patient A, a 64-year old diabetic male who was transferred from UW-Hospital and Clinics for osteomyelitis. In addition to PRN medications, Patient A had routine medications ordered for 7:30, 08:00, 10:00, 11:30, 12:00, 17:00 and 18:00.

5. A review of the charting in the electronic medication administration record (EMAR) showed that Respondent McKnight administered Patient A's 7:30, 08:00, and 10:00 medications beginning at 12:32; his 11:30 medication at 15:44 and his 12:00 medication at 15:57. Patient A's 17:00 medication (insulin) was held and his 18:00 medication was administered at 19:51 by the nurse from the next shift.

6. Respondent did not check vital signs prior to giving cardiac medications and did not chart or note a change in breath sounds for Patient A. The charge nurse evaluated Patient A at 14:01 and found that his lungs "sounded wet." The charge nurse discussed this with the physician who subsequently ordered a chest x-ray and a nebulizer treatment. The charge nurse instructed Respondent McKnight to assess the patient's breath sounds later and she did not do so.

7. Patient A's order for scheduled oxycodone had been increased from 10 mg twice per day to 20 mg twice per day. The charge nurse notified Respondent McKnight of the change. Respondent McKnight gave the 8:00 dose of oxycodone at 12:32 and did not give the additional 10 mg as ordered. The patient's pain level was charted at zero for the entire day shift.

8. Medication administration records for the other four patients assigned to Respondent McKnight were reviewed. Many of the medications were delivered on average greater than one hour after their ordered time. Many medications given late were time sensitive, such as diuretics, blood pressure medications, insulin, methadone and sevelamer (a phosphate binder that must be given with meals).

9. A review was conducted of Respondent McKnight's EMAR administration records from January to mid-March 2009. Late and omitted medication administration was a pattern for Respondent. Respondent had been counseled for this previously and was advised to seek help from her peers if she was not able to keep up. Respondent attended a mandatory presentation on March 9, 2009, on Medication Safety and the 6 Rights. Additionally, Respondent had been recently counseled regarding failure to follow policy related to chest tube care, and most recently, when she had attempted to place a latex Foley catheter in a patient with severe latex allergy.

10. As a result of her conduct, Respondent McKnight's employment was terminated on March 17, 2009.

11. As set out in the Procedural History above, a Complaint and Notice of Hearing were sent to Respondent McKnight at her most recent address on file with the Department of Regulation and Licensing/Wisconsin Board of Nursing on November 4, 2010.

12. On or about November 29, 2010, the undersigned ALJ sent a Notice of Telephone Prehearing Conference for December 15, 2010, to Respondent McKnight at the above-listed address.

13. Respondent McKnight did not appear at this hearing, and the Division made a motion for default which was summarily accepted by the undersigned ALJ.

14. On or about December 15, 2010, the undersigned ALJ sent a Notice of Default to Respondent McKnight at her last known address.

15. Respondent McKnight has not responded to this Notice, or otherwise to the Complaint against her.

16. Respondent McKnight was offered a stipulation, but chose not to sign it. She was additionally warned that if she forced the Division to go through the hearing process, her costs would be higher.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. §§ 441.07 and 441.50(3)(b).

2. Wis. Stat. § 440.03(1) provides that the department (of Regulation and Licensing) may promulgate rules defining uniform procedures to be used by the department... and all examining boards and affiliated credentialing boards attached to the department or an examining board, for... conducting [disciplinary] hearings. These rules are codified in Wis. Admin. Code ch. RL.

3. Wisconsin Administrative Code § RL 2.08(1) provides, in relevant part, that “[t]he complaint, notice of hearing, all orders and other papers required to be served on a respondent may be served by mailing a copy of the paper to the respondent at the last known address of the respondent” and that “[s]ervice by mail is complete upon mailing.” Because the Complaint and Notice of Hearing, Notice of Telephone Prehearing Conference, and Notice of Default were mailed to Respondent McKnight at her last known address, she was duly served with these papers pursuant to Wis. Admin. Code § RL 2.08.

4. As the licensee, it was Respondent McKnight’s responsibility to keep her address on record with the Department of Regulation and Licensing current. Wis. Stat. § 440.11(1).

5. Respondent McKnight has defaulted in this proceeding pursuant Wis. Admin. Code § RL 2.14 by failing to file and serve an Answer to the Complaint as required by Wis. Admin. Code § RL 2.09.

6. Allegations in a complaint are deemed admitted when not denied in an answer. Wis. Admin. Code § RL 2.09. Respondent McKnight has admitted to the allegations of the Complaint by default by not filing an Answer.

7. Pursuant to Wis. Stat. § 441.07(1)(c), the Board of Nursing has authority to “revoke, limit, suspend or deny renewal of a license of a registered nurse” if the board finds that the registered nurse has engaged in “Acts which show the registered nurse, nurse-midwife or licensed practical nurse to be unfit or incompetent by reason of negligence, abuse of alcohol or other drugs or mental incompetency.”

8. Wis. Admin. Code § N 703(1)(b) defines negligence as “An act or omission demonstrating a failure to maintain competency in practice and methods of nursing care.”

9. Respondent McKnight’s conduct, as described in Findings of Fact ¶¶ 4-9, constitutes a violation of Wis. Admin. Code § N 7.03(1)(b), and subjects the respondent to discipline pursuant to Wis. Stat. § 441.07(c).

DISCUSSION

Violations of Wisconsin Statute and Administrative Code

By failing to provide an Answer to the Complaint filed against her, Respondent McKnight has admitted that all allegations contained within the Complaint are true. Wis. Admin. Code § RL 2.09. As such, it is undisputed that with respect to five (5) patients on March 14, 2009, Respondent McKnight: “administered medications to patients late, and omitted medications that were ordered, despite the time-sensitive nature of some of the medications, and despite having been re-educated and counseled” on this previously; (2) “failed to check vital signs before giving medications that could affect vital signs;” (3) “did not note a significant change of (lung) condition” in Patient A; (4) “did not assess [Patient A] despite being instructed to do so;” (5) “did not give the correct amount of a medication (oxycodone) to patient A;” and, sometime before March 19, 2010, (6) “ignored a severe allergy and put a patient at risk.” (See Division’s December 21, 2010, written recommendations for discipline and the imposition of costs, ¶ 2). A review of Respondent McKnight’s EMAR administration records from January to mid-March 2009 shows that this sort of conduct was a pattern.

Such conduct clearly constitutes negligence per Wis. Admin. Code § N. 7.03(1)(b). Respondent McKnight is thus subject to discipline pursuant to Wis. Stat. § 441.07(1)(c). The only question that remains is what kind of discipline is appropriate.

Appropriate Discipline

The Division requests that Respondent McKnight's license to practice nursing be indefinitely suspended, until such time that "she can provide proof that she has been assessed as safe to practice by a qualified nurse who has been approved in advance by the board." (See Division's December 21, 2010, written recommendations for discipline and the imposition of costs, ¶ 3). It further requests that Respondent McKnight be required to take a nurse refresher course¹, at her own expense, (*Id.* at ¶ 4); to take at least three hours of pre-approved continuing education in nursing ethics, (*Id.* at ¶ 5); and, after her suspension is lifted, that her license be limited for a period of at least two (2) years, such that she can work only under direct supervision, and only in a work setting pre-approved by the Board. (*Id.* at ¶ 5).

In support of its recommendations, the Division references recent decisions in which similar orders have been made: As examples of board orders requiring a fitness to practice evaluation, it references <http://online.drl.wi.gov/decisions/2000/lsooo9063nur-00073415.pdf> (In the Matter of Disciplinary Proceedings Against: Sandy Garrand, R.N.) and <http://online.drl.wi.gov/decisions/1997/l9601182nur-00075817.pdf> (In the Matter of Disciplinary Proceedings Against Beth S. Dittman, Holly A. Meier).² As an example of a board order imposing work conditions such as direct supervision and pre-approved work settings, the Division references <http://ice/enforcement/orders/OrderViewDoc.aspx?orderID=5456>.

Though the Division does not *explain why* the specific discipline is requested is warranted in the instant case, (beyond pointing out that similar disciplines have been ordered in recent cases with some similarities), the undersigned ALJ finds discipline it recommends more than appropriate given the respondent's actions.

Indeed, the three purposes of discipline are to (1) to promote the rehabilitation of the licensee; (2) to protect the public from other instances misconduct; and (3) to deter other licensees from engaging in similar contact. *State v. Aldrich*, 71 Wis. 2d 206 (1976). Respondent McKnight's repeated errors in administering medication, even after being alerted to her prior deficiencies in this area, evinces that she is still in need of rehabilitation, and that she is very much a danger to the public, who must be protected. Suspending Respondent McKnight's license to practice nursing until she can demonstrate her fitness to do so; requiring her to successfully complete both a "nurse refresher course" and three hours of continued education in nursing ethics, and limiting the settings in which she can practice, if and when her suspension is lifted, accomplishes both these goals.

Attaching the costs of these disciplinary requirements to Respondent McKnight will deter others from engaging in similar carelessness, accomplishing the third goal of discipline.

¹ Preapproved courses can be located on the Department of Regulation and Licensing website.

² While both these decisions, in essence, involve license suspensions of an indefinite period, the facts behind each decision, and, thus, the terms of each order, are quite different, leaving the undersigned ALJ at a loss as to the specific terms of the discipline sought.

Costs

The Division requests that Respondent McKnight be ordered to pay the full costs of its investigation and of these proceedings.

In *In the Matter of Disciplinary Proceedings against Elizabeth Buenzli-Fritz* (LS 0802183 CHI), the Chiropractic Examining Board found that:

The ALJ's recommendation and the ... Board's decision as to whether the full costs of the proceeding should be assessed against the credential holder..., is based on the consideration of several factors, including:

- 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 parties
- 4) The respondents cooperation with the disciplinary process;
- 5) Prior discipline, if any;
- 6) The fact that the Department of Regulation and Licensing is a "program revenue" agency, whose operating costs are funded by the revenue received from licenses, and the fairness of imposing the costs of disciplining a few members of the profession on the vast majority of the licensees who have not engaged in misconduct;
- 7) Any other relevant circumstances.

The respondent, by nature of her being in default has not presented any evidence regarding any of the above factors that would mitigate the imposition of the full costs of this proceeding. To the contrary, her conduct is of a serious nature. The factual allegations were deemed admitted and proven and there is no argument to apportion any counts that were unproven (being none), or that certain factual findings were investigated and litigated that were unnecessary. Given the fact that the Department of Regulation and Licensing is a "program revenue," agency, whose operating costs are funded by the revenue received for licensees, fairness here dictates imposing the costs of disciplining the respondent upon the respondent and not fellow members of the chiropractic profession who have not engaged in such conduct."

For many of the same reasons as cited in the *Buenzli-Fritz* decision, Respondent McKnight should be assessed the full amount of recoverable costs. Her alleged conduct is of a serious nature, there is no argument that certain factual findings were investigated and litigated unnecessarily, and given the program revenue nature of the Department of Regulation and Licensing, fairness again dictates imposing the costs of disciplining Respondent McKnight on

Respondent McKnight, and not fellow members of the nursing profession who have not engaged in such conduct. Indeed, Respondent McKnight was offered a stipulation, but chose not to sign it. She was additionally warned that if she forced the Division to go through the hearing process, her costs would be higher.

Payment of assessed costs will be necessary before the respondent's license can be reinstated pursuant to Wis. Stat. § 441.07(2). If the Board assesses costs against the respondent, these amount of costs will be determined pursuant Wis. Admin. Code § RL 2.18.

ORDER

For the reasons set forth above, IT IS ORDERED that the license of the Respondent Penny A. McKnight, R.N. to practice nursing in the State of Wisconsin be and is hereby **SUSPENDED FOR AN INDEFINITE PERIOD OF TIME.**

The suspension on Respondent McKnight's license will continue until she provides the Board with proof that she has been assessed as safe to practice by a qualified nurse who has been approved in advance by the Board. Any additional details involved in this process are to be determined by the Board.

IT IS FURTHER ORDERED that Respondent McKnight must complete a nurse refresher course, at her own expense, before the suspension on her license can be lifted.

IT IS FURTHER ORDERED that Respondent McKnight must complete at least three hours of pre-approved continuing education in nursing ethics before the suspension or her license can be lifted.

IT IS FURTHER ORDERED that, if and when the suspension on Respondent McKnight's license is lifted, her license be **LIMITED FOR AT LEAST TWO YEARS** in the following ways.

1. Respondent McKnight shall provide a copy of this Final Decision and Order immediately to supervisory personnel at all settings where she works as a nurse or caregiver or provides health care, during the two-year period.
2. Respondent McKnight shall practice only under the direct supervision of a licensed nurse or other licensed health care professional approved by the Board or its designee.
3. Respondent McKnight shall practice only in a work setting pre-approved by the Board or its designee. Respondent McKnight may not work in a home health care, hospice, pool nursing or agency setting.
4. Respondent McKnight's supervisor(s) shall provide written reports to the Department Monitor, reporting the terms and conditions of Respondent McKnight's employment and evaluating her work performance, on a quarterly basis, as directed by the

Department Monitor. It shall be Respondent McKnight's responsibility to insure that the reports are made in a timely manner.

5. Respondent McKnight shall notify the Department Monitor of any change of nursing employment during the time in which the Order is in effect.
6. During the pendency of this Order and any subsequent related Orders, Respondent McKnight may not practice in another state pursuant to the Nurse Licensure Compact under the authority of a Wisconsin license, unless Respondent McKnight receives prior written authorization to do so from both the Wisconsin Board of Nursing and the regulatory board in the other state.

IT IS FURTHER ORDERED that Respondent McKnight shall pay all recoverable costs in this matter in an amount to be established pursuant to Wis. Admin. Code § RL 2.18. After the amount is established payment shall be made by certified check or money order payable to the Wisconsin Department of Regulation and Licensing and sent to:

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

IT IS FURTHER ORDERED that the above-captioned matter be and hereby is closed as to Respondent Penny A. McKnight.

Dated at Madison, Wisconsin on January 20, 2011.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
5005 University Avenue, Suite 201
Madison, Wisconsin 53705
Telephone: (608) 266-7709
FAX: (608) 264-9885

By: 
Amanda Tollefsen
Administrative Law Judge