

## WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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Before The  
State Of Wisconsin  
Board of Nursing

In the Matter of the Disciplinary Proceedings  
Against **SHERRELL OWENS, L.P.N.**,  
Respondent

**FINAL DECISION AND ORDER  
WITH VARIANCE  
ORDER NO.**

**ORDER 0002492**

**Division of Legal Services and Compliance<sup>1</sup> Case No. 11 NUR 139**

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

Sherrell Owens, L.P.N.  
8042 West Potomac Avenue  
Milwaukee, WI 53218

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

Department of Safety and Professional Services  
Division of Legal Services and Compliance  
P.O. Box 8935  
Madison, WI 53708-8935

**PROCEDURAL HISTORY**

These proceedings were initiated when the Department of Safety and Professional Services (Department), Division of Enforcement (the Division), filed a formal Complaint against Respondent Sherrell Owens (Respondent) on January 11, 2012, alleging violations of Wis. Stat. § 441.07(1)(d), and Wis. Admin. Code § N 7.04(6) and (13). A prehearing conference was held on February 9, 2012 at which Respondent admitted the violations alleged, and the parties agreed to brief the issues of discipline and costs. Pursuant to a briefing order issued in this matter, the Division submitted a brief on the issue of discipline and costs to which Respondent failed to respond as required by the briefing order. The Administrative Law Judge(ALJ) issued a Proposed Decision and Order in this matter on October 12, 2012.

The Proposed Decision and Order of the administrative law judge (ALJ) in this case was reviewed by the Wisconsin Board of Nursing (Board) at its regularly scheduled meeting on

<sup>1</sup> The Division of Legal Services and Compliance was formerly known as the Division of Enforcement. Because the Division was called the Division of Enforcement at the time of the actions described, it is referred to as such in the procedural history of this decision.

December 6, 2012. Upon considering the ALJ's proposed decision and disciplinary recommendations, the Board adopts as its own the findings of fact and conclusions of law set forth in the proposed decision, but varies the Order as set forth below.

### **FINDINGS OF FACT<sup>2</sup>**

1. Respondent Sherrell Owens (DOB 2/13/1981) is licensed as a practical nurse in the State of Wisconsin, having license number 31-306386, first issued on September 1, 2005.

2. At the time of the incidents alleged, Respondent was employed as a practical nurse at Quality Assurance Home Health in Milwaukee, Wisconsin.

3. On February 9-11, 2011, Respondent completed and submitted to her employer visit records for Patient A that included a full set of vital signs, blood sugar level, medication administration, the site of injection and the patient's signature. Upon review of Patient A's file, it was discovered that Patient A was hospitalized on February 9-11, 2011, when Respondent claimed to have seen the patient.

4. On February 22, 2011, Respondent met with her then-employer and admitted to completing Patient A's visit records ahead of time without making actual visits to the patient because she was preparing to go out of town. Respondent admitted she made up the vitals in the report and had the patient sign the report even though she had not made the visit. Respondent also admitted to doing the same thing with Patient B in January 2011.

5. Upon review of Patient B's file, it was discovered that Respondent also completed and submitted visit records for Patient B while Patient B was in the hospital on January 7-8, 2011.

6. Respondent's former employer indicated in a document dated February 22, 2011 that Respondent voluntarily quit during the period of the employer's investigation. The document further shows that Respondent was paid \$17 for each patient visit.

### **ALJ'S DISCUSSION AND CONCLUSIONS OF LAW**

#### **Statutory and Administrative Code Violations**

Wisconsin Admin. Code § SPS 2.09 (3) states, "Allegations in a complaint are admitted when not denied in the answer." Wis. Admin. Code § SPS 2.09(4) states, "An answer to a complaint shall be filed within 20 days from the date of the service of the complaint." The Division served Respondent on January 11, 2012 by sending a copy of the notice of hearing, Complaint and discovery to her last known address. Respondent failed to answer the Complaint

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<sup>2</sup> Findings of fact 1-5 are taken from the Division's Complaint filed in this matter, which, as set forth below, are deemed admitted by Respondent's failure to file an Answer to the Complaint, her admission to the violations at the February 9, 2012 prehearing conference and her failure to respond to the Division's January 10, 2012 requests to admit which were sent to her home address on record and to her e-mail address. Finding of fact 6 is taken from the Affidavit of Aaron A. Konkol, Exhibit C, attached to the Division's brief.

within twenty days following January 11, 2012. Thus, all allegations contained in the Complaint have been admitted and are therefore incorporated into the Findings of Fact, above.

In addition to material facts being admitted by virtue of Respondent's failure to file an Answer to the Complaint, Respondent also admitted to the alleged violations at the February 9, 2012 prehearing conference.

Moreover, Respondent admitted to both the violations and the underlying facts by failing to respond to the Division's Requests for Admission. On January 11, 2012, the Division served the Respondent discovery, which included Requests for Admission, to her last known address pursuant to Wis. Stat. § 804.11. The Requests for Admissions included the underlying facts alleged in the Complaint, as set forth in the Findings of Fact above, and also included the following:

REQUEST TO ADMIT NO. 10: Respondent's conduct violated  
Wisconsin Administrative Code § N 7.04(6).

REQUEST TO ADMIT NO. 11: Respondent's conduct violated  
Wisconsin Administrative Code § N 7.04(13).

To date, those requests have not been answered. (Affidavit of Aaron A. Konkol, Exhibit B, attached to the Division's brief). Wisconsin Stat. § 804.11 sets out the rules for requests for admission and effects of admissions, and states in pertinent part:

**804.11 Requests for admission. (1) Request for admission.**

(a) . . . [A] party may serve upon any other party a written request for the admission . . . of the truth of any matters . . . that relate to statements or opinions of fact or of the application of law to fact . . . .

(b) . . . The matter is admitted unless, within 30 days after service of the request . . . the party to whom the request is directed serves upon the party requesting the admission a written answer or objection addressed to the matter, signed by the party or attorney . . . .

Pursuant to Wis. Stat. § 804.11, the request to admit are deemed admitted when a party fails to address the requests within 30 days after service of the request. Because Respondent failed to respond to the Division's request to admit, the matters contained in the requests are deemed admitted for purposes of this matter.

Although Respondent has admitted to the violations and they therefore need not be proven, this decision nonetheless applies the law to the facts to further establish that the violations alleged occurred.

The Division's Complaint alleged that discipline was warranted under Wis. Stat. § 441.07(1)(d), and Wis. Admin. Code § N 7.04(6) and (13). Wisconsin Stat. § 441.07(1)(d) states that the Wisconsin Board of Nursing (Board) may revoke, limit, or suspend the license of a

licensed practical nurse or may reprimand a licensed practical nurse, if the Board finds that the person committed "[m]isconduct or unprofessional conduct." "Misconduct or unprofessional conduct" means any practice or behavior which violates the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a patient or the public, and includes, *inter alia*, "[f]alsifying or inappropriately altering patient records," Wis. Admin. Code § N 7.04(6), and "[o]btaining or attempting to obtain any compensation by fraud, misrepresentation, deceit or undue influence in the course of nursing practice." Wis. Admin. Code § N 7.04(13).

Clearly, the actions by Respondent constitute unprofessional misconduct as defined by Wis. Admin. Code § N 7.04(6) and (13). Respondent had not only completed and submitted visit records with vital information without even seeing the patients, but submitted the visit reports when the patients were hospitalized. Respondent's former employer initiated an investigation of the conduct with respect to these reports and Respondent admitted to her former employer that she completed Patient A's visit records ahead of time without making actual visits to the patient because she was preparing to go out of town. She further admitted that she made up the vitals in the report and had the patient sign the report even though Respondent had not made the visit. Respondent also admitted to doing the same thing with Patient B in January 2011. Respondent voluntarily quit during the period of investigation. Her pay was based upon the submission of each visit report. Thus, Respondent falsified patient records and attempted to obtain compensation by fraud, misrepresentation or deceit in the course of her nursing practice, in violation of Wis. Admin. Code § N 7.04(6) and (13).

Accordingly, the Wisconsin Board of Nursing has the authority to discipline Respondent in this matter pursuant to Wis. Stat. § 441.07.

### **ALJ's Proposed Discipline**

The three purposes of discipline are: (1) to promote the rehabilitation of the licensee; (2) to protect the public from other instances of misconduct; and (3) to deter other licensees from engaging in similar conduct. *State v. Aldrich*, 71 Wis. 2d 206, 237 N.W.2d 689 (1976). The Division requests that Respondent's license be suspended for a period of six months, and that her license be limited to require that Respondent complete fourteen hours of nursing education. Specifically, the Division requests the Respondent be ordered to take five hours of pre-approved continuing education in documentation, four hours of pre-approved continuing education in ethics of nursing, and five hours of pre-approved continuing education in professional accountability for nurses.

The Division states that similar discipline has been ordered by the Board of Nursing for similar conduct in *In the Matter of Disciplinary Proceedings Against Nicole Savage Burkheimer*, 08NUR266 (Jan. 28, 2010). In that case Ms. Burkheimer, a registered nurse, submitted fraudulent documentation for skilled nursing care home visits that she did not actually provide for twelve home health care visits involving nine different patients. As a result of a stipulated agreement, Ms. Burkheimer's license was suspended for six months and she was ordered to complete a minimum of twelve hours of continuing education in nursing ethics. Ms. Burkheimer was also prohibited from providing any home health nursing care and could not work for any

nursing agency service. She was also required to ensure that her employer submitted quarterly reports to the Department Monitor describing her duties and responsibilities and evaluating her work performance. After a year of satisfactory reports, she could petition the Board to have the limitation removed from her license. Notably, in that case, Ms. Burkheimer apparently cooperated with the Division to reach a stipulated agreement, whereas here, Respondent participated in only one prehearing conference and then discontinued participation in the proceedings, and failed to file a brief as required by the administrative law judge's briefing order. The *Burkheimer* case is instructive in determining the discipline warranted here.

In view of the *Burkheimer* decision, the facts of this case, and the *Aldrich* criteria, the discipline requested by the Division is appropriate. Respondent's intentional acts and failure to take responsibility for her actions, including her failure to participate in this matter following the prehearing conference, exemplifies the need for rehabilitation in this case. A six-month suspension, as well as limiting the Respondent's license to order nursing education, will serve to rehabilitate Respondent and ensure that she understands the rules governing her profession. Respondent's actions were highly unethical and the public was in fact harmed. Respondent must be disciplined so as to protect the public from further harm. Also, there is a need to send a strong message to other licensees to deter them from engaging in similar conduct. The discipline recommended by the Division, and imposed in this matter, will adequately serve the purposes of discipline.

### Costs

The Wisconsin Board of Nursing has the authority to assess costs pursuant to Wis. Stat. § 440.22. The Division requests that Respondent be ordered to pay the full costs of its investigation and of these proceedings. The factors to be considered in assessing costs are: (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 disciplinary process; (5) prior discipline, if any; (6) the fact that the Department 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; and (7) any other relevant circumstances. See *In the Matter of Disciplinary Proceedings Against Elizabeth Buenzli-Fritz*, LS0802183CHI (Aug. 14, 2008). Most of these factors have been addressed in the disciplinary section of this decision, above. Additionally, although Respondent does not have any prior disciplinary action against her, her conduct was serious, there is no argument that certain factual findings were investigated and litigated unnecessarily and, given the program revenue nature of the Department, fairness dictates imposing the costs of these disciplinary proceedings on Respondent, and not on fellow members of the nursing profession who have not engaged in such conduct. Based on the foregoing, it is appropriate to require Respondent to pay the full costs incurred in this matter.

If the Board assesses costs against Respondent, the amounts of costs will be determined pursuant to Wis. Admin. Code § SPS 2.18.



### **EXPLANATION OF VARIANCE TO ALJ'S PROPOSED DECISION**

As the regulatory authority and final decision maker in this Class 2 proceeding, the Board may modify the ALJ's proposed decision. Wis. Stat. § 227.46(2). The Board must provide reasons for any such modifications. *Id.* Here, The Board agrees with the ALJ's conclusion that Respondent's actions in this case were serious, but finds that the limitations recommended by the ALJ do not sufficiently fulfill the purposes of discipline established in the *Aldrich* opinion. The Board finds that additional limitations are required to adequately protect the public and to effectively rehabilitate the licensee.

The difference between this and the *Burkheimer* case, which the ALJ cited to as similar to this one, is that here, Respondent failed to participate in these proceedings beyond attending the pre-hearing conference. Even with Ms. Burkeheimer's cooperation and her stipulation to the disposition, she still received a 6-month suspension, limitations on her license that included a requirement to complete a minimum of 12 continuing education hours in nursing ethics, restrictions on the settings in which she could work after her suspension, and satisfactory quarterly reports from her employer for a continuous 12-month period once employed. Here, Respondent's lack of participation in the proceedings signals a failure to truly take responsibility for her actions, one of the hallmarks of a Respondent's rehabilitation.

The Board concludes that the additional and longer-lasting limitations it imposes in the order below will facilitate Respondent's understanding of the seriousness of her intentional actions, and thus, her rehabilitation. The added length of the limitation period and the three additional conditions of limitation will better serve the purposes of deterrence to Respondent and other nursing licensees from engaging in such intentional misconduct.

### **ORDER**

Accordingly, IT IS ORDERED that the license of Sherrell Owens to practice as a practical nurse in the State of Wisconsin be, and is hereby, SUSPENDED for a period of six months from the date of this Order.

IT IS FURTHER ORDERED that following the period of suspension, the license of Sherrell Owens to practice as a practice nurse in the State of Wisconsin is LIMITED on the following terms and conditions:

1. Within ninety (90) days of the date of this Order, Sherrell Owens shall complete fourteen hours of nursing education, all of which must be pre-approved by the Board and which shall include five hours of continuing education in documentation; four hours of continuing education in ethics of nursing; and five hours of continuing education in professional accountability for nurses. Sherrell Owens shall obtain preapproval of the education programs from the Board or its designee. Upon completion of the programs, Sherrell Owens shall file a certificate from each of the programs with the Department Monitor at the address identified below. All costs of the programs are the responsibility of Sherrell Owens.

2. Upon expiration of the period of suspension, Sherrell Owens may resume practice as a licensed practical nurse on the following terms and conditions which shall continue for a period of at least two years after resumption of practice:

a) Sherrell Owens shall work only in a setting pre-approved by the Board. She shall notify the Board of her initial employment at least 20 days prior to resumption of practice and advise the Board of any proposed change of employment at least ten business days prior to such proposed change.

b) Sherrell Owens may not work in a home health care, assisted living, hospice, pool nursing, or agency setting.

c) Sherrell Owens may only practice under the direct supervision of a licensed nurse or other licensed health care professional approved by the Board or its designee. During the period of limitation, the Board may require work reports from the supervisor as the Board deems necessary. It is the responsibility of Sherrell Owens to insure that any ordered work reports are received by the Department Monitor at the address below at the time specified in the request.


IT IS FURTHER ORDERED that Sherrell Owens shall pay the full costs of the investigation and disciplinary proceedings 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:

**Department Monitor  
Department of Safety and Professional Services  
Division of Legal Services and Compliance  
P.O. Box 8935  
Madison, WI 53708-8935  
Telephone: (608) 267-3817  
Fax: (608) 266-2264**

This Order is effective on the date it is signed, shown below.

Dated at Madison, Wisconsin on June 20<sup>th</sup>, 2013.

Wisconsin Board of Nursing

By:   
Julia Nelson, R.N.  
Chair of the Board of Nursing