

WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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STATE OF WISCONSIN
BEFORE THE DENTISTRY EXAMINING BOARD

IN THE MATTER OF THE PETITION FOR	:	0003358
SUMMARY SUSPENSION AGAINST	:	
JOHN R. KREGENOW, D.D.S.,	:	DLSC Case Nos. 11 DEN 098
RESPONDENT.	:	13 DEN 121, 14 DEN 038 and
	:	14 DEN 061

ORDER OF SUMMARY SUSPENSION

John R. Kregenow, D.D.S.
N1292 East Road
Waupaca, WI 54981

Attorney Sandra L. Nowack
Department of Safety and Professional Services,
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

The Petition for Summary Suspension dated August 4, 2014, was noticed to be presented at 8:30 a.m., or as soon thereafter as the matter could be heard, on September 3, 2014, in Madison, Wisconsin. At that time, Attorney Sandra L. Nowack appeared for the Petitioner, Department of Safety and Professional Services, Division of Legal Services and Compliance. Respondent did not appear.

The Wisconsin Dentistry Examining Board (Board), having considered the sworn August 4, 2014, Petition for Summary Suspension of attorney Sandra L. Nowack; the affidavit of Hannah Whaley; the affidavit of Laura Scudiere; the affidavit of Brian Lewis; the affidavit of Alec Jaret, D.M.D.; the affidavit of Christine E. Adam; the affidavit of Gary L. Stafford, D.M.D.; the affidavit of service of Zachary P. Hendrickson, and; having heard the argument of attorney Sandra L. Nowack, hereby makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Respondent John R. Kregenow, D.D.S., (dob December 16, 1951), is licensed in the state of Wisconsin to practice dentistry, having license number 5002132-15, first issued on July 11, 1978, with registration current through September 30, 2015. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is N1292 East Road, Waupaca, Wisconsin 54981.

COUNT I

Ms. A

2. On August 28, 2011, Respondent met Ms. A in a convenience store parking lot in Marathon County, Wisconsin.

3. Respondent states he did an examination in the parking lot and diagnosed Ms. A with a significant abscess of a molar.

4. Respondent did not make any record of the examination.

5. On August 29, 2011, Ms. A asked Respondent to call a specific Walgreens pharmacy in the city of Milwaukee, and prescribe pain control medication for her.

6. Respondent called the specific Milwaukee pharmacy as requested, and prescribed thirty-six (36) tablets of hydrocodone/acetaminophen 7.5/500 mg. for Ms. A. Respondent justified the prescription because, he says, he saw Ms. A in emergent circumstances.

7. The prescription order Respondent issued for Ms. A, for thirty-six (36) tablets of hydrocodone/acetaminophen 7.5/500 mg., was a larger amount than would have been necessary to relieve pain attendant to an emergent condition such as Respondent described.

8. Respondent did not reexamine Ms. A's tooth, did not treat the tooth, did not refer Ms. A to another dentist, did not document the contact, and did not seriously consider that Ms. A may have been drug-seeking.

9. Respondent did not, within seven (7) days of authorizing the prescription referenced in paragraph 8, reduce the prescription order to writing.

10. The minimally competent treatment of an abscessed tooth requires draining and treating the infection. At the time he prescribed the controlled substance, Respondent did not know if Ms. A had received any treatment for the abscess.

11. Respondent, by the conduct described in paragraphs 2-10, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(6), by administering, dispensing, prescribing, supplying or obtaining controlled substances other than in the course of legitimate practice or as otherwise prohibited by law.

COUNT II

12. Respondent by the conduct described in paragraphs 2-10, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(5), by practicing in a manner which substantially departs from the standard of care ordinarily exercised by a dentist which harms or could have harmed a patient.

COUNT III

Mr. B

13. On or about October 1, 2011, Mr. B was a clerk at a motel outside of Waupun, Wisconsin. Respondent met Mr. B when Respondent was a guest at the motel. Respondent did not know Mr. B.

14. Respondent states that he examined Mr. B in the lobby of the motel, and diagnosed Mr. B as suffering from a broken tooth.

15. Respondent did not make any record of the examination, he did not treat the tooth, nor did he make a referral for definitive treatment.

16. Respondent did not verify that Mr. B had a surgical procedure of any kind.

17. On October 1, 2011, Respondent telephoned a Walgreens pharmacy in Waupun, Wisconsin, and prescribed hydrocodone/acetaminophen 7.5/500 mg., forty (40) tablets, one every six hours for Mr. B for post-operative pain.

18. On October 12, 2011, a person identifying himself as Respondent telephoned a Walgreens pharmacy in Waupun, Wisconsin, and prescribed Mr. B hydrocodone/acetaminophen 7.5/500 mg., forty (40) tablets, one every six hours for post-operative pain.

19. On October 13, 2011, a person identifying himself as Respondent telephoned a Walgreens pharmacy in Waupun, Wisconsin, and prescribed for Mr. B hydrocodone/acetaminophen 7.5/500 mg., forty (40) tablets, one or two every six hours for post-operative pain, and permitted one refill.

20. On October 19, 2011, pursuant to the prescription Respondent ordered on October 13, 2011, Mr. B obtained a refill of the prescription for hydrocodone/acetaminophen 7.5/500 mg., forty (40) tablets.

21. Respondent, by the conduct described in paragraphs 13-20, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(6), by administering, dispensing, prescribing, supplying or obtaining controlled substances other than in the course of legitimate practice or as otherwise prohibited by law.

COUNT IV

22. Respondent, by the conduct described in paragraphs 13-20, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(5), by practicing in a manner which substantially departs from the standard of care ordinarily exercised by a dentist which harms or could have harmed a patient.

COUNT V

Ms. C

23. During approximately 2011, Respondent was employed at Aspen Dental in Wausau, Wisconsin. His last day practicing dentistry in the clinic was September 2, 2011, and he was terminated on October 10, 2011.

24. On February 7, 2012, Ms. C presented a prescription for Vicodin, 5/500 mg., thirty (30) tablets, one every four to six hours for pain, to Sam's Club pharmacy. The prescription was handwritten on a pre-printed Aspen Dental prescription pad from the clinic that had previously employed Respondent. The prescription was dated February 7, 2012, and signed by Respondent.

25. Respondent acknowledges that his prescriptions for Ms. A, Mr. B, and Ms. C were inappropriate and not appropriately documented in a patient health care record.

26. Respondent, by the conduct described in paragraphs 23-25, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(6), by administering, dispensing, prescribing, supplying or obtaining controlled substances other than in the course of legitimate practice or as otherwise prohibited by law.

COUNT VI

Unreliable practice and continuity of care.

27. Between January 9, 2006 and October 24, 2013, Respondent worked at multiple dental practices at different locations throughout the state. Employers report concerns with Respondent's mental health, including paranoid traits and anger issues, as well as patient abandonment.

28. Beginning on January 9, 2006, Respondent was employed at a clinic in Wausau, Wisconsin (the clinic).

29. At the time of Respondent's termination there were concerns about the quality of care he provided and about his mental health.

30. There was at least one instance in which Respondent altered a patient's chart to justify treatment other than had been agreed upon in the original treatment plan.

31. Respondent was given written warnings because he was frequently and severely tardy without justification.

32. Respondent accumulated items in his office that he obtained from the clinic's trash dumpster. Items included expired food and other items that left his office with a foul smell. The volume of his accumulated materials made it difficult to maneuver around his office.

33. Respondent was counseled for throwing dental instruments during patient appointments. When confronted, Respondent shrugged it off, claiming the conduct was intended as a joke.

34. Respondent accused his supervisor of threatening his physical safety. The matter was investigated, but no evidence existed to support Respondent's contention that he had been threatened.

35. Respondent continued to accuse his supervisors of improper drug use, conspiracy and unethical conduct. Each accusation was investigated and unsubstantiated.

36. On more than one occasion community leaders and clinic staff expressed concern about Respondent's mental health. They reported Respondent making bizarre and paranoid comments regarding his employer, including Respondent was being "watched closely" and the clinic was operating under "duress."

37. On March 20, 2009, Respondent's employment was terminated due to breach of contract as a result of his repeated unauthorized "moonlighting" with other employers.

38. After Respondent's termination, he contacted the clinic offering to exchange resumes of dental assistants employed at the clinic and the practice at which he was then employed. When the clinic did not call him back, Respondent left messages in which he indicated that the clinic should call him back because, he stated, "you won't want to see me angry."

39. Respondent also contacted other dentists at the clinic asking them to call him at home but not from a clinic telephone as "people" were listening to him.

40. Between September 2, 2011 and October 10, 2011, Respondent abandoned a position with another employer when he failed to report for work, failed to provide notice of his absences and failed to respond to the employer's telephone calls. Respondent made no arrangements for continuity of patient care.

41. On October 26, 2011, the clinic executive director at the Wausau clinic received a call from the manager at Teaser's Night Club, a "gentlemen's club," in Stratford, Wisconsin.

42. The manager informed the clinic executive director that Respondent had been at the establishment with a prescription pad from the clinic offering her staff prescriptions in exchange for drinks and other services.

43. On November 9, 2012, the clinic received a refill authorization request for a prescription written by Respondent on May 7, 2012, and last filled on August 26, 2012.

44. Respondent had not been authorized to practice dentistry on behalf of the clinic since his termination in 2009.

45. Between April 2, 2012, and October 24, 2013, Respondent had agreed to assist a third dental practice "on call." However, Respondent rarely showed up as agreed, often failed to give any notice of or explanation for his absence and therefore left patients without care.

46. Respondent, by the conduct described in paragraphs 27-45, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(4), by practicing dentistry while the ability to perform services was impaired by a mental or emotional disorder.

COUNT VII

14 DEN 038

47. On February 3, 2014, Respondent began work in the practice of Dr. Alec Jaret, DMD, through a business entity known as HealthDrive.

48. HealthDrive facilitates contracted dental services for nursing homes in Wisconsin.

49. On April 4, 2014, Dr. Jaret terminated Respondent's employment. Respondent was asked to return all equipment, especially open lab cases, as soon as possible, but no later than seven (7) business days.

50. Between April 4, 2014 and May 5, 2014, Respondent failed, despite multiple communications from the former employer, to return dental items in various states of completion, nor did he return a company laptop.

51. The dental items Respondent retained were the property of and relevant to care of nine (9) of his former patients.

52. The former employer scheduled multiple locations and dates of transfer, usually involving a single health care provider with whom the employer had a contract, and at which Respondent had previously provided services.

53. On May 12, 2014, when confronted, Respondent told the Board's investigator that he had not returned the patient items to the previously arranged locations because he was concerned about patient confidentiality under HIPAA.

54. Respondent understood that in failing to return the items he was compromising the patients' continuity of care.

55. On May 12, 2014, the Board's representative, acting on the Board's behalf, instructed Respondent to return the patient items to the former employer no later than May 16, 2014.

56. As of June 2, 2014, Respondent failed to return at least 25% of the patient items.

Ms. D

57. Among the items Respondent retained after June 2, 2014, were the upper dentures of Ms. D., an approximately 90 year-old resident of a nursing home who had lost her lower dentures.

58. Between approximately February and March 2014, Respondent took possession of Ms. D's upper dentures for use in constructing lower denture replacements.

59. In April 2014, Ms. D's daughter, Christine Adams, who holds Ms. D's power of attorney, contacted Respondent by telephone and asked Respondent to return the dentures.

60. Ms. Adams told Respondent that because of her missing dentures Ms. D had no teeth and her health was deteriorating.

61. During the telephone conversation, Respondent angrily ranted about a financial dispute he had with his former employer. Respondent said the former employer owed him money, and he advised Ms. Adams to go the former employer for satisfaction.

62. Ms. Adams, in another appeal to Respondent, sent him, via text message, a photograph of Ms. D. without her teeth.

63. Respondent then said the dentures were in storage at his girlfriend's house in central Wisconsin and because his former employer had not paid him what he was owed, he had no money to get to the location where the dentures were stored.

64. Respondent, in turn, sent his former employer a text with a photograph of an unidentified elderly woman without teeth. The photograph was not accompanied by any explanation or other message.

65. Respondent did not return Ms. D's dentures.

66. Ms. Adams then paid her attorney to send a letter demanding the return of Ms. D's dentures because their loss was having additional negative consequences on Ms. D's health.

67. As of June 30, 2014, Respondent had not returned Ms. D's dentures. He has not communicated any reason for his failure to return the dentures, nor has he communicated any intent to do so.

68. Despite multiple opportunities to do so, Respondent never told the Division's investigator that he had retained Ms. D's dentures or that he lacked funds to return them.

69. Respondent, by the conduct described in paragraphs 47-68, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), by engaging in a practice which constitutes a substantial danger to the health, welfare or safety of a patient or the public.

70. Wisconsin Stat. § 940.295(3)(a)2., prohibits any person employed in a health facility from engaging in conduct that creates a situation of unreasonable risk of harm to a patient or resident, and demonstrates a conscious disregard for the safety of the patient or resident.

COUNT VIII

71. Respondent, by the conduct described in paragraphs 47-68, violated Wis. Stat. § 940.295(3)(a)2., which under the circumstances at issue is a law substantially related to the practice of dentistry.

72. Respondent, by violating Wis. Stat. § 940.295(3)(a)2., violated a law the circumstances of which substantially relate to the practice of dentistry and engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(15).

COUNT IX

14 DEN 061

Waupaca County Circuit Court Case No. 14CF152

73. On approximately June 3, 2014, Ms. E., a married adult woman, reported to the Waupaca County Sheriff's Department that Respondent was having repeated and unwanted contact with her, causing her fear.

74. On June 3, 2014, at approximately 5:00 p.m., Waupaca County Sheriff's Deputy Dave Huberty told Respondent not to have any contact, directly or indirectly, personally or professionally with Ms. E.

75. When Deputy Huberty told Respondent not to have contact with Ms. E., Deputy Huberty informed Respondent that Ms. E. and others felt threatened or uncomfortable by Respondent's words and actions toward them in previous interactions that week.

76. Despite Deputy Huberty's instruction, Respondent contacted Ms. E., within approximately two hours.

77. On June 5, 2014, as a result of the conduct described in paragraph 76, in Waupaca County Circuit Court Case No. 14CF152, Respondent was charged with stalking, a Class I felony, in violation of Wis. Stat. §§ 940.32(2), and 939.50(3)(i).

78. Respondent, by the conduct described in paragraphs 73-77, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(15), by violating any law the circumstances of which substantially relate to the practice of dentistry.

COUNT X

Waupaca County Circuit Court Case No. 14CF173

79. In Case No. 14CF152, the court imposed bail conditions including, inter alia, that Respondent have no contact with Ms. E, her husband or their children.

80. On June 11, 2014, in Waupaca County Circuit Case No. 14CV207, upon Ms. E's petition, the court issued a harassment restraining order that barred Respondent from contacting Ms. E for four years.

81. On June 17, 2014, Respondent agreed, as a condition of bail in Case No. 14CF152, that he could not possess firearms.

82. Respondent told the court that he did not have any firearms.

83. On June 19, 2014, Waupaca County Sheriff's deputies contacted Respondent at his residence. At the deputies' request, Respondent handed over fourteen (14) firearms that were then in his possession.

84. As a result of the conduct set out in paragraph 83, Respondent was charged in Waupaca County Circuit Court Case No. 14CF173, with felony bail jumping, in violation of Wis. Stat. § 946.49(1)(b).

85. Respondent, by the conduct described in paragraphs 79-84, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(15), by violating any law the circumstances of which substantially relate to the practice of dentistry.

COUNT XI

Waupaca County Circuit Court Case No. 14CF174

86. On June 23, 2014, Respondent called his daughter and said that he was on the floor coughing up blood. She asked the Waupaca County Sheriff's Department to check on Respondent's welfare.

87. Waupaca County Sheriff's deputies went to Respondent's residence where they found him outside, intoxicated (BAC .106) and in possession of a .22 long gun.

88. As a result of Respondent's conduct described in paragraph 88, Respondent was charged in Waupaca County Circuit Court Case No. 14CF174, with felony bail jumping and operating a firearm while intoxicated, in violation of Wis. Stat. § 946.1(b) and § 941.20(1)(b), respectively.

89. Respondent, by the conduct described in paragraphs 86-88, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(15), by violating any law the circumstances of which substantially relate to the practice of dentistry.

COUNT XII

90. Respondent, by the conduct described in paragraphs 86-88, engaged in unprofessional conduct as defined by Wis. Admin. Code § DE 5.02(1), by engaging in any practice which constitutes a substantial danger to the health, welfare or safety of the public.

Washington County Circuit Court Case No. 14FO262

91. On July 3, 2014, in Washington County Circuit Court Case no. 14FO262, the court entered a default judgment against Respondent for a non-traffic ordinance violation for retail theft, altering a price. The citation was issued for acts in which Respondent engaged on May 9, 2014.

Expert Opinion, Dr. Gary Stafford, D.D.S.

92. Dr. Gary Stafford, D.D.S., is an expert in the practice of dentistry.

93. According to Dr. Stafford, Respondent's conduct, as set forth above, establishes to a reasonable degree of professional certainty that Respondent has practiced dentistry below the standard of minimal competence and he has placed patients at unacceptable risk of harm.

94. According to Dr. Stafford, Respondent has, to a reasonable degree of professional certainty, exhibited conduct which evidences an impaired ability to safely and reliably engage in the practice of dentistry.

95. Based upon the above findings of fact contained in paragraphs 1 through 94, there is probable cause to find that the public health, safety or welfare imperatively requires emergency suspension of the Respondent's license to practice dentistry in Wisconsin.

CONCLUSIONS OF LAW

1. Sufficient notice of this proceeding has been given to Respondent John R. Kregenow, D.D.S., as required by Wis. Admin. Code § SPS 6.05.

2. The Dentistry Examining Board is authorized, pursuant to Wis. Stat. §§ 227.51(3), 447.07(3), and Wis. Admin. Code § SPS 6.06 to summarily suspend Respondent's license to practice dentistry in the state of Wisconsin upon probable cause to believe that Respondent violated the provisions of Wis. Stat. ch. 447; and probable cause to believe that the public health, safety, or welfare imperatively requires emergency action.

3. There is probable cause to believe that John R. Kregenow, D.D.S., engaged in unprofessional conduct as defined Wis. Admin. Code §§ DE 5.02(1), (4), (5), (6), (15) and Wis. Stat. § 447.07(3)(a), as described in Counts I – XII, above.

4. There is probable cause to believe that John R. Kregenow, D.D.S., violated Wis. Stat. § 940.295(3)(a)2., as described in Count VII and VIII, above.

5. To protect the public's health, safety and welfare, it is necessary to immediately suspend Respondent's license to practice dentistry in the State of Wisconsin.

ORDER

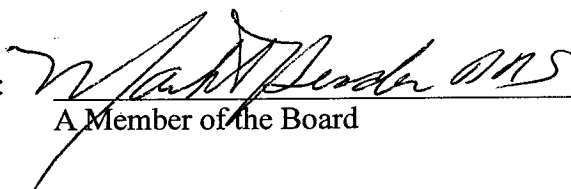
1. The license to practice dentistry in the state of Wisconsin issued to John R. Kregenow, D.D.S., is SUMMARILY SUSPENDED until the effective date of a Final Decision and Order issued in the Disciplinary Proceeding Against Respondent John R. Kregenow, D.D.S., unless otherwise ordered by the Board.

2. A formal Complaint shall, if not already, be filed with the Division of Hearings and Appeals, alleging that Respondent has committed unprofessional conduct.

3. Respondent John R. Kregenow, D.D.S., is hereby notified of his right, pursuant to Wis. Admin. Code § SPS 6.09, to request a hearing to show cause as to why this summary suspension order should not be continued. Respondent is further notified that any request for a hearing to show cause should be filed with the Wisconsin Dentistry Examining Board, 1400 East Washington Avenue, P.O. Box 8366, Madison, Wisconsin 53708-8366.

4. In the event that Respondent John R. Kregenow, D.D.S., requests a hearing to show cause as to why the summary suspension should not be continued, that hearing shall be scheduled to be heard on a date within twenty (20) days of receipt by the Board of Respondent's request for a hearing, unless Respondent requests or agrees to a later time for the hearing.

WISCONSIN DENTISTRY EXAMINING BOARD

By: 
A Member of the Board

9/3/14
Date