WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

Wisconsin Department of Safety and Professional Services
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Safety and Professional Services website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Safety and Professional Services from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Safety and Professional Services data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Safety and Professional Services, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Safety and Professional Services is shown on the Department's Web Site under "License Lookup."

  The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca

- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DSPS website: An individual who believes that information on the website is inaccurate may contact DSPS@wisconsin.gov

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE PETITION FOR SUMMARY SUSPENSION AGAINST	:	
DAWN M. JONES, L.P.N.,	:	DLSC Case No. 16 NUR 369
RESPONDENT.	:	0004962

ORDER OF SUMMARY SUSPENSION

The Petition for Summary Suspension of Dawn M. Jones, L.P.N.'s license to practice nursing, dated October 7, 2016, was noticed to be presented on October 13, 2016, before the Wisconsin Board of Nursing. At that time, Attorney Kim M. Kluck appeared for the Petitioner, the Department of Safety and Professional Services, Division of Legal Services and Compliance. The Respondent appeared by telephone.

The Wisconsin Board of Nursing, having considered the sworn October 7, 2016, Petition for Summary Suspension of Kim M. Kluck; the Affidavit of Alicia Nall, dated October 7, 2016; the Affidavit of Susan Schmitt with attached Exhibit A, dated October 3, 2016; the Affidavit of Kathleen Papa, dated September 28, 2016; the Affidavit of Deputy Craig Siegel, dated September 30, 2016 as evidence, and the Affidavit of Mailing of Meena Balasubramanian swearing that a true and accurate copy of the Notice of Presentation of Petition for Summary Suspension, a Petition for Summary Suspension; the Affidavit of Alicia Nall; the Affidavit of Susan Schmitt with attached Exhibit A; the Affidavit of Kathleen Papa; the Affidavit of Deputy Craig Siegel; and a Petition for Designation of Hearing Official had been mailed via certified and regular U.S. Mail, as well as electronic mail, to the Respondent, and having heard the arguments of counsel and Respondent, hereby makes the following:

FINDINGS OF FACT

1. Respondent Dawn M. Jones, L.P.N., (date of birth March 6, 1981), is licensed in the State of Wisconsin as a licensed practical nurse, having license number 308097-31, which was first granted on January 9, 2007, and current through April 30, 2017.

2. Respondent's most recent address on file with the Department is 3202 West Greenfield Avenue, Milwaukee, Wisconsin 53215.

3. On information and belief, Respondent's current address is 977 West Lincoln Avenue, Milwaukee, Wisconsin 53215.

4. Susan M. Schmitt, L.P.N., is a practical nurse, employed as a private duty nurse to provide home nursing care for Patient A, who is a quadriplegic patient on a ventilator, in Pewaukee, Wisconsin.

5. On July 4, 2016, in the course of Nurse Schmitt's duties as a private duty nurse, she presented to the apartment building where Patient A resides. She arrived at approximately 6:45 a.m., in order to assume her shift which began at 7:00 a.m. Respondent was Patient A's nurse on duty before Nurse Schmitt.

6. Nurse Schmitt entered Patient A's residence and observed that the refrigerator door was open in the kitchen and that there was melted ice cream and other food sitting on the counter of the kitchen island.

7. Nurse Schmitt heard Patient A calling out from his bedroom. She went to his room and he advised that he had been trying to wake Respondent since 5:00 a.m.

8. Nurse Schmitt found Respondent sleeping on the couch in the living room. She noted that Respondent was breathing normally and did not attempt to wake her. Nurse Schmitt contacted her supervisor, Kathleen Papa, to report the situation. Supervisor Papa advised that she would come to Patient A's house and instructed Nurse Schmitt to telephone 911.

9. Nurse Schmitt observed pill bottles and medications on the kitchen island, some belonging to Patient A and others did not.

10. Emergency medical technicians and deputies from the Waukesha County Sheriff's Department arrived at Patient A's residence.

11. Deputy Craig Siegel was one of the Waukesha County Sheriff's Department officers to respond to Patient A's residence. Upon his arrival at the residence, the Pewaukee Fire Department was already on scene. They had woken up Respondent. They were assessing Respondent and searching for overdose dangers or evidence of drug consumption in the apartment.

12. Deputy Siegel observed a purse located on the island area that contained identification of Respondent. Inside the purse, there were four (4) prescription bottles in the name of Respondent, several loose pills, an Altoids® tin box containing medications and a blue pill box containing medications.

13. Respondent advised that she had taken three (3) different types of allergy medications because her allergies were very bad, and that she must be suffering a reaction to the Sudafed® allergy medication.

14. The Pewaukee Fire Department responders completed their assessment and indicated they did not believe there was an emergency, and they allowed Respondent to sign off without being transported. Deputy Siegel noted that while they were speaking to Respondent, she appeared lethargic, her speech was slurred, and her pupils also appeared to be dilated. Deputy Siegel also noted that Respondent urinated on herself.

15. Deputy Siegel observed that the refrigerator door was open as well as most of the cabinets in the kitchen. There was a bottle of liquid codeine sitting on the counter with a dosing cup next to it that had been filled with a red liquid. Nurse Schmitt confirmed that this was Patient A's prescription. There was a bag on the kitchen island that contained some of Patient A's additional prescriptions and other medical accessories in it.

16. Deputy Siegel ran a check of Respondent for warrants, which resulted in a response that Respondent was wanted through the Greenfield Police Department for an ordinance violation. The warrant through Greenfield Police Department was confirmed. Respondent was placed under arrest for that warrant.

17. Respondent was placed in handcuffs and was advised she was under arrest. Respondent was escorted to Deputy Siegel's patrol vehicle, searched with negative results, and secured in the rear seat.

18. Deputy Siegel noted that Respondent's driving status is revoked, and her occupational license was also revoked. A tow truck responded to the scene and removed the vehicle.

19. Deputy Siegel notified Respondent's probation officer of the incident with the numerous pills present, which needed to be identified. The Probation Officer placed a hold on Respondent. Deputy Siegel transported Respondent to the Waukesha County Jail (Jail) to be held on the warrant through the Greenfield Police Department and the probation hold. Respondent was turned over to Jail staff.

20. Deputy Siegel returned to Patient A's residence to continue the investigation. Deputy Siegel was then contacted by Lieutenant Deering and advised that Deputy Siegel needed to return to the Jail and transport Respondent to Waukesha Memorial Hospital for medical care. When Deputy Siegel returned to the Jail, corrections officers advised that Respondent was not responding during their booking process and that she had fallen asleep while sitting on the toilet and had almost fallen off. Deputy Siegel then transported Respondent to Waukesha Memorial Hospital to the emergency department.

21. While escorting Respondent into the emergency department, she seemed unsteady on her feet and stumbled several times. Deputy Siegel was concerned Respondent would fall and had to hold onto her. In the police hold room in the emergency department, Respondent was secured to the bed. Respondent immediately fell asleep and started to snore.

22. A short time later, nurses and a physician's assistant arrived and performed a medical assessment on Respondent. They attempted to retrieve blood and urine samples from Respondent but Respondent advised she was not going to cooperate. The emergency department physician later advised that based on her condition, there was no need to force blood or urine and that Respondent was clear to return to the Jail. Deputy Siegel transported Respondent back to the Jail and turned her over to Jail staff.

23. Deputy Siegel returned to Patient A's residence to continue his investigation. On the kitchen island, he located the following bottle and medications:

a. An empty pill bottle for clonazepam 1 mg, filled on 4/25/16 at Walgreens, prescribed by Dr. Fernando Itable, filled with 60 tablets;

b. Five (5) orange capsules with the imprint "M. Amphet Salts 30 MG", identified as amphetamine-dextroamphetamine 30 mg;

c. Five (5) white pills with an imprint of "CTN 10," identified as cetirizine hydrochloride;

d. One round pill imprinted "1081 10MG", identified as montelukast sodium;

e. One capsule imprinted "5973-004," identified as acetaminophen, butalbital, caffeine; and

f. One sealed package containing ondansetron 4 mg.

24. Deputy Siegel located the following prescription bottles inside Respondent's purse which had her name on the bottles:

a. Alprazolam 1 mg, which was filled on 05/06/16 at Pick 'N Save Pharmacy, prescribed by Dr. Leonardo Aponte, filled with 60 tablets and there were two partial pills remaining;

b. Buspirone 15 mg, which was filled on 06/07/16 at Walgreens Pharmacy, prescribed by Dr. Fernando Itable, filled with 60 tablets and there were 32 ½ tablets remaining;

c. Gabapentin 300 mg, filled on 11/21/15 at Walgreens, prescribed by Dr. Fernando Itable, filled with 150 tablets and there were 23 remaining; and

d. Amphetamine-Dextroamphetamine 15 mg, filled on 05/16/16 at Pick 'N Save Pharmacy, prescribed at Dr. Leonardo Aponte, filled with 30 tablets and with two (2) of the 15 mg tablets remaining as well as two (2) orange pills identified as Adderall® XR which were 20 mg tablets.

25. Inside Respondent's purse, Deputy Siegel also located the following:

a. Three (3) pills that were sealed in their packaging and labeled as ondansetron 4 mg;

b. Three (3) round green pills imprinted "A 214," which were identified as Oxycodone HCL 15 mg;

c. Five (5) pseudoephedrine HCL 30 mg that were in their original packaging;

d. Two (2) pills with an imprint of "1P101," which were identified as gabapentin 100 mg;

e. One (1) blue pill with the imprint "RX904" which was identified as valacyclovir; and

f. One (1) round pill imprinted "1081 10MG", identified as montelukast.

26. Inside Respondent's purse, Deputy Siegel located the following medications in a blue pill sorting box:

a. One-half of a green round tablet, partial imprints of "8" and "0," identified as OxyContin® 80 mg;

b. One (1) yellow and white pill imprinted with "3238," identified as Strattera® 18 mg;

c. Five (5) clonazepam 2 mg tablets, identified by their imprint "C15";

d. One (1) acetaminophen oxycodone HCL tablet, identified by the imprint "4839V"; and

e. Four (4) tablets of one ondansetron 4MG, imprint of "G4."

27. The medications that Deputy Siegel located inside Respondent's purse in the Altoids® tin container were as follows:

a. One (1) white and brown pill with the imprint "A214," identified as oxycodone HCL 15 mg;

b. One (1) pill with the imprint "1081 10 MG," identified as montelukast sodium;

c. One (1) pill with the imprint of "ZA10 20MG," identified as omeprazole 20 mg; and

d. One (1) pill with the imprint "Watson 794 10MG," that was identified as dicyclomine HCL 10 mg.

28. Deputy Siegel performed all his research to identify the medications using the drugs.com website.

29. On July 7, 2016, Respondent telephoned Supervisor Papa to discuss the July 4, 2016, incident. Respondent apologized for falling into a deep sleep at work. Respondent stated that she may not have taken her prescription medications as prescribed.

30. In the course of the investigation by the Department, Investigator Nall obtained and reviewed the police report from the Waukesha County Sheriff's Department. The report revealed that several medications were found on the kitchen island in the home as well as in

Respondent's purse. The report identified each medication, some of which were controlled substances.

31. In the course of the investigation by the Department, Investigator Nall reviewed photographs from Supervisor Papa that were taken of the inside of Patient A's home. One of these photographs was an image of prescription bottles bearing Respondent's name.

32. Investigator Nall was able to discern some of the information from the bottles regarding the pharmacies that filled the prescriptions. Investigator Nall could identify one bottle being from Walgreen's Pharmacy and another from Pick 'n Save Pharmacy.

33. In the course of her investigation, Investigator Nall requested and received a certified copy of Respondent's prescription profile from Walgreen's Pharmacy (store numbers: 1685, 3394, 3509, 3666, 3738, 4350, 4774, 4888, 5417, 5601, 5823, 6020, 6058, 7568, 7661, 9606, 10196, 11237, 11344, and 12783) and a certified copy of Respondent's prescription profile from Pick 'n Save Pharmacies #6366 and #6845.

34. Investigator Nall compared the list of medications in the police report to Exhibits A and B, the prescription profiles that she received from Walgreen's and Pick 'n Save.

35. Four (4) medications were found in Respondent's purse, which were not associated with a valid prescription: clonazepam 2 mg, acetaminophen/oxycodone, oxycodone, and OxyContin®.

36. Based upon the above findings of fact contained in paragraphs 1 through 35, there is probable cause to believe that the Respondent has committed unprofessional conduct and that the public health, safety, or welfare imperatively requires emergency suspension of the Respondent's License to practice nursing in the State of Wisconsin, including the multi-state privilege to practice under the Nurse Licensure Compact.

CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. § 441.07, and has authority to summarily suspend the license of Respondent Dawn M. Jones, L.P.N., to practice nursing in the State of Wisconsin, including the multi-state privilege to practice under the Nurse Licensure Compact, pursuant to Wis. Stat. § 227.51(3) and Wis. Admin. Code ch. SPS 6.

2. Sufficient notice of this proceeding has been given to Respondent Dawn M. Jones, L.P.N., as required by Wis. Admin. Code § SPS 6.05.

3. Pursuant to Wis. Stat. § 961.16(2)(a)11., oxycodone is a schedule II controlled substance for which, under the circumstances at issue, a prescription is required pursuant to Wis. Stat. § 961.38(2).

4. OxyContin® is a form of oxycodone. Pursuant to Wis. Stat. § 961.16(2)(a)11., oxycodone is a schedule II controlled substance for which, under the circumstances at issue, a prescription is required pursuant to Wis. Stat. § 961.38(2).

5. There is probable cause to believe that Respondent Dawn M. Jones, L.P.N., has violated Wis. Stat. § 441.07 and Wis. Admin. Code § N 7.03(6)(e), by practicing nursing while under the influence of alcohol, illicit drugs, or while impaired by the use of legitimately prescribed pharmacological agents or medications.

6. There is probable cause to believe that Respondent Dawn M. Jones, L.P.N., has violated Wis. Stat. § 441.07 and Wis. Admin. Code § N 7.03(6)(f), by being unable to practice safely by reason of alcohol or other substance use.

7. There is probable cause to believe that Respondent Dawn M. Jones, L.P.N., has violated Wis. Stat. § 441.07 and Wis. Admin. Code § N 7.03(8)(e), by obtaining, possessing or attempting to obtain or possess a drug without lawful authority.

8. It is necessary to immediately suspend Respondent Dawn M. Jones, L.P.N.'s license to practice nursing in the State of Wisconsin, including the multi-state privilege to practice under the Nurse Licensure Compact, to protect the public health, safety, or welfare.

ORDER

1. That pursuant to Wis. Stat. §§ 227.51(3), 441.07, and Wis. Admin. Code ch. SPS 6, the license issued to Respondent Dawn M. Jones, L.P.N. (308097-31), to practice nursing in the State of Wisconsin, including the multi-state privilege under the Nurse Licensure Compact, is summarily SUSPENDED, effective immediately upon actual notice of this summary suspension order to Dawn M. Jones, L.P.N.; or upon service of this Order of Summary Suspension upon Dawn M. Jones, L.P.N., pursuant to Wis. Stat. § 801.11, whichever is sooner, and shall remain in effect until the effective date of a Final Decision and Order issued in a disciplinary proceeding against Respondent, unless otherwise ordered by the Wisconsin Board of Nursing.

2. A notice of hearing commencing disciplinary proceedings under Wis. Admin. Code § SPS 2.06 against Respondent Dawn M. Jones, L.P.N., shall be filed with the Division of Hearings and Appeals by the Department of Safety and Professional Services, Division of Legal Services and Compliance within ten (10) days of the issuance of this Order.

3. Respondent Dawn M. Jones, L.P.N., is hereby notified of her right, pursuant to Wis. Admin. Code § SPS 6.09, to request a hearing to show cause why this summary suspension order should not be continued and is further notified that any request for a hearing to show cause should be filed with the Wisconsin Board of Nursing, 1400 East Washington Avenue, P.O. Box 8366, Madison, Wisconsin 53708-8366.

4. In the event that Respondent Dawn M. Jones, L.P.N., requests a hearing to show cause why the summary suspension should not be continued, that hearing shall be scheduled to be heard on a date within 20 days of receipt by the Wisconsin Board of Nursing of Respondent's request for hearing, unless Respondent requests or agrees to a later time for the hearing.

WISCONSIN BOARD OF NURSING

By: _____
A Member of the Board

10/14/16
Date