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Before the
State Of Wisconsin
Board of Nursing

In the Matter of the Disciplinary Proceedings
Against Philip M. Lemon, Sr., L.P.N., Respondent.

FINAL DECISION AND ORDER
ORDER 0007411
Order No. _____

Division of Legal Services and Compliance Case No. 18 NUR 412

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 10 day of June, 2021.

Member
Board of Nursing

Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against PHILIP M. LEMON, SR., L.P.N., Respondent	DHA Case No. SPS-21-0011 DLSC Case Nos. 18 NUR 412

PROPOSED DECISION AND ORDER

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

Philip M. Lemon, Sr.
[redacted]
Tucson, AZ 85705
[redacted]

Philip M. Lennon, Sr.
[redacted]
Youngstown, OH 44505-4436

Philip M. Lemon, Sr.
[redacted]
Tomah, WI 54660

Wisconsin Board of Nursing
P.O. Box 8366
Madison, WI 53707-8366

Department of Safety and Professional Services,
Division of Legal Services and Compliance, by:

Attorney Alicia Kennedy
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190
Alicia.Kennedy@wisconsin.gov

PROCEDURAL HISTORY

The proceedings in this matter were initiated on February 12, 2021, when the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), filed a formal complaint against Respondent Philip M. Lemon, Sr., L.P.N., alleging that Respondent engaged in conduct qualifying as grounds for taking disciplinary action on his license pursuant to Wis. Admin. Code §§ N 7.03(6)(f) and 7.03(8)(d) and Wis. Stat. § 441.07(1g)(c) by being unable to practice safely by reason of alcohol or other substance use; by making errors in prescribing, dispensing, or administering medication; and by engaging in acts which show that he is unfit or incompetent by reason of negligence, abuse of alcohol or other drugs, or mental incompetency. Administrative Law Judge Sally Pederson (ALJ) was assigned to the matter.

The Notice of Hearing and the Complaint (Notice and Complaint) were served on Respondent by the Division on February 12, 2021. The Notice and Complaint were sent by both certified and regular mail. An Answer to the Complaint was to be filed within 20 days from the date of service of the Complaint. No Answer has been filed. Following expiration of the 20-day time period to file an Answer, the ALJ scheduled a telephone prehearing conference for March 18, 2021 at 10:00 a.m. Notice of the prehearing conference was sent to both parties that instructed Respondent to provide the ALJ with a telephone number no later than March 17, 2021, at which Respondent could be reached for the conference. Respondent failed to provide a telephone number. At the prehearing conference held on March 18, 2021, the ALJ called the Respondent twice, at approximately 10:05 a.m. and 10:20 a.m. Respondent did not answer the telephone either time, and there was no voicemail recording that allowed the ALJ to leave a message. An automated message read: "This number (608) 462-3478 cannot be reached." Based upon Respondent's failure to file an Answer to the Complaint and failure to appear at the prehearing conference, the Division moved for default pursuant to Wis. Admin. Code § SPS 2.14 and Wis. Admin. Code § HA 1.07(3)(c).

On March 22, 2021, the ALJ issued a Notice of Default against Respondent and ordered the Division to file a recommended proposed decision and order by April 19, 2021. The Division timely filed its submission.

FINDINGS OF FACT

Facts Related to the Alleged Violations

Findings of Fact 1-11 are taken from the Division's Complaint filed against Respondent in this matter.

1. Respondent Philip M. Lemon, Sr., L.P.N., (DOB [redacted] 1968) is licensed in the state of Wisconsin as a practical nurse, having license number 318806-31, first issued on September 29, 2014, and current through April 30, 2021. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is [redacted] Wisconsin 53704-7635.

2. Upon information and belief, Respondent current address is [redacted] Youngstown, Ohio 44505-4436.

3. At all times relevant to this proceeding, Respondent was employed as a licensed practical nurse at a medical facility (Facility), in Tomah, Wisconsin.

4. On December 10, 2016, Respondent smelled of alcohol upon arriving to work at the Facility. Respondent submitted to a breath alcohol test and was found to have a blood alcohol content of 0.074%. Respondent was suspended from duty from February 12, 2017 to February 25, 2017.

5. On January 15, 2017, Respondent asked another nurse "why a medication wouldn't scan (BCMA)."[1] Respondent had incorrectly removed oxycodone IR from the Omnicell instead of the physician-ordered oxycodone SR. The nurse assisted Respondent before the medication was given to the patient.

6. On January 15, 2017, Respondent incorrectly dispensed morphine oral solution 5mg/0.25ml to a patient. Respondent had not used BCMA appropriately because he had accessed the Omnicell three separate times, in violation of the Facility's policies. The dose that was ordered was 15mg, and 15 mg were removed from the Omnicell, but because Respondent did not use BCMA as required, the ordered dose could not be attributed to the correct patient.

7. On January 19, 2017, Respondent failed to administer four medications to a patient because he believed that the medications were not available. Another nurse informed Respondent that the medications were available in the other Omnicell down the hall and that pharmacy needed to be notified of the discrepancy. Respondent took no further action and did not document withholding or any other information regarding the medications in the electronic medical records.

8. On January 19, 2017, Respondent removed four times the ordered dose of morphine for a patient from the Omnicell. The physician order was for "morphine oral concentrate (20mg/ml) soln, instructions; 5mg/0.25ml oral q2h prn." Respondent documented administering 20mg of morphine.

9. On January 19, 2017, Respondent requested assistance from another nurse to document a discrepancy in the Omnicell regarding morphine-IR 15mg tablets. Respondent had accidentally pulled five tabs instead of four. However, there were other discrepancies for this medication from the same day involving Respondent that could not be reconciled from Respondent's documentation.

10. On February 28, 2017, Respondent's Nurse Manager met with Respondent and Respondent was restricted from working as an L.P.N. from February 28, 2017 to March 2, 2017 but was permitted to perform nursing assistant duties during the day shift, due to potential patient care concerns. Respondent received additional training and orientation. Respondent was restricted to an 8-hour workday, was assigned to work with registered nurse preceptors, and was required to report to the charge nurse. Respondent was placed on L.P.N. orientation on March 3, 2017.

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[1] BCMA stands for barcode medication administration.

11. On March 19, 2017, Respondent made an error in the administration of a medication to Patient A that led to a nursing assistant ingesting the medication. Respondent forgot to give the patient their folic acid 1 mg, and their gabapentin 125mg/2.5ml solution. Respondent mixed the crushed folic acid tablet and gabapentin solution into a bottle of Vitamin Water, which he believed belonged to Patient A. The nursing assistant later took a drink of the Vitamin Water and noticed that Respondent mistakenly mixed the patient's medications into her drink. Respondent did not follow appropriate BCMA procedure, documented that 5ml of gabapentin was given (which was double the ordered dose of gabapentin), did not validate the proper route, and incorrectly documented that the medication was given to the patient.

Facts Related to Default

12. The Notice of Hearing and the Complaint (Notice and Complaint) in this matter were served on Respondent by the Division on February 12, 2021, The Notice and Complaint were sent by both certified and regular mail.

13. An Answer to a Complaint was to be filed within 20 days from the date of service of the Complaint. No Answer has been filed.

14. Following expiration of the 20-day time period to file an Answer, the administrative law judge (ALJ) scheduled a telephone prehearing conference for March 18, 2021 at 10:00 a.m. Notice of this prehearing conference was sent to both parties, with instructions Respondent provide to the ALJ a telephone number at which Respondent could be reached for the conference no later than March 17, 2021. Respondent failed to provide a telephone number.

15. At the prehearing conference held on March 18, 2021, the ALJ called the Respondent twice, at approximately 10:05 a.m. and 10:20 a.m. Respondent did not answer to telephone either time, and there was no voicemail recording that allowed the ALJ to leave a message. An automated message read: "This number (608) 462-3478 cannot be reached."

16. Based upon Respondent's failure to file an Answer to the Complaint and failure to appear at the prehearing conference, the Division moved for default pursuant to Wis. Admin. Code § SPS 2.14 and Wis. Admin. Code § HA 1.07(3)(c).

17. On March 22, 2021, the ALJ issued a Notice of Default against Respondent and ordered that the Division file a recommended proposed decision and order by April 19, 2021.

18. The Division timely filed its recommended proposed decision and order.

DISCUSSION

Jurisdictional Authority

The Wisconsin Board of Nursing (Board) has jurisdiction over this matter pursuant to Wis. Stat. § 441.07(1c). Wisconsin Stat. § 440.03(1) provides that the Department "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. SPS 2.

Pursuant to Wis. Admin. Code § SPS 2.10(2), the ALJ has authority to preside over this disciplinary proceeding in accordance with Wis. Stat. § 227.46(1).

Default

The regulations that govern the procedures in these matters specific that the Department's service upon the Respondent by mail is complete upon mailing. Wis. Admin. Code § SPS 2.08(1). Here, the Division properly served the Notice and Complaint upon Respondent by mailing a copy to the address on file with the Department.

Under Wis. Admin. Code § SPS 2.14, if a respondent "fails to answer as required by s. SPS 2.09 or fails to appear at the hearing at the time fixed therefor, the respondent is in default and the disciplinary authority may make findings and enter an order on the basis of the complaint and other evidence." *See also* Wis. Admin. Code § HA 1.07(3)(c). Respondent violated Wis. Admin. Code § SPS 2.09(4) by failing to file an Answer to the Complaint within 20 days from the date of service. Respondent also failed to appear at the prehearing telephone conference on March 18, 2021 and failed to provide a current telephone number as ordered by the ALJ. Therefore, Respondent is in default, and findings and an order may be entered on the basis of the Complaint.

Violations

The Board has the authority to impose discipline against the Respondent pursuant to Wis. Stat. § 441.07. Following an investigation and disciplinary hearing, if the Board determines that a that a nurse has committed "[o]ne or more violations of this subchapter or any rule adopted by the board under the authority of this subchapter," or "[a]cts which show the registered nurse…to be unfit or incompetent by reason of negligence, abuse of alcohol or other drugs or mental incompetency," or has committed "[m]isconduct or unprofessional conduct," it may "revoke, limit, suspend or deny a renewal of a license of a registered nurse…." Wis. Stat. § 441.07(1g)(b), (c), and (d), respectively.

Pursuant to Wis. Admin. Code § N 7.03, the grounds for denying or taking disciplinary action on a license or certificate are any of the following:

(6) Unsafe practice or substandard care, including any of the following:

…

(f) Unable to practice safely by reason of alcohol or other substance use.

(8) Improper prescribing, dispensing, or administrating medication or drug related offenses, including any of the following:

...

(d) Error in prescribing, dispensing, or administering medication.

Pursuant to Wis. Stat. § 441.07(1g), the Board may deny an initial license or revoke, limit, suspend, or deny the renewal of a license...if the Board finds that the applicant or licensee committed any of the following:

(c) 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.

The facts in this matter are undisputed. On December 10, 2016, Respondent was intoxicated at work with a BAC of 0.074%. Respondent was suspended from his duties from February 12, 2017 to February 25, 2017. Respondent violated Wis. Admin. Code § N 7.03(6)(f) by being unable to practice safely by reason of alcohol or other substance use and Wis. Stat. § 441.07(1g)(c) by committing actions which show the licensed practical nurse to be unfit by reason of negligence, abuse of alcohol or other drugs, or mental incapacity.

Respondent also acted improperly on several occasions while at work with regard to the dispensation and administration of medications. For example, on January 15, 2017, Respondent incorrectly removed oxycodone IR from the Omnicell instead of the physician-ordered oxycodone SR. On January 15, 2017, Respondent incorrectly dispensed morphine oral solution 5mg/0.25ml to a patient.

On January 19, 2017, Respondent failed to administer four medications to a patient because he believed that the medications were not available. Respondent took no further action and did not document withholding or any other information regarding the medications in the electronic medical records. On that same date, Respondent also removed four times the ordered dose of morphine for a patient from the Omnicell and administered it to a patient. In addition, Respondent requested assistance from another nurse to document a discrepancy in the Omnicell regarding morphine-IR 15mg tablets because he had accidentally pulled five tabs instead of four.

On March 19, 2017, Respondent erred in the administration of a medication to Patient A that led to a nursing assistant ingesting the medication.

By engaging in the actions described above, Respondent violated Wis. Admin. Code § N 7.03(8)(d) by committing errors in prescribing, dispensing, or administering medication. Because he violated the rules of professional conduct, Respondent is subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b), (c), and (d), and Wis. Admin. Code § N 7.03.

Discipline

The three purposes of discipline in a professional misconduct case are: (1) to promote the rehabilitation of the credential holder; (2) to protect the public from other instances of misconduct; and (3) to deter other credential holders from engaging in similar conduct. *State v. Aldrich*, 71 Wis. 2d 206, 209, 237 N.W.2d 689 (1976).

The Division has recommended that Respondent's license and any appurtenant right to renew be revoked. The recommended discipline is consistent with the purposes articulated in *Aldrich.* Although promoting rehabilitation is one of the purposes of discipline, rehabilitation seems unlikely in this case. Having obtained no Answer from Respondent following the Notice and Complaint, and having failed to appear for the prehearing conference, the Board cannot determine whether any rehabilitative measures would be effective. Respondent's inactions and failure to cooperate demonstrate a lack of respect for Board authority.

Respondent's conduct was egregious and significantly endangers the public. "Protection of the public is the purpose of requiring a license." *State ex rel. Green v. Clark,* 235 Wis. 628, 631, 294 N.W. 25 (1940). When a license is granted to an individual, Wisconsin is assuring the public that the licensed individual is competent in his or her profession. *Stringez v. Dep't of Regulation & Licensing Dentistry Examining Bd.*, 103 Wis. 2d 281, 287 , 307 N.W.2d 664 (1981). It follows that if the state cannot assure the public of the licensee's competence to practice the profession, then revocation is appropriate. *Gilbert v. State Medical Examining Bd.*, 119 Wis. 2d 168, 189-90, 349 N.W.2d 68 (1984). Revocation of Respondent's license and any appurtenant right to renew are necessary to protect the public from other instances of misconduct. Registered nurses are licensed to care for the sick and injured, a vulnerable population. Respondent worked while intoxicated and made errors in the administration and dispensation of medications. Even after being suspended by his employer, Respondent continued to make medication errors, some of which could have been deadly.

Revocation is also necessary to deter other licensees from engaging in similar conduct. Diversion of controlled substances, exploitation of a vulnerable adult, and falsifying an application for licensure all constitute serious misconduct, which cannot be tolerated. Revocation of Respondent's right to renew will serve to deter others from committing similar violations. Revocation is an appropriate response to Respondent's disrespect for patient welfare, the law, and the licensing authority governing his profession.

Even though Respondent's license may expire before an order is entered, it is appropriate and necessary to impose discipline. Wisconsin Stat. § 440.08(3)(a) allows the holder of a credential to restore the credential even after expiration by simply paying the application renewal fee and a late renewal penalty of $25. The Department is empowered with the ability to promulgate rules requiring credential holders who have failed to renew the credential for five years to complete additional requirements to restore their licenses. *See* Wis. Stat. § 440.08(3)(b). Read together, these provisions have been interpreted by the Department to mean that credential holders retain a right to automatically renew their credentials within five years of expiration by simply paying the required fees. Thus, Respondent would have an automatic right to renew his license until February 27, 2026.

The fact that Respondent retains a right to renew makes the reasoning for discipline against active licensees equally appropriate for expired licensees.

Finally, the discipline imposed is consistent with prior Board decisions. *See In the Matter of Disciplinary Proceedings Against Rochelle A. Current, R.N.,* Board Order No. 06238 (June 13, 2019) (Board revoked nurse's right to renew her license pursuant to the Nurse Licensure Compact for misdemeanor convictions, failure to report convictions to the Board, and discipline in Arkansas);[2] *In the Matter of Disciplinary Proceedings Against Stephanie Y. Gaines, L.P.N.,* Board Order No. 04686 (April 29, 2016) (Board revoked nurse's right to renew her license and privilege to practice nursing pursuant to the Nurse Licensure Compact for failure to cooperate with Board's investigation after complaint that nurse took financial advantage of a patient and was convicted of forgery-uttering, unauthorized use of personal identifying information to obtain money, possession of narcotics and bail jumping);[3] *In the Matter of Disciplinary Proceedings Against Kelly L. Kowalkowski, R.N.,* Board Order 04613 (March 18, 2016) (Board revoked nurse's right to renew her license and privilege to practice nursing pursuant to the Nurse Licensure Compact for failure to cooperate with an investigation by the Board after being charged with several drug-related offenses).[4]

In light of the facts of this case, the factors set forth in *Aldrich*, and prior Board decisions, it is appropriate to revoke Respondent's license and any appurtenant right to renew his license to practice registered nursing in Wisconsin.

Costs

The Board is vested with discretion concerning whether to assess all or part of the costs of this proceeding against Respondent. *See* Wis. Stat. § 440.22(2). In exercising such discretion, the Board must look at aggravating and mitigating facts of the case; it may not assess costs against a licensee based solely on a "rigid rule or invocation of an omnipresent policy," such as preventing those costs from being passed on to others. *Noesen v. State Department of Regulation & Licensing, Pharmacy Examining Board,* 2008 WI App 52, ¶¶ 30-32, 311 Wis. 2d. 237, 751 N.W.2d 385. In previous orders, Boards have considered the following factors when determining if all or part of the costs should be assessed against the Respondent: (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, funded by other licensees; and (7) any other relevant circumstances. *See In the Matter of Disciplinary Proceedings Against Elizabeth Buenzli-Fritz,* LS0802183CHI (Aug. 14, 2008). It is within the Board's discretion as to which of these factors to consider, whether other factors should be considered, and how much weight to give any factors considered.

Considering the above factors, it is appropriate for Respondent to pay the full costs of the investigation and prosecution of these proceedings. Respondent defaulted, and the factual allegations have been deemed admitted. Respondent displayed dangerous and harmful behavior while practicing

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[2] *In the Matter of Disciplinary Proceedings Against Rochelle A. Current, R.N.,* Board Order No. 06238
[3] *In the Matter of Disciplinary Proceedings Against Stephanie Y. Gaines, L.P.N.,* Board Order No. 04686
[4] *In the Matter of Disciplinary Proceedings Against Kelly L. Kowalkowski, R.N.* Board Order 04613

nursing that put himself, his patients, and the public at risk. Finally, Respondent failed to provide current contact information to the ALJ, failed to appear at the prehearing conference, and failed to file an Answer to the Complaint or otherwise provide any argument regarding the allegations brought against his license to practice nursing. Consequently, there is no reason on record as to why Respondent should not bear assessment of full costs in this matter.

The Department is a program revenue agency whose operating costs are funded by the revenue received from credential holders. It would be unfair to impose the costs of pursuing discipline in this matter on those licensees who have not engaged in misconduct. Therefore, it is appropriate for Respondent to pay the full costs of the investigation and this proceeding, as determined pursuant to Wis. Admin. Code § SPS 2.18.

ORDER

For the reasons set forth above, IT IS ORDERED that the licensed and any appurtenant right to renew the Wisconsin licensed practical nurse license of Respondent, License No. 318806-31, is revoked.

IT IS FURTHER ORDERED that Respondent pay all recoverable costs 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 the Department Monitor at:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190, Madison, WI 53707-7190
Telephone (608) 267-3817; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

IT IS FURTHER ORDERED that the terms of the Order are effective the date the Final Decision and Order in this matter is signed by the Board.

Dated at Madison, Wisconsin, on May 7, 2021.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
4822 Madison Yards Way, 5th Floor North
Madison, Wisconsin 53705
Tel. (608) 266-7709
Email: Sally.Pederson@wisconsin.gov

By: _____
Sally J. Pederson
Senior Administrative Law Judge