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JUN 7 2021

DIV LEGAL SERVICES & COMPLIANCE
DEPT SAFETY & PROFESSIONAL SERVICES

Before the
State of Wisconsin
Board of Nursing

In the Matter of the Disciplinary Proceedings
Against Debra S. Murphy, R.N., Respondent.

FINAL DECISION AND ORDER

Ord ORDER 0007520

Division of Legal Services and Compliance Case Nos. 17 NUR 792, 18 NUR 300, and 19 NUR 672

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 12 day of August, 2021.

Member
Board of Nursing

Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against Debra S. Murphy, R.N., Respondent	DHA Case No. SPS-21-0016 DLSC Case Nos. 17 NUR 792, 18 NUR 300, and 19 NUR 672

PROPOSED DECISION AND ORDER

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

Debra S. Murphy, R.N.
7221 W. Sheridan Ave.
Milwaukee, WI 53218

Wisconsin Board of Nursing
P.O. Box 8366
Madison, WI 53708-8366

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

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

PROCEDURAL HISTORY

On February 26, 2021, the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), served the Notice of Hearing and the Complaint in this matter on Debra S. Murphy, R.N. (Respondent), by both certified mail and regular mail, consistent with Wis. Admin. Code § SPS 2.08(1).[1] The Division also emailed a copy of the Notice of Hearing and Complaint to the Respondent's email address on file with the Department on February 26, 2021. An answer to a complaint must be filed within 20 days from the date of service of the complaint. Wis. Admin. Code § SPS 2.09(4). No Answer was filed.

[1] The Division was informed that the copy served on the Respondent via certified mail was lost by the U.S. Postal Service. On April 16, 2021, the Department sent another copy to the Respondent via certified mail. The Postal Service attempted delivery of that copy on April 20, 2021, but no authorized recipient was available, and redelivery was not rescheduled by the Respondent.

Following the expiration of the 20-day period to file an Answer, Administrative Law Judge (ALJ) Kristin Frederic scheduled a telephone prehearing conference for April 5, 2021. The notice ordered the Respondent to contact the ALJ no later than April 2, 2021, to provide her current telephone number and stated that if the Respondent failed to appear at the scheduled conference, default judgment may be entered against her. The Respondent failed to contact the ALJ by April 2, 2021 with a contact number for the conference.

At the prehearing conference on April 5, 2021, the Respondent failed to appear. ALJ Angela Chaput Foy called the Respondent at the number that was on file with the Department three times without an answer and there was no ability to leave a voicemail message, and ALJ also emailed the Respondent and asked her to respond or the ALJ would entertain a motion for default. The Respondent failed to respond.

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

On April 6, 2021, the ALJ issued a Notice of Default against the Respondent and ordered that the Division file a recommended proposed decision and order by May 5, 2021. On April 21, 2021, the Division requested an extension to file its recommended proposed decision and order until May 19, 2021, and the ALJ granted the Division's request. The Division filed its Proposed Decision and Order timely within the extension.

FINDINGS OF FACT

Facts Related to the Alleged Violations

1. The Respondent Debra S. Murphy, R.N., is licensed in the state of Wisconsin as a registered nurse, having license number 139341-30, first issued on September 21, 2001, and current through February 28, 2022.

2. At the time if filed the Complaint, the Respondent's most recent address on file with the Department was 7221 West Sheridan Avenue, Milwaukee, Wisconsin 53218.

DLSC Case Nos. 02 NUR 291 and 03 NUR 226 (Board Order No. LS0509082NUR)

3. On March 9, 2006, the Board of Nursing (Board) suspended the Respondent's registered nurse license and placed her under a five-year monitoring order for using cocaine while pregnant, causing the death of her unborn child.

4. On February 3, 2011, the Board granted full reinstatement of the Respondent's license.

DLSC Case 17 NUR 792

5. At all times relevant to this proceeding, the Respondent was the owner and operator of an adult family home (AFH) located in Milwaukee, Wisconsin.

6. Resident A, a cognitively impaired male born in 1997, was placed in the Respondent's AFH. The Respondent received compensation for Resident A's care, supervision, and room and board.

7. Between February 1, 2017 and May 31, 2017, the Respondent was paid $2,664 for Resident A's room and board, and $10,320 for Resident A's care and supervision. The Respondent billed Resident A's case management organization every day during this period for Resident A's care and supervision.

8. Between March 20, 2017 and May 22, 2017, Resident A's case manager contacted the Respondent multiple times to set up home visits with Resident A. The Respondent repeatedly cancelled scheduled visits or told the case manager that Resident A was not at the AFH, but that she would contact him and set up the home visit.

9. The Respondent told the case manager that Resident A "is here at night, sometimes. He comes and goes." The Respondent maintained no sign-out sheet or plan if Resident A did not return to the AFH.

10. On May 17, 2017, the case manager made an unannounced home visit to the AFH, but nobody was there. The Respondent later reported that Resident A was last at the AFH on May 12, 2017.

11. On June 1, 2017, Resident A was transitioned to another facility.

DLSC Case 18 NUR 300

12. At all times relevant to this proceeding, the Respondent was employed as an agency nurse assigned to an assisted living facility in Milwaukee, Wisconsin.

13. On the morning of April 29, 2018, the Respondent was observed falling asleep while reporting to another nurse during a shift change. During the shift-to-shift narcotic count, the Respondent retroactively filled in several controlled substance sheets for multiple residents because the counts were off.

14. The facility investigated and discovered the following discrepancies in the Respondent's medication administration:

a) On April 29, 2018, one of Resident A's oxycodone IR 5mg tablets was unaccounted for. The Respondent said she may have missed a pill because it was dark during the count.

b) The Respondent signed out for Resident B one oxycodone IR 5mg tablet on April 20, 2018 at 1:20 a.m., one oxycodone IR 5mg tablet on April 28, 2018 at 4:00 p.m., and one oxycodone IR 5mg tablet on April 28, 2018 at an undocumented time. Resident B's order for oxycodone had been discontinued as of March 14, 2018.

c) The Respondent signed out for Resident C one lorazepam 0.5mg tablet on April 28, 2018 at 8:00 p.m. and one lorazepam 0.5mg tablet on April 29, 2018 at 4:00 a.m. The Respondent did not chart any administration of lorazepam tablets to Resident C during the month of April.

d) The Respondent signed out one Lyrica 50mg capsule for Resident D on April 28, 2018 at 8:00 p.m., but did not chart administration to Resident D.

e) The Respondent signed out one hydromorphone 4mg tablet for Resident E on April 28, 2018 at 3:15 p.m. and at 10:00 p.m., but did not chart administration to Resident E.

f) The Respondent signed out one tramadol 50mg tablet for Resident F on April 28, 2018 at 8:00 p.m., but did not chart administration to Resident F.

15. On April 29, 2018, the facility asked the Respondent to go to a hospital and submit to a urine drug screen. The Respondent did not submit to a drug screen until the next afternoon, the results of which were negative.

DLSC Case 19 NUR 672

16. At all times relevant to this proceeding, the Respondent was employed as a registered nurse at a nursing home in Milwaukee, Wisconsin.

17. On October 7, 2019, the Respondent signed out one oxycodone 5mg tablet for Resident A at 9:27 p.m. but did not chart administration to Resident A.

18. On October 8, 2019, the Respondent signed out one oxycodone 5mg tablet for Resident A at 4:00 a.m. but did not chart administration to Resident A.

19. On October 12, 2019, the Respondent signed out one oxycodone 5mg tablet for Resident A at 8:00 p.m. but did not chart administration to Resident A.

20. Resident A's prescription for oxycodone had been discontinued on September 5, 2019.

Facts Related to Default

21. On February 26, 2021, the Notice of Hearing and Complaint were served on the Respondent at her last known address on file with the Department by both certified and first-class mail.

22. On February 26, 2021, the Division also emailed a copy of the Notice of Hearing and Complaint to the Respondent at her last known email address on file with the Department.

23. Neither the copy of the Notice of Hearing and Complaint served on the Respondent by regular, first-class mail or the copy emailed to the Respondent were returned to the Division.

24. The Respondent failed to file an Answer to the Complaint.

25. After the expiration of the 20-day period to file an Answer, the ALJ scheduled a telephone prehearing conference for April 5, 2021. The ALJ sent notice of the conference by U.S. mail to the Respondent. The notice ordered the Respondent to contact the ALJ no later than April 2, 2021 to provide her current telephone number and stated that if the Respondent failed to appear at the scheduled conference, default judgment may be entered against her.

26. The Respondent failed to contact the ALJ by April 2, 2021 with her current telephone number.

27. At the prehearing conference on April 5, 2021, the Respondent failed to appear. The ALJ called the Respondent's telephone number on file with the Department three times without an answer and there was no ability to leave a voicemail message. The ALJ also sent an email to the Respondent at the email address on file with the Department and asked her to respond or the ALJ would entertain a motion for default. The Respondent failed to respond.

28. On April 5, 2021, the Division moved for default judgment based on the Respondent's failure to answer the complaint and failure to appear for the prehearing conference pursuant to Wis. Admin. Code §§ SPS 2.14 and HA 1.07(3)(c).

29. On April 6, 2021, the ALJ issued a Notice of Default and ordered that the Division file and serve a recommended proposed decision and order by May 5, 2021.

30. On April 21, 2021, the Division requested an extension to file its recommended proposed decision and order until May 19, 2021. The ALJ granted the Division's request.

31. The Division filed its recommended Proposed Decision and Order timely within the extension.

DISCUSSION

Jurisdictional Authority

The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. § 441.07(1c). 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." Wis. Stat. § 440.03(1). These rules are codified in Wis. Admin. Code ch. SPS 2.

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

Default

The Division properly served the Notice of Hearing and Complaint upon the Respondent by mailing copies to her at her last known address. Service by mail is complete upon mailing. Wis. Admin. Code § SPS 2.08(1). Certified mailing is not required. *See id.*

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." Wis. Admin. Code § SPS 2.14; *see also* Wis. Admin. Code § HA 1.07(3)(c).

Here, the 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. The Respondent also failed to appear at the prehearing telephone conference on April 5, 2021. Therefore, the Respondent is in default, and findings and an order may be entered based on the Complaint.

Violations

The Board has the authority to impose discipline against the Respondent pursuant to Wis. Stat. § 441.07 and Wis. Admin. Code Ch. N 7. Subject to the rules promulgated under Wis. Stat. § 440.03(1), the Board may "revoke, limit, suspend, or deny an initial license or revoke, limit, suspend, or deny the renewal of a license of a registered nurse...if the board finds that the applicant or licensee committed" one or more violations of this subchapter or any rule adopted by the Board, or misconduct or unprofessional conduct. Wis. Stat. § 441.07(1g)(b) and (d).

Wisconsin Administrative Code § N 7.03 identifies the grounds for taking disciplinary action on a nursing license, which include:

a. Fraud, deception, or misrepresentation, including...[e]ngaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws or state laws. Wis. Admin. Code § N 7.03(5)(c).
b. Unsafe practice or substandard care, including...[d]eparting from or failing to conform to the minimal standards of acceptable nursing practice that may create unnecessary risk or danger to a patient's life, health, or safety. Actual injury to a patient need not be established. Wis. Admin. Code § N 7.03(6)(c).
c. Improper prescribing, dispensing, or administering medication or drug related offenses, including... [e]rror in prescribing, dispensing, or administering medication. Wis. Admin. Code § N 7.03(8)(d).

The Respondent violated Wis. Admin. Code § N 7.03(5)(c) by engaging in abusive or fraudulent billing practices. The Respondent was the owner and operator of an AFH where Resident A, a cognitively impaired male, was placed. Between February 1, 2017 and May 31, 2017, the Respondent billed Resident A's case management organization every day for Resident A's care and supervision, and room and board, even though Resident A was not present at the AFH every day. Between March 20, 2017 and May 22, 2017, Resident A's case manager

contacted the Respondent multiple times to set up home visits and the Respondent repeatedly cancelled the home visits or told the case manager that Resident A was not at the AFH. The Respondent told the case manager that Resident A "is here at night, sometimes. He comes and goes." On May 17, 2017, Resident A's case manager made an unannounced home visit to the AFH, but nobody was there. The Respondent later reported that Resident A was last at the AFH on May 12, 2017.

The Respondent violated both Wis. Admin. Code §§ N 7.03(6)(c) and (8)(d) by departing from or failing to conform to the minimal standards of acceptable nursing practice that may create unnecessary risk or danger to a patient's life, health, or safety, and committing errors in dispensing and administering medications, respectively. On April 29, 2018, the Respondent was observed falling asleep during a shift change while employed. During the shift-to-shift narcotics count, the Respondent retroactively filled in several controlled substance sheets for multiple residents because the counts were off. The facility investigated and discovered many discrepancies in the Respondent's medication administration during April 2018, including a missing oxycodone tablet, signing out oxycodone for a resident whose order had been discontinued, and signing out tramadol, lorazepam, hydromorphone, and Lyrica for various patients but failing to chart their administration. The Respondent was asked to submit to a urine drug screen but did not do so until the following day when the results were negative. In October 2019, at a subsequent facility, the Respondent signed out an oxycodone tablet for a resident on three separate occasions, even though the resident's prescription order had been discontinued, and failed to chart administration to the resident.

The Respondent's medication administration and dispensing errors created unnecessary risk to the health and safety of multiple patients and do not conform to the minimal standards of acceptable nursing practice. Retroactively filling in controlled substance sheets, failing to account for missing narcotics, signing out controlled substances for patients whose prescriptions were discontinued, and failing to chart medication administration to patients is negligent and creates a medical record that is incomplete or inaccurate. If the patient's medical record is not accurate in medication administration, the next provider who reviews it will not have all the information necessary to provide care and may administer too much or too little medication to the patient, causing potential harm.

The Respondent's medication-related errors at two different facilities also indicate signs of potential diversion of controlled substances by Respondent. The Respondent refused to submit to a urine drug screen when requested to do so and only agreed to submit to a urine drug screen the following day. While no positive test was obtained, the Respondent's continued behavior of signing out controlled substances for patients whose orders were discontinued and then failing to chart any administration to those patients may indicate the Respondent is diverting the controlled substances for her own use.

By violating these rules of professional conduct, the Respondent is subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b) and (d), and Wis. Admin. Code Ch. N 7.

Discipline

The Division recommends that the Respondent's license to practice as a registered nurse be suspended until the Respondent provides proof to the Board that she has completed an Alcohol and Other Drug Abuse (AODA) assessment, four hours of education on proper medical documentation, and four hours of education on professional ethics, pursuant to the terms and conditions of the Order below.

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). "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).

The recommended discipline is consistent with the purposes articulated in *Aldrich*. The Division received three separate complaints against the Respondent, all of which contained serious allegations of unprofessional conduct. By the Respondent's default, the facts are undisputed. The Respondent engaged in abusive and fraudulent billing practices at her own AFH and fell below the minimum standard of nursing practice by failing to properly document medication administration. The Respondent additionally engaged in behavior consistent with diversion as she was observed sleeping during shift, refused to submit to a urine drug screen when requested, and has exhibited a pattern of medication discrepancies at multiple facilities. Suspending the Respondent's license until she can provide proof that she has completed an AODA assessment by a pre-approved evaluator is necessary to protect public safety. Requiring the Respondent to undergo an independent AODA assessment and granting the Board authority to further limit the Respondent's license depending upon the results, ensures that the public is protected from further instances of misconduct. Likewise, ordering the Respondent to complete additional education on proper medication administration and professional ethics will promote her rehabilitation and deter other credential holders from engaging in similar misconduct.

The recommended discipline is consistent with Board precedent. *See In the Matter of Disciplinary Proceedings Against Jennifer C. Jondreau, R.N.*, Order Number 0006712 (March 12, 2020) (nurse's license was suspended until she completed an AODA assessment, a fitness-to-practice evaluation, and education for being disciplined in Minnesota for discrepancies in controlled substance administration, including failing to document administration)[2]; *In the Matter of Disciplinary Proceedings Against Julie A. Tews, R.N.*, Order Number 0007255 (March 11, 2021) (nurse's license was suspended until she completed a fitness-to-practice evaluation for departing from or failing to conform to the minimal standards of acceptable nursing practice and being unable to practice safely by reason of psychological impairment);[3] and, *In the Matter of Disciplinary Proceedings Against Eric L. Nielsen, R.N.*, Order Number 0003901 (April 9, 2015) (nurse's license was suspended for at least six months or until he could prove he was amenable to rehabilitation for fraudulently billing Medicaid for nursing services he did not provide).[4]

[2] https://online.drl.wi.gov/decisions/2020/ORDER0006712-00016487.pdf.
[3] https://online.drl.wi.gov/decisions/2021/ORDER0007255-00017511.pdf.
[4] https://online.drl.wi.gov/decisions/2015/ORDER0003901-00011145.pdf.

Considering the facts of this case and the factors set forth in *Aldrich,* suspending the Respondent's license until she provides proof to the Board that she has completed an AODA assessment, four hours of education on proper medical documentation, and four hours of education on professional ethics, pursuant to the terms and conditions of the Order below, is reasonable and warranted.

Costs

The Board has discretion to assess all or part of the costs of these proceedings against the 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 a 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 to decide 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 the Respondent to pay the full costs of the three Division investigations and of these proceedings. The Respondent defaulted and the factual allegations identified in this decision were deemed admitted. The Respondent's actions of unprofessional conduct were serious, involving the health and safety of her patients and fraudulently billing for services she did not provide. Finally, the 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 her license to practice as a registered nurse in Wisconsin.

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 the 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 license to practice as a registered nurse in the state of Wisconsin issued to the Respondent Debra S. Murphy, R.N. (License No. 139341-30), is SUSPENDED for an indefinite period.

The privilege of the Respondent to practice as a registered nurse in the state of Wisconsin under the authority of another state's license pursuant to the Enhanced Nurse Licensure Compact (Compact) is also SUSPENDED for an indefinite period.

The suspension of the Respondent's Wisconsin registered nursing license may be STAYED upon the Respondent petitioning the Board and providing proof, which is determined by the Board, or its designee, to be sufficient that the Respondent complies with the following provisions:

a. Within ninety (90) days of the date of this Order, the Respondent shall, at her own expense, undergo and complete an Alcohol and Other Drug Abuse assessment with an evaluator pre-approved by the Board or its designee who has experience conducting these assessments (Evaluator).

   i. Prior to the assessment, the Respondent shall provide a copy of this Order to the Evaluator. The Respondent shall provide the Department Monitor (listed below) with written acknowledgment from the Evaluator that a copy of this Order has been received by the Evaluator. Such acknowledgment shall be provided to the Department Monitor prior to the assessment.

   ii. The Respondent shall provide and keep on file with the Evaluator current releases complying with state and federal laws. The releases shall allow the Board, its designee, and any employee of the Department of Safety and Professional Services, Division of Legal Services and Compliance to obtain a copy of the assessment. Copies of these releases shall immediately be filed with the Department Monitor.

   iii. The Respondent shall identify and provide the Evaluator with authorizations to communicate with all physicians, mental health professionals, and facilities at which the Respondent has been treated or evaluated.

   iv. The Board, or its designee, may impose additional limitations upon the Respondent's license based on the results of the assessment and/or the Evaluator's recommendations.

   v. The Respondent shall comply with the Evaluator's recommendations.

   vi. The Respondent is responsible for ensuring that the results of the evaluation are sent to the Department Monitor at the address below.

b. Within ninety (90) days of the date of this Order, the Respondent shall, at her own expense, successfully complete four hours of education on the topic of

professional ethics and four hours of education on the topic of proper medical documentation:

i. The Respondent shall be responsible for locating and obtaining the course(s) required under this Order, for providing adequate course descriptions to the Department Monitor listed below, and for obtaining pre-approval of the course(s) from the Board of Nursing, or its designee, prior to commencement of the course(s).

ii. The Board's monitoring liaison may change the number of credit hours and/or education topics in response to a request from the Respondent. The monitoring liaison may consider the topic availability and/or hours of education when determining if a change to the ordered education should occur.

iii. The Respondent shall submit proof of successful completion of the education in the form of verification from the institution providing the education to the Department Monitor at the address stated below.

iv. None of the education completed pursuant to this requirement may be used to satisfy any continuing education requirements that have been or may be instituted by the Board or Department, and they also may not be used in future attempts to upgrade a credential in Wisconsin.

Pursuant to the Nurse Licensure Compact, the Respondent may not practice in another Compact State, other than Wisconsin, while their license is encumbered by any term or restriction of this Order.

IT IS FURTHER ORDERED that in addition to any other action authorized by this Order or by law, the Board, in its discretion, may impose additional limitations or pursue separate disciplinary action for violation of any term of this Order.

IT IS FURTHER ORDERED that the Respondent pay all recoverable costs in these matters 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 address below:

Department Monitor
Division of Legal Services and Compliance
Department of Safety and Professional Services
P.O. Box 7190, Madison, WI 53707-7190
Telephone (608) 266-2112; Fax (608) 266-2264
DSPSMonitoring@wisconsin.gov

The Respondent may also submit this information online at: https://dspsmonitoring.wi.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 this 26th day of May, 2021.

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

By: _____
Angela Chaput Foy
Administrative Law Judge