WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER WITH VARIANCE
	:	ORDER 0007709
TIFFANY GIMENEZ, L.P.N., RESPONDENT.	:	DHA Case No. SPS-21-0056
	:	DLSC Case No. 20 NUR 529

BACKGROUND

On October 6, 2021, Administrative Law Judge Kristin Frederick, State of Wisconsin, Division of Hearings and Appeals, issued a Proposed Decision and Order (PDO) in the above referenced matter. The PDO was mailed to all parties. The parties did not file any objections to the PDO. On November 11, 2021, the Board of Nursing (Board) delegated consideration of the merits of the PDO to the Department of Safety and Professional Services' Chief Legal Counsel Aloysius Rohmeyer. Pursuant to this delegation of authority, Chief Legal Counsel Rohmeyer determined it was appropriate to approve the PDO with a variance. The PDO is attached hereto and incorporated in its entirety into this Final Decision and Order with Variance (Order).

VARIANCE

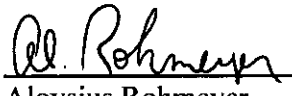
Pursuant to Wis. Stat. §§ 440.035(1) and 441.07, the Board is the regulatory authority and final decision maker governing disciplinary matters of those credentialed by the Board. The matter at hand is characterized as a class 2 proceeding pursuant to Wis. Stat. § 227.01(3). The Board may make modifications to a PDO, a class 2 proceeding, pursuant to Wis. Stat. § 227.46(2). In the present case, the Board adopts the PDO in its entirety and amends the "ORDER" section of the PDO to add the following:

IT IS FURTHER ORDERED that pursuant to Wis. Stat. § 441.51(5)(b), Respondent's multistate licensure privilege to practice in all Compact states besides Wisconsin is deactivated during the pendency of this Order.

The Board finds that this addition is necessary to bring this order into compliance with the requirements of the Nursing Licensure Compact statute (Wis. Stat. § 441.51(5)(b)).

Dated at Madison, Wisconsin this 3rd day of December 2021.

WISCONSIN BOARD OF NURSING

By: 

Aloysius Rohmeyer
Chief Legal Counsel
Department of Safety and Professional Services

Before The
State of Wisconsin
DIVISION OF HEARINGS AND APPEALS

In the Matter of Disciplinary Proceedings Against Tiffany Gimenez, L.P.N., Respondent	DHA Case No. SPS-21-0056 DLSC Case No. 20 NUR 529

PROPOSED DECISION AND ORDER

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

Tiffany Gimenez, L.P.N.
143 Water St., Apt. 100
Berlin, WI 54923

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 June 18, 2021, the Department of Safety and Professional Services, Division of Legal Services and Compliance (Department), filed a formal complaint alleging the following grounds for taking disciplinary action against Respondent Tiffany Gimenez, L.P.N.: (1) failing to cooperate in a timely manner with the Board of Nursing's (Board) investigation of a complaint filed against a license holder, pursuant to Wis. Admin. Code § N 7.03(1)(c); (2) failing to report to a nursing assignment without properly notifying appropriate supervisory personnel and ensuring the safety and welfare of the patient or client, pursuant to Wis. Admin. Code § N 7.03(6)(d); (3) dispensing any drug other than in the course of legitimate practice or as otherwise prohibited by law, pursuant to Wis. Admin. Code § N 7.03(8)(b); (4) committing an error in dispensing or administering medication, pursuant to Wis. Admin. Code § N 7.03(8)(d); and, (5) obtaining, possessing or attempting to obtain or possess a drug without lawful authority, pursuant to Wis. Admin. Code § N 7.03(8)(e). This matter was originally assigned to Administrative Law Judge (ALJ) Andrea E.

Brauer. Following the expiration of the 20-day time period to file an Answer, ALJ Brauer scheduled a telephone prehearing conference for August 4, 2021. ALJ Brauer sent notice of the conference to Respondent with instructions to contact ALJ Brauer no later than August 3, 2021, to provide her current telephone number. The notice also stated that if Respondent failed to appear at the scheduled conference, default judgment may be entered against her.

Respondent failed to contact ALJ Brauer by August 3, 2021, with her current telephone number and failed to appear at the prehearing conference on August 4, 2021. The Department provided ALJ Brauer with Respondent's telephone number on file with the Department. ALJ Brauer attempted to call Respondent at that number twice, but each time received a message that the telephone number was not active, and the call could not be completed as dialed. On August 4, 2021, the Department moved for default based on Respondent's failure to file an Answer to the Complaint and failure to appear at the prehearing telephone conference, pursuant to Wis. Admin. Code §§ SPS 2.14 and HA 1.07(3)(c). ALJ Brauer issued a Notice of Default against Respondent and ordered the Department to file a recommended proposed decision and order by September 7, 2021. The Department timely filed its recommended proposed decision and order.

The matter was subsequently reassigned to ALJ Kristin P. Fredrick and on September 7, 2021. ALJ Fredrick sent an email to the parties advising of the reassignment, confirming her office's receipt of the Department's recommended proposed decision and order, and further confirming no response from the Respondent to either the Notice of Default and Order or the Department's recommended proposed decision. ALJ Fredrick requested that the Respondent provide a response within ten days; however, no response was received.

FINDINGS OF FACT

Facts As Alleged in the Complaint

1. Respondent Tiffany Gimenez, L.P.N., is licensed in the state of Wisconsin as a licensed practical nurse with multistate privileges pursuant to the Enhanced Nurse Licensure Compact (Compact), having license number 318357-31, first issued on June 16, 2014, and current through April 30, 2021.[1]

2. Respondent's most recent address on file with the Department is 143 Water Street, Apartment 100, Berlin, Wisconsin 54923.

3. Pursuant to a complaint filed with the Department in October 2020, the Department became aware of a secondary address for the Respondent's located at 124 Park Lane, Berlin, Wisconsin 54923.

[1] Respondent's license was set to expire on April 30, 2021. However, due to Governor Evers' Emergency Order 2, all health care provider licenses will not expire until thirty days after Emergency Order 2 is no longer in effect. Therefore, Respondent's license remains "Active" despite the fact she has not completed any of the renewal requirements to date. Pursuant to Wis. Stat. § 440.08(3), Respondent retains the right to renew her license upon payment of a fee until April 30, 2026.

4. At all times relevant to this proceeding, Respondent was employed as a licensed practical nurse at a nursing home in Weyauwega, Wisconsin (Facility).

5. On October 12, 2020, the Department received a complaint from the Facility alleging that Respondent signed out narcotics for residents on days she was not scheduled to work.

6. On October 1, 2020, the Facility conducted a review of its controlled drug receipt/record/disposition forms and discovered the following discrepancies with Respondent's medication dispensing and administration:

a) On September 4, 2020, Respondent signed out four hydrocodone/APAP 10-325mg tablets for Resident D.H. Respondent was not on the schedule and did not work on September 4, 2020.

b) Resident S.V. had a prescription order for oxycodone 5mg, one tablet every four hours as needed. Resident S.V. was administered one tablet per day by other nurses until September 5, 6, and 7, 2020, when Respondent signed out four tablets each day for Resident S.V. On September 19, 2020, Respondent signed out five tablets for Resident S.V.

c) On September 11, 2020, Respondent signed out one hydrocodone/APAP 5-325mg tablet for Resident E.M. Respondent was not on the schedule and did not work on September 11, 2020.

d) On September 17 and 18, 2020, Respondent signed out one and two oxycodone 5mg tablets, respectively, for Resident J.O. Respondent was not on the schedule and did not work on September 17 and 18, 2020.

e) On September 18, 2020, Respondent signed out three oxycodone 5mg tablets for Resident B.M. Respondent was not on the schedule and did not work on September 18, 2020.

f) On September 18, 2020, Respondent signed out three oxycodone 5mg tablets for Resident C.F. Respondent was not on the schedule and did not work on September 18, 2020.

g) On September 26, 2020, Respondent signed out two hydrocodone/APAP 7.5-325mg tablets for Resident B.A., but then crossed out the entry and wrote "error." The two tablets remained unaccounted for.

7. The Facility attempted to contact Respondent on October 2 and 6, 2020, but Respondent did not reply.

8. Respondent did not report to the Facility for her scheduled shifts on October 3 and 4, 2020.

9. On November 2 and 11, 2020, the Department sent an email to Respondent at her email address on file with the Department requesting her response to the allegations. Respondent failed to respond.

10. On November 20, 2020, the Department sent a letter to Respondent to her last known mailing address on file with the Department, 143 Water Street, Apartment 100, Berlin, Wisconsin, requesting her response to the allegations. The U.S. Postal Service returned the letter to the Department with a forwarding address of 124 Park Lane, Berlin, Wisconsin, which is the same address identified in paragraph 3.

11. On December 1, 2020, the Department sent a letter to Respondent at the second address of 124 Park Lane, Berlin, Wisconsin, requesting her response to the allegations. Respondent failed to respond.

12. On January 15, 2021, the Department sent another email and letter to Respondent at her email address on file, as well as, the second address of 124 Park Lane, Berlin, Wisconsin, requesting her response to the allegations. Respondent once again failed to respond.

13. Respondent has failed to respond to the allegations against her and to the Department's attempts to contact her on behalf of the Board of Nursing.

Facts Related to Default

14. On June 18, 2021, the Department served the Notice of Hearing and Complaint on Respondent by mailing the Notice and Complaint by both certified and regular first-class mail to both of the Respondent's previously identified addresses of 143 Water Street, Apt. 100, Berlin, Wisconsin and 124 Park Lane, Berlin, Wisconsin, pursuant to Wis. Admin. Code § SPS 2.08 and Wis. Stat. § 440.11(2). (Affidavit of Service ¶ 3(a)-(d)).

15. The Notice of Hearing and Complaint sent to the Respondent via certified mail at the Respondent's address located at 143 Water Street, Apt. 100, Berlin, Wisconsin was returned by the U.S. Postal Services marked "Return to Sender" and "Unable to Forward." However, the copies of the Notice and Complaint sent via regular mail to both addresses, as well as the copy sent via certified mail to the Respondent's address listed at 124 Park Lane, Berlin, Wisconsin, were not returned to the Department.

16. Respondent was required to file an Answer within 20 days from the date of service of the Complaint, pursuant to Wis. Admin. Code § SPS 2.09(4). Respondent failed to file an Answer to the Complaint by July 8, 2021.

17. After the expiration of the 20-day time period to file an Answer, ALJ Brauer scheduled a telephone prehearing conference for August 4, 2021. ALJ Brauer sent notice of the conference to Respondent with instructions to contact ALJ Brauer no later than August 3, 2021, to provide her current telephone number. The notice also stated that if Respondent failed to appear at the scheduled conference, default judgment may be entered against her.

18. Respondent failed to contact ALJ Brauer by August 3, 2021, with her current telephone number.

19. Respondent failed to appear at the prehearing conference on August 4, 2021. The Department provided ALJ Brauer with Respondent's telephone number on file with the Department. ALJ Brauer attempted to call Respondent at that number twice, but each time received a message that the telephone number was not active, and the call could not be completed as dialed.

20. On August 4, 2021, the Department moved for default judgment based on Respondent's failure to file an Answer to the Complaint and failure to appear at the prehearing telephone conference, pursuant to Wis. Admin. Code §§ SPS 2.14 and HA 1.07(3)(c).

22. On August 4, 2021, ALJ Brauer issued a Notice of Default against Respondent and ordered the Department to file a recommended Proposed Decision and Order by September 7, 2021. According to the Notice, "[i]n light of Respondent's failure to file an Answer to the Complaint and failure to appear for the prehearing conference, the ALJ finds Respondent to be in default."

23. The Department timely filed its recommended Proposed Decision and Order.

DISCUSSION

Jurisdictional Authority

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). The Board has the authority to impose discipline against the Respondent pursuant to Wis. Stat. § 441.07(1g).

Default

The Department properly served the Notice of Hearing and Complaint upon Respondent by mailing copies to her at her last known addresses. Wis. Stat. § 440.11(2). Service by mail is complete upon mailing. Wis. Admin. Code § SPS 2.08(1).

An answer to a complaint shall be filed within 20 days from the date of service of the complaint. Wis. Admin. Code § 2.09(4). 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.

For a telephone prehearing, the administrative law judge may find a failure to appear grounds for default if any of the following conditions exist for more than ten minutes after the scheduled time for prehearing conference: (1) the failure to provide a telephone number to the ALJ after it had been requested; (2) the failure to answer the telephone; (3) the failure to free the line

for the proceeding; and (4) the failure to be ready to proceed with the prehearing conference as scheduled. Wis. Admin. Code § HA 1.07(3)(c).

Here, Respondent failed to file an Answer to the Complaint within 20 days from the date of service, failed to appear at the prehearing telephone conference on August 4, 2021, failed to provide a telephone number to the ALJ after it had been requested, failed to answer the telephone when the ALJ called, and failed to be ready to proceed with the prehearing conference as scheduled. Therefore, Respondent is in default, and findings may be made, and an order may be entered, on the basis of the Complaint.

Violations

Following an investigation and disciplinary hearing, if the Board determines 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 has committed "[m]isconduct or unprofessional conduct," it may revoke, limit, or suspend her license, or reprimand her. Wis. Stat. § 441.07(1g)(b) and (d), respectively.

Wisconsin Administrative Code § N 7.03 sets out the grounds for taking disciplinary action against a nurse. The grounds include:

> (1) Noncompliance with federal, jurisdictional, or reporting requirements including any of the following:
>
> ...
>
> (c) After a request of the board, failing to cooperate in a timely manner, with the board's investigation of a complaint filed against a license holder. There is a rebuttable presumption that a credential holder who takes longer than 30 days to respond to a request of the board has failed to cooperate in a timely manner.
>
> ...
>
> ...
>
> (6) Unsafe practice or substandard care, including any of the following:
>
> ...
>
> (d) Failing to report to or leaving a nursing assignment without properly notifying appropriate supervisory personnel and ensuring the safety and welfare of the patient or client.
>
> ...
>
> ...
>
> (8) Improper prescribing, dispensing, or administering medication or drug related offenses, including any of the following:
>
> ...
>
> (b) Dispensing of any drug other than in the course of legitimate practice or as otherwise prohibited by law.
>
> ...
>
> (d) Error in prescribing, dispensing, or administering medication.

(e) Obtaining, possessing or attempting to obtain or possess a drug without lawful authority.

Respondent violated Wis. Admin. Code § N 7.03(1)(c) when she failed to cooperate in a timely manner with the Board's request regarding the Department's investigation of a complaint filed against her. On November 2 and 11, 2020, the Department sent an email to Respondent at her email address on file with the Department requesting her response to the allegations against her. On November 20, 2020, the Department sent a letter to Respondent at her mailing address on file with the Department requesting her response to the allegations against her. When that letter was returned by the U.S. Postal Service with a forwarding address, the Department sent the letter to Respondent at the forwarding address on December 1, 2020. On January 15, 2021, the Department sent another email and letter to Respondent at her email address on file and the forwarding address, respectively, requesting her response to the allegations against her. Respondent failed to respond to all of the Department's attempts to contact her on behalf of the Board of Nursing.

Respondent violated Wis. Admin. Code § N 7.03(6)(d) by failing to report to a nursing assignment without properly notifying appropriate supervisory personnel and ensuring the safety and welfare of the patient or client. After the Facility conducted a review of its controlled drug receipt/record/disposition forms and discovered several discrepancies with Respondent's medication dispensing and administration, the Facility attempted to contact Respondent on October 2, 2020. Not only did the Respondent not reply to the Facility's contact, but she did not report to the Facility for her scheduled shifts on October 3 and 4, 2020.

Respondent violated Wis. Admin. Code § N 7.03(8)(d) by committing an error in dispensing or administering medication. On October 1, 2020, the Facility conducted a review of its controlled drug receipt/record/disposition forms and discovered, among other discrepancies, that on September 26, 2020, Respondent signed out two hydrocodone/APAP 7.5-325 mg tablets for Resident B.A., but then crossed out the entry and wrote "error." The two tablets remained unaccounted for and by not responding to the Facility's or the Department's attempt to contact her for a response, she failed to provide any justifiable explanation for the error.

Respondent violated Wis. Admin. Code §§ N 7.03(8)(b) and (e) by dispensing any drug other than in the course of legitimate practice or as otherwise prohibited by law, and by obtaining, possessing or attempting to obtain or possess a drug without lawful authority, respectively. The Facility's review of its controlled drug receipt/record/disposition forms revealed that Respondent signed out narcotics for various residents on September 4, 11, 17, and 18, 2020 when she was not on the schedule and did not work. The Facility's review also revealed that Respondent signed out oxycodone for Resident S.V. in four or five times the quantities that other nurses had administered to that resident in the past. Again, the Respondent did not provide any explanation for the discrepancies in her dispensing and/or possession of drugs by not responding to the Facility's or the Department's attempt to contact her in the course of their respective investigations.

By her actions, Respondent has committed grounds for discipline pursuant to Wisconsin Administrative Code § N 7.03 and is subject to discipline pursuant to Wis. Stat. § 441.07(1g)(b) and (d), and Wis. Admin. Code § N 7.03.

Discipline

The Department recommends that Respondent's license to practice as a licensed practical nurse in the state of Wisconsin, and her right to renew such license, be suspended indefinitely, giving Respondent the ability to petition the Board to stay the suspension upon providing proof that she completed an alcohol and other drug abuse (AODA) assessment and six hours of education on medication administration within 90 days, 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).

The recommended discipline is consistent with the purposes articulated in *Aldrich*. The uncontroverted allegations against Respondent of signing out controlled substances from the Facility on days she was not scheduled to work, signing out oxycodone in four or five times the quantities other nurses had administered to a resident in the past, signing out hydrocodone tablets in "error" and not accounting for those tablets, and failing to report to her nursing assignment without notifying her supervisor or ensuring the safety and welfare of her patients constitute significant violations. In addition, by failing to cooperate with the Board's investigation of those allegations, Respondent compounded her actions by impeding and delaying the investigation, thus putting public safety at risk.

The recommended discipline protects 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). Suspending Respondent's license (and the right to renew her license) until she provides proof to the Board she has completed an AODA assessment and six hours of education on medication administration, and allowing the Board to further limit her license based on the results of the AODA assessment, protects the public by preventing Respondent from practicing nursing until the Board is assured she can practice safely. The suspension of her license will also remind Respondent of her duty to abide by the Board's rules of professional conduct, to timely respond to Board inquiries, and indicate to Respondent that her actions have serious consequences for her licensure.

The recommended discipline promotes Respondent's rehabilitation. Requiring Respondent to undergo an AODA assessment from an experienced evaluator and complete education in medication administration before she can petition to stay the suspension of her nursing license will help Respondent identify any drug and alcohol concerns she may have and begin to correct them, and assist her to become a better nurse.

The recommended discipline also deters other credential holders from engaging in similar conduct. Respondent has disregarded the Board's authority as well as the laws in place to protect public health and welfare. Imposing anything less than a suspension and an AODA and education requirement would not deter other credential holders from engaging in similar conduct and could imply that such conduct by a licensee is tolerable.

The recommended discipline is consistent with Board precedent. *See In the Matter of Disciplinary Proceedings Against Debra S. Murphy, R.N.*, Order Number 0007520 (August 12, 2021) (nursing license was suspended indefinitely but could be stayed upon petition proving completion of AODA assessment and ethics education for, *inter alia*, exhibiting a pattern of medication discrepancies and other behaviors consistent with diversion of controlled substances)[2]; *see also In the Matter of Disciplinary Proceedings Against Jennifer C. Jondreau, R.N.*, Order Number 0006712 (March 12, 2020) (nursing license was suspended indefinitely but could be stayed upon petition proving completion of AODA assessment, fitness for practice evaluation, and ethics education for being disciplined in Minnesota for, *inter alia*, discrepancies in controlled substance administration).[3]

Based upon the facts of this case and the factors set forth in *Aldrich,* the discipline recommended by the Department, pursuant to the terms and conditions of the Order below, is reasonable and warranted.

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 of this proceeding. The Department met its burden of proof for all charges pled; Respondent defaulted by not filing a written answer to the Department's Notice of Hearing and

[2] This decision is available online at: https://online.drl.wi.gov/decisions/2021/ORDER0007520-00018012.pdf
[3] This decision is available online at: https://online.drl.wi.gov/decisions/2020/ORDER0006712-00016487.pdf

Complaint, and thus, the factual allegations identified in the Complaint are deemed admitted. Respondent failed to cooperate with the Board's investigation after repeated attempts to contact her. 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 response or defense regarding the allegations brought against her license to practice as a licensed practical 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 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 Respondent's license to practice as a licensed practical nurse in the state of Wisconsin (license number 318357-31), Respondent's right to renew such license, and Respondent's privilege to practice as a licensed practical nurse pursuant to the Compact, are SUSPENDED for an indefinite period.

IT IS FURTHER ORDERED that the suspension of Respondent's license, and her right to renew such license, may be STAYED upon Respondent petitioning the Board and providing proof, which is determined by the Board or its designee to be sufficient, that Respondent is in compliance with the following provisions:

a. Within ninety (90) days, Respondent shall, at her own expense, undergo and complete an Alcohol and Other Drug Abuse (AODA) assessment with an evaluator pre-approved by the Board or its designee who has experience conducting these assessments (AODA Evaluator). Requests for pre-approval may be submitted to the Department Monitor at the address below.

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

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

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

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

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

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

b. Within ninety (90) days, Respondent shall, at her own expense, successfully complete six (6) hours of education on the topic of medication administration.

i. Respondent shall be responsible for obtaining the course(s) required under this Order, for providing adequate course descriptions to the Department Monitor, and for obtaining pre-approval of the courses 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 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. 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 also may not be used in future attempts to upgrade a credential in Wisconsin.

c. Respondent shall report to the Board any change in employment status, residence, address, or telephone number within ten (10) days of the date of the change. This report shall not be considered formal change of address notification pursuant to Wis. Stat. § 440.11.

IT IS FURTHER ORDERED that the Board may grant or deny any petition for a stay of the suspension, or may impose further limitations on Respondent's license, in its discretion.

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

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 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

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 October 6, 2021.

STATE OF WISCONSIN
DIVISION OF HEARINGS AND APPEALS
4822 Madison Yards Way, 5th Floor North
Madison, Wisconsin 53705
Tel. (608) 266-2447
Email: Kristin.Fredrick@wisconsin.gov

By: _____
Kristin P. Fredrick
Administrative Law Judge