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**Before the  
State Of Wisconsin  
Board of Nursing**

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In the Matter of the Disciplinary Proceedings  
Against Jennifer J. Hogge, R.N., Respondent.

FINAL DECISION AND ORDER

Order No. **ORDER 0008533**

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**Division of Legal Services and Compliance Case Nos. 21 NUR 639, 22 NUR 341,  
and 22 NUR 358**

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 11th day of May, 2023.

A handwritten signature in black ink, appearing to read 'Robert H. Weber', written over a horizontal line.

Member  
Board of Nursing



Before The  
State Of Wisconsin  
DIVISION OF HEARINGS AND APPEALS

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In the Matter of the Disciplinary Proceedings  
Against Jennifer J. Hogge, R.N., Respondent.

DHA Case No. SPS-22-0056  
DLSC Case Nos. 21 NUR 639,  
22 NUR 341, and 22 NUR 358

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**PROPOSED DECISION AND ORDER**

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

Jennifer J. Hogge

Wisconsin Board of Nursing

Department of Safety and Professional Services,  
Division of Legal Services and Compliance, by Attorney Nicholas Dalla Santa

PROCEDURAL HISTORY

On September 8, 2022, the Department of Safety and Professional Services (Department), Division of Legal Services and Compliance (Division), filed and served the Notice of Hearing and the Complaint on Jennifer J. Hogge, R.N. (Respondent), by both certified and regular mail, consistent with Wis. Stat. § 440.11(2) and Wis. Admin. Code § SPS 2.08. The Respondent failed to file an answer within twenty days of the date of service of the Complaint, as required. Wis. Admin. Code § 2.09(4).

The administrative law judge (ALJ) scheduled a telephone prehearing conference for October 18, 2022, at 10:00 am. At the prehearing conference, the Respondent was ordered to file an answer no later than November 1, 2022. No answer was filed.

At the adjourned prehearing conference on November 7, 2022, the Respondent indicated she had signed a stipulation for a proposed resolution and mailed it to the Division. At the joint request of the parties, the ALJ stayed the matter pending the Board's review of the stipulation. On January 26, 2023, having not received the Respondent's stipulation, the Division moved to lift the stay.

The ALJ scheduled a telephone prehearing conference for February 16, 2023, at 11:00 a.m. Notice of this prehearing conference was sent to both parties. The Respondent did not appear. On February 16, 2023, the Division moved for default based on the Respondent's failure to file an answer to the Complaint and failure to appear at the prehearing conference, pursuant to Wis. Admin. Code §§ SPS 2.14 and HA 1.07(3)(c).

On February 21, 2023, the ALJ issued a Notice of Default against the Respondent and ordered the Division to file a recommended proposed decision and order by March 20, 2023.

## FINDINGS OF FACT

### Facts Related to the Alleged Violations

Findings of Facts 1-29 are derived from the Division's Complaint against the Respondent filed in this matter.

1. The Respondent, Jennifer J. Hogge, R.N., is licensed in the state of Wisconsin to practice as a registered nurse, having license number 156484-30, first issued on October 3, 2006 and current through February 29, 2024.

### 21 NUR 639

2. At all times relevant to the Division's investigation into this complaint, the Respondent was employed as a registered nurse at a hospital located in Baraboo, Wisconsin (Hospital).

3. On October 15, 2021, the Respondent entered an order for 30 mg morphine immediate release tablets every 4 hours as needed for moderate/severe pain into a patient's electronic medical record.

4. The Respondent documented that the order was communicated to her via "telephone with readback" and the order appeared to be signed by a physician (Physician A).

5. Physician A later denied speaking with the Respondent, giving the order to her, or signing the order.

6. Immediately after entering the order, the Respondent dispensed 30 mg of morphine tablets and documented administration to the patient on two occasions.

7. In the morning of October 16, 2021, the Respondent again dispensed 30 mg of morphine tablets on two occasions pursuant to the morphine order referenced above.

8. In the afternoon of October 16, 2021, another physician (Physician B) discontinued the order for morphine.

9. On October 17, 2021, the Respondent entered another order for 30 mg morphine immediate release tablets every four hours as needed for moderate/severe pain and dyspnea, and documented it as communicated via "telephone with readback."

10. This order was sent to Physician A, who declined the order and did not sign it.

11. Despite the declined order, the Respondent dispensed the medication and documented administration to the patient on two occasions.
12. At 12:26 a.m. on October 18, 2021, Physician A discontinued the order.
13. At 1:41 a.m. on October 18, 2021, the Respondent, for a third time, entered an order for 30 mg morphine immediate release tablets every four hours as needed for dyspnea, and documented it as communicated via “telephone with readback.”
14. The Respondent dispensed three morphine tablets pursuant to this order, but only documented one tablet as administered to the patient and another tablet as “dropped on the floor.”
15. The Respondent did not document any administration related to the remaining medication that was dispensed.
16. On October 18, 2021, during the Hospital’s investigation into the fraudulent orders and missing medication, the Respondent signed a written statement in which she admitted to diverting narcotic medication.
17. On April 15, 2022, the Department, while investigating this case on behalf of the Board of Nursing, sent a request for information to the Respondent via USPS certified mail to the Respondent’s address on file with the Department. This letter was delivered on April 18, 2022. The Respondent did not respond.

#### 22 NUR 341

18. At all times relevant to the Division’s investigation into this complaint, the Respondent was employed as a registered nurse at a senior living facility located in Middleton, Wisconsin (Facility).
19. On May 14, 2022, the Respondent worked the afternoon shift at the Facility.
20. Sometime between May 14 and May 15, 2022, a medication documentation error occurred at the Facility. The Facility was unable to determine which staff member was responsible for the error.
21. While investigating the medication discrepancy, the Facility requested the Respondent submit to a drug test.
22. On May 16, 2022, the Respondent submitted to a urine drug test which was positive for marijuana.
23. On June 17, 2022, the Department, while investigating this case on behalf of the Board of Nursing, sent a request for information to the Respondent via USPS certified mail to

the Respondent's address on file with the Department. This letter was delivered on June 21, 2022. The Respondent did not respond.

#### 22 NUR 358

24. At all times relevant to the Division's investigation into this complaint, the Respondent was employed as a registered nurse at a rehabilitation and nursing center in Lodi, Wisconsin (Center).

25. On May 3, 2022, while working at the Center, the Respondent documented that she wasted two medication cards of 30 tablets of oxycodone 2.5 mg each, and that another nurse (Nurse A) witnessed it. However, Nurse A witnessed the Respondent waste only one card of oxycodone.

26. The Respondent sent a text message to Nurse A stating the Respondent wasted the second card of oxycodone alone and knew that she made a mistake.

27. While investigating this event, the Center directed the Respondent to submit to a drug test at the hospital. The Respondent refused and stated she would not pass the test because she had a prescription for oxycodone.

28. The Respondent eventually agreed to submit to a blood draw at a hospital but never reported back to the Center.

29. On June 17, 2022, the Department, while investigating this case on behalf of the Board of Nursing, sent a request for information to the Respondent via USPS certified mail to the Respondent's address on file with the Department. This letter was delivered on June 21, 2022. The Respondent did not respond.

#### Facts Related to Default

1. On September 8, 2022, the Division served the Notice of Complaint on the Respondent at her address as indicated in the Division's Complaint and Notice of Hearing by both certified and regular mail.

2. The Respondent did not file an Answer to the Complaint.

3. After the expiration of the 20-day period to file an answer, the ALJ scheduled a telephone prehearing conference for October 18, 2022.

4. At the prehearing conference on October 18, 2022, the ALJ ordered the Respondent to file an answer no later than November 1, 2022. No answer was filed.

5. At the adjourned prehearing conference on November 7, 2022, the Respondent indicated that she had signed a stipulation for a proposed resolution and mailed it to the Division.

At the joint request of the parties, the ALJ stayed the matter pending the Board's review of the stipulation.

6. On January 26, 2023, having not received the Respondent's signed stipulation, the Division moved to lift the stay. The ALJ scheduled a telephone prehearing conference for February 16, 2023, at 11:00 a.m. Notice of this prehearing conference was sent to both parties, and the notice identified the telephone number the ALJ would use to contact each party at the time of the conference.

7. At the prehearing conference on February 16, 2023, the Respondent did not appear. The ALJ attempted to reach the Respondent at the telephone number on file for the Respondent and identified in the notice. The ALJ called the Respondent at 11:00 a.m. and left a voicemail message, and again at 11:15 a.m. The ALJ also emailed the Respondent at the email address on file. No response email or call was received.

8. On February 16, 2023, the Division moved for default 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).

9. On February 21, 2023, the ALJ issued a Notice of Default against the Respondent and ordered the Division to file and serve a recommended proposed decision and order no later than March 20, 2023. The Division timely filed its recommended proposed decision and order.

## DISCUSSION

### Jurisdictional Authority

The Wisconsin Board of Nursing (Board) has the authority to impose discipline against the Respondent. Wis. Stat. § 441.07(1c) and (1g). The undersigned ALJ has authority to preside over this disciplinary proceeding in accordance with Wis. Stat. § 227.46(1). Wis. Admin. Code § SPS 2.10(2). The Division of Hearings and Appeals has authority to issue the proposed decision and order pursuant to Wis. Stat. §§ 227.43(1m) and 441.51(3)(e), and Wis. Admin. Code § SPS 2.10(2).

### Default

The Division properly served the Notice and Complaint upon the Respondent by mailing a copy to her address of record with the Department. Service by mail is complete upon mailing. Wis. Admin. Code § SPS 2.08(1) and Wis. Stat. § 440.11(2). The Division of Hearings and Appeals also properly served the Respondent with notices of the prehearing conferences by mailing them to her address of record with the Department. Wis. Admin. Code § HA 1.03.

An answer to a complaint must be filed within 20 days of the date of service of the Complaint. Wis. Admin. Code § SPS 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, 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 conference, the ALJ may find a failure to appear grounds for default if any of the following conditions exist for more than 10 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, the Respondent failed to file an answer to the Complaint, failed to appear at the prehearing telephone conference scheduled for February 16, 2023, failed to answer the telephone when the ALJ called, and failed to be ready to proceed with the prehearing conference as scheduled. Therefore, the Respondent is in default, and findings and an order may be entered based on 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,” committed “acts which show the registered nurse . . . to be unfit or incompetent by reason of negligence, abuse of alcohol or other drugs[,]” 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).

Conduct that is grounds for the Board to take disciplinary action includes:

- a. Practicing nursing while under the influence of illicit drugs, or while impaired by the use of legitimately prescribed pharmacological agents or medications. Wis. Admin. Code § N 7.03(6)(e).
- b. Being unable to practice safely by reason of substance use. Wis. Admin. Code § N 7.03(6)(f).
- c. Prescribing of any drug other than in the course of legitimate practice. Wis. Admin. Code § N 7.03(8)(a).
- d. Dispensing of any drug other than in the course of legitimate practice. Wis. Admin. Code § N 7.03(8)(b).
- e. Obtaining or possessing a drug without lawful authority. Wis. Admin. Code § N 7.03(8)(e).
- f. Falsifying or inappropriately altering reports, patient documentation, agency records, or other health documents. Wis. Admin. Code § N 7.03(5)(a).



- g. Practicing beyond the scope of practice permitted by law. Wis. Admin. Code § N 7.03(1)(e).
- h. Failing to cooperate in a timely manner, with the Board's investigation of a complaint filed against a license holder. Wis. Admin. Code § N 7.03(1)(c).
- i. Failing to respond within 30 days to a request for information from the credentialing board in connection with an investigation of alleged misconduct of the credential holder. Wis. Stat. § 440.20(5)(a).

The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(6)(e) by practicing nursing while under the influence of illicit drugs, specifically marijuana and oxycodone. The Respondent tested positive for marijuana while working as a nurse and admitted oxycodone use.

The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(6)(f) by being unable to practice safely by reason of alcohol or other substance use. The Respondent tested positive for marijuana while working and admitted oxycodone use. Substance use, especially when unauthorized, calls a nurse's ability to practice safely into question. In this case, the Respondent failed to provide any evidence that her substance use does not affect her practice or that it is being adequately treated or managed.

The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(8)(a) by prescribing a drug other than in the course of legitimate practice or otherwise prohibited by law. Since the Respondent only holds a license to practice as a registered nurse, she cannot legally prescribe any drug. In this case, the Respondent entered a new order for morphine herself, without any authorization or delegation from an authorized prescriber. The Respondent was therefore not acting in the course of legitimate practice and was prohibited to do so by law.

The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(8)(b) by dispensing a drug other than in the course of legitimate practice. Each time the Respondent fraudulently entered orders for morphine, she immediately dispensed morphine pills. Since the Respondent knew the order for morphine was fraudulent and had no actual authorization to dispense the medication, she was not acting in the course of legitimate practice when she did so.

The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(8)(e) by possessing a drug without lawful authority. The Respondent possessed morphine after dispensing it without any authorization, valid order, or prescription. Therefore, she did not have any lawful authority to possess the drug.

The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(5)(a) by falsifying or inappropriately altering reports, patient documentation, agency records, or other health documents. The Respondent falsely documented that a physician relayed an order for morphine via telephone three separate times. The

Respondent also falsely documented that Nurse A witnessed her waste two oxycodone tablets when Nurse A only witnessed her waste one.

The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(1)(e) by practicing beyond the scope of practice permitted by law. The Respondent, a registered nurse, entered orders to administer controlled substances for patients without authorization from a practitioner with prescribing privileges. Registered nurses do not have the ability to independently prescribe any medication. Therefore, when the Respondent entered orders for morphine without authorization from a physician, she practiced beyond the scope of her license.

The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Stat. § 440.20(5)(a) by failing to respond to a request for information from the credentialing board in connection with an investigation of alleged misconduct. The Respondent failed to respond to the Board's requests for information during its investigation on multiple occasions.

The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(1)(c) by failing to cooperate in a timely manner with the Board's investigation. Prior to the filing of the Complaint, the Respondent failed to timely respond to the Board's attempts to contact her during the Board's investigation. The Board sent a request for information via mail to the Respondent on June 17, 2022. The request was confirmed as delivered, but the Respondent never responded. The Respondent's actions, or lack thereof, amount to a failure to cooperate in a timely manner with the Board's investigation.

By engaging in conduct qualifying as grounds for taking disciplinary action on her license, along with the Respondent's failure to make any argument to the contrary, the Respondent is subject to discipline pursuant to Wis. Stat. §§ 441.07(1g)(b), (c), and (d); 441.51(3)(d); and Wis. Admin. Code § N 7.03.

### Discipline

The Division recommends that the Respondent's license to practice as a registered nurse in Wisconsin and any privilege to practice in Wisconsin pursuant to a multistate license issued by another state be suspended indefinitely, with the provision that the Respondent may petition the Board at any time for a stay of the suspension, and if the Board chooses to stay the suspension, it may also impose conditions or limitations on the Respondent's license that it deems appropriate to protect the health, safety, and welfare of patients and the public, provided they are related to the misconduct proven in this matter and serve the three purposes of discipline as outlined in *State v. Aldrich*, 71 Wis. 2d 206, 237 N.W.2d 689 (1976). Because the Respondent has been found in default, and because the recommended discipline is consistent with the purposes articulated in *Aldrich*, I adopt the Division's recommendation.

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. *Id.*

In this case, the Respondent fraudulently used a physician's name to sign and subsequently enter orders for controlled substance medication into patient medical documentation, diverted controlled substances for personal use, tested positive for marijuana while practicing nursing, admitted to oxycodone use, and refused to submit to a drug test after falsely documenting a coworker witnessed her waste medication. The Respondent subsequently failed to cooperate with the Board's investigation of these matters. While the Respondent's rehabilitation<sup>1</sup> may be possible, this can only be determined if the Respondent cooperates with the Board. The Division's recommendation accounts for this by allowing the Respondent to petition the Board to stay the suspension once the Respondent provides information requested by the Department in relation to this matter.<sup>2</sup> Depending on the information provided, the Board may grant a petition to stay the suspension and impose conditions on the Respondent's license that promote rehabilitation, such as providing verification that the Respondent has not engaged in any further diversion activity or that she has not practiced while impaired by any intoxicants.

The Division's recommended discipline protects the public from other potential instances of misconduct by ensuring that the Respondent cannot practice nursing while the Board cannot adequately monitor her competence. "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 suspension is appropriate. *Gilbert v. State Medical Examining Bd.*, 119 Wis. 2d 168, 189-90, 349 N.W.2d 68 (1984). The Respondent admitted to diverting controlled substances, practiced nursing while impaired, and fraudulently altered patient records. This conduct poses a serious threat to patient safety, and the Respondent has failed to participate in the Board's efforts to address it. Without the Respondent's willing participation in addressing these practice concerns, it is impossible for the Board to ensure the Respondent is safely practicing nursing. As such, an indefinite suspension is appropriate to protect the public.

The recommended discipline also deters other credential holders from engaging in similar conduct. Licensees should be on notice that they cannot avoid disciplinary action by refusing to cooperate with the Board, especially in cases where a licensee has engaged in fraudulent or impaired practice. Suspension of the Respondent's license to practice in Wisconsin will serve to deter others from committing similar violations.

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<sup>1</sup> In this case, "rehabilitation" includes ensuring the Respondent does not practice while impaired, no longer diverts medication for personal use, and no longer disregards the Board's authority. It includes allaying Board concerns of the Respondent's ability to safely practice nursing and heightened risk of future misconduct.

<sup>2</sup> Department investigations involving alleged diversion and impaired practice include, among other things, inquiries into concerns of a respondent's practice while under the influence of drugs or alcohol, gathering of prescription information and other medical documentation, or a request for other evidence that a respondent does not have any ongoing AODA concerns.

The recommended discipline is also consistent with Board precedent. *See In the Matter of the Disciplinary Proceedings Against Linda L. Polanco, R.N.*, Order Number 0007563 (August 25, 2021) (Board suspended respondent's license indefinitely for failing to cooperate with the Board's investigation and proceedings and required completion of education in order to petition for license reinstatement);<sup>3</sup> *In the Matter of the Disciplinary Proceedings Against Amanda Nabbefeldt, R.N.*, Order Number 0007516 (August 12, 2021) (Board suspended respondent's license indefinitely for failing to cooperate with the Board's investigation and proceedings);<sup>4</sup> *In the Matter of the Disciplinary Proceedings Against Nancy M. Mokaya, R.N.*, Order Number 0008013 (June 9, 2022) (Board suspended respondent's license indefinitely for failing to cooperate with the Board's investigation and proceedings and Board granted ability to impose conditions and/or limitations on the license upon stay of suspension).<sup>5</sup>

Based upon the facts of this case, the factors set forth in *Aldrich*, and prior Board decisions, an indefinite suspension of the Respondent's license to practice in Wisconsin, as well as her right to apply to renew that license, and any privilege to practice in Wisconsin pursuant to any multistate license, is warranted.

#### Costs

The Board is vested with discretion concerning whether to assess all or part of the costs of this proceeding 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. *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* (LS0802183 CHI) (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.

It is appropriate for the Respondent to pay the full costs of the investigation and prosecution of these proceedings. Because the Respondent defaulted and did not file an answer, the factual allegations identified in the Division's Complaint were deemed admitted. The level of discipline sought is an indefinite suspension with the Respondent's ability to petition the Board to terminate the suspension, a substantial level of discipline responsive to the violations in this matter. The Respondent failed to cooperate with this disciplinary process by failing to answer the complaint and failing to appear for the prehearing conference. The Respondent has not offered

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<sup>3</sup> *In the Matter of the Disciplinary Proceedings Against Linda L. Polanco, R.N.*, Order Number 0007563.

<sup>4</sup> *In the Matter of the Disciplinary Proceedings Against Amanda Nabbefeldt, R.N.*, Order Number 0007516.

<sup>5</sup> *In the Matter of Disciplinary Proceedings Against Nancy M. Mokaya, R.N.*, Order Number 0008013.

any acceptable justification for her actions. Such conduct demonstrates disregard for the authority of the Board and disregard for her duties as a nurse.

Finally, 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 proceeding 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 prosecution in this matter, as determined pursuant to Wis. Admin. Code § SPS 2.18.

#### CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing (Board) has jurisdiction over this matter pursuant to Wis. Stat. § 441.07(1c) and (1g).
2. The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(6)(e) by practicing under the influence of illicit drugs, or while impaired by the use of legitimately prescribed pharmacological agents or medications.
3. The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(6)(f) by being unable to practice safely by-reason of substance use.
4. The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(8)(a) by prescribing a drug outside the course of legitimate practice.
5. The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(8)(b) by dispensing a drug outside the course of legitimate practice.
6. The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(8)(e) by obtaining or possessing a drug without lawful authority.
7. The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(5)(a) by falsifying or inappropriately altering reports, patient documentation, agency records or other health documents.
8. The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(1)(e) by practicing beyond the scope of practice permitted by law.

9. The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Admin. Code § N 7.03(1)(c) by failing to cooperate in a timely manner with the Board's investigation of a complaint filed against a license holder.
10. The Respondent engaged in conduct that constitutes grounds for disciplinary action under Wis. Stat. § 440.20(5)(a) by failing to respond within 30 days to a request for information from the Board in connection with an investigation of alleged misconduct of the credential holder.
11. As a result of the above violations, suspension of the Respondent's license as ordered is reasonable and appropriate. Wis. Stat. §§ 441.07(1g)(b) and (d), and Wis. Admin. Code § N 7.03.
12. The Division of Hearings and Appeals has authority to issue this proposed decision pursuant to Wis. Stat. § 227.46 and Wis. Admin. Code § SPS 2.10.

#### ORDER

For the reasons set forth above, IT IS ORDERED:

1. The Respondent's license to practice as a registered nurse in Wisconsin (license no. 156484-30) and any privilege to practice in Wisconsin under a multi-state license issued by another state are **SUSPENDED** for an indefinite period.
2. The Respondent may petition the Board for a **STAY** of the suspension by contacting the Department Monitor and providing any information requested by the Board or its designee in relation to this matter in a timely fashion.
3. The Board or its designee may stay the suspension upon determination that the Respondent has cooperated fully with the Department and provided any information requested by the Board or Department in relation to this matter. The Board or its designee may impose conditions and/or limitations on the Respondent's privilege to practice in Wisconsin that it deems appropriate to protect the health, safety, and welfare of patients and the public. Any conditions or restrictions must relate to the misconduct proven in this matter and must serve one of the following purposes: promoting the Respondent's rehabilitation, protecting the public from other instances of misconduct, or deterring other credential holders from engaging in similar conduct.
4. Whether the Board or its designee grants the Respondent's petition for a stay of suspension, and/or imposes any conditions and limitations on the Respondent's privilege to practice in Wisconsin, is within its sole discretion and is not subject to appeal.
5. In the event the Respondent violates any term of this Order, or any subsequent related Order, while a stay of suspension is in place, the Board or its designee may remove the stay, without further notice of hearing, until the Respondent has complied with the terms of the

Order. The Board or its designee may, in conjunction with any removal of any stay, prohibit the Respondent for a specified period of time from seeking a reinstatement of the stay under paragraph 2.

6. The Respondent shall pay all recoverable costs in this matter in an amount to be established pursuant to Wis. Admin. Code § SPS 2.18.

7. Petitions, payments of costs (made payable to Department of Safety and Professional Services), and any other requests for information or submissions related to this Order shall be submitted 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) 266-2112; Fax (608) 266-2264  
DSPSMonitoring@wisconsin.gov

The Respondent may also submit this information online at: <https://dspsmonitoring.wi.gov>.

8. The terms of this Order are effective on the date the Final Decision and Order in this matter is signed by the Board.

Dated at Madison, Wisconsin on April 21, 2023.

STATE OF WISCONSIN  
DIVISION OF HEARINGS AND APPEALS  
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By:   
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Angela Chaput Foy  
Administrative Law Judge