

WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY
PROCEEDINGS AGAINST

RICHARD W. CLASEN, M.D.,
RESPONDENT.

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FINAL DECISION AND ORDER

ORDER 0008821

Division of Legal Services and Compliance Case No. 22 MED 452

The parties to this action for the purpose of Wis. Stat. § 227.53 are:

Richard W. Clasen, M.D.
Wisconsin Rapids, WI 54494

Wisconsin Medical Examining Board
P.O. Box 8366
Madison, WI 53708-8366

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

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final disposition of this matter, subject to the approval of the Medical Examining Board (Board). The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Respondent Richard W. Clasen, M.D., (Year of Birth 1948) is licensed in the state of Wisconsin to practice medicine and surgery, having license number 22783-20, first issued on January 18, 1980, with registration current through October 31, 2023. Respondent's most recent address on file with the Wisconsin Department of Safety and Professional Services (Department) is in Wisconsin Rapids, Wisconsin 54494.

PRIOR BOARD DISCIPLINE

2. On May 19, 2004, the Board issued Order LS0404071MED, which required Respondent to complete 24 hours of continuing medical education on the topic of gastrointestinal blood loss, and indications of and screening for gastro-intestinal cancers. The Order was based on

Respondent's failure to offer a colonoscopy or sigmoidoscopy for a patient exhibiting signs of colorectal cancer. On June 15, 2005, Respondent's license was reinstated to full, unrestricted status.

3. On August 21, 2019, the Board issued Order 0006357 in which Respondent's license was reprimanded for failure to complete sufficient continuing medical education during the 2016-2017 biennium.

CURRENT CASE

4. At all times relevant to this proceeding, Respondent practiced as an internist at a nursing home located in Wisconsin Rapids, Wisconsin (Facility).

5. On September 27, 2022, the Department received a complaint alleging that Respondent provided substandard care to Patient A (an 87-year-old male) during his stay at the Facility between July 19 and August 27, 2022, which contributed to Patient A's death on September 6, 2022.

6. Patient A was admitted to the Facility on July 18, 2022, with acute and chronic conditions including a right humerus fracture, rhabdomyolysis including acute kidney failure, a recent acute GI bleed, hypertension, and heart disease.

7. On July 19, 2022, Respondent saw Patient A and authored a handwritten progress note acknowledging the aforementioned acute and chronic conditions and also noting the existence of trace edema in the patient's legs and that the patient had a foley catheter in place. Respondent noted the patient needed OT and PT, and that he would recheck CBC and BMP.

8. Nursing notes reflect continued edema in Patient A's legs and the development of a pressure ulcer on his left heel.

9. Patient A's foley catheter was removed on July 26, 2022, pursuant to an order from Respondent. Records do not reflect that Respondent saw the patient on that day or that he authored a progress note.

10. Respondent next saw Patient A on August 4, 2022. At that time, he ordered a blood test to see if congestive heart failure (CHF) was causing the patient's leg edema. Respondent did not write any other orders at that time and did not author a progress note.

11. On August 5, 2022, Respondent participated in a meeting with Patient A's family member and the Director of Nursing (DON), at the request of the family member who was concerned about Patient A's condition and treatment. Respondent saw Patient A on that date and wrote orders for, among other things, Furosemide to address the CHF, Lisinopril and metoprolol succinate to address hypertension, and vitamin and protein supplements. Respondent did not author a progress note.

12. On August 8, 2022, Respondent ordered Plavix, 75 mg per day, for Patient A. Records do not reflect that Respondent saw the patient on that day or that he authored a progress note.

13. On August 10, 2022, Respondent saw Patient A and ordered a urine culture to check for urinary tract infection (UTI). Respondent did not author a progress note on this date. Results dated August 11, 2022, were abnormal. Respondent did not order an antibiotic until August 17, 2022.

14. On August 27, 2022, Patient A was found to be bleeding from the anus, was taken to the emergency room and admitted, and was diagnosed with a mid-level GI bleed. Patient A died on September 6, 2022, and the cause of death noted on the death certificate was “acute blood loss anemia” due in part to a GI bleed.

15. The standard of minimally competent medical practice required Respondent to sufficiently and timely follow up with Patient A regarding his acute kidney disease including the status of the foley catheter. Patient A’s catheter was not removed until July 26, 2022, Respondent did not order a culture until August 10, 2022, and did not order antibiotics until August 17, 2022, all of which was below the standard of minimally competent medical practice.

16. The standard of minimally competent medical practice required Respondent to document his medical decision making with regard to the prescription of Plavix to Patient A on August 8, 2022, including a discussion with the patient regarding the risks and benefits of the medication, particularly in light of Patient A’s chronic and acute conditions and risk factors.

17. Respondent’s failure to sufficiently follow up with Patient A and Facility staff to confirm PT and OT were being administered as ordered was below the standard of minimally competent medical practice.

18. In resolution of this matter, Respondent consents to the entry of the following Conclusions of Law and Order.

CONCLUSIONS OF LAW

1. The Board has jurisdiction to act in this matter pursuant to Wis. Stat. § 448.02(3) and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

2. Based on the Findings of Fact, Respondent engaged in unprofessional conduct as defined in Wis Admin Code § Med 10.03(2)(b) by departing from or failing to conform to the standard of minimally competent medical practice which creates an unacceptable risk of harm to a patient or the public whether or not the act or omission resulted in actual harm to any person.

3. Based on the Findings of Fact, Respondent engaged in unprofessional conduct as defined in Wis Admin Code § Med 10.03(3)(e) by failing to establish and maintain timely patient health care records, including records of prescription orders, under Wis. Admin. Code § Med 21.03, or as otherwise required by law.

4. As a result of the above conduct, Respondent is subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

1. The attached Stipulation is accepted.
2. Respondent is REPRIMANDED.
3. Respondent's license and registration to practice medicine and surgery in the state of Wisconsin (license no. 22783-20) is LIMITED as follows:
 - a. Within ninety (90) days of the date of this Order, Respondent shall, at his own expense, successfully complete four (4) hours of education on the topic of medications associated with gastrointestinal bleeds, four (4) hours of education on the topic of infection risk associated with catheters, and four (4) hours of education on the topic of documentation and charting, offered by a provider pre-approved by the Board or its designee, including taking and passing any exam offered for the courses.
 - b. 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. 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. The Board or its designee may change the number of credit hours and/or education topics in response to a request from Respondent. The Board or its designee may consider the topic availability and/or hours of education when determining if a change to the ordered education should occur.
 - d. This limitation shall be removed from Respondent's license and registration after satisfying the Board or its designee that Respondent has successfully completed all the ordered education.
4. Within ninety (90) days from the date of this Order, Respondent shall pay COSTS of this matter in the amount of \$993.00.
5. Any requests, petitions, payments of costs (made payable to Department of Safety and Professional Services), and other information required by this Order shall be submitted to:

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>.

6. In the event Respondent violates any term of this Order, Respondent's license and registration (no. 22783-20), or Respondent's right to renew his license and registration, may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of the Order. The Board may, in addition and/or in the alternative refer any violation of this Order to the Division of Legal Services and Compliance for further investigation and action.

7. This Order is effective on the date of its signing.

WISCONSIN MEDICAL EXAMINING BOARD

By: Clarence Chau (M.D.)
A Member of the Board

10/18/23
Date

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY
PROCEEDINGS AGAINST

RICHARD W. CLASEN, M.D.,
RESPONDENT.

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STIPULATION

ORDER 0008821

Division of Legal Services and Compliance Case No. 22 MED 452

Respondent Richard W. Clasen, M.D., and the Division of Legal Services and Compliance, Department of Safety and Professional Services, stipulate as follows:

1. This Stipulation is entered into as a result of a pending investigation by the Division of Legal Services and Compliance. Respondent consents to the resolution of this investigation by Stipulation.

2. Respondent understands that by signing this Stipulation, Respondent voluntarily and knowingly waives the following rights:

- the right to a hearing on the allegations against Respondent, at which time the State has the burden of proving those allegations by a preponderance of the evidence;
- the right to confront and cross-examine the witnesses against Respondent;
- the right to call witnesses on Respondent's behalf and to compel their attendance by subpoena;
- the right to testify on Respondent's own behalf;
- the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision;
- the right to petition for rehearing; and
- all other applicable rights afforded to Respondent under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and other provisions of state or federal law.

3. Respondent is aware of Respondent's right to seek legal representation and has been provided an opportunity to obtain legal counsel before signing this Stipulation.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Wisconsin Medical Examining Board (Board). The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall then be returned to the Division

of Legal Services and Compliance for further proceedings. In the event that the Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. The parties to this Stipulation agree that the attorney or other agent for the Division of Legal Services and Compliance and any member of the Board ever assigned as an advisor in this investigation may appear before the Board in open or closed session, without the presence of Respondent, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with deliberations on the Stipulation. Additionally, any such advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.

7. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

8. Respondent is further informed that should the Board adopt this Stipulation, the Board's Final Decision and Order will be reported as required by the National Practitioner Databank (NPDB) Guidebook and as otherwise required by any licensure compact or any other state or federal law.

9. The Division of Legal Services and Compliance joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.



Richard W. Clasen, M.D., Respondent
Wisconsin Rapids, WI 54494
License No. 22783-20

9-27-2023
Date



Carley Peich Kiesling, Prosecuting Attorney
Department of Safety and Professional Services
Division of Legal Services and Compliance
P.O. Box 7190
Madison, WI 53707-7190

10/3/2023
Date