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Board of Vocational Nursing and Psychiatric Technicians

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BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANNA LEE TYSON,** **aka ANNA PHILLIPS FLOCKS** **108 Alameda Avenue** **Chowchilla, California 93610** **Vocational Nurse License No. VN 168790** Respondent.	Case No. VN-2009-3235 ACCUSATION

Complainant alleges:

PARTIES

1. Teresa Bello-Jones, J.D., M.S.N., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians ("Board"), Department of Consumer Affairs.

2. On or about August 23, 1994, the Board issued Vocational Nurse License Number VN 168790 to Anna Lee Tyson, also known as Anna Phillips Flocks ("Respondent"). Respondent's vocational nurse license expired on September 30, 2010, and has not been renewed.

STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2875 provides, in pertinent part, that the Board may discipline the holder of a vocational nurse license for any reason provided in Article 3 (commencing with section 2875) of the Vocational Nursing Practice Act.

4. Code section 118, subdivision (b), provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under Code section 2892.1, the Board may renew an expired license at any time within four years after the expiration.

5. Code section 2878 states, in pertinent part:

> The Board may suspend or revoke a license issued under this chapter [the Vocational Nursing Practice Act (Bus. & Prof. Code, 2840, et seq.)] for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> . . . .
>
> (5) The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law.
>
> . . . .
>
> (j) The commission of any act involving dishonesty, when that action is related to the duties and functions of the licensee . . .

6. Code section 2878.8 states:

> The board may deny any application or may suspend or revoke any license issued under this chapter [the Vocational Nursing Practice Act] based upon the denial of licensure, suspension, restriction, or other disciplinary action of a license by another state, any other government agency, or by another California health care professional licensing board. A certified copy of the finding shall be conclusive evidence of that action provided that, if from another state, the findings establish an act which if committed in California would be grounds for discipline.

7. California Code of Regulations, title 16, section 2518.6 states, in pertinent part:

> (a) A licensed vocational nurse shall safeguard patients'/clients' health and safety by actions that include but are not limited to the following:
>
> . . . .
>
> (2) Documenting patient/client care in accordance with standards of the profession . . .
>
> . . . .
>
> (b) A licensed vocational nurse shall adhere to standards of the profession and shall incorporate ethical and behavioral standards of professional practice which include but are not limited to the following:

(1) Maintaining current knowledge and skills for safe and competent practice;

(2) Maintaining patient/client confidentiality;

. . . .

(c) A violation of this section constitutes unprofessional conduct for purposes of initiating disciplinary action.

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Disciplinary Action by the Arizona State Board of Nursing)

9. Respondent is subject to disciplinary action pursuant to Code section 2878.8 in that she was disciplined by the Arizona State Board of Nursing ("Arizona Board"), as follows: On or about September 23, 2009, pursuant to Findings of Fact, Conclusions of Law and Order No. 07A-0612091-NUR in the disciplinary proceeding titled "In the Matter of Practical Nurse License No. LP027054 Issued to: Anna Tyson", the Arizona Board revoked Respondent's practical nurse license, No. LP027054. A true and correct copy of the Board's order is attached as exhibit A and incorporated herein by reference. The Administrative Law Judge hearing the matter found that Respondent had committed acts constituting unprofessional conduct, as set forth below. These acts or omissions if committed in California would be grounds for disciplinary action against Respondent pursuant to Code section 2878, subsections (a), (a)(5), and/or (j).

a. On April 1, 2007, while employed at Avalon Shadows, Respondent misinterpreted an order for "7U" of insulin and administered 70 units of insulin to a patient, which could have caused harm or death to the patient.

b. On September 17, 19, 21, and 26, 2007, Respondent failed to administer Fragmin 5000 to a patient at Freedom Plaza, but charted that she administered the medication.

///

c. Following the incident at Freedom Plaza, Respondent removed confidential patient records from the facility, apparently in an effort to substantiate her claim that others had violated the facility's policy by charting medications that were not, in fact, administered.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians issue a decision:

1. Revoking or suspending Vocational Nurse License Number VN 168790, issued to Anna Lee Tyson, also known as Anna Phillips Flocks;

2. Ordering Anna Lee Tyson, also known as Anna Phillips Flocks, to pay the Board of Vocational Nursing and Psychiatric Technicians the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: September 12, 2011

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
Department of Consumer Affairs
State of California
Complainant

SA2011100158

EXHIBIT A

Findings of Fact, Conclusions of Law and Order No. 07A-0612091-NUR

ARIZONA STATE BOARD OF NURSING
4747 North 7th Street Ste 200
Phoenix AZ 85014-3655
602-771-7800

IN THE MATTER OF PRACTICAL NURSE LICENSE NO. LP027054 ISSUED TO: **ANNA TYSON,** Respondent.	**FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER NO. 07A-0612091-NUR**

A hearing was held before Diane Mihalsky, Administrative Law Judge, at 1400 West Washington Suite 101, Phoenix Arizona, on August 26, 2009. Kim Zack, Assistant Attorney General, appeared on behalf of the State. Anna Tyson ("Respondent") was not present and was not represented by counsel.

On September 10, 2009, the Administrative Law Judge issued Findings of Fact, Conclusions of Law and Recommendations. On September 23, 2009, the Arizona State Board of Nursing met to consider the Administrative Law Judge's recommendations. Based upon the Administrative Law Judge's recommendations and the administrative record in this matter, the Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. The Arizona State Board of Nursing ("Board") has the authority to regulate and control the practice of nursing in the State of Arizona pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664. The Board also has the authority to impose disciplinary sanctions against the holders of nursing licenses for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 to -1667.

2. In 1992, the Board issued Practical Nurse License No. LP027054 to Respondent for practice in the State of Arizona.

3. During the latter part of 2006 and early 2007, the Board received three complaints against Respondent's license from former employers. The complaints were assigned to the Board's nurse consultant, Sr. Rachel Torrez.

4. After an investigation, Sr. Torrez recommended that the first two complaints be dismissed and that the third complaint be substantiated, based in part on Respondent's admission that she had made a medication error in the administration of insulin to a patient at the Avalon Shadows facility.

5. Based on the substantiated complaint and Respondent's communications with Sr. Torrez and other Board staff, the Board directed that Respondent undergo a psychological evaluation.

6. On August 23, 2007, Buffy C. Wooten, Ph.D. performed a psychological evaluation of Respondent. On September 13, 2007, Dr. Wooten issued a report, which concluded in relevant part as follows:

> [Ms. Tyson] appeared to be forthright in acknowledging the behaviors that were the cause of concern however she denied any malpractice with the exception of her medication error.
>
> Ms. Tyson's history of working with registry may have contributed to her visibility and to susceptibility to complaints. Her medical condition [from the aftermath of a 1994 closed-head injury suffered in a motorcycle accident] (which effects [*sic*] her availability to work when needed) also contributes to the negative impression perceived to exist with employers to a degree, which she admits. Additionally, Ms. Tyson's strong concrete values are sited [*sic*] as the source of her vigilance about compliance while at the same time making her less flexible in her demeanor and manner of compliance when interacting with others. Nonetheless there is no indication that she is negligent in practice or at risk of compromising safety for patients or coworkers. Her test results unfortunately do not provide additional insight into her personality or coping strategies due to her defensive test-taking approach. But they also do not suggest that any such problems exist. Therefore no restrictions on practice or treatment are recommended for Ms. Tyson based on the current evaluation. A recurrence of medication errors would certainly warrant further review to include additional testing and/or monitoring. The acceptance of a staff position has also seemed to support a more stable work history and is also improving her working relationships.

7. On October 3, 2007, the Board received a complaint against Respondent's license from Rhonda Wile, the Director of Nursing ("DON") at Freedom Plaza, that Respondent had documented on the Medication Administration Record that she had administered a medication but had admitted verbally that she had not, in fact, administered the medication. According to the complaint, Respondent had not cooperated in the investigation and admitted to having copied confidential patient records, removed the copies from the facility, and provided the records to others, allegedly to prove medication errors made by other nurses at Freedom Plaza.

8. Sr. Torrez investigated the fourth complaint. The Board accepted Sr. Torrez' recommendation that the complaint should be substantiated.

9. The Board provided a copy of the complaint from Freedom Plaza and correspondence from Respondent to Dr. Wooten. Based on this new information, on October 31, 2007, Dr. Wooten amended her initial report of her psychological evaluation of Respondent in relevant part as follows:

> The additional complaint reveals medication documentation errors and the nurse's admission of removing confidential documents from her work site without consent and then refusing to return them upon request. These actions at a minimum indicate poor judgment on the part of Ms. Tyson and potential violations of nursing practice ethics and law. Additionally the correspondence between she and the nursing board suggest concerns in her ability to accurately perceive and judge facts and interpersonal dynamics, especially those revolving around the current investigation.
>
> In my initial report I stated in the recommendations that should there be any additional concerns raised regarding medication errors further review would be indicated. As such it is recommended that Ms. Tyson be referred for individual therapy to further assess her judgment, insight into her behaviors and general psychological functioning. This treatment should include an additionally [*sic*] assessment of her personality and psychological well-being to assist in the diagnosis of existing personality, interpersonal, emotional or cognitive difficulty she may be experiencing. This therapy should last no less than six months occurring biweekly to facilitate diminishing the defensiveness shown in the initial evaluation. Ms Tyson would also be given the opportunity to address in more depth the complaints against her license and her response to the current investigation. There are now also concerns regarding her ability to comply with the rules

of law governing safe nursing practice and as a result a term of probation with close supervision and monitoring should be considered.

10. Based on Sr. Torrez' investigation and Dr. Wooten's evaluation, the Board offered a Consent Agreement to Respondent to resolve the two complaints that the Board had determined to substantiate. The terms of probation included that Respondent undergo therapy with a counselor to reduce her defensiveness and that her work be closely supervised.

11. Respondent declined the Board's offer of a Consent Agreement and requested an administrative hearing.

12. The Board referred the matter to the Office of Administrative Hearings ("OAH"), an independent agency, to schedule and to conduct a fair hearing.

13. On April 24, 2009, the Board issued a Complaint and Notice of Hearing, which described the incidents that led to the complaints against Respondent's license at the Avalon Shadows and Freedom Plaza facilities. Based on these incidents, the Board charged unprofessional conduct under A.R.S. § 32-1663(D) as defined in A.R.S. § 32-1601(16)(d) and (j) and A.A.C. R4-19-403(B)(1), (7), (8), (8a), (9), (16), and (31) (adopted effective November 13, 2005), which furnished grounds to discipline Respondent's license under A.R.S. §§ 32-1663 and 32-1664.

14. Respondent requested that the hearing be continued.

15. After ascertaining the parties' availability, on June 12, 2009, the Administrative Law Judge issued an order setting a continued hearing on August 26, 2009 at 8:00 a.m.

16. On July 1, 2009, the Administrative Law Judge granted Respondent's request to appear telephonically at the continued hearing at her own expense, over the Board's objection.

17. On July 10, 2009, OAH received Respondent's notice that she would not appear at the continued hearing in this matter because "[t]he matters of my case . . . have been turned over to: The Dept. of Justice Civil Rights, Special Litigation – they will contact you accordingly."

18. Respondent attached to her notice a copy of a letter to "Kim" at the United States Department of Justice alleging that the Board, Sr. Torrez, and the Board's attorney had engaged in a criminal conspiracy to deny Respondent's "federal whistleblower sovereign immunity rights" due to a personal vendetta.

19. On July 27, 2009, OAH received in the mail a copy of a summons and complaint in Case No. 1:09CV-01308 OWW GSA in the United States District Court for the Eastern Division of California in Fresno, California. Respondent asserted claims against the Board, OAH, and certain unnamed defendants for civil rights violations, "discrimination & retaillation [*sic*]," "color of title & malfeasance," domestic violence, and the torts of "intentional affliction [*sic*] of emotional distress, duress, coercion, invasion of privacy, libel, slander, [and] deframation [*sic*]." In the complaint, Respondent requested that the Arizona administrative proceeding be dismissed. Respondent also alleged that the Board had conspired with Respondent's family members to deprive her of her rights.

20. Respondent also attached to the Complaint in Case No. 1:09CV-01308 OWW GSA an "Affidavit of Facts that Occurred," which specifically addressed sixteen people, including some of whom were involved in the Board's investigation of the complaints against Respondent, and Respondent's daughters, her best friend, who apparently was deceased, and the Chief of Police of Muldrow, Oklahoma.

21. In the "affidavit," Respondent exhorted her daughter Kari to "[t]ry not to drink please. How many roll-over totaled vehicles has [*sic*] you and your best friend destroyed. The next time someone is going to get killed. It's 4 right?" Respondent also accused her daughter Jamie of welfare fraud and asked, "[C]ouldn't you walk a straight and narrow, like I raised you? Was it really worth what the alcohol made you to become?"

22. A hearing was held on August 26, 2009. The Board presented Sr. Torrez' testimony and submitted thirteen exhibits.

23. Although the beginning of the duly noticed hearing was delayed fifteen minutes to allow Respondent additional time, she did not appear telephonically or through an attorney, did not contact the Office of Administrative Hearings to request another continuance or that the time for the hearing be further delayed, and did not present any evidence to defend her license.

ADDITIONAL HEARING EVIDENCE

24. Sr. Torrez testified that Paula Descheen, the DON at Avalon Shadows, had made the complaint to the Board about Respondent's administration of insulin to a patient. On April 1, 2007, Respondent had misinterpreted "7U" of insulin as "70" units of insulin. After administering the excessive dose, Respondent had realized her mistake and self-reported the error to her supervisor. As a result, the patient had been transferred to the ICU and was appropriately treated.

25. Sr. Torrez mailed an investigative questionnaire to Respondent, requesting certain information and her responses to the three complaints that had been made against her at that time. On April 27, 2007, the Board received Respondent's completed investigative questionnaire.

26. The form investigative questionnaire required Respondent to identify her current employer and her employers for the previous five years. Respondent did not provide this information, instead informing the Board that, "[p]ursuant to A.R.S. § 32-1664 my employers is [*sic*] not considered relevant facts to the matters complained of – or of concern to the matters. The ones I worked for @ the times c/o are in the proper Affidavits."

27. Respondent provided the following explanation for all three incidents in an attachment to the investigative questionnaire:

> I am a Mandated Reporter. And it was brought to my attention long ago, that because I report incidences of concerns or suspected wrong, the State Bd. of Nsg. feels I'm incompetant [*sic*] as an L.P.N and thereby the Board would use their "powers to be" to move for revocation of my license. This knowledge was given to me [illegible] and I have thereby awaited for another unlawful response from the Board.

> Having divulged such information, please realize an (alleged) malfeasance is a criminal act. I purposely with whistleblower intent, expose any unlawful activity. And I will continue to do such. If the Dept of H & H investigates a matter, and/or the A.G. does such, they are the professionals. And I leave the matters alone, after I've sent appropriate facts of Affidavits. I'm sorry if this angers and/or bothers "The Board." I do what I do, under the guidance (as you sister) of "answer" to a higher power. And like you sister, such influences everything I do. In other words, I walk-the-walk too. Should the day ever be when I feel I'm no longer a safe, competent nurse, I will turn my license in. . . .

[Emphasis in original.] Regarding the incident at Avalon Shadows, Respondent's complete explanation was as follows:

> Whistleblower status, addressed to: The Dept. of H & H with allegations of: Refused by Employer the right to "refuse the Assignment" & same from: The facility staff. No further explanations necessary due to privileged status.

28. Sr. Torrez testified that her first direct contact with Respondent was a telephone message, which left Sr. Torrez feeling "threatened." Respondent indicated that she would not be communicating to the Board anymore except in writing, that she was not going to cooperate with the Board, that she did not care who Sr. Torrez was, even if Sr. Torrez was "the president," that Respondent had retained counsel, and that she had a law degree.

29. Sr. Torrez testified that she interviewed Respondent on July 1, 2007 and on October 25, 2007. The Board's employee Teresa Huff was present for both interviews because Sr. Torrez did not want to be accused of saying anything that she had not said. Sr. Torrez testified that it is not the usual practice to have another person present during an investigative interview.

30. Sr. Torrez testified that, when she interviewed Respondent about the medication error at Avalon Shadows, Respondent had admitted her error and notifying her supervisor about the error. Respondent had been "devastated" by the error.

31. Sr. Torrez testified that the standard of practice for a nurse's administration of insulin is for another nurse to double check the dosage. Respondent had not been aware of that standard.

32. Sr. Torrez testified that administering ten times the appropriate dosage of insulin to a patient was a serious error. The patient could have died. Respondent had apparently realized her error when she charted her administration of the dose.

33. Sr. Torrez testified that Respondent had been terminated from Freedom Plaza for a medication error. A patient under Respondent's care had been prescribed Fragmin 5000 units daily, which was to prevent deep vein thrombosis. Sr. Torrez explained that deep vein thrombosis involves blood clots that can develop in a patient due to immobility after surgery. The blood clots can travel through the blood and cause death or stroke.

34. The chart for the patient was submitted. Respondent had indicated on the patient's chart that she had administered the Fragmin 5000 by drawing a circle with her initials inside it on September 17, 19, 21, and 26, 2007.

35. According to the complaint from Rhonda Wile, the DON at Avalon Shadows, when the pharmacy indicated that only 21 of the 25 doses of Fragmin 5000 shown on the chart had been delivered, each of the nurses who had cared for the patient were questioned. Respondent had admitted that she had not administered the Fragmin 5000.

36. After Respondent had been approached, she charted that the Fragmin 5000 had not been given and "Fragmin circled in error on 9/17, 9/19, 9/21 & 9/26."

37. Sr. Torrez testified that standard practice requires a nurse to circle a dose not given, with no initial, and provide an explanation on the back of the chart, for example, "not available," "patient asleep," etc. An initial with no circle indicates that the medication was given.

38. As a result of the medication error, Respondent was counseled at Freedom Plaza. Respondent signed the counseling form and added the following comment:

> For approx. 7 days all pm shift nurses were signing they were giving the med & it was nowhere in the med cart. Each time I was put back on the station I ordered the med. It finally came Mon 9/26 @ 10:35 – 10:40 pm & I put it in the cart. Each is the same for mulpt. meds not in the carts at all stations.

39. The Board submitted a memo from Ms. Wile dated August 20, 2007, providing the following steps to be followed by the nurses at Avalon Shadows if prescribed medications were not in the cart:

> 1. Check the e-kit for medication (if not in e-kit)
> 2. Call Pharmacy and order med. STAT (if unable to get med. by time due)
> 3. Call the M.D. and get an order for another med. that may be used and is available OR get an order to hold med. until available from pharmacy.
>
> If you do not do this then it is a medication error. NO EXCEPTIONS! As a licensed nurse you are required to follow all MD orders as written if you are not able then you must communicate it to the MD for further orders.

40. Sr. Torrez interviewed Ms. Wile and was informed that all the nurses employed at Freedom Plaza were aware of this policy.

41. Sr. Torrez testified that, if the patient did not receive the prescribed doses of Fragmin 5000 at the prescribed time, there was an increased risk of blood clot causing a stroke or death.

42. Sr. Torrez interviewed Respondent about the incident at Freedom Plaza on October 1, 2007 and October 25, 2007. During the second interview, Respondent had admitted that she had removed patient records from Freedom Plaza to submit to the Attorney General consumer advocacy section.

43. The Board obtained the patient records that Respondent had taken from Avalon Shadows and given the Attorney General's Office. The patient names had not been redacted, although the names were redacted from the copies of records that were submitted at the hearing.

44. Sr. Torrez testified that federal HIPPA laws relating to patient privacy and the confidentiality of medical records prohibited Respondent from removing the records from Freedom Plaza. Respondent's removal of the records was also a violation of the Nurse Practice Act. The prohibition on disclosure or removal of confidential patient records protects the patient.

45. Sr. Torrez testified that, in some of her conversations, Respondent seemed reasonable. The person who had left the message in the early stage of the investigation did not seem to be the same person that Sr. Torrez interviewed. Sr. Torrez testified that, in addition, Respondent had sent "a lot of paperwork" to the Board. The paperwork did not provide the information requested, was inconsistent, and was frequently incomprehensible. Respondent had not been forthcoming during the Board's investigation. For all these reasons, Sr. Torrez had recommended a psychological evaluation of Respondent.

46. Although after the Freedom Plaza complaint Dr. Wooten had recommended that Respondent be placed on probation with close supervision, Sr. Torrez testified at the hearing that, in her opinion, Respondent's license should be revoked. The Board cannot force licensees to comply with the terms of probation. If the Board placed Respondent on probation, she would be required to provide reports and submit to close monitoring. In Sr. Torrez' opinion, based on her interaction with Respondent throughout the course of the investigation, Respondent was not capable of complying or willing to comply with the terms of a probationary term.

47. On January 20, 2009, Respondent's daughter Jamie Snow called the Board's employee Susan Barber. According to the notes that the Board submitted, Ms. Snow thought her mother might be

schizophrenic and needed help. Ms. Snow also reported that both daughters had gotten restraining orders against Respondent, Respondent had called Ms. Snow as many as 12 times a day, Respondent had threatened to kidnap Ms. Snow's children, and Ms. Snow and her sister both thought that Respondent was "unstable."

48. In response to the Administrative Law Judge's question, Sr. Torrez stated that Respondent's license had expired on April 6, 2009. The license should be revoked because, otherwise, if Respondent submitted an application to renew the license, the application would be automatically granted pending a hearing. Respondent was licensed in California, Arkansas, and Oklahoma.

CONCLUSIONS OF LAW

1. This matter lies within the Board's jurisdiction.[1]

2. The expired status of Respondent's license does not prevent the Board from investigating the complaints against Respondent or prevent the Board from imposing disciplinary sanctions against Respondent's license if it determines that she has violated the Nurse Practice Act.[2]

3. The notice of the continued hearing that OAH mailed to Respondent was reasonable and it appears that Respondent actually received notice of the hearing.[3]

4. The Board bears the burden of proof and must establish Respondent's violations of the Nurse Practice Act and any factors in aggravation of the penalty by a preponderance of the evidence.[4]

5. "A preponderance of the evidence is such proof as convinces the trier of fact that the contention is more probably true than not."[5] A preponderance of the evidence is "[t]he greater weight of the evidence, not necessarily established by the greater number of witnesses testifying to a fact but by

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[1] *See* A.R.S. §§ 32-1606(A)(9) and (10), 32-1664(B), (E), and (H).
[2] *See* A.R.S. § 32-1664(C).
[3] *See* A.R.S. §§ 41-1092.04; 41-1092.05(D).
[4] *See* A.R.S. § 41-1092.07(G)(2); A.A.C. R2-19-119; *see also Vazanno v. Superior Court*, 74 Ariz. 369, 372, 249 P.2d 837 (1952).
[5] Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

evidence that has the most convincing force; superior evidentiary weight that, though not sufficient to free the mind wholly from all reasonable doubt, is still sufficient to incline a fair and impartial mind to one side of the issue rather than the other."[6]

6. The Board has borne its burden to establish that, on April 1, 2007, when employed at Avalon Shadows, Respondent misinterpreted an order for "7U" of insulin and administered 70 units of insulin to a patient, which could have caused harm or death to the patient. The Board has thereby established that Respondent's mistake constituted unprofessional conduct as defined by A.R.S. § 32-1601(16)(d) and (j)[7] and A.A.C. R4-19-403(B)(9) and (31).[8]

7. The Board also has borne its burden to establish that, on September 17, 19, 21, and 26, 2007, Respondent failed to administer Fragmin 5000 a patient at Freedom Plaza but charted that she had administered the medication. The Board has thereby established that Respondent's failure and

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[6] BLACK'S LAW DICTIONARY at page 1220 (8th ed. 1999).

[7] These statutory subsections define "unprofessional conduct" in relevant part as follows:

> (d) Any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.
>
> (j) Violating a rule that is adopted by the board pursuant to this chapter.

[8] This duly promulgated regulation further defines "unprofessional conduct" in relevant part as follows:

> 9. Failing to take appropriate action to safeguard a patient's welfare or follow policies and procedures of the nurse's employer designed to safeguard the patient.
>
> 31. Practicing in any other manner that gives the Board reasonable cause to believe the health of a patient or the public may be harmed.

false statement constituted unprofessional conduct as defined by A.R.S. § 32-1601(16)(d) and (j) and A.A.C. R4-19-403(B)(1), (7), (8), (8a), (9), and (31).[9]

8. The Board also has borne its burden to establish that, following the incident at Freedom Plaza involving Respondent's failure to administer Fragmin 5000 to a patient, Respondent removed confidential patient records from the facility, apparently in an effort to substantiate her claim that others had violated the facility's policy by charting medications that were not in fact administered. The Board has thereby established that Respondent's unauthorized removal of patient records from Freedom Plaza constituted unprofessional conduct as defined by A.A.C. R4-19-403(B)(1), (9), and (16).[10]

9. Respondent's commission of these three acts of unprofessional conduct furnishes grounds on which the Board may discipline her license under A.R.S. § 32-1663(D).

10. With respect to the appropriate penalty, Respondent's communications to the Board and to the Administrative Law Judge demonstrate that, at this time, she cannot be regulated. The Board's

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[9] This regulation further defines "unprofessional conduct" in relevant part as follows:

> 1. A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice;
>
> . . . .
>
> 7. Failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient;
>
> 8. Falsifying or making a materially incorrect, inconsistent, or unintelligible entry in any record:
>
> a. Regarding a patient, health care facility, school, institution, or other work place location . . . .

[10] This regulation further defines "unprofessional conduct" in relevant part as follows:

> 16. Removing, without authorization, a narcotic, drug, controlled substance, supply, equipment, or medical record from any health care facility, school, institution, or other work place location.

purpose is "to protect the public health and safety . . . ."[11] Protection of the public at this time would best be served by revoking Respondent's practical nurse license.

ORDER

In view of the Findings of Fact and Conclusions of Law, the Board issues the following Order:

Pursuant to A.R.S. § 32-1664(N), the Board **REVOKES** practical nurse license number LP027054 issued to Anna Tyson.

Pursuant to A.R.S. § 41-1092.09, Respondent may file, in writing, a motion for rehearing or review within 30 days after service of this decision with the Arizona State Board of Nursing. The motion for rehearing or review shall be made to the attention of Amy Foster, Arizona State Board of Nursing, 4747 North 7th Street Ste 200, Phoenix AZ 85014-3655. For answers to questions regarding a rehearing, contact Amy Foster at (602) 771-7850. Pursuant to A.R.S. § 41-1092.09(B), if Respondent fails to file a motion for rehearing or review within 30 days after service of this decision, Respondent shall be prohibited from seeking judicial review of this decision.

Respondent may apply for reinstatement of the said license pursuant to A.A.C. R4-19-404 after a period of five years.

DATED this 23rd day of September, 2009.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N
Executive Director

[11] Laws 1992, Ch. 308, § 16.

COPIES mailed this 25th day of September, 2009, by Certified Mail No. 7007 3020 0002 5377 7183 and First Class Mail to:

Anna Tyson
5423 E Laurel
Fresno CA 93727

COPIES mailed this 25th day of September, 2009, by Certified Mail No. 7007 3020 0002 5377 7190 and First Class Mail to:

Anna Tyson
1080 Whitney Dr
Hanford CA 93230

COPIES of the foregoing mailed this 25th day of September, 2009, to:

Case Management
Office of Administrative Hearings
1400 W Washington Ste 101
Phoenix AZ 85007

Kim Zack
Nina Zimmerman
Assistant Attorney General
1275 W Washington LES Section
Phoenix AZ 85007

By: Vicky Driver