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ARIZONA STATE BOARD OF NURSING
4747 North 7th Street Ste 200
Phoenix AZ 85014
602-889-5150

IN THE MATTER OF PROFESSIONAL NURSE LICENSE NO. RN127460 ISSUED TO:

DAVID ALAN STEPP,

Respondent.

AMENDED FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER NO. 05A-0406023-NUR

A hearing was held before Diane Mihalsky, Administrative Law Judge ("ALJ"), at 1400 West Washington Suite 101, Phoenix Arizona, on January 27, 2006, April 6, 2006 and June 20, 2006. Daniel R. Christl, Assistant Attorney General, appeared on behalf of the State. David Alan Stepp ("Respondent") was present and was represented by counsel, Teressa M. Sanzio.

On July 10, 2006, the ALJ issued Findings of Fact, Conclusions of Law and Recommendations. On September 11, 2006, the Arizona State Board of Nursing met to consider the ALJ's recommendations. Based upon the ALJ's recommendations and the administrative record in this matter, the Board modified the ALJ's Findings of Facts as follows:

A) Finding of Fact ("FOF") # 73 is corrected to delete the words "which Mr. Stepp signed on May 31, 2004."

B) FOF # 82 is corrected to delete the sentence "Mr. Stepp signed the error report"; and

C) FOF # 172 – The first sentence is corrected to state, "The parties stipulated that Mr. Nevitt is not a Board-approved evaluator."

The above changes to the Findings of Fact are made by stipulation of parties' Attorneys to better reflect the documents in the record.

2. Accepts the ALJ's Conclusions of Law in its entirety; and

3. Accepts the ALJ's recommended discipline for a 12 month Probation with terms and conditions. However, corrects the language in the recommendation that states, *"Prior to termination of probation, Mr. Stepp shall work as a professional nurse for a minimum of eighteen months . . ."* to state, *"Prior to termination of probation, Respondent shall work as a professional nurse for a minimum of twelve (12) months . . ."* The change is made to be consistent with the Order for a 12 month Probation.

On November 15, 2006, the Arizona State Board of Nursing met to consider the State's Request for Review or Rehearing and the Respondent's Request for Review or Rehearing. The Board voted to grant the requests for review of the parties, both citing A.A.C. R4-19-608 (b) (5): excessive or insufficient penalties. Further, **the Board granted the State's request to modify the Order** (insufficient penalty) **to include an on-site supervision term to assure proper supervision during the Probationary period and to include a restriction that Respondent's wife shall not be the supervisor to assure objective oversight; denied Respondent's request to eliminate the evaluation term** (excessive penalty); **and modified the evaluation term to allow Respondent an additional 30 days to complete the evaluation (increased from 60 days to 90 days).**

FINDINGS OF FACT

1. On April 12, 2004, the Board issued professional nurse license no. RN127460 (temporary) to Respondent.

2. Before he was issued this license, on July 6, 1999, Respondent was licensed by the state agency in Florida that is analogous to the Board. At the time of the hearing, Respondent's Florida license was in good standing and no complaints had been made against it.

3. On June 1, 2004, P.S., a licensed practical nurse ("LPN") employed by The Forum at Desert Harbor in Peoria, Arizona ("the Forum") made telephonic complaints to the Board against Respondent and his wife, Madonna Stannus Stepp. P.S. made the complaints telephonically because, she said, she feared for her personal safety. P.S. alleged that Respondent (1) Was verbally abusive with staff, patients, and aides; (2) Sat with his wife Madonna with their legs intertwined, rubbing each other's feet, while on duty; and (3) Made numerous medication errors. P.S. also alleged that Respondent was unfamiliar with common nursing practices, such as locking up and counting narcotics at the end of the shift.

4. The complaint was assigned to the Board's Investigator/Consultant Sydney Munger. Ms. Munger had subpoenas issued to obtain the records of Respondent's employment for the two years before the complaint was filed and interviewed Respondent, his wife Madonna, and some of Respondent's former supervisors and co-workers.

5. Jerry Mahoney, the Director of Nursing at the Forum, told Ms. Munger that, if the complaint were made by P.S., "it should be taken with a grain of salt" because she "had been known to carry tales, and he had caught her telling lies."

6. The Board eventually determined to close P.S.'s complaint as unsubstantiated. However, as a result of Ms. Munger's investigation, the Board issued a complaint, charging Respondent with committing acts that furnished cause to discipline his license 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(1), (5), and (25).

7. The complaint was originally scheduled to be heard in the Office of Administrative Hearings on December 19, 2005. However, the matter was vacated pursuant to the order of the Executive Director of the Board on October 27, 2005 and remanded to the Board for further action.

8. The matter was resubmitted to the Office of Administrative Hearings and a hearing scheduled in due course. A hearing was held on three dates, during which Respondent testified on his own behalf, presented the testimony of his wife, Madonna Stepp, and certified employee assistance specialist and licensed social worker and independent substance abuse counselor Hal M. Nevitt, and had admitted into evidence twenty-one exhibits. The Board presented the testimony of Ms. Munger, Louis Kass, RN (telephonic), Marjorie Sopata, RN, Amy Walker, RN (telephonic), and Valerie Smith, RN, MS and had admitted into evidence twenty exhibits.

THE FACTUAL ALLEGATIONS IN THE COMPLAINT AND THE EVIDENCE PRESENTED AT HEARING WITH RESPECT TO THE ALLEGATIONS[1]

ALLEGED MISCONDUCT DURING THE BOARD'S INVESTIGATION

9. Paragraph 25 of the Board's Complaint alleged as follows:

> On or about June 30, 2004, in a telephone conversation with Board staff regarding the complaint filed against his license, Respondent's tone of voice was loud and confrontational. When informed by Board staff that Respondent could not continue to yell, Respondent's wife intervened.

10. Ms. Munger was assigned to investigate P.S.'s anonymous complaints against both Mr. and Mrs. Stepp. After the complaints were received, Ms. Munger sent an investigative questionnaire to Respondent and had subpoenas duces tecum issued to obtain their employment history.

11. Ms. Munger testified that her initial interaction with Respondent was right after he received her letter informing him that a complaint had been made against him. Ms. Munger testified that Mr. and Mrs. Stepp called her, upset at the complaint, which they felt was retaliatory. Ms. Munger testified that Respondent raised his voice in the telephone conversation and that, after she told him that she would not tolerate being yelled at, his wife, who was on the extension, intervened.

[1] The alleged acts of misconduct are divided according to the context of the act, that is, the place of employment or the Board's investigation.

12. Ms. Munger testified that this interaction was before much investigation had occurred. Ms. Munger testified that she was concerned that, during her first interaction with Respondent, before they had any history, he was already raising his voice at and challenging her.

13. Ms. Munger testified that the Board typically goes back several years when it obtains a nurse's employment records after a complaint, to see if there is any pattern or practice of similar misconduct.

Mrs. Stepp

14. Mrs. Stepp testified that she was always on the extension when Ms. Munger called. Respondent had never raised his voice to Ms. Munger. Mrs. Stepp testified that she had never intervened.

Respondent

15. Respondent denied having yelled at Ms. Munger in any telephone conversation. When she accused him of yelling, he apologized and said he had a loud voice. He also denied that Mrs. Stepp had to intervene.

ALLEGED MISCONDUCT WHILE EMPLOYED BY AVENTURA MEDICAL CENTER ("AVENTURA") IN AVENTURA, FLORIDA

16. Paragraphs 3 through 8 of the Board's Complaint alleged as follows:

> 3. From on or about September 23, 2002, to on or about November 15, 2002, Respondent was employed as a professional nurse at Aventura Medical Center in Aventura, Florida.
>
> 4. On or about November 15, 2002, Donna Small and Linda Flayer, from Aventura Medical Center, signed a termination recommendation. The report stated Respondent is aggressive, confrontational, and intimidating to others.
>
> 5. The November 15, 2002 recommendation further stated that Respondent has been unable to establish a suitable working relationship with his immediate supervisors to include, Charge Nurses, Administrative Supervisors, Directors, and Vice President of Nursing.

> 6. The November 15, 2002, recommendation stated: terminate employment immediately due to threatening, intimidating, or coercing patients, customers, employees or others.
>
> 7. On or about November 15, 2002, Respondent resigned his employment in lieu of termination. Respondent indicated in his resignation letter that he resigned in order to be considered eligible for rehire.
>
> 8. On the Board's Investigative Questionnaire received on July 26, 2004, Respondent wrote he left his position at Aventura Medical Center due to "health reasons." This information to the Board was false and misleading. (Incorporate Findings of Fact 4, 5, 6, and 7.)

Documents from Aventura

17. Ms. Munger provided foundation for Respondent's employment records from Aventura Medical Center in Florida. Included among the records obtained from Aventura was a note dated November 15, 2002, signed by Donna Small and Linda Flayer, recommending that Respondent's employment be immediately terminated because (1) "various members of the administrative team" had reported him to be "aggressive, confrontational, and intimidating to others," (2) he had "shown a lack of respect for management level employees" and had "been unable to establish a suitable working relationship with his immediate supervisors," and (3) he had "failed to exhibit Aventura . . . values of respect to all."

18. No one with first-hand knowledge of Respondent's employment at Aventura testified at the hearing. The November 15, 2002 letter was not on Aventura letterhead and Respondent did not sign it. Ms. Small's and Ms. Flayer's positions at Aventura were not specified.

19. Ms. Munger admitted on cross-examination that, usually, if an employee receives a warning, he is expected to sign the written warning. But if an employee receives verbal counseling, there is usually no way to tell if the counseling did not happen. Sometimes an employee refuses to sign a written warning. Ms. Munger admitted that the documents from Aventura did not contain any written warnings to Respondent.

20. The Board also obtained a Personal Action Request ("PAR") from Aventura, signed by Ms. Flayer for Human Resources and another illegible signature for Senior Manager, to terminate Respondent from the ICU Preceptorship program. The employee's signature on the form is optional and Respondent did not sign it. According to the PAR, Respondent's last day at Aventura was November 15, 2002. According to the PAR, Respondent was eligible for rehire but did not give adequate notice.

21. The documents obtained from Aventura also contained a resignation letter that Respondent signed, dated November 15, 2002, as follows:

> The ADON Donna Small & the Director of Human Resources (Linda) has informed me that if I do not resign today, that I would be fired due to my "attitude." This is coming from an individual (Donna Small) pointing to the top of her head & stated "I've had it up to here with the both of you." (meaning me and Madonna Stannus RN). Upon our second encounter with her the only thing I have to gain by resigning is that both Donna & Linda agreed that my file for HCA would not indicate "do not rehire."

[Emphasis in original.]

22. The Board had Respondent's completed investigative questionnaire admitted into evidence. According to the questionnaire, Respondent had left Aventura for "health reasons." Ms. Munger testified that she believed that Respondent's statement on the questionnaire that he left Aventura for "health reasons" was misleading.

Respondent

23. Respondent testified that his contract with Aventura required him to work one or two years. In return, Aventura agreed to pay for courses that would train him to become a critical care nurse.

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24. Respondent had admitted into evidence an Applicant Interview Evaluation from Aventura dated September 16, 2002, that found his demeanor, appearance, job knowledge, motivation, and personality to be satisfactory.

25. Respondent testified that he had health problems at Aventura and had to take himself to the hospital with chest pains. Respondent had admitted into evidence a computer printout that indicated that, on November 5, 2002 at 11:01 p.m., he was admitted and that, on November 7, 2002 at 10:48 p.m. he was discharged.

26. Respondent had admitted into evidence a note from Robert Johnson, MD "to whom it may concern" that Respondent was medically cleared to return to work on November 14, 2002. Respondent had written at the bottom of the note, "NO ONE at Aventura Hospital or HCA has my permission to contact my doctor or his staff."

27. Respondent pointed out that the date of his resignation from Aventura was November 15, 2002. Respondent testified that, when he returned to work at 7:00 a.m. on November 15, 2002, he wanted to submit a letter of resignation giving two weeks' notice because of his health concerns. The Assistant Director of Nursing, Ms. Small, refused to accept his resignation letter and, instead, demanded that he resign immediately because she had "had it up to here" with his "attitude."

28. Respondent testified that he had never seen any documentation of any work issues at Aventura until the Board's complaint. Until he was forced to resign effective immediately, no one at Aventura had ever told him there were concerns about the quality of his work. Respondent denied that he resigned Aventura in lieu of termination; he meant to resign for health reasons, giving a two-week notice, but was forced to resign immediately. He acquiesced because Aventura Hospital is one of the largest health care facilities in Miami-Dade; he wanted to be able to work there again if his health allowed him.

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ALLEGED MISCONDUCT WHILE EMPLOYED BY THE GARDENS COURT IN PALM BEACH GARDENS, FLORIDA

29. Paragraphs 9 through 11 of the Board's Complaint alleged as follows:

> 9. From on or about June 26, 2003, to on or about November 11, 2003, Respondent was employed as a professional nurse at The Gardens Court in Palm Beach Gardens, Florida.
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> 10. On or about August 27, 2003, while discussing Respondent's request to go home early, Respondent raised his voice to his manager and stated he did not like his manager's attitude. On August 27, 2003, Respondent received and signed a written warning for poor attendance, calling off frequently, and going home in the middle of his shift, although he had been cleared to return to light duty.
>
> 11. On or about November 11, 2003, Respondent voluntarily terminated his employment with The Gardens Court, when he failed to return to duty after being medically cleared to return to a sedentary position. Respondent is ineligible for rehire.

Louis Kass

30. Louis Kass was the Director Nursing at the Garden Courts when Respondent worked there, starting in June 2003. Mr. Kass described Respondent as a "strong individual" whose "face turned beet red" and "became explosive" when he encountered conflict. According to Mr. Kass, Respondent had developed a poor attitude toward his work. Nurses who show no control and yell at their supervisors and co-workers may upset residents.

31. Mr. Kass testified that, in late August 2003, he noticed Respondent at the nurse's station, yelling. When Mr. Kass approached Respondent, he said he had to go home. Mr. Kass said, "Just go." Mr. Kass testified that, when he returned to his office, Respondent followed him and "raised his voice" and said he didn't like Mr. Kass' attitude. Mr. Kass testified that, after he told Respondent that "'this behavior will not be tolerated,'" Respondent "calmed down." Mr. Kass then asked Respondent to sign a counseling form. Although Respondent initially refused to do so until after he consulted his attorney

and left Mr. Kass' office, Respondent returned after about fifteen minutes and signed the counseling form.

32. The Board had admitted into evidence a written warning, dated August 27, 2003, signed by Mr. Kass and Respondent. Mr. Kass' statement was that Respondent had poor attendance and had "called off frequently" or had gone home in the middle of his shift. Respondent's comment was that he "called off" work because he was "still on workers' compensation," in "a lot of pain," and could not take his pain medication within 8 hours of or during his shift.

33. The Board had admitted into evidence a letter from Patricia Allard, CNHA, the Executive Director of The Gardens Court, on its stationery, dated November 11, 2003 to Respondent that, since he had failed to return to work as instructed after Dr. H. Phlanzer had cleared him for sedentary duty, The Gardens Court considered him to have been voluntarily terminated.

34. Mr. Kass testified that he "absolutely" would not hire Respondent again because he considered Respondent to be volatile and unethical.

35. Mr. Kass admitted on cross-examination that Respondent had completed seven courses at The Gardens Court between July and September 2003.

36. Mr. Kass also admitted on cross-examination that he had supervised Respondent before and had given him a positive evaluation in a telephone reference check. According to the reference check, Respondent had not lost much time from his job, did good quality work, did not require much supervision, and he was "above average" in his ability to get along with other people. Mr. Kass testified that he had never observed Respondent become explosive toward a resident or inspire fear in a resident.

37. Mr. Kass testified on cross-examination that he had observed Respondent violate the Florida Nurse Practice Act. According to Mr. Kass, Respondent had told nurses to document "red

butts," which means a stage one pressure ulcer, on residents on admission. Mr. Kass never reported this alleged misconduct to authorities, however, even though the Florida Nurse Practice Act required it to be reported and never wrote up a complaint against Respondent about it.

38. Mr. Kass testified on redirect that the nurses who reported that Respondent had told them to report red butts on residents were afraid of Respondent. Mr. Kass testified he did not follow up on the misconduct because Respondent never again reported to work at The Gardens Court.

39. Mr. Kass also testified that he was aware of Respondent's workers' compensation claim and that he had aggravated a prior back injury while he was employed by The Gardens Court. Mr. Kass knew Respondent was in pain while he was working.

Respondent

40. Respondent testified that Mr. Kass hired him to be the supervisor of the 3 to 11 p.m. shift. He was never written up at The Gardens Court for any patient care issues. The allegation that he told nurses to document "red butts" on admittees was false and was never made to the Florida Board of Nursing.

41. Respondent testified that he had hurt his back in 2000, while he was working in construction, moving heavy equipment. He suffered a herniated disk at the L4-S1 level. Respondent testified that he disclosed his preexisting injury to every employer, including Mr. Kass.

42. Respondent testified that The Gardens Court had carpeted hallways and "huge" medication carts that weighed 250 or 350 pounds. He had told Mr. Kass that he could not pass medications if he had to push the cart regularly, although he might be able to push the cart once in a while. But Mr. Kass required him to push the medication cart on a regular basis.

43. Respondent testified that he re-injured his back on July 16, 2003, pushing the medication cart. Respondent had admitted into evidence the judge's decision in his Workers'

Compensation, which he used to refresh is recollection. Respondent testified that he continued to work on light duty status until September 25, 2003, when his treating physician took him off work.

44. Respondent testified that he tried to work his full shift, but sometimes was in too much pain. The Florida Nurse Practice Act prohibits a nurse from working within eight hours of having taken pain medication. Respondent therefore sometimes left early. This is what happened when Mr. Cass gave him the written warning on August 27, 2003. Respondent testified that he had never seen Mr. Kass' handwritten account of the event until after the Board investigated the complaint.

45. Respondent testified that Mr. Kass' account was "half true and half false." Respondent was at the nurse's station, in pain, when he turned his chair to Mr. Kass and said, "I'm sorry to do this, but I'm in pain and need to go home and take my medicine." Mr. Kass responded by saying, "Just go," in a manner that Respondent described as "very unprofessional," in front of nurses that Respondent supervised. Respondent testified that he felt "very frustrated." When Mr. Kass "paced back to his office," Respondent followed him and tried to question him about his response. Respondent testified that he did not mean to yell at Mr. Kass and, when Mr. Kass said to stop yelling, he responded, "I'm not yelling at you."

46. Respondent testified that he refused to sign Mr. Kass' written warning until he consulted his attorney, because he did not know the effect of his signature on his worker's compensation claim. His attorney told him that he was receiving worker's compensation for a work-related injury; he had a right to go home. So he added his own comment to the form and signed it.

47. Respondent testified that, contrary to Ms. Allard's letter, his last day working for The Gardens Court was not November 11, 2003. Although he did receive the letter, the worker's compensation judge found that he was on no-work status between November 13, 2003 and January 16,

2004 and was entitled to benefits until February 16, 2003. The last day for which he received compensation for his employment at The Gardens Court was therefore February 16, 2004.

48. Respondent testified on cross-examination that he did not yell at Mr. Kass when Mr. Kass confronted him in August 2003. He did not remember whether he told Mr. Kass that "I don't like your attitude." He denied ever raising his voice to Mr. Kass, but admitted that he has a loud voice.

ALLEGED MISCONDUCT WHILE EMPLOYED BY MEDICAL STAFFING NETWORK ("MSN" AT BOSWELL HOSPITAL)

49. Paragraphs 12 through 18 of the Board's Complaint alleged as follows:

> 12. From in or about December 2002, to on or about May 12, 2004, Respondent worked for [MSN], a staffing agency, in Boca Raton, Florida.
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> 13. On or about April 26, 2004, Respondent and his wife started an assignment with Medical Staffing Network at Boswell Hospital in Sun City, Arizona.
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> 14. On or about May 12, 2004, Respondent ended his [MSN] contract at Boswell Hospital, indicating the reason that Respondent's father had been in an automobile accident, was in critical condition, and Respondent and his wife were flying to Florida to see him.
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> 15. On the Board's Investigative Questionnaire, Respondent write, he left his position at Boswell Hospital due to "health reasons."
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> 16. Respondent started a new nursing position in Peoria, Arizona, on May 14, 2004. Respondent started this new nursing job two days after terminating the Boswell Hospital, Sun City, contract, for reasons related to flying to Florida to see his critical father.
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> 17. On or about October 20, 2004, Respondent stated to Board staff that he and his wife traveled to Florida to see his father following the termination of their travel contract with Boswell Hospital. On or about October 20, 2004, in a separate interview, Respondent's wife denied they traveled to Florida at that time. Respondent provided false and misleading information to the Board, about the circumstances surrounding the termination of his contract with Boswell Hospital.
>
> 18. On or about October 21, 2004, Respondent attempted to recant the information provided to the Board that he went to Florida to see his father after terminating the contract with Boswell Hospital.

Ms. Munger

50. Ms. Munger provided foundation for the documents that had been obtained from Boswell Hospital ("Boswell"). Melissa Castro, the recruiter at MSN who placed Respondent at Boswell, wrote a letter dated June 4, 2004, addressed "To Whom It May Concern," that Respondent had resigned his position at Boswell due to a "family tragedy." According to Ms. Castro's "Communication Information Action (CIA) Form," on May 12, 2004, Mr. and Mrs. Stepp left a message that "David's father was in a car accident and is in critical condition. They had to leave the contract until further notice. Last day was 5/12."

51. According to the questionnaire, Respondent had left Boswell for "health reasons." Ms. Munger testified that she believed that Respondent's statement on the questionnaire that he left Boswell for "health reasons" was misleading.

52. According to documents obtained pursuant to subpoena, Respondent began working at The Forum on May 14, 2004. Ms. Munger testified that Respondent could not have gone to Florida to take care of his father and started working at The Forum two days after his last day at Boswell.

53. Ms. Munger testified that she interviewed both Mr. and Mrs. Stepp separately in their attorney's presence. Both had stated on their questionnaire that they had resigned from Boswell on May 12, 2004. Respondent told her in the interview that he and his wife had gone to Florida after resigning from Boswell. Mrs. Stepp told her that the two had remained in Arizona.

54. Ms. Munger testified that Respondent came the next day to finish his interview. The first thing he said was that he had not gone to Florida immediately after his resignation from Boswell.

Mrs. Stepp

55. Mrs. Stepp testified that she and Respondent took a travel contract to work at Boswell, where they worked the 7 a.m. to 7 p.m. shift. On a Friday they returned home at about 8:30 p.m. to a

message from Respondent's sister in Florida, informing them that his father had been injured in a serious car accident. Mrs. Stepp testified that they left a message at MSN on Saturday that they would be flying back to Florida to be with Respondent's father. But when they started looking into air fare, they realized they did not have enough money to get back to Florida at that time. The following Monday they talked to someone at MSN to say that they would be back at work after all, but were told it was too late and their contract was canceled.

56. Mrs. Stepp testified that she and her husband's last day of work at Boswell was May 8, 2004. They "scrambled" to find another job, and found two positions at The Forum. Their first day of work at the Forum was May 14, 2004.

57. Mrs. Stepp testified that Ms. Munger asked her whether she and Respondent went back to Florida immediately after terminating their contract at Boswell and she said "no." She and Respondent did go to Florida several months later.

Respondent

58. Respondent provided the same account of his and Mrs. Stepp's employment at Boswell as his wife. When he received his sister's message, he felt it was very important to return to Florida because no one else in his family has a medical background.

59. Respondent testified that, after MSN told them they could not return to their contract at Boswell, he and Mrs. Stepp were "desperate." They had just moved to Arizona. But, due to the nursing shortage, there were jobs. Mrs. Stepp set up an appointment with Mr. Mahoney at The Forum.

60. Respondent testified that, when Ms. Munger asked him whether he went back to Florida after working at Boswell, he was looking through papers. He did not hear her ask whether he had gone back to Florida immediately. Because he and his wife had returned to Florida to tend to his father several months later, he answered "Yes" to Ms. Munger's question.

61. Respondent testified that he never received any formal document terminating his contract with MSN. He tried to explain to Ms. Munger that Boswell had provided incorrect dates of his employment. Boswell won't release his time records because he is a travel nurse, not an employee. He spoke to Nicole and Donna at MSN and they confirmed that his last date at Boswell was May 8, 2004. But they could not send him a copy of the records because they are not supervisors.

62. Respondent testified that he believed he left Boswell for "health reasons," as he stated on the investigative questionnaire. He left for his father's health, not his own.

ALLEGED MISCONDUCT WHILE EMPLOYED BY THE FORUM AT DESERT HARBOR

63. Paragraphs 19 through 24 of the Board's Complaint alleged as follows:

> 19. On or about May 14, 2004, to on or about June 4, 2004, Respondent was employed as a professional nurse at The Forum at Desert Harbor in Peoria, Arizona.
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> 20. On or about May 28, 2004, Respondent circled resident M.E.'s 8:00 p.m. scheduled dose of Oxycontin 10 mg. on the medication administration record ("MAR"), indicating that the resident refused the medication. However, Respondent failed to sign out the medication, Oxycontin 10 mg, in the narcotics book.
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> 21. On or about May 30, 2004, Respondent passed medications to resident G.K. Respondent signed out 30 mg. (1.5 ml.) of MSIR at 2:30 a.m. for G.K., a dose that was not due until 6:00 a.m. Respondent documented in the nurses' notes that he gave 1.5 mg. at 2:30 a.m. Respondent documented on the MAR that he administered 10 mg. Respondent failed to properly document the amount of MSIR that he signed out and administered to resident G.K. on May 30, 2004.
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> 22. Respondent administered G.K. MSIR, three and a half hours before the medication was due, in violation of the standard of care.
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> 23. On or about May 30, 2004, Respondent was confrontational and demeaning in his interaction with fellow staff members at The Forum at Desert Harbor, while discussing G.K.'s medications.
>
> 24. On or about June 4, 2004, Respondent's employment with The Forum at Desert Harbor was terminated for negative interactions with staff and a vendor. Respondent was made ineligible for rehire.

Marjorie Sopata

64. Marjorie Sopata, RN testified that she was the charge nurse at The Forum at Desert Harbor ("The Forum") while Mr. and Mrs. Stepp worked there. When the Director of Nursing was absent, Ms. Sopata testified that she was responsible for supervising nurses. Ms. Sopata has worked 23 years as a nurse in many capacities. In June 2004, Ms. Sopata had worked for The Forum for five years.

65. Ms. Sopata testified that, at the change of shift, she witnessed a confrontation at the nurses' station involving Respondent. The nursing station is located at the end of two hallways, near the public elevators. When she witnessed the confrontation, Ms. Sopata was about 15 feet away.

66. Ms. Sopata testified that Respondent's face was red and his voice was raised, "condemning a hospice nurse, who wasn't there to defend herself," about a patient who was "snowed" and so he withheld the patient's morning medication. Ms. Sopata testified that she was "stunned" because Respondent's behavior was so unprofessional. She could not believe that someone so new to the facility would be so demeaning to staff. Patients are very sensitive to negative staff interaction and such confrontations put staff cooperation in jeopardy, which can affect patient care.

67. Ms. Sopata testified that Respondent said that G.K. was "snowed," so he had withheld her morning dose of medication. She wondered what had happened to make G.K. "snowed."

68. Ms. Sopata wrote a note to the Director of Nursing at the Forum, Mr. Mahoney, that, on May 30, 2004, Respondent had charted that he had given patient G.K. 15 mg. of MSIR, a form of morphine, that the order was for 10 mg. of MSIR, and that Respondent had checked out 30 mg. of MSIR in the narcotics book. The Board had admitted into evidence G.K.'s prescription for MSIR, which was for 1.5 ml. (30 mg.). Ms. Sopata testified that the doctor had ordered that G.K. be administered 30 mg. BID MSIR twice a day, in the morning and evening. On May 30, 2004, Respondent had circled the 8:00 p.m. dose, which indicated that he did not administer it.

69. The Board had admitted into evidence the "PRN" (or as needed) medication chart for the medications that the nurse has some discretion in administering. The PRN dose of MSIR was 5 mg. for "mild pain" and 10 mg. for "mod-severe pain."

70. The Board had admitted into evidence G.K.'s chart, which includes Respondent's notation that, at 2:30 a.m. on May 30, 2004, G.K. was "in bed yelling out help me," complaining of "generalized pain," and that he gave her 15 mg. of MSIR "as ordered PRN."

71. Ms. Sopata testified that the amount of MSIR that Respondent showed as having administered on G.K.'s chart was inconsistent with the amount that he wrote on the narcotics book, which was 1.5 ml., and the authorized PRN amounts.

72. Ms. Sopata testified that Mr. Mahoney was not in town when the incident involving G.K. occurred. She therefore wrote the following note to him:

> [G.K.] has been calling out for help & needing freq reassurance. Hospice nurse felt it was more psychotic & not due to pain – so Hospice Dr. ordered Haldol . . . .
>
> David Stepp was very much in mine & Tina's face re: Haldol order "Hospice nurse doesn't know what she's doing" & "This needs to be changed & you need to take care of this" & "Jerry needs to be advised of this" & then he proceeded to tell us how "snowed & drugged" she was during the night and that "liver in elderly can't handle Haldol & MSIR together" & that he held her morning MSIR. He lectured us in a demeaning voice/manner for several minutes. I told him I would handle it.
>
> Upon reviewing all the med sheets found he did give Haldol @ 2000 on 5/29, gave her the PRN MSIR @ 0230 & then held 0600 dose of MSIR because she was "out of it." Upon further review found he gave 30 mg. of MSIR @ 0230 rather than 10 mg as ordered.

73. The Board had a Medication Error Report admitted into evidence, that G.K. had been given 30 mg. of MSIR at 2:30 a.m. on May 30, 2004, rather than the 15 mg. that had been ordered. The

physician and pharmacy had been notified, but not the family. No explanation was provided for the failure to notify G.K.'s family. The outcome to the patient was "increased lethargy."

74. Ms. Sopata testified that, although she was Respondent's supervisor in Mr. Mahoney's absence, she did not write or sign the Medication Error Report. Kathy Witt, the Medicare Coordinator, had reviewed her report and prepared the Medication Error Report.

75. Ms. Sopata admitted on cross-examination that Ms. Munger's investigative report to the Board did not describe the confrontation about which Ms. Sopata testified at the hearing. She did not remember whether she had told Ms. Munger that Respondent had made "numerous medication errors," as Ms. Munger reported.

76. Ms. Sopata testified that Respondent had not made "numerous medication errors." Ms. Sopata admitted that there was no notation of a medication error involving G.K. on May 30, 2004 on The Forum's Incident Report Log, but she testified she did not prepare the log. Ms. Sopata admitted that, in her practice, like most nurses, she has made medication errors.

77. Ms. Sopata testified that, as a result of Respondent's error concerning the MSIR given to G.K., she reviewed his records of medication given to other patients and discovered that he had not checked out the Oxycontin prescribed to patient M.E.

Ms. Munger

78. According to documents obtained pursuant to subpoena, Respondent worked for The Forum from May 14, 2004 to June 3, 2004, when he voluntarily resigned. He is not eligible for rehire. The termination code was 114, which meant "Company Policies."

79. Ms. Munger testified that The Forum records showed that Respondent had made a medication error at The Forum in his care of patient M.E. The MAR for M.E. showed that she had been prescribed Oxycontin 10 mg. PO BID for chronic pain at 0800 and 2000 hours. Ms Munger testified that Oxycontin is a very strong opiate used to treat severe pain and is usually given twice daily.

On May 28, 2004, the MAR showed Respondent had failed to give M.E. her Oxycontin at 2000 hours, which he indicated by circling his initials.

80. Respondent's notes on M.E.'s chart for May 28, 2004 state that M.E. "refused to take" the 2000 hours dose of 10 mg. Oxycontin.

81. The narcotics sheet for The Forum shows that Respondent did not sign any Oxycontin out on May 28, 2004. Ms. Munger testified that the proper procedure for physician-ordered medication was for the nurse to remove the medication and account for it on the narcotic sign-out sheet, pour it out, and take it to the patient, who can then refuse it. The only time that the prescription-ordered Oxycontin was not removed for this patient was on May 28, 2006, when Respondent failed to remove it.

82. A Medication Error Report had been prepared to document Respondent's failure to administer the prescribed 10 mg. of Oxycontin to M.E. on May 28, 2004 at 8:00 p.m. The physician and pharmacy were notified.

83. Ms. Munger also identified a facsimile to M.E.'s doctor dated May 29, 2004, as follows:

> [M.E.] did not get 2000 dose of Oxycontin on 5/28. The morning of 5/29 she was wide awake, yelling for help NOW & wheeling herself around. After she got her 0800 dose of Oxycontin she calmed down. No other outcome from missed dose.

84. Ms. Munger testified that MSIR is a form of immediate release morphine. According to the narcotic sign-out sheet, Respondent removed 1.5 ml. of MSIR (which equals 30 mg., according to the prescription). Although G.K.'s 30 mg. dose was not due until 6:00 a.m., Respondent administered the dose at 2:30 a.m., when he documented on her chart that G.K. was awake and calling for help.

85. Ms. Munger testified that Respondent told her that the 1.5 ml. on the narcotic sign-out sheet was not correct. On G.K.'s MAR, Respondent indicated he gave her 1.5 mg. of MSIR at 2:30 a.m., even though the doctor prescribed 10 mg. PRN for moderate to severe pain. Ms. Munger testified

that it is impossible to know that dose of medication Respondent gave G.K. If Respondent gave G.K. the entire amount of MSIR that he removed, it was three times the amount prescribed.

86. Ms. Munger testified that Respondent withheld G.K.'s 0600 dose of MSIR, presumably because he gave her 30 mg. (or 1.5 ml.) at 0230 hours. But his notes on her chart say that he gave her 15 mg. of MSIR at 0230 hours.

87. Ms. Munger testified that medication errors and documentation errors affect patient safety by creating a lack of clarity in the record. All members of a health care team have access to the record so that they can know the care given and the patient's response to care. An inaccurate or incomplete record can lead to subsequent errors.

88. Ms. Munger testified that it is proper to bring to the patient medications that the patient's doctor has ordered on a specific schedule, according to what is needed to control the patient's pain and to maintain the medication at a constant level in the patient's blood.

89. Ms. Munger testified that the two documentation errors occurred within days of each other. Both involved narcotics. They do not appear to be isolated events. Although one witness at The Forum accused Respondent of having made many medication errors, there is not documentation to establish any more than the two charged in the complaint.

90. Ms. Munger admitted on cross-examination that she had not interviewed G.K.'s or M.E.'s doctors and could not testify why they prescribed, respectively, MSIR and Oxycontin the way they did. She admitted that patients have a right to refuse prescribed medication.

91. Ms. Munger testified that the MAR showed that M.E. took her prescribed Oxycontin most of the time. Ms. Munger admitted on cross-examination that, on at least three and possibly four occasions, M.E. had refused and had not been given her prescribed dose of Oxycontin, when she was under the care of nurses other than Respondent.

92. Ms. Munger testified on cross-examination that, if a nurse removed a narcotic that the patient subsequently refused, the nurse would have to waste the medication, which would require documentation. Ms. Munger could not tell whether the other nurses had wasted the MSIR that M.E. refused to take. Ms. Munger testified that a nurse who asked the patient if she wanted her narcotic medication before the nurse removed it would violate accepted nursing practice.

93. Ms. Munger admitted on cross-examination that the medical record is not the only way nurses communicate with each other. They also give reports at the end of their shift to the nurses who are starting their shifts.

94. Ms. Munger identified Mr. and Mrs. Stepp's letter of resignation, in relevant part as follows:

> We resign as of today June 3rd 2004 due to many unprofessional security who leave doors open at 4 a.m., abusive recreational assistants who was seen verbally abusing a patient -- & unprofessional CNA's all who have been resistant to working [with] 2 professionals who did what we were told to do by our D.O.N. The Director ([P.S.]) – is too unprofessional to speak [with] us & hear our side of the story. Therefore we resign.

Ms. Munger testified that this document was not included The Forum's personnel file for Mr. and Mrs. Stepp.

<u>Mrs. Stepp</u>

95. Mrs. Stepp testified that she and Respondent worked Friday, Saturday, and Sunday at The Forum, alternating the 6 a.m. to 6 p.m. and 6 p.m. to 6 a.m. shifts. There were only two other nurses on the day shift at The Forum and they were "not friendly."

96. Mrs. Stepp testified that, because she and Respondent were the only professional nurses on their shift, they felt some responsibility for the other employees, although they had not been hired as charge nurses or supervisors. Mrs. Stepp described the CNAs that she worked with at The Forum as "difficult and resistant." When she asked them to get a patient a pitcher of water, they said "No"

because it would cause the patient to urinate and require them to have to change the patient's clothes and bedding. She had to do everything herself. The CNAs were "always out on their smoking break."

97. Mrs. Stepp identified a complaint that she and Respondent had made against "Barb," an activities assistant, that she had refused to respect patient confidentiality by eavesdropping on a conversation that the Stepps were having about a patient and then abused a patient by yelling at her after she threw a health shake (or some other pink substance) into a sink. The complaint described the ensuing confrontation with "Barb" in relevant part as follows:

> We were staring at Barb when she came towards me & in a loud voice said "Your patient [V.] threw something pink all over my sink – what did you give her?" I said I [cut off] but it probably was a health shake – but she could check that further [with] the CNA's since they give residents their drinks. I also told her [V.] has the right to refuse anything & everything – and if she wants to throw something in the sink – she also has the right to do that. Barb said, "Excuse me!!!" I replied "There is no excuse for you." . . . .

Mrs. Stepp testified that, when she told Barb that she would make a report, Barb had said she "had friends" in management. Barb's friend was P.S., the administrator at The Forum and original complainant. Mrs. Stepp testified that she told Mr. Mahoney that she did not want to be scheduled with "someone who abused clients."

98. Mrs. Stepp testified that the nurses at The Forum did not like her and her husband because they reduced the overtime available on the weekend. Most of nurses had been working at The Forum ten years or more.

99. Mrs. Stepp testified that Mr. Mahoney had handed her and Respondent a couple pages of purported medical errors that were "ripped from her hands" before she could read them. She never saw the documents that were admitted into evidence against Respondent to establish medication errors in the care of G.K. and M.E. She and Respondent resigned from The Forum after they were told that "Nothing will be done if you resign." Then they received the complaint.

100. Mrs. Stepp testified that she and Respondent did not work with Ms. Sopata. The original complainant, P.S., relieved them and they gave her reports.

101. Mrs. Stepp denied that Respondent had ever yelled at anyone at the nurse's station while Ms. Sopata was present.

102. Mrs. Stepp testified that one weekend she and Respondent were working the night shift. They locked the doors at 11:00 p.m. The maintenance man kept unlocking the doors, because he said that is what he had always done. Respondent went down four times to lock the doors and admonish the security guard. Early in the morning, they saw a man walk in, who was there to deliver the newspaper. Mrs. Stepp testified that they complained about this security breach.

Respondent

103. Respondent testified that P.S. made her complaint, which was not substantiated, after he and Mrs. Stepp resigned from The Forum.

104. Respondent denied that he ever verbally abused anyone at The Forum. He believes that the complaint was made because he and Mrs. Stepp took the nurses' overtime. The nurses at The Forum were "hateful and hostile" to him and Mrs. Stepp. Because they were hired so quickly, the schedules had to be moved around.

105. Respondent testified consistently with Mrs. Stepp about the complaint against "Barb." "Barb" had said, "Go ahead and make a report; I'm good friends with the administrator." The complaint had been made a few days after that exchange.

106. Respondent testified that a vendor was delivering Oxygen and wanted to sign for it. Although generally he signs to show receipt of goods, the line that the vendor wanted him to sign said he accepted financial responsibility for the delivery. Respondent therefore refused to sign. The vendor said he would take the supplies back. Respondent testified that he called the Director of Nursing, who said "fine, I wouldn't sign either."

107. Respondent testified he had a run-in with a maintenance man who was working nights and providing security. Because the director of nursing had said to make sure the doors were locked, he walked down to the first floor and locked the doors. The maintenance man kept unlocking the doors. One morning when he was doing patient care, he saw a strange man on the floor, who turned out to be delivering newspapers. Respondent testified that locking the doors to the facility at night was in the best interest of the patients, because people were killing and burning dogs in the area at that time. Even hospitals kept their doors locked.

108. Respondent testified that he never worked with Ms. Sopata. He always worked with Mrs. Stepp. When they first started working at The Forum, Ms. Sopata was out on a worker's compensation claim. When the director of nursing hired the Stepps, he had told him that he had a supervisor that he was not happy with.

109. Respondent testified that Ms. Sopata came back to work the last weekend that he and his wife worked and relieved them once or twice. They spoke to her for about a half hour, making reports. There was never any confrontation. Ms. Munger's report of her interview of Ms. Sopata did not mention any confrontation.

110. Respondent testified that he and his wife were the only nurses working at The Forum when they worked their shift. He has never heard of a nurse "talking down" to another nurse when giving a report on patient care at the end of the shift.

111. Respondent testified that he never saw Ms. Sopata's handwritten account of the alleged confrontation until he saw it as part of the Board's investigation. He has great respect for hospice nurses, who are generally very knowledgeable in his experience. He has never seen a hospice nurse who did not know what she was doing.

112. Respondent testified that G.K. had refused her MSIR at 8:00 p.m. If the patient is awake and oriented, he does not sign a narcotic out until he has asked the patient if she wants her medication and she responds affirmatively. If he has to waste a narcotic, he must have another nurse witness it, which costs the employer more money.

113. Respondent had admitted into evidence a copy of "Residents' Rights" from The Forum, which provided that "[t]he Resident has the right to refuse treatment . . . ."

114. Respondent testified that, later on, at 2:30 a.m., G.K. complained of pain. When he suggested the smaller PRN dose, she said that she wanted her full 8:00 p.m. dose. So he administered the 8:00 p.m. dose at 2:30 a.m. and asked the nurse who came onto duty to obtain an order from the doctor for a one-time dose of MSIR. The nurse on the next shift knew G.K. and her doctor and said she would take care of the one-time dose.

115. Respondent admitted that he did not sign out the Oxycontin because M.E. refused it. He denied that M.E. was harmed by having not been given the drug. After she refused her medication, he continued to monitor her. When he ended his shift at 6:00 a.m., she was sleeping. He finds it hard to believe that she would be wheeling herself around two hours later.

116. Respondent testified that G.K. was not harmed by his administration at 2:30 a.m. of the MSIR dose that she had refused at 8:00 p.m. He did not give her the 8:00 a.m. dose 3½ hours early.

117. Respondent testified that he had never seen the Medication Error Report for the 10 mg. of Oxycontin that he did not give M.E.

118. Respondent admitted paragraph 21 of the complaint. He accidentally wrote "mg." when he meant "ml." on the MAR. It had been a hectic night. G.K. was not harmed. Respondent pointed out that her family was not notified on The Forum's medication error report.

119. Respondent testified that, as a supervisor, he knows that the proper way to hand a medication error is (1) check patient safety, i.e., check for allergic or other negative reaction; (2) speak to the nurse and find out what went wrong; (3) speak to the doctor, pharmacist, and family and, if the doctor is upset, report the error. No one ever spoke to him about the two medication errors charged in the complaint.

120. Respondent testified that he was not terminated from The Forum; he resigned. He admitted that he resigned after he was given the choice of resigning or being fired. Before the Board's investigation, he had never seen the Sunrise Termination form. He never received any written complaints at The Forum.

121. Respondent denied on cross-examination that he was involved in any confrontations at The Forum, only "misunderstandings." Although he has a loud voice, he has never yelled at another nurse at the nurse's station. Yelling is an intentional act; he never meant to yell at anyone.

122. Respondent admitted that it is standard practice to draw narcotic medications that a doctor has ordered to be given to patients and then offer the medications to them. But he testified that his practice of asking patients who are awake and alert whether they want the medication before it is drawn is also standard practice, which he learned in Nursing 101 in Palm Beach Community College. Patients have a right to refuse medications. Respondent testified that, if a patient sleeping, he will sometimes wake the patient to ask if the patient wants his medication, but not always.

123. Respondent testified that he did not call the physician to modify G.K.'s 2:30 PRN dosage because his administration of the 8:00 p.m. dose at 2:30 a.m. was not prompted by any emergency. The director of nursing at The Forum had told him not to call doctors in the middle of the night unless there was an emergency.

124. Respondent testified on cross-examination that the on-coming nurse "dropped the ball" by failing to call G.K.'s doctor to obtain a one-time order of MSIR.

ADDITIONAL EVIDENCE

125. According to Respondent's completed Investigative Questionnaire, his last 10 employers follow: (1) MSN (present); (2) Boswell Hospital (through MSN); (3) Delray Medical Center in Delray Beach, Florida (10/02 to 01/03); (4) Aventura; (5) Jupiter Medical Center (2003); (6) Delray Medical Center (1999 to 2000, left for "higher pay/new job"); (7) Manor Care in Delray Beach, Florida (2000 to 2001, left for "better opportunity"); (8) Cago Vista Care Center in Delray, Florida (2001, where Lou Kass was his supervisor, and which he left for "transfer to MH"); (9) Menorah House in Boca Raton, Florida (2001, left for "personal" reason); and (10) Gardens Court in West Palm Beach, Florida (2003, left for "personal" reason).

Ms. Munger

126. Ms. Munger testified that the complaints about Respondent's interpersonal conflicts with co-workers were a concern because healthcare is delivered by a team. Communication and cooperation among CNAs, LPNs, RNs, and physicians were essential because all members of the team must be able to easily communicate information about the patient. If a member of the team has difficulty communicating with another, there is a potential adverse impact on the patient.

127. Ms. Munger testified that she is concerned about the blow-ups at The Forum and The Gardens Court because they occurred out in the open. Patients are very vulnerable. Witnessing conflict between staff has potential to cause patients and family members to question their care.

128. Ms. Munger's investigative report of her interviews with Jerry Mahoney, RN, the Director of Nursing at The Forum, and Marjorie Sopata, RN, who testified at the hearing that she was in charge when Mr. Mahoney was out of town, did not report that anyone at The Forum told her that Mr. or Mrs. Stepp had management responsibilities while they worked there. Mr. Mahoney did say that

The Forum's investigation was done while he was out of town and referred to the investigation as a "one-sided witch-hunt." Because Mr. Mahoney had been "aware there were some issues with the Stepps, . . . he directed the MDS coordinator to call him if there were problems," but she did not do this and "instead went to human resources directly without even involving the administrator."

Mr. Nevitt

129. Hal M. Nevitt has been licensed as a social worker and substance abuse counselor by the Arizona Board of Behavioral Health Examiners and has worked in the mental health field since 1992. He has been the Director of the Member Assistance Program at the State Bar of Arizona since February 2004. Blue Cross Blue Shield, Cigna, United Healthcare and other insurance companies have authorized Mr. Nevitt to provide critical stress management to their insureds. Mr. Nevitt is the senior human relations counselor at Innovative Workplace Solutions, which contracts with employers to assist employees who may benefit from anger management or substance abuse counseling. Mr. Nevitt seldom provides counseling services to individuals; instead, he works with employers to identify issues in their employers that may need counseling to resolve and makes referrals.

130. In addition to working with attorneys, judges, and law students through the State Bar, Mr. Nevitt teaches group dynamics and sociology at Grand Canyon University and teaches online for Charter Oaks, which is for law enforcement personnel. Mr. Nevitt also provides assessments to hospital boards and executive councils and monitors the performance of physicians who have been identified through the peer review process as possibly needing assistance. Mr. Nevitt has testified as an expert for the Attorney General's Office. He worked for St. Luke's Behavioral Health Systems from May 1998 to May 2001 and created an employee assistance program for doctors and nurses to help them satisfy the behavioral health component of the preceptor program.

131. For eight years, Mr. Nevitt was a police officer. After he started working undercover in drug enforcement, Mr. Nevitt became addicted to cocaine and alcohol. He ended up being convicted of

a felony and spent several years in prison. He recently learned that the Arizona Peace Officer Standards and Training Board revoked his peace officer certification in 1986 after his felony conviction. Mr. Nevitt testified that his personal experience with drug addition and prison has made him a better counselor. He discloses his felony conviction to everyone he works with. He knows from personal experience that "people make mistakes but have an amazing capacity to change." His licenses from the Board of Behavioral Health Examiners are in good standing and have never been disciplined.

132. Mr. Nevitt is not presently on the Board's list of approved evaluators, although in the past he has been approved by the Board and, in the past, evaluated two licensees pursuant to the Board's referral.

133. Mr. Nevitt testified that he had reviewed the Board's notice of charges, complaint, and updated investigative report when he evaluated Respondent, as well as the documents from Aventura Hospital and The Forum that were admitted into evidence.

134. Respondent also had two letters from Respondent's supervisors at Promise Specialty Hospital in Phoenix, where he worked as case manager between December 2005 to shortly after the first hearing date in this matter. Rhonda Hawker, RN, Nurse Manager, wrote as follows:

> While the time has been brief, it has been very pleasant and I have been quite impressed by Respondent. He walked in to our facility with no idea of what he would face, took a moment to get settled, receive direction and then ran with it. He has shown himself to be the epitome of professionalism and has completed every task presented to him beyond our expectations with minimal supervision. In his brief time here, he has been able to establish positive working relationships with physicians, patients, family and staff. Respondent has demonstrated the ability to handle anything that comes his way with professionalism, and a caring attitude that garners positive outcomes for everyone. I believe that Respondent has the knowledge and fortitude to be a tremendous success at whatever he attempts to do and would truly be an asset to any company that should choose to hire him.

Respondent also provided a letter from Lizabeth Stephens, RN, MBA, Promise Specialty Hospital's Administrator/CEO, in relevant part as follows:

> David Stepp, RN has been working at Promise Specialty Hospital on a temporary assignment as case manager since December 19, 2005. He stepped into the position with little coaching and has managed with superlative skill. I have had feedback fro0m staff, patients and family complementing him on his friendly and efficient manner, working diligently to find the right discharge placement for each patient. I see David as a very competent case manager, putting forth maximum effort with a true desire to learn and enhance his skill level.
>
> I believe David would be an excellent addition to any healthcare team. If there were an additional opening at my facility, he would definitely be a part of mine. . . .

Neither Ms. Stephens nor Ms. Hawker testified at the hearing. Mr. Nevitt testified that he initiated a telephone call to Ms. Stephens and asked her questions about her letter. Ms. Stephens confirmed that Respondent was an employee, whom she described as having a "calm demeanor," who dealt "appropriately with grieving relatives despite their insistence that the cause of their grief was his problem." Mr. Nevitt testified that Ms. Stephens told him that Respondent consulted her and staff about how to deal with stressful situations at work.

135. Mr. Nevitt interviewed Respondent three times. Mrs. Stepp was included in two of the interviews, because Mr. Nevitt wanted to see how Respondent resolved conflict with his wife. Mr. Nevitt did not perform any psychological tests on Respondent because he saw no need. Mr. Nevitt's determined that Respondent was not depressed, anxious, psychotic or suffering from any other mental illness.

136. Mr. Nevitt determined that Respondent experienced anger much like a number of people do. Mr. Nevitt concluded that Respondent did not have any anger or conflict issues that would require treatment. Respondent experienced anger in a normal fashion and was able to verbalize strategies for coping with anger. Mr. Nevitt testified that, if one thought of a thermometer that measured a person's

possible reaction to conflict, with annoyance at lower temperatures and uncontrollable rage at the higher temperatures, he would say that Respondent exhibited irritability and frustration, which would be at the lower end of the range.

137. Mr. Nevitt testified that Respondent had indicated that he was frustrated and angry at the situation involving the Board. Respondent believed he had been singled out unfairly and that the complaint from the former employer was retaliatory.

138. Mr. Nevitt testified that Mr. and Mrs. Stepp told him that the Director of Nursing at the Forum who hired them put them in positions of management and leadership, then left for vacation. That was a tough position to put Mr. and Mrs. Stepp in, which may have led to the complaint. Mr. Nevitt testified that the revised investigative report did not change his opinion but bolstered Respondent's account.

139. Mr. Nevitt testified that Respondent is a "highly client-conscious individual" who "takes pride in his profession as a nurse." Having his professionalism questioned caused Respondent to become agitated, and Mr. Nevitt admitted on cross-examination that, at least once when Respondent was discussing the Board's investigation in his office, his face became very red, his voice was raised, and he would quiver. These physiological responses were apparent during the hearing on the Board's complaint. Mr. Nevitt described Respondent's "candor about the impact of the Board's investigation" as "striking."

140. Mr. Nevitt testified that, although he had observed Respondent to be moderately irritated and frustrated at the Board's investigation, he did not observe any symptom of an Axis I diagnosis. In Mr. Nevitt's opinion, Respondent's agitation or interpersonal skills did not relate to his ability to competently and safely practice nursing. Mr. Nevitt is "a passionate man" who "wants to take care of

his patients." Mr. Nevitt testified that, in his opinion, Respondent is able to perform his duties as a nurse without negative impact on himself or others.

141. Mr. Nevitt admitted on cross-examination that he did not know the difference in the professional responsibilities of a professional nurse, as compared to those of a licensed practical nurse. On redirect, Respondent testified that he is not an occupational therapist. He does not know the exact duties of an attorney, except generally, but can discern if an attorney is safe to practice.

142. Mr. Nevitt admitted on cross-examination that he did not administer any psychological tests to Respondent. He is not qualified to give the MMPI-2, but he can refer a patient for the test. He did not so refer Respondent. Mr. Nevitt testified that he was not familiar with the Anger Disorder Scale test and is not trained to administer the Millón test.

Respondent

143. Respondent testified that he has been a licensed nurse for seven years. This is the only complaint that has ever been made against his license.

144. Respondent testified that that in junior high school and high school he engaged in sports. After he got out of high school, he worked in construction as a sheet metal apprentice. He then went to the St. Augustine, Florida police academy and received peace officer certification. But the department he wanted to work for was not hiring. He waited 8 or 9 months, then joined the Marines. Respondent testified that he was given a high security clearance and was put in charge of all radio operators. After four years, he was honorably discharged. Respondent had admitted into evidence four letters or certificates of commendation related to his military service from 1988 to 1990.

145. Respondent testified he then worked as a military police officer, training other officers and performing investigations. He considered returning to civilian law enforcement, but "there had been a lot of police shootings." Because he had "the heart and skill to help others," he decided to become a nurse. Respondent had admitted into evidence 11 letters of commendation from patients,

family members, and supervisors at Del Ray Hospital and Manor Care Health Services dated between 1999 and 2001, praising his skill as a nurse and compassion.

146. Respondent admitted that he was extremely nervous about the Board's complaint. When he is nervous, his face gets "beet red," he gets "teary," and he feels like he has "rocks in his stomach." The first day he testified, he had gone to be bathroom three times before he got on the stand. He also coughs. He was not angry; he was just upset.

147. Respondent testified that his first job as a nurse supervising others was at Del Ray Hospital, where he started as a floor nurse then was promoted to assistant director of nursing. Respondent testified that, although he and Mrs. Stepp were not supervisors at The Forum, they were the only professional nurses on the floor.

148. Respondent testified that, for years, his wife and many people he knows have been telling him he talked too loudly. But he has never yelled at or tried to intimidate anyone in a work setting. On September 23, 2005, he was evaluated by audiologist Ed Dobbins, M.S., CCC-A. Mr. Dobbins' report, which was admitted into evidence, found that Respondent had a 50% hearing loss in both ears and that he therefore was a candidate for hearing aids in both ears. When he is able to work steadily again, Respondent plans to purchase hearing aids. Because hearing aids cost $1,000 each, he cannot afford to purchase them now.

149. Respondent testified that, after he applied for a position at Promise Specialty Hospital, Amy Walker had interviewed him over the telephone. He heard people asking her questions in the background and assumed that she was the director of nursing, a busy person answering questions from her desk. Ms. Walker told him his resumé was impressive. He said he could start on Monday. Five minutes after he hung up, the company called him to tell him that it wanted him to start on Monday.

150. Respondent testified that he did not remember Ms. Walker telling him her title when she interviewed him. Promise Specialty Hospital is a 60-bed full-fledged hospital. His job as case manager was to set up transitions for discharge, for example, home health care or rehabilitation. He had to review the chart, speak to the nurse, patient, patient's family, insurance company, and new caregiver or facility to formulate appropriate discharge placement and obtain the patient's approval. The first day he worked at Promise, he was able to discharge 3 patients. The administrator told him she had been hoping he could get just one discharge completed.

151. Respondent testified that working at Promise was difficult because he did not know the paperwork or protocol. Ms. Stephens was the administrator who supervised his work. When Ms. Stephens was not available, Ms. Hawker supervised him. He did not meet Ms. Walker until two weeks after he started working at Promise. She was the Chief Clinical Officer ("CCO") and not his direct supervisor.

152. Respondent testified that he understood the position at Promise was a temporary position. The hospital had hired a permanent case manager who had been unable to start work until February 2006.

153. Respondent testified that Ms. Hawker had asked him to stay two weeks after the permanent case manager started work. But, after the Board's attorney contacted Promise, Ms. Hawker told him on the new case manager's first day of work that he would not be needed anymore.

154. Respondent testified he asked Ms. Hawker and Ms. Stephens to write letters of reference for him because Promise was the first job he had been able to obtain since leaving The Forum in June 2004. The pending complaint against his license made it very difficult for him to find work. He wanted to have something to show other potential employers.

155. Respondent testified that his first direct interaction with Ms. Walker occurred when Ms. Stephens and Ms. Hawker were not available. A brother of a confused patient called to make arrangements to come to Arizona and sign paperwork that would give him control over the patient's checkbook. The brother said he would be in Arizona in a month. Because Respondent knew that his time was short and because he did not know the new case manager, he gave the brother Ms. Walker's name. She was upset when he told her what he had done and said it was not her job. Ms. Walker had never otherwise criticized his job performance. He had no idea what she would testify about.

156. Respondent testified that he decided to obtain an evaluation from Mr. Nevitt because he wanted an unbiased opinion after the Board had expressed concerns about an anger management problem. He was not under an order or referral from the Board for an evaluation. He went to see Mr. Nevitt to see if he was handling his anger appropriately. If Mr. Nevitt had recommended treatment, he would have obtained it.

157. Respondent testified that the Board's complaint almost broke up his marriage. He and Mrs. Stepp have had to file for bankruptcy. He has not been able to obtain employment until recently. He is willing to be punished for the one documentation error he admits, but the Board does not want to acknowledge his strengths as a nurse or to listen to his side of the story. Respondent testified on cross-examination that he believes he did an excellent job at Aventura, The Gardens Court, Boca Raton, Boswell, and The Forum.

158. Respondent admitted on cross-examination that a nurse should not blow up and yell at another nurse or staff member in a place where the interaction may be seen or heard by other staff, patients, or family members. Such behavior is unprofessional and rude. When he worked as a supervisor, if an issue needed to be addressed, he would address the issue privately with the supervisee or that person's supervisor. A nurse's unprofessional outburst could negatively impact patients and

make them depressed and upset and make family members wonder whether the patient was receiving appropriate care, especially if the argument involved the patient.

159. Respondent insisted on cross-examination that a nurse's inappropriate reactions to interpersonal conflict did not constitute a violation of the Arizona Nurse Practice Act, at least if the nurse were not arguing about a specific patient's care in the hearing of the patient or patient's family.

Ms. Walker

160. Amy Walker testified on the last day of hearing that she is the CCO and Interim Acting CEO at Promise. Ms. Stephens had left Promise on March 13, 2006. As CCO, she oversees finances, staffing, patient care, and hiring and termination of employees.

161. Ms. Walker testified that Promise is a long-term acute care facility whose patients say an average of 25 days. Promise takes patients from ICU units in hospital and cares for them until they are ready to be discharged home or to a nursing facility. Promise has 36 beds.

162. Ms. Walker testified that Respondent worked at Promise through a temporary contract. He applied for the position of case manager but the CEO at that time, Ms. Stephens, picked another candidate. Because the person hired could not start until February, Promise hired Respondent to be case manager for the interim.

163. Ms. Walker testified that she received numerous complaints from patients, patients' families, and staff about Respondent's "military manner" and lack of compassion. One physician called him "a jerk." Ms. Walker testified that this general low opinion of Respondent was shared by Ms. Hawker, the Director of Respiratory Therapy.

164. Ms. Walker testified that one patient's family told her that, when Respondent was working on a "difficult discharge" for a patient who was "running out of insurance," Respondent had told the family that Promise would "'kick the patient out'" if the patient and family did not agree to the

placement that Respondent proposed. Ms. Walker testified that she would not hire Respondent because he was "too abrupt."

165. Ms. Walker admitted on cross-examination that she had never seen Ms. Stephens' or Ms. Hawker's letters of reference for Respondent.

166. Ms. Walker admitted on cross-examination that no paperwork had been prepared about the patient complaints. Only one patient's family came to her office to complain formally about Respondent. Respondent was not counseled regarding this complaint because he was only a temporary employee. Because Respondent worked through a Registry, it would be the Registry's responsibility to handle complaints. She did not provide anything in writing to the Registry about any complaint regarding Respondent.

167. Ms. Walker also admitted that her testimony that she received complaints about Respondent on almost an hourly basis "was probably an exaggeration." She insisted that she did receive multiple complaints, however. Although she agreed that his purported statement threatening to "kick [a patient] out" of Promise was egregious, Ms. Walker did not believe that it required a follow up to Respondent, the Registry, or the Board.

168. Ms. Walker also testified that Respondent had taken documentation home because he was unable to complete the documentation during work hours. She had told him not to take the documentation, but he did anyway. After Respondent left Promise, the lack of documentation made it difficult to know what care patients had been given.

169. Ms. Walker testified that she was concerned after Respondent told her that he had given her name to the family of a patient that was being discharged because she was not supposed to be involved in discharges. Nurses should have compassion and psychosocial skills, which in her opinion Respondent lacks.

170. Ms. Walker testified that she had been contacted by the Board's attorney after Respondent's employment had ended. She was not in town when Respondent was terminated. Although he had been asked to stay for the transition while the new, permanent case manager took over, nurse manager Rhonda Hawker determined he was no longer needed.

171. Ms. Walker testified that she spoke to the Board's attorney 30 to 45 minutes on the phone the first time they spoke. Altogether, she spoke to him five or six times for a total of approximately three hours. The purposes of the conversations were to schedule her testimony and to "make sure she understood the issues." The Board's attorney had not told her about allegations at other facilities or told her what to testify.

Ms. Smith

172. The parties stipulated that Mr. Nevitt is not a Board-approved evaluator. Ms. Smith testified that the appropriate education level for an expert would be a Ph.D. who could conduct a psychological examination with psychological testing, including the MMPI. The results of psychological testing would reveal information that might not be revealed in a clinical interview.

173. Ms. Smith testified that the Board's allegations concerned a pattern of misconduct, in which Respondent was aggressive and confrontational in interactions with supervisors and co-workers at two or three places of employment. If psychological testing revealed management issues, a psychologist would be able to make treatment recommendations.

174. Ms. Smith testified that the Board requires psychological tests even if the evaluator's clinical interview identifies no concerns. The complexity of the case determines the level of the evaluation. This case is very complex.

175. Ms. Smith testified on cross-examination that the MMPI has been used for 50 or 60 years. It has been testified and evaluated, although she admitted that she has heard of practitioners who

say that the MMPI is not valid. Although the results of an MMPI-2 test can be manipulated, such manipulation is harder than manipulation of the outcome of a clinical interview.

176. Ms. Smith testified that verbal abuse, whether of a patient, co-worker, or supervisor, was a violation of the Nurse Practice Act and within the mandatory reporting requirements.

APPLICABLE LAW

1. Both parties agreed that the statutes and regulations that were in effect when Respondent worked at the Forum and P.S. made the initial complaint, published in the Board's April 2004 compilation, governed this dispute. These statutes were charged in the Board's Complaint and Notice of Hearing, are taken from the April 2004 compilation, and are set forth below.

2. A.R.S. § 32-1663(D) allowed the Board to discipline a license if, after affording the licensee an opportunity for a hearing, the Board finds that the licensee has committed an act of unprofessional conduct.

3. A.R.S. § 32-1664(E) allowed the Board to conduct an investigation of any complaint it receives that a licensee has committed unprofessional conduct. Subsection (F) of that statute allows the Board, "for reasonable cause," to require a licensee to undergo the psychological examinations "necessary to determine a person's competence and conduct."

4. A.R.S. § 32-1601(16) defined "unprofessional conduct" to include the following:

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

5. Pursuant to its statutory authority, the Board promulgated A.A.C. R4-19-403, which in 2004[2] defined "a practice that is or might be harmful or dangerous to the health of a patient or the public" under A.R.S. § 32-1601(16)(d) in relevant part:

> (1) A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice.
> . . . .
>
> (5) Failing to maintain for each patient a record which accurately reflects the nursing care and treatment provided to a patient.
> . . . .
>
> (25) Practicing in any other manner which gives the Board reasonable cause to believe that the health of a patient or the public may be harmed.

CONCLUSIONS OF LAW

1. This matter lies within the Board's jurisdiction under A.R.S. § 32-1606(A)(8).

2. The Board bears the burden of proof and must establish cause to sanction Respondent's professional nurse's license by a preponderance of the evidence.[3] "A preponderance of the evidence is such proof as convinces the trier of fact that the contention is more probably true than not."[4] A preponderance of the evidence is "evidence which is of greater weight or more convincing than evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not."[5]

RESPONDENT'S ALLEGEDLY FALSE AND MISLEADING STATEMENTS TO THE BOARD

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[2] These regulations have since been renumbered A.A.C. R9-19-403(B)(1), (7), and (31).

[3] *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).

[4] Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

[5] BLACK'S LAW DICTIONARY at page 1120 (8th ed. 2004).

3. Respondent established at the hearing that he had been hospitalized between November 5 and 7, 2002 and that he had been medically cleared to return to work on November 14, 2002, which was the day before Aventura terminated his employment. His testimony that he meant to resign for health reasons, after giving a two-week notice, is uncontroverted. His testimony that no one had complained about the quality of his work or his attitude until he became ill is uncontroverted. Ms. Small and Ms. Flayer did not testify. Their letters are therefore hearsay.[6] Although hearsay may be admitted in an administrative hearing,[7] it should not be relied upon if it is unreliable or not the kind of evidence that reasonable persons would rely upon in serious matters.[8] The Board therefore did not establish that Respondent's statement on the investigative questionnaire that he resigned from Aventura for "health reasons" was false and misleading (Complaint ¶ 7).

4. Respondent's explanation that he lost his job at Boswell due to his plan, which was almost immediately aborted, to fly to Florida to be with his father is uncontroverted and supported by Mrs. Stepp's testimony. Because Respondent's explanation that he meant his father's health when he stated on the Board's investigative questionnaire that he left his position at Boswell for "health reasons" was credible, the Board has not established that the statement false or misleading (Complaint ¶ 15).

5. Respondent's explanation that he did not understand that Ms. Munger had asked him whether he immediately, rather than eventually, flew to Florida after notifying Boswell of his intent to do so because he was looking at papers during the interview was credible. The Board therefore has not

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[6] *See* Ariz. R. Evid. 801.

[7] *See* A.R.S. § 41-1092.07(F)(1).

[8] *See Plowman v. Arizona State Liquor Board*, 152 Ariz. 331, 337, 732 P.2d 222, 228 (App. 1986) (citing *Begay v. Arizona Department of Economic Security*, 128 Ariz. 407, 626 P.2d 137 (App. 1981).

established that his statement that he traveled to Florida to see his father following the termination of their travel contract with Boswell was false and misleading (Complaint ¶ 17).

6. Even if the Board had established that Respondent provided false or misleading information during the course of the investigation, its Complaint did not charge Respondent under any statute or regulation that could have furnished grounds to discipline his license for this misconduct. The statutes and regulations in effect in 2004 contained no provision that could have been charged that would have allowed such discipline if the factual predicate had been proven.[9]

[9] The Board subsequently adopted A.A.C. R4-19-403(B)(25) and (26), which include in the definition of "any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public" under A.R.S. § 32-1601(d)(16)(d) the following:

> 25. Failing to:
>
> a. Furnish in writing a full and complete explanation of matter reported pursuant to A.R.S. § 32-1664 . . . .
> . . . .
>
> 26. Making a written false or inaccurate statement to the Board or the Board's designee in the course of an investigation . . . .

RESPONDENT'S ALLEGED MEDICATION AND DOCUMENTATION ERRORS

7. Respondent admitted that he erred in writing "1.5 mg" rather than "1.5 ml" on the nurse's notes for G.K. on May 30, 2004 at The Forum, which improperly documented the amount of MSIR that he had administered (Complaint ¶ 21), in violation of A.R.S. § 32-1601(d) and (j) and A.A.C. R4-19-403(1) and (5).

8. Respondent's testimony that the MSIR dose he gave G.K. was the 8:00 p.m. dose was uncontroverted. The Board therefore has not established that Respondent administered G.K.'s MSIR dose "three and a half hours before the medication was due, in violation of the standard of care" (Complaint ¶ 22).

9. Ms. Munger's testimony that the accepted standard of practice is for a nurse to check out narcotics that a doctor has ordered on a specific schedule to administer to a patient was more credible than Respondent's testimony that a nurse may ask the patient first whether she wants medication that a doctor has ordered before checking it out. The Board therefore has established that Respondent committed a documentation error by failing to sign out M.E.'s Oxycontin in the narcotics book at The Forum on May 28, 2004 (Complaint ¶ 19), in violation of A.R.S. § 32-1601(d) and (j) and A.A.C. R4-19-403(1).

RESPONDENT'S ALLEGED CONFRONTATIONAL AND AGGRESSIVE BEHAVIOR

10. Respondent admitted at the hearing that a nurse's confrontations with supervisors, co-workers, and staff could upset patients, residents, and family members who witness the confrontation. Therefore, such misconduct could furnish cause to penalize a nurse's license under A.R.S. § 32-1601(16)(d) and (j) and A.A.C. R4-19-403(1) and (25).

11. Respondent characterized the Board's investigation as a "witch hunt" that involved character assassination from dubious sources. The Board characterized the gravamen of its complaint as a pattern of confrontation and aggression in Respondent's interpersonal communications at work.

Because evidence of other wrongs or acts generally should not be considered to show that a person acted in conformity therewith,[10] the Administrative Law Judge has attempted to analyze the Board's charges individually rather than collectively.

12. As noted above, Ms. Small and Flayer did not testify at the hearing. An inference could be drawn that they were upset about the money that Aventura had invested in training Respondent to be a critical care nurse when he told them that he was submitting his resignation. The Board has not established that Respondent's reaction in 2002 to whatever conflicts existed at Aventura constituted a violation of the Arizona Nurse Practice Act (Complaint ¶¶ 3-7).

13. The Board has established that Respondent did yell at Ms. Munger in the early stage of her investigation (Complaint ¶ 25). Because this act did not occur while Respondent was at work, it is not a violation of the Nurse Practice Act and should not be considered as part of any pattern by Respondent of alleged misconduct that consisted of inappropriate behavior at work.

14. Mr. Kass' attitude to Respondent changed after he made a workers' compensation claim against The Gardens Court. Mr. Kass wrote Respondent up for behaviors that were more attributable to his industrial injury, rather than to any concomitant aggressive or uncooperative attitude. Mr. Kass' relationship with Respondent was adversarial. Mr. Kass, not Respondent, provoked any confrontation that might have occurred on August 27, 2003 by telling Respondent "Just go," in response to Respondent's statement that his physical symptoms prevented him from remaining on the job. The Board therefore has not established that Respondent's reaction in 2003 to whatever conflict Mr. Kass initiated at The Gardens Court constituted a violation of the Arizona Nurse Practice Act (Complaint ¶¶ 9-11).

[10] *See* Ariz. R. Evid. 404(b).

15. The Board did not allege that Respondent was aggressive or confrontational at Boswell (Complaint ¶¶ 12-18).

16. Ms. Sopata credibly testified that she witnessed Respondent being "confrontational and demeaning in his interaction with fellow staff members at The Forum at Desert Harbor, while discussing G.K.'s medications."

17. Although Respondent admitted that he had not been hired to be a supervisor at The Forum, his own account of his employment is characterized by escalating confrontations with people whom he had just met. He or his wife told Barb, the activities director, that "There is no excuse for you" after she objected to the manner in which the Stepps had reprimanded her. Respondent testified that he and the maintenance man locked and unlocked doors for most of the night. Although Barb may have been unprofessional and the maintenance man may have had a poor understanding of the need for security, Respondent's intervention was confrontational and escalated the conflict. Respondent did not promote teamwork or patient welfare.

18. The Board therefore established that Respondent violated the Nurse Practice Act by confronting his fellow staff members at the nurse's station at the change of shift on or about May 30, 2004.

19. The Administrative Law Judge agrees with Mr. Nevitt that Respondent does not exhibit any symptoms of a recognized mental illness. She agrees that Respondent is a talented and committed professional nurse who is capable to making significant contributions to the profession and his patients. But, although Respondent may be able to deal appropriately with conflict in his personal life, the Board has established that he does not always deal with conflict appropriately in his professional life.

20. With respect to the remedy, Mr. Kass and Ms. Sopata both testified that, when they witnessed Respondent encounter conflict, his face became red and he raised his voice. Mr. Nevitt noted

in his testimony and the Administrative Law Judge observed Respondent exhibit the same response to conflict at hearing. This response likely would be perceived by patients and colleagues as anger. As noted above, however, not only does Respondent exhibit anger in ways that he testified are unintentional, he also intentionally responds to conflict in ways that are likely to escalate the conflict. He may require professional treatment to identify and control both manifestations in inappropriate confrontational behavior.

ORDER

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

A. Respondent's license is placed on probation for twelve (12) months. Prior to termination of probation, Respondent shall work as a professional nurse for a minimum of 12 months (not less than sixteen hours a week).

B. If Respondent is noncompliant with any of the terms of the Order, Respondent's noncompliance shall be reviewed by the Board for consideration of possible further discipline on Respondent's nursing license.

C. If Respondent is convicted of a felony, Respondent's license shall be automatically revoked for a period of five years. Respondent waives any and all rights to a hearing, rehearing or judicial review of any revocation imposed pursuant to this paragraph.

D. Probation is subject to the following terms and conditions:

TERMS OF PROBATION

1. Stamping of License

Within seven days of the effective date of this Order, Respondent shall submit his license to be stamped **"PROBATION."** While this Order is in effect, if the Board issues any

certificates or licenses authorized by statute, except a nursing assistant certificate, such certificate or license shall also be stamped "probation." Respondent is not eligible for a multistate "Compact" license.

2. Refresher Course in Pharmacology

Within thirty days of the effective date of this Order, Respondent shall submit to the Board or its designee for prior approval, a course outline/objectives of a refresher educational course for pharmacology. Respondent shall then provide written proof from the instructor or provider of the course verifying enrollment, attendance, and successful completion of each required course or program. Following the successful completion of each course or program, the Board or its designee may administer an examination to test Respondent's knowledge of the course or program content. The Board reserves the right to amend the Order based on the recommendation(s) of the course instructor.

3. Psychological Evaluation/Treatment

Within 30 days of the effective date of the Order, Respondent shall make an appointment to undergo a psychological evaluation (with psychometric testing) by a Board-approved Psychologist to be completed within ninety (90) days of the effective date of the Order. Respondent shall execute the appropriate release of information form(s) to allow the evaluator to communicate information to the Board or its designee. Prior to the evaluation, Respondent shall furnish a copy of this Order to include Findings of Fact and Conclusions of Law to the evaluator who shall verify receipt of the Order to include Findings of Fact in a written report on letterhead to the Board. Respondent shall direct the evaluator to provide a report to the Board summarizing the evaluation within thirty days after the evaluation is completed.

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The report shall include a history and physical, relevant laboratory data if appropriate, psychological testing if appropriate, recommendations for treatment, if any, and an assessment as to Respondent's ability to function safely in nursing.

If it is recommended that Respondent undergo medical treatment and/or psychological therapy or counseling, Respondent shall, within seven days of notification of the recommendation(s), provide to the Board or its designee for prior approval, the name and qualifications of treatment professional(s) with appropriate level of expertise of Respondent's choice. Upon approval of the treatment professional(s), Respondent shall provide a copy of the entire Order which the treatment professional(s) shall verify in writing on letterhead in their first report to the Board. Respondent shall undergo and continue treatment until the treatment professional(s) determines and reports to the Board in writing and on letterhead, that treatment is no longer considered necessary. Respondent shall have the treatment professional(s) provide written reports to the Board every three (3) months. The Board reserves the right to amend this Order based on the evaluation results or the treatment professional's recommendations.

4. Practice Under On-Site Supervision

Respondent shall practice as a professional nurse only under the on-site supervision of a professional nurse in good standing with the Board. Respondent's wife shall not be the supervising nurse during the probationary period to assure objective oversight. On-site supervision is defined as having a professional nurse present in the building while Respondent is on duty**.** The supervising nurse shall have read this Consent Agreement and Order to include the Findings of Fact and Conclusions of Law, and Order, and shall provide input on Respondent's employer evaluations to the Board. The supervising nurse shall be primarily one person, who may periodically delegate to other qualified personnel, who shall also have read this Consent Agreement and Order to include Findings of Fact,

Conclusions of Law. In the event that the assigned supervising nurse is no longer responsible for the supervision required by this paragraph, Respondent shall cause her new supervising nurse to inform the Board, in writing and on employer letterhead, acknowledgment of the new supervisor's receipt of a copy of this Consent Agreement and Order to include the Findings of Fact and Conclusions of Law and the new supervising nurse's agreement to comply with the conditions of probation within ten days of assignment of a new supervising nurse.

5. Notification of Practice Settings

Any setting in which Respondent accepts employment, which requires nursing licensure, shall be provided with a copy of the entire Order on or before the date of hire. Within seventy-two hours of Respondent's date of hire, Respondent shall cause his immediate supervisor to inform the Board, in writing and on employer letterhead, acknowledgment of the supervisor's receipt of a copy of this Order and the employer's ability to comply with the conditions of probation. In the event Respondent is attending a nursing program, Respondent shall provide a copy of the entire Order to the Program Director. Respondent shall cause the Program Director to inform the Board, in writing and on school letterhead, acknowledgment of the program's receipt of a copy of the Order and the program's ability to comply with the conditions of probation during clinical experiences.

6. Quarterly Reports

Within 7 days of each assigned quarterly reporting due date, if Respondent is working in any position which requires nursing licensure Respondent shall cause **every** employer Respondent has worked for during the quarter to provide to the Board, in writing, employer evaluations on the Board-approved form. The first report is due on the first assigned quarterly report due date after the effective date of the Order. Receipt of notice of an unsatisfactory employer evaluation, verbal or written warning, counseling or disciplinary action any of which pertain to patient care practice issues, or

termination from a place of employment shall be considered as noncompliance with the terms of the Order. In the event Respondent is not working in a position which required RN licensure, or attending school during any quarter or portion thereof, Respondent shall provide to the Board, in writing, a self-report describing other employment or activities on the Board-approved form. Failure to provide employer evaluations/or self-reports within 7 days of the reporting date shall be considered as noncompliance with the terms of the Order.

7. Acceptable Hours of Work

Respondent shall work only the day or evening shift. Evening shift is defined as a shift that ends prior to midnight. Within a 14-day period Respondent shall not work more than 84 scheduled hours.

Respondent may work three 12-hour shifts in one seven day period and four 12-hour shifts in the other seven-day period, but Respondent may not work more than 3 consecutive 12-hour shifts during this probationary period. Respondent shall not work 2 consecutive 8 hour shifts within a 24 hour period or be scheduled to work 16 hours within a 24 hour period.

8. Registry Work Prohibited

Respondent may not work for a nurse's registry, home health, traveling nurse agency, any other temporary employing agencies, float pool, or position that requires on-call status.

9. Out-of-State Practice/Residence

Before any out-of-state practice or residence can be credited toward fulfillment of these terms and conditions, it must first be approved by the Board prior to leaving the state. If Respondent fails to receive such approval before leaving the state, none of the time spent out-of-state will be credited to the fulfillment of the terms and conditions of this Order.

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10. Release of Information Forms

Respondent shall sign all release of information forms as required by the Board or its designee and return them to the Board within 10 days of the Board's written request. If Respondent fails to execute the releases, his license shall be reviewed by the Board for consideration of possible further discipline on Respondent's license.

11. Interview With the Board or Its Designee

Respondent shall appear in person or if residing out of state telephonically for interviews with the Board or its designee upon request at various intervals and with reasonable notice.

12. Renewal of License

In the event Respondent's professional nurse license is scheduled to expire while this Order is in effect, Respondent shall apply for renewal of the license, pay the applicable fee, and otherwise maintain qualification to practice nursing in Arizona.

13. Change of Employment/Personal Address/Telephone Number

Respondent shall notify the Board, in writing, within one week of any change in nursing employment, personal address or telephone number.

14. Obey All Laws

Respondent shall obey all federal, state and local laws, and all laws/rules governing the practice of nursing in this state. Offenses such as driving under the influence may subject Respondent to further disciplinary action, however, commission of minor civil traffic moving violations are excluded.

15. Costs

Respondent shall bear all costs of complying with this Order.

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16. Violation of Probation

If Respondent is noncompliant with this Order in any respect, the Board or its designee may notify Respondent's employer of the noncompliance. Additionally, the Board may revoke probation and take further disciplinary action for noncompliance with this Order after affording Respondent notice and the opportunity to be heard. If a complaint or petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

17. Voluntary Surrender of License

Respondent may, at any time this Order is in effect, voluntarily request surrender of his license.

18. Completion of Probation

Upon successful completion of the terms of probation, Respondent shall request formal review by the Board, and after formal review by the Board, Respondent's nursing license may be fully restored by the appropriate Board action if compliance with this Order has been demonstrated.

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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 Susan Barber, R.N., M.S.N., Arizona State Board of Nursing, 4747 North 7th Street Ste 200, Phoenix AZ 85014. For answers to questions regarding a rehearing, contact Susan Barber at (602) 889-5161. 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.

DATED this 15th day of November, 2006.

ARIZONA STATE BOARD OF NURSING

SEAL

____

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

COPIES mailed this 24th day of November 2006, by Certified Mail No. 7005 1820 0007 1873 9763 and First Class Mail to:

David Alan Stepp
PO Box 5089
Peoria AZ 85385

COPIES of the foregoing mailed this 24th day of November 2006, to:

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By: Vicky Driver