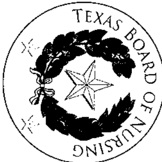


I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.

Executive Director of the Board

IN THE MATTER OF PERMANENT	§	BEFORE THE TEXAS
REGISTERED NURSE LICENSE	§	BOARD OF NURSING
NUMBER 685893 ISSUED TO	§	ELIGIBILITY AND
PENNY LYNNE BARTON	§	DISCIPLINARY COMMITTEE

ORDER OF THE BOARD

TO: Penny Lynne Barton
2186 Jackson Keller Drive #208
San Antonio, TX 78213

During open meeting held in Austin, Texas, on February 12, 2013, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, Chapter 301 of the Texas Occupations Code, for retention of Respondent's license(s) to practice nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by reference for all purposes and the Staff's recommended sanction of revocation by default. This Order

will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN.CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

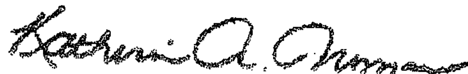
All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Registered Nurse License Number 685893, previously issued to PENNY LYNNE BARTON, to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

Entered this 12th day of February, 2013.

TEXAS BOARD OF NURSING

BY: 

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Attachment: Formal Charge filed November 6, 2012.

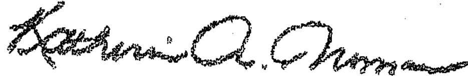
Re: Permanent Registered Nurse License Number 685893
Issued to PENNY LYNNE BARTON
DEFAULT ORDER - REVOKE

CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of February, 2013, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested
Penny Lynne Barton
2186 Jackson Keller Drive #208
San Antonio, TX 78213

Via USPS First Class Mail
Penny Lynne Barton
8514 W. Townley Ave.
Peoria, AZ 85345



BY: ______________________________
KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

In the Matter of Permanent Registered Nurse License Number 685893 Issued to PENNY LYNNE BARTON, Respondent	§ § § §	BEFORE THE TEXAS BOARD OF NURSING

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, PENNY LYNNE BARTON, is a Registered Nurse holding License Number 685893 which is in delinquent status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about December 22, 2010, Respondent voluntarily surrendered her license to practice professional nursing in the State of Missouri, due to allegations of misappropriation of Dilaudid and a positive drug screen for Marijuana, Meperidine and Normeperidine. A copy of the Settlement Agreement and Order issued by the Missouri State Board of Nursing, dated December 22, 2010, is attached and incorporated by reference as part of this charge.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

CHARGE II.

On or about July 25, 2011, the Arizona State Board of Nursing issued an Order of Emergency Summary Suspension wherein Respondent's license to practice professional nursing in the State of Arizona was Summarily Suspended due to allegations of diversion of Dilaudid. Subsequently, on or about November 14, 2011, the Arizona State Board of Nursing issued a Final Order wherein Respondent's license to practice professional nursing was Revoked. Copies of the Order of Emergency Summary Suspension issued by the Arizona State Board of Nursing dated, July 25, 2011, and Findings of Fact, Conclusions of Law and Order issued by the Arizona State Board of Nursing, dated November 14, 2011, are attached and incorporated by reference as part of this charge.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license/s to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 Tex. Admin. Code §§ 213.27 - 213.33. Additionally, staff will seek to impose on Respondent

the administrative costs of the proceeding pursuant to Section 301.461, Texas Occupations Code. The cost of proceedings shall include, but is not limited to, the cost paid by the Board to the State Office of Administrative Hearings and the Office of the Attorney General or other Board counsel for legal and investigative services, the cost of a court reporter and witnesses, reproduction of records, Board staff time, travel, and expenses. These shall be in an amount of at least one thousand two hundred dollars ($1200.00).

NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, which can be found at www.bon.texas.gov/disciplinaryaction/discp-matrix.html.

NOTICE IS ALSO GIVEN that Respondent's past disciplinary history, as set out below and described in the Order(s) which are attached and incorporated by reference as part of these charges, will be offered in support of the disposition recommended by staff: Settlement Agreement and Order issued by the Missouri State Board of Nursing, dated December 22, 2010, Order of Emergency Summary Suspension issued by the Arizona State Board of Nursing dated, July 25, 2011, and Findings of Fact, Conclusions of Law and Order issued by the Arizona State Board of Nursing dated, November 14, 2011.

BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK.

CONTINUED ON NEXT PAGE.

Filed this __________ day of ____________________, 20_____.

Filed this 6th day of November, 2012.

TEXAS BOARD OF NURSING

James W. Johnston, General Counsel
Board Certified - Administrative Law
Texas Board of Legal Specialization
State Bar No. 10838300
Jena Abel, Assistant General Counsel
State Bar No. 24036103
Lance Robert Brenton, Assistant General Counsel
State Bar No. 24066924
John R. Griffith, Assistant General Counsel
State Bar No. 24079751
Robert Kyle Hensley, Assistant General Counsel
State Bar No. 50511847
Nikki Hopkins, Assistant General Counsel
State Bar No. 24052269
John F. Legris, Assistant General Counsel
State Bar No. 00785533
TEXAS BOARD OF NURSING
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-6811
F: (512) 305-8101 or (512)305-7401

Attachments: Settlement Agreement and Order issued by the Missouri State Board of Nursing, dated December 22, 2010, Order of Emergency Summary Suspension issued by the Arizona State Board of Nursing dated, July 25, 2011, and Findings of Fact, Conclusions of Law and Order issued by the Arizona State Board of Nursing dated, November 14, 2011.

D/2012.06.19

SETTLEMENT AGREEMENT BETWEEN MISSOURI STATE BOARD OF NURSING AND PENNY BARTON, RN 096325

Case Number 2009-003149

Comes now Penny Barton (Licensee) and the Missouri State Board of Nursing (Board) and enter into this Settlement Agreement for the purpose of resolving the question of whether Licensee's license to practice as a registered professional nurse will be subject to discipline.

Pursuant to the terms of §536.060 RSMo, the parties hereto waive the right to a hearing by the Administrative Hearing Commission of the State of Missouri and, additionally, the right to a disciplinary hearing before the Board under §621.110 RSMo and stipulate and agree that a final disposition of this matter may be effectuated as described herein.

Licensee acknowledges that she understands the various rights and privileges afforded her by law, including the right to a hearing of the charges against her; the right to appear and be represented by legal counsel; the right to have all charges against her proven upon the record by competent and substantial evidence; the right to cross-examine any witnesses appearing at the hearing against her; the right to a decision upon the record by a fair and impartial administrative hearing commissioner concerning the charges pending against her and, subsequently, the right to a disciplinary hearing before the Board at which time she may present evidence in mitigation of discipline; and the right to seek to recover attorney's fees incurred in defending this action against her license. Being aware of these rights provided her by operation of law, Licensee knowingly and voluntarily waives each and every one of these rights and freely enters into this Settlement Agreement and agrees to abide by the terms of this document, as they pertain to her.

Licensee acknowledges that she has received a copy of the investigative report and other documents relied upon by the Board in determining there was cause for discipline, along with

RECEIVED
NOV 29 2010
MISSOURI STATE
BOARD OF NURSING

citations to law and/or regulations the Board believes were violated. For the purpose of settling this dispute, Licensee stipulates that the factual allegations contained in this Settlement Agreement are true and stipulates with the Board that Licensee's license to practice as a registered professional nurse, license number 096325, is subject to disciplinary action by the Board in accordance with the provisions of Chapters 621 and 335 RSMo.

JOINT STIPULATION OF FACTS

1. The State Board of Nursing is an agency of the State of Missouri created and established pursuant to §335.021 RSMo, for the purpose of executing and enforcing provisions of Chapter 335 RSMo; the Nursing Practice Act.

2. Penny Barton is licensed by the Board as a registered professional nurse, license number 096325. Licensee's license was current and active at all times relevant herein.

COUNT I

3. Licensee was employed as a registered nurse in the Emergency Department at Missouri Baptist Sullivan Hospital in Sullivan, Missouri at all times relevant to Count I.

4. Following an incident on May 12, 2009 involving Dilaudid being removed by Licensee for a patient who did not have an order for Dilaudid, a chart audit was conducted.

5. The Chief Nursing Executive discovered twelve (12) charts that showed Licensee had removed and wasted 2 mg Dilaudid for patients who did not have orders for Dilaudid.

6. When Licensee was questioned regarding these discrepancies, she could not offer an explanation as to why she had withdrawn the Dilaudid.

7. Licensee's conduct, as described in Count I, constitutes incompetency, gross negligence and misconduct in the performance of the functions and duties of a nurse.

8. Licensee's conduct, as described in Count I, constitutes a violation of a professional trust or courtesy.

COUNT II

9. Licensee was employed in the Emergency Department of Mineral Area Regional Medical Center at all times relevant to Count II.

10. Due to multiple medication discrepancies, Licensee was requested to submit to a hair and urine drug screen on September 4, 2009.

11. On September 14, 2009, the hair test returned a positive result for marijuana.

12. On September 15, 2009, the urine drug screen was positive for Meperidine and Nomeperidine. Licensee did not report taking Meperidine or Nomerperidine prior to the testing and did not provide a valid prescription after she was made aware of the results.

13. Marijuana, Meperidine and Nomeperidine are controlled substances. Licensee did not have a prescription for these controlled substances.

14. Licensee's conduct, as described herein, constitutes a violation of the drug laws of the State of Missouri.

JOINT CONCLUSIONS OF LAW

1. Cause exists for Petitioner to take disciplinary action against Licensee's license under §335.066.2(1), (5), (12) and (14) RSMo, which states in pertinent part:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:
>
> (1) Use or unlawful possession of any controlled substance, as defined in chapter 195, RSMo, or alcoholic beverage to an extent that such use impairs a person's ability to perform the work of any profession licensed or regulated by sections 335.011 to 335.096;
>
> (5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions

or duties of any profession licensed or regulated by sections 335.011 to 335.096;

(12) Violation of any professional trust or confidence;

(14) Violation of the drug laws or rules and regulations of this state, any other state or the federal government;

JOINT AGREED ORDER

1. Based upon the foregoing, the parties mutually agree and stipulate that the following shall constitute the order entered by the Board in this matter under the authority of §621.045.3 RSMo.

2. Licensee's license to practice as a licensed practical nurse in the State of Missouri, license number RN 096325, is hereby **VOLUNTARILY SURRENDERED**.

3. The Board will maintain this Settlement Agreement as an open and public record of the Board as required by law. The Board will report this Settlement Agreement to data banks, other appropriate entities and in its newsletter. The original of this document shall be kept in the Board's file and its contents shall be disclosed to the public upon proper request.

4. The terms of this Settlement Agreement are contractual, legally enforceable and binding, not merely recital. Except as otherwise contained herein, neither this Settlement Agreement nor any of its provisions may be changed, waived, discharged or terminated, except by an instrument in writing signed by the party against whom the enforcement of the change, waiver, discharge or termination is sought.

5. Licensee, together with her heirs and assigns and her attorney(s), do hereby waive, release, acquit and forever discharge the Board, its respective members and any of its employees, agents or attorneys, including any former Board members, employees, agents and attorneys, of, or from, any liability, claim, actions, causes of action, fees, costs and expenses and compensation, including, but not limited to, any claims for attorney's fees and expenses, including any claims

pursuant to §536.087 RSMo, or any claim arising under 42 U.S.C. § 1983, which may be based upon, arise out of, or relate to any of the matters raised in this case, its settlement or from the negotiation or execution of its settlement. Licensee acknowledges that this paragraph is severable from the remaining portions of this Settlement Agreement in that it survives in perpetuity even in the event that any court of law deems this Settlement Agreement or any portion thereof void or unenforceable.

6. This Settlement Agreement goes into effect 15 days after the document is signed by the Executive Director of the Board.

LICENSEE	**BOARD OF NURSING**
Penny Barton	Lori Scheidt Executive Director Missouri State Board of Nursing
Date: 11/26/10	Date: 12.07.2010

EFFECTIVE
DATE
December 22, 2010
MISSOURI BOARD OF NURSING

Janice K. Brewer
Governor

Joey Ridenour
Executive Director

Arizona State Board of Nursing
4747 North 7th Street, Suite 200
Phoenix AZ 85014-3655
Phone (602) 771-7800 Fax (602) 771-7888
E-Mail: arizona@azbn.gov
Home Page: http://www.azbn.gov

AFFIDAVIT OF CUSTODIAN OF RECORDS

STATE OF ARIZONA

COUNTY OF MARICOPA

I, Joey Ridenour, Executive Director for the Arizona State Board of Nursing, County of Maricopa, State of Arizona, do hereby certify that I am the officer having the legal custody for the records hereto attached in the office of the Arizona State Board of Nursing, County of Maricopa, State of Arizona, a public office of said State. The attached copies are true copies of the records on **PENNY LYNNE BARTON**. Personnel of the Arizona State Board of Nursing prepared the records during the ordinary course of business.

Witness my hand and the seal of the Arizona State Board of Nursing at 4747 N. 7th Street, Suite 200, Phoenix, Arizona 85014-3655 on December 7, 2011.

SEAL

Joey Ridenour RN MN FAAN

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

NAME Ms. PENNY LYNNE BARTON

GENDER: F **ETHNICITY:** Other

PLACE OF BIRTH CITY: GIBSON CITY **STATE:** IL

MAILING ADDRESS

8514 W TOWNLEY AVE
PEORIA AZ 85345
County: Maricopa
Country: UNITED STATES

HOME PHONE: N/A **PAGER:** N/A **CELL PHONE:** N/A
BUSINESS PHONE: N/A **FAX:** N/A

OTHER NAMES

NAMES USED	REASON	NAMES USED	REASON
PENNY LYNNE BUSH		PENNY LYNNE LUNDY	

AZ LICENSE/CERTIFICATION INFORMATION:

License/Certificate Number: RN145785 **License Type:** REGISTERED NURSE
Original Date: 05/15/2007
License Valid Until: 04/01/2015
Last Issued Date: 03/25/2011

Original State of Licensure/Certification: MISSOURI

AZ LICENSE STATUS HISTORY

STATUS	FROM	TO	LAST MODIFIED BY:
Temporary	04/26/2007	05/15/2007	DONNA FRYE
Application Deficiency Notice Sent	04/26/2007	05/15/2007	DONNA FRYE
Pending Fingerprint Results	04/26/2007	05/14/2007	DONNA FRYE
Valid in Arizona Only	05/15/2007	07/11/2011	MARY RAPPOPORT
Active: Good Standing	05/15/2007	07/25/2011	MARY RAPPOPORT
Complaint/Self Report	01/18/2011	07/25/2011	MARY RAPPOPORT
Contact Board Staff	07/11/2011		MARY RAPPOPORT
Remove from Online Verification	07/11/2011		MARY RAPPOPORT
Suspended	07/25/2011		MARY RAPPOPORT

SCHOOL INFORMATION

NAME	LOCATION	NCLEX CODE	DEGREE OBTAINED	GRADUATION DATE
LINCOIN UNIVERSITY	JEFFERSON CITY MO		Associates in Nursing	05/12/1984

OTHER STATES OF LICENSURE/CERTIFICATION

LIC/CERT NO	STATE	LIC/CERT TYPE	STATUS	LIC/CERT DATE	ORIG STATE
096325	MO	REGISTERED NURSE		09/15/1984	Y
685893	TX	REGISTERED NURSE		04/24/2002	N
9212806	FL	REGISTERED NURSE		02/11/2004	N

MOST RECENT APPLICATION INFORMATION

Year: 2011
Employment Status:
Type of Nursing Position:
Major Clinical or Teaching Area in Nursing:
Principle Field of Employment:

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

ARIZONA STATE BOARD OF NURSING
4747 N. 7TH STREET, SUITE 200
PHOENIX ARIZONA 85014-3655

IN THE MATTER OF REGISTERED NURSE LICENSE NO. RN145785 ISSUED TO: PENNY LYNNE BARTON; aka PENNY LYNNE BUSH; PENNY LYNNE LUNDY; PENNY LYNNE MANAHAN Respondent.	**FINDINGS OF PUBLIC EMERGENCY AND ORDER OF SUMMARY SUSPENSION NO. 1101079**

On July 25, 2011, the Arizona State Board of Nursing ("Board") met at 4747 North 7th Street, Ste. 200, Phoenix, Arizona 85014-3655, to consider a complaint filed against PENNY LYNNE BARTON, ("Respondent"), the holder of registered nurse license number RN145785. Information was presented to the Board and, as a result, the Board made the following Preliminary Findings of Fact, Conclusions of Law and Order.

PRELIMINARY FINDINGS OF FACT

1. On or about January 31, 2011, the Board received notification that, on December 22, 2010, Respondent voluntarily signed a "Settlement Agreement" [attached and incorporated by reference] with the Missouri Board of Nursing, in Case Number 2009-003149, wherein Respondent voluntarily surrendered her registered nurse license number 096325, and the ability to practice nursing in the State of Missouri. Based upon this information, the Board initiated an investigation.

2. According to Respondent's "Settlement Agreement", she stipulated to the fact that, while she was employed as a registered nurse at Missouri Baptist Sullivan Hospital, in Sullivan, Missouri, she removed and documented wasting twelve, 2mg doses of intravenous Dilaudid, a controlled substance, for patients that did not have a valid physician order for Dilaudid.

3. According to Respondent's "Settlement Agreement," she stipulated to the fact that, while she was employed as a registered nurse at Mineral Area Hospital, in Farmington, Missouri, there were multiple narcotic discrepancies her patient's medical records. Based upon this information, Respondent agreed to submit to for-cause hair and urine drug tests on September 4, 2009. On September 14, 2009, Respondent's urine test result reflected that she was positive for Meperidine (Demerol) and Normeperidine (a Demerol metabolite). On September 15, 2009, Respondent's hair test results reflected that she was positive for marijuana, an illegal substance. Respondent stipulated to the fact that she did not have valid prescriptions for Meperidine or Marijuana, both controlled substances.

4. On or about March 7, 2011, during a telephonic interview with Respondent, Board staff reviewed the Findings of Fact in the December 22, 2010 "Settlement Agreement," set forth by the Missouri Board of Nursing. Respondent asserted that her September 4, 2009, urine and hair drug tests were positive due to an August 13 to 15, 2009 hospitalization, at Salem Memorial Hospital, Salem, Missouri, claiming that she was under her physician's care, she was administered Demerol (Meperidine) for pain control. Respondent's explanation for the positive drug test results is not plausible, since Demerol is excreted from the body within 24 to 48 hours after its administration.

5. According to Board staff's review of Respondent's personal medical records from her primary care provider, and her August 13 to 15, 2009, Salem Memorial Hospital treatment records, Respondent's last authorized and known prescribed Demerol dose was on August 15, 2009 at 06:55, for 100 mg, this was two weeks and four days prior to her positive drug testing.

6. Respondent admitted to Board staff that she smoked marijuana, in or about July or August 2009, claiming it was to alleviate her chronic pain.

COMPLAINT #2

7. On or about April 4, 2011, the Board received a complaint from the Chief Nursing Officer at WVH, alleging that, from on or about March 3, 2011, to on or about March 22, 2011,

Respondent's AcuDose (an automated medication dispensing machine) records, reflected multiple narcotic discrepancies in 18 patient records.

8. From on or about February 21, 2011, to on or about March 22, 2011, Respondent was employed as a registered nurse by Nurse Finders, Inc., a nursing registry, in Phoenix, Arizona. From on or about March 9, 2011, to on or about March 22, 2011, Respondent was assigned to 12-hour night shifts (19:00 to 07:00) at West Valley Hospital (WVH), in Goodyear, Arizona. Based upon WVH's complaint and allegation, Nurse Finders Inc. terminated Respondent's employment.

9. On April 5, 2011, Board staff interviewed WVH telemetry unit's Nurse Manager regarding Respondent's multiple narcotic discrepancies in their AcuDose system. According to the Nurse Manager, Respondent frequently removed narcotics using an "override" process. According to the Nurse Manager, an "override" is an action wherein licensed staff access AcuDose for a group of specified medications for a patient, and the "override" event may occur, but is not limited to, the following instances arising on a patient care unit:

a) An emergency situation arises requiring the nurse to immediately access a medication ordered by a physician, or a medication ordered by a unit-based protocol;
b) A newly admitted patient with valid physician written medication(s) orders, requiring the administration of medication(s), but the patient has not been entered into the AcuDose system by the Pharmacy Department, and/or;
c) A "one-time" physician order for a medication(s) that requires the nurse to administer the medication as soon as possible, but is not an emergency situation.

According to the Nurse Manager's review of Respondent's AcuDose records, Respondent's multiple "overrides" for narcotics occurred repeatedly and included suspicious reasons why Respondent allegedly needed to dispose of (wasted) multiple narcotics. According to the Nurse Manager, Respondent documented in AcuDose that she twice "dropped" Dilaudid vials which in fact, are pre-loaded syringes that are not easily shattered. Respondent frequently documented that some her alleged narcotic wastages were due to a physician giving her an order and then discontinuing the order soon after Respondent removed the narcotic from AcuDose. The Nurse

Manager stated that her night shift staff nurses informed her that when they co-signed Respondent's narcotic wastes, they frequently did not witness Respondent wasting the narcotic(s) in their full view. According to the Nurse Manager, Respondent fully disclosed the Missouri Board action and while in Missouri admitted taking narcotics for her spouse who was diagnosed with cancer.

11. On April 26, 2011, Board staff conducted a second interview with Respondent. Board staff asked Respondent to provide an explanation about the AcuDose narcotic discrepancies, Respondent stated that her nursing documentation "... became sloppy..." or she forgot to document a physician's order, or the physician changed his mind about the original order. Respondent stated that she only used the "override function" when there was "...a new medication order." Respondent could not explain why she had multiple AcuDose "overrides" on patients for whom she had already obtained Dilaudid.

12. On April 26, 2011, during an interview with Board staff, Respondent repeatedly denied having a substance abuse problem or diverting any controlled substance for self-use, or diverting any controlled substance for a third party.

13. According to the WVH's complaint, 18 patient records were identified as having narcotic discrepancies attributable to Respondent. Of those 18 patient medical records, 11 patient records were identified as having multiple narcotic irregularities. Board staff reviewed all 11 records, however, four (4) patient records were omitted because Board staff could not substantiate allegations of narcotic irregularities. The following is a summary of Board's staff WVH patient chart review:

a) From on or about March 9, 2011, to no or about March 22, 2011, Respondent's AcuDose records reflected that she removed a total of thirty-four (34) Dilaudid 2mg intravenous, pre-loaded syringes/vials, and three (3) Morphine Sulfate 2mg or 4mg intravenous pre-loaded syringes/vials, by accessing AcuDose, wherein there was either no physician written order, or a "one-time" order(s) that were written by Respondent and not ordered by a physician, and/or used

1 the "override" function in situations that did not conform to the usual and acceptable standards of
2 medication removal by a nurse at WVH. [attached and incorporated herein as Exhibit A].
3 14. On or about March 13, 2011, Respondent voluntary submitted to a substance abuse
4 evaluation, with an emphasis on substance abuse with Dr. Maryanna Foley, APRN, Ph.D. On
5 April 14, 2011, Board staff provided Dr. Foley with additional information and documentation
6 related to Respondent's second complaint. Dr. Foley opined that Respondent was not fit for duty
7 if she was allowed to have access to controlled substances. Dr. Foley recommended Respondent
8 participated in the following, but not limited:
9 a) Monitoring program no less than two to three years by the Board;
10 b) Participate in an intensive outpatient (IOP)substance abuse program;
11 c) Submit to random drug testing;
12 d) Consider participation in either psychiatric or psychological counseling to
13 specifically address her erratic behavior and poor judgment; and
14 e) Complete a college level course in Nursing Ethics and Substance Abuse.
15 **COMPLAINT #3**
16 15. On or about June 28, 2011, during an interview with Board staff, Concentric
17 Healthcare Staffing [CHS] coordinator informed Board staff that Respondent was made a "do
18 not return" from her recent nursing assignment with Promise Select Hospital of Phoenix [PSH],
19 in Mesa, Arizona. According to the CHS coordinator, PSH alleged that Respondent improperly
20 removed Dilaudid, a controlled substance in or about April 2011.
21 16. From on or about April 1, 2011, to on or about May 11, 2011, Respondent was
22 employed as registered nurse by Concentric Healthcare Staffing, a nursing registry, in Scottsdale,
23 Arizona. On April 29, 2011, Respondent was assigned to 12-hour night shifts (19:00 to 07:00) at
24 PSH. At or about 18:45, and before Respondent's shift, according to a written witness statement
25 from a PHS licensed practical nurse (LPN), Respondent was visually observed accessing the
26 unit's AcuDose, removing a medication, placing the medication in her uniform pocket, then

walked directly into the unit's medication room (where syringes, alcohol swabs etc. are stored), and then directly entered into the administrative bathroom. According to the LPN's written statement, Respondent did not enter any patient room after exiting the bathroom. The LPN immediately notified the 12-hour night shift charge nurse, who immediately notified PHS's Nurse Administrator.

17. On or about July 1, 2011, Board staff interviewed PHS's Nurse Administrator. According to the Nurse Administrator, she immediately reviewed Respondent's AcuDose record, which reflected that at 18:45:25, Respondent removed one Dilaudid 2mg intravenous and pre-loaded syringe/vial for patient DOF. According to the Nurse Administrator, Respondent was not assigned to care for DOF on that shift. The Nurse Administrator stated that she verified with patient DOF, that she did not request any pain medication or received any pain medication from any nurse at or between 18:45 to 19:00, on April 29, 2011.

18. Board staff reviewed the PSH medical record of patient DOF, an 82 year old female admitted on April 27, 2011, with a right ankle wound infection. Board staff's review reflected that, from on or about April 27, 2011 at 19:00, to on or about April 28, 2011 at 07:00, Respondent was assigned to care for DOF. Board staff reflected that Respondent removed nine (9) Dilaudid 1mg/ml intravenous pre-loaded syringes/vials, under DOF's name, in time intervals that were not ordered by the physician. In four separate instances, Respondent failed to document the administration of Dilaudid on DOF's medication administration record. [attached and incorporated herein as Exhibit B].

19. On or about June 28, 2011, June 29, 2011 and July 6, 2011, Board staff left voicemail messages on Respondent's phone number of record, requesting that she contact Board staff regarding Dr. Foley's March 22, 2011 psychological evaluation and recommendations. Respondent failed to respond.

20. On or about June 28, 2011 Board staff attempted to contact Respondent using her email address of record, but Board staff's email was returned as "undeliverable." On June 28,

2011, Board staff mailed a complaint and notification letter with a Board Investigative Questionnaire to Respondent's address of record, Respondent failed to respond and the mail has not been returned to the Board.

PRELIMINARY CONCLUSIONS OF LAW

1. The Arizona State Board of Nursing ("Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§ 32-1601, 32-1606, 32-1663, 32-1664, and 41-1092.11(B). The Board also has the authority, pursuant to A.R.S. § 32-1663 and A.R.S. § 32-1664, to impose disciplinary sanctions against the holders of nursing licenses for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 through 1669, and A.A.C. R4-19-101 to R-19-815.

2. The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. § 32-1663(D) as described in A.R.S. § 32-1601 (16) (d) (any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public) (effective May 9, 2002).

3. The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. § 32-1663(D) as described in A.R.S. § 32-1601 (16) (g) (willfully or repeatedly violating a provision of this chapter or a rule adopted pursuant to this chapter) (effective May 9, 2002).

4. The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. § 32-1663(D) as described in A.R.S. § 32-1601 (16) (h) (committing an act that deceives, defrauds or harms the public) (effective May 9, 2002).

5. The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. §

32-1663(D) as described in A.R.S. § 32-1601 (16) (j) (violating a rule that is adopted by the Board pursuant to this chapter) (effective May 9, 2002).

6. The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. § 32-1663(D) as described in A.R.S. § 32-1601 (18) (d) (any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public) (effective October 14, 2009).

7. The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. § 32-1663(D) as described in A.R.S. § 32-1601 (18) (f) (having a license, certificate, permit or registration to practice a health care profession denied, suspended, conditioned, limited or revoked in another jurisdiction and not reinstated by that jurisdiction) (effective October 14, 2009).

8. The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. § 32-1663(D) as described in A.R.S. § 32-1601 (18) (g) (willfully or repeatedly violating a provision of this chapter or a rule adopted pursuant to this chapter) (effective October 14, 2009).

9. The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. § 32-1663(D) as described in A.R.S. § 32-1601 (18) (h) (committing an act that deceives, defrauds or harms the public) (effective October 14, 2009).

10. The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. §

32-1663(D) as described in A.R.S. § 32-1601 (18) (j) (violating a rule that is adopted by the Board pursuant to this chapter) (effective October 14, 2009) specifically:

A.A.C. R4-19-403 (1) (a pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice) (effective February 2, 2009);

A.A.C. R4-19-403 (7) (failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient) (effective February 2, 2009);

A.A.C. R4-19-403 (8) (falsifying or making a materially incorrect, inconsistent, or unintelligible entry in any record: a. Regarding a patient, health care facility, school, institution, or other work place location; b. Pertaining to obtaining, possessing, or administering any controlled substance as defined in the federal Uniform Controlled Substances Act, 21 U.S.C. 801 et seq., or Arizona's Uniform Controlled Substances Act, A.R.S. Title 36, Chapter 27) (effective February 2, 2009);

A.A.C. R4-19-403 (9) (failing to take appropriate action to safeguard a patient's welfare or follow policies and procedures of the nurse's employer designed to safeguard the patient) (effective February 2, 2009);

A.A.C. R4-19-403 (15) (removing, without authorization, any money, property, or personal possessions, or requesting payment for services not performed from a patient, school, institution, or other work place location) (effective February 2, 2009);

A.A.C. R4-19-403 (16) (removing, without authorization, a narcotic, drug, controlled substance, supply, equipment, or medical record from any health care facility, school, institution, or other work location) (effective February 2, 2009);

1 Dated this 25th day of July, 2011.

2 **SEAL**

3

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

5

6

7 COPIES mailed this 26th ay of July, 2011, by First Class Mail and Certified Mail Receipt No. 7009 0080 0000 0430 1772 to:

8

9 Penny Lynn Barton
8514 W Townley Ave
Peoria AZ 85345

10

11 COPIES hand- delivered this 26th day of July, 2011, to:

12 Elizabeth A. Campbell
Assistant Attorney General
13 1275 W Washington LES Section
Phoenix AZ 85007

14

15 By: ______________________

16

17

18

19

20

21

22

23

24

25

26

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

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

IN THE MATTER OF REGISTERED NURSE LICENSE NO. RN145785

ISSUED TO:

PENNY LYNNE BARTON, aka PENNY LYNNE BUSH, PENNY LYNNE LUNDY, PENNY LYNNE MANAHAN,

Respondent.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER NO. 11A-1101079-NUR

A hearing was held before Diane Mihalsky, Administrative Law Judge ("ALJ"), at 1400 West Washington Suite 101, Phoenix Arizona, on September 2, 2011. Elizabeth A. Campbell, Assistant Attorney General, appeared on behalf of the State. Penny Lynne Barton ("Respondent") was not present and was not represented by counsel.

On September 23, 2011, the ALJ issued Findings of Fact, Conclusions of Law and Recommendations. On November 14, 2011, 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 makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. The Arizona State Board of Nursing ("the Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§ 32-1606, 1663, and 1664.

2. Penny Lynne Barton ("Respondent") holds Board-issued Registered Nurse License No. RN145785. Respondent has been licensed as a registered nurse in Arizona since on or about May 15, 2007.

3. In 2011, the Board received three complaints against Respondent, as follows: (1) On or about January 31, 2011, notification from the Missouri State Board of Nursing ("the Missouri Board")

that Respondent had voluntarily surrendered her license to practice in Missouri while she was under investigation for multiple narcotic discrepancies and diversion of narcotics; (2) On or about April 4, 2011, a complaint from Jane Karzan, RN, MSN, the Chief Nursing Officer of West Valley Hospital in Goodyear, Arizona, Respondent's previous employer, that 18 patient records that Respondent had prepared contained narcotic discrepancies; and (3) On or about June 28, 2011, a complaint from Concentric Healthcare Staffing, a registry that previously employed Respondent, that it had terminated Respondent's employment after a staff member at Promise Hospital in Mesa, Arizona reported that Respondent had accessed an AcuDose medication dispenser to obtain narcotics for a patient who was not assigned to her care and who had not been prescribed such medication.

4. After the Board received the complaint from the Missouri Board and Respondent informed the Board that she was working as a nurse at West Valley Hospital, the Board required Respondent to undergo a chemical dependency and mental health evaluation. On or about March 22, 2011, Maryanna H. Foley, Ph.D., PMHNP, B.C., LISAC evaluated Respondent. On or about April 14, 2011, the Board received Dr. Foley's report of her evaluation of Respondent and recommendations based on the evaluation.

5. The Board assigned nurse consultant, Mary Rappoport, RN, MSN, to investigate the three complaints. Ms. Rappoport obtained documents relating to the three complaints and presented an Investigative Report of her investigation to the Board.

6. At the Board's July 2011 meeting, it considered Dr. Foley's and Ms. Rappoport's reports. Based on those reports, the Board found that the public health, safety, and welfare imperatively required emergency action, and issued an order summarily suspending Respondent's license.

7. The Board referred the matter to the Office of Administrative Hearings ("the OAH"), an independent agency, for an expedited evidentiary hearing on whether Respondent should be allowed to keep her license to practice nursing in Arizona.

8. On July 28, 2011, the Board issued a Complaint and Notice of Hearing, setting a hearing on September 2, 2011, at 8:00 a.m. and alleging cause to discipline Respondent's registered nurse license under A.R.S. §§ 32-1663(D) and 32-1664(D) because she had committed unprofessional conduct as defined by A.R.S. § 32-1601(16)(d), (g), (h), and (j) (effective May 9, 2002), and as later defined by A.R.S. § 32-1601(18)(d), (g), (h), and (j), specifically A.A.C. R4-19-403(1), (7), (8), (9), (15), (16), (17), (18), (25)(a), and (31) (effective February 2, 2009).

9. The Board mailed a copy of the Complaint and Notice of Hearing to Respondent's address of record.

10. A hearing was held on September 2, 2011. The Board submitted nineteen exhibits and presented the testimony of four witnesses: (1) Ms. Rappoport; (2) Dr. Foley; (3) Matthew Walters, LPN, the staff member at Promise Hospital who witnessed Respondent accessing the AcuDose dispenser to obtain a narcotic under suspicious circumstances; and (4) Melissa Moton, the Interim Director of Quality and Risk at Promise Hospital, who investigated the incident that Mr. Walters witnessed.

11. Respondent did not request to appear telephonically at the hearing and did not request that the hearing be continued. Although the start of the duly noticed hearing was delayed fifteen minutes to allow Respondent additional travel time, Respondent did not appear, personally or through an attorney, and did not contact the OAH to request that the start of the hearing be further delayed. Consequently, Respondent did not present any evidence to defend her license.

HEARING EVIDENCE

Respondent's Voluntary Surrender of her Missouri License

12. The Board submitted a copy of the settlement agreement with the Missouri Board memorializing Respondent's voluntary surrender of her Missouri license ("the settlement agreement"). Respondent signed the settlement agreement on November 22, 2010, and it became effective on December 22, 2010.

13. Respondent acknowledged in the settlement agreement that in approximately May 2009, while she was employed as a registered nurse at Missouri Baptist Sullivan Hospital in Sullivan, Missouri, she removed and documented wasting twelve, 2mg doses of intravenous Dilaudid,[1] a controlled narcotic substance, for patients who did not have a valid physician order for Dilaudid.

14. Respondent acknowledged in the settlement agreement that while she was employed as a registered nurse in the Emergency Department of Mineral Area Hospital in Farmington, Missouri, there were multiple narcotic discrepancies in her patients' medical records. Respondent also acknowledged that on September 4, 2009, based on the discrepancies, she agreed to submit to for-cause hair and urine drug tests, that a September 14, 2009 urine drug test was positive for meperidine (Demerol) and normeperidine (a Demerol metabolite), and that a September 15, 2009 hair drug test was positive for

[1] Dilaudid is the manufacturer's name for the pain medication hydromorphone hydrochloride. The terms Dilaudid and hydromorphone are used interchangeably in this recommended decision.

marijuana, an illegal substance. Respondent also acknowledged that she did not have a valid prescription for meperidine, a controlled substance, while she was employed by Mineral Area Hospital.

Dr. Foley's Chemical Dependency and Mental Health Evaluation of Respondent

15. Dr. Foley reported that Respondent developed a severe case of Erysipelas in 2006 that damaged her veins and required the installation of a venous access device ("VAD") so that she could receive intravenous medication. Dr. Foley reported that in August 2009, Respondent was hospitalized with a recurrence of the Erysipelas, and was administered intravenous Demerol (meperidine) with Phenergan and oral tablets of hydrocodone for pain, but that when Respondent was discharged on August 15, 2009, neither Demerol nor Vicodin was listed on the medication list.

16. Dr. Foley also reported that Respondent stated that she recalled feeling stressed and overwhelmed at the time that she was terminated from the hospitals in Missouri before she accepted the Missouri Board's settlement offer and surrendered her Missouri license, and that the stressful events in her life at that time included a protracted bout of Erysipelas that kept her bedridden for at least one month in 2006, an on-and-off relationship with her third husband, and the deaths of both of her parents. Respondent told Dr. Foley that she was taking the antidepressant, Paxil, 20 mg daily and the anti-anxiety drug Xanax .025 mg as needed at bedtime.

17. Dr. Foley concluded the evaluation with the following Assessment and Recommendation:

> [Respondent] presents herself as an experienced, hardworking, dedicated nurse, who has been beset with a series of negative life events, not the least of which was the loss of her Missouri Nursing License. However, the behaviors that precipitated her termination from two medical facilities and loss of her Missouri license could, **at the least**, be attributed to poor judgment, poor communication with co-workers, exhaustion, emotional imbalance due to psychiatric or family issues and/or her medical condition – any one of which could have contributed to her errors in following hospital protocol or to her confusion about the many discrepancies. **Or** it can be hypothesized that [Respondent] had a need to use the "wasted" medication to help her deal with her own pain and/or dependence and the 2009 positive drug screen for meperidine was a result of [Respondent's] use of diverted patients' meds. ***And/or*** [Respondent] continues a pattern of diverting medication to sell or give them to someone else.
>
> **On April 13, 2011, this writer was given information that [Respondent] was reported to have been again involved in more than a few instances of "wasting" pain medication and asking other nurses to sign off as witnesses even if they did not, in fact, witness the "wasting." This occurred recently while she was working nights as**

1 **an ER nurse at Abrazo West Valley Hospital. Furthermore, it is reported to this writer that [Respondent] admitted that while she was**
2 **working in Missouri, she had diverted meds to help her husband**
3 **who is dying of cancer.**

4 In her idealized sense of self, [Respondent] may navigate in the world with a level of denial and rationalization that allows her to see herself as
5 righteous, but misunderstood, and if rules were broken – they, perhaps,
6 did not apply to her, or she had a good reason to break them. Her tenacity is remarkable while at the same time, her credibility, judgment,
7 and ethics are in question.

8 It is my opinion that [Respondent] is not fit for duty as an RN administering medication to patients. Given the records supplied by the
9 [Board] and the more recent information, there is pattern of behavior that
10 is consistent with diversion of pain medication, and suspicion of substance abuse
11 and/or dependence.

12 (Emphasis in original.)

13 18. Dr. Foley testified that Respondent was very calm during the interview and, overall, had a
14 good appearance. Dr. Foley testified that Respondent told her that the VAD made it impossible for her
15 to take drugs intravenously. Dr. Foley testified that because more recent information indicated that
16 Respondent was continuing the same behaviors that led her to surrender her Missouri license in the
17 settlement agreement, Dr. Foley stood by her assessment and recommendations.

18 19. Ms. Rappoport testified that she confirmed from Respondent's medical records that the
19 VAD was in the left side of Respondent's chest, under the skin, and that the VAD facilitated, not
20 prevented, administration of intravenous medications.

21 **Respondent's Multiple Narcotic Discrepancies at West Valley Hospital**

22 20. From on or about February 21, 2011, to on or about March 26, 2011, Respondent was
23 employed as a registered nurse by Nurse Finders, Inc., a nursing registry in Phoenix, Arizona. From on
24 or about March 9, 2011, to on or about March 26, 2011, Respondent was assigned to 12-hour night
25 shifts (7:00 p.m. to 7:00 a.m.) on the telemetry unit at West Valley Hospital. Based on West Valley
Hospital's complaint to the Board against Respondent, Nurse Finders, Inc. terminated her employment.

26 21. West Valley Hospital's policy is that, absent exceptional circumstances, a nurse may
27 "override" a physician's verbal or telephone order and obtain medication from the AcuDose dispenser
28 only under the following circumstances:

29 a. An emergency situation has arisen that requires the nurse to access immediately a medication that a physician has ordered, but that the

Pharmacy Department has not yet entered in the AcuDose system, or that a unit-based protocol has ordered;

b. A newly admitted patient with a valid physician medication order requires the administration of the medication, but the Pharmacy Department has not yet entered the patient into the AcuDose system; or

c. A physician has made a "one-time" order for a medication that requires the nurse to administer the medication as soon as possible, even though no emergency exists.

22. Ms. Rappoport reviewed the records of the patients for whom Respondent had cared at West Valley Hospital and identified multiple narcotic discrepancies for seven patients, JH, MM, ES, IM, WDJ, GH, and MMP.

23. Ms. Rappoport testified that the Nurse Practice Act and the standard of care in the nursing profession requires that narcotic medications that are removed from the medication dispenser be documented as administered, wasted, as witnessed by another nurse, or returned to the dispenser.

Patient JH

24. On March 18, 2011, at approximate 7:15 p.m., Respondent wrote a new verbal order for 2mg Dilaudid tablets. At 9:40 p.m., Respondent wrote on JH's chart that she was discontinuing the Dilaudid order because she misunderstood the physician's order. Ms. Rappoport testified that the AcuDose dispenser at West Valley Hospital did not show that Respondent removed the dose, although JH's chart showed the dose was administered.

25. On March 18, 2011, Respondent removed a syringe of hydromorphone IV 2mg/1ml from the AcuDose for JH at 7:11 p.m. Ms. Rappoport noted that Respondent's reason for the override for the 7:11 p.m. dose was "pain," and that pain was not a valid reason for an override under West Valley Hospital's policy. Respondent removed from the AcuDose another syringe of hydromorphone IV 2mg/1ml for JH at 7:31 p.m. and a 2mg tablet of hydromorphone at 7:36 p.m. Ms. Rappoport testified that administering a drug intravenously and five minutes later, administering the same drug orally, violated the standard of care. Ms. Rappoport testified that the three doses of hydromorphone at 7:11 p.m., 7:31 p.m., and 7:36 p.m. did not comply with the telephone order that Respondent recorded in JH's chart.

26. On March 18, 2011, at 9:40 p.m., Respondent noted in JH's chart the physician's order to "discontinue Dilaudid 2 mg po every 4 hours as needed for pain," but to continue "morphine 4 mg EVP every 3 hours as needed for pain."

27. On March 19, 2011, at 5:58 a.m., Respondent removed a 2mg/1ml hydromorphone syringe from the AcuDose for JH, providing "pain" as the reason for the override. At 6:06 a.m., Respondent removed another dose, then wasted the dose, providing as the reason, "Order changed by MD."

28. Although another nurse was identified on the AcuDose record as a witness to the waste, Ms. Rappoport testified that when she interviewed T.J. Land, RN, the nurse manager on the telemetry unit at West Valley Hospital, Ms. Land told her that the hospital had a group of new graduate nurses who did not always physically and visually witness the nurse throwing the medication away.

29. On the next shift that Respondent worked at West Valley Hospital, March 19, 2011, she noted a physician's telephone order for JH at 7:00 p.m. for Dilaudid 2 mg. Ms. Rappoport pointed out that the telephone order did not include any intravenous medication for pain. At 7:15 p.m., Respondent noted the physician's telephone order, "Do not give Dilaudid," and her note, "Misunderstood order."

30. On March 19, 2011, at 7:11 p.m., Respondent removed from the AcuDose another 2mg/1ml syringe of hydromorphone for JH, providing "pain" as the reason for the override, and removed another dose at 8:04 p.m. Respondent wasted the 8:04 p.m. dose for the reason that "Order changed by M.D." Ms. Rappoport testified that Respondent violated West Valley Hospital's policy and the standard of practice by removing hydromorphone without a physician's order.

31. Ms. Rappoport testified that the hydromorphone doses that Respondent removed from the AcuDose for JH on March 18, 2011, at 5:58 a.m. and on March 19, 2011, at 7:11 p.m. were not documented as given, wasted, or returned.

Patient MM

32. On March 25, 2011, at approximately 8:55 p.m., Respondent removed a syringe of hydromorphone IV 2mg/1ml from the AcuDose for MM. The reason that Respondent provided for the override was "pain."

33. Ms. Rappoport pointed out that when MM was admitted to West Valley Hospital at 5:00 p.m. on March 25, 2011, there were no physician orders for hydromorphone or Dilaudid.

34. Ms. Rappoport pointed out that Respondent performed an extensive admission examination on MM, and reassessed MM at 12:00 a.m. and 4:00 a.m. on March 26, 2011, and that Respondent did not note on MM's chart any complaints of pain.

35. Ms. Rappoport testified that Respondent did not document the hydromorphone IV as given, wasted, or returned.

Patient ES

36. On March 24, 2011, Respondent removed a syringe of hydromorphone IV 2mg/1ml from the AcuDose under the name of patient ES at 12:11 a.m., 12:52 a.m., 4:28 a.m., and 4:29 a.m. Respondent documented the 12:52 a.m. dose as wasted because "Order read wrong," but did not document the other three doses as given, wasted, or returned.

37. On March 24, 2011, at approximately 4:30 a.m., Respondent wrote a new verbal order for IV Dilaudid 2mg/1ml for pain. Patient ES had no prior order for Dilaudid.

38. On March 25, 2011, at 6:37 p.m., before the start of Respondent's shift, she removed a syringe of hydromorphone IV 2mg/1ml from the AcuDose under the name of patient ES, providing as a reason for the override, "Severe agitation." Ms. Rappoport testified that Dilaudid is not used to treat agitation, and West Valley Hospital's policy does not allow an override for agitation.

39. On March 26, 2011, at 2:05 a.m., Respondent wrote a verbal order in ES' chart for Dilaudid 2mg IV. At 2:10 a.m., Respondent wrote, "Hold Dilaudid." At 2:10 p.m., the physician wrote in large letters, "Do Not Give Dilaudid" in ES' chart.

40. Ms. Rappoport testified that Ms. Land told her that the physician whom Respondent identified as giving the verbal order for Dilaudid was not on the floor for the night shift of March 25-26, 2011.

41. At 3:43 a.m. on March 26, 2011, Respondent documented as wasted the hydromorphone dose that she had removed from the AcuDose at 2:05 a.m. because "Order changed by M.D." Ms. Rappoport testified that Respondent had waited nearly an hour and forty minutes to waste the 2:05 a.m. dose. Ms. Rappoport testified that it was a violation of hospital policy and the standard of practice for a nurse to "carry narcotic medication in her pocket." Ms. Rappoport testified that Respondent did not document the 6:37 p.m. dose as given, wasted, or returned.

Patient IM

42. A physician ordered 2 mg of IV morphine, a controlled substance, every 3 hours as needed for chest pain to IM. On March 12, 2011, at 8:33 p.m. and 9:30 p.m., Respondent removed a syringe of morphine 2mg/1ml from the AcuDose under the name of patient IM. Respondent failed to document the dose removed at 8:33 p.m. as given, wasted, or returned. For the 9:30 p.m. dose, Respondent documented that the patient's family refused the dose. Ms. Rappoport testified that a family's refusal is

not an acceptable reason to not administer medication that was prescribed to a competent adult, and that IM was a competent adult.

Patient WDJ

43. On March 26, 2011, at 7:35 p.m., Respondent wrote a physician's verbal order for Dilaudid 1 mg IV every 4 hours as needed. On March 26, 2011, Respondent removed a syringe of hydromorphone IV 2mg/1ml from the AcuDose under the name of patient WDJ at 7:41 p.m. and 8:29 p.m.

44. Respondent used an override to obtain the 7:41 p.m. dose from AcuDose. Ms. Rappoport testified that the override was not necessary or reasonable, because the medication had been prescribed. Respondent wasted the 8:29 p.m. dose because "Ordered Dose Unavailable." Ms. Rappoport testified that the reason for the waste did not make sense, because a nurse may administer half of a syringe.

Patient GH

45. On March 25, 2011, at 1:54 a.m. and 5:10 a.m., Respondent removed a syringe of hydromorphone IV 2 mg/1 ml from the AcuDose under the name of patient GH. There was no physician order for hydromorphone for GH. Respondent wasted the 5:10 a.m. dose as "pulled on wrong patient and removed from package," but Ms. Rappoport testified that Respondent did not document the 1:54 a.m. dose as given, wasted, or returned.

Patient MMP

46. On March 20, 2011, without any physician order, Respondent removed a syringe of hydromorphone IV 2mg/1ml from the AcuDose under the name of patient MMP at 6:55 p.m. as an override for the reason, "New Order," and at 10:33 p.m. as an override for "pain." Ms. Rappoport testified that Respondent did not document either dose as given, wasted, or returned.

47. At 8:00 p.m. on March 20, 2011, Respondent entered a telephone order for Dilaudid 2 mg IV for pain in MMP's chart. At 10:38 p.m. Respondent entered a telephone order to discontinue the Dilaudid because it was the wrong patient.

48. At 12:45 a.m. on March 21, 2011, Respondent removed a syringe of hydromorphone IV 2mg/1ml from the AcuDose under the name of patient MMP and wasted the medication due to "Order changed by M.D."

49. At 6:45 p.m. on March 21, 2011, Respondent removed a syringe of hydromorphone IV 2mg/1ml from the AcuDose under the name of patient MMP as an override for "Pain, one-time order." Respondent's evening shift did not start until 7:00 p.m.

50. Respondent made the entry in MMP's chart for March 21, 2011, at 6:40 p.m. that the Dilaudid 2 mg IV was "pulled from AcuDose then wasted – not ordered on this pt. Mistaken entry." Ms. Rappoport testified that Respondent's entry was problematic and did not meet the standard of practice because it did not indicate the physician who gave the order. Ms. Rappoport testified that the AcuDose record did not show that the dose was wasted or that the waste was witnessed. Ms. Rappoport testified that Respondent's entry in MMP's chart contradicted the AcuDose entry.

51. At 8:17 p.m. on March 21, 2011, Respondent removed a syringe of hydromorphone IV 2mg/1ml from the AcuDose under the name of patient MMP. Respondent wasted the medication for the reason, "Order Changed by M.D." Ms. Rappoport testified that Respondent's entry in AcuDose did not make any sense, since Respondent's earlier entry in MMP's chart stated that there was no order for the medication.

Respondent's Failure to Document Administration of Dilaudid and Unauthorized Removal of Dilaudid at Promise Hospital

52. From on or about April 1, 2011, to on or about May 11, 2011, Respondent was employed as a registered nurse by Concentric Healthcare Staffing, a nursing registry, in Scottsdale, Arizona. On April 27, 2011, Respondent was assigned to 12-hour night shifts (7:00 p.m. to 7:00 a.m.) at Promise Hospital.

53. Before Respondent's shift on April 29, 2011, Mr. Walters, an LPN who also worked at Promise Hospital, saw Respondent access the unit's AcuDose dispenser, remove a medication, place the medication in her uniform pocket, then walk directly into the unit's medication room, where syringes, alcohol, swabs, and other medical supplies were stored, and then directly into the administrative bathroom.

54. Because Mr. Walters thought Respondent's behavior was suspicious, he followed her and after she entered the bathroom, reported her behavior to his supervisor, Ms. Moton. Ms. Moton requested that the pharmacist pull the AcuDose report for Respondent and when Respondent exited the bathroom, Ms. Moton and the pharmacist confronted her.

55. Respondent's AcuDose record for April 29, 2011, at Promise Hospital reflected that at 6:45 p.m. Respondent removed one Dilaudid 2 mg intravenous and re-loaded syringe/vial for patient DOF. Respondent was not assigned to care for DOF on that shift. DOF later informed Promise Hospital staff that she did not request any pain medication or receive any pain medication from any nurse between 6:45 p.m. and 7:00 p.m. on April 29, 2011.

56. Ms. Moton testified that because DOF was assigned to another nurse, Promise Hospital's policy did not allow Respondent to remove medication for DOF. When Ms. Moton told Respondent what Mr. Walters had reported, Respondent stated that a CNA at the nursing station had asked Respondent to give medication to DOF because she was in pain. Ms. Moton testified that she went through every person on the day or night shift with Respondent, and she could not identify the person who gave her the alleged instruction. After DOF denied requesting or receiving any pain medications, Respondent "started changing her story."

57. Ms. Moton contacted Concentric Healthcare Staffing and a representative appeared at Promise Hospital and administered a drug test to Respondent. Ms. Moton testified that because Respondent did not appear to be under the influence of any drug, she allowed Respondent to drive herself home. Ms. Moton testified that she made Respondent "Do Not Return." Ms. Moton testified that she believed the urine test was positive for prohibited substances but because Concentric Healthcare Staffing paid for the test, it received the final report.

58. After the April 29, 2011 incident, Promise Hospital performed an audit of Respondent's AcuDose entries. From April 27, 2011, at 7:00 p.m. to April 28, 2011, at 7:00 a.m., Respondent had been assigned to care for DOF. Respondent's AcuDose record reflected that during her shift, Respondent removed multiple Dilaudid 1mg/ml intravenous pre-loaded syringes/vials under DOF's name in time intervals that were not ordered by the physician. In four separate instances, Respondent failed to document the administration of Dilaudid on DOF's chart or to document the Dilaudid as wasted or returned.

Respondent's Failure to Cooperate with the Board's Investigation

59. On or about June 28, 2011, June 29, 2011, and July 6, 2011, Ms. Rappoport left voicemail messages on Respondent's telephone number of record, requesting that she contact Ms. Rappoport regarding Dr. Foley's psychological evaluation and recommendation. Respondent failed to respond to Ms. Rappoport's messages.

60. On or about June 18, 2011, Ms. Rappoport attempted to contact Respondent using her e-mail address of record, but Ms. Rappoport's e-mail was returned as "undeliverable."

61. On June 28, 2011, Ms. Rappoport mailed a complaint and notification letter with the Board's Investigative Questionnaire to Respondent's address of record. Respondent failed to respond and the letter has not been returned to the Board as undeliverable. Respondent has not returned to the Board a completed Investigative Questionnaire for any of the three complaints.

CONCLUSIONS OF LAW

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

2. The Complaint and Notice of Hearing that the Board mailed to Respondent at her address of record was reasonable, and Respondent is deemed to have received notice of the hearing.[2]

3. The Board bears the burden of proof to establish cause to discipline Respondent's registered nurse 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] If the Board determines that a licensee has committed an act of unprofessional conduct, it may take disciplinary action under A.R.S. § 32-1663(D)[5] and 32-1664(N).[6]

4. Respondent's surrender of her Missouri license in the settlement agreement constitutes unprofessional conduct as defined by A.R.S. § 32-1601(18)(f) (effective October 14, 2009).[7]

5. The misconduct that Respondent acknowledged in the settlement agreement that she had committed in two Missouri hospitals constitutes unprofessional conduct as defined by A.R.S. § 32-1601(16)(d),[8] (g),[9] (h),[10] and (j)[11] (effective May 9, 2002), and A.A.C. R4-19-403(1), (7), (8), (9), (15), (16), (17), (18), and (31) (effective February 2, 2009).[12]

---

[2] *See* A.R.S. §§ 41-1092.04; 41-1092.05(D).
[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] A.R.S. § 32-1663(D) provides that "[I]f the board finds, after affording an opportunity to request an administrative hearing pursuant to title 41, chapter 6, article 10, that a person who holds a license or certificate issued pursuant to this chapter has committed an act of unprofessional conduct, it may take disciplinary action."
[6] A.R.S. § 32-1664(N) provides that "[i]f the regulated party is found to have committed an act of unprofessional conduct or to have violated this chapter or a rule adopted pursuant to this chapter, the board may take disciplinary action."
[7] A.R.S. § 32-1601(18)(f) defines unprofessional conduct to include "[h]aving a license, certificate, permit or registration to practice a health care profession denied, suspended, conditioned, limited or revoked in another jurisdiction and not reinstated by that jurisdiction."
[8] A.R.S. § 32-1601(16)(d) formerly defined unprofessional conduct to include "[a]ny conduct or practice that is or might be harmful or dangerous to the health of a patient or the public."
[9] A.R.S. § 32-1601(16)(g) formerly defined unprofessional conduct to include "[w]ilfully or repeatedly violating a provision of this chapter or a rule adopted pursuant to this chapter."
[10] A.R.S. § 32-1601(16)(h) formerly defined unprofessional conduct to include "[c]ommitting an act that deceives, defrauds or harms the public."
[11] A.R.S. § 32-1601(16)(j) formerly defined unprofessional conduct to include "[v]iolating this chapter or a rule that is adopted by the board pursuant to this chapter."
[12] A.A.C. R4-19-403 further defines unprofessional conduct in relevant part as follows:

1. A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice;

. . . .

1 6. The misconduct that the Board established at the hearing that Respondent committed in
2 Arizona at West Valley Hospital and Promise Hospital constitutes unprofessional conduct as defined by
3 A.R.S. § 32-1601(18)(d), (g), (h), and (j), (effective October 14, 2009),[13] and A.A.C. R4-19-403(1), (7),
4 (8), (9), (15), (16), (17), (18), and (31) (effective February 2, 2009).

5

6

7

8

9

10

11

12 7. Failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient;
13 8. Falsifying or making a materially incorrect, inconsistent, or unintelligible entry in any record:
14 a. Regarding a patient, health care facility, school, institution, or other work place location; or
15 b. Pertaining to obtaining, possessing, or administering any controlled substance as defined in the federal Uniform Controlled Substances Act, 21
16 U.S.C. 801 et seq., or Arizona's Uniform Controlled Substances Act, A.R.S. Title 36, Chapter 27;
17 9. Failing to take appropriate action to safeguard a patient's welfare or follow
18 policies and procedures of the nurse's employer designed to safeguard the patient;

. . . .
19 15. Removing, without authorization, any money, property, or personal possessions,
20 or requesting payment for services not performed from a patient, employer, co-worker, or member of the public.
21 16. Removing, without authorization, a narcotic, drug, controlled substance, supply, equipment, or medical record from any health care facility, school, institution, or
22 other work place location;
17. A pattern of using or being under the influence of alcohol, drugs, or a similar
23 substance to the extent that judgment may be impaired and nursing practice detrimentally affected, or while on duty in any health care facility, school,
24 institution, or other work location;
18. Obtaining, possessing, administering, or using any narcotic, controlled
25 substance, or illegal drug in violation of any federal or state criminal law, or in violation of the policy of any health care facility, school, institution, or other work
26 location at which the nurse practices;

. . . .
27 31. Practicing in any other manner that gives the Board reasonable cause to believe the health of a patient or the public may be harmed.

28

[13] Current A.R.S. § 32-1601(18)(d), (g), (h), and (j) have the same language as former A.R.S. § 32-1601(16)(d),
29 (g), (h), and (j).

7. Respondent's failure to return the Board's Investigative Questionnaire constitutes unprofessional conduct as defined by A.R.S. § 32-1601(18)(g) and (j), and A.A.C. R419-403(25)(a).[14]

8. Respondent's acts of unprofessional conduct are serious and repeated. The Board established that the public health, safety, and welfare imperatively required it to summarily suspend Respondent's registered nurse license in July 2011. In light of Respondent's failure to respond to the Board's investigation or to appear at the duly noticed hearing, the Board also established that Respondent cannot be regulated at this time.

ORDER

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

Pursuant to A.R.S. § 32-1664(N), the Board **REVOKES** registered nurse license number RN145785 issued to Penny Lynne Barton.

RIGHT TO PETITION FOR REHEARING OR REVIEW

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 Llysia Gauntt, Arizona State Board of Nursing, 4747 North 7th Street Ste 200, Phoenix AZ 85014-3655, and must set forth legally sufficient reasons for granting a rehearing. A.A.C. R4-19-608.

For answers to questions regarding a rehearing, contact Llysia Gauntt at (602) 771-7852. 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.

This decision is effective upon expiration of the time for filing a request for rehearing or review, or upon denial of such request, whichever is later, as mandated in A.A.C. R4-19-609.

---

[14] A.A.C. R. 4-19-403(25)(a) further defines unprofessional conduct to include "[f]ailing to...[f]urnish in writing a full and complete explanation of a matter reported pursuant to A.R.S. § 32-1664 . . ."

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

DATED this 14th day of November, 2011.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour RN MN FAAN

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

COPIES mailed this 17th day of November, 2011, by Certified Mail No. 7009 0080 0000 0430 1239 and First Class Mail to:

Penny Lynne Barton
8514 W Townley Ave
Peoria AZ 85345

COPIES of the foregoing mailed this 17th day of November, 2011, to:

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

Elizabeth A. Campbell
Assistant Attorney General
1275 W Washington LES Section
Phoenix AZ 85007

By: Llysia Gauntt