

1 **ARIZONA STATE BOARD OF NURSING**
2 **1651 East Morten Avenue, Suite 210**
3 **Phoenix, Arizona 85020**
4 **602-889-5150**

5 IN THE MATTER OF PROFESSIONAL
6 NURSE LICENSE NO. RN093939
7 ISSUED TO:

8 **DAWN MARIE FALK,**

9 Respondent.

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER NO. 05A-0411071-NUR**

10 On March 20, 2006, the Arizona State Board of Nursing (“Board”) considered the State’s
11 Motion to Deem Allegations Admitted and Respondent’s Response to the Motion, if any, at the
12 Arizona State Board of Nursing Conference Room, 1651 E. Morten Avenue, Suite 210, Phoenix,
13 Arizona. Ann Olson, Assistant Attorney General, appeared on behalf of the State. Respondent was not
14 present and was not represented by counsel.

15
16 On March 20, 2006, the Board granted the State’s Motion to Deem Allegations Admitted.
17 Based upon A.R.S. § 32-1664(I) and the Complaint and Notice of Hearing No. 05A-0411071-NUR
18 filed in this matter, the Board adopts the following Findings of Fact and Conclusions of Law, and
19 **REVOKES** Respondent’s license.
20

21 **FINDINGS OF FACT**

22 1. The Arizona State Board of Nursing (“Board”) has the authority to regulate and control
23 the practice of nursing in the State of Arizona, pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664.
24 The Board also has the authority to impose disciplinary sanctions against the holders of nursing
25 licenses/nursing assistant certificates for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 to -
26 1667.
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1 2. Dawn Marie Falk (“Respondent”) holds Board issued professional nurse license number
2 RN093939, in the State of Arizona.

3 3. On or about November 19, 2004, the Board received a letter from Ronald Fish,
4 Respondent’s former husband, outlining Respondent’s behavior towards him, a copy of an Order of
5 Protection dated November 15, 2004, a letter dated November 12, 2004 from Mary Dawson,
6 Administrative Supervisor, and five Phoenix, Arizona Police Department reports.
7

8 4. On or about January 14, 2003, Respondent failed to control the speed of her car and
9 collided into the rear of a car that was stopped, causing a chain reaction involving three other
10 vehicles. When the police officer arrived and talked to Respondent, the officer noted the strong odor
11 of alcohol on Respondent’s breath. The officer asked Respondent to turn off the engine of her car,
12 but she refused. Respondent told the officer she was going home and placed her hand on the
13 gearshift. The officer opened the door and pulled Respondent from the car. Respondent then lay
14 down on the street and refused to get up. Respondent’s Breathalyzer test results were 0.285 and .291.
15

16 5. On or about March 13, 2003, Respondent’s driver’s license was suspended for 30 days
17 and then restricted for 60 days. On or about November 3, 2004, in Phoenix Municipal Court, Case
18 No. 20039028181, Respondent was found guilty of DUI by a jury trial and fined \$905, ordered to
19 spend 90 days in jail with 60 days suspended, ordered to complete Substance Abuse Screening
20 (SASS) and placed on probation until December 27, 2009.
21

22 6. On or about October 8, 2003, Respondent was arrested for driving under the influence
23 with a Breathalyzer test result of .250. On or about July 20, 2004, Respondent pled no contest in
24 Phoenix Municipal Court, Case No. 20039039854, to the charges of DUI and DUI with a BAC of
25 0.15 or greater. Respondent was ordered to: pay a fine of \$1140, spend 30 days in jail with 17 days
26 suspended, complete SASS and was placed on probation.
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1 7. From on or about February 1998 to on or about December 2004, Respondent was
2 employed by Health Temps in Phoenix, Arizona.

3 8. Attached to a Registry Program Performance Evaluation from Phoenix Memorial
4 Hospital dated February 26, 2003, Cathy Staford, RN, wrote that a patient requested Respondent not
5 care for him as she did not suction him when he was on a ventilator and his heart rate was between 160
6 and 180 beats per minute. In the same memo, Staford wrote that another nurse notified her that when
7 she assumed the care of a patient from Respondent and found the Esmolol and insulin intravenous drips
8 completely dry, and the patient's blood pressure was 260/140. The patient and family requested that
9 Respondent provide no further care. The patient also said that Respondent treated her roughly.
10 Another undated letter written by Kent Silvas indicated that Respondent, while caring for a 1:1 patient,
11 only assessed the patient three times and did not keep the patient sedated as ordered.
12

13 9. On a Registry Program Performance Evaluation from Scottsdale Healthcare, Shea dated
14 August 1, 2003, Respondent was rated as Unsatisfactory in "Administers medications and treatment as
15 ordered". A patient complained that Respondent failed to adequately medicate him post-operatively.
16

17 10. On or about December 29, 2004, Board staff interviewed Respondent in the Board
18 office. During the interview, Respondent admitted being an alcoholic for eleven years. Respondent
19 told Board staff that she attended an outpatient chemical dependency treatment program in Rockford,
20 Illinois. Board staff requested Respondent to complete a Recovery Questionnaire by January 31, 2005,
21 obtain a chemical dependency evaluation by a Board-approved addictionist by February 15, 2005, and
22 provide proof of attendance at the outpatient chemical dependency treatment program in Rockford,
23 Illinois. Respondent failed to complete the Recovery Questionnaire within the timeframe, failed to
24 obtain a chemical dependency evaluation by a Board-approved addictionist, and failed to submit proof
25 of attendance at the outpatient chemical dependency treatment program in Rockford, Illinois.
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1 11. During the interview on December 29, 2004, Respondent stated that her Arizona driver's
2 license was suspended and friends were driving her to her appointments and to work. Upon leaving the
3 Board office, Respondent was observed entering the driver's side of a sport utility vehicle and driving
4 the car from the Board office parking lot.
5

6 12. On or about March 17, 2005, the Board reviewed the Investigative Report and voted to
7 issue Notice of Charges. On March 25, 2005, the Notice of Charges was mailed to Respondent and on
8 April 11, 2005, Respondent submitted a written response to the Notice of Charges and included the
9 Recovery Questionnaire that was due in the Board office by January 31, 2005. Respondent failed to
10 sign the Recovery Questionnaire and have it notarized.
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12 13. On the Recovery Questionnaire, the first question under "Recovery History" asks,
13 "Have you completed a drug/alcohol rehabilitation program?" Respondent failed to answer the
14 question.
15

16 14. On the Recovery Questionnaire, the second question under "Recovery History" asks,
17 "Have you completed an aftercare program?" Respondent marked "no" to this question.
18

19 15. On page 6 of the Recovery Questionnaire, Respondent failed to answer the question
20 asking if she has ever been evaluated by an addictionist, and answered "no" to having been evaluated
21 by a relapse prevention counselor.
22

23 16. On page 6 of the Recovery Questionnaire, Respondent answered "yes" to the question
24 asking, "Since you have had your license, have you had any counseling for your substance abuse
25 problem? If yes, provide documentation. Describe your recovery program," Respondent stated the
26 following: "I attend AA meetings approx 4 times a week. I have talked with two people 1:1 and have
27 their phone numbers and they have mine. I have a good friend who calls me daily to see how I'm doing
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1 and if I need anything. Either he or his girlfriend take me shopping, to MD visits, etc.” Respondent
2 failed to provide documentation of any counseling related to chemical dependency.
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4 17. On page 13 of the Recovery Questionnaire, received on April 11, 2005, Respondent
5 stated that she had been sober for 90 days.
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7 CONCLUSIONS OF LAW

8 1. The conduct and circumstances alleged in the Findings of Fact constitute violations of
9 A.R.S. § 32-1663(D) as defined in A.R.S. § 32-1601(16), (b), (d), (h) and (j) and A.A.C. R4-19-
10 403(1), (2), (12), (24a) and (25).
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12 2. The conduct and circumstances described in the Findings of Fact constitute
13 unprofessional conduct pursuant to A.R.S. § 32-1601(16) (b), (committing a felony, whether or not
14 involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by
15 a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission),
16 and is grounds for disciplinary action pursuant to A.R.S. § 32-1663 and § 32-1664.
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18 3. The conduct and circumstances described in the Findings of Fact constitute
19 unprofessional conduct pursuant to A.R.S. § 32-1601(16) (d), (any conduct or practice that is or
20 might be harmful or dangerous to the health of a patient or the public), and is grounds for disciplinary
21 action pursuant to A.R.S. § 32-1663 and § 32-1664.
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23 4. The conduct and circumstances described in the Findings of Fact constitute
24 unprofessional conduct pursuant to A.R.S. § 32-1601(16) (h), (committing an act that deceives,
25 defrauds or harms the public), and is grounds for disciplinary action pursuant to A.R.S. § 32-1663
26 and § 32-1664.
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28 5. The conduct and circumstances described in the Findings of Fact constitute
29 unprofessional conduct pursuant to A.R.S. § 32-1601(16) (j), (violating a rule that is adopted by the

1 board pursuant to this chapter, specifically, A.A.C. R4-19-403 (1), [a pattern of failure to maintain
2 minimum standards of acceptable and prevailing nursing practice], and is grounds for disciplinary
3 action pursuant to A.R.S. § 32-1663 and § 32-1664.
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5 6. The conduct and circumstances described in the Findings of Fact constitute
6 unprofessional conduct pursuant to A.R.S. § 32-1601(16) (j), (violating a rule that is adopted by the
7 board pursuant to this chapter, specifically, A.A.C. R4-19-403 (2), [intentionally or negligently
8 causing physical or emotional injury], and is grounds for disciplinary action pursuant to A.R.S. § 32-
9 1663 and § 32-1664.
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11 7. The conduct and circumstances described in the Findings of Fact constitute
12 unprofessional conduct pursuant to A.R.S. § 32-1601(16)(j), (violating a rule that is adopted by the
13 board pursuant to this chapter, specifically, A.A.C. R4-19-403 (12), [a pattern of use or being under
14 the influence of alcoholic beverages, medications, or other substances to the extent that judgment
15 may be impaired and nursing practice detrimentally affected, or while on duty in any health care
16 facility, school, institution, or other work location], and is grounds for disciplinary action pursuant to
17 A.R.S. § 32-1663 and § 32-1664.
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19 8. The conduct and circumstances described in the Findings of Fact constitute
20 unprofessional conduct pursuant to A.R.S. § 32-1601(16)(j), (violating a rule that is adopted by the
21 board pursuant to this chapter, specifically, A.A.C. R4-19-403 (24a), [failing to cooperate with the
22 Board by: (a). not furnishing in writing a full and complete explanation covering the matter reported
23 pursuant to A.R.S. § 32-1664], and is grounds for disciplinary action pursuant to A.R.S. § 32-1663
24 and § 32-1664.
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27 9. The conduct and circumstances described in the Findings of Fact constitute
28 unprofessional conduct pursuant to A.R.S. § 32-1601(16)(j), (violating a rule that is adopted by the
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1 board pursuant to this chapter, specifically, A.A.C. R4-19-403 (25), [practicing in any other manner
2 which gives the Board reasonable cause to believe that the health of a patient or the public may be
3 harmed], and is grounds for disciplinary action pursuant to A.R.S. § 32-1663 and § 32-1664.
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5 10. The conduct and circumstances described in the Findings of Fact constitute sufficient
6 cause pursuant to A.R.S. § 32-1664(N) to suspend or revoke the license of Dawn Marie Falk to
7 practice as a professional nurse in the State of Arizona.
8

9 **ORDER**

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

12 Pursuant to A.R.S. § 32-1664(N), the Board **REVOKES** professional nurse license number
13 RN093939 issued to Dawn Marie Falk.
14

15 Pursuant to A.R.S. § 41-1092.09, Respondent may file, in writing, a motion for rehearing or
16 review within 30 days after service of this decision with the Arizona State Board of Nursing. The
17 motion for rehearing or review shall be made to the attention of Susan Barber, R.N., M.S.N., Arizona
18 State Board of Nursing, 1651 E. Morten, Ste. 210, Phoenix AZ 85020. For answers to questions
19 regarding a rehearing, contact Susan Barber at (602) 889-5161. Pursuant to A.R.S. § 41-1092.09(B), if
20 Respondent fails to file a motion for rehearing or review within 30 days after service of this decision,
21 Respondent shall be prohibited from seeking judicial review of this decision.
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23 This decision is effective upon expiration of the time for filing a request for rehearing or review,
24 or upon denial of such request, whichever is later, as mandated in A.A.C. R4-19-609.
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1 Respondent may apply for reinstatement of the said license pursuant to A.A.C. R4-19-404 after
2 a period of five years.

3 DATED this 20th day of March 2006.

4 ARIZONA STATE BOARD OF NURSING

5
6 SEAL

7 

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

10
11 COPIES mailed this 24th day of March 2006, by Certified Mail No. 7001 1940 0003 4510 1404 and
12 First Class Mail to:

13 Dawn Marie Falk
14 2136 W Sharon Ave
15 Phoenix AZ 85007

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

17 Ann Olson
18 Assistant Attorney General
19 1275 W. Washington, LES Section
20 Phoenix, AZ 85007

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22 By: Vicky Driver
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