

1 **ARIZONA STATE BOARD OF NURSING**
2 **4747 North 7th Street, Ste 200**
3 **Phoenix, Arizona 85014-3655**
4 **602-771-7800**

5 IN THE MATTER OF THE PRACTICAL
6 NURSE LICENSE NO. LP047864 AND
7 CERTIFIED NURSING ASSISTANT
8 CERTIFICATE NO. CNA431082803 (Expired)
9 ISSUED TO:

10 **BENEDETTE EPIUM**
11 **RESPONDENT**

12 **FINDINGS OF FACT,**
13 **CONCLUSIONS OF LAW**
14 **AND ORDER NO. 1201047**

15 On July 25, 2014, the Arizona State Board of Nursing (“Board”) considered the State’s Motion
16 to Deem Allegations Admitted and Recommended Discipline and Respondent’s Response to the
17 Motion, if any, at the Arizona Board of Nursing, 4747 North 7th Street, Suite 200, Phoenix Arizona
18 85014-3655. Carrie H. Smith, Assistant Attorney General, appeared on behalf of the State. Respondent
19 was not present and was not represented by counsel.

20 On July 25, 2014, the Board granted the State’s Motion to Deem Allegations Admitted. Based
21 upon A.R.S. § 32-1663(F) and Notice of Charges No.1201047 issued in this matter, the Board adopts
22 the following Findings of Fact, Conclusions of Law, and **REVOKES** Respondent’s license/certificate.

23 **FINDINGS OF FACT**

- 24 1. Benedette Epium, (“Respondent”) holds Board issued practical nurse license no.
25 LP047864 (expires April 1, 2016) and certificate no. CNA431082803 (expired February 29, 2012).
26 2. On or about December 30, 2011, the Board received a complaint from the Director of
27 Nursing at Avalon Southwest Health and Rehabilitation in Tucson, Arizona alleging that Respondent
28 administered 300 mg of liquid Morphine Sulfate to the wrong patient, M.M. resulting in patient M.
29 M.’s overdose, hospitalization and treatment in an Intensive Care Unit while Respondent was
employed as a LPN at Avalon. Based on this information, the Board conducted an investigation.

1 3. On or about September 14, 2010, while on duty and employed as a CNA at HealthSouth
2 Rehabilitation Hospital (“HealthSouth”) in Tucson, Arizona, Respondent sent a physician coworker,
3 Physician A, a card stating “I love you” and also tricked Physician A into calling her at home after
4 Respondent had previously sent a certified letter to HealthSouth and confronted coworkers
5 complaining that Physician A or others were spreading sexual rumors about her. Several facility
6 coworkers stated that the only person from whom they had heard about the rumors about Respondent
7 was Respondent herself.
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10 4. On or about August 19, 2013, during an interview with Board staff, Respondent was
11 asked why she sent a card to Physician A in which she put, “I love you” after she complained that
12 Physician A was spreading rumors about her. Respondent replied, “Lord Almighty knows why I did
13 it. I don’t know what made me do it. Please disregard the card.”
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15 5. On or about December 3, 2011, while employed by Compass Health System, Tucson,
16 Arizona, and on duty as a Behavioral Health Technician and CNA Medication Monitor, Respondent
17 clocked in for her shift at 11:05 p.m. and assumed patient care duties, but abruptly left her shift and
18 her assigned patients at 11:45 p.m. without notifying her supervisor and without a replacement. On
19 or about August 19, 2013, Respondent admitted to Board staff during the interview that she left her
20 assigned shift without a replacement and stated that she told a Behavioral Health Technician
21 (“BHT”) that she needed to go home. Respondent asserts that “(the BHT) said it was all right to
22 leave.” Respondent claimed in the Board staff interview that she did not know she should have
23 talked to her supervisor before leaving her shift and her patient assignment. On December 7, 2011,
24 Compass Health System terminated Respondent’s employment due to this incident.
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27 6. On or about December 30, 2011, while employed and on duty as a LPN at Avalon
28 Southwest Health and Rehabilitation Center (“Avalon”), Tucson, Arizona, Respondent administered
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1 at least 15 ml (300 mg) of liquid Morphine, ordered for patient R.L., to patient M.M. who had a
2 physician order for Morphine Extended Release 15 mg tablet. Respondent went beyond the scope of
3 practice by administering medication without an order from an authorized prescriber and violated the
4 Avalon Nursing Job Description for LPNs which states “Administer medication and perform
5 treatments accurately”.

7 7. On or about December 30, 2011, while employed and on duty as a LPN at Avalon
8 Southwest Health and Rehabilitation Center, Tucson, Arizona, Respondent reported to the Assistant
9 Director of Nursing for the facility that she spilled some of patient R. L.’s liquid morphine solution
10 and did not report the spillage or record the medicine as having been wasted, in violation of the
11 Avalon Job Description, which required Respondent to assure that narcotics were properly
12 accounted for.

14 8. On or about December 30, 2011 while employed and on duty as a LPN at Avalon
15 Southwest Health and Rehabilitation Center, Tucson, Arizona, Respondent failed to notify patient
16 M.M.’s medical provider, Nurse Practitioner A, that she made an error in dosing and administration,
17 as required by the standard of care and facility policy. Specifically, Respondent failed to notify
18 M.M.’s provider that she overdosed M.M. with approximately 300mg of liquid morphine, which was
19 not ordered for M.M. This error violated the Avalon’s Medication Error and Adverse Drug Reaction
20 Reporting, Policy 6.2.

23 9. On or about December 29, 2011, while employed and on duty as a LPN at Avalon,
24 Respondent documented in patient M.M.’s Medication Administration Record that she gave M.M.
25 Morphine Extended Release 15 mg tablet at 8:13 p.m., however she reported to two CNA coworkers
26 that she had “just given [patient M.M.] something for pain” shortly after midnight, which
27 Respondent did not document in M.M.’s Medication Administration Record. Facility personnel
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1 concluded that Respondent in fact gave M.M. 300 mg to 475 mg of liquid morphine at
2 approximately 4:00-5:00 a.m. on or about December 30, 2011, based on M.M.'s condition at 6:00
3 a.m. that morning.

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5 10. On or about December 30, 2011, while employed and on duty as a LPN at Avalon
6 Southwest Health and Rehabilitation Center, Tucson, Arizona, Respondent told Totten, former
7 Director of Nursing for the facility, that "something wasn't right in [Respondent's] body," and
8 mentioned her blood pressure, as a reason for why she had overdosed patient M.M. with liquid
9 morphine.

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11 11. On or about December 30, 2011, while employed and on duty as a LPN at Avalon,
12 Respondent admitted to the Assistant Director of Nursing for the facility that she took Ativan from
13 patient J.B.'s supply and used it to medicate patient M.H., instead of giving M.H. the ordered dose
14 of hydrocodone.

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16 12: On or about February 14, 2011, Respondent stated in her written response to the
17 Board's Investigative Questionnaire that she had realized her error with patient M.M.'s Morphine
18 Sulfate ER when she checked the patient's Medication Administration Record, however, Respondent
19 contradicted this statement during her interview on August 19, 2013 with Board staff, when
20 Respondent reported that she was counting narcotics with the day shift LPN, when she realized that
21 she had made an error with the medications.

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23 13. Respondent's February 14, 2012, written response to the Board's Investigative
24 Questionnaire question regarding past employment, Respondent failed to disclose her employment at
25 Compass Health Care Inc., from June 14, 2010 to December 7, 2011.

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27 14. Respondent's February 14, 2012 written response to the Board's Investigative
28 Questionnaire stated "No" to the question "Do you have a history of discipline by current or
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1 previous employer(s) for practice issues” when Respondent had actually been involuntarily
2 terminated from HealthSouth on April 20, 2009, terminated from Avalon on December 30, 2011,
3 and involuntarily terminated on December 7, 2011 from Compass Behavioral Health, Tucson,
4 Arizona.
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6 15. On or about August 19, 2013, during an interview with Board staff, Respondent stated that
7 she did not know what was meant by the term “appropriate boundaries” as it pertained to her
8 professional relationships with co-workers and physicians (in relation to Respondent’s
9 communications with Physician A). Respondent was asked to name the “5 rights of medication
10 administration”, and Respondent named “right dose, right name, right time”. Even with prompting
11 from Board staff, Respondent could not remember the other two medication administration rights
12 (right route, right drug). Respondent was also asked by Board staff what she would do if she found a
13 patient unresponsive in a bed within the facility, and Respondent replied, “I don’t know.” The
14 standards of care requires that the nurse immediately call for assistance in managing the patient and
15 determine the patency of the patient’s airway, if the patient is spontaneously breathing and whether
16 the patient has a heartbeat. Based on these assessments, and while awaiting the arrival of emergency
17 assistance, the nurse may provide cardiopulmonary resuscitation for the patient provided the criteria
18 is met for doing so and always preserve the patient’s airway and breathing.
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22 16. On November 22, 2013, the Board issued an Interim Order to Respondent ordering
23 Respondent to obtain a psychological evaluation by a Board approved evaluator, and a nurse practice
24 evaluation, within 60 days. After the Interim Order was issued, it was discovered that there are no
25 nurse practice evaluations currently available to LPNs, so the Board did not sanction Respondent for
26 failing to complete the nurse practice evaluation, since that was beyond her control. However,
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1 Respondent also failed to obtain a psychological evaluation within 60 days of the issuance of the
2 Interim Order.

3 CONCLUSIONS OF LAW

4 Pursuant to A.R.S. §§ 32-1606, 32-1663, 32-1664, 32-1668 Article II, III and V, the Board has
5 subject matter and personal jurisdiction in this matter.

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7 The conduct and circumstances described in the Findings of Fact constitute a violation of A.R.S. §32-
8 1601(18) (d), (e), (g), (h) and (j) (effective September 30, 2009): 18. "Unprofessional conduct"
9 includes the following whether occurring in this state or elsewhere: (d) Any conduct or practice that is
10 or might be harmful or dangerous to the health of a patient or the public; (e) Being mentally
11 incompetent or physically unsafe to a degree that it is or might be harmful or dangerous to the health of
12 a patient or the public; (g) Willfully or repeatedly violating a provision of this chapter or a rule adopted
13 pursuant to this chapter; (h) Committing an act that deceives, defrauds or harms the public; (j)
14 Violating a rule that is adopted by the board pursuant to this chapter and A.R.S. §32-1663(D) as
15 defined in A.R.S. §32-1601(22) (d), (e), (g), (h) and (j) (effective August 2, 2012): 22. "Unprofessional
16 conduct" includes the following whether occurring in this state or elsewhere: (d) Any conduct or
17 practice that is or might be harmful or dangerous to the health of a patient or the public; (e) Being
18 mentally incompetent or physically unsafe to a degree that it is or might be harmful or dangerous to the
19 health of a patient or the public; (g) Willfully or repeatedly violating a provision of this chapter or a
20 rule adopted pursuant to this chapter; (h) Committing an act that deceives, defrauds or harms the public.
21 (j) Violating a rule that is adopted by the board pursuant to this chapter and A.A.C. § R4-19-403(1),
22 (2), (7), (9), (26), and (31) (effective January 31, 2009): 1. A pattern of failure to maintain minimum
23 standards of acceptable and prevailing nursing practice; 2. Intentionally or negligently causing physical
24 or emotional injury; 7. Failing to maintain for a patient record that accurately reflects the nursing
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1 assessment, care, treatment, and other nursing services provided to the patient; 9. Failing to take
2 appropriate action to safeguard a patient's welfare or follow policies and procedures of the nurse's
3 employer designed to safeguard the patient; 26. Making a written false or inaccurate statement to the
4 Board or the Board's designee in the course of an investigation. 31. Practicing in any other manner that
5 gives the Board reasonable cause to believe the health of a patient or the public may be harmed.
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7 **ORDER**

8 In view of the above Findings of Fact and Conclusions of Law, the Board issues the following
9 Order:
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11 Pursuant to A.R.S. § 32-1664(N), the Board **REVOKES** practical nurse license number
12 LP047864 and certified nursing assistant certificate number CNA431082803 (February 29, 2012)
13 issued to Benedette Epium.
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15 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

16 Pursuant to A.R.S. § 41-1092.09, Respondent may file, in writing, a motion for rehearing
17 or review within thirty (30) days after service of this decision with the Arizona State Board of
18 Nursing. The motion for rehearing or review shall be made to the attention of Trina Smith,
19 Arizona State Board of Nursing, 4747 North 7th Street Ste 200, Phoenix AZ 85014-3655, and must
20 set forth legally sufficient reasons for granting a rehearing. A.A.C. R4-19-608.
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22 For answers to questions regarding a rehearing, contact Trina Smith at (602) 771-7844.
23 Pursuant to A.R.S. § 41-1092.09(B), if Respondent fails to file a motion for rehearing or review
24 within thirty (30) days after service of this decision, Respondent shall be prohibited from seeking
25 judicial review of this decision.
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27 This decision is effective upon expiration of the time for filing a request for rehearing or
28 review, 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/certificate pursuant to A.A.C. R4-
2 19-404 and A.A.C. R4-19-815 after a period of five years.

3 DATED this 25th day of July, 2014.

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5 SEAL

ARIZONA STATE BOARD OF NURSING

6 *Joey Ridenour R.N. M.N. F.A.A.N.*

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

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10 COPIES mailed this 28th day of July, 2014 by Certified Mail No. 7011 3500 0001 5219 1862 and First
Class Mail to:

11 Benedette Epium
12 3489 N. Crystal Hill Avenue
13 Tucson, AZ 85745

14 By: Trina Smith
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