

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 CERTIFIED NURSING
6 ASSISTANT CERTIFICATE NO.
7 CNA1000006774
8 ISSUED TO:

9 TANYA MARIA FORSYTHE
10 RESPONDENT

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER NO. 1306111**

11 On March 27, 2015, the Arizona State Board of Nursing (“Board”) considered the State’s
12 Motion to Deem Allegations Admitted and Recommended Discipline and Respondent’s Response to
13 the Motion, if any, at the Arizona Board of Nursing, 4747 North 7th Street, Suite 200, Phoenix Arizona
14 85014-3655. Elizabeth A. Campbell, Assistant Attorney General, appeared on behalf of the State.
15 Respondent was not present and was not represented by counsel.

16 On March 27, 2015, the Board granted the State’s Motion to Deem Allegations Admitted.
17 Based upon A.R.S. § 32-1663(F) and Notice of Charges No.1306111 issued in this matter, the Board
18 adopts the following Findings of Fact, Conclusions of Law, and **REVOKES** Respondent’s certificate.

19 **FINDINGS OF FACT**

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21 1. Tanya Maria Forsythe (“Respondent”) holds Board issued Certified Nursing Assistant
22 Certificate (“CNA”) No. CNA1000006774, originally issued August 19, 2005.

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24 2. On or about June 12, 2013, the Board received a complaint alleging that Respondent,
25 while employed and on-duty as a CNA at Mountain View Manor in Prescott, Arizona, was hostile
26 and negligent towards the patients, and frequently yelled at and acted forcefully with the patients.
27 Respondent also allegedly left patients in wet beds/clothes/underpants until the next shift so another
28 aide had to change them. Based on the information received, the Board conducted an investigation.
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1 3. On or about May 31, 2013, while Respondent was on duty at Mountain View Manor in
2 Prescott, Arizona (“Mountain View”), Respondent did not change a patient’s brief but reported to the
3 oncoming night shift staff that she did so.

4 4. On or about June 15 and June 16, 2013, while Respondent was on duty at Mountain
5 View, Respondent did not complete the weights for three patients that were assigned to Respondent
6 during her shift as described in their care plan.

7 5. On or about October 22, 2013, Respondent received a written warning while working
8 as a CNA at Mountain View for not changing three patients that were assigned to Respondent during
9 her shift.

10 6. On or about January 10, 2014, Respondent refused to make a Mountain View patient’s
11 bed, did not cleaning patients sufficiently after toileting, and became angry at the patients when the
12 patients requested help. When the Mountain View Director of Nursing informed Respondent that she
13 was being terminated for this conduct, Respondent called the Director of Nursing a “bitch,” walked
14 out and slammed the door and security had to escort Respondent out of the building.

15 7. On or about August 19, 2013, Board investigative correspondence sent to Respondent’s
16 address of record with the Board, including an investigative questionnaire, were returned to the
17 Board, marked “Unknown-Unable to forward.” On or about September 30, 2013, Board
18 correspondence to Respondent regarding a newly assigned investigator with another investigative
19 questionnaire was returned to the Board marked “Return to Sender-Unable to forward.” On or about
20 October 9, 2013, Board Staff called Respondent’s two phone numbers of record, both of which were
21 no longer valid. On or about October 9, 2013, Board Staff emailed Respondent a letter regarding the
22 Nurse Practice Act’s requirement to keep an updated address with the Board of Nursing. On or about
23 September 4, 2014, Board Staff attempted to call both phone numbers of record, with neither one
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1 being valid. On or about September 4, 2014 Board Staff emailed and mailed a letter to Respondent's
2 addresses of record asking Respondent to contact the Board regarding Respondent's investigation.
3 Respondent failed to respond. Respondent failed to maintain updated current address and phone
4 number on record at the Board, as required by statute and rule.
5

6 CONCLUSIONS OF LAW

7 The conduct and circumstances alleged in the Findings of Fact above constitute violations of the
8 Act, specifically unprofessional conduct, as described in A.R.S. § 32-1663 (D), and as defined in
9 A.R.S. § 32-1601 (22) (effective August 2, 2012). "Unprofessional conduct" includes the following
10 whether occurring in this state or elsewhere: (d) Any conduct or practice that is or might be harmful or
11 dangerous to the health of a patient or the public, (g) Willfully or repeatedly violating a provision of
12 this chapter or a rule adopted pursuant to this chapter, and (j) Violating a rule that is adopted by the
13 Board pursuant to this chapter, specifically: and Arizona Administrative Code Rule(s) 4-19-814
14 (effective January 31, 2009), (4) Failing to accurately document care and treatment provided to a
15 patient or resident; (6) Failing to follow an employer's policies and procedures, designed to safeguard
16 the patient or resident; (7) Failing to take action to protect a patient or resident whose safety or welfare
17 is at risk from potential or actual incompetent health care practice, or to report the practice to the
18 immediate supervisor or a facility administrator; (9) Violating the rights or dignity of a patient or
19 resident; (11) Neglecting or abusing a patient or resident physically, verbally, emotionally, or
20 financially; (23) Failing to cooperate with the Board during an investigation by: (a) Not furnishing in
21 writing a complete explanation of a matter reported under A.R.S. §32-1664, (c) Not completing and
22 returning a Board-issued questionnaire within 30 days; or (d) Not informing the Board of a change of
23 address or phone number within 10 days of each change; (29) Practicing in any other manner that gives
24 the Board reasonable cause to believe that the health of a patient, resident, or the public may be harmed.
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1 **ORDER**

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

4 Pursuant to A.R.S. § 32-1664(N), the Board **REVOKES** certified nursing assistant certificate
5 number CNA1000006774 issued to Tanya Marie Forsythe.
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7 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

8 Pursuant to A.R.S. § 41-1092.09, Respondent may file, in writing, a motion for rehearing
9 or review within thirty (30) days after service of this decision with the Arizona State Board of
10 Nursing. The motion for rehearing or review shall be made to the attention of Trina Smith,
11 Arizona State Board of Nursing, 4747 North 7th Street Ste 200, Phoenix AZ 85014-3655, and must
12 set forth legally sufficient reasons for granting a rehearing. A.A.C. R4-19-608.
13

14 For answers to questions regarding a rehearing, contact Trina Smith at (602) 771-7844.
15 Pursuant to A.R.S. § 41-1092.09(B), if Respondent fails to file a motion for rehearing or review
16 within thirty (30) days after service of this decision, Respondent shall be prohibited from seeking
17 judicial review of this decision.
18

19 This decision is effective upon expiration of the time for filing a request for rehearing or
20 review, or upon denial of such request, whichever is later, as mandated in A.A.C. R4-19-609.
21

22 Respondent may apply for reinstatement of the said certificate pursuant to A.A.C. R4-19-815
23 after a period of five years.

24 DATED this 27th day of March, 2015.

25
26 SEAL

ARIZONA STATE BOARD OF NURSING

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

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

1 COPIES mailed this 30th day of March, 2015 by Certified Mail No. 7014 3490 0001 0379 9001 and
2 First Class Mail to:

3 Tanya Maria Forsythe

4 [REDACTED]
5 [REDACTED]

6 By: Trina Smith

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