ARIZONA STATE BOARD OF NURSING
4747 North 7th Street, Suite 200
Phoenix, Arizona 85014-3655
602-771-7800

IN THE MATTER OF REGISTERED NURSE LICENSE NO. RN057911 AND ADVANCED PRACTICE CERTIFICATE NO. AP0313 ISSUED TO: DANA LILESTOL ROSDAHL RESPONDENT	CONSENT FOR ENTRY OF VOLUNTARY SURRENDER ORDER NO. 1105006, 1305064 and 1408035

A complaint charging Dana Lillestol Rosdahl ("Respondent") with violation of the Nurse Practice Act has been received by the Arizona State Board of Nursing ("Board"). In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements, and the responsibilities of the Board, and pursuant to A.R.S. § 32-1605.01(D), Respondent voluntarily surrenders her license for a minimum of 3 years.

Based on the evidence before it, the Board makes the following Findings of Fact, Conclusions of Law:

FINDINGS OF FACT

1. Respondent is the holder of registered nurse license no. RN057911 and advanced practice certificate number AP0313 in the State of Arizona.

2. On May 6, 2011 Board staff initiated a complaint after becoming aware of a media report alleging Respondent misdiagnosed patient A.G. with Lyme disease and mismanaged her care from June 2009 to February 2010 at Gilbert Internal Medicine as Whole Person Health LLC, which later moved to Chandler's Remnant Health Care in Chandler, Arizona. Based on the information contained in this media report, the Board opened an investigation

3. On January 4, 2013, the Board received a second complaint alleging Respondent failed to adequately diagnose and treat patient M.F. from 2009 through 2012 while working as a nurse practitioner at Chandler's Remnant Health Care in Chandler, Az.

4. On May 28, 2013 the Board received a third complaint alleging misdiagnosis and inappropriate treatment of patient R.W. between 2008 and 2010 by Respondent while working at Gilbert Internal Medicine and Remnant Health Center in Chandler, Arizona.

5. On August 20, 2014 the Board received a fourth complaint alleging Respondent prescribed several medications to Patient D.S. without an appropriate diagnosis while working at Remnant Health Care Center in Chandler, Arizona.

COMPLAINT #1

6. From June 11, 2009 through February 10, 2010 Respondent provided care to A.G. an 18 year-old female with dysmenorrhea, facial acne, allergies/asthma, migraine headaches, arthralgias, enlarged thyroid, hypoadrenia, and an elevated fibrinogen.

7. From June 11, 2009 through February 10, 2010, A.G.'s condition deteriorated. The care and treatment provided to A.G. was below the standard of care for failing to involve a specialist(s) or other provider who could assist with A.G.'s care. From June 11, 2009 through February 10, 2010, Respondent violated the standard of practice for prescribing multiple antibiotics, which states antibiotic use is only appropriate when a bacterial infection is present and tests have been done to prove it, when she prescribed 10 different antibiotics to A.G. all without a diagnosis or confirmation of infection prior to prescribing, Additionally, Respondent prescribed other medications not well documented, providing treatment for pertussis without a diagnosis of pertussis, providing acyclovir without a clear diagnosis.

8. Respondent inappropriately prescribed Pyrazinamide (indicated for active tuberculosis (TB) for A.G.'s asthma. "Because there is some thought that asthma may have some viral components"

and A.G. was in a "clinical trial of hers for asthma." There is no documentation in the medical record indicating that A.G. was informed or consented to participation in a "clinical trial".

9. On Patient A.G.'s fourth visit on December 10, 2009, Respondent prescribed Lexapro to A.G. for depression. Respondent's records do not indicate that she conducted an appropriate screening for depression before prescribing an antidepressant.

10. On December 23, 2009, during A.G.'s fifth visit, Respondent deviated from standard of practice when she:

a. Prescribed a supplemental thyroid hormone in the form of sustained release tri-iodothyronine (SR T3) 7.5 mg twice daily #60. A.G.'s thyroid studies from June 26, 2009 were all normal. The standard of practice requires a TSH assay should be used as the primary test to establish the diagnosis of primary hypothyroidism. Respondent violated the standard of practice by prescribing levothyroxine-plus-T3 for A.G. The medical records do not reflect Respondent consulted with an endocrinologist as is the standard of practice with patients age 18 years or less.

b. Prescribed Ambien 10mg 1 daily #30 for A.G. for a "sleep disorder" without exploring other non-pharmaceutical options first and without starting at the recommended dose of 5 mg. The standard of practice requires that, if the practitioner determines that a pharmaceutical solution for complaints of sleep disturbances is necessary, the practitioner should prescribe the recommended dose first (5 mg), in a small amount with no refills to begin, and then conduct a follow-up visit with the patient to determine the medication's efficacy.

11. Respondent deviated from the standard of practice when she failed to document a physical examination, including neurological examination of A.G. for complaints and symptoms

reported by A.G. including feeling "sometimes like ants are moving on my legs," complaints of shaking, and an increase in tinnitus.

12. January 24, 2010, A.G. complained to Respondent that she was having "chest pain that is stabbing in nature off and on with mid back [sic]." Despite a negative chest x-ray, Respondent prescribed A.G. Lasix and potassium. Respondent did not order a complete metabolic panel (CMP) or a basic metabolic panel (BMP) prior to starting Lasix and potassium. This violated the standard of practice, which requires that when a patient complains of stabbing chest and back pain, the nurse practitioner obtain a complete physical examination including appropriate diagnostic evaluations including a BMP prior to starting prescription diuretics.

13. On January 31, 2010, patient A.G. complained of "unrelenting pain" for which Respondent described as "generalized." Respondent prescribed Duragesic patch 12 mcg/hr #5 and told A.G. to titrate, by starting with ½ (cut patch in half) of 12 mcg/hr to start every 72 hours. The standard of practice before prescribing this type of pain medication requires that the nurse practitioner determine the pain generator and start with the lowest possible dose and potency of analgesic and increase if needed. Respondent violated the standard of practice when she failed to perform a physical examination, obtain diagnostic studies and consider other etiologies for A.G.s pain. Respondent violated the standard of practice when she instructed the patient to cut the patch in half, which is contraindicated by the manufacturer.

14. Respondent disputes the facts as alleged. Respondent asserts that she performed an assessment and working diagnosis on A.G. Further, Respondent asserts treatment was initiated through informed consent and Respondent believes that she met the standard of care for functional medicine.

COMPLAINT #2

15. Respondent cared for M.F. On or about February 25, 2010, Respondent ordered labs on patient M.F. that revealed abnormally elevated blood urea nitrogen (28 mg/dl) and creatinine (1.7 mg/dl) and failed to order a repeat lab or refer M.F. for further evaluation. M.F. was admitted to Chandler Regional Hospital on November 30, 2012 where she was identified as likely having chronic kidney disease. On December 9, 2012, Patient M.F. was referred for a renal transplant evaluation. Additionally, Respondent prescribed sustained released thyroid to patient M.F. despite the fact that M.F.'s TSH levels were normal. This is outside the standard of practice in which a TSH assay should always be used as the primary test to establish the diagnosis of primary hypothyroidism.

16. Respondent alleges that the care and treatment for M.F. was appropriate and met the standard of care and that the medical record demonstrates rationale for treatment including assessment, diagnosis and a proper treatment plan. Respondent denies that the standard of care requires a practitioner to rely on a TSH assay to establish a diagnosis of hypothyroidism.

COMPLAINT #3

17. From February 18, 2009 through February 10, 2010, Respondent provided care to R.W. a 73-year-old male with gastrointestinal issues. Respondent incorrectly diagnosed R.W. with Lyme disease and failed to follow the standard of practice by not referring the patient to another health care provider or consult with a physician when his condition deteriorated. Additionally, Respondent violated the standard of practice for prescribing multiple antibiotics, which states antibiotic use is only appropriate when a bacterial infection is confirmed.

18. Respondent asserts that she met the standard of care with regard to her treatment of Patient R.W.

COMPLAINT #4

19. On February 4, 2014 Respondent cared for D.S and exceeded her scope of practice when she diagnosed patient D.S. with depression, failed to refer her to a mental health specialist and deemed her disabled. Additionally, the medications ordered by Respondent for D.S. were not justified. There is insufficient information in the medical record to support the finding of disability and the record contains information that is contrary to the finding of disability.

20. On May 13, 2014 Respondent deviated from the standard of care for antibiotic use when she prescribed an antibiotic for a diagnosis of "Unspecified infectious and Parasitic Disease" despite no abnormalities noted in Respondent's physical exam, no documented evidence of a bacterial infection and with documented evidence of negative serology for mycoplasma pneumonia and legionella pneumophillia.

21. Respondent asserts that the records show that D.S. was properly assessed, diagnosed and treated and that D.S. was satisfied with her care. According to Respondent, in late March early April the patient presented with clinical symptoms of infectious illness corroborated by laboratory studies. DS had high monocytes on 3/27/14 at 14 which Respondent asserts would suggest a bacterial infection. In addition, on 3/31/14 DS's Mycoplasma pneumonia showed a high IgG level at 224 and Legionella pneumophila 2.38. Respondent asserts Levaquin is indicated for both infections. The Levaquin was given at the time of appointment after physical assessment.

22. On or about September 15, 2015, Respondent requested to voluntarily surrender her license, pending transition of her patients to other care providers, which shall be completed no later than September 30, 2015.

CONCLUSIONS OF LAW

Pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664, the Board has subject matter and personal jurisdiction in this matter.

The conduct and circumstances described in the Findings of Fact constitute violations of A.R.S. § 32-1601 (22)[1] ""Unprofessional conduct" includes the following whether occurring in this state or elsewhere: (d) Any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.(j) Violating a rule that is adopted by the board pursuant to this chapter. And A.A.C. § R4-19-403) (adopted effective January 31, 2009) For purposes of A.R.S. § 32-1601(22)(d), any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public includes one or more of the following: (1) A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice; (7) Failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient; (12) Assuming patient care responsibilities that the nurse lacks the education to perform, for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse; (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.

The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to A.R.S. §§ 32-1605.01(D) and 32-1664(N) to take disciplinary action against Respondent's license to practice as a registered nurse in the State of Arizona.

While Respondent disputes the Findings of Fact, Respondent understands the Board has determined that the Findings of Fact are conclusive evidence of a violation of the Nurse Practice Act

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[1] Previously cited as § 32-1601(16) (effective May 9, 2002) and A.R.S. § 32-1601(18) (effective September 2009)

and may be used for purposes of determining sanctions in any future disciplinary matter.

In lieu of a formal hearing on these issues, Respondent agrees to issuance of the attached Order and waives all rights to a hearing, rehearing, appeal or judicial review relating to this matter. Respondent further waives any and all claims or causes of action, whether known or unknown, that Respondent may have against the State of Arizona, the Board, its members, offices, employees and/or agents arising out of this matter.

Respondent understands that all investigative materials prepared or received by the Board concerning these violations and all notices and pleadings relating thereto may be retained in the Board's file concerning this matter.

Respondent understands that the admissions in the Findings of Fact are conclusive evidence of a violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any future disciplinary matter.

Respondent understands the right to consult legal counsel prior to entering into the Consent Agreement and such consultation has either been obtained or is waived.

Respondent understands that this voluntary surrender is effective upon its acceptance by the Executive Director or the Board and by Respondent as evidenced by the respective signatures thereto. Respondent's signature obtained via facsimile shall have the same effect as an original signature. Once signed by Respondent, the agreement cannot be withdrawn without the Executive Director or the Board's approval or by stipulation between Respondent and the Executive Director or the Board. The effective date of this Order is September 30, 2015.

Respondent understands that Voluntary Surrender constitutes disciplinary action. Respondent also understands that she may not reapply for re-issuance during the period of Voluntary Surrender.

Respondent agrees that she may apply for re-issuance after the period of voluntary surrender

under the following conditions, and must comply with current law at the time of their application for re-issuance:

The application for re-issuance must be in writing and shall contain therein or have attached thereto substantial evidence that the basis for the voluntary surrender has been removed and that the re-issuance of the license does not constitute a threat to the public's health, safety and welfare. The Board may require physical, psychological, or psychiatric evaluations, reports and affidavits regarding Respondent as it deems necessary. These conditions shall be met before the application for re-issuance is considered.

Respondent

Date: 9/16/15

ARIZONA STATE BOARD OF NURSING

SEAL

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

Dated: September 16, 2015

ORDER

Pursuant to A.R.S. § 32-1605.01(D) the Board hereby accepts the Voluntary Surrender of registered nurse license number RN057911 and advanced practice certificate number AP0313, issued to DANA LILLESTOL ROSDAHL effective September 30, 2015. This Order of Voluntary Surrender hereby entered shall be filed with the Board and shall be made public upon the effective

date of this Consent Agreement. Respondent shall not practice in Arizona under the privilege of a multistate license.

IT IS FURTHER ORDERED that Respondent may apply for re-issuance of said license after a period of 3 years.

SEAL

ARIZONA STATE BOARD OF NURSING

Joey Ridenour

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

Dated: September 16, 2015

COPY mailed this 16th day of September, 2015, by First Class Mail to:

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By: T. Smith
Legal Secretary