IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

DEBRA R. GRACIANI, Appellant, v. STATE OF ALASKA, BOARD OF NURSING, Appellee.	Case No. 3AN-22-08001CI

ORDER AFFIRMING REVOCATION OF NURSING LICENSE

This appeal arises out of a 19-day hearing where ALJ Cheryl Mandala heard evidence presented by the Division and from respondent, Debra "Rena" Graciani. On June 13, 2022, Judge Mandala issued a 66-page decision, recommending revocation of Ms. Graciani's nursing license. The Board of Nursing subsequently met and adopted Judge Mandala's Decision and revoked Graciani's nursing license. Graciani appeals. For the following reasons, revocation of Graciani's nursing license is AFFIRMED.

I. Facts

a. Employment history

Graciani received her nursing degree from the University of Alaska – Anchorage and was licensed as a registered nurse in July 2011.[1]

Graciani worked at Fresenius Medical Care from November 2011 until her termination in 2013.[2] For six months from October 2013 until April 2014 Graciani worked at Denali Dialysis until she was fired.[3]

[1] [Exc. 74]
[2] [Exc. 412]; Joanne Tracy test. Day 16, p. 58.
[3] [Exc. 773-774]; Mary Carol Miller test. Day 18, p. 10.

In February 2014, Graciani began working part-time as a nurse at Providence Alaska Medical Center (Providence). By August 2014, she was put on a performance management process.[4] Graciani accepted a full-time position in the Dialysis Center in May 2015.[5] Graciani was terminated from Providence in November 2016 for the improper handoff of a patient (M.L.).[6]

Following arbitration, Graciani was reinstated at Providence, taking a nursing position in the Intensive Care Unit (ICU) in 2018.[7]

On January 7, 2020, the Division filed an Accusation against Graciani, seeking action against her nursing license, including but not limited to possible revocation.[8] Trial started in October 2021, but was subsequently continued to conduct additional discovery. Trial resumed in February 2022 and was completed on February 24, 2022.[9] At the time of trial, Graciani maintained her position in the ICU, but was on medical leave.[10]

b. Patient care

i. October 2016 Handoff incident of M.L.

In nursing, the hand-off procedure is the industry standard. When a nurse returns

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[4] [Exc. 649]
[5] [Exc. 679]
[6] *Id.*
[7] [Exc. 75]
[8] [Exc. 434-439] Ultimately, the Division filed a Second and Third Amended Accusations against Graciani. The Third Amended Accusation specifically sought revocation of Graciani's nursing license.
[9] [Exc. 75]
[10] [Exc. 88]

a patient to their home floor after a procedure, handoff procedures require that the "sending" nurse communicate directly with the receiving floor nurse prior to the sending nurse ending their oversight of the patient.[11]

In October 2016, Graciani was caring for patient M.L. in the dialysis suite. About 40 minutes after her treatment ended, M.L. arrived back on her home floor in the ICU.[12] M.L.'s primary nurse in the ICU, Ben Jack, was surprised to see M.L. According to Jack, there was no communication between the dialysis unit and the home floor that M.L. was returning.[13] Jack was also surprised to see M.L.'s condition had significantly worsened since he saw her earlier in the day—she was weak and complaining of dizziness and was "noticeably more" lethargic than earlier that day.[14]

The parties dispute who initiated the call, but Jack and Graciani spoke briefly related to M.L.'s condition at 18:55.[15] The call was cut short because M.L. began to code, only 17 minutes after she returned to the ICU from dialysis, and died a few hours later.[16]

When interviewed three days after the incident, Graciani told the interviewers that she does not hold patients back in the dialysis suite until she is able to complete a handoff because holding patients can cause delays.[17] Graciani told interviewers that trying to track down a charge nurse is "a hassle" and it is something she no longer attempts to do.[18] Manager Carrie Doyle testified that she remembers this statement by Graciani even years

[11] [Exc. 661-667; Exh. 27 Handoff Policy]
[12] [Exc. 77]
[13] [Exc. 652-655]
[14] [Exc. 668]; Ex. 68.
[15] [Exc. 257-260, 670, 673]
[16] [Exc. 78, 225, 251]
[17] [Exc.79, 664]
[18] [Exc. 662-664]

later "because it was so egregious."[19] On November 1, 2016, Graciani received a Final Notice and was instructed that "failing to perform acts within the nurse's scope of practice which are necessary to prevent substantial risk or harm to a patient is a serious concern."[20]

Graciani was fired following this incident, but sought reinstatement. At arbitration, Graciani testified differently than she did in her interview three days after the incident. At arbitration, Graciani testified that she called the front desk at the ICU four times trying to reach Jack before sending M.L. back to the ICU.[21] Graciani testified that each time she spoke to a female at the desk and that when the female attempted to transfer the call to Jack, the call was dropped.[22]

Jody LeCrone, System Administrator of Providence's Network of Telecommunications and Operations testified both at arbitration and at the underlying hearing in this matter. LeCrone testified that internal hospital phone records record every connected call.[23] Those records show the call into the dialysis suite at 18:55 (the call Jack initiated to Graciani) and a call at 18:57.[24] LeCrone testified that there is no record of any other calls between dialysis and the ICU between 17:46 and 18:57.[25] In other words, Graciani's statement that she called the ICU four times and spoke to someone but the call was dropped in the transfer to Jack is inconsistent with hospital phone records.

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[19] Doyle testimony Day 5, P. 142; Exh. 30-31.
[20] [Exc. 649]
[21] [Exc. 258-259, 686]
[22] [Exc. 686]
[23] [Exc. 674-677]
[24] [Exc. 673]
[25] [Exc. 673, 677, 688]

The arbitrator ordered Graciani reinstated because Providence was unclear about their handoff procedure requirements, making it unfair to hold her strictly accountable.[26] The arbitrator expressed concerns about Graciani's truthfulness at arbitration.[27]

Following Graciani's reinstatement, Providence further investigated the incident and concluded that Graciani manually deleted M.L.'s poor vital signs and re-entered new, stable vital signs for M.L. after she began to code.[28] Graciani testified that based on M.L.'s vitals, there was no pressing concern for M.L.'s health prior to the handoff.[29] In contrast, Jack observed that M.L. was in bad shape from the moment he noticed she had returned to her home room, prompting him to call Graciani before abruptly ending the call because M.L. began to code.[30]

It is undisputed on appeal that Graciani manually deleted M.L.'s vital signs in Epic, replacing them with stable vital signs after M.L. began to code.[31] Per Epic, M.L.'s machine measured vitals on October 8, 2016 at 18:08 were (63/46) meeting criteria for hypotension.[32] However, around 19:18, the '18:08' reading was deleted and manually replaced at 19:21 with a normal blood pressure reading of 97/64.[33] Graciani argues she preserved the correct data, and it is not uncommon to manually enter information when there is a cuff slip.[34] At 18:48, M.L.'s vitals were recorded by Marie Badjan as a BP of

[26] [Exh. 20, p. 18]
[27] *Id.* at 18-19.
[28] [Exc. 709-714, 715-716, 717, 718]
[29] [Exc. 825]
[30] [Exc. 670]
[31] [Exc. 709-714]
[32] [Exc. 228, 709-714]
[33] [Exc. 223; 228; 706; 710; 720-723]
[34] [App. Br. at 13]

92/64 and a MAP of 71.[35] Mr. Jack testified that when M.L. returned from dialysis, her vitals were normal though her condition had deteriorated.[36]

ii. October 2019 Arterial Sheath Removal/ACT Test Incident

In July 2019, while working in the ICU, Graciani was tasked with removing a patient's arterial sheath after a cardiac catherization procedure.[37] Graciani committed multiple errors during the procedure, including failing to check an activated clotting time (ACT) to determine whether the sheath could be safely removed.[38] In September 2019, Graiciani received a Written Warning/Corrective Action related to the July incident and was provided a copy of Providence's Arterial Sheath Removal Policy.[39]

Despite this, when Dr. April Rodriguez ordered an ACT test in October 2019, and Graciani could not find the test, she substituted the Thrombin Time Test for the ACT Test.[40] There were serious issues with Graciani ordering the wrong test, including: (1) the ACT test was medically necessary; (2) ACT test results are faster than a thrombin time test, and such a delay created a significant risk of harm; (3) changing the type of test ordered is outside the scope of Graciani's license; and (4) Graciani charted that Dr. Rodriguez had ordered the thrombin time test, when in fact she had not.[41]

Managers found Graciani to be 'evasive' and 'dishonest' when questioned about the incident.[42] Graciani first told managers that Dr. Rodriguez verbally ordered the Thrombin

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[35] [App. Reply Br. at 2; Exc. 222]
[36] [App. Reply Br. at 3; Exc. 243]
[37] [Exc. 733]
[38] *Id.*
[39] [Testimony of Jenny Irene McDonald, Day 17, p. 140]
[40] [App. Br. at 14-15]
[41] [Exc. 87]
[42] It was reported that Graciani changed her story multiple times. *Id.*

test.[43] When Graciani was later notified that Dr. Rodriguez denied this, Graciani told managers that when she could not find the ACT test in Epic she substituted the Thrombin test because it was the only clotting-related test she had found.[44] On November 20, 2019, Graciani received a Final Written Warning, specifically for dishonesty and for practicing outside the scope of her license as an RN.[45] Graciani argues that she did not 'intentionally' practice outside the scope of her license.[46]

iii. January 2016 vancomycin incidents

In January 2016, Ms. Graciani failed to give two dialysis patients, G.R. and K.A., their antibiotic vancomycin as ordered. G.R.'s incident occurred on January 13, 2016,[47] and K.A.'s occurred a few days later, on January 18, 2016.[48]

1. G.R. incident (01/13/2016)

G.R. was prescribed vancomycin to be administered during the last hour of dialysis.[49] But, Graciani did not administer the drug and did not communicate to G.R.'s primary nurse that G.R. still needed vancomycin.[50] Instead, Graciani recorded the task as "performed" but entered a note in G.R.'s chart that the medication was "not available," and

[43] [Exh. 105]; Testimony of Lorrie Hubbard, Day 17, p. 106, 124; Testimony of Jenny Irene McDonald, Day 17, p. 138-140.
[44] [Exc.728-730, 733-740, 741, 742, 743]
[45] The director of Adult Critical Care Services at Providence, Lorrie Hubbard noted that this corrective action was for fabricating a verbal order and not for ordering the wrong test. [Exc. 88; Exh. 105, p. 2]
[46] [App. Br. at 14-15]
[47] Franz test Day 4, P. 10-11.
[48] Franz test Day 4, P 18.
[49] Franz test Day 4, P. 10-18, 32.
[50] [Exc. 658] Franz test Day 4, P. 10-18.

thus the task had not actually been performed.[51] By coding the task as "performed" the usual warning indicator that would communicate to G.R.'s other providers that they had not received the dose did not appear.[52] The following day, pharmacist Ryan Friesen read Graciani's note and learned that the drug was never administered and reported it.[53] There was a 24-hour delay in getting G.R. their vancomycin.[54] Graciani received a Letter of Counseling following this incident and was informed that by charting that she had given the medication, she prevented the "red banner" from appearing in the patient's chart showing the medication as overdue, thereby preventing G.R.'s primary nurse from knowing the medication had been missed.[55]

2. K.A. Incident (01/18/2016)

Five days later, Graciani failed to administer vancomycin to patient K.A. and failed to notify K.A.'s primary nurse that the vancomycin had not been administered.[56] K.A. was an "outrun patient,"—a patient receiving dialysis in their assigned unit because they are too sick to travel to the dialysis unit.[57] Vancomycin was to be administered to K.A. during dialysis and was the responsibility of the dialysis nurse.[58]

Brenda Franz, Clinical Nursing Director at Providence, investigated both incidents and concluded that Graciani failed to accept responsibility for her actions.[59] Graciani was

[51] [Exc. 658]
[52] *Id.*
[53] Franz test Day 4, P. 14-15.
[54] [Exc. 658-59]
[55] [Exc. 658-60]
[56] [Exc. 658]; Franz test Day 4, P. 18, 29-30.
[57] [Exc. 159]
[58] [Exc. 658]
[59] Franz test Day 4, P. 29-30.

issued a Letter of Counseling noting Graciani's failure to communicate with colleagues about critical matters of patient care, and failure to conduct handoff communication to the patient's primary nurse, which could have avoided a delay in care.[60] The letter also noted an incident where Graciani was rude to a presenter during staff training and disruptive to the training.[61] The presenter had to stop their presentation twice.[62] Graciani was clearly and directly informed in this letter that interpersonal skills are required in her position.[63]

iv. Magnesium sulfate incident involving patient P.F. (February 11, 2016)

On February 11, 2016, Graciani failed to administer magnesium sulfate to dialysis patient P.F., as prescribed by the patient's cardiovascular surgeon, Dr. Valdes.[64] P.F. was also being treated nephrologist Dr. Andrzej Maciejewski (Dr. Mac). Per Graciani, she withheld the magnesium on Dr. Mac's orders. Dr. Mac likewise testified that he told Graciani to hold the magnesium.[65] The parties dispute whether Graciani completed a proper handoff to P.F.'s floor nurse, who later administered the medication.

c. Unprofessional workplace interactions

Judge Mandala found numerous incidents where Graciani's work behavior was unprofessional. These incidents occurred at Fresenius, Denali Dialysis, and Providence.

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[60] [Exc. 658-660, 700-702]
[61] [Exc. 659]
[62] *Id.*
[63] *Id.*
[64] [Exc. 701]
[65] [Exc. 293; 301-303]

i. Behavioral concerns at Fresenius and Denali Dialysis

At the hearing, Graciani denied that she was terminated from her earlier jobs at Fresenius and Denali Dialysis.[66] In their rebuttal case, the Division called witnesses from Graciani's former employers. These witnesses testified that Graciani had conflicts with co-workers and patients and sometimes strayed from physician orders; after multiple warnings, she was terminated from Fresenius.[67]

Similarly, Graciani was the subject of "complaints and concerns from staff members and patients" during her time at Denali Dialysis.[68] Mary Carol Miller, the clinical coordinator at Denali Dialysis, testified that Graciani was dismissed largely because her behavior had an overall negative effect on the workplace.[69]

ii. Behavioral concerns at Providence

1. Managers' testimony

At Providence, Graciani received numerous complaints and was the subject of workplace investigations regarding her unprofessional interactions with co-workers and, less frequently, patients. Brenda Franz and Jim Blankenship testified that during Graciani's employment in the dialysis suite, she generated an exceptionally 'very high' volume of complaints and conflicts from other caregivers.[70] These complaints were notable because of the number filed, their internal consistency (i.e., similar complaints

[66] Graciani testimony Day 15, p. 16, 111-112.
[67] Patient care technicians complained that Ms. Graciani was not using the dialysis machine settings ordered by physicians, and instead she was using settings that differed from what had been ordered by the physicians. [Exc. 99-100, 849-854, 857]
[68] [Exc. 99-100]; Mary Carol Miller testimony Day 18, p. 3-10.
[69] [Exc. 773-774]; Mary Carol Miller testimony Day 18, p. 3-10; Graciani disputes this testimony because she says Denali Dialysis never formally fired her. *See* Graciani testimony Day 15, p. 111-112.
[70] [Exc. 744-746,748-749]

from multiple unrelated sources), and their similarities to incidents at Denali Dialysis and Fresenius. Ms. Franz testified that Graciani's communication issues harmed the work quality at Providence and that Graciani behaved noticeably differently around physicians, treating the physicians with much more respect compared to nurses and caregivers.[71]

Jim Blankenship was Providence's interim manager of Renal Nursing throughout much of 2016. Blankenship testified he was "unable to count" the number of complaints he received regarding Graciani "from other departments and coworkers," but estimated he spent 1-2 hours per day on issues relating to complaints about or by Graciani.[72] Blankenship previously managed hundreds of nurses but "never had to invest that much time in any one nurse as far as following up on complaints."[73] Graciani attended meetings to address some of these complaints and said the events were blown out of proportion.[74]

2. Specific behavior-related complaints

a. Complaints from within the dialysis suite

The first documented complaints about Graciani at Providence were filed in September and October of 2015.[75] There was tension in the dialysis unit, and it was partly caused by Graciani's general rudeness and her occasional explosive anger.[76] In early 2016,

[71] [Exc. 747-749, 828]
[72] [Exc. 744-746]
[73] *Id.*
[74] Graciani was accompanied by Joey Peacott (her union rep) during those meetings. Peacott stated that some of these complaints could be racially motivated. [Exc. 102]
[75] Franz test. re: complaints submitted by Joanie Tracey (9/17/15), Hazel Swenko (9/30/15), and Dawn Bennett (10/5/15).
[76] *Id.*

coworkers complained that Graciani's lack of communication and disrespectful demeanor were putting patients at risk.[77]

Several witnesses described an 'uncomfortable' interaction between Graciani and Kelly Whitworth.[78] Witnesses described Graciani "angrily" taking control over a lab that Whitworth was performing on a patient.[79] The incident happened in front of patients, including a minor patient, R.H., who submitted a written complaint describing the incident as "very uncomfortable and very unprofessional."[80] In another incident, Rebecca Hallstrom (R.H.'s mother) filed a complaint against Graciani after witnessing Graciani "snapping" at an elderly patient.[81] Additionally, in April 2019, fellow ICU nurse Sasha Wastsjold reported Graciani for 'berating' phlebotomist Jacqueline Boone (formerly Jacqueline Filley) in front of patients and staff, after Ms. Boone drew a lab on one of Graciani's patients.[82]

Former dialysis suite employees testified that Graciani often ignored colleagues' questions, spoke in a dismissive manner, was argumentative, and had negative body language.[83] Nurses and hospital staff described Graciani as unpredictable, uncooperative, unprofessional, confrontational, disrespectful, and disruptive.[84] Terrie DuBois testified that Graciani is "bossy," argumentative, and condescending.[85] In contrast, former dialysis

[77] [Exc. 103, 761, 763-765, 777, 782]
[78] Including Kelly Whitworth, Mario Saturnino, Joanie Tracey, and Ms. Hallstrom. *Id.*
[79] [Exc. 770-771]
[80] [Exc. 103-104, 770-771]
[81] *Id.*
[82] Sasha Watsjold Test. Day 6, pp. 94-100; [Exc. 754-756 Exh. 44]
[83] [Exc.101-106, 776-777,778-779] Exh. 47; Terrie DuBois testimony Day 4, p. 192; Dar'shon Tucker testimony Day 1, pp. 101-102.
[84] *Id.*
[85] [Exc. 106]; Terrie DuBois testimony Day 4, p. 192.

nurse Dyan Dyer testified that Graciani was just "direct and to the point," which Dyer appreciated but could see that other hospital staff did not.[86]

b. Complaints from outside the Dialysis Suite

Various hospital employees outside the dialysis suite also filed complaints about Graciani, including members of the transportation and lift staff, the housekeeping staff, pharmacists, emergency department providers, and ICU and Renal Care Unit nurses.[87] The complaints alleged various actions, such as Ms. Graciani speaking in a very short, directive tone; failing to communicate effectively and respectfully; hanging up on or abruptly discontinuing conversations; refusing to allow housekeeping staff into the suite; and other behavior that was perceived as disrespectful.[88] Graciani routinely and intentionally would get in the way of transport staff, refuse to move when asked, and then dramatically exclaim that they almost ran her over.[89]

3. Testimony in support of Graciani

Doctors Gitomer, Lefler, and Maciewjewski testified on behalf of Graciani at the hearing. All three physicians described Graciani as an "exceedingly competent" dialysis nurse, able to draw upon a "broad fund of knowledge," "very, very knowledgeable," and a "very, very good nurse."[90] Dr. Gitomer testified that Graciani was the best dialysis nurse in terms of skill and ability. Dr. Gitomer described Graciani's interactions with other

[86] [Exc. 104-105, 392]
[87] Most of these complaints were about Graciani's perceived 'rudeness'. *See* [Exc. 104-107]
[88] *Id.*
[89] [Exc. 105, 757, 829-830] Transportation staff move patients from their home floor to procedures, like dialysis.
[90] [App. Br. at 20-28]

nurses as "always a little bit tight."[91] Dr. Lefler testified that Graciani was "a very proactive, pertinent, and professional" dialysis nurse.[92] Dr. Maciejewski ("Dr. Mac") described Graciani as focused on patients, and not talkative.[93] Certainly, these physicians found Graciani professional. Drs. Gitomer, Lefler, and Mac each testified that they had received no negative feedback from patients in reference to Graciani.[94] All three characterized Graciani as a reliable nurse and someone they would have no concerns about if she provided care for their patients.[95] They also testified that, to their knowledge, they had never heard a patient or another nephrologist complain about Ms. Graciani.[96]

Additionally, there were nurses who testified in support of Graciani. Nurse Karyl Dyan Dyer testified that she never experienced Graciani behaving inappropriately, nor did she ever witness Graciani treating others rudely or disrespectfully.[97] Nurse Paula Rogers testified that she enjoyed working with Graciani because Graciani is a team player and that Graciani communicated effectively with patients.[98] Nurse Kaylee Jenkins testified that she had a good working relationship with Graciani and would describe Graciani as always professional, clear, concise, organized, and systematic in her communication with other coworkers.[99] Nurse Laura Crawford wrote that Graciani was good at accepting feedback

[91] [Exc. 353-354] Dr. Gitomer's testimony actually corroborates other witness' testimony reflecting that Graciani had interpersonal conflict with co-workers.
[92] [Exc. 363-364]
[93] [Exc. 291]
[94] [Exc. 248-258, 291, 365]
[95] *Id.*
[96] *Id.*
[97] [Exc. 397-399]
[98] [Exc. 418-419]
[99] [Exc. 424-431]

and improving herself.[100] Dialysis nurse Wynn Pentecostes supervised Graciani at Fresenius. Pentecostes described Graciani as a "fast learner" and "professional."[101]

iii. Allegations of retaliatory complaints by Ms. Graciani

The Division alleged that Graciani filed complaints against coworkers as a form of retaliation. In one complaint, Graciani alleged that colleague Mario Saturnino sexually harassed her in the workplace, when he gave her a "side hug" on Mother's Day in 2016.[102] Graciani testified that Saturnino kissed her on the face and ran his hand down her back.[103] While the hug is undisputed, no witnesses saw Saturnino kiss Graciani or run his hand down her back.[104]

iv. Behavior-related disciplinary history

ALJ Mandala observed that Graciani's behavior caused a disciplinary track record at Providence just like it had at Fresenius and Denali Dialysis.[105] ALJ Mandala quoted the arbitrator's assessment of Ms. Graciani's disciplinary history:

> Throughout her relatively brief career, [Ms. Graciani] has been a less than satisfactory employee. Thus, in fairly rapid succession, she received repeated counseling and warnings, primarily directed at her shortcomings in communicating with her colleagues, a skill that is critical to support the hospital's mission of creating a safe environment for its patients.[106]

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[100] [Exc. 416-417]
[101] Test. Wynn Pentecostes, Day 18, p. 45.
[102] [Exc. 106, 327-336, 841-843]; Test. Hallstrom Day 1, p. 127-128.
[103] [Exc. 107] Graciani testimony Day 13, p. 98; Graciani testimony Day 15, p. 10.
[104] [Exc. 107]; Testimony of Kelly Whitworth Day 8, p. 35-37; Testimony of Brenda Franz Day 4, p. 55-56.
[105] [Exc. 108]
[106] [Exc. 108, 697]

The ALJ noted that the arbitrator's findings are neither evidence nor authority, but that this summary is valid under the ALJ's independent findings.[107] After reviewing Providence's steps attempting to remedy the situation, Judge Mandala highlighted Graciani's statements about being willing to change and be a 'better' communicator after her first write up.[108] However, the complaints kept coming in, and there were multiple witnesses stating that Graciani was engaging in inappropriate conduct at work.[109] Providence continually offered Graciani resources to help improve interpersonal skills in the workplace, but at some point Graciani stopped being receptive.[110] Graciani responded to the February 2016 corrective action by saying she disagreed with it and writing, "I don't think my directness should be perceived as rudeness."[111]

In May 2016, Graciani received her last behavior-related disciplinary action before being terminated in November 2016.[112] The May 2016 Corrective Action was in regards to unprofessional behavior and expressed concern about Graciani's perceived "refusal and/or unwillingness [to] improve" an ongoing "lack of effective communications, collaboration, and empathy for our patients[.]"[113]

After Graciani returned to Providence in 2018, she continued to receive write-ups for her communication issues.[114]

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[107] [Exc. 108, n. 188]
[108] The first write up was on June 24, 2015, less than one month after Graciani gained a full-time position at Providence. *See* [Exc. 109; Exh. 26]
[109] [Exc. 109-110, 658-660]
[110] [Exc. 744-756, 781, 828; Exh. 49, p.2]; Franz testimony Day 2, p. 262.
[111] [Exc. 110,781; Exh. 28, p. 3]
[112] [Exc. 111]
[113] [Exc. 744-756; Exh. CZ, 29]
[114] [Exc. 733-740; Exh. 41-45]

d. Protected Health Information Violations

On three separate occasions at Providence, Graciani was found improperly in possession of patient protected health information.

i. Patient Records in Graciani's Cubby

In November 2016, following Graciani's termination, Providence confiscated confidential documents from Graciani's personal cubby, but because Graciani had already been terminated, Providence took no further action at that time.[115] After Graciani was reinstated, Providence addressed the issue of why Graciani had confidential documents in her personal cubby on her first day back.[116] Dar'Shon Tucker (HR consultant) asked Graciani about the documents in her cubby and said Graciani's original answer was "for later review, I guess."[117] Graciani also reportedly claimed that she was never told she could not hang on to patient information after the patient was no longer in her care.[118]

At the hearing, Graciani denied ever having the documents in her cubby and stated that her responses to Tucker's questioning about the documents were 'theoretical.'[119] The ALJ found Graciani's denial to be 'uncredible' and 'bizarre'.[120] Furthermore, the ALJ found that on recross, Graciani again changed her story and said that she intended to tell Ms. Tucker that the documents were in her cubby because nobody had told her that she could not have them in there.[121] But then on redirect after recross, Graciani again changed

[115] [Exc. 113]; Test. Dar'shon Tucker Day 2, p. 124.
[116] *Id.;* [Exh. AU]
[117] [Exc. 114, Exh. AU, p.4]
[118] [Exc. 114, Exh. AU, pp. 6-7]; At no point during the initial questioning did Graciani deny having the documents. *See* [Exh. AU, p. 8.]
[119] [Exc. 114]; Graciani Test. Day 6, pp. 84, 88.
[120] [Exc. 114]
[121] [Exc. 114]; Graciani Test. Day 15, p. 78.

her story, testifying that when she met with Ms. Tucker, she said; "I don't know where those documents came from."[122]

ii. Graciani accesses ex-husband's medical record

It is undisputed that Graciani accessed her ex-husband's medical record and, as a result, received a written reprimand in August 2014 and was given a copy of the hospital's privacy policy.[123]

iii. Graciani accesses D.F.'s medical records

In March 2016, Graciani accessed patient D.F.'s records despite the fact she was not on D.F.'s care team.[124] The Division alleged that this was a breach of D.F.'s confidentiality. But it was not uncommon for nephrologists to have nurses gather records of intensive care patients who would likely be in need of dialysis.[125]

c. The Decision

On June 13, 2022, Judge Mandala concluded that the Division had met its burden of proof as to multiple violations of Graciani's nursing license that taken together warrant revocation. On August 5, 2022, the Board of Nursing adopted the decision revoking Graciani's nursing license and the decision became final. Counsel for Graciani withdrew and Graciani filed a Motion for Reconsideration which was denied.[126] Graciani subsequently retained counsel and this appeal follows.

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[122] [Exc. 114, 821]; Graciani Test. Day 15, p. 147.
[123] [App. Br. at 34, Exc. 115]
[124] [Exc. 115]; [Exh. 48]; Stephanie Tasker Test. Day 3, pp. 10-15; Maureen Shaw test. Day 3, pp. 146, 162-164.
[125] Maureen Shaw Test. Day 3, pp. 36-39.
[126] [Exc. 637-646]

II. Assignments of Error

Graciani has assigned as error that (1) revocation of Graciani's nursing license is not supported by substantial evidence; (2) the Board's decision to revoke Graciani's nursing license is inconsistent with Alaska statutes, nursing regulations, and Board precedent, and (3) the Board violated Graciani's due process rights when it failed to afford her an opportunity to challenge the Division's attorney's five-minute legal argument.

III. Standard of Review

This case comes to the Court following the Board of Nursing's revocation of Ms. Graciani's nursing license. The superior court applies four principal standards of review in administrative appeals: The "substantial evidence" test is used for questions of fact. The "reasonable basis" test is used for questions of law involving agency expertise. The "substitution of judgment" test is used for questions of law where no expertise is involved. The "reasonable and not arbitrary" test is used for review of administrative regulations."[127] In addition, an agency's selection of a particular disciplinary sanction is reviewed for abuse of discretion.[128]

IV. Discussion

a. Revocation of nursing license

i. The Board's revocation of Graciani's nursing license is supported by substantial evidence.

Substantial evidence is defined as "such relevant evidence as a reasonable mind

[127] *Estate of Basargin v. State, Commercial Fisheries Entry, Com'n*, 31 P.3d 796, 799 (Alaska 2001) (citing *Romann v. State, Dept. of Transp. and Public Facilities*, 991 P.2d 186, 189 (Alaska 1999)).
[128] *Odom v. State Division of Corporations*, 421 P.3d 1, 6 (Alaska 2018).

might accept to support a conclusion."[129] While a 'highly deferential' standard, the Court must review the entire record to ensure that the evidence *detracting* from the agency's decision is not *dramatically* disproportionate to the evidence supporting it such that the Court cannot 'conscientiously' find the evidence supporting the decision to be 'substantial.'[130] The substantial evidence standard "reflects the prudence of deferring to a state professional board's special competence in recognizing violations of professional standards."[131]

Ms. Graciani specifically appeals four accusations by the Board, arguing that the substantial evidence does not support each independent accusation, nor the resulting revocation of her nursing license. The Court will take up each in turn:

1. The accusation related to M.L. is supported by substantial evidence.

In reference to M.L., Judge Mandala found two violations by Graciani: (1) Graciani failed to complete a handoff of M.L. before returning her to their home floor from the dialysis unit; and (2) Graciani went into the hospital's digital recordkeeping program and manually changed M.L.'s blood pressure reading in an effort to make M.L.'s condition appear stable at the time she returned M.L. to her home floor.[132]

Appellant argues that Ms. Graciani did initiate handoff procedures for M.L.[133]

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[129] *Widmyer v. State, Commercial Fisheries Entry Com'n*, 267 P.3d 1169 (Alaska 2011) (citing *State, CFEC v. Baxter*, 806 P.2d 1373, 1374 (Alaska 1991) ((quoting *Keiner v. City of Anchorage*, 378 P.2d 406, 411 (Alaska 1963).
[130] *Odom*, 421 P.3d at 6.
[131] *State, Dep't of Commerce, Cmty. & Econ. Dev., Div. of Corps., Bus. & Prof'l Licensing v. Wold*, 278 P.3d 266, 273 (Alaska 2012).
[132] [Exc. 126-129]
[133] App. Br. at 11-12.

Graciani contends that the phone log shows that she initiated the call to Jack.[134] Appellant further argues that Graciani manually entered a corrected blood pressure reading when the blood pressure cuff slipped down M.L.'s arm.[135] In contrast, the Division argues that Jack initiated a brief handoff after Graciani had returned M.L., to her home unit, but was forced to abruptly end the call when M.L. began to code.[136] Graciani argues she could not change the blood pressure information based on M.L. coding because she had already transferred the information to Mr. Jack at 18:56 during the phone call.[137]

Even if the Court were to credit Graciani's testimony and find that she initiated the call to Ben Jack, Graciani still did not follow handoff protocol. The handoff should have occurred before or when M.L. arrived on her home unit.

That said, based upon the testimony of Jack and LeCrone, and the Providence call log, the Court finds that that it is more likely than not that Jack initiated the call at 18:55, as reflected in the call log. Providence's call log shows the calls to and from the dialysis desk phone, device 25698.[138] Calls labeled "Int" are calls outgoing from the dialysis phone.[139] "Intln" are incoming calls to the dialysis phone.[140] So, at 18:55, a call was made from 25764 to the dialysis suite (as indicated by the "Intln" notation on that line).[141] This was the call from Jack to Graciani. The only call logged to the ICU from the dialysis suite

[134] App. Br. at 12.
[135] App. Br. at 13.
[136] Ae. Br. at 6-7.
[137] App. Br. at 13.
[138] [Exc. 673-677]
[139] [Exc. 674-675]
[140] [Exc. 675]
[141] [Exc. 673-677]

recorded between 17:46 and 18:57 was at 18:57 when Graciani called the ICU.[142] And the Court will not disrupt Judge Mandala's credibility finding that Nurse Jack was the more credible witness.[143]

In addition, Phillip Miller testified at the hearing that Epic's metadata shows that Graciani manually went in Epic and changed M.L.'s highly concerning blood pressure readings with stable readings.[144] Graciani argues that the blood pressure readings she inputted after "cuff slips" were consistent with readings earlier in the day taken by other staff.[145] The argument here is that M.L. deteriorated upon arriving back in the ICU, rather than during dialysis. But, M.L. was only in the ICU for 17 minutes before M.L. coded and needed CPR.[146] This Court concludes that the substantial evidence supports Judge Mandala's findings in reference to M.L.

2. The ACT test accusation is supported by substantial evidence.

It is undisputed that Graciani ordered the wrong test. Appellant argues that Graciani relied on a lab technician and a more senior ICU Nurse when she selected the Thrombin Time code for the Active Clotting Time (ACT) test ordered by Dr. Rodriguez.[147] Appellant argues she believed the tests were interchangeable, but this contention is belied by the fact that she asked others how to proceed first and had already received a Corrective Action

[142] [Exc. 673]
[143] [Exc. 77]
[144] [Exc. 80, 855-856]
[145] App. Br. at 13.
[146] [Exc. 78, 225]
[147] App. Br. at 13-15.

and Providence's policy the month before.[148] The Division argues that the Board correctly found that substituting one test for another was outside the scope of her license, a breach of her duty as a nurse, and put her patient at substantial risk of harm.[149]

Only physicians can order tests. Dr. Rodriguez ordered the ACT test for the patient.[150] Selecting and ordering a different test was both outside of Graciani's scope of practice as a nurse and also involved falsifying information in the patient's chart.[151] In addition, because the Thrombin Time test takes longer, ordering the wrong test placed the patient at substantial risk of harm; the ACT test was medically necessary.[152] The Board did not err when it found substantial evidence upon which to conclude that Graciani acted outside the scope of her license, breached her duty as a nurse, and placed her patient at substantial risk of harm.[153]

3. The Vancomycin and Magnesium Sulfate accusations are supported by substantial evidence.

a. Vancomycin accusation

In reference to the vancomycin accusation, Appellant argues first that the vancomycin was not available to administer, and then argues that she properly withheld the medication from patient G.R. because for the two days prior it was given post hemodialysis as opposed to in the last hour of dialysis.[154] In contrast, the Division argues

[148] App. Br. at 14.
[149] App. Br. at 29.
[150] [Exc. 86, 728]
[151] [Exc. 728]
[152] *Id.*
[153] *Id.*
[154] App. Br. at 15.

that Graciani failed to administer the vancomycin per the physician's orders and that she also failed to communicate to the patient's primary nurse that the vancomycin had not been given, which caused a treatment delay.[155] Furthermore, the Division asserts that the Appellant's explanation for why she did not administer the vancomycin has been inconsistent throughout the hospital's investigation into the incident, the administrative hearing, and the post hearing brief.[156]

Graciani's contention that the medicine was not available is belied by the fact that she was able to indicate in the patient's chart that she administered the medicine.[157] It was not until the next day that the pharmacist saw her note in the patient's chart that she did not administer the medication at all.[158] While less egregious, K.A. also experienced a delay in getting their vancomycin.[159] Judge Mandala did not err when she concluded that the substantial evidence supported the conclusion that Graciani failed to administer the vancomycin to both of these patients during dialysis, and then failed to communicate to their primary nurses so the patients did not receive a further delay in care.[160]

b. Magnesium Sulfate accusation

Appellant argues that she did not fail to follow physician orders when she disregarded the cardiovascular surgeon's order to give patient P.F. magnesium sulfate, and instead relied on a subsequent order from Dr. Mac to hold the magnesium sulfate.[161] Judge

[155] Ae. Br. at 13.
[156] *Id.*
[157] [Exc. 89, 282]
[158] [Exc. 90, 658]; Franz test. Day 2, pp. 281-288.
[159] [Exc. 658]
[160] [Exc. 91]
[161] [Exc. 293, 301-303]

Mandala correctly concluded that where Graciani relied on the direction of a physician she did not act without a doctor's order. [162]

Graciani, however, should have communicated that she did not administer the magnesium to P.F.'s nurse. The Appellant argues that the delay in administration of magnesium sulfate was 13 minutes, not three hours after P.F.'s hemodialysis treatment as argued by the Division and found by Judge Mandala.[163] Graciani wrongly focuses on the 13 minutes that P.F. was back on their home unit. The patient went without the necessary medicine for nearly three hours.[164] The substantial evidence supports Judge Mandala's conclusion that Graciani's failure to communicate with either Dr. Valdes or the primary nurse related to withholding the magnesium sulfate placed the patient at risk of harm.[165]

4. The accusations of hostile workplace behavior are supported by substantial evidence.

Appellant argues that the final decision "wholesale adopts" the Division's view of Graciani's "unprofessional conduct" and disputes that her workplace behavior had an impact on patient safety.[166] The Division argues that Graciani repeatedly engaged in unprofessional conduct that jeopardized the health and welfare of the public.[167]

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[162] [Exc. 96]
[163] App. Br. at 17-18; App. Reply Br. at 9; [Exc. 92]
[164] [Exc. 316] (establishes that at 7:00 on 2/11/2016 Dr. Valdes orders the magnesium. Then at 9:40 Graciani holds the medicine *per* Dr. Mac's orders. *See* Dr. Mac Test. Day 3, p. 75. At 12:31 (nearly three hours later) Nurse Gehrcke administers the magnesium.
[165] [Exc. 96, 658-660]
[166] App. Br. at 18-19.
[167] App. Br. at 26.

a. Workplace behavior

i. Testimony supporting Graciani

Appellant argues that the Board's Decision overlooks testimony from a trio of Nephrologists, and dialysis and ICU nurses. Despite this contention, Judge Mandala specifically referenced the positive opinions from physicians in her Proposed Decision, as well as affidavits provided by two additional nurses, Laura Crawford and Paula Rogers.[168] Judge Mandala clearly considered the testimony of these professionals and still concluded their testimony was significantly outweighed by many others who had worked with Graciani over the years.

ii. The weight of the evidence

While this Court acknowledges, as Judge Mandala did, that some doctors and nurses found Graciani proficient and professional, the sheer weight of the evidence supports the conclusion reached by the Board: Graciani created a hostile work environment for her colleagues and that significant HR resources were dedicated to addressing complaints related to her behavior. Multiple former colleagues from Providence, and one from Denali Dialysis, testified in a consistent manner to Graciani's rude, unprofessional conduct.[169]

Jim Blankenship managed the renal care unit at Providence in 2016. Blankenship testified that he spent one to two hours per day on complaints about Graciani's conduct and

[168] [Exc. 108, n. 187]

[169] Terrie DuBois, former nephrology suite nurse at Providence (retired); Mary Carol Miller, Clinical Coordinator for Denali Dialysis; Joanne Tracey, former Providence nurse; Sasha Watsjold, former Providence ICU nurse; and, Kelly Whitworth, former Providence nurse.

from Graciani against other employees.[170] Blankenship testified that in his decades-long career managing nurses, he had "never had to invest that much time with any one nurse."[171] Brenda Franz, Clinical Director of Nursing for the Medical/Surgical Division, testified that she received "multiple, multiple" complaints about Graciani.[172] In thirty years of nursing, Franz testified she had never experienced one nurse having so many communication-related problems.[173] Manager Carrie Doyle testified that in her time as an administrator, she had never experienced so extensive a collection of issues with respect to any single nurse.[174] In other words, Graciani was the common denominator in workplace conflict.

Graciani was unprofessional and rude to staff whom came in and out of the dialysis suite as part of their job, transporting patients and cleaning the suite, putting staff on edge.[175] And, this was not new. Graciani was terminated from Fresenius and Denali Dialysis for similar reasons.[176] In fact, when Graciani took the job at Denali Dialysis, they talked with her about the reasons she was fired from Fresenius, and she assured them she had learned from that experience, and that she had learned to work effectively with staff of all different skill sets.[177]

As discussed above, some evidence was also presented that patients and their families found Graciani unprofessional. Rebecca Hallstrom testified that she originally observed Graciani to be professional and proficient, but subsequently observed Graciani

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[170] [Exc. 105]
[171] [Exc. 744-746]
[172] [Exc. 747]
[173] [Exc. 828]
[174] [Exc. 750]
[175] [Exc. 105, 659, 757, 829-830; Exh. 44, 63 p.38]
[176] [Exc. 74, 412, 773-774]; Joanne Tracy test. Day 16, p. 58; Mary Carol Miller test. Day 18, p. 10.
[177] [Exc. 773]

treat her co-workers and even some patients badly.[178] Hallstrom observed Graciani scold her co-workers in front of patients.[179] Her daughter, a minor dialysis patient, also complained in writing about Graciani's unprofessional demeanor.[180]

Graciani, throughout her Brief, attempts to shift blame to Providence, the Board of Nursing, and Judge Mandala. It is noteworthy that it was not just Providence employees who had negative experiences with Graciani. On rebuttal, the Division put on witnesses from Graciani's two earlier employers, Fresenius and Denali Dialysis to show that Graciani was disciplined and eventually terminated from those jobs for similar conduct.[181]

Judge Mandala concluded "that Ms. Graciani's presence on the dialysis team at Providence negatively impacted the overall working environment."[182]

In reference to patients, Judge Mandala further found that:

> it is more likely true than not that on at least some occasions, Ms. Graciani's disruptive behavior had a negative impact on patient care. The PCT argument that occurred in front of Ms. Hallstrom's daughter, the incident with the elderly dialysis patient, and the incident with the phlebotomist all occurred in front of patients. In all three instances, the patients themselves or other caregivers nearby raised concerns that the disruptive behavior was negatively impacting patient well-being.[183]

Without question, Graciani has created a reasonable doubt as to whether she was the source of the problems in the workplace environment: some doctors and nurses found her professional. It is a closer question whether the evidence would meet the clear and

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[178] [Exc. 104]
[179] [Exc. 791]
[180] [Exc. 103-104, 770-771]
[181] [Exc. 849-851, 852-854, 857]; Mary Carol Miller test. Day 18, p. 10; Stacy Catania test. Day 19, pp. 86-87.
[182] [Exc. 130]
[183] [Exc. 131]

convincing standard, although Judge Mandala characterized the evidence as "overwhelming."[184] But, clear and convincing evidence is not the applicable standard either. *All* the evidence need not support the conclusion to reach the conclusion that the substantial evidence supports the finding. The evidence detracting from the conclusion that Graciani was unprofessional in the workplace environment is easily outweighed by the evidence supporting it. Finding no error, this Court will not disrupt this finding.

iii. Report of sexual harassment

Graciani argues that Judge Mandala was biased against her as evidenced by a comment in the Decision calling into question Graciani's motivation for filing a workplace report of sexual harassment related to the Mother's Day "side hug" she received from a colleague, Mario Saturnino.[185] But, Judge Mandala concluded that Graciani has every right to complain about unwanted touching, and therefore this was a valid complaint.[186] Judge Mandala is also clear that she did not rely on the incident in reaching conclusions regarding Graciani's workplace conduct.[187] Even when Graciani's report of sexual harassment is set aside, there remains substantial evidence upon which to conclude that Graciani's behavior in the workplace was disruptive and placed patients at risk.

5. Graciani improperly accessed and handled confidential patient records.

[184] *Id.*
[185] App. Br. at 20.
[186] [Exc. 107]
[187] *Id.*

Appellant argues that the Board erred in finding that Graciani inappropriately accessed patient medical records, but only addresses two of the three alleged violations.[188]

a. Ex-husband's medical records

It is undisputed that early in her time at Providence, Graciani accessed her ex-husband's medical records and was reprimanded for doing so.[189] This is a violation.

b. D.F.'s records

Judge Mandala found that nephrologists gathered records of intensive care patients who would likely be in need of dialysis.[190] Judge Mandala wrote: "It is more likely true than not true that Ms. Graciani's access of D.F.'s chart occurred in accordance with that practice, and not for a reason other than a request by the patient's physician."[191] The Board found no fault with Graciani's possession of D.F.'s records.[192]

c. Records in Graciani's cubby

Judge Mandala concluded that Graciani gave inconsistent testimony related to Providence management finding hundreds of pages of patient medical records in her cubby at the time of her firing from the nephrology unit.[193] Judge Mandala found that Graciani violated patient confidentiality by maintaining patients records in her cubby and engaged in unprofessional conduct.[194] On appeal, Graciani does not mention this violation at all, thereby conceding it. This incident constitutes a violation of patient confidentiality.

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[188] [App. Br. at 28, 34-35]
[189] [App. Br. at 34]
[190] [Exc. 115]
[191] *Id.*
[192] *Id.*
[193] [Exc. 119-20]
[194] [Exc. 131]

ii. The Board did not abuse its discretion when it revoked Graciani's nursing license.

An agency's selection of a particular disciplinary sanction is reviewed for abuse of discretion.[195] The Board of Nursing is authorized to revoke a nursing license where the licensee has intentionally or negligently engaged in conduct that resulted in an injury or significant risk to a patient or has willfully or repeatedly violated the statute or regulations.[196] A "board shall seek consistency in the application of disciplinary sanctions" and must explain in its order "any significant departure from prior decisions involving similar situations."[197] "[T]he ultimate goal in fashioning appropriate sanctions is not punishment; the goal is to protect the public and instill public respect and confidence."[198]

Appellant argues that the Division acted harshly when it pursued revocation as opposed to a less drastic sanction.[199] The Division argues that no sanction short of revocation would protect the public due to the nature and number of Graciani's violations combined with Graciani's dishonesty about her conduct.[200]

1. Statutory and regulatory framework

Alaska Statute 08.68.270 provides the grounds to deny, suspend or revoke a nursing license.[201] The Board revoked Graciani's nursing license pursuant to three grounds:

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[195] *Odom*, 421 P.3d at 6.
[196] AS 08.68.270(5) and (8).
[197] AS 08.01.075(f).
[198] *Ness v. Alaska State Board of Dental Examiners*, No. 3AN-06-8587CI (April 28, 2008), Superior Court Decision at 6.
[199] [App. Br. at 47-48]
[200] [Ae. Br. at 25-26]
[201] The board may deny, suspend, or revoke the license of a person who
(1) has obtained or attempted to obtain a license to practice nursing by fraud or deceit;
(2) has been convicted of a felony or other crime if the felony or other crime is substantially related to the qualifications, functions, or duties of the licensee;
(3) habitually abuses alcoholic beverages, or illegally uses controlled substances;

- Licensee "willfully or repeatedly violated a provision of this chapter or regulations adopted under this chapter or AS 08.01."[202]
- Licensee "is guilty of unprofessional conduct as defined by regulations adopted by the board."[203]
- Licensee "has willfully or repeatedly violated a provision of this chapter or regulations adopted under this chapter or AS 08.01."[204]

The Board's regulations provide a list of circumstances where the Board has discretion to revoke a nursing license.[205] In her findings, Judge Mandala identified three circumstances applicable to Graciani:

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(4) has impersonated a registered, advanced practice registered, or practical nurse;
(5) has intentionally or negligently engaged in conduct that has resulted in a significant risk to the health or safety of a client or in injury to a client;
(6) practices or attempts to practice nursing while afflicted with physical or mental illness, deterioration, or disability that interferes with the individual's performance of nursing functions;
(7) is guilty of unprofessional conduct as defined by regulations adopted by the board;
(8) has wilfully or repeatedly violated a provision of this chapter or regulations adopted under this chapter or AS 08.01;
(9) is professionally incompetent;
(10) denies care or treatment to a patient or person seeking assistance if the sole reason for the denial is the failure or refusal of the patient or person seeking assistance to agree to arbitrate as provided in AS 09.55.535(a);
(11) has prescribed or dispensed an opioid in excess of the maximum dosage authorized under AS 08.68.705; or
(12) has procured, sold, prescribed, or dispensed drugs in violation of a law, regardless of whether there has been a criminal action or harm to the patient.

[202] AS 08.68.270(5).
[203] AS 08.68.270(7).
[204] AS 08.68.270(8).
[205] (a) The board will, in its discretion, revoke a license if the licensee
(1) commits a violation that is a second offense;
(2) violates the terms of probation from a previous offense;
(3) obtains or attempts to obtain, by fraud or deceit, a license to practice nursing;
(4) is convicted of a felony or other crime, if the felony or other crime is substantially related to the qualification, functions, or duties of the licensee;
(5) habitually abuses alcoholic beverages, or illegally uses a controlled substance, as defined in AS 11.71.900(4), to the extent that the abuse or use interferes with nursing functions, and if the licensee fails or refuses to participate in a rehabilitation program acceptable to the board;
(6) impersonates another health care provider;
(7) intentionally or negligently engages in conduct that results in a significant risk to the health or safety of a client or injury to a client;
(8) engages in unprofessional conduct, as described in 12 AAC 44.770, if the health, safety, or welfare of another person is placed at risk; or

> (6) impersonates another health care provider;
> (7) intentionally or negligently engages in conduct that results in a significant risk to the health or safety of a client or injury to a client; or
> (8) engages in unprofessional conduct, as described in 12 AAC 44.770, if the health, safety, or welfare of another person is placed at risk[.][206]

Notably, Judge Mandala did not rely on subsection (1) of 12 AAC 44.770(a)—where the licensee "commits a violation that is a second offense."[207]

In responding to the State's brief, Appellant argues that the Board cannot revoke a license as its first action on a license.[208] But, even if read the way Appellant urges, 12 AAC 44.720(a) is a list of nine situations where a nursing license may be revoked, and those situations are set off by "or" not "and" meaning only one of the identified situations must be satisfied to pursue revocation. The Court agrees with the Board that Graciani has engaged in both "intentional or negligent conduct" as well as "unprofessional conduct" that has placed the health, safety, or welfare of patients at risk.[209] In addition, when Graciani ordered the Thrombin Time test, she held herself out as Dr. Rodriguez, and was therefore impersonating a physician. These types of conduct may form the basis for revocation of a nursing license regardless of whether this is the first action on the licensee's license.[210]

12 AAC 44.770 is entitled "Unprofessional conduct" and identifies multiple forms of unprofessional conduct, four of which directly apply here. Unprofessional conduct is defined as "Nursing conduct that could adversely affect the health and welfare of the public

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(9) if professionally incompetent, if the incompetence results in risk of injury to a client.
[206] 12 AAC 44.720(a).
[207] 12 AAC 44.720(a)(1).
[208] App. Reply Br. at 13.
[209] 12 AAC 44.720(a)(8).
[210] *Id.*

constitutes unprofessional conduct under AS 08.68.270(7)." The Division must show by a preponderance of the evidence that Graciani committed the alleged violations.[211]

2. Graciani's violations of her license

a. Falsifying physician orders and practicing outside the scope of her nursing license.

When Graciani ordered the Thrombin Time under Dr. Rodriguez's name rather than the Activated Clotting Time test originally ordered by Dr. Rodriguez,[212] Graciani violated her license in three ways: she falsified a physician order;[213] she practiced outside the scope of her nursing license;[214] and, she engaged in unprofessional conduct.[215]

b. Falsifying a patient record

This Court has already determined that the substantial evidence supports Judge Mandala's finding that Graciani manually changed M.L.'s vital signs in Epic, intentionally falsifying M.L.'s records.[216] This act by Graciani was a violation of 12 AAC 44.770(10).

c. Medication errors

Graciani failed to administer vancomycin to patients G.R. and K.A. in January 2016,

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[211] AS 44.62.360; *Odom*, 421 P. 3d at 7.
[212] Testimony of Lorrie Hubbard, Day 17, p. 106, 124; Testimony of Jenny Irene McDonald, Day 17, p. 138-140.
[213] Violating 12 AAC 44.770(10) ("failing to maintain a record for each client which accurately reflects the nursing problems and interventions for the client, or falsifying a client's records or intentionally making an incorrect entry in a client's chart.")
[214] Violating 12 AAC 44.770(5) ("failing to perform acts within the nurse's scope of practice which are necessary to prevent substantial risk or harm to a client.")
[215] Violating 12 AAC 44.770(1) ("failing to use sufficient knowledge, skills or nursing judgment in the practice of nursing as defined by the level of licensure.")
[216] [Exc. 126-129]

and failed to communicate with their primary nurses so the medication could be timely administered.[217] G.R. went a whole day without their necessary medication.[218] These medication errors by Graciani constituted unprofessional conduct pursuant to 12 AAC 44.770(1).[219]

d. Failure to comply with handoff protocols

Handoff communication is the standard of care in nursing.[220] As described in detail above, Graciani failed to follow handoff protocols as to G.R., K.A., P.F., and M.L.[221] Graciani's failure to initiate handoff protocols and communicate regarding patient needs and status violates 12 AAC 44.770(5).[222]

e. Unprofessional workplace behavior

There are two regulations related to unprofessional workplace behavior in the nursing context that are applicable to Graciani. 12 AAC 44.770(29) references "harassing, disruptive, or abusive behavior by a licensee directed at staff or a client, a client's relative, or a client's guardian." Relatedly, 12 AAC 44.770(30) provides for "disruptive behavior by a licensee at the workplace that interferes with the provision of client care."

Judge Mandala concluded on the evidence that "Ms. Graciani engaged in extensive disrespectful and otherwise disruptive behavior toward dialysis coworkers and other

[217] [Exc. 658]; Franz test Day 4, P. 10-11, 18.
[218] Franz test Day 4, P. 15.
[219] [Exc. 127]
[220] [Exc. 661-667; Exh. 27]
[221] [Exc. 316, 652-655, 658]
[222] 12 AAC 44.770(5) is violated by "failing to perform acts within the nurse's scope of practice which are necessary to prevent substantial risk or harm to a client."

hospital staff."[223] She further concluded that this conduct was both frequent and severe.[224] As discussed above in detail in Section IV.a.i.4 above, the evidence supports this conclusion. Finding no error, the Court affirms the violation under 12 AAC 44.770(29).

In addition, the record establishes three different incidents where Graciani's behavior specifically disrupted patient care: (1) Graciani's 'unprofessional' confrontation with Primary Care Technician (PCT) Kelly Whitworth that occurred in front of Ms. Hallstrom's daughter,[225] (2) Graciani's 'impatient and rude' treatment of an elderly patient;[226] and (3) Graciani's 'loud' incident with phlebotomist Jacqueline Boone[227] all occurred in front of patients and were reported by patients or their caregivers.[228] Finding no error, the Court will not disrupt Judge Mandala's finding, by a preponderance of the evidence, that at times, Graciani's disruptive behavior had a negative impact on patient well-being.[229]

f. Violations of patient confidentiality

With limited exceptions not applicable here, unprofessional conduct includes "violating the confidentiality of information or knowledge concerning a client".[230]

At the administrative hearing, Graciani did not dispute that she accessed her ex-husband's medical records in 2014. Graciani likewise does not appeal the Board finding

[223] [Exc. 200]
[224] *Id.*
[225] [Exc. 771]; Kelly Whitworth Test. Day 4, p. 109; Rebecca Hallstrom Test. Day 1, p. 131.
[226] [Exc. 770]
[227] Sasha Watsjold Test. Day 6, pp. 94-100; [Exh. 44]
[228] [Exc. 765, 770, 771]
[229] [Exc. 131]
[230] 12 AAC 44.770(6).

that she had hundreds of pages of patient records in her cubby at the time of her firing from Providence. The third alleged violation: having a prospective patient's medical records (D.F.'s records), Judge Mandala correctly concluded Graciani did not breach confidentiality.

Ultimately, Judge Mandala found two violations of 12 AAC 44.770(6): accessing the ex-husband's records and the voluminous PHI of various patients in Graciani's cubby.[231] Judge Mandala noted that maintaining unsecured patient documents in an open cubby was not only "a significant patient confidentiality violation" but also "constituted unprofessional conduct under the Board's regulations."[232] This Court finds that Judge Mandala did not err in concluding, by a preponderance of the evidence, that Graciani violated confidentiality in each instance, and engaged in unprofessional conduct when she stored records in an unsecured cubby.[233]

3. Precedent

There is not an existing OAH or appellate decision revoking a nursing license that implicates the number and variety of violations that Graciani racked up in her brief career. Appellant argues that the Board relied on cases distinguishable from Graciani's in recommending revocation as opposed to a lesser sanction.[234] The Division argues that revocation was the only option, and no lesser sanction would correct her behavior.[235]

a. In Alaska

[231] [Exc. 131]
[232] *Id.*
[233] [Exc. 200]
[234] [App. Br. at 47-48]
[235] [Ae. Br. at 36]

Appellant asks this Court to order a lesser sanction and conclude as the Alaska Supreme Court did in *Odom v. State*, that the Board's decision was not based upon "substantial evidence."[236] *Odom* is distinguishable from the facts here, both in terms of the procedure utilized in reaching a decision, but also in the number of violations alleged.

In *Odom*, Dr. Odom's license to practice medicine was revoked for prescribing phentermine to a patient known to have cardiomyopathy and for prescribing increasing doses of thyroid hormone to the same patient.[237] The Medical Board adopted the Division's Proposal for Action and no factual findings were made by the ALJ.[238] The Alaska Supreme Court disagreed with the Medical Board both in terms of the procedures used and disagreed that the substantial evidence supported the allegations.[239]

Here, Judge Mandala has made detailed factual findings related to Graciani's multiple violations of her nursing license, those findings were adopted by the Board, and supported by the substantial evidence. Graciani's violations were both greater in number than Dr. Odom's and also frequently involved dishonesty and practicing outside the scope of her nursing license. In short, *Odom* is not helpful to Graciani.

Appellant cites the Board of Nursing's sanctions in two matters, *In re Small, OAH*, and *In re Paula Korn, OAH*, as instructive in demonstrating that revocation should not be the Board's first action on a license.[240] As discussed above, there is no law or regulation that prevents the Division from seeking revocation as the first action on a license.

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[236] [App. Br. at 46-47]
[237] *Odom*, 421 P. 3d at 9, 11-12.
[238] *Id.* at 8.
[239] *Id.*
[240] [App. Br. at 48]

Audrey Small was licensed as an RN, ANP, and was also a midwife.[241] In *In re Small*, the Division originally reached a consent agreement with Small suspending her ANP license after she delivered an infant who died shortly after his birth—a single but serious act of misconduct.[242] When Small did not comply with the terms of the consent agreement, namely that she be supervised by a physician, the Board suspended her RN license.[243] Amid new allegations of misconduct, both of Small's nursing licenses were revoked.[244]

Graciani's case is different from Small's. Small's first interaction with the Board of Nursing was related to a single act of misconduct. Graciani's involvement with the Board of Nursing arises out of a pattern of conduct occurring over the course of a decade.

In *Korn*, the Division first disciplined Paula Korn via a consent agreement for treating a female patient for an extended period of time for pain management and inadequately charting her work related to these prescriptions.[245] When Korn continued to prescribe pain medication to patients and failed to adequately chart these prescriptions, her RN license was suspended for six months and her ANP license was suspended for three years.[246]

Korn is not particularly instructive to the Court here either. While Korn's prescribing practices for the original patient constituted an ongoing violation of her license,

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[241] *In re Small*, OAH NO. 09-0396-NUR & 10-0057-NUR, at 3.
[242] *Id.* at 5.
[243] *Id.* at 1.
[244] *Id.* at 50-53. It is noteworthy that in *Small*, multiple patients testified in support of Small. Even so, the ALJ found that the substantial evidence supported revocation of both of Small's nursing licenses. The Court references this to demonstrate that while there were three physicians and some nurses who spoke positively about Graciani, that does not prevent the ALJ from concluding that the substantial evidence supports revocation.
[245] *In re Paula Korn*, OAH NO. 20-0696-NUR at 2 (Alaska Board of Nursing 2021).
[246] *Id.* at 29.

it involved a single patient. Korn's subsequent violations were related to her pattern of over-prescribing pain medication; the Division suspended Korn's ANP license preventing her from prescribing medication at all during her suspension. In contrast, revocation of Graciani's license here is based upon multiple different types of unprofessional conduct and is frankly therefore harder to address through the targeted sanction the Board gave Korn—taking away her prescribing authority. Certainly, this Court recognizes that both Graciani and Korn placed multiple patients at risk of harm throughout their careers.

b. Outside of Alaska

In addition, Appellant argues that Judge Mandala's reliance on *Holmes v. Louisiana State Board of Nursing* misses the mark.[247] While this Court recognizes Graciani does not have a criminal record as Holmes did, Holmes and Graciani engaged in similar workplace conduct: they were disruptive employees who made the workplace hostile to staff and in Graciani's case, unsafe for patients.[248] Ultimately, both Holmes and Graciani received multiple complaints and supervisory resources were taken up with these issues.[249]

4. Judge Mandala's findings in support of revocation

Judge Mandala recognized in her Proposed Decision that the "sheer number and breadth of Ms. Graciani's violations makes it difficult to locate directly comparable cases."[250] In the past, the Board of Nursing has revoked registered nursing licenses in cases involving separately or in some combination falsification of records, misconduct relating

[247] App. Br. at 44.
[248] *Holmes v. Louisiana State Board of Nursing*, 156 So.3d 183, 191 (La. Ct. App. 2014).
[249] *Id.*
[250] [Exc. 13]

to prescriptions, dishonesty, and disruptive behavior.[251] As argued by the Division, there is no Alaska case, however, that involves a registered nurse engaged in all of these behaviors repeatedly, willfully, and over the span of years and multiple employers.[252]

In recommending revocation, Judge Mandala likewise referenced the severity and variety of Graciani's violations holding:

> If this were only a case about unprofessional workplace interactions, the recommended sanction would likely consist of a reprimand, additional training, and a period of probation or other supervision. If this were only a case about improper handling and storage of PHI, the recommended sanction might rise to include a short suspension. Even as to the patient care violations, if this were a case about the missed administration of vancomycin or about communication between nurses about medication timing, those incidents alone would be unlikely to warrant revocation.
>
> But this case involves – in addition to the workplace violations, the PHI violations, and the medication handoff incidents – several additional violations so severe as to compel the result. The most glaring violations in this case were revealed relatively late in the hearing and are far more severe than some of the other violations found above. In particular, Ms. Graciani's falsification of the thrombin time test, failure to conduct a handoff communication for M.L., and falsification of M.L.'s chart – as well as her dishonesty about all three events – are extremely serious violations of her license. These incidents showcase both a callous disregard for patient well-being and a fundamentally dishonest character inconsistent with the most basic obligations of the profession.[253]

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[251] *In re Acha*, OAH No. 17-0906-NUR (2018) (denial of license due to dishonesty); *In re Kimble*, OAH No. 06-0032-NUR (2006) (license denied for deception and dishonesty regarding work history); *In re Hamshar*, OAH No. 06-0555-NUR (August 2007) (dishonest documentation); *In re Small*, OAH NO. 09-0396-NUR & 10-0057-NUR, at 48 (2010) (misconduct involving prescriptions and practiced outside the scope of her license); *In re Medley*, Case Nos. 2300-93-008, 2300-96-004, final decision Nov. 17, 2000 (practice outside the scope); *In re Fields Kruzie*, Case No. 2300-89-2, final decision Dec. 7, 1989 (falsification of vital signs); *In re Polon*, Case Nos. 2304-03-005, 006, 010, 012, 016, 107, final decision Sept. 22, 2004 (records falsification, disruptive behavior).

[252] App. Br. at 34.

[253] [Exc. 133]

Among the reasons honesty is important in nursing is because there will be times in administering medication that the wrong amount is given.[254] When a mistake is made, the nurse must own their mistake and inform the physician and caregivers so steps can be taken to correct the mistake, to the extent possible.[255] Judge Mandala did not find Graciani to be a credible witness and doubted Graciani possessed the honesty nursing requires.[256]

Upon review of the record as a whole, this Court finds revocation of Graciani's nursing license to be supported by the substantial evidence admitted at the hearing (see section IV.a.i.1-4 above) and likewise finds there is a reasonable basis in law having considered the applicable statutory and regulatory framework. The Board of Nursing did not abuse its discretion in revoking Ms. Graciani's nursing license.

b. Graciani's Due Process claim fails.

Appellant alleges a due process violation occurred when her attorney was not able to respond to arguments made by the Division's attorney at the Board of Nursing meeting.[257] The substitution of judgment test is used for questions of law where no agency expertise is involved.[258]

In advance of the Board of Nursing meeting, Ms. Graciani, through counsel requested to address the Board.[259] Her attorney asked to be present only for "moral support" and recognized that Division counsel "might wish to address the Board if Ms.

[254] *In re Kimble*, OAH No. 06-0032-NUR, at 12 (Alaska Board of Nursing 2006).
[255] *Id.* at 10.
[256] [Exc. 135-36]
[257] [App. Br. at 48-50]
[258] *Estate of Basargin*, 31 P.3d at 799.
[259] [Exc. 432-33]

Graciani is allowed to give a statement."[260] The Board initially indicated that only Graciani would be heard.[261] On August 1, 2022, the Board reached out again and informed the parties that Ms. Milks would also be permitted to speak at the meeting.[262] It is undisputed that at the meeting Ms. Graciani was allocated five minutes to speak and Ms. Milks was permitted five minutes to respond. No evidence has been presented suggesting that Graciani's counsel asked (before or during the meeting) to be heard.

i. Plain error analysis.

There is no suggestion, either in the written communications in the days leading up the meeting or during the meeting itself, that Graciani or her counsel objected to the plan for Milks to speak at the hearing. There is no evidence that Graciani's counsel asked to be heard, either before the meeting or at the meeting. As such, the alleged due process violation is not preserved and is reviewed only for plain error.[263] Plain error requires an "obvious mistake" that is "obviously prejudicial."[264] Even assuming that it was an obvious mistake to not give Graciani's counsel an opportunity to rebut the Division, the mistake was not obviously prejudicial to Graciani under the circumstances given the revocation of Graciani's license was based upon the evidence at the 19 day hearing, not the Board of Nursing meeting.

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[260] [Exc. 432]
[261] [Exc. 635]
[262] *Id.*
[263] *In re Hospitalization of Connor J.*, 440 P.3d 159, 163 (Alaska 2019).
[264] *In re Hospitalization of Gabriel C.*, 324 P.3d 835, 838 (Alaska 2014).

ii. In the alternative, applying the *Matthews v. Eldridge* balancing test, the Court finds no Due Process violation.

The three factors to be balanced in determining the process due are:

> First, the private interest that will be affected by the official action;
> Second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and,
> Finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.[265]

Ms. Graciani has a protected property interest in her nursing license.[266] "To determine the risk of erroneous deprivation on an individual basis, [the Court] consider[s] the likelihood that [the requested procedure] might alter the outcome."[267] Here, the Court cannot find that if Ms. Graciani's counsel had been prompted to respond to the Division's argument, that the outcome would have been different. Thus, the risk of erroneous deprivation of Ms. Graciani's nursing license here is exceedingly low. Certainly, allowing Ms. Graciani's attorney to respond to the Division's argument would not have been burdensome to the government, and would have made the proceedings just a bit longer.

On balance, the Court finds that while Ms. Graciani has a protected interest in her nursing license, that giving her attorney a chance to respond to the Division's attorney, while not a burden to the Board of Nursing, in no way would have changed the outcome of the proceeding. Therefore, any error was harmless.

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[265] *Mathews v. Eldridge*, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976); *Barber v. Schmidt*, 354 P.3d 158, 161 (Alaska 2015); *Midgett v. Cook Inlet Pre-Trial Facility*, 53 P.3d 1105-1111 (Alaska 2002).
[266] *Sniadach v. Family Finance Corp.*, 395 U.S. 337, 89 S. Ct. 1820, 23, L. Ed. 2d 349 (1969).
[267] *D.M. v. State, Div. of Family & Youth Serv.*, 995 P.2d 205, 212-13 (Alaska 2000).

Graciani argues that Milks' argument "torched" her credibility with the Board.[268] But, Judge Mandala had already made findings that Graciani is not a credible witness writing that Graciani "failed to answer direct questions and engaged in painful degrees of wordsmithing and attempts to avoid taking responsibility for past actions or statements."[269] Judge Mandala found "this conduct during her testimony was similar to the evasiveness that multiple managers reported during workplace investigations and disciplinary meetings, and made those accounts more credible."[270] Graciani's credibility was at issue, but five minutes of argument from the attorney for the Division was not what "torched" her credibility, it was Graciani's own testimony and how it conflicted with the largely consistent testimony of multiple witnesses, that led the Board to adopt the ALJ's decision.

In addition, the substantial evidence admitted at the 19-day hearing amply supported the proposed Decision reached by Judge Mandala and adopted by the Board. The risk of erroneous deprivation of Ms. Graciani's rights was very low where the Board's Decision is based upon the record from the 19-day hearing. The Proposed Decision was the result of the hearing, not the Board of Nursing meeting. On appeal, no due process violations are alleged to have occurred at the underlying hearing, and Graciani had ample opportunity to present her evidence at the hearing. For these reasons, Graciani's due process claim related to the conduct of the Board of Nursing meeting fails.

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[268] [App. Br. at 36]
[269] [Exc. 118-121]
[270] [Exc. 119]

V. Conclusion

For the reasons set forth above, the Court AFFIRMS the decision by the Board of Nursing to Revoke Ms. Graciani's nursing license. IT IS SO ORDERED.

DATED at Anchorage, Alaska this 24th day of November, 2023.

LAURA HARTZ
Superior Court Judge