

3rd AGENDA

BOARD OF NURSING
October 23, 2014 – 8:30 a.m.
Room 474 (Fourth Floor)
Heber M. Wells Building
160 E. 300 S. Salt Lake City, Utah

This agenda is subject to change up to 24 hours prior to the meeting.

ADMINISTRATIVE BUSINESS:

1. Sign Per Diem
2. Call Meeting to Order.
3. Introduction of Bureau Manager, Dr. Suzette Farmer
4. Administer Oath of Office to Debra Hobbins, new Board member
5. Review and approve September 11, 2014 minutes

BOARD BUSINESS:

- 8:45 a.m.** - Mitchell Jones
9:00 a.m. - Marilyn Johnson, canceled
9:10 a.m. - Proposed Rule change to the membership of the Peer Education Committee
9:15 a.m. - Lisa Young, re-licensure application
9:30 a.m. - Connie Call, compliance report, probationer requests/miscellaneous
10:00 a.m. – 11:00 a.m. - Informal Adjudicative Proceeding – Kenneth Cook

PROBATION INTERVIEWS:

Please note: The compliance report, report from Committees and probation interviews may result in a closed meeting in accordance with §52-4-205(1)(a).

Group 1 Room 474

- 11:00 a.m.** Rachel Zimmermann, non-compliance
11:15 a.m. Alecia Hall, non-compliance
11:30 a.m. Brett Alexander, non-compliance
11:45 a.m. Rebecca Davis, non-compliance

Group 2 Room 475

- Leslie Mitchell, non-compliance
Suzanne Irish Menatti, non-compliance
Lori Wright, non-compliance
Katherine Roach, her request

LUNCH: 12:00 noon – 12:30 p.m.

BOARD BUSINESS:

PROBATION INTERVIEWS CONTINUED:

Group 1 Room 474

- 12:30 p.m.** Kelly Powell, her request
12:45 p.m.
1:00 p.m. Amy Nau, non-compliance
1:15 p.m. Helen Gallegos, new Order
1:45 p.m. Hyeshin Koo, new Order
2:15 p.m. Layne Lowry, new Order
2:45 p.m. JoAnne Somers, review Order

Group 2 Room 475

- Julie Porter, non-compliance
Nina Manning, non-compliance
Robin Walker, non-compliance
Rebecca McInnis, new Order
Michele McArdle, new Order
Carol Gittins, new Order
Jeffrey Alleman, new Order

BOARD BUSINESS:

Reports from Committees

Discussion regarding requests from William Schwarz.

NEXT MEETING: November 13, 2014

Meetings scheduled for the next quarter: December 11, 2014; January 8, 2015 and February 12, 2015.

Note: In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify, Dave Taylor, ADA Coordinator, at least three working days prior to the meeting. Division of Occupational & Professional Licensing, 160 East 300 South, Salt Lake City, Utah 84115, 801-530-6628 or toll-free in Utah only 866-275-3675

DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
Heber M. Wells Building
160 East 300 South
PO Box 146741
Salt Lake City, UT 84114-6741
Telephone: (801) 530-6628

BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING
OF THE DEPARTMENT OF COMMERCE
OF THE STATE OF UTAH

IN THE MATTER OF THE LICENSE OF : NOTICE OF INFORMAL AGENCY
KENNETH MAYNARD COOK : ACTION
TO PRACTICE AS A :
LICENSED PRACTICAL NURSE : Case No. DOPL 2014-⁷⁷⁷
IN THE STATE OF UTAH : ₇₇₇

THE DIVISION OF OCCUPATION AND PROFESSIONAL LICENSING
("DIVISION") TO KENNETH MAYNARD COOK ("Respondent"):

KENNETH MAYNARD COOK
323 34TH STREET, FRONT
OGDEN, UT 84401

The Division of Occupational and Professional Licensing hereby files this Notice of Agency Action to determine whether a basis exists to revoke your license as a licensed practical nurse, and/or suspend, restrict, fine, or place probationary terms and conditions on your license due to a criminal conviction.

This action is based upon Division records and an investigation, which show that you were convicted of one count of threat/use of dangerous weapon in a fight, a Class A misdemeanor, and one count of one count of unlawful detention, a Class B misdemeanor, in Second District Court, Weber County, Utah, on November 1, 2012. As a result, you have engaged in unprofessional conduct, in violation of Utah Code Annotated Section 58-1-501(2)(a) and (c).

ALLEGATIONS SUPPORTING THIS ACTION

1. Respondent was first licensed as a licensed practical nurse in the State of Utah on or about May 21, 1993.
2. On or about March 6, 2012, Respondent was involved in an incident in Ogden, Utah where Respondent argued with his spouse and prevented his spouse from leaving the argument by using his car to block his spouse's car. When police arrived, Respondent threatened police with a three-foot sword.
3. On or about November 1, 2012 pleaded guilty to one count of threat/use of a dangerous weapon in a fight, a violation of Utah Code Ann. § 76-10-506, and a Class A misdemeanor; and one count of unlawful detention, a violation of Utah Code Ann. § 76-5-304, and a Class B misdemeanor, in Second District Court, Weber County, Utah, based upon the conduct described in paragraph 2 above.
4. On or about January 23, 2014 Respondent was submitted an application for renewal of licensure to the Division, wherein Respondent informed the Division of his criminal conviction.

NOTICE OF INFORMAL PROCEEDING

The adjudicative proceeding designated herein is, pursuant to Utah Administrative Code R156-46b-202(2)(d)(i), to be conducted on an *informal basis*, which means that you are not entitled to a hearing. The decision in this matter will be based upon a review of the Division records, any response filed by you, and a brief meeting before the Utah Board of Nursing.

Within thirty (30) days of the mailing date of this notice, you are required to file a written response with the Division. Your response will be helpful in clarifying, refining or narrowing the facts and the violation alleged herein. Your written response shall be mailed to:

Division of Occupational and Professional Licensing
Attn: Dr. Debra F. Hobbins, Bureau Manager
160 East 300 South, 4th Floor
PO Box 146741
SALT LAKE CITY, UT 84114-6741

If you fail to submit to the Division a written response within thirty (30) days of the mailing date of this notice, the

Division may enter an Order of Default revoking your license without any further notice to you. If an Order of Default is entered your meeting with the Utah Board of Nursing will be cancelled without any further notice to you.

You may represent yourself or legal counsel may represent you, at your own expense, while this action is pending. If you are represented by legal counsel, your attorney must file a Notice of Appearance with the Division at the address stated above. Until a Notice of Appearance is filed, the presiding officer will communicate directly with you.

A copy of the Division's relevant and non-privileged evidence supporting the allegations described above has been provided to you along with this notice.

A one hour meeting with the Utah Board of Nursing has been set to review this matter at the following date, time, and place:

Thursday, October 23, 2014 at 10:00 am

**Division of Occupational and Professional Licensing
Heber Wells Building
160 South 300 East, 4th Floor
Salt Lake City, UT 84114**

The meeting with the Utah Board of Nursing ("Board") is not an adversarial hearing. Following the discussion of evidence of your misconduct, you will have an opportunity to present your position to the presiding officer and the Board.

If you do not appear at the time and date set forth in this notice, the Division will proceed based upon the record before it.

If you or your attorney has any questions regarding the procedures related to this matter, Dr. Hobbins can be contacted at the above address, or via telephone at (801) 530-6789.

At the expiration of your deadline to submit a response, and after the meeting set with the Utah Board of Nursing, Mark Steinagel, the Division Director, who is the presiding officer in this matter, will make an informal review of the record in this matter and determine whether you have violated Utah Code Annotated Section 58-1-501(2)(a) and (c) and therefore subject you to sanctions under Utah Code Annotated Section 58-1-401(2)(a).

The maximum administrative sanction in this case is revocation of your license. Other administrative sanctions may be imposed by the Division, including suspension of your license, imposition of probationary terms and conditions, a fine consistent with Utah Administrative Code R156-31b-402, and/or a public reprimand.

Please conduct yourself accordingly.

Dated this 14 day of July, 2014.



W. Ray Walker
W. Ray Walker
Regulatory and Compliance
Officer

CERTIFICATE OF SERVICE

I hereby certify that on the 14 day of June, 2014, a true and correct copy of the foregoing NOTICE OF AGENCY ACTION was served on the parties of record in this proceeding by mailing a copy thereof, properly addressed by first class mail with postage prepaid, to the following:

KENNETH MAYNARD COOK
323 34TH STREET, FRONT
OGDEN, UT 84401

Carol Inglesby
Carol Inglesby
Administrative Assistant

August 11, 2014

Kenneth Cook
323 34th St. Front
Ogden, UT 84401
801-860-3892
knnththn@aol.com

Division of Occupational and Professional Licensing
Attn: Dr. Debra F. Hobbins, Bureau Manager
160 East 300 South, 4th Floor
PO Box 146741
Salt Lake City, UT 84114-6741
801-530-6628

DOPL-Board of Nursing:

The following is a response regarding the correspondence of a notice of informal agency action Case No. DOPL 2014-333.

1. The information provided is quite confusing. On page 1, the Board has declared a determination that I have engaged in unprofessional conduct in violation of Utah Code 58-1-501(2) (a) and (c). But then on page 3, apparently an informal meeting will be held, without me being present, to determine if I violated the Utah Code. On one hand you are saying I am guilty of violation of that, but then on page 3, you have to determine if I am guilty? Which one is it? Referring to the Utah Code 2(a), it states aiding and abetting another person to violate a rule, there is no other person, just me. Section 2(c) states that "it bears a reasonable relationship to the licensee's or applicant's ability to safely or competently practice the occupation or profession." The incident does not fit into this statute because the incident was not related to nursing in anyway. In fact, this was proven by my continued employment as a nurse, where I safely handled the care of many patients who were considered to be dangerous in a behavioral health facility. The companies that I worked for knew about my charges and were able to accept my employment without any restrictions.
2. As related to the incident on March 6, 2012, according to the police departments' records, no one was hurt (except me), nor was there any property damage. (Please see police report that states that there was no damage to the van and no damage to the car.) Inasmuch as there was no damage or injury, I am relieved that no one besides me was hurt and there was no damage done.
3. Regarding the allegations supporting this action, respondent agrees with Numbers 1, 3, and 4. I disagree with the Board's allegations concerning Number 2, the facts of which are verified in the police reports. It is agreed that myself and my spouse were having an argument, but as per the police report, I did not use my car to block her car. I was in the family's van and allegedly used the van to ram the family car. The van was not used to block the car. Left out in the allegations in Number 2, was where the respondent was when the police arrived. I had left apparently and went home, per my spouse's statement. Agreed is there was a sword involved, but the allegation states a measurement of the three foot sword. That allegation has no evidence supporting the size of the sword.

During the meeting that I had with the Board of Nursing, there were several facts offered to the Board concerning the reasons why the events of that night happened. They are not alleged, but are true events in my life and in fact, were diagnosed because of PTSD and from being bi-polar. I briefly touched on past traumatic experiences that led to my

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& PROFESSIONAL LICENSING

delayed diagnosis of PTSD, during the Board meeting on February 13, 2014, but did not have enough time to fully explain the events from my past. The first being extensive, horrific child abuse by my mother and stepfather that occurred often throughout my childhood and adolescence. The second and worst of all, was coming home from working a night shift at my job the early morning of June 14, 1979, walking in to check on my children and finding my youngest, 7 ½ month old baby girl hanging by her neck from her crib, dead, already in rigor mortis and having to wake up my wife and be the one to tell her that our daughter was dead. That is the worst, most traumatic event of my life and one that has caused much pain, sorrow and torment. I was not aware of my need for grief counseling. I just went on, living day after day with the grief, keeping busy always, but never "getting over" the grief. I also witnessed one family member and two others burn to death in an ultralight aircraft crash that happened right in front of many family members who were at the site watching. I ran to try to rescue them from the wreckage, when the ultralights exploded into flames a few feet from me and I had to watch all three burn to death, screaming, watching one of their heads explode from the fire and I was helpless to do anything to help them. Also, I experienced extreme stress while serving over 450 troops at the Piute Reservoir area. I had 3 different locations to cover, 1 at the 10,000 foot area accessible only by helicopter and 2 at the Reservoir site. Being the only medic, not only did I take care of minor things like headaches, aches and pains, but critically ill and critically injured soldiers. One had been on a D-9 Cat Bulldozer, which rolled down a hill, the operator being critically wounded with acid from the battery and antifreeze in both eyes, plus a concussion. A soldier who had a bowel obstruction and had it for a week (7 days), his condition was that it was so severe that I smelled BM on his breath and when I transported him to the hospital in the helicopter, he had given me a note asking me if he was going to die. In essence, me taking sole responsibility to save his life, which I did. He was hospitalized for over two weeks with septicemia. He was on antibiotics for more than two weeks. Another young soldier was experiencing heat stroke, but his captain refused to let me transport him to the hospital and in fact, ordered the Medevac to be cancelled, which at that time I had to contact my captain, who arrived and while my captain and his captain were heatedly debating whether to send this young man to the hospital, the young man went into grand-mal seizures. I was able to get him to the hospital because my captain ordered the Medevac and he spent a week in the hospital and was medically discharged from the military. The Doctor who treated him, contacted me and told me if I hadn't gotten him to the hospital when I did, he would have been dead within an hour. Last but not least, another example is when the air conditioning unit for one of the portable kitchens broke down and the temperature inside the metal building exceeded 110 degrees. Soldiers were arm to arm preparing meals when 2 of the cooks each grabbed a knife and since I was right there when it happened, I stepped between both of them, risking my life to stop them from hurting each other. By the way, as I talk about inconsistencies in the police reports, in the minutes of the Board meeting on February 13, 2014 that were unfortunately released for the public to see, stated that I was at the Piute Indian Reservation and my tour of duty was NOT on the Piute Indian Reservation. This is exactly what I mean when I talk about inconsistencies and how they can damage someone's reputation.

Because a person suffers from an injury or mental illness, does not necessarily mean they are incapable of doing work in their profession. Apparently the Board is disallowing the fact of my mental illness as noted by the attempt to make this into a criminal act only, as the police did. The police are not trained in recognizing the signs and symptoms of one having a mental breakdown or an acute mental problem. All they do is approach it from the criminal side because they are not trained to recognize those signs and symptoms. Whereas the Board of Nursing should absolutely know how to correctly recognize the signs of symptoms of someone having an acute mental event. It should have not been a criminal event, but it ended up being that due to the fact that my attorney, who is not knowledgeable about mental health situations, advised me to plead guilty to the two charges, so that I would be able to put the event behind me and retain my nursing license. The Board has ignored, by virtue of the recent mailing, the letters of support that I have received from various individuals, sustaining the fact that I am competent to do my job and have been. In fact, even two letters, one from my spouse supporting me and a letter from my step-daughter supporting me. This I found strange that

the Board of Nursing chose to ignore that information, coming from the victim herself who wrote it without coercion, but of her own free will.

Miss Parrish has, in her position on the Board, had a very aggressive approach, for an unknown reason, indicating that I have not taken responsibility for my actions. Let me approach that.

1. A person who has not sought out counseling and hospitalization plus treatment and medications would be a person that is not accepting responsibility. As far as saying "yes, I know what happened and I apologize for my actions", I can't do that because I do not remember the events of that night. With PTSD, having not been diagnosed or treated previously, there was no way to prevent the events of that night. I find it in poor taste that someone on the Board of Nursing, who was responsible for making decisions for licensure, has failed miserably in knowing the diagnosis and knowing how the signs and symptoms of PTSD present themselves. PTSD that is untreated and undiagnosed definitely has the possibility of someone having a mental breakdown and amnesia of the events. So, Miss Parrish, I have taken full responsibility for what I do know, have sought out counseling and take my medications as ordered. I have NEVER denied that the events of that night happened. What I did say was that there are inconsistencies in the police reports. Miss Parrish, in no way at all, had enough time to read, compare and make a judgment that there were no inconsistencies, as she so did during the Board of Nursing meeting. I feel this sets a dangerous precedence because as a nurse, if that is what Miss Parrish is, her actions should have been, I should read this later and compare to see if there are inconsistencies, plus be open minded to the respondent, highlighting the inconsistencies. There was not enough time in the meeting for either myself or Miss Parrish. Attached to this letter is a listing of inconsistencies in the police reports. Be it so noted that, I have even approached my spouse and apologized for what happened that night, even though I don't remember the events. I also apologized to my step-daughter and to the rest of my family. In fact, my step-daughter, who has a daughter who at the time was 2 years old, trusted me completely to babysit my sweet little granddaughter then and still to this day. If I was so dangerous, or my spouse thought I was so dangerous, do you think they would allow me the responsibility of babysitting her for long periods of time, by myself? Not just hours, but days, even spending nights with her Papa, who she stated to her Mom that "Papa would never hurt anybody."
2. Since March 6, 2012, as stated before, I have been working as a nurse successfully. As I notified the Board during the last meeting, I was no longer with a company in Idaho, because I was a whistleblower, where I witnessed severe patient abuse, that resulted in a patient having a broken right humerus, medications not given to him, nor the proper nutrition via a G tube and an injury to his left hand that luckily was negative for fractures. Also, the same patient was complaining of pain in his right hip in a non-verbal way, and after I received a Doctor's order to get an X-ray done, the DON came into work and took it upon herself, without conferring with the Doctor, stating "he doesn't need one, he always has pain." The administrator was approached and the administrator refused to take responsibility and take the proper actions that needed to be taken because of the director of nursing's failure to address the situation. I followed through as required by my license and reported to the State of Idaho what I had witnessed and what I was told and the actions that were not taken by the management. The State of Idaho came into the facility, researched the alleged actions and substantiated all the allegations that I had reported. When I did this, the DON retaliated and terminated my employment. So I have to ask the question, does this sound like

someone who does not have the ability to be a nurse? Someone who is mentally competent, not afraid to report and do what is right?

I have a huge concern with how the Board of Nursing has approached the situation. It really presents itself as the Board is bullying me. The neuropsychological testing that the Board wants me to take does not in any way represent my ability to do my job. By the definition itself of a neuropsychological test is to find a diagnosis, to obtain IQ level and a few other items, none of which relate to the situation of March 6, 2012. In my whole career as a nurse, I have never had anyone question my ability, IQ or professionalism concerning me doing my job. In fact, I have had commendations given to me throughout my career, from a 6 year old little girl, who told me I was the best nurse ever, which was really sweet, to the wife of a gentleman where I held her hand and her husband's hand as he passed away. From taking on officers in the Army demanding the right care for my patients at the time, assuring that my critical condition patients got to the hospital in time and saving their lives. To assisting a family whose baby passed away at 3 months old, to being in someone's home for hours, taking care of patients on ventilators. I have done so much and have been so successful. All that I've done as a nurse, has only been accomplished because God has used me as an instrument to help people and be successful.

I believe it is unfair that the Board ordered me to take a neuropsychological evaluation, that the Board knew would cost me upwards of \$3000 to \$5000, knowing that I am struggling to find a job and am living on unemployment which gives me an income of only \$1400 a month. You knew that I was struggling and decided to hit me while I'm down. I thought that my records of evaluations from my psychiatrist and others who have evaluated me, would be sufficient to prove my mental capability to continue to practice Nursing. Even the offer given by the psychologist of \$1200, is too much for me to afford and I have no assets that I can liquidate to come up with that money. Nor can I get a good loan for that amount due to my lack of employment.

I believe the Board is harassing me by making me take a neuropsychological evaluation that is so expensive, that it would be difficult for anyone to afford, let alone a person whose sole income is unemployment. My diagnosis of PTSD and bi-polar have already been diagnosed professionally by psychiatrists at Highland Ridge Hospital and by a very competent psychiatrist, Dr. Jeffrey Mc Cann at the Intermountain Health Clinic in Logan.

I have already initiated my own counseling. I already have a psychiatrist who diagnosed me. I have already set in place safety nets for when I have a problem. So if I thought I was going to have a problem, I would be able to recognize it and use the safety nets, but I have not had to do that. I take my medications as ordered. There was an occurrence several years ago that I reported to the Utah Board of Nursing that a nurse verbally and physically abused a patient. This was a psychiatric patient who swore like a sailor, was physically destructive and was in a lock-down mental health unit. One day, this particular nurse told me in report that this patient had been swearing profusely, banging on the window and so forth and that she told the patient that if she didn't stop, she was going to wash the patient's mouth out with soap, which is verbal assault on a patient. After she told the patient that, the patient of course swore at her again and gave her the one finger salute, at which time, the nurse admitted that she got up, walked in to the unit, got a handful of foaming hand soap and shoved it into the patient's mouth. After hearing that in report, I immediately found out from the MSDS book, the risk factors of that soap as related to ingestion and I went in and physically assessed the patient. I called the Doctor, the DON and Administrator and was very shocked a few years later that this same nurse, after physically assaulting a patient, still had her nursing license. There is a wide chasm from what happened with me and to what happened with this nurse.

Also, the Board of Nursing broke their own rules/laws. How, you might ask? Anytime a change is made in charting or documentation, a single line is to be drawn through the sentence or word and a reason given why with the

person who is correcting or changing the entry, having to write their initial next to the entry. The letter that was written, requiring me to get a neuropsychological test and a physical done, dated March 5, 2014, had the requirement of me getting a physical blacked out with a permanent marker, instead of a single line through it. Another example of this is me being told that the Board of Nursing does not make recommendations, but I was told when I called the Board of Nursing office, that ARS was where I needed to go to get the neuropsychological test done. Would that not be a recommendation? I took the initiative and the responsibility to call and talk to Shirlene, asking who I should see for the neuropsychological test and who the Board would approve for me to see to get my physical done. At which time I was told by Shirlene to go to ARS to get the neuropsychological test done and in a later call to Shirlene, I asked her what Doctor I should go to to get the physical done, in which she told me that I could use my Doctor as long as his license was clean/clear. It really is confusing when a person does not get the right information, but I was the one who took the initiative to call and make sure of what I needed to do. I was not even told what the neuropsychological tests would be about. One of the biggest things in nursing is to ensure that the patient is given information in a timely manner, so they can give what is called informed consent. But yet that is not what happened with the Board of Nursing concerning me. The Board of Nursing fails to abide by their own rules. In fact, blaming me for having gotten the wrong test done and telling me that I had plenty of time to get everything done. If I was instructing a patient that the Doctor had ordered a colonoscopy or same type of test, I am required as a nurse to properly inform the patient when, where and with who to get this test done. That in no way creates a liability for me, it only provides the patient with the correct information. Providing a list of Doctors and clinics in no way signifies sponsorship by the Board of Nursing. There is no phone book of providers that is accessible to even determine where I am to go or set up an appointment to go.

In conclusion, I would like to say this. I have done nursing for 21 years. I was an Army Medic for 10 years and enjoyed and learned something new from every interaction. If the Nursing Board fails to look at the facts and the emotions as Florence Nightengale started Nursing off many years ago, then I feel they are not taking an interest in the fact, that I am a competent, well educated nurse. With all the facts in this response and with the attached police reports describing the incidents, accompanied by a fact sheet showing the inconsistencies of the police reports, I state the following. If the Board of Nursing cannot renew my license unencumbered, without restrictions, without fines (this would be Double Jeopardy, since I have already been through the court system and pled guilty, therefore I cannot be retried on the charges.), then I would have to withdraw my request for renewal and place the responsibility that if I would happen upon a medical situation, then I would have to appoint the Board of Nursing responsibility and blame to not be able to intervene and save someone's life. I am very competent and have proven so without a doubt, of doing my job safely. The statements in this response are not said with anger, but are said in sadness and with a heavy heart, because the next life that I might save as an LPN might be someone who is on the Board, family members of the Board, it will be your responsibility to decide that. I truly desire to be able to be actively involved in patient care, because that is where my heart is. I want to also be able to help when necessary in a public setting in any medical emergency, where I could not if my license is taken away from me. I would ask that you consider that I was 55 years old at the time of the occurrences and had never had any criminal convictions prior to that time or since. I was fully competent in every way to do my job safely as a nurse for all that time previously and even during the time immediately following the events of March 6, 2012, I have been competent in my job as a nurse. I have taken full responsibility and paid for my actions that night and continue to pay for them.

I believe the Board is harassing me by making me take a neuropsychological evaluation that is so expensive, that it would be difficult for anyone to afford, let alone a person whose sole income is unemployment. My diagnosis of PTSD and bi-polar have already been diagnosed professionally by psychiatrists at Highland Ridge Hospital and by a very competent psychiatrist, Dr. Jeffrey Mc Cann at the Intermountain Health Clinic in Logan. Also, the Board has continued to criminalize my mental illness, my disability as did the Ogden Police. I believe it is unfair to be treated as a criminal

when I had never been in trouble with the law previously and it was determined that I had a nervous breakdown and suffered from amnesia of these events. I have paid for my "crimes" in many ways and continue to do so. I went to jail and served the time that I did, successfully completed my probation, paid the monthly fee every time I went in, paid for my DNA test to be done, saw a counselor and continue to do so, take my daily medications and I fight every day to try to get a job and to get my life back. It is an everyday struggle to try to persuade places that want to hire me, that my criminal charges will not affect my job performance and it was an isolated incident. I hate that that night in March 2012 ever happened, I would do anything to be able to go back and change things. If I would have known that I had PTSD and bi-polar disorder, I would have sought help way earlier and had it treated. Even though I do not remember the events of that night, I regret what happened and I have taken full responsibility for my actions as previously noted.

I would hope the Board of Nursing would use the care and compassion needed as medical professionals to make the right decision based on the letters of support (even from the victim) and from several others and using the knowledge that I am not afraid to stand up for doing the right thing, like what I had to do with the nursing home in Idaho. There should not be any questions about my physical and mental ability to do my job or to handle my responsibilities as a nurse. I have already proven myself to be a very capable and truthful nurse and citizen of the State of Utah.

Respectfully,

A handwritten signature in black ink that reads "Kenneth M. Cook". The signature is written in a cursive style with a large, stylized initial "K".

Kenneth M. Cook

August 11, 2014

Kenneth Cook
323 34th St. Front
Ogden, UT 84401
801-860-3892
knnththn@aol.com

Division of Occupational and Professional Licensing
Attn: Dr. Debra F. Hobbins, Bureau Manager
160 East 300 South, 4th Floor
PO Box 146741
Salt Lake City, UT 84114-6741
801-530-6628

To the State Board of Nursing:

The following are the inconsistencies in the police report.

1. Page 12 of 24, Identification of vehicle driven by Kenneth Cook states it is a Ford Econoline E350 and says that registration is expired for no insurance.
 - 1a. The van is an E150 which is completely different than an E350. The registration was NOT expired and insurance was on the van through American Family Insurance. If the officer had done his job correctly, than he would have had that correct information, but he did not.

2. Page 13 of 24, officer states that I "jumped through the window and laid on top of and that I continued to yell and spit on her while lying on top of her."
 - 2a. This inconsistency involves the following: It would be impossible for me to "jump" through the car window because of my size related to weight and that I have a steel plate in my neck, a steel plate in my lower back, having both of those fused. Also, how could I spit on her, because if I jumped through the window I would be face down ..I can't jump backwards, so how could I spit when I'm facing downwards and lying across her...I would have to turn my head 180 degrees.

3. The statement was made that I rammed the car with the van and knocked the car into the cement wall.
 - 3a. If that had been true, then there would be damage to the van and damage to the car, plus the airbags would have deployed, which they did not. If someone rams something with another something, there is going to be damage or marks or something. In the police report, it was noted that there was NO damage to either vehicle.

 - 3b. Page 22 of 24 this is also per officer Caygle's report talking about the 1994 Chrysler Concorde. Officer Caygle states that the tag on the car was expired in September of 2005, but

yet it was expired in September of 2012. Also, he states in his narrative notes that there is no damage to the Chrysler. But on Page 22 of 24 it says damaged, so which one is it?

4. Page 13 of 24, in the officer's statement that he was told over the radio that I had a gun, was an absolute lie.

4a. This same officer spoke with Shannon and he asked her at the time if there were any guns in the house and she told them specifically that the gun had been sold 2 to 3 weeks before that day. And if the Board of Nursing would like, she is more than agreeable to write a statement to that and submit it to the Board. It must be noted that there were no other officers at the residence and this officer arrived before them. It was the neighbor that lived downstairs who decided to add their two cents worth about me having a gun. He also stated that I was crazy.

5. Page 14 of 24, the statement was made that the officer told me to drop the sword and then it says that I did so by throwing it to the ground at my feet. Then he says he told me to get to the ground so he could detain me. He further states that I turned away from him, back into the house and towards the couch. The report also states that he put a charge of Aggravated Assault of a police officer.

6a. First of all, an officer would not tell someone to get on the ground, right then and there, especially if the weapon is right there at their feet. First the officer says that he is going to detain me and says to place him in custody, so which one was it in those few moments? For the later dismissed charge of Aggravated Assault of a police officer, there was zero substantiating evidence to support it. But the officer, by his own admission states he punched me in the face, which also was unnecessary because on page 18 of 24, this officer states that they drew their taser. Why wasn't it used instead of me being punched by two officers, one in my face and one in my left side. That is a huge discrepancy.

6. This officer report on page 15 of 24, states that officer Caygle, told me through the door that he has charges against me for the incident that happened at Lofthouse. This officer states that I turned and started to run into the residence. That I ran into the front room and then I jumped on a couch.

1a. But yet officer Caygle states in his report three different things, first being that he wanted to talk about the incident with me, then he wanted to detain me and finally place me in custody. So, which one was it? It changes throughout Mr. Caygle's report. It would be impossible for me to do the following: to run back into the house because I was never out of it, according to the rest of the police reports, I opened the door and stood in the doorway of the house. The distance from the door to the sofa was less than 10 feet and there was a coffee table in front of the sofa that in my physical condition would be impossible for me to jump.

7. Page 17 of 24 in this report, this officer states that I was simply detained and placed in handcuffs. It also adds on information to lead someone to believe that there was a gun in the house, which

again, there was not one in the house and officer Caygle knew positively that there was not one in the house. Page 18 of 24 this officer states that I held out the sword with the tip end away from officers and that I started running towards the living room area of the house, after I was told to lie on my stomach. This officer goes on to lie and states that Shannon told him that I had a gun in the house, but I may or may not have sold it.

8a. This officer's statement is a blatant lie. This officer had talked to officer Caygle, and told him plain flat out that the gun had been sold two weeks ago. This is just the officer's attempt to dramatize the whole situation. Also, the front door of the residence is in the living room area, so it would be impossible for me to run towards the living room area since I was already there. Page 19 of 24 this officer states that he told me that I was under arrest for the crimes that I committed earlier and would be taken into custody. He also states that I was told to face away and lay on the floor and he didn't want me to get into my home and possibly grab another weapon. He also states that by the time he caught up with me, I was near my couch and that I was forced onto the couch and struggled for a brief moment.

8. Why is it that 4 out of 5 officers who were at the scene, in their reports stated that I pointed the tip of the sword at myself and not at officers? Why did the initial reporting officer state that I pointed it at officers, but the other 4 state that I had the sword tip pointed at my chest and put it down when asked to without a fight?

In conclusion, my statement that the reports are inconsistent has been proven without a doubt. Some officers say this, some officers say that, who is telling the truth? Again, if you want, I can have the victim Shannon Cook talk to you, so she can tell you what really happened. It is highly suggested though, to have Board members review all of the reports and facts, instead of claiming that there are no inconsistencies. Especially in this instance, Ms Parrish, who jumped to the conclusion that there were no inconsistencies and she did this in the short 20 minute meeting that there was and even less time to review the information during the meeting which leads me to believe that Miss Parrish was not paying attention to what I was saying. It highly concerns me that the approach now being made is the focus as to be a criminal event, but yet before it was that I was to get a neuropsychological test and physical exam done, which one is it? Is it a criminal aspect that you are looking at or an episode of PTSD that was undiagnosed, it has to be one or the other? Right now, I'm not sure. As nurses our goal is always to heal, comfort and not judge. We are not to condemn. During my 56 years of age I have experienced enough abuse, pain and suffering and in one night (fifteen minutes to be more accurate) out of those 56 years my mind shut down because it could not handle the excruciating trauma. Now I live with people trying to condemn, judge and punish me more. I refuse to allow it though. In fact I am more determined to push on. Whether or not I have my license I have helped healed, saved lives, comforted, and not judged others and those times can never be taken away from me.

Respectfully,

Kenneth Cook

DOPL PROPOSES SANCTIONS FOR KENNETH COOK'S LPN LICENSE:

Respondent's license shall be revoked. The revocation shall be immediately stayed. Respondent's license shall be immediately suspended, and shall remain suspended until Respondent has: (1) successfully completed all the requirements set forth in subparagraph (b) below; (2) Respondent fully complies with any treatment recommendations made by an evaluator; and (3) Respondent meets with the Board and the Board determines that Respondent may safely practice as a nurse. Once the suspension is lifted, Respondent's license shall be subject to a term of probation for a period of five years. The period of probation shall commence on the date the Division Director signs an Amended Order lifting the suspension. During the period of probation Respondent's licenses shall be subject to all of the following terms and conditions. If the Board or Division later deems any of the conditions unnecessary such deletions may be made by an amended order issued unilaterally by the Division.

- a. **Meet with the Board:** Respondent shall meet with the Board at the Board's next scheduled meeting following the signing of the accompanying Order. Respondent shall meet with Division Compliance Specialist Connie Call within two weeks following the effective date of this Stipulation and Order and prior to Respondent's first meeting with the Board to review this agreement. Ms. Call may be reached at (801) 530-6295, or by email at cscall@utah.gov. For the remainder of the duration of probation, Respondent shall meet with the Board or with the Division, as directed by the Division, quarterly or at such other greater or lesser frequency as the Division may direct.
- b. **Neuropsychological and Physical Evaluations.** Respondent shall successfully complete a neuropsychological and physical evaluation provided by a Division-approved licensed provider within sixty (60) days of the effective date of this Stipulation and Order. Respondent shall schedule the initial appointment to be held within 30 days of the effective date of this Stipulation and Order. Respondent shall attend all appointments and follow-up appointments in a timely manner. Respondent shall cooperate fully with the evaluator to ensure a fair and complete evaluation. Respondent shall notify the Division immediately after successfully completing the evaluations and inform the Division that Respondent has successfully completed the evaluations. Respondent shall sign any

release which permits the evaluator to release the evaluation report, data the evaluation is based upon, and any other information the evaluator feels is important for the Division and Board to review. Respondent shall obtain a letter from each evaluator which states clearly whether or not Respondent is mentally and physically fit to practice as a nurse. If Respondent's evaluation shows that Respondent cannot safely practice as a nurse, Respondent's license shall be remain suspended until the evaluator states that Respondent can safely practice as a nurse. Respondent shall undergo any other type of evaluation directed by the Division or Board and shall comply with any recommendations contained in the evaluations.

- c. **Ongoing Therapy and Release of Information.** Respondent shall attend any therapy recommend in any evaluation report until the Division or Board decides otherwise. Respondent shall successfully complete any therapy or treatment recommended by the neuropsychological evaluation report in a timely manner. Respondent shall follow any treatment recommendations made by the evaluator, the Division, and/or Board. Respondent shall execute any necessary releases to allow the therapist to provide reports to the Division and Board regarding Respondent's progress. Respondent's therapy should focus on the areas of concern identified by the evaluator. Respondent shall cause progress reports to be submitted to the Division and Board by the therapist on a quarterly basis, or at a greater or lesser frequency as determined by the Division and Board. Respondent shall be responsible for all treatment expenses.
- d. **Continuing Education.** Respondent shall successfully complete continuing professional education courses focused on ethics, professionalism, appropriate treatment of patients, and any other course directed by the Board. All courses shall be pre-approved by the Division and Board. Respondent shall submit documentation to the Division and Board verifying that Respondent has successfully completed the courses. The courses shall be completed within one year of the effective date of this Stipulation and Order. The courses shall not count toward Respondent's regular continuing education requirement, if any.

- e. **Responsibility for costs of Order:** Failure of Respondent to pay the costs associated with this Order constitutes a violation of the Order.
- f. **Reports and documentation:** All reports and documentation required in this Stipulation and Order shall be submitted to the Board on a monthly basis, on the first day of each month, for the first six months of probation. If Respondent is in compliance with all terms and conditions of the Order at the end of that time, all reports and documentation shall be submitted on a quarterly basis for the remainder of probation. If Respondent is not in compliance with all terms and conditions of the Order by the end of the first six (6) months of probation, all reports and documentation shall be submitted on a monthly basis until Respondent is in compliance with the Order, after which all reports shall be submitted on a quarterly basis.
- g. **Self-assessment:** Respondent shall complete and submit to the Board a self-assessment report at the frequency described in subparagraph (f) above. The self-assessment report shall be completed on a form prescribed by the Division.
- h. **Employer notification/evaluations:** Respondent shall notify any employer of Respondent's restricted status and the terms of this agreement. Respondent shall further cause Respondent's employer to submit performance evaluations to the Board at the frequency described in subparagraph (f) above. The receipt of an unfavorable report may be considered to be a violation of probation. If Respondent is not employed as a nurse, Respondent shall submit the employer report form on the date it is due and indicate on that form that Respondent's current employment is not in nursing or that Respondent is not currently working.
- i. **Notification of employer/school of nursing:** Respondent shall provide to Respondent's employer(s) and/or school of nursing a copy of this Stipulation and Order and cause each employer or school of nursing to acknowledge to the Board in writing, that a copy of this Stipulation and Order has been provided to the employer and/or school of nursing within 14 days of the effective date of this Stipulation and Order or any new employment date.

- j. **Work hours:** Respondent shall only work day shifts. Within any 14-day period Respondent shall not work more than 80 hours. Respondent may work three 12-hour shifts in one seven day period and four 12-hour shifts in the other seven day period, but Respondent may not work more than three consecutive 12-hour shifts. Respondent shall not work two consecutive 8-hour shifts within a 24-hour period or be scheduled work 16 hours within a 24-hour period. In the event Respondent does not practice as a nurse for a period of sixty (60) days or longer, Respondent shall notify the Board in writing of the date Respondent ceased practicing. The period of time in which Respondent does not practice shall not be counted toward the time period of this Stipulation and Order. It shall be within the discretion of the Board to modify this requirement if Respondent satisfactorily explains to the Board that compliance in Respondent's case was impractical or unduly burdensome. Respondent must work at least sixteen (16) hours per week to be considered "practicing" in Respondent's profession.

- k. **Supervision:** Respondent shall practice only under the direct supervision of a registered nurse or a licensed physician in good standing with the Division. The supervising nurse or supervising physician shall be primarily one (1) person who may periodically delegate her supervisory responsibilities over Respondent to other qualified personnel. The supervising nurse or supervising physician shall be approved by the Division and Board. Respondent shall cause Respondent's supervisor to read this Stipulation and Order in its entirety and cause the supervisor to provide input on Respondent's employer evaluations to the Division and Board. The employer reports shall be submitted to the Division and Board on pre-approved forms, at the frequency set forth in subparagraph (f) above. Employer reports submitted after the first day of the month shall be considered a violation of this Stipulation and Order. "Direct supervision" as defined in Utah Administrative Code R156-1-102a(4)(a) means that the supervising licensee is present and available for face-to-face communication with Respondent, when and where nursing services are being provided.

- l. **Nurse Licensure Compact:** Respondent shall not practice nursing in any other state that is a party to the Nurse Licensure Compact without prior authorization from such other party state.

- m. **Change in employment/practice status:** Respondent shall notify the Board in writing within one (1) week of any change of employer, employment status, or practice status. This notification is required regardless of whether Respondent is employed in Respondent's profession.
- n. **Leaving the state of Utah:** If Respondent leaves the State of Utah for a period longer than sixty (60) days, Respondent shall notify the Division and Board in writing of the dates of Respondent's departure and return. The licensing authorities of the jurisdiction to which Respondent moves shall be notified by Respondent in writing of the provisions of this Stipulation and Order. Periods of residency or practice outside the State of Utah may apply to the reduction of the period this Stipulation and Order is in effect, if the new state of residency places equal or greater conditions upon the Respondent as those contained in this Stipulation and Order.
- o. **Arrests/charges or admissions to healthcare facilities:** If Respondent is arrested or charged with a criminal offense by any law enforcement agency, in any jurisdiction, inside or outside the State of Utah, for any reason, or should Respondent be admitted as a patient to any institution in this state or elsewhere for treatment regarding the abuse of or dependence on any chemical substance, or for treatment for any emotional or psychological disorder, Respondent agrees to cause the Division and Board to be notified immediately. If Respondent is seen in an emergency room, Respondent shall provide the Division and Board with a copy of Respondent's emergency room discharge papers. If Respondent at any time during the period of this agreement is convicted of a criminal offense of any kind, or enters a plea in abeyance to a criminal offense of any kind, including a pending criminal charge, the Division may take appropriate action against Respondent, including imposing appropriate sanctions, after notice and opportunity for hearing. Such sanctions may include revocation or suspension of Respondent's license, or other appropriate sanctions.
- p. **Nursing license:** Respondent shall maintain an active license at all times during the period of this agreement.

- q. **Change of Address:** Respondent shall immediately notify the Division in writing of any change in Respondent's residential or business address.
- r. **Report submission:** Respondent shall submit reports on the date they are due and shall appear at scheduled meetings with the Division and Board promptly. Failure to do so shall be considered a violation of this Stipulation and Order.
- s. **Essay:** Respondent shall submit an essay to the Division and Board, within 60 days of the effective date of this Stipulation and Order, that sets forth the a description of the misconduct in Respondent's own words, along with the effect of the misconduct on Respondent, Respondent's family, and Respondent's patients and employer.
- t. **Suspension if not working for one year.** If Respondent does not work in Respondent's licensed profession for a period of one year or longer, then Respondent's license shall be suspended. When Respondent begins working in Respondent's licensed profession and provides the Division with written notice of this fact, and Respondent is otherwise qualified to practice, the suspension shall be immediately lifted.

R156-31b. Nurse Practice Act Rule.

R156-31b-202. Advisory Peer Education Committee Created - Membership - Duties.

(1) In accordance with Subsection 58-1-203(1)(f), there is created the Advisory Peer Education Committee.

(2) The duties and responsibilities of the Advisory Peer Education Committee are to:

(a) review applications for approval of nursing education programs;

(b) monitor a nursing education program that is approved for a limited time under Section R156-31b-602 as it progresses toward accreditation; and

(c) advise the Division as to nursing education issues.

(3) The composition of the Advisory Peer Education Committee shall be:

(a) ~~five~~ seven RNs or APRNs actively involved in nursing education, including at least one representative from public, private, and proprietary nursing programs; and

(b) any member of the Board who wishes to serve on the committee.