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April 29, 2024

Members of the Arizona Legislature

The Honorable Katie Hobbs, Governor

Ms. Joey Ridenour, Executive Director
Arizona Board of Nursing

We have issued a 30-month follow-up report on the Arizona State Board of Nursing (Board) regarding the implementation status of the recommendations from our September 2021 performance audit and sunset review (see Report 21-111). The Board is responsible for regulating nursing practice in Arizona by issuing and renewing licenses and certificates to qualified applicants, investigating complaints, administering disciplinary actions against regulated parties who violate Board statutes and rules, and providing information to the public about license and certificate holders. Our September 2021 performance audit and sunset review made 11 recommendations to the Board, 7 of which the Board had either implemented or implemented in a different manner at the time of our initial followup.

However, during this 30-month followup, similar to our initial follow-up findings, we found the Board has not implemented our recommendation to resolve public complaints within 180 days. Additionally, we identified additional deficiencies in its processes, and we made 4 new recommendations to the Board to address these areas. Both the previous and new deficiencies we found potentially put patient safety at risk. Specifically:

- The Board did not resolve within 180 days approximately 75 percent of the more than 2,000 public complaints we reviewed, including 78 high-risk complaints involving allegations such as prescribing a 233 percent increase in a patient's opioid dosage and sexually harassing patients. Additionally, the Board's practice of combining multiple complaints involving an individual licensee into a single investigation led to complaint resolution delays of multiple years, sometimes up to 6.5 years, during which licensees the Board eventually determined had engaged in unprofessional and/or unsafe conduct continued to practice.

- The Board did not document if or when it referred some complaints to the Arizona Attorney General to pursue a settlement of formal hearing with the Arizona Office of Administrative Hearings.

- We identified 2 new deficiencies in the Board's complaint-handling processes that may impact public safety:

    - Board staff closed 200 public complaints without recording a closure date. Without documented information regarding a complaint's closure, the Board potentially cannot ensure the timeliness and appropriateness of these closures.

    - The Board did not initially investigate some complaints that alleged licensees engaged in unprofessional conduct, including allegations they stole medication from their workplaces.

- Although contracting with vendors to provide investigative assistance could help mitigate the previous deficiencies we reported and the new deficiencies we found, the Board has not done so because it stated it does not have sufficient monies. The Board had a fiscal year 2023 ending fund balance of nearly $12.7 million, which it has not been authorized to spend, and although the Board conducted a preliminary analysis of contracting for investigators, it should continue to assess the cost and feasibility of doing so.

This 30-month follow-up review also found the Board has not implemented new and revised public information policies and procedures as recommended in our September 2021 audit. Additionally, although the Board has developed policies and procedures for periodically reviewing the appropriateness of its fees, it is not scheduled to do so until 2026, so our recommendation to periodically review the appropriateness of its fees is not yet applicable.

We plan to initiate the Board's next performance audit and sunset review later in calendar year 2024. During this upcoming audit, we will follow up with the Board on the status of the recommendations from our September 2021 audit report that have not yet been implemented and the 4 new recommendations we made in this followup, and further review the impact of the Board's practice of combining multiple complaints involving an individual licensee into a single investigation.

Sincerely,

Lindsey A. Perry

Lindsey A. Perry, CPA, CFE
Auditor General

Cc: Arizona State Board of Nursing members

Conclusion

The September 2021 Arizona State Board of Nursing (Board) performance audit and sunset review found that the Board generally issued licenses/certificates we reviewed in accordance with statute and rule but did not resolve some complaints in a timely manner, which may affect patient safety; remit all required revenues to the State General Fund; and provide sufficient public information. In our September 2022 followup, we reported the Board had implemented 7 of our 10 applicable recommendations.[1]

However, during this 30-month followup, we found the Board has not made progress toward implementing the 3 remaining recommendations, including our recommendation to resolve complaints it received from the public (public complaints) within 180 days.[2] Specifically, the Board did not resolve within 180 days 1,559 of 2,077 public complaints (approximately 75 percent) it either closed between March 1, 2022 and March 17, 2023, or were open as of March 17, 2023, including 78 high-risk public complaints, potentially putting patient safety at risk (see pages 2 through 5 for more information). We also found that the Board's practice of combining multiple complaints involving an individual licensee into a single investigation led to delays of multiple years in resolving some complaints (see pages 5 through 7).

The Board requested and the Governor included in her fiscal year 2025 budget proposal additional staff to help the Board more timely resolve complaints (see pages 7 through 8). However, if approved, it will take time for these additional investigation staff to positively impact the Board's ability to timely resolve complaints because it would not be able to start hiring these additional staff until July 2024. Additionally, the Board reported that new staff will require months of training before handling a full complaint investigation workload, and the Board has and may again experience attrition among its complaint investigation staff in the meantime.

Based on our continued review of the Board's complaint handling, we made 2 new recommendations to the Board related to improving its documentation of complaints referred to the Arizona Attorney General and further assessing the cost and feasibility of contracting for investigators.

Additionally, during this 30-month followup, we identified 2 new deficiencies in the Board's complaint-handling processes that may impact public safety. First, Board staff closed 200 public complaints without recording a closure date (see page 8). Second, the Board did not initially investigate some public complaints that alleged licensees engaged in unprofessional conduct, including allegations they stole medication from their workplaces (see page 9). We made 2 new recommendations to address these deficiencies.

We plan to initiate the Board's next performance audit and sunset review later in calendar year 2024.[3] During this upcoming audit, we will follow up with the Board on the status of the recommendations from our initial September 2021 report that have not yet been implemented and the 4 new recommendations we made in this followup, and further review the impact of the Board's practice of combining multiple complaints involving an individual licensee into a single investigation.

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[1] Our September 2021 recommendation that the Board implement its policies and procedures for periodically reviewing the appropriateness of its fees is not yet applicable because the Board is not scheduled to review its fees until 2026.

[2] The Board has also not implemented its new and revised public information policies and procedures. Specifically, we placed 1 anonymous call to the Board in June 2023 and found that it did not provide some required public information over the phone, including information related to the licensee's disciplinary actions and basic licensing information such as where the licensee attended school, contrary to Board policy.

[3] The Board's next performance audit and sunset review is statutorily required to be published by October 1, 2025.

Board continues to take more than 180 days to resolve most public complaints, including most high-risk complaints, potentially putting patient safety at risk

Board did not resolve within 180 days approximately 75 percent of 2,077 public complaints we reviewed—Our review of 2,077 public complaints the Board either closed between March 1, 2022 and March 17, 2023, or were open and unresolved as of March 17, 2023, found that it did not resolve 1,559 of these complaints, or approximately 75 percent, within 180 days.[1,2] Specifically:

- **Board took more than 180 days to resolve approximately 82 percent of public complaints it closed, including 44 high-risk public complaints—**Our review of all 910 public complaints the Board closed between March 1, 2022 and March 17, 2023, found that it did not resolve 749 complaints within 180 days (see Figure 1, page 3). The Board took more than 3 years to resolve 133 of these complaints, some of which included unprofessional and/or unsafe conduct that the Board eventually substantiated. For example, the Board received a public complaint in January 2019 alleging that a licensee administered intravenous (IV) fluids to someone not registered as a patient and without the authorized provider's knowledge, order, or consent or other triage process. The Board substantiated the allegations and issued a decree of censure to the licensee in June 2022, more than 3 years after receiving the complaint.

  Further, although the Board reported it prioritizes high-risk complaints for investigation, the Board took more than 180 days to resolve most of the public complaints it classified as high-risk within the complaints we reviewed.[3] Specifically, the Board untimely resolved 44 of 60 high-risk public complaints, including taking more than 3 years to resolve 5 of these high-risk complaints.[4] For example, the Board received a public complaint in April 2019 it classified as high-risk that alleged a licensee sexually harassed a patient. While investigating this allegation, the Board received subsequent public complaints with similar sexual harassment allegations. The Board substantiated the allegations and accepted the licensee's voluntary surrender of their license and ordered the licensee can apply for reissuance after a period of 3 years in May 2022, more than 3 years after receiving the initial complaint.[5]

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1 The Board provided a complaint database consisting of 24,240 complaints it received between January 1, 2017 and June 30, 2023, for our review. However, we excluded 22,163 complaints for the following reasons: 15,638 complaints were resolved by the Board before or after the March 1, 2022 through March 17, 2023, follow-up review time frame; 4,385 complaints pertained to background checks/license application concerns that were not the result of a public complaint (see footnote 2 for more information); 1,163 complaints were combined with other complaints (see pages 5 through 7 for more information); 200 complaints were closed with no recorded closure date (see page 8 for more information); and 777 complaints were triaged and closed without an investigation (see page 9 for more information on the Board's closure of some of these complaints contrary to Board policy). We reviewed the 2,077 remaining complaints, which consisted of 910 closed complaints and 1,167 open complaints as of March 17, 2023.

2 As noted in footnote 1, in addition to the 2,077 public complaints the Board either closed between March 1, 2022 and March 17, 2023, or were open and unresolved as of March 17, 2023, the Board initiated 4,385 complaints that pertained to a background check or license application concern. Similar to a public complaint, according to the Board, staff are required to triage these complaints and determine whether to conduct an investigation. Our review of these 4,385 complaints found that the Board closed 3,572 without conducting an investigation, the majority of which were closed within 2 weeks. For the remaining 813 complaints, the Board resolved 165 within 180 days, did not close or had yet to resolve 622 within 180 days, and investigated and resolved but did not have a recorded closure date for the remaining 26 complaints.

3 Although the Board classifies some complaints as high-risk upon receipt, in some cases, it may reclassify complaints as high-risk during its review and investigation of the complaint. As a result, complaints may not be classified as high-risk for the entire time they are open.

4 The Board classifies a complaint as high-risk if the allegation includes an act that is a substantial danger to public safety and represents a potential for an imminent threat. For example, high-risk complaints include allegations of significant physical abuse of a patient resulting in injury, sexual conduct involving a patient, and criminal conduct with significant injury to another person.

5 According to Arizona Administrative Code (AAC) R4-19-404, a person whose nursing license has been voluntarily surrendered may apply to the Board for reissuance subject to conditions including evidence that the basis for surrendering the license has been removed and a Board investigation that determines the licensee's ability to safely practice. The Board may approve the reissuance of a license with or without limitations or with additional conditions, or it may deny reissuance of the license.

Figure 1
Board took more than 180 days to resolve 82 percent of public complaints it closed between March 1, 2022 and March 17, 2023, including high-risk complaints
(Unaudited)

[1] 145 of the 149 complaints were closed before the 180-day deadline. The remaining 4 complaints were closed after the 180-day deadline but prior to the end of the 6-month period.

Source: Auditor General staff review of Board complaint database.

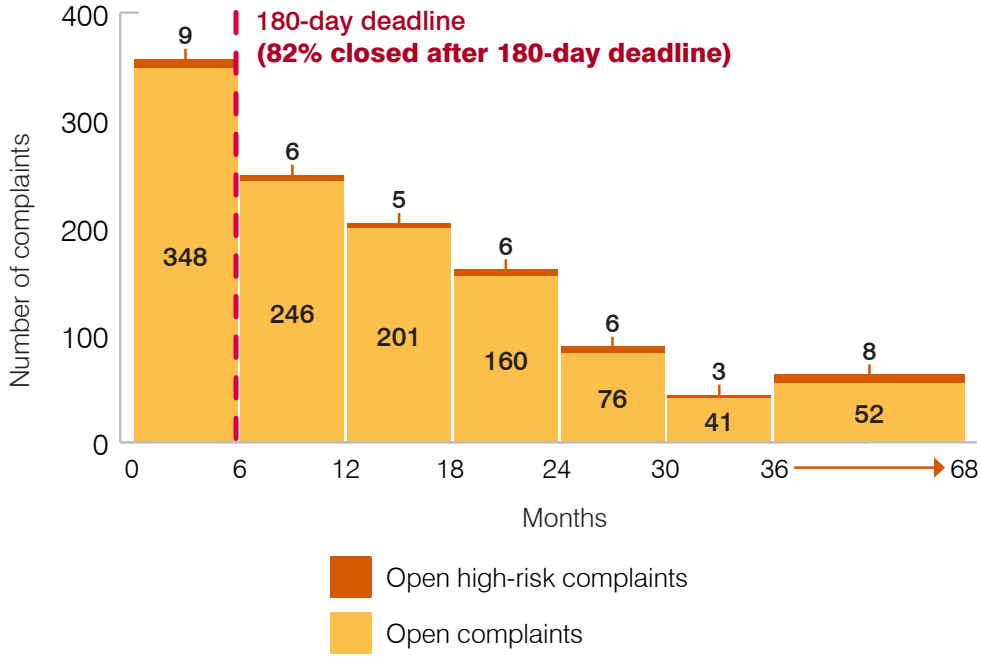
- **Approximately 69 percent of Board's open public complaints had been open at least 180 days, including 34 high-risk public complaints—**Our review of all 1,167 open public complaints as of March 17, 2023, found that 810 complaints had been open and unresolved for at least 180 days (see Figure 2, page 4 and footnote 1, page 2 for information on complaints reviewed).[6] Additionally, 60 of these 810 open public complaints had been open and unresolved for at least 3 years, including allegations of unprofessional and potentially harmful conduct. For example, in August 2017, the Board received 1 public complaint alleging verbal abuse of a patient that had been open for more than 5.5 years at the time of our review (see pages 6 through 7 for additional information on this complaint's allegations and status).

  Further, despite the Board reporting that it prioritizes high-risk public complaints for investigation, we found that most of these complaints had been open and unresolved for at least 180 days. Specifically, 34 of 43 open high-risk public complaints had been open for at least 180 days, including 8 complaints that had been open for at least 3 years. For example, in November 2019, the Board received a public complaint it classified as high-risk that included an allegation the licensee inappropriately prescribed a 233 percent increase in a patient's opioid dosage. In July 2020, the Board substantiated the allegations and voted to issue a Notice of Hearing, which according to Board staff, involved referring the complaint to the Arizona Attorney General to pursue a settlement or formal hearing with the Arizona Office of Administrative Hearings. However, the Board's complaint database did not contain documentation of if or when it referred

[6] Our review of the Board's complaint database found that 68 of 810 complaints that had been open and unresolved for at least 180 days were reported to have been referred to the Arizona Attorney General to pursue a settlement or formal hearing with the Arizona Office of Administrative Hearings.

the complaint to the Arizona Attorney General. In August 2023, the licensee voluntarily surrendered their license but can apply for reissuance after 2 years.[7]

Figure 2
Board had not resolved approximately 69 percent of complaints that were open as of March 17, 2023, within 180 days, including high-risk complaints
(Unaudited)



Source: Auditor General staff review of Board complaint database and complaint log.

Board's continued failure to timely resolve complaints may negatively affect patient safety and may cause undue burden for licensees under investigation for lengthy periods of time— As reported in our September 2021 performance audit and sunset review of the Board, untimely complaint resolution may negatively impact patient safety when delays allow licensees alleged to have engaged in unprofessional conduct as defined by Board statutes and rules to continue to practice while under investigation even though they may be unfit to do so.[8] For example, our review of 2 complaints the Board resolved in February 2023 and February 2024 found that the Board's untimely investigation and resolution of these complaints allowed the licensees to continue practicing unrestricted for nearly 4 years and approximately 5 years, respectively, during which the Board renewed both licenses 1 time until the Board eventually suspended their licenses. One complaint alleged the licensee failed a random drug test during their work shift that resulted in their termination from the employer that requested the drug test. However, according to Board documentation, the licensee continued to work for another employer while the Board investigated the complaint for nearly 4 years. The other complaint alleged the licensee diverted medication at their workplace and, in some cases, administered medication to patients ahead of schedule. Although the licensee was terminated from the employer that submitted the complaint, the licensee was hired by and continued to practice with 2 other employers while the Board investigated the complaint for approximately 5 years. The Board substantiated both of these complaints and entered into consent agreements with the licensees that suspended their licenses for 1 year, required a comprehensive psychological evaluation, completion of identified treatment, drug testing, and, contingent on receiving confirmation that the licensee was safe to return to practice, placing the licensee on probation for at least 36 months.

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[7] As of March 17, 2023, this complaint was open and unresolved and therefore part of our open complaint sample.

[8] Arizona Revised Statutes (A.R.S.) §§32-1601(27) and 32-1663, and AAC R4-19-403.

In addition, even when the Board does not substantiate and dismisses complaints, untimely complaint handling subjects licensees to unproven allegations of unprofessional or harmful conduct for longer than necessary. Untimely complaint handling may also create an undue burden for licensees who are under investigation, as they may be required to be responsive to Board requests for information or documentation for a lengthy period of time. For example, the Board took nearly 5.5 years to investigate a complaint it dismissed because it did not substantiate the allegations (see page 2 and Figure 1, page 3). Although the Board eventually determined that the licensee did not violate statute or rule or engage in an unsafe practice, it cannot make this determination until after it completes its investigation. Further, while licensees are under investigation, statute does not permit the Board to make information available to the public regarding complaints involving a licensee.[9] Similarly, the Board cannot provide this information on Nursys, a national online database that state nursing boards, employers, and the public use to verify the licensure, discipline, and practice privileges of licensed nursing professionals, until it resolves the complaint. [10]

Board's practice of combining multiple complaints it receives involving a licensee into a single, ongoing investigation has further affected its ability to timely resolve complaints, exacerbating patient safety risks—According to the Board's complaint database, it combined the allegations from 1,163 complaints it received between January 1, 2017 and June 30, 2023, into ongoing complaint investigations it had already initiated related to the same licensees.[11] Board staff reported that this practice improves the quality of its investigations by allowing it to identify patterns in licensee behavior and may improve complaint-handling efficiencies. However, our review of a sample of 7 of these complaints, which the Board combined into 7 separate ongoing licensee complaint investigations, found that as of March 1, 2024, it had yet to complete 6 of these investigations and resolve the associated complaints, exacerbating patient safety risks.[12] Specifically, these 6 open and combined complaint investigations had been open for between 283 days and approximately 6.5 years. For example:

- The Board received a complaint in August 2020 involving a licensee withholding care and medications and, while conducting an investigation, subsequently received 3 additional complaints involving the license that it combined into its existing investigation—the last received in May 2023, more than 2.5 years after it received the initial complaint.[13] The subsequent complaints alleged that the licensee inappropriately prescribed medication, including a schedule 2 narcotic. As of March 2024, the Board's investigation had been open and unresolved for more than 3.5 years, and the licensee has continued to practice without restriction (see Figure 3, Licensee 1, page 6).[14]

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[9] A.R.S. §32-3214.

[10] According to the National Council of State Boards of Nursing, all 50 states plus Washington D.C. and 4 U.S. territories provide information on Nursys regarding licensed nursing professionals.

[11] These 1,163 combined complaints were listed on the Board's complaint database, which consists of 24,240 complaints the Board received between January 1, 2017 and June 30, 2023, and do not include combined complaints pertaining to background checks/license application concerns (see footnote 1, page 2). However, the 1,163 combined complaints do not include the initial complaints and the associated investigations into which they were combined. Therefore, we are unable to identify how many complaint investigations involved multiple complaints against a single licensee. Additionally, we were unable to determine when 14 of 1,163 complaints were combined as there was no date recorded in the complaint database.

[12] We sampled 7 complaints for review among 1,163 complaints, categorized as combined complaints by the Board, by randomly selecting 6 complaints and judgmentally selecting 1 additional combined complaint classified as high-risk and open for more than a year. Of the 7 cases sampled, all involved 7 different ongoing licensee complaint investigations.

[13] Our review of the Board's complaint database found an October 2022 Board note stating there is an additional complaint involving this licensee that was not entered into the Board's database as an official complaint, and therefore, this complaint's status is unknown and not included in our analysis. Further, in October 2022, the Board elevated this investigation to a high-risk status.

[14] The Board reported this investigation, like many of its complaint investigations, included coordination with other agencies, including law enforcement, which contributed to investigative delays. Specifically, the Board reported it paused its investigation of this licensee in October 2022 after receiving information about a federal investigation into this licensee but that it did not have documentation of a request to pause its investigation. In December 2022, the licensee voluntarily surrendered for cause their Drug Enforcement Administration Certificate of Registration, prohibiting them from prescribing controlled substances and which ended the federal investigation. The Board reported that it again paused its investigation at the request of the Arizona Attorney General in December 2022 but that it did not have documentation of the request. The Board further reported it resumed the investigation in February 2024 after a discussion with the Arizona Attorney General and also indicated that the federal investigation has been completed.

- The Board received a complaint involving a second licensee in August 2017 that alleged verbal abuse toward a patient, including profanity, disrespectful statements, and statements that could be perceived as a threat. In July 2020, nearly 3 years after receiving this complaint, the Board offered a consent agreement to the licensee to address substantiated allegations of patient abuse. The licensee did not return a signed consent agreement and Board staff reported that, in October 2020, it subsequently referred this complaint to the Arizona Attorney General. However, the Board's complaint database did not contain any documentation demonstrating if or when it referred the complaint to the Arizona Attorney General. Six months later, in April 2021, the Board received a second complaint against this licensee alleging patient abuse, withdrew the unsigned consent agreement, and combined this second complaint into its investigation of the licensee, despite the fact it had substantiated the original allegations of patient abuse. In March 2023, the initial complaint was scheduled for a formal hearing with the Arizona Office of Administrative Hearings, and Board staff reported that the scheduling had been delayed because of the reassignment of multiple Board-assigned Assistant Attorney Generals. However, again, the Board's complaint database did not contain documentation demonstrating if or when it referred the complaint to the Arizona Attorney General prior to the hearing being scheduled. In July 2023, the scheduled hearing was cancelled because the Board had yet to complete its investigation of the second complaint. As of March 2024, a formal hearing has not occurred. Therefore, these complaints have been open and unresolved for approximately 6.5 years and nearly 3 years, respectively, and the licensee has continued to practice without restriction (see Figure 3, Licensee 2, page 7).

Figure 3
2 examples of complaints alleging unprofessional conduct that the Board has combined into a single investigation that have exceeded 180 days and remain unresolved as of March 2024
(Unaudited)

Licensee 1

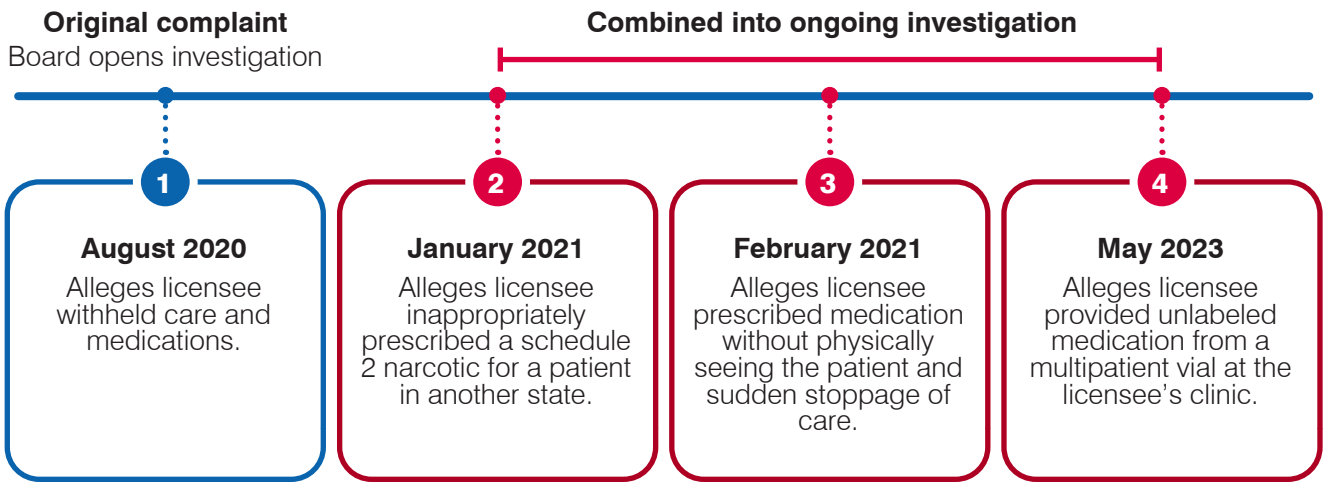
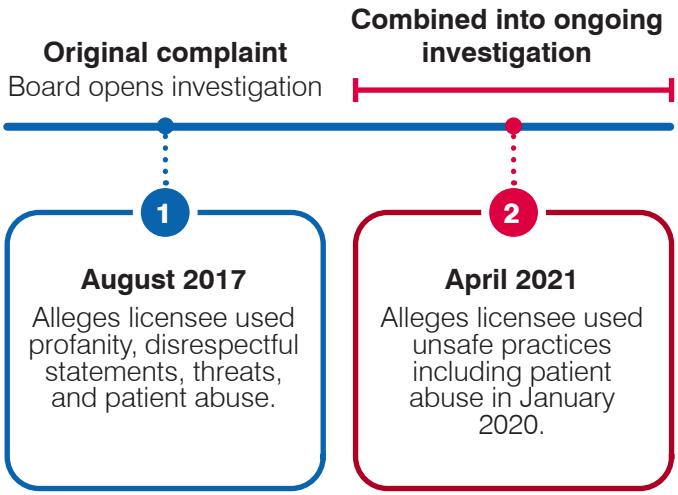


Figure 3 continued

Licensee 2



Source: Auditor General staff review of Board complaint database and complaint log.

Board has requested additional complaint investigation staff for fiscal year 2025 to help it resolve complaints within 180 days, but additional investigation staff will take time to positively impact the Board's complaint-handling timeliness

As of August 2023, the Board reported it had more than 1,800 open complaints either under investigation or awaiting investigation, yielding an average complaint investigation caseload of 84 cases for each of its 7 Advanced Practice Consultants (APC) staff and 102 cases for each of its 12 Senior Investigators (SI) staff.[15] See textbox for more information on APC and SI positions. Based on this number of open complaints and according to its fiscal year 2025 budget request, the Board reported that adding 8 combined APC and SI investigative staff positions will allow it to achieve complaint investigation caseload goals of 60 cases per APC and 75 cases per SI, and increase its ability

[15] Our review of the Board's complaint database found that for fiscal years 2020 through 2022, the Board annually opened an average of 1,153 investigations. These investigations may include background checks/application concerns and public complaints, and investigations may involve multiple complaints that the Board has combined into a single investigation (see pages 5 through 7 for more information on combined cases). Therefore, the number of complaints received will be higher than the number of investigations opened.

Board investigative staff

The Board has 2 types of staff positions that investigate complaints. Various factors determine the assignment of a complaint to 1 of these staff positions, including the type of license the licensee holds:

Advanced Practice Consultant (APC) and Nurse Practice Consultants (NPC)—APCs and NPCs must be certified advanced practice registered nurses (APRNs) or Registered Nurses for at least 5 years and investigate complaints related to clinical standards regarding alleged violations of Board statutes and rules involving nurse practitioners, certified nurse midwives, clinical nurse specialists, certified nurse anesthetists, and licensed practical nurses.

Senior Investigator (SI)—SIs are nonnurse investigators and investigate complaints regarding nonclinical issues such as legal issues, fraud and deceit, criminal histories, professional misconduct, and alleged violations of Board statutes and rules involving licensees without advanced licenses.

Source: Auditor General staff review of Board website and Board-provided documentation.

to resolve complaints within 180 days.[16] As a result, the Board requested and the Governor has included in her fiscal year 2025 budget proposal 8 additional investigative staff consisting of 3 APC and 5 SI.[17]

However, if approved, it will take time for these additional investigative staff positions to positively impact the Board's ability to timely resolve complaints. First, because the Board made its request for additional staffing and the associated funding as part of its fiscal year 2025 budget request, if approved, the Board would not receive this funding and then have the opportunity to start hiring these additional staff until July 2024. Additionally, the Board reported new investigative staff may not reach optimal caseloads until they are fully trained and experienced, which it estimated can take up to 18 months. Finally, the Board reported it continues to experience investigative staff turnover. Specifically, in its fiscal year 2025 budget request, the Board reported that 11 investigative staff have either resigned or retired between September 2022 and August 2023 because of high caseloads and stress. Our September 2022 initial followup similarly reported that the Board had 7.5 vacancies out of 21 investigative staff positions listed on the Board's August 2022 organization chart. Although additional investigative staff should result in lower caseloads, which in turn could reduce staff stress and associated turnover, continued turnover among its investigative staff and the time required to fill vacant positions and train new investigative staff may lessen the impact of the new investigative staff positions the Board hopes to achieve. Although contracting with vendors to provide investigative assistance could help mitigate these issues, the Board reported it conducted a preliminary analysis of contracting for investigators and determined it does not have sufficient monies, including staff vacancy savings, to do so. Additionally, although the Board had a fiscal year 2023 ending fund balance of nearly $12.7 million, which represents more than a $3.5 million increase in its ending fund balance since fiscal year 2021, it has not been authorized to spend these monies.[18] We will continue to assess the Board's efforts to increase its investigative staff and timely resolve complaints during the Board's next performance audit and sunset review, which we plan to initiate in calendar year 2024.

Our follow-up review identified new deficiencies in Board's complaint-handling processes resulting in some complaints missing a recorded closure date or not being investigated

Board closed some complaints without a recorded closure date and thus potentially cannot ensure the timeliness and appropriateness of these closures—The Board's complaint database included 200 complaints the Board received between January 1, 2017 and February 3, 2023, that had a status indicating the complaints have been closed but with no recorded closure date, which the Board attributed to clerical errors (footnote 1, see page 2). Our review of information in the Board's database for a random sample of 5 of these complaints identified sufficient information to confirm that 3 of these complaints should be reflected as closed, even though the closure dates were missing.[19] However, there was insufficient information in the Board's database to confirm whether the other 2 complaints should be reflected as closed. Without documented information regarding a complaint's closure and the reasons for closing the complaint, the Board potentially cannot ensure the timeliness and appropriateness of these closures. According to the Board, complaints without a recorded closure date are the result of errors from transferring files from its old database to its new database or staff data entry errors. The Board reported that it is reviewing some of the complaints without a recorded closure date to determine whether it can manually correct the information or if it needs to take additional steps if necessary, such as a Board review of the complaint.

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[16] The Board reported that APCs have a lower caseload expectation than SIs because they handle more complex complaint investigations and work with licensees' legal counsel.

[17] During the 2024 legislative session, the Legislature introduced House Bill 2686, which if enacted would establish complaint-handling procedures and time frames for health profession regulatory boards, including this Board. Additionally, this bill includes a fiscal note that outlines the Board's estimated costs for an additional 5 APCs and 5 SIs.

[18] State of Arizona *Annual Financial Report* for fiscal years 2021 and 2023.

[19] The Board received the 5 complaints in our random sample between March 2017 and February 2021.

Board did not appropriately triage, review, and investigate 2 complaints alleging unprofessional conduct, potentially jeopardizing public safety—Our review of a sample of 18 complaints the Board received, triaged, and determined not to investigate found 2 complaints that, according to Board policy, Board staff should have investigated because of allegations involving unprofessional conduct, including allegations that licensees stole medication from their workplace for either personal use or to distribute to children (see textbox below for more information on these 2 complaints).[20,21] These 2 complaints were open for 54 and 83 days, respectively, before Board staff determined not to investigate them. By determining not to investigate these complaints, the Board did not protect the public by ensuring these licensees were qualified to practice. After we brought these 2 complaints to Board staff's attention, they confirmed that the 2 complaints should have been investigated and reopened them for investigation in September 2023. Board staff further explained that the former Board employee responsible for triaging complaints and determining not to investigate them did not adhere to the Board's policies and procedures.

Board did not investigate 2 complaints alleging licensees engaged in unprofessional conduct, in accordance with its policies and procedures

Complaint 1—The Board received a complaint in January 2023 alleging unprofessional conduct, including child abuse, theft of medication from the workplace, and distribution of medication to the licensee's children.[1] Two months later, in March 2023, Board staff closed this complaint without an investigation, stating it should be closed because it was a duplicate complaint and a family issue and therefore should be resolved in family court. However, even though the Board received a subsequent complaint a month later with similar allegations, Board staff closed both the January 2023 complaint and the subsequent complaint it received.[2] Additionally, although the complainant self-identified as the licensee's family member, Board policy does not identify such a relationship as a valid reason for closing a complaint without an investigation. Therefore, Board staff should have opened an investigation for this complaint. After we informed the Board, it opened an investigation in September 2023. The Board reviewed and dismissed the complaint in January 2024 after it did not substantiate the allegations. Specifically, according to the Board's investigative report, Board investigators spoke with the licensee's employer, who researched the matter and did not substantiate the medication theft allegations. Additionally, the investigative report notes that the Arizona Department of Child Safety did not substantiate the allegations of suspected child abuse.

Complaint 2—The Board received a complaint in May 2022 alleging unprofessional conduct, including theft of medication from the licensee's workplace for personal use or to sell to other individuals, and providing sufficient information to open a complaint investigation. However, 3 months later in August 2022, Board staff closed this complaint without an investigation. Because the staff person who closed this complaint is no longer with the Board, current Board staff were unable to explain the reason for closing this complaint without an investigation. Furthermore, a second complaint against the same licensee was received by the Board in August 2022, 1 day prior to Board staff closing both complaints, which included the same allegations as the initial complaint. After we informed the Board, it opened an investigation in September 2023 but does not have an expected date for Board review.

[1] According to Board documentation, the complainant also referred this complaint to the Arizona Department of Child Safety.

[2] Our review of the licensee's disciplinary history identified another complaint the Board received in February 2023 that included similar allegations from a different complainant that the Board received, triaged, and closed without an investigation, stating it was a family law matter.

Source: Auditor General staff review of Board policies, complaint database, and A.R.S. §§32-1601 and 32-1660.

[20] We originally generated a random sample of 45 complaints from a population of 3,708 complaints that were closed without a Board investigation between March 1, 2022 and March 17, 2023, for review. However, based on our initial review of the sample and clarification the Board provided, we determined the Board categorized and grouped background checks/application concerns with public complaints. Consequently, the random sample of 45 complaints consisted of 18 public complaints and 27 application background check/application concerns. Additionally, the 18 public complaints we reviewed were open between 15 and 106 days before the Board triaged and determined not to investigate them.

[21] A.R.S. §§32-1601(27), 32-1660(A)(2), and 32-1663, and AAC R4-19-403(16).

Additionally, the Board's policies and procedures do not require a secondary review of staff determinations to not investigate complaints. A secondary review would help ensure the appropriateness of complaint triage decisions, including investigating all complaints that include allegations that licensees engaged in unprofessional conduct. Board staff reported that supervisors now review all public complaints that Board staff initially determine not to investigate.

Board should implement recommendations from 2021 audit and address additional deficiencies identified in this followup

To better protect the public's health, safety, and welfare, the Board should implement the 3 remaining applicable and 1 not yet applicable recommendation from the 2021 performance audit and sunset review and also address the additional deficiencies we identified in this follow-up report. Specifically, the Board should:

- Consistently document all investigative activities and time frames, such as if and when it refers complaints to the Arizona Attorney General to pursue a settlement or formal hearing with the Arizona Office of Administrative Hearings. If necessary, the Board should revise its policies and procedures to include this requirement.
- Continue to assess the cost and feasibility of contracting for investigators, including determining whether it has any staff vacancy savings it can redirect for this purpose.
- Perform a risk-based review of complaints Board staff failed to investigate to determine if Board policies and procedures require the allegations to be investigated, and complete complaint investigations for any complaints it identifies that should have been investigated. Risk factors for identifying complaints for Board review should include the time period during which the former employee incorrectly triaged complaints and the length of time a complaint was open before a determination was made not to open an investigation.
- Revise and implement its complaint triage policies and procedures to require a supervisory review of complaints that are initially determined not to require an investigation to help ensure the appropriateness of complaint triage decisions.