

**DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO**

PANEL:	Robert MacKay, Chairperson	Public Member
	Renate Davidson	Public Member
	Terry Holland, RPN	Member
	George Rudanycz, RN	Member
	Heather Stevanka, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO)	<u>JESSICA LATIMER</u> for
)	College of Nurses of Ontario
- and -)	
)	
ROSEANNE TOTH)	<u>DANIELLE BISNAR</u> for
Reg. No. 0428995)	Roseanne Toth
)	
)	
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)	
)	Heard: January 30, 2017

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the “Panel”) on January 30, 2017 at the College of Nurses of Ontario (“the College”) at Toronto.

The Allegations

The allegations against Roseanne Toth (the “Member”) as stated in the Notice of Hearing dated October 7, 2016 are as follows.

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(a) of the *Health Professions Procedural Code of the Nursing Act, 1991*, S.O. 1991, c. 32, as amended, in that, on May 25, 2015, you were found guilty of an offence relevant to your suitability to practise, and in particular, in the Ontario Court of Justice, in St. Catharines, Ontario, you were found guilty of operating a vessel while impaired by alcohol, contrary to section 253(1)(b) of the *Criminal Code*.
2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code of the Nursing Act, 1991*, S.O. 1991,

c. 32, as amended, and defined in subsection 1(18) of *Ontario Regulation 799/93*, in that, between March 2010-January 2011, you contravened a term, condition or limitation of your certificate of registration, as provided by section 5(3)3. of *Ontario Regulation 275/94* of the *Nursing Act, 1991*, as it was at that time, with respect to failing to provide the College with details of a proceeding for professional misconduct, incompetency or incapacity, and in particular, the proceeding in Florida that resulted in the Order of the State of Florida Board of Nursing on January 4, 2011.

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(18) of *Ontario Regulation 799/93*, in that, on or around January 4, 2011, you contravened a term, condition or limitation of your certificate of registration, as provided by section 5(3)2. of *Ontario Regulation 275/94* of the *Nursing Act, 1991*, as it was at that time, with respect to failing to provide the College with details of a finding of professional misconduct, incompetency or incapacity, and in particular, the Order of the State of Florida Board of Nursing on January 4, 2011.
4. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(23) of *Ontario Regulation 799/93*, in that, in or around November 2010, you failed to take reasonable steps to ensure that information you were required to provide to the College pursuant to section 1.5(1)2. of *Ontario Regulation 275/94* of the *Nursing Act, 1991* was provided in a complete and accurate manner, and in particular, you indicated on your 2011 Annual Membership Renewal form that you were currently practicing nursing, and you listed an employer in Florida as your current employer, at a time when your license to practice nursing in Florida was suspended.
5. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, between March 2010-January 2011, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional, and in particular, you failed to provide the College with details of:
 - a. a proceeding for professional misconduct, incompetency or incapacity, and in particular, the proceeding in Florida that resulted in the Order of the State of Florida Board of Nursing on January 4, 2011; and
 - b. a finding of professional misconduct, incompetency or incapacity, and in particular, the Order of the State of Florida Board of Nursing on January 4, 2011.

Member's Plea

The Member admitted the allegations set out in paragraphs numbered 1, 2, 3, 4, and 5 (a) and (b)

in the Notice of Hearing. The Panel conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts (ASF)

Counsel for the College and the Member advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads as follows.

THE MEMBER

1. Roseanne Toth (the "Member") obtained a diploma in nursing from Niagara County Community College in New York in 2002.
2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Practical Nurse ("RPN") in the General Class in February 2001. Her RPN certificate of registration ("certificate") was suspended for non-payment of fees from May 2004 until February 2013, when she resigned her RPN certificate.
3. The Member registered with the College as an RN in the General Class in August 2004. Her RN certificate was suspended for non-payment of fees between April 2008 and November 2008, but has otherwise remained active since that time.
4. The Member is currently employed as an RN at the Niagara Health System, Welland Site, and has been employed there on a full-time basis since June 2012.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Proceeding and Finding of Professional Misconduct in Florida Not Reported to the College

5. The Member was initially licensed as an RN in Florida in October 2008.
6. On or about October 7, 2009, the Member provided a urine sample for a pre-employment drug screen at Wellington Regional Medical Center. The urine sample tested positive for cocaine metabolites.
7. If the Member were to testify, she would say that she did not use cocaine prior to the positive urine sample taken on October 7, 2009. She would also testify that the positive sample on October 7, 2009 was the only positive result she ever received out of approximately 200 employment-related drug screens, including random testing.
8. On or about January 21, 2010, the Member was notified by the State of Florida Department of Health (the "Department of Health") that she tested positive for cocaine and was given 20 days to respond with a prescription and a legitimate medical reason for using the cocaine. None was provided.
9. As a result, on March 9, 2010, an Order of Emergency Suspension of Licence was issued by the Department of Health, which suspended the Member's licence to

practise nursing in Florida immediately. The Order further stated that a proceeding seeking a formal suspension or discipline of the Member's licence to practise as an RN would be instituted promptly.

10. The matter appeared before the State of Florida Board of Nursing (the "Board") on December 2, 2010. The Member did not dispute the facts set out by the Department of Health and on January 4, 2011 the Board issued an order ("Order") finding that the Member violated certain sections of the Florida Statutes. The Board ordered the following as a result:
 - the Member's licence was reprimanded;
 - the Member was to pay an administrative fine of \$250 and investigative costs of \$3,592.93;
 - the Member's licence was suspended and would remain suspended until she entered the Intervention Project for Nurses ("IPN") and complied with all terms and conditions imposed by the IPN. As long as the Member participated in the IPN, her suspension would be stayed; and
 - to be reinstated and remove the Order, the Member would need to appear before the Board to demonstrate her ability to engage in the safe practice of nursing, which would include two years of documented continuous sobriety.
11. The above Order of the Board on January 4, 2011 constitutes a finding of professional misconduct.
12. The Member failed to report to the College that a proceeding had been initiated against her in Florida, and that a finding had been made against her as a result of the proceeding, which resulted in the January 4, 2011 Order of the Board.
13. If the Member were to testify, she would state that she had no intention of misleading the College by failing to report the proceeding and the finding in Florida. The Member was not aware of her obligation to report proceedings and findings in another jurisdiction to the College, and this oversight occurred at a time when she was not residing or practising nursing in Ontario. However, the Member now admits that it was her responsibility to be aware of the terms, conditions and limitations on her certificate that required such reporting, and that she should have reported both the proceeding and the finding to the College pursuant to *Ontario Regulation 275/94*.

Inaccurate Information Reported by the Member on her 2011 Annual Membership Renewal

14. The Member participated in the IPN program from approximately February 22, 2011 until May 24, 2012, and as a result, she was entitled to practise during that time. The Member's licence was suspended again on May 29, 2012, when the IPN program was discontinued as the Member had chosen to move out of Florida.

15. On the Member's 2011 Annual Membership Renewal, which was submitted by the Member on November 18, 2010, she indicated that she was currently practising nursing and listed the Medical Staffing Network in Boca Raton, Florida, as her nursing employer, even though she had been suspended by the Board and did not have her suspension lifted until February 22, 2011.
16. If the Member were to testify, again, she would say that she had no intention of misleading the College when she filled out her 2011 Annual Membership Renewal form and that she had just made an error. The Member now admits that it was her responsibility to ensure that the form was completed accurately before submitting it, and that she should have done so at the time.

Finding of Guilt in Ontario

17. In August 2014, the Member was stopped by the Marine Unit of the Niagara Regional Police on Lake Erie and was criminally charged with operating a vessel while impaired by alcohol over the legal limit.
18. At trial, the court found that the Member had been operating the boat that she owned, with other passengers on board, while under the influence of alcohol above the legal limit.
19. As a result of the finding of guilt, the Member was fined \$1,200 and prohibited from operating a vessel for one year from May 25, 2015.
20. The Member reported both the charge and the finding of guilt to the College, as required.
21. The Member appealed the decision, and the appeal was dismissed on February 12, 2016.
22. If the Member were to testify, she would say that she regrets her conduct, but admits that the conviction is relevant to her suitability to practise in that it reflects a disregard for public safety, which would not encourage public trust in the nursing profession.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

23. The Member admits that she committed the act of professional misconduct as alleged in paragraph 1 of the Notice of Hearing, and as described in paragraphs 17 to 22 above, in that she was found guilty of operating a vessel while impaired by alcohol, contrary to s. 253(1)(b) of the *Criminal Code*, which is relevant to her suitability to practise nursing.
24. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2 and 3 of the Notice of Hearing, and as described in paragraphs 5 to 13 above, in that she failed to provide the College with details of a proceeding for professional misconduct, as well as details of a finding of professional misconduct, which contravened a term, condition or limitation on her certificate of

registration. The Member further admits that she committed the acts of professional misconduct in paragraphs 5(a) and (b) of the Notice of Hearing, and in particular, that the conduct would reasonably be regarded by members of the profession as unprofessional.

25. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 4 of the Notice of Hearing, and as described in paragraphs 144 to 16 above, in that she failed to complete her 2011 Annual Membership Renewal form accurately by indicating that she was currently practising nursing and listing the Medical Staffing Network as her nursing employer when her licence in Florida was suspended at the time.

Decision

The Panel found that the Member committed acts of professional misconduct as alleged in paragraphs 1, 2, 3, 4, and 5 (a) and (b) of the Notice of Hearing. As to allegation #5, the Panel found that the Member engaged in conduct that would reasonably be considered by members of the profession to be unprofessional.

Reasons for Decision

The Panel considered the Agreed Statement of Facts and the Member's plea and found that this evidence supports findings of professional misconduct as alleged in the Notice of Hearing.

Allegation #1 in the Notice of Hearing is supported by paragraphs 17, 18, 19, 20, 21 and 22 in the Agreed Statement of Facts. The Member was found guilty of the criminal offence of operating a motor boat while her blood alcohol level was above the legal limit. The Panel agrees with the Member's admission that this offence is relevant to her suitability to practise because it shows a disregard for public safety, which is fundamentally contrary to what the public expects of nurses.

Allegations #2 and #3 in the Notice of Hearing are supported by paragraphs 5, 6, 7, 8, 9, 10, 11, 12, and 13 in the Agreed Statement of Facts. These two allegations are connected. At the time these events occurred, the relevant regulation provided that it was a condition of registration with the College that the Member provide the College with details of any finding of professional misconduct, incompetence or incapacity, whether in Ontario or in another jurisdiction and whether in relation to the nursing profession or another health profession; and that the Member provide the College with details of any proceeding for professional misconduct, incompetence or incapacity, whether in Ontario or in another jurisdiction and whether in relation to the nursing profession or another health profession. By failing to report the proceeding in Florida, and the eventual finding of the Florida Nursing Board, the Member committed professional misconduct. As the Member herself now realizes, it is no excuse that she did not know or understand her reporting obligations.

Allegation #4 in the Notice of Hearing is supported by paragraphs 14, 15, and 16 in the Agreed Statement of Facts. By stating on her 2011 Annual Membership Renewal form that she was currently practicing nursing in Florida, when in fact her license to practice nursing in Florida was

suspended, the Member failed to take reasonable steps to ensure that information she was required to provide to the College was accurate.

With respect to Allegation #5 the Panel finds that the Member's failure to report to the College the proceedings against the Member by the State of Florida Board of Nursing and a subsequent finding of professional misconduct was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations. Nurses are required to know and understand their reporting obligations to the College, as this is a fundamental facet of self-governance and accountability.

Penalty

Counsel for the College and the Member advised the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission requests that this Panel make an order as follows.

1. Requiring the Member to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.
2. Directing the Executive Director to suspend the Member's certificate of registration for two months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in the practising class.
3. Directing the Executive Director to impose the following terms, conditions and limitations on the Member's certificate of registration:
 - a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at her own expense and within six months from the date that this Order becomes final. To comply, the Member is required to ensure that:
 - i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;
 - ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:
 1. the Panel's Order,
 2. the Notice of Hearing,
 3. the Agreed Statement of Facts,
 4. this Joint Submission on Order, and
 5. if available, a copy of the Panel's Decision and Reasons;
 - iii. Before the first meeting, the Member reviews the following College publications and completes the associated Reflective Questionnaires, online learning modules and online participation forms (where applicable):

1. *Professional Standards*, and
 2. *Mandatory Reporting*;
- iv. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and online participation forms;
 - v. The subject of the sessions with the Expert will include:
 1. the acts or omissions for which the Member was found to have committed professional misconduct,
 2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,
 3. strategies for preventing the misconduct from recurring,
 4. the publications, questionnaires and modules set out above, and
 5. the development of a learning plan in collaboration with the Expert;
 - vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:
 1. the dates the Member attended the sessions,
 2. that the Expert received the required documents from the Member,
 3. that the Expert reviewed the required documents and subjects with the Member, and
 4. the Expert's assessment of the Member's insight into her behaviour;
 - vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;
- b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:
 - i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;
 - ii. Provide her employer(s) with a copy of:
 1. the Panel's Order,
 2. the Notice of Hearing,

3. the Agreed Statement of Facts,
 4. this Joint Submission on Order, and
 5. a copy of the Panel's Decision and Reasons, once available;
- iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:
1. that they received a copy of the required documents, and
 2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and
4. All documents delivered by the Member to the College, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Penalty Submissions

Counsel for the College submitted that the proposed order is reasonable, in the public interest and addresses the goals of a penalty – general deterrence, specific deterrence, rehabilitation and protection of the public.

Counsel submitted to the Panel that it is expected that panels will accept a joint submission on order unless it is clearly contrary to the public interest or falls so far outside the range of reasonable penalties as to call the administration of justice at the College into disrepute.

The aggravating factors in this case include the nature of the misconduct, which is wide-ranging and includes impaired boating, non-reporting of proceedings against the Member and a finding of professional misconduct in another jurisdiction, and providing inaccurate information to the College on the Member's annual renewal form.

The mitigating factors in this case are that the Member has no previous discipline finding with the College; and the Member has co-operated with the College, has admitted her misconduct and accepted responsibility for her actions.

General and specific deterrence are provided through a reprimand and the two-month suspension.

The proposed penalty provides for remediation and rehabilitation through the terms, conditions, and limitations imposed on the Member's certificate of registration as well as meeting with the Nursing Expert to review the standards of practice.

The public is protected because the Member is required to advise her employer(s) of this decision for an appropriate period of time, i.e. 12 months. This penalty also sends a clear message to the profession about the seriousness of this type of behaviour.

Counsel submitted that allegations of this sort are very fact-specific and as such there are no clear parallel cases. Counsel therefore presented some cases with similarities that would provide a sense of the range of reasonable outcomes for this kind of misconduct.

CNO vs Gary Smith (Discipline Committee, Feb. 2012). This case related to an offence relevant to suitability to practice. There were multiple offences of a more serious nature and the member failed to disclose them to the College. The case ultimately proceeded by way of an ASF and JSO that included a reprimand, suspension of the member's certificate of registration for four months, and the imposition of terms, conditions, and limitations on the member's certificate of registration.

CNO vs Jan Jasper Soriano (Discipline Committee, Feb., 2016). This case related to an offence relevant to suitability to practice and involved assault and possession of a weapon. The member did report the conviction and demonstrated efforts to remediate himself. The case ultimately proceeded by way of an ASF and JSO that included a reprimand, suspension of the member's certificate of registration for two months, and the imposition of terms, conditions, and limitations on the member's certificate of registration.

CNO vs Linda Smith (Discipline Committee, Oct., 2015). This case related to acts of professional misconduct in another jurisdiction. It involved patient care, and failure to inform the College of the investigation and findings of professional misconduct. The member also failed to inform the College of these findings at the time of her reinstatement in Ontario and during subsequent registration renewals. The case ultimately proceeded by way of an ASF and JSO that included a reprimand, suspension of the member's certificate of registration for three months, and the imposition of terms, conditions, and limitations on the Member's certificate of registration.

College Counsel submitted that although the facts were different in the cases cited, they demonstrate that the proposed penalty in this case falls within the range of acceptable outcomes for this type of conduct.

Counsel for the Member submitted that the Member has acknowledged her mistakes. She stated that this case does not cause issues regarding patient care and/or patient safety. She submitted that the Joint Submission on Order is reasonable and in the public interest and should be accepted by the Panel.

Penalty Decision

The Panel accepted the Joint Submission as to Order and accordingly ordered:

1. The Member is required to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.
2. The Executive Director is directed to suspend the Member's certificate of registration for two months. This suspension shall take effect from the date that this Order becomes final

and shall continue to run without interruption as long as the Member remains in the practising class.

3. The Executive Director is directed to impose the following terms, conditions and limitations on the Member's certificate of registration:
 - a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at her own expense and within six months from the date that this Order becomes final. To comply, the Member is required to ensure that:
 - i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;
 - ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:
 1. the Panel's Order,
 2. the Notice of Hearing,
 3. the Agreed Statement of Facts,
 4. this Joint Submission on Order, and
 5. if available, a copy of the Panel's Decision and Reasons;
 - iii. Before the first meeting, the Member reviews the following College publications and completes the associated Reflective Questionnaires, online learning modules and online participation forms (where applicable):
 1. *Professional Standards*, and
 2. *Mandatory Reporting*;
 - iv. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and online participation forms;
 - v. The subject of the sessions with the Expert will include:
 1. the acts or omissions for which the Member was found to have committed professional misconduct,
 2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,
 3. strategies for preventing the misconduct from recurring,
 4. the publications, questionnaires and modules set out above, and
 5. the development of a learning plan in collaboration with the Expert;
 - vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
 2. that the Expert received the required documents from the Member,
 3. that the Expert reviewed the required documents and subjects with the Member, and
 4. the Expert's assessment of the Member's insight into her behaviour;
- vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;
- b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:
- i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;
 - ii. Provide her employer(s) with a copy of:
 1. the Panel's Order,
 2. the Notice of Hearing,
 3. the Agreed Statement of Facts,
 4. this Joint Submission on Order, and
 5. a copy of the Panel's Decision and Reasons, once available;
 - iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:
 1. that they received a copy of the required documents, and
 2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and
4. All documents delivered by the Member to the College, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Reasons for Penalty Decision

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The Panel also considered the penalty in light of the principle that joint submissions should not be interfered with lightly.

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel found that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection.

General and specific deterrence are provided through the reprimand and a two-month suspension of the Member's certificate of registration. It discourages the Member in the future and generally it sends a message to members of the profession that it is their professional and regulatory requirement to complete College forms in a timely, accurate and complete manner, and to ensure compliance with the requirement that proceedings and decisions made in other jurisdictions must be disclosed.

Rehabilitation and remediation is provided through the imposition of terms, conditions and limitations on the Member's certificate of registration that include meeting with a Nursing Expert of review the standards of practice, and mandatory reporting.

The public is protected through the requirement of the Member to inform her employer (s) of this decision for a period of twelve months. This penalty also sends a clear message to the profession about the seriousness of this type of misconduct.

The penalty falls within the range of reasonable outcomes based on previous decisions of the Discipline Committee.

I, Robert MacKay, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel as listed below:

Chairperson

Date

Panel Members:

Robert Mackay, Public Member
Renate Davidson, Public Member
Terry Holland, RPN
George Rudanycz, RN
Heather Stevanka, RN