**ARIZONA STATE BOARD OF NURSING**
**1740 WEST ADAMS STREET, SUITE 2000**
**PHOENIX ARIZONA 85007**
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| IN THE MATTER OF ADVANCED PRACTICE REGISTERED NURSE MIDWIFE CERTIFICATE NO. APRN-CNM250551 AND THE PRIVILEGE TO PRACTICE NURSING UNDER THE NURSE LICENSURE COMPANY IN THE STATE OF ARIZONA, ISSUED TO:<br><br>**WENDY LEE SHAW,**<br><br>RESPONDENT<br><br>ALABAMA NURSE LICENSE NO. RN1-099151 | **FINDINGS OF PUBLIC EMERGENCY AND ORDER OF SUMMARY SUSPENSION**<br><br>**CASE NO. 2024090405** |

On July 23, 2026, the Arizona State Board of Nursing ("Board") met at 1740 West Adams Street, Suite 2000, Phoenix, Arizona 85007, to consider a complaint filed against Wendy Lee Shaw ("Respondent"), the holder of advanced practice registered nurse midwife certificate no. APRN-CNM250551 and privilege to practice nursing under the nurse licensure compact in the State of Arizona. Information was presented to the Board and, as a result, the Board made the following Preliminary Findings of Fact, Conclusions of Law and Order.

## COMPLAINT SUMMARY

1. Complaint #1: On September 18, 2024, the Board received an anonymous complaint alleging that on March 13, 2020, July 8, 2020, June 4, 2023, July 21, 2023 and August 10, 2023, while Respondent was working as a Certified Nurse Midwife (CNM) at Willow Midwife Center for Birth & Wellness (Willow) in Mesa, Arizona, emergency services were dispatched with reports of substandard care of patients during labor resulting in harm to babies. Based upon this information, the Board conducted an investigation.

2. Complaint #2: On January 17, 2025, another state agency reported that it had received a complaint on November 7, 2024, from Patient N.Z., a patient at Willow Midwife Center for Birth and Wellness (Willow) in Mesa, Arizona. Patient N.Z. wrote that she was 42 weeks pregnant when she went into labor, and continued her labor at Willow beginning at noon on November 10, 2023. Patient N.Z. wrote that meconium *(the first stool passed by a newborn baby)* was noted during cervical examinations, but the option to go to the hospital was not offered. Later in the evening, the baby's heart rate decreased and Patient N.Z. was transported to the hospital where she underwent an emergency cesarean-section (C-section) (cesarean section, a surgical procedure used to deliver a baby through an incision in the mother's abdomen and uterus) and her baby was stillborn *(death of the baby before delivery).* Based upon this information, the Board conducted an investigation.

3. Complaint #3 and #4: On February 14, 2025, the Board received a complaint from Patient C.N., a patient at Willow Midwife Center for Birth and Wellness (Willow) in Mesa, Arizona. Patient C.N. wrote that in 2023, she gave birth at Willow at 41 weeks pregnant, where her labor failed to progress, eventually delivering a baby boy who was not breathing. Based upon this information, the Board conducted an investigation.

4. Complaint #5: On June 23, 2025, the Board received a cross report from another state agency alleging while Respondent was working as a Certified Nurse Midwife (CNM) and owner of Willow Midwife Center for Birth & Wellness (Willow) in Mesa, Arizona, Patient N.Q.'s baby was born with thick meconium and respiratory distress requiring emergency transfer to the hospital. Based upon this information, the Board conducted an investigation.

## PRELIMINARY FINDINGS OF FACT

1. On or about August 10, 2023, while Respondent was working as a Certified Nurse Midwife (CNM) at Willow Midwife Center for Birth and Wellness (Willow) in Mesa, Arizona, Respondent assumed responsibility for the intrapartum care of Patient A.S. and was responsible for ongoing assessment and management of maternal and fetal well-being, including fetal surveillance utilizing intermittent auscultation, in accordance with accepted standards of obstetric and nurse-midwifery practice.

During Respondent's period of care, Respondent documented fetal heart tones at approximately 11:30 a.m., 12:00 p.m., 12:23 p.m., 12:40 p.m., 12:44 p.m., 12:51 p.m., 12:58 p.m., 1:08 p.m., 1:15 p.m., and 1:19 p.m. The fetal heart rate was documented as approximately 140 beats per minute during each assessment, except at approximately 12:58 p.m., when Respondent documented a fetal heart rate of approximately 120 beats per minute with an increase to 140 beats per minute. At none of these documented fetal heart rate assessments did Respondent document a concurrent maternal pulse assessment.

Accepted standards of practice for Certified Nurse-Midwives performing intermittent auscultation, including standards recognized by the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) and the American College of Nurse-Midwives (ACNM), require the CNM to perform reliable and accurate fetal surveillance through appropriate assessment, interpretation, and documentation of fetal heart rate findings. Intermittent auscultation requires more than recording a fetal heart rate value; it requires confirmation that the heart rate being assessed is fetal in origin and accurate interpretation of the finding within the clinical context, including maternal condition, uterine activity, labor progress, and any concerning changes in fetal status.

Accepted standards further require assessment and documentation of the maternal pulse at appropriate intervals and whenever confirmation of the source of the auscultated heart rate is clinically indicated. The purpose of concurrent maternal pulse assessment is to distinguish the maternal heart rate from the fetal heart rate and ensure that the documented heart rate reflects the fetus rather than the mother. When a fetal heart rate is obtained by intermittent auscultation without a concurrent maternal pulse assessment, the provider cannot verify that the auscultated heart rate represents fetal cardiac activity rather than maternal cardiac activity. Failure to distinguish the maternal and fetal heart rates may result in inaccurate fetal surveillance, missed recognition of fetal compromise, delayed intervention, and inappropriate clinical decision-making.

The CNM is responsible for ensuring that fetal surveillance findings are sufficiently accurate, clinically meaningful, and contemporaneously documented to support safe intrapartum management. This includes documenting maternal and fetal assessments, identifying abnormal findings, evaluating fetal response to labor, and maintaining a record that demonstrates appropriate monitoring and clinical judgment throughout labor.

Respondent failed to comply with these accepted standards by documenting multiple fetal heart rate assessments without performing or documenting concurrent maternal pulse assessments. As a result, the medical record does not demonstrate that Respondent verified the auscultated heart rates represented fetal heart rates rather than maternal heart rates. Respondent failed to establish reliable fetal surveillance, failed to document complete maternal and fetal assessments necessary to support interpretation of fetal status, and failed to maintain documentation sufficient to demonstrate compliance with accepted standards of intermittent

auscultation. These failures constituted a departure from accepted obstetric and nurse-midwifery standards governing intrapartum fetal monitoring and fetal assessment.

2. On or about August 10, 2023, while Respondent was working as a Certified Nurse Midwife (CNM) at Willow Midwife Center for Birth and Wellness (Willow) in Mesa, Arizona, Respondent assumed responsibility for the intrapartum care of Patient A.S., and was responsible for ongoing assessment and management of maternal and fetal well-being, labor, delivery, and emergency transfer and the reproduction of reliable clinical events.

The contemporaneous medical record contains multiple material inconsistencies that impair reliable reconstruction of the clinical course. Respondent's November 14, 2024 retrospective statement conflicts with contemporaneous chart documentation regarding the timing of EMS activation, initiation of oxygen therapy, notification of the NICU, EMS departure, and hospital arrival. Because neonatal resuscitation and emergency transport are time-sensitive clinical events, these conflicting accounts prevent reliable determination of when critical interventions occurred, whether escalation of care was timely, and whether the infant received appropriate resuscitation and transfer support.

The delivery record also contains internally inconsistent documentation regarding umbilical cord management. Two entries document that the umbilical cord was double clamped and cut at approximately four minutes after birth, while another entry records a cord cut time of 1:23:50 p.m. with "minutes until cord cut: 0." These entries cannot both be accurate. Accurate documentation of cord management is clinically significant because the infant was nonvigorous at birth and required resuscitation. The conflicting documentation prevents reliable reconstruction of the sequence of birth, delayed cord clamping, cord cutting, and initiation of neonatal resuscitative interventions.

The record contains inconsistent documentation regarding placental delivery. One portion of the record identifies the placenta as delivered by the Duncan mechanism (maternal side first), while another identifies the delivery as Schultz (fetal side first). These mechanisms are clinically distinct and cannot both accurately describe the same delivery. Accurate documentation of placental delivery is relevant to assessment of placental completeness, retained placental tissue or membranes, and postpartum hemorrhage risk. The inconsistent documentation impairs evaluation of whether the placenta and membranes were adequately assessed and whether postpartum hemorrhage risk was appropriately recognized and managed.

These inconsistencies render the medical record an unreliable chronology of labor, delivery, neonatal resuscitation, and emergency transfer, limiting the ability to accurately reconstruct the clinical events and evaluate the appropriateness and timeliness of care.

The standard of practice requires that the Certified Nurse-Midwife maintain an accurate, contemporaneous, complete, and internally consistent medical record that reliably documents the clinical course, assessments, interventions, clinical decision-making, communications, and patient response. Documentation must accurately reflect the timing and sequence of significant clinical events, particularly during obstetric emergencies and neonatal resuscitation, because these records are essential for continuity of care, clinical decision-making, patient safety, and quality review.

The standard also requires that documentation of labor, delivery, placental delivery, neonatal resuscitation, and emergency transfer be sufficiently accurate to permit reliable reconstruction of the clinical course. Material discrepancies regarding critical interventions, timelines, or clinical findings should be reconciled promptly and corrected in accordance with

accepted documentation practices. Retrospective statements should not conflict with contemporaneous medical records without clear explanation or supporting documentation.

Respondent failed to meet the applicable standard of practice when she failed to maintain an accurate, contemporaneous, complete, and internally consistent medical record that reliably documented the clinical course. Respondent documented conflicting timelines regarding EMS activation, initiation of oxygen therapy, NICU notification, EMS departure, and hospital arrival without reconciliation or explanation. These inconsistencies prevented reliable determination of when critical interventions occurred and whether escalation of care and neonatal resuscitation were timely and appropriate.

Respondent further failed to meet the standard of practice when she documented contradictory information regarding umbilical cord management. The medical record contains entries stating that the cord was double clamped and cut at approximately four minutes after birth, while another entry documents a cord cut time of 1:23:50 p.m. with "minutes until cord cut: 0." These entries cannot both be accurate. Because the infant required resuscitation, accurate documentation of cord management was necessary to establish the sequence of birth and resuscitative interventions.

Respondent also failed to meet the standard of practice when she documented inconsistent placental delivery mechanisms without clarification or correction. The record identifies the placenta as both Duncan and Schultz delivery, which are mutually exclusive mechanisms. This inconsistency impaired assessment of placental completeness, retained tissue risk, and postpartum hemorrhage risk.

Respondent failed to meet the standard of practice when her November 14, 2024 retrospective statement conflicted with the contemporaneous medical record without

documented reconciliation. Rather than clarifying the clinical course, the retrospective statement introduced additional discrepancies that further undermined the reliability and integrity of the medical record.

3. On or about June 3 through June 4, 2023, while Respondent was working as a Certified Nurse Midwife (CNM) at Willow Midwife Center for Birth and Wellness (Willow) in Mesa, Arizona, Respondent was providing intrapartum care to Patient C.N. at Willow and was responsible for the ongoing assessment, documentation, and management of labor progression in accordance with accepted standards of obstetric and nurse-midwifery practice.

The labor record demonstrated inconsistent, non-linear documentation of labor progression, with significant discrepancies in cervical examinations, stage assignment, and overall labor progress. At approximately 6:10 p.m. on June 3, 2023, Patient C.N.'s cervix was documented as 9 centimeters dilated, 100 percent effaced, and at 0 station. Despite incomplete cervical dilation, the labor record documented that Patient C.N. began pushing before complete cervical dilation was achieved. At approximately 8:30 p.m., the cervix continued to be documented as having an anterior lip, reflecting only minimal cervical change over approximately two and one-half hours. Complete cervical dilation was not documented until approximately 1:10 a.m. on June 4, 2023. Delivery occurred at approximately 7:48 a.m., resulting in approximately seven hours for progression from documentation of 9-centimeter dilation to complete cervical dilation, approximately six hours and thirty-eight minutes of second-stage labor, and approximately thirteen and one-half hours from documentation of 9-centimeter dilation until delivery.

The expert CNM consultant concluded that the labor record demonstrated a profound breakdown in obstetric judgment. Respondent:

a. Failed to recognize prolonged labor despite documentation reflecting approximately seven hours for progression from 9-centimeter cervical dilation to complete cervical dilation, approximately six hours and thirty-eight minutes of second-stage labor, and approximately thirteen and one-half hours from documentation of 9-centimeter dilation until delivery;

b. Failed to recognize, diagnose, and appropriately manage labor dystocia despite prolonged labor progression and minimal cervical change over several hours;

c. Failed to apply accepted evidence-based labor progression standards, including recognized labor progression frameworks such as the Friedman and Zhang labor curves, to objectively assess labor progression and identify abnormal labor patterns;

d. Permitted Patient C.N. to begin pushing before complete cervical dilation in contravention of accepted obstetrical standards defining the second stage of labor;

e. Failed to objectively document labor progression in a manner sufficient to accurately assess cervical change, fetal descent, and stage of labor or to timely recognize abnormal labor progression.

f. Failed to recognize and appropriately respond to prolonged labor progression, thereby increasing the risk of impaired uteroplacental perfusion, fetal hypoxia, fetal compromise, and preventable fetal injury.

The expert CNM consultant concluded that these cumulative deficiencies constituted significant departures from accepted standards governing labor progression, recognition and

management of labor dystocia, and obstetric and nurse-midwifery management of intrapartum care.

Accepted standards of practice for Certified Nurse-Midwives (CNMs), including those established by the American College of Nurse-Midwives (ACNM) and the American College of Obstetricians and Gynecologists (ACOG), require the CNM to continuously assess, accurately document, and critically evaluate maternal and fetal status and labor progress throughout the intrapartum period. Labor progress must be assessed through serial cervical examinations, fetal descent and position, contraction pattern, maternal condition, and fetal well-being. The CNM is responsible for recognizing when labor deviates from the expected physiologic course, identifying prolonged or abnormal labor patterns and labor dystocia, reassessing the appropriateness of continued out-of-hospital management, implementing appropriate interventions within the CNM's scope of practice, obtaining consultation when indicated, and initiating timely transfer to a higher level of care when the clinical circumstances exceed the capabilities of the birth center.

Accepted obstetrical standards define the second stage of labor as beginning only after complete cervical dilation has been confirmed. Maternal pushing efforts should not be initiated or encouraged before complete cervical dilation except in rare emergent circumstances that are clearly documented and clinically justified. Allowing or directing a patient to push against an incompletely dilated cervix is contrary to accepted obstetrical and nurse-midwifery practice because it increases the risk of cervical edema, cervical laceration, maternal exhaustion, prolonged labor, failure of fetal descent, impaired uteroplacental perfusion, fetal hypoxia, fetal compromise, and the need for operative delivery.

The CNM is further responsible for maintaining an accurate, chronological, and internally consistent medical record that objectively reflects labor progression. Documentation must accurately identify cervical dilation, effacement, fetal station, stage of labor, maternal assessments, fetal assessments, interventions performed, the patient's response to those interventions, and the clinical rationale supporting ongoing management decisions. Significant discrepancies or inconsistencies in documentation that prevent accurate determination of labor progression interfere with appropriate clinical decision-making, delay recognition of labor abnormalities, compromise continuity of care, and impair the ability of subsequent providers to evaluate the patient's condition.

Respondent failed to comply with these standards by failing to accurately recognize, document, and appropriately manage abnormal labor progression. Specifically, Respondent failed to recognize that the labor record reflected prolonged labor despite approximately seven hours between documentation of 9-centimeter cervical dilation and complete dilation, approximately six hours and thirty-eight minutes of second-stage labor, and approximately thirteen and one-half hours from documentation of 9-centimeter dilation until delivery. Respondent failed to recognize and appropriately manage labor dystocia, permitted Patient C.N. to begin pushing before complete cervical dilation despite persistent documentation of an anterior cervical lip, failed to maintain an accurate and internally consistent medical record reflecting labor progression, and failed to reassess whether continued management in the birth center remained appropriate in light of the prolonged labor course. These failures delayed recognition of an abnormal labor pattern and increased the risk of maternal morbidity, impaired uteroplacental perfusion, fetal hypoxia, fetal compromise, and preventable fetal injury.

4. On or about June 3 through June 4, 2023, while Respondent was working as a Certified Nurse Midwife (CNM) at Willow Midwife Center for Birth and Wellness (Willow) in Mesa, Arizona, Respondent was responsible for providing intrapartum care to Patient C.N., including ongoing fetal surveillance utilizing intermittent auscultation throughout labor in accordance with accepted standards of obstetric and nurse-midwifery practice.

The labor record documents thirty-eight (38) separate fetal heart rate assessments spanning approximately fourteen hours of labor. Specifically, fetal heart rate assessments were documented on June 3, 2023, at approximately 4:38 p.m., 4:54 p.m., 5:03 p.m., 5:27 p.m., 6:10 p.m., 6:20 p.m., 6:21 p.m., 6:36 p.m., 6:57 p.m., 7:30 p.m., 8:20 p.m., 9:00 p.m., 9:36 p.m., 10:05 p.m., 11:11 p.m., 11:33 p.m., 11:40 p.m., and 11:52 p.m. On June 4, 2023, additional fetal heart rate assessments were documented at approximately 12:10 a.m., 12:20 a.m., 12:41 a.m., 1:10 a.m., 1:25 a.m., 1:40 a.m., 1:55 a.m., 2:06 a.m., 2:24 a.m., 2:45 a.m., 4:45 a.m., 5:00 a.m., 5:17 a.m., 5:30 a.m., 5:45 a.m., 6:00 a.m., 6:15 a.m., 6:30 a.m., 6:45 a.m., and 7:00 a.m.

At none of these thirty-eight documented fetal heart rate assessments did Respondent document the maternal heart rate or maternal pulse. The absence of maternal pulse documentation was not an isolated omission but a continuous pattern throughout the course of labor. Because maternal pulse was neither obtained nor documented during any fetal heart rate assessment, the record does not establish that the auscultated heart rate represented the fetus rather than the mother, thereby significantly compromising the reliability of the intermittent auscultation performed.

The labor record further reflects inconsistent and incomplete fetal surveillance documentation, including failure to consistently document fetal heart rate variability, contraction timing in relation to fetal heart rate assessments, baseline fetal heart rate

interpretation, evaluation for decelerations, and interpretation of fetal heart rate patterns. The expert CNM consultant further concluded that Respondent failed to recognize episodes of absent fetal heart rate variability, failed to appropriately interpret concerning fetal heart rate findings and their clinical significance, failed to implement and document appropriate intrauterine resuscitative measures despite concerning fetal heart rate findings, failed to escalate and document escalation of care despite concerning fetal assessment findings, and failed to consider or initiate transfer to a higher level of care in accordance with accepted obstetrical and nurse-midwifery standards. The labor record also contains an approximately eighteen-minute gap in fetal heart rate assessment immediately preceding delivery.

The expert CNM consultant identified the approximately eighteen-minute lapse in fetal heart rate assessment immediately before delivery as a period during which acute fetal compromise could have occurred without detection. The consultant further concluded that Respondent's repeated failure to document maternal pulse concurrently with fetal heart rate assessments significantly compromised the reliability of intermittent auscultation because it prevented verification that the auscultated heart rate represented the fetus rather than the mother.

The expert CNM consultant concluded that Respondent failed to perform, document, interpret, recognize, and respond to intrapartum fetal surveillance in accordance with accepted professional standards. Specifically, Respondent:

a. Failed to document maternal pulse concurrently with any of the thirty-eight (38) documented fetal heart rate assessments, thereby failing to verify that the auscultated heart rate represented the fetus rather than the mother;

b. Failed to adequately document fetal heart rate characteristics, contraction timing, baseline fetal heart rate interpretation, fetal heart rate variability, and evaluation for decelerations as required for reliable intermittent auscultation;

c. Failed to recognize episodes of absent fetal heart rate variability and failed to appropriately interpret concerning fetal heart rate findings and their clinical significance;

d. Failed to implement and document appropriate intrauterine resuscitative measures despite concerning fetal heart rate findings;

e. Failed to recognize the need for, escalate, and document escalation of care despite concerning fetal assessment findings;

f. Failed to consider or initiate transfer to a higher level of care despite concerning fetal findings consistent with accepted obstetrical and nurse-midwifery standards; and

g. Failed to perform continuous and reliable fetal surveillance during the approximately eighteen-minute period immediately preceding delivery, a period during which, according to the expert CNM consultant, acute fetal compromise could have occurred without detection.

The expert CNM consultant concluded that these cumulative deficiencies constituted significant departures from accepted standards governing intermittent auscultation, intrapartum fetal surveillance, obstetric emergency recognition, and obstetric and nurse-midwifery management of potentially compromised fetuses.

Accepted standards of practice for Certified Nurse-Midwives (CNMs), including those established by the American College of Nurse-Midwives (ACNM), the Association of Women's

Health, Obstetric and Neonatal Nurses (AWHONN), and the American College of Obstetricians and Gynecologists (ACOG), require that intermittent auscultation be performed as a systematic process of intrapartum fetal surveillance rather than merely recording a numerical fetal heart rate. The CNM is responsible for obtaining sufficient clinical information to accurately evaluate fetal well-being, including assessment of the fetal heart rate in relation to uterine contractions, determination of the baseline fetal heart rate, assessment of fetal heart rate rhythm and variability when clinically assessable by intermittent auscultation, evaluation for accelerations and decelerations, assessment of maternal status, contraction pattern, and labor progress, and integration of those findings into ongoing clinical decision-making. The CNM must recognize changes in fetal status, determine their clinical significance, initiate appropriate intrauterine resuscitative measures, obtain consultation when indicated, and timely escalate care or initiate transfer to a higher level of care when maternal or fetal conditions exceed the capabilities of the birth center.

Accepted standards of practice require the CNM to distinguish the fetal heart rate from the maternal heart rate whenever there is uncertainty regarding the source of the auscultated heart rate or when abnormal fetal heart rate findings are identified. AWHONN and ACNM recognize concurrent maternal pulse assessment as the accepted method for confirming that the heart rate obtained by intermittent auscultation represents the fetus rather than the mother. In the absence of concurrent maternal pulse assessment when clinically indicated, the provider cannot verify that the auscultated heart rate is fetal, thereby compromising the reliability of fetal surveillance and increasing the risk that fetal compromise may go unrecognized. The CNM is further responsible for accurately and contemporaneously documenting all clinically significant maternal and fetal assessments, interpretations, interventions, patient responses, and clinical

decision-making sufficient to demonstrate that accepted standards of fetal surveillance have been met.

The standard of practice further requires that fetal surveillance become increasingly vigilant as labor progresses, particularly during the second stage of labor and immediately preceding delivery, when the risk of acute fetal deterioration increases. Prolonged intervals without fetal assessment, incomplete documentation of fetal status, failure to recognize abnormal fetal heart rate findings, or failure to respond appropriately to concerning fetal assessments may delay recognition of fetal hypoxia, acidemia, or other obstetric emergencies, thereby increasing the risk of preventable fetal injury.

Respondent failed to comply with these accepted standards. Throughout approximately fourteen hours of labor, Respondent documented thirty-eight separate fetal heart rate assessments without documenting a single concurrent maternal pulse assessment, thereby failing to verify that the auscultated heart rate represented the fetus rather than the mother whenever confirmation was clinically indicated. Respondent further failed to consistently document essential components of intermittent auscultation, including interpretation of the baseline fetal heart rate, fetal heart rate characteristics, relationship of the fetal heart rate to uterine contractions, evaluation for decelerations, and clinically meaningful assessment of fetal status. Respondent failed to recognize and appropriately interpret concerning fetal heart rate findings, including episodes identified by the expert consultant as demonstrating absent fetal heart rate variability, failed to implement and document appropriate intrauterine resuscitative measures, failed to reassess and escalate care despite concerning fetal findings, and failed to consider or initiate transfer to a higher level of care despite evidence of potential fetal compromise. Respondent additionally failed to perform and document fetal surveillance during

the approximately eighteen-minute period immediately preceding delivery, a critical period during which acute fetal deterioration could have occurred without detection. Collectively, these failures constituted significant departures from accepted standards governing intermittent auscultation, intrapartum fetal surveillance, recognition of fetal compromise, and Certified Nurse-Midwife management of laboring patients.

5. On or about June 4, 2023, while Respondent was working as a Certified Nurse Midwife (CNM) at Willow Midwife Center for Birth and Wellness (Willow) in Mesa, Arizona, during the delivery of Patient C.N.'s infant at Willow Midwife Center for Birth and Wellness, Respondent was responsible for recognizing, managing, and documenting obstetrical emergencies, including shoulder dystocia, in accordance with accepted standards of obstetric and nurse-midwifery practice.

The delivery record documents an interval of approximately two minutes and forty-five seconds between delivery of the fetal head and delivery of the remainder of the infant's body. The expert CNM consultant concluded that, under normal obstetrical circumstances, restitution and delivery of the shoulders typically occur within approximately thirty seconds after delivery of the fetal head. According to the consultant, a head-to-body interval of approximately two minutes and forty-five seconds is highly suspicious for shoulder dystocia until proven otherwise.

The medical record contains no documentation recognizing shoulder dystocia and no documentation that accepted shoulder dystocia maneuvers, including McRoberts positioning, suprapubic pressure, rotational maneuvers, or delivery of the posterior arm, were performed.

The expert CNM consultant concluded that Respondent failed to recognize, document, and appropriately manage a prolonged head-to-body delivery interval highly suspicious for shoulder dystocia. Respondent:

a. Failed to recognize that the approximately two-minute and forty-five-second interval between delivery of the fetal head and delivery of the infant's body was highly suspicious for shoulder dystocia until proven otherwise;

b. Failed to recognize and document shoulder dystocia as an obstetrical emergency;

c. Failed to document performance of accepted shoulder dystocia maneuvers, including McRoberts positioning, suprapubic pressure, rotational maneuvers, or delivery of the posterior arm;

d. Failed to document an organized emergency response consistent with accepted obstetrical management of suspected shoulder dystocia; and

e. Failed to appropriately manage and document an obstetrical emergency in accordance with accepted standards of obstetric and nurse-midwifery practice.

The expert CNM consultant concluded that these cumulative deficiencies constituted significant departures from accepted standards governing recognition, management, and documentation of shoulder dystocia and obstetrical emergencies.

Accepted standards of practice for Certified Nurse-Midwives (CNMs), including standards established by the American College of Nurse-Midwives (ACNM), the American College of Obstetricians and Gynecologists (ACOG), and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), require the CNM to promptly recognize, respond to, and appropriately manage obstetrical emergencies occurring during labor and delivery. Shoulder dystocia is a time-critical obstetrical emergency that occurs when the fetal anterior

shoulder becomes impacted behind the maternal pubic symphysis after delivery of the fetal head, preventing delivery of the remainder of the infant's body. The CNM must recognize clinical indicators suggestive of shoulder dystocia, including a prolonged interval between delivery of the fetal head and delivery of the body, failure of restitution or external rotation of the fetal head, and difficulty with delivery of the shoulders. When shoulder dystocia is suspected, the CNM must immediately initiate an organized emergency response, call for assistance, communicate the emergency to available personnel, perform appropriate evidence-based maneuvers, evaluate maternal and fetal status, document the sequence and timing of events, and accurately record the interventions performed and the infant's response.

Accepted standards require prompt intervention because prolonged shoulder impaction can result in interruption of fetal oxygenation, fetal hypoxia, metabolic acidosis, brachial plexus injury, permanent neurologic injury, or death. The CNM is responsible for recognizing that delay between delivery of the fetal head and delivery of the infant's body may represent an obstetrical emergency requiring immediate assessment and intervention. A prolonged head-to-body interval should be treated as shoulder dystocia until evaluated and resolved, and failure to recognize and respond to this finding may result in delayed emergency management and increased risk of preventable neonatal injury.

The CNM is also responsible for complete and contemporaneous documentation of obstetrical emergencies. Documentation must accurately reflect recognition of the emergency, timing of events, personnel involved, maneuvers attempted, maternal positioning, fetal and neonatal assessments, response to interventions, and outcome. In the absence of such documentation, the medical record does not demonstrate that appropriate emergency recognition, assessment, intervention, or response occurred.

Respondent failed to comply with these accepted standards. Respondent failed to recognize that the approximately two-minute and forty-five-second interval between delivery of the fetal head and delivery of the infant's body represented a prolonged head-to-body interval highly suspicious for shoulder dystocia until proven otherwise. Respondent failed to identify and document shoulder dystocia as an obstetrical emergency, failed to document initiation of an organized emergency response, failed to document performance of accepted shoulder dystocia maneuvers including McRoberts positioning, suprapubic pressure, rotational maneuvers, or delivery of the posterior arm, and failed to document the clinical assessment, interventions, and response necessary to demonstrate appropriate management of the emergency. By failing to recognize, manage, and document a delivery complicated by a prolonged head-to-body interval, Respondent departed from accepted standards of obstetric and nurse-midwifery practice governing the management of obstetrical emergencies and placed the infant at increased risk for hypoxia, metabolic acidosis, neurologic injury, and other preventable complications.

6. On or about June 4, 2023, while Respondent was working as a Certified Nurse Midwife (CNM) at Willow Midwife Center for Birth and Wellness (Willow) in Mesa, Arizona, Respondent was responsible for the management, assessment, and documentation of the third stage of labor following delivery of Patient C.N.'s infant in accordance with accepted standards of obstetric and nurse-midwifery practice.

The medical record documents that the placenta delivered spontaneously and intact. However, the record lacks structured documentation regarding the duration of the third stage of labor, assessment for retained placenta or retained placental tissue, systematic maternal assessment following placental delivery, ongoing uterine tone assessment, postpartum bleeding assessment, and evaluation for abnormal placental separation.

The expert CNM consultant concluded that Respondent failed to adequately assess, monitor, document, and manage the third stage of labor in accordance with accepted professional standards. Respondent:

a. Failed to document the duration of the third stage of labor;

b. Failed to document assessment for retained placenta or retained placental tissue following placental delivery;

c. Failed to perform and document a systematic maternal assessment following placental delivery;

d. Failed to adequately assess and document uterine tone following delivery of the placenta;

e. Failed to adequately assess and document postpartum bleeding;

f. Failed to document evaluation for abnormal placental separation; and

g. Failed to document third-stage labor management in a manner sufficient to demonstrate that appropriate postpartum surveillance and assessment were performed.

The expert CNM consultant concluded that the absence of timed documentation and structured postpartum assessment prevented a determination that appropriate third-stage labor management occurred and constituted significant departures from accepted standards governing third-stage labor management and obstetric and nurse-midwifery postpartum care.

Accepted standards of practice for Certified Nurse-Midwives (CNMs), including standards established by the American College of Nurse-Midwives (ACNM) and the American College of Obstetricians and Gynecologists (ACOG), require the CNM to actively manage, assess, and document the third stage of labor from delivery of the infant through delivery of the

placenta and completion of the immediate postpartum assessment. The third stage of labor is a critical period during which the CNM must remain vigilant for maternal complications, including postpartum hemorrhage, uterine atony, retained placenta, retained placental fragments, abnormal placental separation, and other causes of postpartum deterioration. The CNM is responsible for timely assessment of placental delivery, evaluation of the completeness of the placenta and membranes, monitoring uterine tone, assessing vaginal bleeding and maternal vital signs, identifying deviations from expected postpartum physiology, initiating appropriate interventions when indicated, and ensuring accurate and contemporaneous documentation of all assessments, interventions, and maternal responses.

Accepted standards require that management of the third stage of labor include objective assessment sufficient to determine whether placental separation and delivery occurred normally and whether the mother remains clinically stable. Following delivery of the placenta, the CNM must assess and document uterine firmness, amount and character of vaginal bleeding, maternal condition, and other findings necessary to evaluate for postpartum hemorrhage and other complications. The CNM must also document the timing of significant third-stage events, including delivery of the placenta, because prolonged third-stage labor may increase the risk of retained placenta, postpartum hemorrhage, and the need for additional intervention. Failure to perform and document these assessments prevents confirmation that appropriate postpartum surveillance occurred and may delay recognition and treatment of potentially life-threatening maternal complications.

Respondent failed to comply with these accepted standards by failing to adequately assess, monitor, and document management of the third stage of labor following delivery of Patient C.N.'s infant. Although the medical record documents that the placenta delivered

spontaneously and intact, Respondent failed to document the duration of the third stage of labor, failed to document a structured assessment for retained placenta or retained placental tissue, failed to document systematic maternal assessment following placental delivery, failed to adequately document uterine tone assessment, failed to adequately document postpartum bleeding assessment, failed to document evaluation for abnormal placental separation, and failed to document the maternal surveillance necessary to demonstrate appropriate postpartum management.

By failing to perform and/or document essential third-stage labor assessments, Respondent failed to demonstrate that she adequately evaluated Patient C.N. for postpartum hemorrhage, uterine atony, retained placental tissue, or other postpartum complications requiring timely intervention. The absence of structured and contemporaneous documentation represented a significant departure from accepted standards governing third-stage labor management, postpartum assessment, and nurse-midwifery care because the medical record does not establish that appropriate maternal surveillance, clinical evaluation, and risk assessment were performed.

7. On or about June 4, 2023, while Respondent was working as a Certified Nurse Midwife (CNM) at Willow Midwife Center for Birth and Wellness (Willow) in Mesa, Arizona, following the delivery of Patient C.N.'s infant at Willow, Respondent was responsible for the immediate assessment and management of the newborn, including neonatal resuscitation when indicated, accurate documentation of all resuscitative interventions, and maintenance of a complete, accurate, and contemporaneous medical record reflecting the care provided.

The expert consultant identified deficiencies in Respondent's management and documentation of neonatal resuscitation that were inconsistent with accepted Neonatal

Resuscitation Program (NRP) standards. The expert further identified discrepancies between the clinical events documented by Emergency Medical Services (EMS) and fire department personnel and the subsequent birth center medical record. These inconsistencies raised concerns regarding the accuracy, completeness, and reliability of the documentation surrounding the infant's condition at birth, the interventions performed, and the infant's response to those interventions.

The expert consultant determined that portions of the medical record were modified after the clinical event without being identified as late entries, amendments, or corrections and without preserving a clear audit trail of the changes made. Such modifications prevented the record from reliably demonstrating the original contemporaneous documentation of the infant's condition, the sequence and timing of resuscitative interventions, and the clinical decision-making occurring during a neonatal emergency.

Accepted standards of practice for Certified Nurse-Midwives providing newborn care, including Neonatal Resuscitation Program (NRP) guidelines, require the provider responsible for neonatal resuscitation to promptly assess the newborn, initiate appropriate resuscitative measures based on objective clinical findings, utilize appropriate monitoring equipment when indicated, evaluate the infant's response to interventions, and accurately document the timing, sequence, and effectiveness of all resuscitative actions. Neonatal resuscitation requires precise documentation because delays in recognition, incomplete monitoring, or inaccurate recording of interventions may impair evaluation of whether appropriate care was provided and may contribute to preventable neonatal morbidity.

Accepted professional documentation standards require that the medical record be accurate, complete, contemporaneous, and maintained in a manner that preserves its integrity,

chronology, and reliability. Corrections, additions, or clarifications made after the time of the original documentation must be clearly identified as late entries, amendments, or corrections, must include the date and time of the modification, and must preserve the original entry to ensure transparency and auditability. Alteration of a medical record without appropriate identification compromises the reliability of the record and interferes with continuity of care, quality review, peer review, and regulatory evaluation.

Respondent failed to comply with these accepted standards by failing to ensure that neonatal resuscitation was performed and documented in accordance with accepted NRP principles, failing to maintain a record that accurately reflected the sequence and timing of neonatal interventions, and failing to reconcile or address discrepancies between EMS/fire department documentation and the birth center record. Respondent further failed to preserve the integrity of the medical record by modifying entries after the clinical event without identifying the changes as late entries or amendments and without maintaining documentation sufficient to establish what information was changed, when it was changed, or the reason for the changes.

These failures constituted departures from accepted standards governing neonatal resuscitation, emergency newborn management, clinical documentation, and continuity of patient care because they compromised the accuracy and reliability of the medical record and impaired the ability to determine whether appropriate neonatal assessment, intervention, monitoring, and escalation of care occurred.

8. On November 22, 2024, during Respondent's deposition in Maricopa County Superior Court Case No. CV2024-017746, Respondent testified that after Baby W.N. was born and transferred to the hospital, she later accessed the electronic medical record and edited, added, and deleted information contained within the chart. Respondent acknowledged that she

did not identify the subsequent entries as late entries, addenda, or amendments, did not preserve a record of the changes made, and could not recall the specific information that had been edited, added, or deleted. On March 5, 2026, during an investigative interview with Board staff, Respondent again admitted that she had modified the medical record following the delivery by changing, editing, adding, and deleting entries.

Accepted standards of professional nursing, midwifery, and medical documentation require that the medical record be accurate, complete, contemporaneous, and maintained in a manner that preserves its integrity, chronology, and reliability. When corrections, additions, or clarifications to a medical record are necessary after the time of the original entry, accepted documentation standards require that the changes be clearly identified as late entries, amendments, or corrections, include the date and time of the modification, preserve the original documentation, and maintain an auditable record of what information was changed and why. The purpose of these requirements is to ensure transparency, prevent alteration of the clinical record after the fact, support continuity of care, and allow subsequent providers, investigators, and regulatory bodies to accurately determine the care provided.

Respondent failed to comply with accepted documentation standards by accessing and modifying the medical record after the infant's transfer without identifying the changes as late entries or amendments, without maintaining a record of the modifications, and without preserving the original information in a manner that allowed the integrity and chronology of the record to be verified. By altering the medical record without appropriate identification and auditability, Respondent compromised the reliability of the medical record and impeded the ability to determine the accuracy of the documented care provided to Patient C.N. and Baby W.N.

During the same November 22, 2024 deposition, Respondent acknowledged that the Emergency Medical Services (EMS) report documented that Baby W.N.'s bag-valve mask was not connected to supplemental oxygen during the initial neonatal resuscitation at Willow. Respondent testified that supplemental oxygen was later connected and administered at a concentration of 100 percent based upon her clinical judgment that the infant was not improving. Respondent further admitted that she did not obtain or document Baby W.N.'s oxygen saturation following birth.

Accepted Neonatal Resuscitation Program (NRP) standards require objective assessment and monitoring during neonatal resuscitation, including use of pulse oximetry when positive pressure ventilation and/or supplemental oxygen are administered. Pulse oximetry provides objective data regarding the infant's oxygenation status and guides appropriate titration of supplemental oxygen during resuscitation. The CNM responsible for neonatal care must recognize when an infant requires escalation of resuscitative support, ensure appropriate equipment and monitoring are utilized, assess the infant's response to interventions, and accurately document the timing, sequence, and effectiveness of resuscitative measures.

Respondent failed to comply with accepted neonatal resuscitation standards by failing to obtain and document oxygen saturation measurements during neonatal resuscitation despite administration of supplemental oxygen. Without objective oxygen saturation data, Respondent lacked a documented physiologic measurement to guide oxygen therapy or assess the infant's response to treatment. This failure represented a departure from accepted neonatal resuscitation practices and impaired the ability to evaluate whether oxygen administration was appropriately guided and effective.

Respondent further acknowledged that Willow's policy required the CNM to accompany an infant transferred to the hospital. Respondent testified that she did not accompany Baby W.N. during transport because Patient C.N. had not yet delivered the placenta and further testified that she did not subsequently travel to the hospital while Baby W.N. remained hospitalized.

Accepted standards of nurse-midwifery practice require continuity of care during emergency transfers, including appropriate communication with receiving providers, transfer of relevant clinical information, and participation in the transition of care when required by facility policy and clinical circumstances. When a newborn requires emergency transport following resuscitation, the responsible provider must ensure that the receiving team receives an accurate handoff regarding the infant's condition, interventions performed, response to treatment, and ongoing concerns.

Respondent failed to comply with these standards by failing to accompany Baby W.N. during emergency transport as required by Willow's policy and failing to provide ongoing provider involvement during the infant's transition to hospital care. This failure impaired continuity of care and limited the ability to provide direct communication regarding the infant's condition, resuscitative interventions, and clinical course.

With respect to intrapartum fetal surveillance, Respondent testified that either she or the birth assistant monitored fetal heart tones during Patient C.N.'s labor and acknowledged that periods of absent fetal heart rate variability occurred for unknown durations. Respondent admitted that the duration of absent variability was unknown. Respondent further admitted that Patient C.N.'s maternal pulse was not obtained or documented during labor.

Accepted standards for intermittent auscultation require the CNM to perform reliable fetal surveillance through accurate assessment, interpretation, and documentation of fetal heart rate findings. This includes assessment of fetal heart rate in relation to contractions, recognition of abnormal patterns, evaluation of fetal heart rate variability when clinically assessable, and appropriate response to concerning findings. Accepted fetal monitoring standards further require concurrent or periodic maternal pulse assessment when clinically indicated to distinguish maternal heart rate from fetal heart rate and confirm that the auscultated rate represents the fetus. Without maternal pulse assessment, the provider cannot reliably verify that the documented heart rate reflects fetal status rather than maternal status.

Respondent failed to comply with accepted intrapartum fetal monitoring standards by failing to obtain and document maternal pulse assessments and by acknowledging that she could not determine the duration of absent fetal heart rate variability. Respondent failed to establish a reliable assessment of fetal status, failed to accurately characterize the duration and significance of abnormal fetal heart rate findings, and failed to demonstrate timely recognition and response to potentially concerning fetal conditions. These failures represented departures from accepted standards governing intrapartum fetal surveillance and management of potentially compromised fetuses.

Respondent further testified that her labor documentation frequently consisted of entries such as "progress being made" or "descent noted." Respondent acknowledged that she did not objectively document or quantify the degree of cervical dilation, fetal descent, or labor progression reflected by those entries and stated only that the progress was "minimal, but it was progress."

Accepted standards of obstetric and nurse-midwifery practice require objective, measurable, and contemporaneous documentation of labor progression, including cervical dilation, effacement, fetal station, fetal position, contraction pattern, maternal status, fetal status, interventions performed, and response to care. Accurate labor documentation is essential for identifying prolonged labor, labor dystocia, abnormal fetal descent, and situations requiring additional intervention, consultation, or transfer of care.

Respondent failed to comply with accepted documentation standards by failing to objectively quantify labor progression and instead relying on vague and nonspecific descriptions such as "progress being made" and "descent noted." These entries were insufficient to demonstrate accurate assessment of labor status, prevented reliable evaluation of whether labor was progressing appropriately, and impaired timely recognition of abnormal labor patterns requiring intervention.

9. On or about January 18, 2025, in the matter of CV2024-017746, a Stipulation for Dismissal with Prejudice was filed in the civil action arising from the care provided to Patient C.N. The civil action was dismissed with prejudice following settlement of the matter.

10. On or about September 20, 2024, while Respondent was working as a Certified Nurse Midwife (CNM) at Willow Midwife Center for Birth and Wellness (Willow) in Mesa, Arizona, Respondent provided Patient N.Q.'s routine 28-week prenatal examination. During the encounter, Respondent documented that Patient N.Q. completed gestational diabetes mellitus (GDM) screening preparation by consuming jelly beans at approximately 1:15 p.m. Twenty-eight-week laboratory studies were obtained. Respondent documented that Patient N.Q. denied questions or concerns, had resumed magnesium supplementation, was sleeping well, maintained adequate protein intake, and was otherwise doing well. Routine obstetrical

follow-up was scheduled for two weeks later, and no maternal or fetal complications were documented during the encounter.

Accepted standards of obstetric and nurse-midwifery practice require that screening for gestational diabetes mellitus be performed using validated, evidence-based screening methods that provide a standardized glucose load and reliable interpretation of results. Guidelines published by the American College of Obstetricians and Gynecologists (ACOG) recognize the 50-gram oral glucose challenge test as the standard screening method for GDM because it delivers a known quantity of glucose under controlled conditions, allowing for consistent interpretation and identification of patients at risk for gestational diabetes who require further diagnostic evaluation and management.

The purpose of standardized GDM screening is to accurately identify abnormal maternal glucose tolerance during pregnancy because undiagnosed or inadequately managed gestational diabetes is associated with increased risks to both the pregnant patient and fetus, including fetal macrosomia, shoulder dystocia, birth trauma, hypertensive disorders of pregnancy, neonatal hypoglycemia, and other adverse perinatal outcomes. Because screening accuracy directly impacts subsequent clinical management, the CNM is responsible for utilizing accepted screening methods or clearly documenting an evidence-based rationale for any deviation from established standards.

Respondent departed from accepted standards of obstetric and nurse-midwifery practice by utilizing a jelly bean challenge in place of the standardized 50-gram oral glucose beverage for gestational diabetes screening. The jelly bean method does not provide a validated or standardized glucose load because the amount of carbohydrate consumed, absorption rate, timing, and individual variation may affect the resulting glucose measurement. The use of a

nonstandardized screening method may produce unreliable results, including false reassurance from a falsely normal value or failure to identify a patient requiring further diagnostic evaluation and treatment.

By substituting a nonstandardized jelly bean challenge for the accepted glucose screening method, Respondent failed to utilize a validated approach for evaluation of gestational diabetes and failed to ensure that Patient N.Q. received screening consistent with accepted obstetrical and nurse-midwifery standards. This deviation compromised the reliability of GDM screening and created a risk that an abnormal glucose tolerance condition could go unrecognized, resulting in missed opportunities for appropriate maternal counseling, monitoring, and management to reduce preventable maternal and neonatal complications.

## PRELIMINARY CONCLUSIONS OF LAW

The Board has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§ 32-1606, 32-1663, 32-1664, and 41-1092.11(B). The Board also has the authority, pursuant to A.R.S. § 32-1663 and A.R.S. § 32-1664, to impose disciplinary sanctions against the holders of nursing licenses for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 through 1667, and A.A.C. R4-19-101 to R-19-904. If the Board determines that a licensee has committed unprofessional conduct, it may take disciplinary action.

The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. §§ 32-1663 and 32-1664, and violates the following statutes and rules currently cited as A.R.S. § 32-1663(D) as defined in A.R.S. § 32-1601(27) (effective September 29, 2021), where "Unprofessional conduct" includes the following, whether occurring in this state, or elsewhere:

11. A.R.S. § 32-1601(27)(d) Any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public.

12. A.R.S. § 32-1601(27)(g) Wilfully or repeatedly violating a provision of this chapter or a rule adopted pursuant to this chapter.

13. A.R.S. § 32-1601(27)(h) Committing an act that deceives, defrauds or harms the public.

14. A.R.S. § 32-1601(27)(j) Violating this chapter or a rule that is adopted by the board pursuant to this chapter.

For purposes of A.R.S. § 32-1601(27)(d), any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public includes one or more of the following (currently cited as A.A.C. R4-19-403 (adopted effective 01/31/2009)):

15. A.A.C. R4-19-403(1) A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice;

16. A.A.C. R4-19-403(2) Intentionally or negligently causing physical or emotional injury;

17. A.A.C. R4-19-403(7) Failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient;

18. A.A.C. R4-19-403(8) Falsifying or making a materially incorrect, inconsistent, or unintelligible entry in any record:

a. Regarding a patient, health care facility, school, institution, or other work place location; or

19. A.A.C. R4-19-403(9) Failing to take appropriate action to safeguard a patient's welfare or follow policies and procedures of the nurse's employer designed to safeguard the patient;

20. A.A.C. R4-19-403(26) Making a written false or inaccurate statement to the Board or the Board's designee in the course of an investigation;

21. A.A.C. R4-19-403(31) Practicing in any other manner that gives the Board reasonable cause to believe the health of a patient or the public may be harmed.

**FINDING OF PUBLIC EMERGENCY AND ORDER**

Based upon the facts and circumstances set forth in the Preliminary Findings of Fact and Preliminary Conclusions of Law, the Board finds that the public health safety and welfare imperatively requires emergency action.

**IT IS THEREFORE ORDERED, pursuant to A.R.S. § 41-1092.11(B), and effective immediately, that Wendy Lee Shaw ("Respondent"), the holder of advanced practice registered nurse midwife certificate no. APRN-CNM250551 and privilege to practice nursing under the nurse licensure compact in the State of Arizona is SUMMARILY SUSPENDED pending proceedings for revocation and other action by the Board. A hearing in this matter shall be promptly instituted and determined.**

Dated this 23rd day of July, 2026.

**SEAL**

Joey Ridenour

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

COPIES HAND-DELIVERED in the Board office this 23rd day of July, 2026 to:

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