ARIZONA STATE BOARD OF NURSING
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IN THE MATTER OF ADVANCED PRACTICE REGISTERED NURSE CERTIFICATE NO. APRN-CNM219067, ISSUED TO: **PAMELA JEAN MORAN,** AKA PAMELA JEAN EPERTHERER, PAMELA JEAN EPERTHENER, PAMELA JEAN COOPER, RESPONDENT.	**FINDINGS OF PUBLIC EMERGENCY AND ORDER OF SUMMARY SUSPENSION** **CASE NO. 2024110129**

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 Pamela Jean Moran, AKA Pamela Jean Epertherer, Pamela Jean Eperthener, Pamela Jean Cooper ("Respondent"), the holder of advanced practice registered nurse certificate no. APRN-CNM219067. 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 November 7, 2024, the Board received a complaint from Patient N.Z., a patient at Willow Midwife Center for Birth and Wellness (Willow), in Mesa, AZ. 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 to be present in her cervical checks, 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.

2. Complaint #2: On January 21, 2025, the Board received a cross report from another state agency alleging that on November 10, 2023, while Respondent was working as a Certified Nurse Midwife (CNM) and owner of Willow Midwife Center for Birth & Wellness in Mesa, AZ (Willow), Patient N.Z's had fetal decelerations (fetal heart drop) with the presence of meconium resulting in an emergent transfer, emergency caesarean section, and a stillbirth. (Complaint #1 and Complaint #2 are the same complaint and hereafter are merged.)

3. Complaint #3: On March 13, 2025, the Board received a complaint from Patient M.M., who wrote that on December 17, 2022, she delivered her daughter at Willow Midwife Center for Birth & Wellness (Willow) with Respondent as her midwife, with assistance of CPM Amador (Certified Professional Midwife, not regulated by the Board of Nursing). Respondent wrote that she experienced a cord avulsion (when the umbilical cord tears or ruptures during childbirth) and suffered severe post-partum hemorrhaging necessitating multiple medications and two rounds of manual evacuation of the placenta by Respondent (where a provider uses their hand to detach and remove a placenta that has not separated naturally after birth). Patient M.M. was discharged from Willow four hours later with no labs drawn and no referral to a higher level of care.

PRELIMINARY FINDINGS OF FACT

1. On or about March 31, 2023, and continuing through November 10, 2023, Respondent was employed as a Certified Nurse Midwife at Willow Midwife Center for Birth and Wellness ("Willow") in Mesa, Arizona. Patient N.Z., a 24-year-old primigravida (first

pregnancy), entered into midwifery care with the intention of having an out-of-hospital birth at the birth center. Patient N.Z. had an estimated due date of October 27, 2023.

On November 9, 2023, at approximately 11:00 a.m., Patient N.Z. was admitted to the birth center in labor by a Certified Professional Midwife (CPM) at 41-weeks and 6-days gestation. Respondent assumed care on November 10, 2023, at approximately 2:50 p.m. At that time, Patient N.Z. was 42-weeks gestation, had been in labor for approximately 27 hours, and had made minimal cervical change (progress of dilation and effacement indicating labor progress).

a) On or about November 10, 2023, Respondent failed to transfer Patient N.Z. to a higher level of care upon assuming responsibility for her management. At the time Respondent assumed care, Patient N.Z. met a birth center exclusion criterion identified in Willow's Risk Assessment Tool, which lists postmaturity (greater than 42 weeks gestation) as a transfer factor requiring consultation, referral, and consideration for transfer from the birth center setting. Despite the presence of this exclusion criterion, Respondent continued labor management at the birth center.

b) On or about November 10, 2023, at approximately between 8:00 and 8:06 p.m., and more than five hours after Respondent assumed care, examination revealed thick meconium (an indicator of fetal stress), and fetal heart tones decreased into the 70s beats per minute (normal range 110-160 beats per minute), necessitating emergency transfer to a hospital.

Respondent failed to adhere to the applicable standard of practice for birth center care. Upon reaching 42-weeks gestation, Patient N.Z. met an established birth center exclusion criterion for postmaturity. The standard of practice required Respondent to recognize that Patient N.Z. was no longer an appropriate candidate for ongoing birth center management,

counsel her regarding the increased maternal and fetal risks associated with post-term pregnancy, and arrange for consultation, referral, or transfer to obstetrical and/or hospital-based care. Respondent did not initiate the required transfer after the exclusion criterion developed and instead continued management within the birth center setting. This conduct constituted a departure from accepted professional standards and Willow's applicable birth center protocols.

2. On or about November 10, 2023, while providing intrapartum care to Patient N.Z. at Willow Midwife Center for Birth and Wellness ("Willow") in Mesa, Arizona, Respondent assumed and continued management of a labor that had been ongoing for an extended period and was complicated by multiple evolving maternal and fetal risk factors.

Prior to Respondent assuming care at approximately 2:50 p.m., Patient N.Z. had been laboring for 27 hours. The medical record reflects ruptured membranes for approximately 15 hours, and the presence of meconium-stained amniotic fluid. At the time Respondent assumed care, and as labor progressed, Patient N.Z. demonstrated minimal cervical change over time. At approximately 11:25 a.m., the CPM documented that Patient N.Z. was 7 centimeters dilated and 90 percent effaced. At approximately 4:00 p.m., Respondent document that Patient N.Z. was 8 centimeters dilated and 90 percent effaced. At approximately 8:00 p.m., Respondent documented that Patient N.Z. was 9 centimeters dilated and 90 percent effaced despite many additional hours of labor, reflecting prolonged active labor and labor dystocia with abnormal progression.

Patient N.Z. demonstrated multiple clinical risk factors, including postmaturity at 42-weeks gestation, prolonged labor, and prolonged rupture of membranes, persistent meconium-stained amniotic fluid, Group B Streptococcus positive status, and ongoing slow labor progression.

At approximately 8:00 p.m., Respondent documented thick meconium, representing a worsening progression from previously noted thin meconium. At approximately 8:05 p.m., fetal heart tones dropped into the 70s beats per minute before recovering into the 110s, indicating an acute fetal heart rate deceleration. Transfer to a higher level of care was initiated only after this significant fetal heart rate deceleration occurred. Upon arrival at Banner Desert Medical Center, fetal heart tones could not be located, an emergency cesarean section was performed, and the infant was delivered stillborn (deceased).

Respondent failed to adhere to the applicable standard of practice requiring ongoing reassessment of Patient N.Z's suitability for continued birth center management in the presence of accumulating maternal and fetal risk factors, as well as timely recognition and management of prolonged labor and labor dystocia. The standard of practice required continuous reassessment of maternal and fetal status, identification of abnormal labor progression, and timely escalation of care, including consultation, referral, or transfer when labor failed to progress or when non-reassuring fetal status developed. Respondent failed to appropriately escalate care or initiate timely transfer despite minimal cervical change over many hours and the presence of multiple accumulating risk factors, constituting a departure from accepted professional standards and applicable birth center policies and protocols.

3. On or about November 10, 2023, while providing intrapartum care to Patient N.Z. at Willow Midwife Center for Birth and Wellness ("Willow") in Mesa, Arizona, Respondent was responsible for ongoing fetal and maternal assessment using intermittent auscultation during labor management.

Intermittent auscultation requires differentiation between maternal pulse and fetal heart rate to ensure accurate fetal surveillance and to avoid misinterpretation of maternal heart rate as

fetal heart tones. During Respondent's period of care, fetal heart tones were documented at multiple intervals, including approximately 3:20 p.m., 4:00 p.m., 4:30 p.m., 5:00 p.m., 5:30 p.m., 6:00 p.m., 6:30 p.m., 7:30 p.m., and 8:05 p.m.

The medical record reflects that maternal pulse was not documented during many of these fetal heart tone assessments. The investigative report further notes that maternal pulse was absent from multiple documented fetal heart tone entries during Respondent's care.

Respondent failed to adhere to the applicable standard of practice for maternal and fetal assessment during labor. The standard of practice for intermittent auscultation requires that the provider assess and document both fetal heart rate and maternal pulse at appropriate intervals to ensure accurate differentiation between maternal and fetal heart rates and to support safe intrapartum monitoring. Respondent's failure to consistently perform and document maternal pulse assessments during fetal heart tone monitoring constituted a departure from accepted professional standards for intrapartum care and fetal surveillance.

4. On or about and between August 26, 2022, and December 17, 2022, Respondent was employed as a Certified Nurse Midwife (CNM) at Willow Midwife Center for Birth and Wellness ("Willow") in Mesa, Arizona. During this period, Patient M.M., a 35-year-old female, gravida 7, entered midwifery care with the intention of an out-of-hospital birth at the birth center and ultimately delivered under Respondent's care on December 17, 2022.

During delivery, a cord avulsion occurred (detachment of the umbilical cord from the placenta), necessitating manual removal of the placenta. Following delivery, Patient M.M. experienced a postpartum hemorrhage with a cumulative estimated blood loss of approximately 900 mL, which is clinically significant as it exceeds the typical expected blood loss for a

vaginal delivery (approximately 500 mL) and meets criteria for postpartum hemorrhage, indicating increased risk for maternal hemodynamic instability.

Respondent administered multiple uterotonic medications (medications that stimulate uterine contractions to reduce bleeding), including Pitocin (synthetic oxytocin used to promote uterine contraction and decrease bleeding), Cytotec (misoprostol, a medication that induces uterine contractions to control hemorrhage), and tranexamic acid (TXA) (an antifibrinolytic agent that reduces bleeding by preventing clot breakdown), and later prescribed Methergine (methylergonovine, a medication that produces sustained uterine contractions to control postpartum hemorrhage) due to continued concern for ongoing bleeding.

Despite these interventions and ongoing concern for retained placental tissue, Respondent did not obtain point-of-care laboratory assessment, including hemoglobin (a red blood cell protein that carries oxygen; low levels may indicate blood loss or anemia) and hematocrit (the percentage of blood composed of red blood cells; decreased levels may indicate significant blood loss), nor was a bedside blood evaluation performed.

Patient M.M. was discharged approximately four hours after delivery without hospital-based stabilization, definitive imaging, or documented confirmation that retained placental tissue had been excluded.

Respondent failed to adhere to the applicable standard of practice in the management of postpartum hemorrhage and suspected retained products of conception. The standard of practice required timely and ongoing assessment of maternal hemodynamic status, appropriate diagnostic evaluation to determine the severity and etiology of hemorrhage, and escalation of care when indicated, including consideration of hospital transfer for stabilization and further evaluation. Respondent's failure to obtain appropriate laboratory assessment, failure to

definitively rule out retained products of conception, and discharge of the patient without adequate stabilization constituted a departure from accepted professional standards of care for a CNM managing postpartum hemorrhage.

Subsequent medical evaluation confirmed retained placental tissue requiring surgical intervention.

5. On or about December 17, 2022, during the delivery of Patient M.M. at Willow, during the delivery, Patient M.M. sustained a perineal laceration that was initially assessed and repaired by Respondent. Respondent failed to accurately identify and properly classify the degree of the perineal tissue injury at the time of initial assessment and repair.

Subsequent clinical evaluations determined that the extent of the perineal injury was more severe than originally documented by Respondent. As a result of the inadequate initial assessment and repair, Patient M.M. required additional perineal repair procedures on multiple occasions.

Respondent failed to adhere to the applicable standard of practice for the assessment, classification, documentation, and repair of perineal lacerations. The standard of practice requires accurate identification of the degree of perineal trauma, appropriate repair technique based on injury classification, and adequate documentation of findings and procedures performed. Respondent's failure to properly assess and document the severity of the laceration and resulting need for repeat repair procedures constituted a departure from accepted nurse-midwifery standards of care.

6. On or about December 17, 2022, following the delivery of Patient M.M. at Willow, Respondent managed a postpartum course complicated by ongoing clinical concerns requiring escalation of care. Respondent consulted with a physician regarding Patient M.M.'s

postpartum condition; however, despite this consultation, Respondent discharged Patient M.M. from the birth center without ensuring immediate hospital evaluation.

At the time of discharge, Patient M.M. continued to demonstrate significant risk factors, including substantial blood loss, ongoing concern for retained placental tissue, and the need for additional uterotonic medication administration. No diagnostic imaging was obtained prior to discharge to rule out retained products of conception (POC).

Subsequent medical evaluation at a hospital setting confirmed retained placental tissue requiring surgical management.

Respondent failed to adhere to the applicable standard of practice requiring timely escalation to a higher level of care when clinical indicators demonstrate ongoing risk and potential complications beyond the scope of outpatient birth center management. The standard of practice required ensuring appropriate hospital-based evaluation prior to discharge when significant hemorrhage and suspected retained products of conception are present. Respondent's failure to secure timely access to higher-level care constituted a departure from accepted professional standards of nurse-midwifery practice.

7. On or about December 17, 2022, following the delivery of Patient M.M. at Willow, Respondent provided postpartum care during a period in which hospital evaluation and further treatment were recommended.

Respondent documented that Patient M.M. declined recommended evaluation and treatment following delivery. However, the medical record does not contain contemporaneous or detailed documentation sufficient to demonstrate informed refusal or completion of an Against Medical Advice (AMA) process.

Specifically, the medical record lacks documentation identifying the specific medical concerns necessitating hospital evaluation, the risks associated with declining evaluation, available alternative treatment options, confirmation that the patient understood the risks of refusal, or completion of a formal AMA process. The medical record contains no documentation demonstrating comprehensive informed refusal counseling.

Respondent failed to adhere to the applicable standard of practice regarding informed refusal and AMA documentation. The standard of practice requires that when a patient declines recommended evaluation or treatment, the provider must document the clinical indication for the recommendation, the risks of refusal, available alternatives, confirmation of patient understanding, and the patient's informed decision in a manner sufficient to establish that informed refusal occurred. Respondent's documentation was insufficient to establish informed refusal and did not meet accepted standards for AMA documentation in the postpartum setting.

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:

1. 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.

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

3. 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)):

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

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

6. 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;

7. 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;

8. 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 PAMELA JEAN MORAN AKA PAMELA JEAN EPERTHERER, PAMELA JEAN EPERTHENER, PAMELA JEAN COOPER ("Respondent"), the holder of advanced practice registered nurse certificate no. APRN-CNM219067 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, R.N., M.N., F.A.A.N.
Executive Director

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