In the Matter of	§	**BEFORE THE TEXAS**
Permanent Registered Nurse	§	
License Number 690565	§	**BOARD OF NURSING**
Issued to MICHELLE RENE GILLIN,	§	
Respondent	§	**ELIGIBILITY AND**
	§	
	§	**DISCIPLINARY COMMITTEE**

ORDER OF THE BOARD

TO: Michelle Gillin
30505 Canyon Hills Road
Unit 304
Lake Elsinore, CA 92532

During open meeting held in Austin, Texas, on November 10, 2020, the Texas Board of Nursing Eligibility and Disciplinary Committee (hereinafter "Committee") heard the above-styled case, based on the failure of the Respondent to appear as required by 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that notice of the facts or conduct alleged to warrant disciplinary action has been provided to Respondent in accordance with Texas Government Code § 2001.054(c) and Respondent has been given an opportunity to show compliance with all the requirements of the Nursing Practice Act, Chapter 301 of the Texas Occupations Code, for retention of Respondent's license(s) to practice nursing in the State of Texas.

The Committee finds that the Formal Charges were properly initiated and filed in accordance with section 301.458, Texas Occupations Code.

The Committee finds that after proper and timely Notice regarding the violations alleged in the Formal Charges was given to Respondent in this matter, Respondent has failed to appear in accordance with 22 TEX. ADMIN. CODE Ch. 213.

The Committee finds that the Board is authorized to enter a default order pursuant to Texas Government Code § 2001.056.

The Committee, after review and due consideration, adopts the proposed findings of fact and conclusions of law as stated in the Formal Charges which are attached hereto and incorporated by

reference for all purposes and the Staff's recommended sanction of revocation by default. This Order will be properly served on all parties and all parties will be given an opportunity to file a motion for rehearing [22 TEX. ADMIN. CODE § 213.16(j)]. All parties have a right to judicial review of this Order.

All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

NOW, THEREFORE, IT IS ORDERED that Permanent Registered Nurse License Number 690565, previously issued to MICHELLE RENE GILLIN to practice nursing in the State of Texas be, and the same is/are hereby, REVOKED.

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

Entered this 10th day of November, 2020

TEXAS BOARD OF NURSING

BY: Katherine A. Thomas

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

Attachment: Formal Charges filed September 14, 2020

d17r(2020.10.09)

CERTIFICATE OF SERVICE

I hereby certify that on the 13th day of November, 2020, a true and correct copy of the foregoing DEFAULT ORDER was served and addressed to the following person(s), as follows:

Via USPS Certified Mail, Return Receipt Requested,
Copy Via USPS First Class Mail

Michelle Gillin
30505 Canyon Hills Road
Unit 304
Lake Elsinore, CA 92532

BY: Katherine A. Thomas

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR ON BEHALF OF SAID BOARD

In the Matter of	§	**BEFORE THE TEXAS**
Permanent Registered Nurse	§	
License Number 690565	§	
Issued to MICHELLE RENE GILLIN,	§	**BOARD OF NURSING**
Respondent	§	

FORMAL CHARGES

This is a disciplinary proceeding under Section 301.452(b), Texas Occupations Code. Respondent, MICHELLE RENE GILLIN, is a Registered Nurse holding license number 690565 which is in delinquent status at the time of this pleading.

Written notice of the facts and conduct alleged to warrant adverse licensure action was sent to Respondent at Respondent's address of record and Respondent was given opportunity to show compliance with all requirements of the law for retention of the license prior to commencement of this proceeding.

CHARGE I.

On or about June 21, 2019, the Board of Registered Nursing, Department of Consumer Affairs for the State of California, Sacramento, California, adopted a Decision and Order against Respondent's license to practice professional nursing in the State of California. A copy of the Decision, Proposed Decision, and Findings dated June 21, 2019, is attached and incorporated, by reference, as part of these Formal Charges.

The above action constitutes grounds for disciplinary action in accordance with Section 301.452(b)(8), Texas Occupations Code.

NOTICE IS GIVEN that staff will present evidence in support of the recommended disposition of up to, and including, revocation of Respondent's license(s) and/or privilege(s) to practice nursing in the State of Texas pursuant to the Nursing Practice Act, Chapter 301, Texas Occupations Code and the Board's rules, 22 TEX. ADMIN. CODE §§ 213.27 - 213.33.

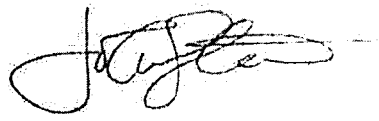
NOTICE IS GIVEN that all statutes and rules cited in these Charges are incorporated as part of this pleading and can be found at the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on adopted policies related to Substance Use Disorders and Other Alcohol and Drug Related Conduct, on adopted policies related to Behavior Involving Lying and Falsification, and on adopted policies related to Behavior Involving Fraud, Theft, and Deception, which can be found under the "Discipline & Complaints; Board Policies & Guidelines" section of the Board's website, www.bon.texas.gov.

NOTICE IS GIVEN that, based on the Formal Charges, the Board will rely on the Disciplinary Matrix, located at 22 TEX. ADMIN. CODE §213.33(b), which can be found under the "Discipline & Complaints; Board Policies & Guidelines" section of the Board's website, www.bon.texas.gov.

Filed this 14 day of September, 2020.

TEXAS BOARD OF NURSING



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Board Certified - Administrative Law
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333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-8657
F: (512) 305-8101 or (512) 305-7401

Attachment: Decision and Order by the Board of Registered Nursing, Department of Consumer Affairs for the State of California, dated June 21, 2019

D(2020.08.25)

I do hereby certify this to be a complete, accurate, and true copy of the document which is on file or is of record in the offices of the Texas Board of Nursing.

Executive Director of the Board

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2018-739
MICHELLE RENE GILLIN	OAH No. 2018100239
Registered Nurse License No. 578433	
Respondent.	

DECISION

The attached Decision and Order of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on **June 21, 2019.**

IT IS SO ORDERED this **22nd day of May 2019.**

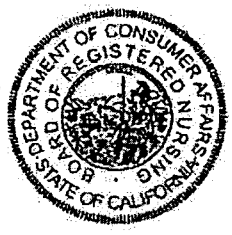
Trande Phillips RN

Trande Phillips, President
Board of Registered Nursing
Department of Consumer Affairs
State of California

I hereby certify the foregoing to be a true copy of the documents on file in our office.

BOARD OF REGISTERED NURSING

Joseph L. Morris, PhD, MSN, RN
Executive Officer



BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MICHELLE RENE GILLIN, Registered Nurse License No. 578433, Respondent.	Case No. 2018-739 OAH No. 2018100239

PROPOSED DECISION

Debra D. Nye-Perkins, Administrative Law Judge, Office of Administrative Hearings, heard this matter on March 13, 2019, in Murrieta, California.

Marichelle S. Tahimic, Deputy Attorney General, represented complainant, Joseph L. Morris, Ph.D., MSN, RN, Executive Officer, Board of Registered Nurses (board), Department of Consumer Affairs, State of California.

John D. Bishop, Attorney at Law, represented respondent, Michelle Rene Gillin, who was present throughout the hearing.

The matter was submitted on March 13, 2019.

FACTUAL FINDINGS

Jurisdiction

1. On March 9, 2001, the board issued Registered Nurse License number 578433 to respondent. Respondent's license will expire on November 30, 2020, unless renewed or revoked. Respondent's registered nurse license has had no prior discipline.

2. On May 4, 2018, complainant signed an accusation in Case No. 2018-739 against respondent. The accusation seeks to revoke or suspend respondent's registered nurse license based on three asserted causes for discipline for activity occurring in July 2015. The first cause for discipline alleges respondent was incompetent for failing to address the pain level of two patients in a timely manner, failing to perform a pain assessment of a patient

after administration of pain medication, and failing to properly document the removal and administration of controlled substances for three patients. The second cause for discipline alleges respondent falsified or made grossly incorrect or inconsistent entries in patient records pertaining to the removal and administration of controlled substances, as well as failure to document a pain assessment for a patient after medication administration. The third cause for discipline alleges that respondent's conduct as described in the first two causes for discipline constitutes unprofessional conduct. The accusation seeks to recover costs incurred by the board in the investigation and enforcement of the accusation against respondent.

The accusation specifically alleges that respondent mishandled and failed to properly document controlled substances with regard to four patients. The allegations regarding each of the four patients are summarized below:

- Patient #108 – On July 18, 2015, at 8:18 p.m. respondent documented the administration of hydromorphone (Dilaudid)[1] of 1mg/ml to Patient #108. However, there was no record of withdrawal of the hydromorphone from the Pyxis[2] machine. On July 18, 2015, at 10:25 p.m. respondent withdrew 1 mg/ml of hydromorphone from Pyxis. Patient records show that at 11:13 p.m. Patient #108's pain level was 8 out of 10 on a 10-point scale with 10 representing the worst pain and 0 representing no pain. Complainant alleges that respondent waited 48 minutes to address the patient's pain level after administration of hydrocodone.

- Patient #484 – On July 19, 2015, at 2:58 a.m. respondent withdrew 1 mg/ml of hydromorphone from the Pyxis machine, and at 3:00 a.m. respondent documented the administration of that 1 mg/ml of hydromorphone to Patient #484. Five minutes later at 3:05 p.m. respondent again documented the administration of 1 mg/ml of hydromorphone to Patient #484, but there was no record of removal of the second 1 mg/ml of hydromorphone from Pyxis.

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[1] Hydromorphone, sold under the brand name of Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug pursuant to Business and Professions Code section 4022. Hydromorphone is used to treat moderate to severe pain.

[2] "Pyxis" is a trade name for the automatic single-dose medication dispensing system that records information such as patient name, physician orders, the date and time the medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. The user is required to enter a second "PIN" number, similar to an ATM machine, to gain access to medications. Sometimes only portions of the withdrawn medications are administered to the patient. The portions not administered are referred to as "wastage." Wasted medications must be disposed of in accordance with hospital rules and must be witnessed by another authorized user and recorded in Pyxis.

On July 19, 2015, at 5:01 a.m. respondent withdrew 1 mg/ml of hydromorphone from Pyxis. At 5:53 a.m. respondent documented that she administered that 1 mg/ml of hydromorphone to Patient #484, 52 minutes after its withdrawal from Pyxis. At 5:53 a.m. respondent documented that Patient #484's pain level was 9 out of 10. Complainant alleges that respondent waited 52 minutes to address Patient #484's pain level.

- Patient #087 – On July 20, 2015, at 8:33 p.m. respondent withdrew 2 mg/1 ml of lorazepam (Ativan)[3] from Pyxis. Respondent documented that she administered 1 mg/0.5 ml of lorazepam to Patient #087 and documented wastage of 1.5 mg of lorazepam, which is 0.5 mg more lorazepam than was withdrawn from Pyxis.

- Patient #155 – On July 30, 2015, at 9:11 p.m. respondent withdrew 1 tablet of 5 mg/325 mg of hydrocodone/acetaminophen[4] from Pyxis and documented its administration to Patient #155 at 9:19 p.m. Complainant alleges that respondent did not perform a pain re-assessment of Patient #155 after administration of the hydrocodone/acetaminophen and failed to document Patient #155's response to that medication.

3. Respondent timely filed a Notice of Defense, and this hearing followed.

Respondent's Work at Southwest Healthcare System – Inland Valley Medical Center

4. Respondent worked from May 2015 to August 2015 as a registry nurse employed by a company called MGA Healthcare California, Inc., which is a registry nurse broker that contracts with various hospitals to provide nurses to work on a short-term basis at those hospitals. During the time respondent was employed by MGA she was assigned to work as a registry nurse at Southwest Healthcare System, Inland Valley Medical Center (IVMC) assigned to the medical/surgical/telemetry units. Respondent worked the night shift at IVMC from 7:00 p.m. to 7:00 a.m. about three to four days per week.

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[3] Lorazepam, brand name Ativan, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Business and Professions Code section 4022. Lorazepam belongs to a group of drugs called benzodiazepines, a group of psychotropic agents prescribed to treat anxiety and other conditions, such as seizures, insomnia, alcohol withdrawal, nausea, vomiting, and to provide general anesthesia and muscle relaxation.

[4] Hydrocodone and acetaminophen, brand name Vicodin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat moderate to severe pain.

IVMC's Audit of Controlled Substances

5. Southwest Healthcare System is a company that operates two hospitals, one of which is IVMC. In 2015, the policy of Southwest Healthcare System, including IVMC, dictated that a monthly audit of the withdrawal and administration of controlled substances be conducted by the Pharmacy Director of Southwest Healthcare System. Cheryl Daniels is currently employed by Southwest Healthcare System as the Director of Pharmacy, and she has held that position for the past nine years. Ms. Daniels has been a licensed pharmacist for 34 years.

6. Ms. Daniels testified at the hearing regarding the monthly audit of controlled substances at IVMC for the removal and administration of controlled substances in July 2015. Ms. Daniels explained that the monthly audits are conducted the month after the audit period, so that the July 2015 audit occurred in August 2015. The audits are random in nature and Ms. Daniels selects certain controlled substances and runs a report from the Pyxis machine that shows all of the removals of those controlled substances, as well as any wastage of those substances. Additionally, a report is generated on Pyxis showing all the withdrawals of the controlled substances for each nurse on the medical/surgical/telemetry floors so that a comparison between those nurses can be made regarding the frequency of withdrawals. If a nurse falls outside of three standard deviations from the median of controlled substances administered as compared to other nurses on her floor, then that nurse is selected for further analysis. Once a nurse is selected, a comparison of the information in Pyxis is made to patient charts to ensure that the correct drugs were given in the correct amounts as ordered by the physicians. Ms. Daniels testified that respondent was selected for further analysis because for the month of July 2015 and the first two weeks of August 2015 she was outside of the three standard deviations of the median of other nurses on her controlled substance withdrawals from Pyxis. Specifically, respondent was from 3.0 to 4.8 standard deviations outside of the median for other nurses for her administration of five controlled substances.

7. Ms. Daniels thereafter began an audit of respondent's withdrawal and administration of controlled substances for a two-week period in July 2015 by comparing respondent's withdrawals of controlled substances in Pyxis with the corresponding patient records showing doctors' orders and medication administration. Ms. Daniels created a report showing her analysis by patient number for all the withdrawals, administration, and wastage of controlled substances by respondent. Ms. Daniels's comparison of information from Pyxis to patient charts showed some discrepancies regarding respondent's withdrawal and administration of hydromorphone for 11 different patients. Ms. Daniels provided her summary of information regarding respondent's controlled substance discrepancies to the Chief Nursing Officer for Southwest Healthcare System, Kristen Johnson, and discussed her findings with Ms. Johnson.

8. Respondent's withdrawal, administration, wastage and assessments for the four patients at issue in the accusation were provided in documentation from patient records and Pyxis records and are summarized below:

- With regard to Patient #108, respondent documented that she administered 1 mg/ml of hydromorphone on July 18, 2015, at 8:18 p.m., to Patient #108, but there was no withdrawal of hydromorphone from the Pyxis for that patient corresponding to that administration. Respondent withdrew 1 mg/ml of hydromorphone on July 18, 2015, at 10:25 p.m. from the Pyxis, but did not administer that hydromorphone to Patient #108 until 11:13 p.m., which was 48 minutes after she withdrew that dosage from Pyxis.

- With regard to Patient #484, Pyxis documentation shows that respondent withdrew 1 mg/ml of hydromorphone on July 19, 2015, at 2:58 a.m., and patient documentation shows she administered that 1 mg/ml of hydromorphone to Patient #484 at 3:00 a.m. Patient documentation shows that respondent again administered 1 mg/ml of hydromorphone to Patient #484 at 3:05 a.m., only five minutes later. However, there is no corresponding Pyxis documentation to show that respondent ever withdrew the hydromorphone dosage administered at 3:05 a.m. to Patient #484. Also, on July 19, 2015, Pyxis documentation shows that respondent withdrew 1 mg/ml of hydromorphone at 5:01 a.m., but patient documentation shows that respondent administered the 1 mg/ml of hydromorphone to Patient #484 at 5:53 a.m., which was 52 minutes after she withdrew it from Pyxis. The patient documentation also shows that at 5:53 a.m. Patient #484's pain level was 9 out of 10, indicating extreme pain.

- With regard to Patient #087, Pyxis documentation shows that respondent withdrew 2 mg/1 ml of lorazepam at 8:20 p.m. on July 20, 2015. Patient documentation shows that respondent administered 1 mg/0.5 ml of lorazepam to Patient #087 at 8:33 p.m. on July 20, 2015. Pyxis documentation also shows that respondent wasted 1.5 mg of lorazepam at 8:20 p.m. on July 20, 2015, which is 0.5 mg more lorazepam than she withdrew from Pyxis.

- With regard to Patient #155, Pyxis documentation shows that respondent withdrew 1 tablet of 5 mg/325 mg of hydrocodone/acetaminophen at 9:11 p.m. on July 30, 2015, and administered that tablet to Patient #155 at 9:19 p.m. on July 30, 2015. Patient documentation shows that respondent did not document that she performed any pain re-assessment of Patient #155 after she administered that tablet and respondent failed to document Patient #155's response to the administration of the tablet.

IVMC Policies

9. IVMC has hospital policies regarding the administration of controlled substances and other medication, which were in place in July 2015. Those documented IVMC hospital polices were received into evidence. Additionally, the Chief Nursing Officer for Southwest Healthcare Services, Kristen Johnson, testified regarding the polices in place

at IVMC in July 2015 regarding the withdrawal, administration, and wastage of controlled substances, as well as the hospital policy regarding the assessment and re-assessment of a patient's pain level before and after the administration of a controlled substance used to control pain. Ms. Johnson has been the Chief Nursing Officer for Southwest Healthcare Services for the past five-and-a-half years, and she has been a licensed registered nurse for the past 34 years. The documented IVMC policies in place in July 2015 for medication administration provide that "[m]edication will be obtained immediately prior to administration," "PRN[5] medications for pain relief will be administered 15 minutes or less from time patient makes request," and with regard to any PRN medication administered, the administration "must be documented in the medical record along with the indication for administration and patient response," and "[a]ssessment of patient response to the medication must occur within one hour following the administration." Ms. Johnson testified that all nurses at IVMC, including all registry nurses from registry agencies, are trained in all IVMC policies prior to being assigned any patients. Ms. Johnson further explained that all registry nurses must complete mandatory training, which includes training on electronic documentation and a full orientation, as well as an "RN day" where the registry nurse shadows another registered nurse, who shows the registry nurse how things are done at IVMC, including use of the Pyxis machine. Ms. Johnson testified that respondent completed all this training, including training on the IVMC polices, prior to working at IVMC.

10. Ms. Johnson testified that IVMC policy also dictates that when a nurse wastes a controlled substance taken from Pyxis, the wastage must be witnessed by another registered nurse, who also documents that wastage in Pyxis. She emphasized that with regard to the administration of pain medication, IVMC policy and the standard of practice of a registered nurse dictates mandates that an assessment of the patient's pain must be made prior to the administration of the pain medication, as well as within an hour after the administration of the pain medication in order to assess the effectiveness of the pain medication. Ms. Johnson also testified that IVMC policy dictates that when a registered nurse pulls a controlled substance from Pyxis for administration to a patient, the nurse must immediately administer the controlled substance to the patient and not carry it around for later administration. However, Ms. Johnson also stated that there are unusual situations where a nurse may withdraw a controlled substance for administration to a patient, and before the nurse is able to administer the controlled substance to the patient, an emergency (such as another patient having a cardiac arrest) may occur, pulling the nurse away so that the administration of the controlled substance is not immediate. She clarified that if such an emergency did occur that delayed the administration of the controlled substance, it is best practice for the nurse to document that delay in patient records, but it is not required.

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[5] PRN is common medical terminology used in prescriptions and order writing by physicians and is an abbreviation for the Latin phrase "pro re nata" meaning "as circumstances may require" or "as necessary."

The Board's Investigation

11. On October 27, 2015, Ms. Johnson completed a complaint form regarding respondent and submitted it to the board. Ms. Johnson testified that she submitted this complaint form based upon the results from the IVMC controlled substances audit performed. The complaint form, which was received into evidence, provides in part as follows:

> Michelle Gillin was working for Southwest as a registry RN when needed on the night shift. During a routine controlled substances audit by the Director of Pharmacy, based on a greater than 3 standard deviation report regarding dilaudid, percocet and ativan administration on the Med-Surg-Tele units at Inland Valley Medical Center, Michelle's medication administration practices were "red flagged." It was discovered that Michelle was administering multiple doses of dilaudid, percocet, and ativan to patients during her shift, more frequently during her shift and the same patietns [*sic*] were not receiving pain medications druing [*sic*] the shift prior not the shifts following. These "red flags" were concerning to the Director of Pharmacy, who brought the issues and supporting reports to my attention (The CNO) as potential diversion. Michelle was made a "Do Not Return" for Southwest Facilities.

12. On September 2, 2015, respondent sent an email to the board's enforcement email address with the subject line of "accusations," which stated as follows:

> To Whom It May Concern
>
> I am an RD [*sic*] working for Mga [*sic*] nursing registry. One of the hospitals I was working accused me of taking patients' drugs's [*sic*]. So my agency did a drug test that came back negative. I knew it would because I never took any of my patient's medicine.
>
> My agency told them the results but the hospital still says they are going to report me to the BRN. They did a [*sic*] audit of all the patients. They said I gave my patients lots of medications and some were given only by me. I just addressed the patients [*sic*] pain and anxiety. I only gave what was ordered and nothing more to make my patient's [*sic*] comfortable.
>
> I don't understand how I can be reported to the BRN for doing my job. No one reported that I appeared to be under the influence because I wasn't. Why am I accused because I

> addressed my patients [*sic*] pain/anxiety and other nurses didn't? I have never been accused of something like this before.
>
> My registry and I are at a lost [*sic*] as to what we should do? Diversion is only for nurses who drug test came back positive. The hospital is Inland Valley Medical Center in Wildomar.

In a follow-up September 5, 2015, email to the board's enforcement email address, respondent wrote in part as follows:

> I was wondering if I could initiate the investigation? These accusations are causing me so much stress.

13. Based upon respondent's emails dated September 2, 2015, and September 5, 2015, as well as the October 27, 2015, complaint from Ms. Johnson, the board began an investigation of respondent. On December 15, 2015, Rafaela Vasquez, a special investigator for the board, was assigned to investigate this matter. Ms. Vasquez has been a special investigator for the board since October 2014, and she testified at the hearing. Her duties include the investigation of complaints related to registered nurses, nurse practitioners, and nurse midwives, and the preparation of reports summarizing her investigations. Ms. Vasquez began her investigation of this matter by obtaining an authorization from respondent to obtain her employment records from MGA Healthcare California, Inc., reviewing those records, as well as reviewing patient records (including Pyxis records) for 11 patients at IVMC who were the subject of the IVMC controlled substances audit related to respondent, reviewing IVMC policies and procedures for July 2015, and reviewing IVMC staffing assignment sheets. As part of her investigation, Ms. Vasquez also interviewed Ms. Johnson and respondent. Ms. Vasquez also obtained a urine sample from respondent on August 22, 2016, to test for controlled substances, and the test was negative for controlled substances. Ms. Vasquez summarized her findings in a report signed on September 9, 2016.

The Board's Expert

14. Randy Delacruz is currently employed as a perioperative nurse manager at Sharp Hospital in the outpatient surgery center, where he has worked since June 2012. He has been licensed as a registered nurse in California for 16 years and has practiced as a registered nurse during those 16 years. Mr. Delacruz received his Bachelor of Science degree in Nursing from Point Loma Nazarene University in May 2003 and received his Master of Science degree in Nursing Leadership from San Diego State University in 2012. In addition to his work at Sharp Hospital, Mr. Delacruz has worked as an expert witness for the board since December 2015. Mr. Delacruz has provided his expert opinion to the board in three other cases where he reviewed patient treatment records to provide an opinion on whether the nursing provided met "acceptable standards of practice for a registered nurse under the California Nursing Practice Act." Mr. Delacruz is very familiar with Pyxis and uses it in his current job, and he is familiar with the duties of a registered nurse in a medical/surgical/telemetry unit. In his current job at Sharp Hospital Mr. Delacruz is the

direct supervisor of 40 nurses and is responsible for managing the policies and procedures of the hospital to make sure they are current and that the nurses he supervises are performing competently the best practices according to national standards. Mr. Delacruz testified that he keeps current with the standards of practice of registered nurses by working with regulatory, pharmacy and safety practitioners to stay current with national best practices. He also is involved with national nursing organizations that assist him with his knowledge of national best practices.

15. Mr. Delacruz was assigned by the board to review patient records and Pyxis documentation from July 2015 regarding respondent's work at IVMC to provide an opinion in this matter. Mr. Delacruz testified that the board provided him with these documents for review "with the accusation that [respondent] was diverting medications." Mr. Delacruz reviewed documents, including the complaint filed with the board by Ms. Johnson, IVMC patient medical and medication administration records from July 2015, policies and procedures of IVMC applicable during July 2015, Waste Narcotic Training Completed by respondent on July 5, 2015, and July 15, 2015, Medication Administration Training electronically signed by respondent on May 15, 2015, and the Director of Pharmacy of IVMC's audit report, to provide his opinion in this matter. Mr. Delacruz summarized his review and opinions in a report signed on October 25, 2016. He testified that as part of his review of documentation in this matter, he reconciled the Pyxis report to the corresponding patient medical records for the four patients at issue in this matter, as well as two additional patients, to create a chart with a column showing his findings, which he included in his report. Mr. Delacruz testified that he determined the "standard of care" in this case by his years of experience, training for regulatory compliance, and knowledge of medication administration. In his report Mr. Delacruz wrote that the "standard of practice" for a registered nurse, which corresponds to the policies of IVMC, requires the following three practices: (1) before the administration of medication to a patient, the nurse must confirm the "five rights" which are right patient, right drug, right dose, right time, and right route; (2) documentation for the administration of PRN medications in the patient's medical record requires documentation of the reason for the medication administration, as well as the patient's response to the medication, which must be recorded within one hour following administration of the medication; and (3) a nurse must properly account for all controlled substances, including wastage, discrepancies, and inventories. His report also noted:

> The American Nurses Association (ANA) 2010 defines the Standard of Professional Nursing Practice as authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently.

However, Mr. Delacruz did not define what he meant by "standard of care" in either his report or his testimony beyond this statement. He also provided no explanation or characterization of any degree of departure from the standard of care in his report or testimony regarding the allegations against respondent.

16. Mr. Delacruz testified and summarized in his report that the records he reviewed indicated that respondent committed the following departures from the "standard of practice" with the four patients at issue in the accusation as follows:

- With regard to Patient #108, respondent administered intravenous pain medication of hydromorphone 1 mg/ml at 11:13 p.m., and did so 48 minutes after she removed that controlled substance from the Pyxis machine at 10:25 p.m. At 11:13 p.m. Patient #108's pain was at a level of 8 out of 10, which is a high level of pain. Mr. Delacruz concluded that respondent departed from the standard of care by waiting 48 minutes to address Patient #108's pain, which also violated the IVMC policies and procedures requiring that the pain medication be provided at the "right time." Notably, Mr. Delacruz did not provide any opinion regarding the degree of the departure from the standard of care regarding this incident. Also, with regard to Patient #108, Mr. Delacruz opined that respondent documented in Patient #108's medical record that she administered 1 mg/1 ml of hydromorphone to Patient #108 at 8:18 p.m., but there was no corresponding documentation in Pyxis showing that respondent had withdrawn that dosage from the Pyxis machine thereby making that administration impossible. As a result, Mr. Delacruz opined that respondent departed from the standard of care by incorrectly documenting the "drug, time and route" of administration of the medication. Again, Mr. Delacruz offered no opinion or explanation regarding whether this departure from the standard of care was an extreme departure, a simple departure, or any other degree of departure.

- With regard to Patient #484, respondent documented in the medical record for this patient that she administered 1 mg/1 ml of hydromorphone at 3:05 a.m. However, there was no corresponding withdrawal of that medication from Pyxis making its administration impossible. As a result, Mr. Delacruz opined that respondent departed from the standard of care by incorrectly documenting the "drug, time and route" of administration of the medication. Again, Mr. Delacruz offered no opinion regarding the degree of the departure from the standard of care regarding this incident. Also, on July 19, 2015, at 5:53 a.m. respondent administered 1 mg/1 ml of hydromorphone to Patient #484, which was 52 minutes after she removed that medication from Pyxis at 5:01 a.m. Respondent documented that Patient #484's pain level was 9 out of 10 at 5:53 a.m. Mr. Delacruz opined that respondent departed from the standard of care by waiting 52 minutes to address Patient #484's pain, which also violated the IVMC policies and procedures requiring that the pain medication be provide at the "right time." Again, Mr. Delacruz did not provide any opinion regarding the degree of the departure from the standard of care regarding this incident.

- With regard to Patient #155, respondent documented that she administered one tablet of 5 mg/325 mg hydrocodone/acetaminophen to Patient #155 at 9:19 p.m. on July 30, 2015, but she failed to document any reassessment of Patient #155's pain level after administration of that medication. Mr. Delacruz opined that respondent's failure to do so was a departure from the standard of care, as well as a violation of IVMC's policies and procedures, which require assessment of a patient's response to pain medication within one hour following the administration of the medication. Again, Mr. Delacruz offered no opinion or testimony regarding the degree of departure from the standard of care regarding this incident.

- With regard to Patient #087, on July 20, 2015, at 8:20 p.m. respondent withdrew 2 mg/1 ml of lorazepam from Pyxis. Respondent documented that she administered 1 mg/0.5 ml of lorazepam to Patient #087 at 8:33 p.m. on July 20, 2015. At 8:33 p.m. on July 20, 2015, respondent documented that she wasted 1.5 mg of lorazepam, which totaled 0.5 mg more lorazepam than she had withdrawn, which is impossible. Accordingly, Mr. Delacruz opined that respondent departed from the standard of care because her documentation was not correct and was the result of either an incorrect administration or wastage of that medication. He also opined that her inaccurate documentation was a departure from the IVMC policies and procedures. Again, Mr. Delacruz offered no opinion or testimony regarding the degree of departure from the standard of care regarding this incident.

17. Mr. Delacruz testified that while none of the patients discussed above were harmed as a result of respondent's departure from the standard of care, there was potential for serious harm to those patients. However, he noted that respondent's failure to meticulously document her administration, withdrawal, and wastage of controlled substances could create "stack medication dosing, late medication dosing, or missed dosing," all of which can be harmful to patients.

18. Mr. Delacruz also testified and opined in his report that while respondent did depart from the standard of care of a nurse and she did violate IVMC policies as stated above, he found no evidence that respondent was diverting controlled substances for any purpose.

19. On cross-examination, Mr. Delacruz testified hospital polices can differ from facility to facility. He also stated that when he is evaluating whether an act demonstrates incompetence, he relies on the hospital policy where the person works to determine if the act constitutes incompetence. Notably, Mr. Delacruz admitted that any act that falls below hospital policy, even if it is a mistake, constitutes incompetence. Mr. Delacruz even stated that any departure from the standard of care by a nurse constitutes incompetence. Notably, he never testified or explained the degree of departure from the standard of care he

considered necessary to distinguish between simple negligence, gross negligence or incompetence.

Evidence Submitted by Respondent

RESPONDENT'S TESTIMONY

20. Respondent is 50 years old and has been working as a registered nurse since 2001 when she received her registered nurse license from California. She currently works at Loma Linda University Medical Center in Murrieta as a registered nurse in the float pool working in various units throughout the hospital. She has held that position for three years. Prior to this position she worked as a registry nurse for MGA Healthcare California, Inc. and was assigned to IVMC.

21. Respondent testified that she worked at IVMC from May to August of 2015 about three to four days per week during the night shift, which was from 7:00 p.m. to 7:30 a.m. During the time she worked at IVMC she worked on the second floor units, which are medical/surgical/telemetry. During each of her shifts at IVMC she was typically assigned to care for four to six patients at a time, most of whom had serious health issues.

22. Respondent stated that she understands that the board began an investigation against her because Ms. Johnson accused her of diverting drugs from her patients. Respondent testified that she has never diverted drugs, never taken drugs not prescribed to her, never sold drugs, and never failed a random drug test, which are routinely given to her in her job as a nurse.

23. Respondent testified that she had no recollection of treating any of the four patients at issue in the accusation, but she did recall providing patient care generally after review of the patient records. Respondent explained that with regard to administration of medications to any patient, at IVMC she was required to remove the medication from Pyxis and then go to the patient's bedside, scan the patient's armband, then scan the medication and then give the medication to the patient. She explained that the "scan" she referred to was a bar code scanner that recorded the information in the patient's medical record on a computer by the bedside. She stated that there were some times when she would attempt to scan the bar code of the medication, but it would not work. She stated that you could override the system and type the information in manually, but she would never do so with regard to controlled substances. So, if the controlled substance scan did not work, she would simply keep trying to scan it. She stated that sometimes when she scanned it she "heard a beep" but did not see an entry on the computer screen, so she scanned the medication again.

24. Respondent testified that while she worked at IVMC she did not administer medication to any patient that she did not document as administered. She admitted that if she documented the administration of a medication to a patient, then she did administer that medication.

25. With regard to Patient #108, respondent stated that she had no idea how the medical record showed that she administered a medication to that patient that had not been documented as having been withdrawn from Pyxis.

26. With regard to the allegations that she waited 48 minutes to provide pain medication to Patient #108, and she waited 52 minutes to administer pain medication to Patient #484, respondent had no recollection of treating those patients. However, she stated it was her practice to administer the medication as soon as possible after checking to make sure that the patient was allowed to receive the medication pursuant to doctor's orders and it would not be too soon since the last administration of pain medication. She stated that there were a few occasions when she was not able to deliver medication to a patient in a timely manner at IVMC because of patient emergencies that arose. Specifically, she explained that a patient emergency could be a "code blue," which was when a patient went into cardiac or respiratory arrest. She stated that if a code blue occurred on the floor of IVMC, all nurses were required to respond and other patient care "was secondary."

27. With regard to the allegations related to Patient #484 that respondent "double dosed" the patient by administering 1 mg of hydromorphone at 3:00 a.m. and again at 3:05 a.m. on July 19, 2015, as documented in the patient records, respondent testified that she had never "double dosed" a patient at IVMC intentionally. Respondent admitted that it is dangerous if a patient medical record shows that a medication was administered when it was not actually administered. She admitted that it is important for a patient record to be accurate, particularly with regard to controlled substance administration.

28. With regard to the allegations related to Patient #087 that respondent wasted more lorazepam than she withdrew from the Pyxis, respondent stated she did not recall this wastage, but it is possible that she accidentally put the wrong dosage on the patient record. She stated that IVMC policy required, and she always followed that policy, that a witness watch any wastage and withdrawal of medication. She stated that she has never concealed any wastage from a witness and did not know why the records show that she wasted more lorazepam than was possible based upon what she recorded that she withdrew and administered to the patient.

29. With regard to the allegations regarding Patient #155 that respondent failed to reassess Patient #155's pain after administration of pain medication, respondent admitted that she may have failed to document any reassessment of this patient after administering the pain medication. She stated that it was her normal practice to do so, and she did not recall treatment of this specific patient so she did not know if her reassessment happened. However, she admitted that she failed to document any such reassessment in the patient record.

30. Respondent testified that prior to starting work at IVMC she did receive an orientation packet specific to that hospital, and she completed competency tests on the computer regarding medication administration, including controlled substances. She stated

that she did not receive a full orientation like those given to registered nurses who were directly employed by IVMC, but she did receive an orientation packet.

RESPONDENT'S DOCUMENTARY EVIDENCE

31. Respondent provided various documents, including three work evaluations from Loma Linda University Medical Center from 2016 to 2017, showing that she met or exceeded the standards of her work as a nurse; four letters of support from various other nurses who are or were co-workers of respondent; and her resume, which notably excluded her work for MGA Healthcare California, Inc. at IVMC. Each of the four nurses who wrote letters on behalf of respondent praised her professionalism, compassion, and skill as a nurse.

Costs of Investigation and Enforcement

32. In a Declaration of Investigative Costs filed in support of complainant's request for recovery of the costs of investigation, Rafaela Vasquez declared on September 13, 2016, that she worked 58.25 hours in fiscal years 2016/2017 at an hourly rate of $88.09 for a total of $5,131.24. The declaration divided the 58.25 hours into three categories: hours of investigation (39.75); hours for travel (2.83); and hours of report preparation (11.17)[6]. The declaration did not specify the time it took to perform the tasks listed under each category or the date the tasks in each category was performed. Additionally, the declaration provided that $62.50 was a cost incurred for the processing of respondent's urine sample. Furthermore, there was an additional certified document from the board showing that the costs incurred for investigation as of January 23, 2019, totaled $6,038.10. The certification document provided a simple chart that showed the "BRN Investigation" totaling $5,131.24 based upon the Declaration dated September 13, 2016, plus "BRN Investigation" of 4.50 hours at a rate of $88.09 for an additional cost of $396.41, plus "Expert Practice Consultant hours + postage" for 6.5 hours at a rate of $75.00 per hour for an additional cost of $510.45. The certification document provided no explanation of the tasks completed for each of those hours or who performed those tasks.

33. Complainant also submitted a Certification of Prosecution Costs and Declaration of Deputy Attorney General Marichelle S. Tahimic to recover costs of enforcement pursuant to Business and Professions Code section 125.3. The certification outlined the legal services provided by the Office of the Attorney General. Counsel was well prepared and professional. The Deputy Attorney General's certification was supported by a billing summary detailing the professionals who worked on the matter, the date the professionals worked on the matter, the tasks performed, the amount of time billed for the activities and the hourly rate of the professionals who performed the work. That documentation established that the board was billed $9,917.50 for legal services, which included work by five different attorneys and one paralegal. The declaration also included a statement that for the fiscal year of 2018 that Ms. Tahimic anticipated billing an additional

[6] Notably, these three total hours only add up to 53.75 hours. Accordingly, it is not known what category the remaining 5 hours fall under.

2.0 hours at a rate of $170 for a total of $340 to further prepare the case up to the commencement of the hearing. The total amount of costs of prosecution sought based on this declaration was $10,257.50.

LEGAL CONCLUSIONS

Standard and Burden of Proof

1. The standard of proof in an administrative disciplinary action seeking the suspension or revocation of a professional license is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) "Clear and convincing evidence" requires a high probability of the existence of the disputed fact, greater than proof by a preponderance of the evidence. Evidence of a charge is clear and convincing as long as there is a high probability that the charge is true. (*People v. Mabini* (2001) 92 Cal.App.4th 654, 662.) Complainant bears the burden of proof of establishing that the charges in the accusation are true.

Applicable Statutory and Regulatory Provisions

2. Business and Professions Code section 482 requires the board to "develop criteria to evaluate the rehabilitation of a person when . . . (b) considering suspension or revocation of a license under Section 490." Section 482 also requires the Board to "take into account all competent evidence of rehabilitation furnished by the applicant or licensee."

3. Business and Professions Code section 2761, subdivision (a), provides that the "board may take disciplinary action against a certified or licensed nurse" for unprofessional conduct, which includes "[i]ncompetence, or gross negligence in carrying out the usual certified or licensed nursing functions."

4. Business and Professions Code section 2762 provides in part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter, it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

[¶] . . . [¶]

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

5. California Code of Regulations, title 16, section 1443, provides:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

6. California Code of Regulations, title 16, section 1443.5, provides:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

7. California Code of Regulations, title 16, section 1444.5, provides, in part:

In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the board shall consider the disciplinary guidelines entitled: "Recommended Guidelines for Disciplinary Orders and Conditions of Probation" (10/02) which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the board in its sole discretion determines that the facts of the particular case warrant such a deviation - for example: the presence of mitigating factors; the age of the case; evidentiary problems.

Disciplinary Guidelines

8. The board's "Recommended Guidelines for Disciplinary Orders and Conditions of Probation" (10/02) (Guidelines) provide criteria to consider in determining the appropriate level of discipline, including: the nature and severity of the acts under consideration, the actual or potential harm to the public, the actual or potential harm to any patient, respondent's prior disciplinary record, the number and/or variety of current violations, evidence of mitigation and rehabilitation, and the amount of time that has passed since the occurrence of the acts under consideration.

9. The board's Guidelines permit the respondent to present evidence of mitigating circumstances at a hearing and lists "examples" of "appropriate evidence" a respondent may submit to demonstrate his or her rehabilitative efforts and nursing competency, as follows:

A) Recent, dated written statements from persons in positions of authority who have on-the-job knowledge of the respondent's current nursing competence. Each statement should include the

period of time and capacity in which the person worked with the respondent and should contain the following sentence at the end: "I declare, under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct." It should be signed by the one making the statement and dated.

B) Recent, dated letters from counselors regarding respondent's participation in a rehabilitation or recovery program, where appropriate. These should include a description of the program, the number of sessions the respondent has attended, the counselor's diagnosis of respondent's condition and current state of rehabilitation (or improvement), the counselor's basis for determining improvement, and the credentials of the counselor.

C) Recent, dated letters describing respondent's participation in support groups, e.g., Alcoholics Anonymous, Narcotics Anonymous, Nurse Support Groups, etc., where appropriate, and sobriety date.

D) Recent, dated laboratory analyses or drug screen reports, where appropriate.

E) Recent, dated performance evaluation(s) from respondent's employer.

F) Recent, dated physical examination or assessment report by a licensed physician, nurse practitioner, or physician assistant.

G) Certificates or transcripts of courses related to nursing which respondent may have completed since the date of the violation. . . .

10. The Guidelines provide the minimum discipline for a first offense of violating Business and Professions Code section 2762, subdivision (e), falsifying and/or making grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to controlled substances, is revocation stayed for three years with minimum conditions of probation numbers 1 through 13 and others as appropriate. In other cases involving repeated and similar acts, the recommended discipline is revocation stayed for three years with minimum conditions of probation numbers 1 through 19.

11. The Guidelines provide the minimum discipline for a first offense of violating Business and Professions Code section 2761, subdivision (a)(1), incompetence or gross negligence, is revocation stayed for three years with minimum conditions of probation

numbers 1 through 13 and others as appropriate, including condition 19 if patient death occurred. In other cases, the recommended discipline is revocation.

12. The Guidelines provide the minimum discipline for a first offense of violating Business and Professions Code section 2761, subdivision (a), other actions which constitute unprofessional conduct, is revocation stayed for three years with minimum conditions of probation numbers 1 through 13 and others as appropriate. In other cases, the recommended discipline is revocation.

Evaluation

13. Public protection is the highest priority for the Board of Registered Nursing. The purpose of professional license discipline is not to punish the individual, but to protect the public. (*Ettinger v. Board of Medical Quality Assurance, supra.*)

14. A registered nurse is in a position that requires honesty, trustworthiness, and impeccable compliance with the laws and regulations governing the duties and responsibilities of a nurse. A registered nurse has access to controlled substances. A registered nurse is on the frontline of patient care and routinely exercises independent judgment and discretion to make important medical decisions that can significantly impact a patient's health and recovery.

15. Cause does not exist to discipline respondent's registered nurse license pursuant to Business and Professions Code sections 2761, subdivision (a)(1), because complainant failed to prove that respondent was incompetent in her care of Patient #108, Patient #484, Patient #087, and Patient #155. Complainant's expert witness provided no testimony or documentation in his report regarding the "degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse" under the circumstances of the treatment of each of the four patients above. He did provide testimony regarding what he called "standard of practice" or "standard of care" without ever defining those phrases, and he testified about "best practices" of a nurse, which does not correlate with what is "ordinarily possessed and exercised by a competent registered nurse." Mr. Delacruz even testified that any departure from a hospital policy, which may vary from hospital to hospital, was determinative of whether or not a nurse was incompetent. If a hospital policy may vary from facility to facility, it can't be determinative of the definition of incompetence as defined in Business and Professions Code sections 2761, subdivision (a)(1), which requires uniformity for all nurses in the state of California. Complainant provided no other evidence regarding how respondent's actions would constitute incompetence. Accordingly, complainant failed to establish that respondent was incompetent and failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse.

16. Cause exists to discipline respondent's registered nurse license pursuant to Business and Professions Code sections 2762, subdivision (e), for making grossly incorrect, grossly inconsistent, or unintelligible entries into hospital and patient records because

respondent documented the administration of 1 mg of hydromorphone to Patient #108 when there was no record of the withdrawal of that medication from Pyxis; because respondent documented the administration of 1 mg of hydromorphone to Patient #484 when there was no record of the removal of hydromorphone in the Pyxis records; because respondent failed to document any performance of a pain assessment of Patient #155 after the administration of pain medication; and because respondent documented that she withdrew 2 mg/1 ml of lorazepam from Pyxis and administered 1 mg/0.5 ml to Patient #087 and documented that she wasted 1.5 mg of lorazepam, which was more lorazepam than she removed from Pyxis. Although, no patients were harmed as a result of respondent's actions, her actions had the potential for harm, jeopardized the safety of her patients, and constituted unprofessional conduct.

17. Cause exists to discipline respondent's registered nurse license pursuant to Business and Professions Code sections 2761, subdivision (a), because respondent's actions of making grossly incorrect, grossly inconsistent, or unintelligible entries into hospital and patient records for Patient #108, Patient #484, Patient #155, and Patient #087, as described above, constituted unprofessional conduct. Her actions had the potential for harm and jeopardized the safety of her patients.

The Appropriate Level of Discipline

18. Respondent engaged in violations of the Nursing Practice Act. Determining the appropriate level of discipline involves an evaluation of the rehabilitation and mitigation criteria enumerated in the board's Guidelines.

19. Rehabilitation is a state of mind and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) Fully acknowledging the wrongfulness of past actions is an essential step towards rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.) The mere expression of remorse does not demonstrate rehabilitation. A truer indication of rehabilitation will be presented if a petitioner can demonstrate by sustained conduct over an extended period of time that he is rehabilitated and fit to practice. (*In re Menna* (1995) 11 Cal.4th 975, 987, 991.) The evidentiary significance of misconduct is greatly diminished by the passage of time and by the absence of similar, more recent misconduct. (*Kwasnik v. State Bar* (1990) 50 Cal.3d 1061, 1070.)

20. Respondent's demeanor at the hearing was respectful, candid, and sincere. Respondent accepted responsibility for her failure to properly document any reassessment of one of her patient's pain after administration of pain medications, her failure to properly document the wasting of the lorazepam, her other failures to properly document medication administration in the patient records, and she demonstrated remorse. Respondent admitted that she failed to properly document any reassessment of a patient's pain after administration of pain medications and stated that she must have made a mistake with regard to the one incident of wasting of the lorazepam. Her testimony that she simply did not remember her

treatment of the four patients at issue in the accusation was sincere and credible. She provided explanations of what may have happened with regard to the duplicate entries in the medical records for Patient #484 with regard to the documentation of the administration of hydromorphone five minutes apart, namely that she may have scanned the medication more than once. However, she also testified that if she made an entry into a patient's records regarding the administration of a medication, then that meant she did administer the medication, which would mean that Patient #484 received two doses of hydromorphone five minutes apart. Respondent's failure to properly document the administration, withdrawal and wastage of controlled substances creates a risk for patients because the medical record would be unclear at best.

21. The board's investigation of respondent was initially based on an assertion by Ms. Johnson that respondent was potentially diverting controlled substances. There was no evidence presented to indicate that respondent ever diverted controlled substances or that she ever consumed controlled substances.

22. The board's Guidelines include numerous probationary requirements enacted to protect the public. Although there were facts raised at the hearing that were the cause for some concern regarding respondent's documentation regarding controlled substances, complainant failed to establish that respondent was incompetent or that she ever illegally obtained narcotics for her own use.

23. Upon consideration of the entirety of the facts and the application of the disciplinary criteria, protection of the public can be achieved by revoking respondent's license and placing her on probation under terms and conditions that will ensure she is practicing nursing safely. These would require her, among other requirements, to complete continuing education courses related to medication administration and documentation.

Reasonable Costs of Investigation and Prosecution

24. Under Business and Professions Code section 125.3, complainant may request that an administrative law judge "direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case." "A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case." (Bus. & Prof. Code, § 125.3, subd. (c).)

25. The Office of Administrative Hearings has enacted regulations for use when evaluating an agency's request for costs under Business and Professions Code section 125.3. (Cal. Code Regs., tit. 1, § 1042.) Under the regulations, a cost request must be accompanied by a declaration or certification of costs. For services provided by persons who are not agency employees, the declaration must be executed by the person providing the service and describe the general tasks performed, the time spent on each task, and the hourly rate. In lieu

of the declaration, the agency may attach copies of the time and billing records submitted by the service provider. (Cal. Code Regs., tit. 1, § 1042, subd. (b)(2).)

26. Complainant seeks costs related to the prosecution of this matter in the amount of $10,257.50 for costs incurred by the Attorney General's Office. The request for costs incurred complies with the Office of Administrative Hearings regulations. However, the costs incurred include billing from five different attorneys, which given the nature of this matter is excessive. Additionally, the declaration included a time estimation from 2018 for two hours to prepare for trial, which is vague and speculative considering the hearing happened in March 2019. The amount claimed by the Attorney General for costs in this case is therefore not reasonable given the scope of the matter. A reduction of the costs incurred by the Attorney General's Office to $5,128.75 is reasonable under the circumstances.

27. Complainant also seeks to recover $6,038.10 in investigative services provided to the board by Rafaela Vasquez and possibly others who are unnamed. The certificate of costs and supporting declarations do not comply with the Office of Administrative Hearings regulations. The request for reimbursement of these costs is denied on that basis.

28. Another consideration in determining costs is *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32. In *Zuckerman*, the California Supreme Court decided, in part, that in order to determine whether the reasonable costs of investigation and enforcement should be awarded or reduced, the agency must decide: (a) whether the licensee has been successful at hearing in getting charges dismissed or reduced; (b) the licensee's subjective good faith belief in the merits of his or her position; (c) whether the licensee has raised a colorable challenge to the proposed discipline; (d) the financial ability of the licensee to pay; and (e) whether the scope of the investigation was appropriate to the alleged misconduct.

29. In this case, respondent achieved a reduction in the severity of the discipline sought to be imposed, and she showed a good faith belief in the merits of her position at the hearing even though she did not fully prevail. The scope of the investigation initially involved allegations of diversion of controlled substances, but those allegations were not confirmed by the investigation and were not alleged. Respondent provided no evidence regarding her ability to pay costs in this matter.

30. Applying the *Zuckerman* criteria in the instant matter results in a determination that respondent is required to pay the $5,128.75 prosecution costs as reimbursement to the board for costs it incurred to enforce the action against her. Respondent shall be permitted to pay the costs pursuant to a payment plan to be determined by the board.

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ORDER

It is hereby ordered that respondent's Registered Nurse License Number 578433 is revoked, the order of revocation is stayed, and respondent is placed on probation for a period of three (3) years on the following conditions:

SEVERABILITY CLAUSE

Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

(1) OBEY ALL LAWS

Respondent shall obey all federal, state and local laws. Respondent shall report a full and detailed account of any and all violations of law to the board, in writing, within 72 hours of occurrence. To permit monitoring of compliance with this condition, respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

If respondent is under criminal court orders, including probation or parole, and the order is violated, this shall be deemed a violation of these probation conditions, and may result in the filing of an accusation and/or petition to revoke probation.

(2) COMPLY WITH THE BOARD'S PROBATION PROGRAM

Respondent shall fully comply with the conditions of the Probation Program established by the board and cooperate with representatives of the board in its monitoring and investigation of the respondent's compliance with the board's Probation Program. Respondent shall inform the board, in writing, within 15 days of any address change and shall at all times maintain an active, current license status with the board, including during any period of suspension.

(3) REPORT IN PERSON

During the period of probation, respondent shall appear in person at interviews/ meetings as directed by the board or its designated representatives.

(4) RESIDENCY, PRACTICE, OR LICENSURE OUTSIDE OF STATE

Periods of residency or practice as a registered nurse outside of California shall not apply toward a reduction of this probation time period. Respondent's probation is tolled, if she resides outside of California. Within 15 days of any change of residency or practice

outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state, respondent must provide written notice to the board.

Respondent shall provide a list of all states and territories where she has been licensed as a registered nurse, vocational nurse, or practical nurse. Further, respondent shall provide information regarding the status of each license and any changes in such license status during the term of probation. Respondent shall inform the board if she applies for or obtains a new nursing license during the term of probation.

(5) SUBMIT WRITTEN REPORTS

During the period of probation, respondent shall submit or cause to be submitted written reports/declarations and verification of actions under penalty of perjury, as required by the board. These reports/declarations shall contain statements relative to respondent's compliance with the conditions of the board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the board or its representatives. Respondent shall provide a copy of this decision to the nursing regulatory agency in every state and territory in which she has a registered nurse license.

(6) FUNCTION AS A REGISTERED NURSE

During the period of probation, respondent shall engage in the practice of registered nursing in California for a minimum of 24 hours per week for six consecutive months or as determined by the board.

For purposes of compliance with the section, "engage in the practice of registered nursing" may include volunteer work as a registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse, when approved by the board.

The board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for six consecutive months or as determined by the board.

If respondent has not complied with this condition during the probationary term, and respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, in its discretion, the board may grant an extension of the respondent's probation period up to one year without further hearing in order to comply with this condition. During the one-year extension, all original conditions of probation shall apply.

(7) EMPLOYMENT APPROVAL AND REPORTING REQUIREMENTS

Respondent shall obtain prior approval from the board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Upon request of the

board, Respondent shall cause to be submitted to the board all performance evaluations and other employment related reports as a registered nurse.

Respondent shall provide a copy of this decision to her employer and immediate supervisors prior to commencement of any nursing or other health care related employment.

In addition to the above, respondent shall notify the board in writing within 72 hours after she obtains any nursing or other health care related employment. Respondent shall notify the board in writing within 72 hours after she is terminated or separated, regardless of cause, from any nursing or other health care related employment with a full explanation of the circumstances surrounding the termination or separation, respondent shall notify the board in writing.

(8) SUPERVISION

Respondent shall obtain prior approval from the board regarding respondent's level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse or education and training that includes patient care.

Respondent shall practice under the direct supervision of a registered nurse in good standing (no current discipline) with the board, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate - The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours respondent works.

(c) Minimum - The individual providing supervision and/or collaboration has person-to-person communication with respondent at least twice during each shift worked.

(d) Home Health Care - If respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with respondent each work day, as required by the board. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration during each work-day, as required by the board. The individual providing supervision and/or collaboration shall conduct periodic, on-site visits to patients' homes visited by respondent, with or without, respondent present as required by the board.

(9) EMPLOYMENT LIMITATIONS

Respondent shall not work for a nurse's registry in a private duty position as a registered nurse, temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool.

Respondent shall not work for a licensed home health agency as a visiting nurse unless the board approves the registered nursing supervision and other protections for home visits. Respondent shall not work in any other registered nursing occupation where home visits are required.

The board may restrict respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a board approved continuing education program unless she first obtains formal written approval from the board.

Respondent shall work on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity.

If respondent is working or intends to work in excess of 40 hours per week, the board may request documentation to determine whether there should be restrictions on the hours of work.

(10) COMPLETE A NURSING COURSE(S)

At her own expense, respondent shall enroll in and successfully complete a course(s) relevant to the practice of registered nursing no later than six months prior to the end of her probationary term.

Respondent shall obtain prior approval from the board before enrolling in the course(s). Respondent shall submit to the board the original transcripts or certificates of completion for the above required course(s). The board shall return the original documents to respondent after photocopying them for its records.

(11) COST RECOVERY

Respondent shall pay to the board costs associated with its enforcement pursuant to Business and Professions Code section 125.3 in the amount of $5,128.75. Respondent shall be permitted to pay these costs in a payment plan approved by the board, with payments to be completed no later than three months prior to the end of the probation term.

(12) VIOLATION OF PROBATION

If respondent violates the conditions of her probation, after giving notice and an opportunity to be heard, the board may set aside the stay order and impose the stayed discipline (revocation/suspension) of respondent's license.

During the period of probation, if an accusation or petition to revoke probation is filed against respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the board.

(13) LICENSE SURRENDER

During respondent's term of probation, if she ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation, respondent may surrender her license to the board. The board reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, respondent will no longer be subject to the conditions of probation.

Surrender of respondent's license shall be considered a disciplinary action and shall become a part of respondent's license history with the board. A registered nurse whose license has been surrendered may petition the board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

(a) Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or

(b) One year for a license surrendered for a mental or physical illness.

DATED: April 12, 2019

DocuSigned by:
Debra Nye-Perkins
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DEBRA D. NYE-PERKINS
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHELLE RENE GILLIN** **30505 Canyon Hills Rd, Unit 304** **Lake Elsinore, CA 92532** **Registered Nurse License No. 578433** Respondent.	Case No. 2018-739 A C C U S A T I O N

Complainant alleges:

PARTIES

1. Joseph L. Morris, PhD, MSN, RN (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 9, 2001, the Board of Registered Nursing (Board) issued Registered Nurse License Number 578433 to Michelle Rene Gillin (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY AND REGULATORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> A(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> ...

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> ...
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Title 16, California Code of Regulations, (CCR), section 1443, states:

As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. Title 16, CCR, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DRUGS

11. Hydromorphone, sold under the brand name Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat moderate to severe pain.

12. Lorazepam, sold under the brand name Ativan, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Business and Professions Code section 4022. It belongs to a group of drugs called benzodiazepines. Benzodiazepines are a group of psychotropic agents prescribed to treat anxiety, and other conditions such as seizures, insomnia, general anesthesia, muscle relaxation, alcohol withdrawal, nausea and vomiting.

13. Oxycodone and acetaminophen, sold under the brand name Percocet, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (M), and a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat moderate to severe pain.

FACTS

14. At all times relevant to the allegations in this Accusation, Respondent was a registry nurse assigned to the Medical/Surgical/Telemetry Unit at Southwest Healthcare System - Inland Valley Medical Center (IVMC). She worked the night shift from 7 p.m. – 7 a.m.

15. A routine random audit of Dialudid, Percocet and Ativan was performed. As a result of the audit, further investigation was conducted regarding Respondent's medication administration practices. The investigation included a review of 11 patient records between July 16, 2015 to July 30, 2015, including her medication administration, nursing documentation and Pyxis reports. The investigation revealed the following:

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16. **Patient # ----108 (Patient #108):** On July 18, 2015, at 2018 hours, Respondent documented administration of hydromorphone (Dilaudid) 1 mg/1ml. However, there was no record of its withdrawal in Pyxis.[1]

17. On July 18, 2015, at 2225 hours, Respondent withdrew hydromorphone 1 mg/ml from Pyxis. Respondent documented IV administration of hydromorphone at 2313 hours, 48 minutes after withdrawal from Pyxis. The patient's pain level at 2313 hours was noted to be 8 out of 10 on a 10-point pain scale with 10 representing the highest level of pain and 0 representing no pain. Respondent departed from the standard of practice by waiting 48 minutes to address the patient's pain level.

18. **Patient # ----484 (Patient #484):** On July 19, 2015, at 0258 hours, Respondent withdrew hydromorphone 1 mg/ml from Pyxis. At 0300 hours, Respondent documented administration of hydromorphone 1 mg/ml. Five minutes later on July 19, 2015, at 0305 hours, Respondent documented administration of hydromorphone 1 mg/ml, however there was no record of this medication's removal from Pyxis.

19. On July 19, 2015, at 0501 hours, Respondent withdrew hydromorphone 1mg/ml from Pyxis. Respondent documented IV administration of hydromorphone at 0553 hours, 52 minutes after withdrawal from Pyxis. The patient's pain level at 0553 hours was noted to be 9 out of 10. Respondent departed from the standard of practice by waiting 52 minutes to address the patient's pain level.

20. **Patient # ----087 (Patient #087):** On July 20, 2015, at 2033 hours, Respondent withdrew lorazepam (Ativan) 2 mg/1ml injection. Respondent documented administration of 1 mg/0.5 ml, and documented wastage of 1.5 mg which is 0.5 mg more lorazepam than withdrawn.

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[1] Pyxis is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. The user is required to enter a second code "PIN" number, similar to an ATM machine, to gain access to medications. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as "wastage." This waste must be witnessed by another authorized user and is also recorded by the Pyxis machine.

21. **Patient # ----155 (Patient #155):** On July 30, 2015, at 2111 hours, Respondent withdrew 1 tablet hydrocodone/acetaminophen 5 mg/325 mg and documented administration at 2119 hours. Respondent did not perform a pain re-assessment after medication administration and failed to document the patient's response to the medication.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

22. Respondent is subject to discipline under Code section 2761(a)(1) for incompetence, as defined by title 16, CCR, 1443, in that Respondent failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as set forth in paragraphs 14-21 above and incorporated herein in that :

a. on July 18, 2015, Respondent waited 48 minutes to address Patient #108's pain level;

b. on July 18, 2015, at 2018 hours, Respondent documented the administration of hydromorphone 1 mg/ml for Patient #108 when there was no record of the removal of hydromorphone 1 mg/1 ml in Pyxis;

c. on July 19, 2015, Respondent waited 52 minutes to address Patient #484's pain level;

d. on July 19, 2015, at 0305 hours, Respondent documented the administration of hydromorphone 1 mg/ml for Patient #484 when there was no record of the removal of hydromorphone 1 mg/1 ml in Pyxis;

e. on July 30, 2015, Respondent did not perform a pain assessment of Patient #155 after medication administration and failed to document the patient's response to medication; and,

f. on July 20, 2015, at 2020 hours, Respondent withdrew lorazepam (Ativan) 2 mg/1ml injection for Patient #087, documented administration of 1 mg/0.5 ml, and documented wastage of 1.5 mg which is 0.5 mg more lorazepam than withdrawn.

SECOND CAUSE FOR DISCIPLINE

(Falsify or Make Gross Incorrect or Inconsistent Record)

23. Respondent is subject to discipline under Code section 2762(e) for falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record, as set forth in paragraphs 14-21 above and incorporated herein in that:

a. on July 18, 2015, at 2018 hours, Respondent documented the administration of hydromorphone 1 mg/ml for Patient #108 when there was no record of the removal of hydromorphone 1 mg/1 ml in Pyxis;

b. on July 19, 2015, at 0305 hours, Respondent documented the administration of hydromorphone 1 mg/ml for Patient #484 when there was no record of the removal of hydromorphone 1 mg/1 ml in Pyxis;

c. on July 30, 2015, Respondent did not perform a pain assessment of Patient #155 after medication administration and failed to document the patient's response to medication; and,

d. on July 20, 2015, at 2020 hours, Respondent withdrew lorazepam (Ativan) 2 mg/1ml injection for Patient #087, documented administration of 1 mg/0.5 ml, and documented wastage of 1.5 mg which is 0.5 mg more lorazepam than withdrawn.

THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

24. Respondent is subject to discipline under Code section 2761(a) for unprofessional conduct, as set forth in paragraphs 14-21 above and incorporated herein in that:

a. on July 18, 2015, Respondent waited 48 minutes to address Patient #108's pain level;

b. on July 18, 2015, at 2018 hours, Respondent documented the administration of hydromorphone 1 mg/ml for Patient #108 when there was no record of the removal of hydromorphone 1 mg/1 ml in Pyxis;

c. on July 19, 2015, Respondent waited 52 minutes to address Patient #484's pain level;

d. on July 19, 2015, at 0305 hours, Respondent documented the administration of hydromorphone 1 mg/ml for Patient #484 when there was no record of the removal of hydromorphone 1 mg/1 ml in Pyxis;

e. on July 30, 2015, Respondent did not perform a pain assessment of Patient #155 after medication administration and failed to document the patient's response to medication; and,

f. on July 20, 2015, at 2020 hours, Respondent withdrew lorazepam (Ativan) 2 mg/1ml injection for Patient #087, documented administration of 1 mg/0.5 ml, and documented wastage of 1.5 mg which is 0.5 mg more lorazepam than withdrawn.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 578433 issued to Michelle Rene Gillin

2. Ordering Michelle Rene Gillin to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: May 4, 2018

for JOSEPH L. MORRIS, PHD, MSN, RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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