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BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke
Probation Against:

MICHELE DENISE PEETZ
327 W. 15th Avenue, #20
Escondido, CA 92025

Vocational Nurse License No. VN 178501

Respondent.

Case No. VN-2010-2438

DEFAULT DECISION AND ORDER

[Gov. Code, §11520]

FINDINGS OF FACT

1. On or about April 7, 2016, Complainant Kameka Brown, PhD, MBA, NP, in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians, (Board) Department of Consumer Affairs, filed Petition to Revoke Probation No. VN-2010-2438 against Michele Denise Peetz (Respondent) before the Board. (Petition to Revoke Probation attached as Exhibit A.)

2. On or about October 24, 1996, the Board issued Vocational Nurse License No. VN 178501 to Respondent. The Vocational Nurse License was in full force and effect at all times relevant to the charges brought in Petition to Revoke Probation No. VN-2010-2438 and expired on June 30, 2016, and has not been renewed.

1 3. On or about April 18, 2016, Respondent was served by Certified and First Class Mail
2 copies of the Petition to Revoke Probation No. VN-2010-2438, Statement to Respondent, Request
3 for Discovery, Notice of Defense, and Government Code sections 11507.5, 11507.6 and 11507.7
4 at Respondent's address of record which, pursuant to Business and Professions Code section 136,
5 is required to be reported and maintained with the Board. Respondent's address of record was
6 and is: 327 W. 15th Avenue, #20, Escondido, CA 92025.

7 4. Service of the Petition to Revoke Probation was effective as a matter of law under the
8 provisions of Government Code section 11505, subdivision (c) and/or Business & Professions
9 Code section 124.

10 5. Government Code section 11506(c) states, in pertinent part:

11 (c) The respondent shall be entitled to a hearing on the merits if the respondent
12 files a notice of defense . . . and the notice shall be deemed a specific denial of all
13 parts of the accusation . . . not expressly admitted. Failure to file a notice of defense
14 . . . shall constitute a waiver of respondent's right to a hearing, but the agency in its
15 discretion may nevertheless grant a hearing.

16 6. Respondent failed to file a Notice of Defense within 15 days after service upon her of
17 the Petition to Revoke Probation, and therefore waived her right to a hearing on the merits of
18 Petition to Revoke Probation No. VN-2010-2438.

19 7. California Government Code section 11520(a) states, in pertinent part:

20 (a) If the respondent either fails to file a notice of defense . . . or to appear at
21 the hearing, the agency may take action based upon the respondent's express
22 admissions or upon other evidence and affidavits may be used as evidence without
23 any notice to respondent

24 8. Pursuant to its authority under Government Code section 11520, the Board finds
25 Respondent is in default. The Board will take action without further hearing and, based on the
26 relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as
27 taking official notice of all the investigatory reports, exhibits and statements contained therein on
28 file at the Board's offices regarding the allegations contained in Petition to Revoke Probation No.
VN-2010-2438, finds that the charges and allegations in Petition to Revoke Probation No. VN-
2010-2438, are separately and severally, found to be true and correct by clear and convincing
evidence.

1 9. Taking official notice of its own internal records, pursuant to Business and
2 Professions Code section 125.3, Respondent is required to repay the previous costs ordered by the
3 Board in the amount of \$2,500.00 prior to, or upon reinstatement of the license.

4 DETERMINATION OF ISSUES

5 1. Based on the foregoing findings of fact, Respondent Michele Denise Peetz has
6 subjected her Vocational Nurse License No. VN 178501 to discipline.

7 2. The agency has jurisdiction to adjudicate this case by default.

8 3. The Board of Vocational Nursing and Psychiatric Technicians is authorized to revoke
9 Respondent's Vocational Nurse License based upon the following violations alleged in the
10 Petition to Revoke Probation which are supported by the evidence contained in the Default
11 Decision Evidence Packet in this case.:

12 a. Respondent's probation is subject to revocation because she failed to comply
13 with the Board's probation program, Condition No. 2, by failing to submit written reports as
14 required by Condition No. 3, and by failing to complete coursework as required by Condition No.
15 10.

16 b. Respondent's probation is subject to revocation because she failed to submit
17 written reports on the following dates:

18 January - March 2015 Due on April 7, 2015

19 April - June 2015 Due on July 7, 2015

20 c. Respondent's probation is subject to revocation because she failed to comply
21 with Probation Condition 10, by failing to complete required course work although she was given
22 additional time to comply.

23 ORDER

24 IT IS SO ORDERED that Vocational Nurse License No. VN 178501, heretofore issued to
25 Respondent Michele Denise Peetz, is revoked.

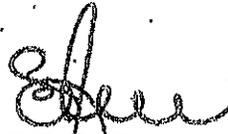
26 Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a
27 written motion requesting that the Decision be vacated and stating the grounds relied on within

28 ///

1 seven (7) days after service of the Decision on Respondent. The agency in its discretion may
2 vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

3 This Decision shall become effective on DEC 30 2016

4 It is so ORDERED NOV 23 2016

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8 FOR THE BOARD OF VOCATIONAL
9 NURSING AND PSYCHIATRIC TECHNICIANS
10 DEPARTMENT OF CONSUMER AFFAIRS

11 81440466.DOC
12 DOJ Matter ID:SD2016800254

13 Attachment:
14 Exhibit A: Petition to Revoke Probation

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Exhibit A

Petition to Revoke Probation

(MICHELE DENISE PEETZ)

1 KAMALA D. HARRIS
Attorney General of California
2 GREGORY J. SALUTE
Supervising Deputy Attorney General
3 SHERRY L. LEDAKIS
Deputy Attorney General
4 State Bar No. 131767
600 West Broadway, Suite 1800
5 San Diego, CA 92101
P.O. Box 85266
6 San Diego, CA 92186-5266
Telephone: (619) 645-2078
7 Facsimile: (619) 645-2061
Attorneys for Complainant

8
9 **BEFORE THE**
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11
12 In the Matter of the Petition to Revoke
Probation Against:
13 MICHELE DENISE PEETZ
14 327 W. 15th Avenue, #20
Escondido, CA 92025
15 Vocational Nurse License No. VN 178501
16
17 Respondent.

Case No. VN-2010-2438

PETITION TO REVOKE PROBATION

18 Complainant alleges:

19 **PARTIES**

20 1. Kameka Brown, PhD. MBA, NP (Complainant) brings this Petition to Revoke
21 Probation solely in her official capacity as the Executive Officer of the Board of Vocational
22 Nursing and Psychiatric Technicians, Department of Consumer Affairs.

23 2. On or about October 24, 1996, the Board of Vocational Nursing and Psychiatric
24 Technicians issued Vocational Nurse License Number VN 178501 to Michele Denise Peetz
25 (Respondent). The Vocational Nurse License was in effect at all times relevant to the charges
26 brought herein and will expire on June 30, 2016, unless renewed.

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1 FIRST CAUSE TO REVOKE PROBATION

2 (Compliance With the Board's Probation Program)

3 8. At all times after the effective date of Respondent's probation, Condition 2 stated;

4 COMPLIANCE WITH PROBATION PROGRAM

5 Respondent shall fully comply with the conditions of probation established by
6 the Board and she shall cooperate with representatives of the board in its monitoring
and investigation or respondent's compliance with the Probation Program.

7 9. Respondent's probation is subject to revocation because she failed to comply with
8 Probation Condition 2, referenced above in that she violated conditions of her probation as
9 described below.

10 SECOND CAUSE TO REVOKE PROBATION

11 (Submit Written Reports)

12 10. At all times after the effective date of Respondent's probation, Condition 3 stated;

13 SUBMIT WRITTEN REPORTS

14 Respondent shall submit or cause to be submitted, under penalty of perjury, any
15 written reports or declarations and verifications of actions as required by the Board or
its representatives. These reports or declarations shall contain statements relative to
16 respondent's compliance with all the conditions of the Board's Probation Program.

17 Respondent shall immediately execute all releases of information forms as may
be required by the Board or its representatives.

18 In the first report, respondent shall provide a list of all states and territories
19 where she has ever been licensed as a vocational/practical nurse, psychiatric
technician, or registered nurse. Respondent shall provide information regarding the
20 status of each license and any change in license status during the period of probation.
Respondent shall inform the Board if she applies for or obtains a new nursing or
21 psychiatric technician license during the period of probation.

22 Respondent shall provide a copy of the Board's Decision to the regulatory
agency in every state and territory in which he/she has applied for or holds a
23 vocational/practical nurse, psychiatric technician, or registered nurse license.

24 11. Respondent's probation is subject to revocation because she failed to comply with
25 Probation Condition 3, referenced above. Respondent failed to submit written reports on the
26 following dates:

27 January - March 2015 Due on April 7, 2015.

28 April - June 2015 Due on July 7, 2015

1 July – September 2015 Due on October 7, 2015

2 October -- December 2015 Due on January 7, 2016

3 THIRD CAUSE TO REVOKE PROBATION

4 (Completion of Educational Course)

5 12. At all times after the effective date of Respondent's probation, Condition 10 stated:

6 COMPLETION OF EDUCATIONAL COURSE(S)

7 Respondent, at her own expense, shall enroll and successfully complete
8 coursework substantially related to the violation(s) no later than the end of the first
9 year of probation.

10 The coursework shall be in addition to that required for license renewal. The
11 Board shall notify respondent of the course content and number of contact hours
12 required. Within 30 days of the Board's written notification of assigned coursework,
13 respondent shall submit a written plan to comply with this requirement. The Board
14 shall approve such plan prior to enrollment in any course of study.

15 Upon successful completion of the coursework, respondent shall submit
16 "original" completion certificates to the Board within 30 days of course completion.

17 13. Respondent's probation is subject to revocation because she failed to comply with
18 Probation Condition 10, referenced above despite being given additional time to comply. The
19 facts and circumstances regarding this violation are as follows:

20 A. On or about December 10, 2014, Respondent met with her probation monitor and all
21 the terms and conditions of her probation were discussed and all of her questions answered.
22 During that meeting, Respondent was informed that she was required to complete 30 contact
23 hours in remedial educational courses related to the subject of Nursing Procedures to be in
24 compliance with the Probationary Order. Respondent was informed that she must submit a
25 written plan identifying the courses she selected to complete for approval prior to purchasing or
26 enrolling into any course of study. The plan was required to contain the name of the educational
27 provider, course title, a detailed description of the course content and the number of hours or
28 units. Upon approval of the course(s) Respondent was required to complete the course(s) within
the first year of probation.

B. On April 6, 2015, the probation monitor approved 15 contact hours in a course
entitled Pediatric Health and Physical Assessment. However, the probation monitor did not

1 approve the course entitled "Documentation for Nurses," because Respondent failed to provide
2 information regarding the course content, and the probation monitor was unable to verify the
3 course was offered by Western Schools.

4 C. On June 30, 2015, Respondent's probation monitor sent her a letter informing her that
5 she that was in violation of terms 2, 3 and 10 of the Disciplinary Order. The letter required
6 Respondent to submit the following documents to the probation monitor in order to avoid further
7 disciplinary action being taken against her license. These documents were:

8 a. A written response explaining her failure to comply with her probation terms
9 and how she planned on correcting these matters by July 14, 2015;

10 b. Submit her delinquent Quarterly Written Reports immediately;

11 c. Submit a plan to complete the educational assignment of 30 contact hours in
12 Nursing Procedures, no later than July 14, 2015; and

13 d. Submit a statement regarding Respondent's plan to complete payment of the
14 outstanding balance due by the scheduled end of probation (October 23, 2017) no later than July
15 14, 2015.

16 14. Respondent failed to submit a written plan identifying the course(s) she selected for
17 prior approval to the probation monitor and she failed to provide verification of course
18 completion by October 24, 2015.

19 15. On January 26, 2016, Respondent was notified by the Board that she was in violation
20 of her probation by failing to comply with terms 2, 3 and 10 of the Order.

21 PRAYER

22 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
23 and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians issue
24 a decision:

25 1. Revoking the probation that was granted by the Board of Vocational Nursing and
26 Psychiatric Technicians in Case No. VN-2010-2438, and imposing the disciplinary order that was
27 stayed thereby revoking Vocational Nurse License No. VN 178501 issued to Michels Denise
28 Peetz;

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- 2. Revoking or suspending Vocational Nurse License No, VN 178501, issued to Michele Denise Feetz; and
- 3. Taking such other and further action as deemed necessary and proper.

DATED: 04/07/14



KAMEKA BROWN, PHD. MBA, NP
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
Department of Consumer Affairs
State of California
Complainant

SD2016800254
81288766.doc

Exhibit A

Decision and Order

Board of Vocational Nursing and Psychiatric Technicians Case No. VN-2010-2438

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BEFORE THE
BOARD OF VOCATIONAL NURSING
AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

5 In the Matter of the Accusation
6 Against:

Case No. VN-2010-2438

7 MICHELE DENISE PEETZ
8 327 W. 15th Ave., #20
Escondido, CA 92025

OAH No. 2013031052

9 Vocational Nurse License No.
10 VN 178501

11 Respondent.

12
13 DECISION

14
15 The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the
16 Board of Vocational Nursing and Psychiatric Technicians as the final Decision in the above-entitled
17 matter.

18
19 This Decision shall become effective on October 24, 2014.

20
21 IT IS SO ORDERED this 24th day of September, 2014.

22
23
24 
Todd D'Braunstein, PT
25 President

BEFORE THE
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

MICHELE DENISE PEETZ, LVN

Vocational Nurse License No. VN 178501,

Respondent.

Case No. VN 2010-2438

OAH No. 2013031052

PROPOSED DECISION

James Ahler, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on February 19 and 28, 2014, in San Diego, California.

Sherry L. Ledakis, Deputy Attorney General, Department of Justice, State of California, represented complainant, Teresa Bello-Jones, J.D., M.S.N., R.N., Executive Officer, Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs, State of California.

David M. Balfour, Attorney at Law, represented respondent, Michele Denise Peetz, LVN, who was present throughout the proceeding.

The matter was submitted on February 28, 2014.

FACTUAL FINDINGS

Jurisdictional Matters

1. On February 11, 2013, complainant signed the accusation in Case No. VN 2010-2438. The accusation alleged that respondent was grossly negligent in her care and treatment of a 16-year-old patient because (1) she failed to notify the patient's treating physician or her supervisor that a fingertip oxygen-saturation probe continued to fall off the patient's finger when he experienced muscle spasms, and (2) she failed to perform chest compressions when providing cardiopulmonary resuscitation to the patient. The accusation and other required documents were served on respondent.

Respondent timely filed a notice of defense.

On February 19, 2014, the administrative record was opened; jurisdictional documents were presented; documentary evidence was produced; and sworn testimony was received. The hearing in the matter was continued to take additional evidence. On February 28, 2014, documentary evidence was produced; sworn testimony was received, closing arguments were given; the record was closed; and the matter was submitted.

License History

2. On October 24, 1996, the Board issued Vocational Nurse License Number VN 178501 to respondent. Respondent's license expires on June 30, 2014.

There is no history of any administrative discipline having been imposed against respondent's license.

Respondent's Background, Education, Training and Experience

3. Respondent was born in Los Angeles in 1962. She grew up in Poway and Escondido.

After graduating from high school, respondent attended community college and a vocational school. Respondent gained the education and training necessary to become employed as a medical assistant. Respondent found she very much enjoyed working in the health care profession.

Respondent married. She and her husband traveled throughout the United States while her husband was on active military duty. She gave birth to three children, all of whom are now adults.

After respondent and her family returned to Escondido, respondent obtained the education and training necessary to become a certified nursing assistant. Respondent worked as a CNA for three years after obtaining certification. Respondent then enrolled in an ROP program. She obtained the education and training necessary to become a licensed vocational nurse. In October 1996, after completing required training, respondent became licensed as a vocational nurse.

Respondent was employed as a licensed vocational nurse at several skilled nursing facilities in North San Diego County including SunBridge Care and Village Square. She was responsible for all nursing activities other than hanging IV bags and providing intravenous medications.

After working as an LYN for more than a decade, respondent took time off to address some personal health concerns. She then returned to work for Maxim Healthcare Services, Inc. as an in-home health care provider. While employed by Maxim, respondent cared for patients diagnosed with a variety of chronic medical problems including cerebral palsy, Down's syndrome, and other debilitating conditions.

4. Respondent provided letters of reference and documents attesting to her superior nursing skills, good moral character and continuing education in the nursing field. These letters supplemented and explained other credible evidence concerning respondent's background, education, training, experience and current fitness to practice nursing.

Christie Donehue, LVN, worked with respondent for more than a decade. Ms. Donehue believed respondent was a compassionate professional who provided excellent care to all patients with whom she had contact.

Sandra Leilani Ahkoi described respondent as a kind, soft-spoken, honest individual who provided the community with much needed volunteer service in the mental health field. According to Ms. Ahkoi, respondent possesses the highest ethics.

Performance evaluations from Maxim stated respondent met all expectations before the incident involving SM.

A certificate of completion from Western Schools established that respondent successfully completed 30 hours of professional education in the area of home health nursing on January 20, 2014.

A certificate of completion from Elite Continuing Education established that respondent successfully completed 30 hours of professional education in the area of chronic cardiovascular diseases, strokes and geriatric assessments on August 4, 2012.

A certificate of completion from Avalon Hospice & Palliative Care established that respondent successfully completed a course in dementia training on August 28, 2013.

A certification dated August 2012 established that respondent successfully completed the American Heart Association's cognitive and skills evaluation for healthcare providers.

Patient SM

5. In May 2008, SM was riding a bicycle when he was struck by an automobile. As a result of that incident, SM's spinal cord was severely injured at C1-C4; he was rendered quadriplegic; he sustained numerous internal injuries that resulted in acute pancreatitis and other internal problems; he experienced chronic respiratory failure requiring a tracheotomy and reliance on a mechanical ventilator; his right leg had to be amputated below the knee. After prolonged hospitalization, SM was discharged to his parents' home in Escondido.

6. Dr. Albert Martinez was SM's attending physician following SM's discharge from Children's Hospital. Maxim Healthcare Services was hired to provide in-home nursing services in accordance with Dr. Martinez's plan of care. In-home nursing care involved the services of two licensed vocational nurses who provided two 12-hour shifts per day, thereby affording SM constant nursing care. The in-home LVNs regularly reported to a clinical supervisor regarding SM's status and completed flow sheets and other documentation.

7. SM's in-home care included respiratory care. SM was required to be on a mechanical ventilator 24 hours a day with assigned settings. A fingertip pulse oximeter monitor was used to monitor SM's pulse and oxygen saturation levels.

Dr. Martinez's plan of care required SM's oxygen saturation level to be checked twice per shift during the day and as needed whenever SM experienced respiratory distress, shortness of breath, or a change in status. The plan of care required continuous oxygen saturation monitoring throughout the night when SM was sleeping. The plan of care required that SM's oxygen saturation level remain at 95% or above.

If SM could not maintain an oxygen saturation level of 95% or above, the plan of care required the attending LVN to immediately contact the attending physician or a clinical supervisor. SM's trach tube was required to be suctioned to maintain a clear airway and at SM's request. Ventilator breaths or AMBU bag breaths could be provided to assist SM in breathing if he experienced shortness of breath with suctioning under the plan of care.

8. In March 2010, respondent began providing in-home nursing care for SM. She provided nursing services during the night shift, from 7:00 p.m. to 7:00 a.m., five days a week. Services were provided in SM's bedroom, where respondent was always present and remained awake throughout her shift.

SM was 15 years old when respondent began caring for him. He attended classes at San Pasqual High School. He was a "nice kid," and respondent and SM established an excellent professional and personal relationship. SM and respondent followed professional football; SM was a Raiders fan; respondent was a Chargers fan; SM and respondent engaged in spirited conversations about their favorite teams. SM had a good sense of humor, and he enjoyed spending time with family members, watching TV, watching his brother play video games, attempting to use the computer in his bedroom, and interacting with respondent. SM trusted respondent, and he did not hesitate to ask respondent to suction his trach tube or provide him with other services when necessary.

9. On November 27, 2010, respondent reported to SM's home for the evening shift. Respondent checked SM's vital signs every hour. SM watched his brother play video games in SM's bedroom until approximately 1:30 a.m., when SM's mother told SM and his brother that it was late and time to go to bed. The brother left SM's bedroom. Respondent got SM ready for bed. SM did not complain of pain or any other problems. His vital signs were normal and the ventilator was functioning properly. SM fell asleep.

10. Around 4:00 a.m., SM began having muscle spasms. SM had experienced muscle spasms many times before, and the spasms were violent enough to disconnect the fingertip pulse oximeter monitor. When that happened, an alarm sounded that awakened SM. The spasms occurred often enough before November 27, 2010, that SM had asked respondent not to reattach the fingertip pulse oximeter monitor and to turn off the alarm so it would not sound and awaken him. Respondent acceded to SM's request and, following that discussion, respondent did not reattach the fingertip pulse oximeter monitor when it became disconnected. On those occasions, she turned off the monitor's alarm. The potential result

of the arrangement was that if SM's oxygen saturation dropped below 95% when the fingertip pulse oximeter monitor was not attached, an alarm would not sound. To cover this possibility, respondent manually checked SM's oxygen saturation level once an hour or so when SM was sleeping and whenever the fingertip monitor was not attached. Respondent did not notify the attending physician or a clinical supervisor of the arrangement she reached with SM, which was wholly inconsistent with the physician's plan of care.

11. On November 28, 2010, around 4:00 a.m., SM experienced muscle spasms that resulted in the fingertip monitor becoming disconnected. Respondent did not reattach the monitor and turned off the alarm. She remained in SM's bedroom. The ventilator continued to function and SM's chest continued to rise and fall. SM appeared to be sleeping soundly. His vital signs were stable.

SM's oxygen saturation level was 98% when respondent checked on SM at 5:00 a.m. Respondent did not conduct a blood pressure check or a heart rate check at that time.

12. At approximately 6:15 a.m., respondent touched SM's leg. It was cool to the touch. Respondent turned on a light and observed that SM was cyanotic. While SM was not breathing, he registered a pulse when SM attached the pulse oximeter. She determined that SM's heart rate was 37.¹ The ventilator appeared to be working and the ventilator alarm was not sounding. Respondent ran to SM's mother's bedroom, awoke SM's mother, and directed her to call 911. She then returned to SM's bedroom, followed closely by SM's mother. The ventilator was turned off² and SM's mother directed respondent to "Bag him." Respondent disconnected the ventilator airway tube attached to the trach tube, attached the AMBU bag to the trach tube fitting, and began cardiopulmonary resuscitation by providing breaths through the AMBU bag. SM was lying supine on his bed while this occurred. Respondent did not provide chest compressions as a part of her resuscitative efforts.

13. Paramedics arrived within five minutes of the mother calling 911. Paramedics removed SM from the bed, placed him on the floor, and initiated advanced cardiopulmonary lifesaving efforts. SM was ventilated, chest compressions were provided, epinephrine injections were administered, but no pulse was returned. Paramedics could not revive SM.

Paramedics discontinued cardiopulmonary resuscitation at 6:34 a.m.

SM was pronounced. SM was 16 years old at the time of his death.

¹ Heart rate is typically expressed in beats per minute (bpm). The heart rate varies according to the body's physical needs, including the need to absorb oxygen and excrete carbon dioxide. Activities that can provoke such changes include physical exercise, sleep, anxiety, stress and illness. The normal human heart rate ranges from 60-100 bpm.

² It was unclear whether SM's mother or respondent turned off the ventilator. SM's mother did not testify.

Investigations

14. The Escondido Police Department and the County of San Diego's Office of the Medical Examiner conducted investigations. Respondent was interviewed. She was not asked about the use or nonuse of the pulse oximeter monitor during those investigations. Although her statements to the officers and investigators were consistent, respondent did not disclose that the fingertip pulse oximeter monitor had not been attached to SM's finger the early morning hours of November 28, 2010, or that the alarm had been turned off.

15. Following SM's death, Maxim conducted its own investigation. The results of that investigation were set forth in a disciplinary action form dated December 1, 2010. Laura Bothwell, RN, respondent's supervisor, signed that form.

The form stated that on November 28, 2010, at approximately 6:00 a.m., respondent "did not have continuous O2 sat monitor on patient as ordered per plan of care." The form also stated, "Patient was having strong and frequent spasms which caused the finger probe to keep falling off so [respondent] was doing intermittent checks at least every hour."

Maxim placed respondent on a temporary suspension pending further investigation. Respondent was reminded of her obligation to always follow the physician's orders and plan of care and, if she was unable to do so, to contact the physician or a supervisor.

16. On December 18, 2010, Maxim prepared a disciplinary action form that stated respondent was being terminated from employment because "LVN did not follow doctor's orders on plan of care. Nurse was not keeping sat monitor on continuously per Dr. Orders."

17. On December 27, 2010, Maxim reported to the Board respondent's termination from employment as required by law.

Complainant's Evidence

18. Complainant called Nurse Bothwell as a percipient witness. Nurse Bothwell has been licensed as a registered nurse for 22 years. She was employed as a clinical supervisor by Maxim for seven and one-half years before leaving Maxim for her current employment.

Nurse Bothwell testified that respondent was under a duty to follow the attending physician's plan of care when providing in-home nursing services to SM. Under the plan of care, oxygen saturation was to be monitored by a finger probe when SM was sleeping. An alarm was supposed to sound if SM's oxygen saturation level fell below 95%.

Nurse Bothwell reviewed the nursing flow sheet that respondent prepared for the November 27, 2010, shift in which respondent reported various events occurring during the night shift. At 1:00 a.m., respondent reported that SM had no signs or symptoms of distress. Respondent provided gentle stretching for SM and repositioned him on his bed. At 2:00 a.m., respondent covered SM and dimmed the lights. She left the music on in the bedroom

and continued to monitor SM. At 3:00 a.m., respondent changed SM's briefs, provided perineal care, and repositioned SM. At 4:00 a.m., respondent observed SM having occasional muscle spasms. Respondent repositioned SM and determined that SM's oxygen saturation level was 97%. At 5:00 a.m., respondent noted that SM was "resting quietly" and determined that his oxygen saturation level was 98%. SM exhibited no signs or symptoms of distress. Respondent continued to monitor SM. The 6:00 a.m. entry stated, "Cool to touch. Cyanotic. Mother notified & she called 911. Respirations via AMBU bag until paramedics arrived and took over." The 7:00 a.m. entry stated, "Spoke to police officer, awaiting coroner to arrive."

Nurse Bothwell reviewed a written summary documenting her conversation with respondent in which "she [respondent] reports she did not check for a pulse or start compressions." Nurse Bothwell did not provide respondent with an opportunity to review that summary or respond to it.

Nurse Bothwell described SM as a high risk, quadriplegic, ventilator-dependent patient who could not tolerate being without ventilator assistance for 15 to 20 seconds. Nurse Bothwell testified that respondent told her that she had not used the pulse oximeter probe to monitor SM's oxygen saturation level for "several weeks" before SM's death because whenever SM experienced muscle spasms the spasms caused the fingertip probe to become disconnected. Respondent did not document that she disconnected the pulse oximeter.

19. Complainant called Patricia E. Karnstedt, RN, MSN, as an expert witness. Nurse Karnstedt received her registered nursing license in 1990. She obtained a bachelor's degree in nursing and public health from California State University, Dominguez Hills, in 1997. She received a master's degree in nursing from the University of Phoenix in 2004. She has served as an expert witness for the Board of Registered Nursing and the Board of Vocational Nursing since 2003.

Nurse Karnstedt reviewed various materials, including SM's hospital and medical records and the flow sheet respondent prepared. She observed that the attending physician's plan of care required SM to have continuous oxygen saturation monitoring at night while SM was sleeping. Nurse Karnstedt observed that after respondent began breathing for the patient with the AMBU bag, there were no chest compressions as a part of respondent's resuscitative efforts. In her written report, Nurse Karnstedt concluded:

I find that the subject nurse deviated from the Standard of Care during the care of her patient and exhibited "Unprofessional Conduct" with regard to failing to follow physician orders to provide continuous oxygen monitoring during the night for the patient in her care.

The subject nurse exhibited "gross negligence" in her duty to provide safe oxygen monitoring for her patient. Continued oxygen monitoring via a finger probe would have provided an

alarm system that would have provided an audible alert if the oxygen level had dropped below 95% at which time the care provider could respond appropriately to prevent an untoward event from occurring. The physician order stated that should the oxygen level fall below 95%, the nurse was to call the MD or Clinical supervisor.

The subject nurse charted that the patient was having occasional spasms and had to be repositioned, but there is no mention of the ordered oxygen monitoring finger probe not being applied.

The prudent VN would have followed the physician orders and placed the finger probe thus providing appropriate oxygen monitoring. If the patient was having spasms that made placement of the probe difficult or not possible, the nurse should have called the MD or the Clinical Supervisor for directions to comply with the order. A prudent VN would have initiated CPR completely with respiration and compressions. There is no way to know if the outcome would have been different if the oxygen monitor had been in place but the patient was denied the ability to change the outcome and have interventions applied if the oxygen saturation could not be maintained at or above 95%.

20. Nurse Karnstedt testified that respondent's failure to follow the attending physician's plan of care requiring continuous oxygen saturation monitoring with the fingertip pulse oximeter monitor involved gross negligence. This conclusion was well supported by the evidence because respondent's misconduct, coupled with her failure to contact her clinical supervisor or the attending physician concerning her decision to turn off the pulse oximeter alarm at night in the several weeks preceding SM's death, involved a measure of indifference towards SM's safety.

21. Nurse Karnstedt concluded that respondent's failure to provide SM with chest compressions constituted gross negligence. She opined that if the ventilator was working, there was no need to use the AMBU bag and the use of the AMBU bag did not substitute for chest compressions. Nurse Karnstedt theorized that even with a pulse of 37 bpm, respondent should have concluded that SM's immediate problem was a circulatory problem and not a breathing problem because the ventilator was working. Nurse Karnstedt believed that chest compressions were required and that respondent's failure to provide them involved gross negligence. The evidence does not support such a conclusion.

22. Under California Code of Regulations, title 16, section 2519, gross negligence requires proof that the licensee engaged in a substantial departure from the standard of care required of a competent licensed vocational nurse under the circumstances that could have resulted in harm to a consumer, together with proof that the licensee exercised so little care as to justify a belief that the licensee consciously disregarded or was indifferent to the patient's health, safety, or welfare.

When respondent determined that SM was cool to the touch and cyanotic, she immediately contacted SM's mother and directed the mother to call 911. Doing so was in accordance with the attending physician's orders, which stated in part, "Call 911 and seek immediate MD attention for any respiratory distress . . . difficulty" Respondent obtained a pulse rate of 37 bpm by using the pulse oximeter, and it was not unreasonable for respondent to rely on that reading and conclude that SM had a heart rhythm. The ventilator was disconnected and respondent was told to "Bag him." Based upon what was occurring at that moment, respondent could reasonably conclude that there might be a mechanical problem with the ventilator and that a lack of oxygen was the cause of SM's distress. While other LVNs may not have disconnected or permitted the ventilator to be disconnected, it cannot be concluded that doing so involved gross negligence.

After the ventilator was disconnected, respondent began providing SM with breaths with the AMBU bag. This action was necessary because SM could not breathe on his own. Respondent did not provide chest compressions because using the AMBU bag required her to use of both her hands. Given SM's pulse rate that respondent believed existed, she reasonably could have concluded that SM was suffering from a breathing problem and not a circulatory problem, even though other LVNs might reach a conclusion to the contrary.

Finally, even if respondent engaged in some measure of negligence by disconnecting the ventilator or permitting that to occur, and that fact was not established by clear and convincing evidence, respondent's actions thereafter could never be rationally characterized as evincing a conscious disregard or indifference to SM's health, safety, or welfare.

Nurse Karnstedt's ultimate conclusion of gross negligence relating to chest compressions was not supported by clear and convincing evidence.

Respondent's Testimony

23. Respondent provided testimony about her background, education, training and experience as set forth in Factual Finding 3. Respondent provided testimony about her care of SM as set forth in Factual Findings 8-12. Respondent stated she completed the flow sheet that detailed her activities on the night shift in question as mentioned in Factual Finding 18.

24. Respondent recalled that after awakening SM's mother and having her call 911, she and the mother returned to SM's bedroom. She credibly testified that she used the pulse oximeter upon reentering SM's bedroom and determined that SM had a pulse of 37 bpm. The ventilator appeared to be working at that time, but after SM's mother entered the room, the ventilator was disconnected and respondent was told to "Bag him." The ventilator alarm sounded for the first time. Respondent disconnected the ventilator line from the trach tube, attached the AMBU bag to the trach tube, and began providing breaths to SM by using the AMBU bag. Respondent used both hands to squeeze the bag to provide breaths. She rested after each breath to give SM time to exhale. She observed SM's chest rise and fall. She said she did not provide chest compressions because she was using the AMBU bag and because she believed SM had a heart rate of 37 bpm. She knew paramedics would be arriving in the very near future.

Paramedics arrived and removed SM from the bed to the floor. They checked SM's heart rhythm, used an AMBU bag to continue respiration, and affixed an IV to SM's left leg. Paramedics determined that SM had no pulse by the time the paramedics arrived.

Respondent completed the 6:00 a.m. and 7:00 a.m. charting after SM expired. She spoke with police officers and others. She was not asked by police officers or investigators whether the pulse oximeter monitor was in use or whether the pulse oximeter alarm was disconnected when SM went into cardiopulmonary arrest. She did not volunteer that information to the police or investigators; however, she did not withhold that from Maxim in the course of Maxim's investigation.

25. Respondent acknowledged that she made a grave mistake by not contacting the attending physician to discuss the situation. Respondent would not now discontinue the use of a pulse oximeter that had been ordered by an attending physician without first seeking the attending physician or a supervisor's approval, and she would never take any other action that might be contrary to or inconsistent with a treating physician's plan of care without first obtaining appropriate authorization. SM's death and respondent's role in his death has been a transformative experience. She is extremely remorseful. She takes full responsibility for her misconduct.

26. Respondent decided not to work as a vocational nurse following SM's death. However, after several months of not working she reconsidered her decision. In October 2012, respondent began working on a part-time basis for BrightStar, a home healthcare agency. Before beginning her employment there, respondent disclosed to BrightStar's owner the facts and circumstances surrounding SM's death.

27. Michael Inga, Vice President and BrightStar's owner, wrote a letter in which he advised of his company's employment of respondent. He represented that respondent voluntarily provided him with information about the events involving her employment with Maxim and SM's death. He represented that respondent has become an integral part of BrightStar's nursing staff. She has always exuded professionalism. She was observed by preceptors and proved her competency. Respondent currently works about 10 hours per week and earns \$17.50 an hour. She holds no other employment.

Respondent's Expert

28. Gresham Bayne, MD, provided expert testimony. Dr. Bayne received a medical degree from the Medical College of Virginia in 1973, completed a straight surgical internship at the Naval Regional Medical Center in San Diego in 1974, a general surgery residency at the Naval Regional Medical Center in 1976, and an Emergency Medicine residency at Georgetown University in Washington, D.C. in 1979. He was on active duty with the United States Navy from 1970 through 1982; he was in the Naval Reserves from 1982 through 1990; he was recalled to active duty for Desert Storm in 1990; he retired from active duty with the rank of Captain in 1991. He has been a Fellow of the American Academy of Emergency Medicine since 1991. He was to some extent familiar with the

responsibilities of an LVN and some of the applicable LVN standards of care by reason of his practical experience.

29. Dr. Bayne reviewed numerous materials related to respondent's care and treatment of SM. He believed that on the morning of November 28, 2010, respondent heard an alarm shortly after 4:00 a.m. after fingertip monitor became disconnected as a result of muscle spasm. He believed that on an earlier occasion, SM asked respondent not to reattach the oximeter alarm because it woke him up when it went off. He believed that respondent honored SM's request, and that respondent monitored SM's oxygen saturation level hourly when SM's fingertip monitor was not attached.

On the morning of November 28, 2010, Dr. Bayne believed that respondent checked SM's oxygen saturation level at 5:00 a.m. and found it was 98%. Dr. Bayne believed that shortly after 6:00 a.m., respondent found SM was cyanotic and that the ventilator was still on because the ventilator alarm was not sounding. He believed that respondent determined that SM's pulse was 37 bpm, resulting in her assumption that SM had blood flow and a heart rhythm. SM's mother believed there might be a problem with the ventilator. After the ventilator was disconnected, respondent provided SM with breaths through an AMBU bag.

About five minutes later, the EMT's arrived, removed SM to the floor, and commenced full CPR. SM did not respond. The autopsy report stated that SM's death was the result of "complications of quadriplegia due to blunt force trauma to the neck."

Dr. Bayne opined that strong and frequent spasm in SM's extremities caused the fingertip monitor to shake off and that respondent's failure to contact the attending physician or a clinical supervisor early the morning of November 28, 2010, had no impact on the course of events that followed. Dr. Bayne opined that respondent's use of the AMBU bag while awaiting the arrival of the paramedics was appropriate. He reasoned: the decision to remove SM from the ventilator was reasonable since most cardiopulmonary crisis situations involving young patients with normal hearts are the result of a mechanical malfunction of a ventilator; respondent's attempt to resuscitate SM with an AMBU bag was necessary since he was no longer on a ventilator; observing SM's pulse rate was 37 bpm allowed respondent to focus on the breathing aspect of cardiopulmonary resuscitation; it was not feasible for respondent to provide chest compression and use the AMBU bag since using the AMBU bag required the use of both hands; and, finally, respondent acted well within the vocational nursing standard of care.

30. Dr. Bayne's testimony was essentially consistent with the opinions and conclusions set forth in his expert report. His limited knowledge of licensed vocational nursing standards of care was evident on voir dire, but Dr. Bayne's education, training and experience was sufficient to permit him to render admissible expert opinions even though some of them were not particularly compelling.

Dr. Bayne's opinion that respondent did not engage in gross negligence because she did not call the attending physician or a clinical supervisor in the early morning hours of November 28, 2010, was seriously undercut by his failure to consider that respondent had

been disconnecting the fingertip monitor alarm for several weeks before, and that she did not contact either the attending physician or a clinical supervisor to discuss that matter when she could have done so. Despite Dr. Bayne's testimony to the contrary, the evidence that respondent engaged in gross negligence by ignoring the attending physician's plan of care requiring the use of continuous oxygen saturation monitoring was clear and convincing.

However, Dr. Bayne's testimony raised questions about the alleged impropriety of respondent's conduct in response to SM's cardiopulmonary crisis. His testimony that mechanical failure of a ventilator is the most common cause of cardiopulmonary distress in a young person with no history of heart problems was drawn directly from his education, training and experience. Without doubt, respondent's providing breaths to SM through an AMBU bag became necessary once the ventilator was turned off. Dr. Bayne's testimony that it was reasonable for respondent to use the AMBU bag and not provide chest compressions because respondent believed SM had a heart rate of 37 bpm was reasonable, as was his opinion related to the difficulties and dangers associated with one-person cardiopulmonary resuscitation. This testimony was particularly compelling since paramedics were scheduled to arrive at SM's home shortly after respondent's resuscitative efforts began. The American Heart Association standards on which Dr. Bayne was extensively cross-examined did not contradict Dr. Bayne's testimony or make it less than credible. Dr. Bayne's testimony raised reasonable questions about Nurse Karnstedt's conclusion that respondent's attempt to resuscitate SM involved gross negligence.

Cause for Discipline

31. Clear and convincing evidence established that respondent substantially departed from the standard of care expected of an ordinary, reasonable and prudent licensed vocational nurse in the early morning hours of November 28, 2010, by ignoring the attending physician's plan of care for several weeks before that date and by failing to make certain SM's oxygen saturation level was being monitored continuously with a pulse oximeter while he slept. Respondent's conduct in this regard posed a risk of harm to SM. Cause for discipline exists on this basis.

32. Clear and convincing evidence did not establish that respondent's failure to provide chest compressions during her attempt to resuscitate SM involved gross negligence. Respondent was involved in an emergency situation. She responded in a fashion that was not unreasonable under all the circumstances. She was not negligent because her efforts were unsuccessful or because she made an error in judgment that was sensible at the time. Respondent was not negligent because she chose an accepted method of care that was different than another accepted method of care that may have been a better choice in retrospect. Cause for discipline does not exist on this basis.

Evidence in Aggravation, Exemption, Mitigation and Rehabilitation

33. The several weeks that passed between SM's request that the pulse oximeter alarm be turned off and the date on which SM's cardiopulmonary crisis occurred was to some extent an aggravating factor. Respondent had sufficient time to consider what she was

being asked to do and to bring the issue to the attention of SM's attending physician or a clinical supervisor.

34. Respondent believed that she was helping SM remain comfortable and asleep by turning off the alarm when the fingertip monitor became disconnected as a result of SM's muscle spasm. Respondent cared deeply for SM, and her misconduct was not the result of a general lack of concern for SM's health, safety or welfare.

35. Respondent promptly notified SM's mother of SM's cardiopulmonary crisis. At no point after that crisis did respondent attempt to mislead anyone about what occurred on November 27 and 28, 2010. Her testimony about the events occurring on November 27 and 28, 2010, was believable.

36. SM's death was a tragic experience for respondent. She mourns his passing and his family's loss.

37. The negligence that was established in this matter was not part of any pattern misconduct. Other than the incident involving SM, respondent enjoys a disciplinary free record as a health care provider. She is respected by peers and employers. She provided letters of reference and other documentation that corroborated her nursing skills and good moral character.

38. Since the incident in question, respondent has successfully completed 30 hours of professional education in the area of home health nursing, 30 hours of professional education in the area of chronic cardiovascular diseases, strokes and geriatric assessments, and a course in dementia. Respondent is currently certified by the American Heart Association.

The Board's Disciplinary Guidelines

39. The introduction to the Board's disciplinary guidelines states:

Business and Professions Code sections 2841.1 and 4501.1 mandate that protection of the public shall be the highest priority for the Board of Vocational Nursing and Psychiatric Technicians (Board) in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

To facilitate uniformity of disciplinary orders and to ensure that its disciplinary policies are known, the Board adopted these Disciplinary Guidelines and Uniform Standards Related to Substance Abuse.

The Disciplinary Guidelines are intended for use by individuals involved in disciplinary proceedings against vocational nurse and psychiatric technician licensees or applicants, including administrative law judges and attorneys, as well as the Board members who review proposed decisions and stipulations and have ultimate authority to make final decisions.

While recognizing the concept that administrative law judges must be free to exercise their discretion, the Board requests that the Disciplinary Guidelines be followed to the extent possible and that any departures be noted and explained in the Proposed Decision.

The Board requests that matters in extenuation and mitigation, as well as those in aggravation, be fully considered and noted in the Proposed Decision. Of primary importance is the effect Respondent's conduct had or could have had on the health, safety, and welfare of California consumers.

40. For violations that involve unprofessional conduct or gross negligence, the disciplinary guidelines recommend a maximum sanction of an outright revocation; an intermediate sanction of revocation, stayed, with three years probation; and a minimum sanction of revocation, stayed, with two years probation. Standard terms and conditions of probation require that a probationer obey all laws; comply with the probation program; submit written reports; notify the Board of change of address, residency or practice outside California; meet with Board representatives; notify employers about being on probation; be limited in duties where appropriate; maintain supervision requirements; complete relevant educational courses; maintain a valid license; and pay costs of investigation and enforcement when required.

The guidelines state:

In determining whether revocation, suspension or probation should be imposed in a given disciplinary action, the following factors should be considered:

- o Nature and severity of the act(s), offense(s), or crime(s) under consideration.
- o Actual or potential harm to the public.
- o Actual or potential harm to any patient.
- o Overall disciplinary record.

- Overall criminal actions taken by any federal, state or local agency or court.
- Prior warnings on record or prior remediation.
- Number and/or variety of current violations.
- Mitigation evidence.
- In case of a criminal conviction, compliance with terms of sentence and/or court-ordered probation.
- Time passed since the act(s) or offense(s) occurred.
- If applicable, evidence of proceedings to dismiss a conviction pursuant to Penal Code section 1203.4.
- Cooperation with the Board and other law enforcement or regulatory agencies.
- Other rehabilitation evidence.

The Appropriate Measure of Discipline

41. The gross negligence at issue occurred more than three years ago. It was a singular event. While clear and convincing evidence did not establish that respondent's gross negligence was directly responsible for SM's death, her negligence posed a significant risk of harm to SM's well-being. Respondent provided extenuating evidence that explained how the negligence occurred. She cooperated with investigators, law enforcement, her employer and the Board in the investigations of this matter. Respondent provided much evidence in rehabilitation. It is unlikely that a similar incident will happen again.

Imposing an outright revocation of respondent's license is not necessary to protect the public; however, a disciplinary order should be imposed that enables the Board to monitor respondent's licensed activities and ensures that she has adequate supervision. Imposing a revocation, stayed, with three years probation on standard terms and conditions of probation is certainly within the public interest. Such an order is well within the Board's disciplinary guidelines and does not constitute punishment.

Costs of Investigation and Enforcement

42. The Board's Executive Officer signed a certification of investigative costs. That certification stated that 22.50 hours of investigative services were billed at the rate of \$162.00 per hour in this matter. A total of \$4,131.00 was claimed for costs of investigation.

A certification of costs was prepared by the deputy who represented complainant. Her declaration stated that 66.75 hours were billed by the deputies involved this matter and that 0.50 hours were billed by a paralegal. Attorney services were billed at the rate of \$170 per hour. Paralegal services were billed at the rate of \$120 per hour. The hourly rates were reasonable. The legal charges in this matter were not contested. The deputy who tried the matter was well prepared and highly professional.

Total costs of enforcement are determined to be \$11,407.50.

43. Respondent argued that she defended the matter in good faith and is unable to pay the costs. Counsel for complainant demanded an outright revocation. In response, respondent used the hearing process to obtain a reduction in the severity of the recommended discipline. She had a subjective good faith in the merits of her position and raised a successful challenge to the proposed discipline. And, she established that she has no real ability to make payments.

Under *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, it is concluded that imposing an award of costs in excess of \$2,500 would be unreasonable.

LEGAL CONCLUSIONS

Purpose of License Discipline

1. Administrative proceedings to revoke, suspend or impose discipline on a professional license are noncriminal and nonpenal; they are not intended to punish the licensee, but rather to protect the public. (*Griffiths v. Superior Court* (2001) 96 Cal.App.4th 757, 768.) The main purpose of license discipline is protection of the public through the prevention of future harm, and the improvement and rehabilitation of the licensee. (*Ibid*, at p. 772.)

Burden and Standard of Proof

2. In disciplinary administrative proceedings, the burden of proving the charges rests upon the party making the charges. The obligation of a party to sustain the burden of proof requires the production of evidence for that purpose. (*Brown v. City of Los Angeles* (2002) 102 Cal.App.4th 155, 175.)

3. The standard of proof in an administrative action seeking to suspend or revoke 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 finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Evidentiary Considerations

4. "Evidence" means testimony, writings, material objects, or other things presented to the senses that are offered to prove the existence or nonexistence of a fact. (Evid. Code, § 140.) The burden of producing evidence as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence. (Evid. Code, § 550.)

The burden of proof is a rebuttable presumption. The burden of proof and the burden of producing evidence are distinct and should not be confused. The burden of proof means the obligation of a party to establish a requisite degree of belief concerning a fact in the mind of the trier of fact or the court. In contrast, the burden of producing evidence is the obligation of a party to introduce evidence sufficient to avoid a ruling against him on the issue. During the course of a trial or hearing the burden of producing evidence, once met, may shift between the parties as further evidence is introduced, while the burden of proof stays with the party designated by law. (*Estate of Trikha* (2013) 219 Cal.App.4th 791, 803.)

Standard of Care

5. The standard of care requires a health care professional to possess and exercise that level of knowledge and skill ordinarily possessed by other members of the profession in good standing. (*N.N.V. v. American Assn. of Blood Banks* (1999) 75 Cal.App.4th 1358, 1384.) The standard of care must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) The standard of care is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.) The process of deriving a standard of care requires some evidence of an ascertainable practice. (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

Expert Testimony

6. A person is qualified to testify as an expert if he has special knowledge, skill, experience, training, or education sufficient to qualify him as an expert on the subject to which his testimony relates. Against the objection of a party, such special knowledge, skill, experience, training, or education must be shown before the witness may testify as an expert, and may be shown by any otherwise admissible evidence, including his own testimony. (Evid. Code, § 720, subs. (a), (b).)

The qualifications of an expert must relate to the particular subject upon which he is giving expert testimony. Whether a person qualifies as an expert in a particular case depends upon the facts of the case and the witness's qualifications. A trial court's determination of whether a witness qualifies as an expert is a matter of discretion and will not be disturbed absent a showing of manifest abuse. Error regarding a witness's qualifications as an expert will be found only if the evidence shows that the witness clearly lacks qualification as an expert. The question of the degree of the expert's knowledge goes more to the weight of the evidence than its admissibility. (*People v. Tuggle* (2012) 203 Cal.App.4th 1071, 1079-1080.)

When a witness qualifies as an expert, he does not possess a carte blanche to express any opinion within the area of expertise. For example, an expert's opinion based on assumptions of fact without evidentiary support or on speculative or conjectural factors has no evidentiary value. Similarly, when an expert's opinion is purely conclusory because it is unaccompanied by a reasoned explanation connecting the factual predicates to the ultimate conclusion, that opinion has no evidentiary value. An expert who gives only a conclusory opinion does not assist a trier of fact in determining what occurred, but instead supplants the function of the trier of fact by declaring what occurred. (*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1116-1118.)

Although a trier of fact may not arbitrarily or unreasonably disregard the testimony of an expert, the trier of fact must give each expert opinion the weight which that opinion deserves. (*Howard v. Owens Corning* (1999) 72 Cal.App.4th 621, 633.)

Disciplinary Statutes and Regulations

7. Business and Professions Code section 2875 authorizes the Board to impose discipline upon the holder of a vocational nurse license.

8. Business and Professions Code section 2878 provides in part:

The board may suspend or revoke a license issued under this chapter for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to the following:

(1) Incompetence, or gross negligence in carrying out usual nursing functions

9. California Code of Regulations, title 16, section 2519 provides in part:

As set forth in Section 2878 of the Code, gross negligence is deemed unprofessional conduct and is a ground for disciplinary action. As used in Section 2878 "gross negligence" means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed vocational nurse, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard of care.

Rehabilitation

10. California Code of Regulations, title 16, section 2522 sets forth the Board's rehabilitation criteria. It provides in part:

When considering . . . the suspension or revocation of a license . . . the Board in evaluating the rehabilitation of an individual and . . . her present eligibility for a license, will consider the following criteria:

- (1) Nature and severity of the act(s), offense(s), or crime(s) under consideration.
- (2) Actual or potential harm to the public.
- (3) Actual or potential harm to any patient.
- (4) Overall disciplinary record.
- (5) Overall criminal actions taken by any federal, state or local agency or court.
- (6) Prior warnings on record or prior remediation.
- (7) Number and/or variety of current violations.
- (8) Mitigation evidence.
- (9) In case of a criminal conviction, compliance with terms of sentence and/or court-ordered probation.
- (10) Time passed since the act(s) or offense(s) occurred.
- (11) If applicable, evidence of proceedings to dismiss a conviction pursuant to Penal Code section 1203.4.
- (12) Cooperation with the Board and other law enforcement or regulatory agencies.
- (13) Other rehabilitation evidence.

11. Rehabilitation is a state of mind. The law looks with favor upon rewarding with the opportunity to serve, one who has achieved reformation and regeneration. (*Hightower v. State Bar* (1983) 34 Cal.3d 150, 157.) 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 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.)

Cause Exists to Impose Discipline

12. Cause exists to impose discipline under Business and Professions Code section 2878, subdivision (a)(1). Clear and convincing evidence established that respondent substantially departed from the standard of care expected of an ordinary, reasonable and prudent licensed vocational nurse by ignoring the attending physician's plan of care for SM for several weeks and by failing to make certain SM's oxygen saturation level was monitored continuously with a pulse oximeter while he slept. Respondent's conduct in this regard posed a risk of harm to SM. Cause for discipline exists on this basis.

13. However, clear and convincing evidence did not establish that respondent's failure to provide chest compressions during her attempt to resuscitate SM involved gross negligence. Respondent was involved in an emergency situation. She responded in a prompt fashion that was not unreasonable under the circumstances. She was not negligent because her efforts were unsuccessful or because she made an error in judgment that was sensible under the circumstances. Respondent was not negligent because she chose an accepted method of care that was different than another accepted method of care that may have been a better choice in retrospect.³ Cause does not exist to impose discipline as a result of respondent's failure to provide chest compressions because that conduct did not involve gross negligence.

The Measure of Discipline

14. Cause exists to enter a disciplinary order that will enable the Board to monitor respondent's licensed activities and ensure that respondent has adequate supervision while she is on probation. Imposing a revocation, stayed, with three years probation on standard terms and conditions of probation is certainly within the public interest. Such an order is well within the Board's disciplinary guidelines and does not constitute punishment.

The Award of Costs

15. Business and Professions Code section 125.3 provides in part:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department . . . upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the

³ These standard medical malpractice jury instructions properly set forth existing law and apply to nursing cases. See, for example, *Fraijo v. Hartland Hospital* (1979) 99 Cal.App.3d 331, 340-341.

licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

16. *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 held that imposing costs under California Code of Regulations, title 16, section 317.5 (a regulation that is nearly identical to Business and Professions Code section 125.3) did not violate due process so long as the Board of Chiropractic Examiners exercised its discretion so that enforcement of the cost regulation did not deter chiropractors with potentially meritorious claims or defenses from exercising their right to a hearing.

The Supreme Court set forth four factors that must be considered in deciding whether to reduce or eliminate costs: (1) Whether the chiropractor used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed; (2) whether the chiropractor had a "subjective" good faith belief in the merits of his position; (3) whether the chiropractor raised a "colorable challenge" to the proposed discipline; and (4) whether the chiropractor had the financial ability to make payments.

Since Regulation 317.5 and Business and Professions Code section 125.3 contain substantially the same language and seek the same sort of cost recovery, *Zuckerman's* reasoning must be applied to Business and Professions Code section 125.3 to avoid constitutional pitfalls.

17. Evidence was presented that supports the reduction of costs under the *Zuckerman* criteria. Cause exists under Business and Professions Code section 125.3 to issue an order directing respondent to pay to the Board the sum of \$2,500 for its reasonable costs of investigation and enforcement.

ORDER

Licensed Vocational Nurse License No. VN 178501 issued to respondent, Michele Denise Peetz, is revoked; provided, however, that the order of revocation is stayed and respondent is placed on probation for a period of three years on the following terms and conditions of probation.

1. OBEY ALL LAWS

Respondent shall obey all federal, state and local laws at all times, including all statutes and regulations governing the license. Respondent shall submit, in writing, a full and detailed account of any and all violations of the law, including alleged violations, to the Board within five days of occurrence. This provision applies during any period of non-practice, in state or out of state.

To ensure compliance with this condition, respondent shall submit fingerprints through the Department of Justice and Federal Bureau of Investigation within 30 days of the effective date of the Decision, unless the Board determines that fingerprints were previously

submitted by respondent to the Board.

Respondent shall also submit to the Board a recent 2" x 2" photograph of herself within 30 days of the effective date of the Decision.

2. COMPLIANCE WITH PROBATION PROGRAM

Respondent shall fully comply with the conditions of probation established by the Board and she shall cooperate with representatives of the Board in its monitoring and investigation of respondent's compliance with the Probation Program.

3. SUBMIT WRITTEN REPORTS

Respondent shall submit or cause to be submitted, under penalty of perjury, any written reports or declarations and verifications of actions as required by the Board or its representatives. These reports or declarations shall contain statements relative to respondent's compliance with all 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.

In the first report, respondent shall provide a list of all states and territories where she has ever been licensed as a vocational/practical nurse, psychiatric technician, or registered nurse. Respondent shall provide information regarding the status of each license and any change in license status during the period of probation. Respondent shall inform the Board if she applies for or obtains a new nursing or psychiatric technician license during the period of probation.

Respondent shall provide a copy of the Board's Decision to the regulatory agency in every state and territory in which he/she has applied for or holds a vocational/practical nurse, psychiatric technician, or registered nurse license.

4. NOTIFICATION OF ADDRESS AND TELEPHONE NUMBER CHANGE(S)

Respondent shall notify the Board, in writing, within five days of any change in address or telephone number(s).

Respondent's failure to claim mail sent by the Board to her address of record may be deemed a violation of these probation conditions.

5. NOTIFICATION OF RESIDENCY OR PRACTICE OUTSIDE OF STATE

Respondent shall notify the Board, in writing, within five days, if she leaves California to reside or practice in another state. Periods of residency or practice outside of California shall not apply toward a reduction of this probation time period. If respondent

resides or practices outside of California, the period of probation shall be automatically extended for the same time period she resides or practices outside of California. Respondent shall provide written notice to the Board within five days of any change of residency or practice.

Respondent shall notify the Board, in writing, within five days, upon her return to California.

6. MEETINGS WITH BOARD REPRESENTATIVE(S)

Respondent shall appear in person at meetings as directed by the Board or its designated representatives.

7. NOTIFICATION TO EMPLOYER(S)

When currently employed or applying for employment in any capacity in any health care profession, respondent shall notify her employer of the probationary status of respondent's license. This notification to respondent's current health care employer shall occur no later than the effective date of the Decision. Respondent shall notify any prospective health care employer of her probationary status with the Board prior to accepting such employment. At a minimum, this notification shall be accomplished by providing the employer or prospective employer with a copy of the Board's Accusation or Statement of Issues and Disciplinary Decision.

Respondent shall provide to the Board the name(s), physical address(s), mailing address(s), and telephone number(s) of all health care employers and supervisors. Respondent shall complete the required consent forms and sign an agreement with her employer(s) and supervisor(s) authorizing the Board and the employer(s) and supervisor(s) to communicate regarding Respondent's work status, performance, and monitoring.

The Health Care Profession includes, but is not limited to: Licensed Vocational Nurse, Psychiatric Technician, Registered Nurse, Medical Assistant, Paramedic, Emergency Medical Technician, Certified Nursing Assistant, Home Health Aide, and all other ancillary technical health care positions.

Respondent shall cause each health care employer to submit to the Board all performance evaluations and any other employment related reports as required by the Board. Respondent shall notify the Board, in writing, of any difficulty in securing employer reports within five days of such an event.

Respondent shall notify the Board, in writing, within five days of any change in employment status. Respondent shall notify the Board, in writing, if she is terminated or separated, regardless of cause, from any nursing or health care related employment with a full explanation of the circumstances surrounding the termination or separation.

8. EMPLOYMENT REQUIREMENTS AND LIMITATIONS

Respondent shall work in her licensed capacity in the state of California. This practice shall consist of no less than six continuous months and of no less than 20 hours per week.

Respondent shall not work for a nurses' registry or in any private duty position, a temporary nurse placement agency, as a faculty member in an accredited or approved school of nursing, or as an instructor in a Board approved continuing education course except as approved, in writing, by the Board. Respondent shall work only on a regularly assigned, identified and predetermined work site(s) and shall not work in a float capacity except as approved, in writing, by the Board.

9. SUPERVISION REQUIREMENTS

Before commencing or continuing employment in any health care profession, respondent shall obtain approval from the Board of the supervision provided to respondent while employed.

Respondent shall not function as a charge nurse (i.e., work in any healthcare setting as the person who oversees or directs licensed vocational nurses, psychiatric technicians, certified nursing assistants, or unlicensed assistive personnel) or supervising psychiatric technician during the period of probation, except as approved, in writing, by the Board.

10. COMPLETION OF EDUCATIONAL COURSE(S)

Respondent, at her own expense, shall enroll and successfully complete coursework substantially related to the violation(s) no later than the end of the first year of probation.

The coursework shall be in addition to that required for license renewal. The Board shall notify respondent of the course content and number of contact hours required. Within 30 days of the Board's written notification of assigned coursework, respondent shall submit a written plan to comply with this requirement. The Board shall approve such plan prior to enrollment in any course of study.

Upon successful completion of the coursework, respondent shall submit "original" completion certificates to the Board within 30 days of course completion.

11. MAINTENANCE OF VALID LICENSE

Respondent shall, at all times, maintain an active current license with the Board.

Should respondent's license expire, by operation of law or otherwise, upon renewal or reinstatement, respondent's license shall be subject to any and all conditions of this probation not previously satisfied.

12. COST RECOVERY REQUIREMENTS

Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of \$2,500.

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 period. The filing of bankruptcy by respondent shall not relieve respondent of her responsibility to reimburse the Board for its investigation and prosecution costs. Failure to make payments in accordance with any formal agreement entered into with the Board or pursuant to any Decision by the Board shall be considered a violation of probation.

If respondent has not complied with this condition during the probationary period, and respondent presents sufficient documentation of her good faith effort to comply with this condition, and if no other conditions have been violated, the Board or its representatives may, upon written request from respondent, extend the probation period up to one year, without further hearing, in order to comply with this condition. During the extension, all original conditions of probation will apply.

Except as provided above, the Board shall not renew or reinstate the license of any respondent who has failed to pay all the costs as directed in a Decision.

13. LICENSE SURRENDER

During probation, if respondent 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 without further hearing. Upon formal acceptance of the tendered license, 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 licensee who surrenders his or her license may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary Decision for the surrender:

- Three years for reinstatement of a license surrendered for any reason other than a mental or physical illness; or
- One year for a license surrendered for a mental or physical illness.

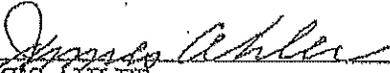
14. VIOLATION OF PROBATION

If respondent violates the conditions of her probation, the Board, after giving respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline (revocation) of respondent's license. If during probation, an Accusation or Petition to Revoke Probation has been 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.

15. SUCCESSFUL COMPLETION OF PROBATION

Upon successful completion of probation, respondent's license will be fully restored.

DATED: April 1, 2014


JAMES AHLER
Administrative Law Judge
Office of Administrative Hearings

FILED

FEB 11 2013

Board of Vocational Nursing
and Psychiatric Technicians

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8
 9 **BEFORE THE**
BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS
DEPARTMENT OF CONSUMER AFFAIRS
 10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:
 12
 13 MICHELE DENISE PEETZ
 327 W. 15th Avenue, #20
 Escondido, CA 92025
 14
 Vocational Nurse License No. VN 178501
 15
 Respondent.
 16

Case No. VN-2010-2438

ACCUSATION.

17 Complainant alleges:

18 PARTIES

19 1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this Accusation solely in
 20 her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric
 21 Technicians, Department of Consumer Affairs.

22 2. On or about October 24, 1996, the Board of Vocational Nursing and Psychiatric
 23 Technicians issued Vocational Nurse License Number VN 178501 to Michele Denise Peetz
 24 (Respondent). The Vocational Nurse License was in full force and effect at all times relevant to
 25 the charges brought herein and will expire on June 30, 2014, unless renewed.

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28 ///

JURISDICTION

3. This Accusation is brought before the Board of Vocational Nursing and Psychiatric Technicians (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 118(b) of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Bureau jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under section 2892.1 of the Code, the Bureau may renew an expired license at any time within four years after the expiration.

5. Section 2875 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline the holder of a vocational nurse license for any reason provided in Article 3 (commencing with section 2875) of the Vocational Nursing Practice Act.

6. Section 2878 of the Code states:

The Board may suspend or revoke a license issued under this chapter [the Vocational Nursing Practice Act (Bus. & Prof. Code, 2840, et seq.)] for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to the following:

(1) Incompetence, or gross negligence in carrying out usual nursing functions.

REGULATORY PROVISION

6. California Code of Regulations, title 16 Section 2519 states:

As set forth in Section 2878 of the Code, gross negligence is deemed unprofessional conduct and is a ground for disciplinary action. As used in Section 2878 "gross negligence" means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed vocational nurse, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of

1 the consumer shall be considered a substantial departure from the above standard of
2 care.

3 COST RECOVERY

4 7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
5 administrative law judge to direct a licensee found to have committed a violation or violations of
6 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
7 enforcement of the case.

8 FACTS

9 8. In 2010, Respondent was employed as a licensed vocational nurse by Maxim
10 Healthcare Services, Inc. as a home healthcare nurse. She was assigned to care for a 16 year-old
11 male who had been in a serious accident with a car while riding his bicycle two years previously.
12 As a consequence of the accident, the patient severed his spinal cord rendering him a
13 quadriplegic, and ventilator dependent. Also, his right leg below the knee was amputated. He
14 lived at home with his mother and step-father and had 24-hour nursing care from two licensed
15 vocational nurses who each worked 12-hour shifts. Respondent cared for the patient from 7:00
16 p.m. to 7:00 a.m. each day. The physician's Plan of Care for the patient included continuous
17 oxygen saturation monitoring via a finger probe, which would have caused an alarm to sound if
18 the patient's oxygen saturation level dropped below 95 percent.

19 9. At approximately 1:30 a.m. on November 28, 2010, the patient was sitting in his
20 wheelchair watching his brother play videogames when their mother entered the room and told
21 them it was time for bed. At about 2:00 a.m., Respondent had the patient prepared for bed.
22 Respondent checked on the patient at 5:00 a.m. and found he was sleeping and his oxygen
23 saturation level was at 98 percent. Respondent checked on him at approximately 6:14 a.m. and he
24 felt cool to the touch. She turned on the light and saw that the patient was cyanotic. Respondent
25 left the patient and woke up his mother asking her to call 911. Respondent then returned to the
26 patient and started ambu bagging him until the paramedics arrived. Respondent admitted she did
27 not check for a pulse or start chest compressions. The patient died.

28 ///

1 10. Later when asked by her employer why she did not follow the doctor's order for
2 continuous oxygen saturation monitoring, Respondent stated that the patient was having "strong
3 and frequent spasms" which caused the finger probe to fall off so she performed intermittent
4 checks of the patient's oxygen saturation level instead of continuous monitoring.

5 CAUSE FOR DISCIPLINE

6 (Gross Negligence)

7 11. Respondent has subjected her license to discipline for unprofessional conduct
8 pursuant to Code section 2878(a)(1), in that she was grossly negligent in her care and treatment of
9 her 16-year-old patient, as demonstrated by the following::

10 a. Respondent failed to contact the physician or nursing staff when the oxygen
11 saturation probe continued to fall off of the patient's finger; and

12 b. Respondent failed to perform chest compressions on her patient as part of
13 providing CPR to her patient.

14 PRAYER

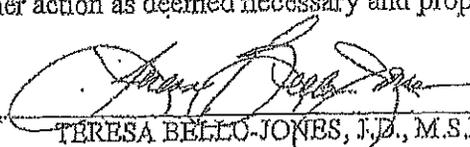
15 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
16 and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians
17 issue a decision:

18 1. Revoking or suspending Vocational Nurse License Number VN 178501, issued to
19 Michele Denise Peetz;

20 2. Ordering Michele Denise Peetz to pay the Board of Vocational Nursing and
21 Psychiatric Technicians the reasonable costs of the investigation and enforcement of this case,
22 pursuant to Business and Professions Code section 125.3;

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

24 DATED: FEB 11 2018

25 
TERESA BELLO-JONES, J.D., M.S.N., R.N.
26 Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
27 Department of Consumer Affairs
State of California
28 Complainant