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

In the Matter of the Accusation Against: Renee Ann Lazcano 17817 Saint Andrews Pl Torrance, CA 90504 Vocational Nurse License No. VN 706038 Respondent.	Case No. 43020200001379 OAH No. 2022070321 Precedential Decision No: 2024-02

DESIGNATION OF DECISION AS PRECEDENTIAL

Pursuant to Government Code section 11425.60, subdivision (b), the Board of Vocational Nursing and Psychiatric Technicians hereby designates the attached decision, in its entirety, as precedential.

This precedential designation shall be effective immediately.

IT IS SO ORDERED this 17th day of May 2024.

SIGNATURE ON FILE
Dr. Carel Mountain
President

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

In the Matter of the Accusation Against:

RENEE ANN LAZCANO

Vocational Nurse License Number VN 706038,

Respondent.

Agency Number: 4302020001379

OAH Number: 2022070321

PROPOSED DECISION

Administrative Law Judge Deena R. Ghaly, Office of Administrative Hearings (OAH), State of California, heard this matter on October 3, 4, and 5, 2023, by videoconference.

Deputy Attorney General Sheronda L. Edwards represented complainant Elaine Yamaguchi, acting in her official capacity as Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians (Board). Attorney James V. Kosnett represented respondent Renee Ann Lazcano who was present throughout the hearing.

Documentary evidence and testimony were received, and argument was heard. The record closed, and the matter was submitted for decision on October 5, 2023.

SUMMARY

Complainant seeks to discipline Respondent's vocational nurse license for gross negligence and general unprofessional conduct. Complainant also seeks to recover the Board costs for enforcement expenses of $22,318.75.

Clear and convincing evidence established the two causes for discipline alleged in the Accusation. Applying the Board's disciplinary guidelines, the appropriate discipline is revocation stayed and a period of probation with standard terms and conditions. In addition, respondent will pay costs to the Board in the amount requested by complainant.

FACTUAL FINDINGS

Jurisdictional Matters

1. On July 29, 2019, the Board issued Vocational Nursing License number VN 706038 to respondent. The license was in effect at all times relevant to this matter and will expire on March 31, 2025, unless it is renewed.

2. On January 24, 2022, complainant signed the Accusation alleging grounds to discipline respondent's license. Respondent timely filed a notice of appeal requesting a hearing on the merits of the Accusation. Thereafter, this hearing ensued.

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Complainant's Allegations

3. At all times relevant to the Accusation, respondent was employed at California Hematology Oncology Medical Group (CHOMG), a small medical practice of four physicians specializing in cancer and blood disease treatment and a staff of nurses and administrative personnel. Complainant alleged that, on November 8, 2019, while working at CHOMG, respondent administered intravenous (IV) medications and mixed and administered chemotherapy and immunotherapy to patients and these actions exceeded the scope of practice for a licensed vocational nurse (LVN).

Complainant's Evidence

RN WALES

4. Registered Nurse (RN) Lisa Marie Wales (formerly, Lisa Marie Rich) (RN Wales) worked at CHOMG from 1999 until November 2019, when she was terminated from her position. Three months later, in January 2020, RN Wales lodged the complaint with the Board giving rise to the instant matter. The complaint states:

> I was released from my employment as the senior RN from my outpatient oncology job within 3 months of our medical assistant [respondent] obtaining her LVN license. [Respondent] has had no further education including IV certification which is necessary to work in an infusion setting, limiting as it would be for her. Initially she was accessing portacaths and infusing non-chemo medications on Friday my day off and I had advised her several times not to do so and that she was risking her license. She stated she could not say no to our employer, [CHOMG Office

> Manager] Lorene Cangiano, as she had paid for her LVN school so she felt she had to. I continued to tell [respondent], our employer, Lorene and office manager, Jessica Hernandes that she was working outside the scope of her practice but I was ignored completely. I was then asked by our scheduler . . . if [respondent] could give chemotherapy and I said no she can not. (sic) The next day, 11/7/19, I was given a one month notice of termination from my employer, Lorene Cangiano, stating there was no longer a need for 2 RNs in our practice and they would keep one RN and one LVN. On 11/8/19, [respondent] mixed and gave the chemotherapy that I had advised her not to give. . . I continue to worry for the safety of the patients who now are receiving their infusions from an unqualified LVN.

(Exh. 4, p. A62.)

5. In January 2023, RN Wales suffered a stroke, causing her to lose parts of her memory. As she explained during her testimony and as noted below, this memory loss impacted RN Wales's recollection of some of the events relevant to this matter.

6. During RN Wales's tenure there, CHOMG had two offices, one in Torrance and one in El Segundo. RN Wales divided her time between the two locations. RN Wales was one of two RNs working at CHOMG, each stationed at one of the two locations.

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7. Among the duties the RNs routinely performed was reconstituting the drugs which sometimes came in powder form and had to be mixed with saline or other liquid, as well as administering these drugs to patients by injection or by IV infusion through a port. Each of CHOMG's locations had a "chemo room," where medications were prepared and administered.

8. According to RN Wales, each step of the process involved in handling these often very toxic medications require knowledge and skill even RNs would not have without specialized training. For her part, RN Wales held certifications as an oncology nurse and completed continuing education courses addressing oncology subjects each year she worked at CHOMG.

9. RN Wales described the challenges of reconstituting and administering cancer-fighting medications as follows: (i) in reconstituting the medications, failing to do so correctly could weaken or increase their potency, either of which could endanger patients' lives; (ii) some medications needed to be dosed at higher or lower levels based on patients' weights, calculated by using a complicated mathematical formula, and with the reconstitution phase, miscalculating dosage would result in life-threatening adverse effects; (iii) the medications can be very painful for patients as they are infused into their bodies, especially for those receiving repeat treatments into sites already bruised or where body tissue hardened from earlier applications and experienced RNs know how to vary the speed of medication delivery to minimize pain; (iv) patients receiving their medication through a surgically implanted port are in danger of an additional complication, "blood return," where their own blood backs into the tube delivering the medication and RNs know how to position and re-position patients and help them change their breathing patterns to minimize this adverse effect; and (v) patients receiving medications for cancer are susceptible to very serious

side effects, including kidney, liver, or heart failure. RNs are trained to monitor for these side effects, spot the sometimes subtle indications they are happening, and take the necessary action to assist patients.

10. RN Wales stated the complications and challenges of administering cancer-fighting medications are such that, even with her specialized knowledge and ongoing training, she and the other RN on duty, also duly trained, worked together. Over the phone, they checked each other's dosage calculations or consulted with each other regarding a given patient's adverse effects as a further safety step.

11. After respondent completed her LVN studies and obtained her license in July 2019, RN Wales recalled seeing her take an increasingly prominent role in treating patients at CHOMG, including reconstituting medications and administering them through both IVs and injections.

12. RN Wales was sufficiently concerned about what respondent was doing that she spoke to respondent directly, warning her not to undertake these responsibilities because they were not within even an experienced LVN's scope of practice and respondent, being very recently licensed, often working alone on RN Wales's weekly day off, could make a serious mistake. Respondent replied she had no choice but to follow orders because CHOMG had paid for her LVN studies.

13. RN Wales also spoke to CHOMG's staff physicians and office administrator Lorene Cangiano, none of whom seemed to take her concerns seriously.

14. RN Wales does not recall whether she was at CHOMG on November 8, 2019, the only day complainant alleged respondent performed acts giving rise to discipline. (See, Exh. 1, p. A8.) As noted below, CHOMG's office manager, Jessica Ramirez (formerly, Jessica Hernandez), testified at the hearing and stated CHOMG's

timekeeping records reflect that RN Wales did not work at CHOMG on November 8, 2019. RN Wales's complaint, submitted three years before her stroke, states her last day at CHOMG was November 7, 2019.

15. During the hearing, RN Wales was asked whether doctors working at the practice ever administered medications. RN Wales responded that the doctors never administered the drugs in the chemo room and, in fact, except for briefly stopping by to ask a nurse there a question, assiduously avoided even entering the chemo room.

16. During the hearing, RN Wales was repeatedly asked whether she was a "disgruntled" former employee who brought the complaint against respondent to avenge her anger at being terminated. RN Wales readily admitted to being deeply upset and hurt about being summarily dismissed from CHOMG but stated she brought the complaint because she believed respondent could not safely undertake reconstituting and administering cancer-fighting medication for which RN Wales and other similarly educated and experienced professionals had spent years honing the necessary skills and knowledge.

Board Investigation

17. Associate Governmental Analyst Rachel Vierra was the first Board investigator assigned to investigate RN Wales's complaint. In a letter dated February 13, 2020, Analyst Vierra wrote to respondent explaining the nature of the investigation and requesting documents and information responsive to her inquiry. Notably, Analyst Vierra did not state in her letter that she was requesting information about respondent's actions on any particular dates, just that there had been a complaint that "while employed by [CHOMG], you are working outside your scope of practice by

administering IV medications, accessing central line portocaths, and mixing and administering chemotherapy and immunotherapy to patients." (Exh. 6, p. A80.)

18. In a letter dated February 24, 2020, respondent replied to Analyst Vierra, stating in part, her duties at CHOMG include administering all injections and immunotherapy, under physicians' supervision: "I am always supervised by the Physician who also checks the Patient's labs and gives the order to administer the immunotherapy. I have recently completed the IV Therapy and Blood Withdrawal Certification course." (Exh. 6, p. A84.) On February 23, 2020, Respondent received her certification to administer medications through IVs and to draw blood. (See, Exh. E.)

19. CHOMG Administrator Lorene Cangiano, herself an RN, also responded in writing to Analyst Vierra's inquiry. In a letter dated February 19, 2020, she wrote:

> [CHOMG] is a private medical practice. [Respondent] works under the supervision of a physician at all times. The physicians approve any treatment or procedure that [respondent] does. [Respondent] works closely with a Chemotherapy Certified registered nurse. Nothing [respondent] does is independent of complete supervision of a doctor or nurse.

(Exh. 7.)

20. Analyst Vierra also requested respondent's written job description, any record of disciplinary action or counseling memos and the report and supporting documentation from any investigation CHOMG undertook based on RN Wales's complaint. (See, Exh. 9, p. A93.) One of CHOMG's physicians and its medical director, Dr. Wade Nishimoto responded to this inquiry, stating in part that respondent has not

violated any of CHOMG's policies and procedures and "[n]o incidents have occurred 12-01-19 through present." (Exh. 9, p. A92.)

21. In response to Analyst Vierra's request for "the nursing flow sheet for the shift [respondent] worked on November 8, 2019" (Exh. 11, p.A102) CHOMG staff provided a document listing the patients treated at CHOMG that day. The document resembles a calendar with appointment times along the left side of the sheet and treatments listed next to the appointments. Some of these entries have "rl" or "RL" input after the treatment. RL are respondent's initials. (See, Exh. 13, pp. A113-A115.)

22. Rosemary Chavez was the second Board investigator assigned to investigate the complaint against respondent. Investigator Chavez served a subpoena on CHOMG directing production of "[r]edacted/de-identified copies of documentation for the 13 patients [respondent] provided care on . . . November 8, 2019. The Physician Orders, Nursing Notes, 24-hour chart, or any other applicable records for the incident." (Exh. 19, p. A141.) The subpoena directed that identifying patient information should be redacted and further instructed: "**DO NOT redact/de-identify the names of other health care providers.**" (Exh. 19, p. A143 [capitalized and bold text in original].)

23. In response to the subpoena, CHOMG's office manager produced an "Appointment Detail Report" (see, Exh. 20) listing 13 patient ID numbers and the medications the patients received including one patient receiving Gemzar, one receiving Neupogen, three receiving Vidaza, and two receiving Velcade. These are all cancer-fighting medications loosely categorized under the umbrella term, chemotherapy.

24. During the hearing, complainant presented Administrator Cangiano's written statement, providing in part "[n]othing [respondent] does is independent of

complete supervision of a doctor or nurse." (Exh. 7.) Complainant also presented the recording of Investigator Chavez's interview with respondent (Exh. 27.) In the recording at minute 4:14, respondent states she "gives immunotherapy infusions" in response to a question about her duties at CHOMG. At minutes 5:50-5:51, she states she works "with a physician on site." At minute 10:32, respondent states the doctors come in "every 20 to 30 minutes" while she is administering immunotherapy. At minute 8:34, she answers in the affirmative to the question about whether LVNs may administer medications via IV infusion, noting this is the case because CHOMG is a private practice, not a large institutional facility. At minutes 11:53-11:59, respondent states she gave injections but not infusions before obtaining her LVN license.

BOARD EXPERT

25. Rosenda Jewell testified as an expert witness on behalf of complainant. She has been an LVN in California since 2005 and in Washington State since 1995. Ms. Jewell is currently an LVN mentor and trainer at Unitek College in Sacramento. Her curriculum vitae lists dozens of LVN positions both as part of her military service and as a civilian dating back to 1988. (See, Exh. 21.)

26. Ms. Jewell prepared a report (Exh. 22) and testified at the hearing. Her testimony was consistent with the report and is summarized as follows: In reviewing CHOMG's medical records from November 8, 2019, Ms. Jewell assumed, consistent with standard charting practices, the entries marked with respondent's initials indicated treatments administered by respondent. As such, Ms. Jewell found evidence of respondent violating the standard of practice. This is the case because the entries reflect administration of medications by IV. Pursuant to applicable law and regulations, LVNs can only administer IV's after they have received certification to do so from a Board-approved provider, something respondent did not do until February

2020, and even then, can only administer IV's delivering electrolytes, nutrients, vitamins, blood, and blood products, not medications. RNs may administer medications by IV methods but if those medications are chemotherapy, immunotherapy or similar medications, they may only be administered by an RN who has specialized certification and training in oncology. Generally, LVNs may administer medications by injection but not medications such as Gemzar, Kyprolis, and Velcade, which are generally grouped under the umbrella term, chemotherapy. Ms. Jewell further stated LVNs are taught they are subject to a defined scope of practice and understanding these limitations is part of an LVN's duties. Ms. Jewell concluded respondent's actions in reconstituting and administering cancer-fighting medications at CHOMG constituted gross negligence and unprofessional conduct. Her testimony was well-reasoned and cogent and is therefore credited.

Respondent's Evidence

DR. WADE NISHIMOTO

27. Dr. Wade Nishimoto is an oncologist and served as CHOMG's medical director until June 30, 2021. He experienced some memory difficulties while testifying at the hearing. Dr. Nishimoto stated he recalled clearly, however, that he was working at CHOMG on November 8, 2019, and on that day, personally administered all infusions and injections for the patients. According to Dr. Nishimoto's testimony at the hearing, he and CHOMG's other staff physicians routinely did this from time to time.

28. At the hearing, Dr. Nishimoto was shown CHOMG medical records for November 8, 2019, reflecting in part, a notation, "rl," next to the medications administered to some of the patients. (See, Exh. 15.) Dr. Nishimoto was asked why respondent's and other CHOMG personnel's initials appear on the records but not

those of Dr. Nishimoto. Dr. Nishimoto stated none of the doctors charted treatments they personally administered and, in fact, did not even have access to the electronic patient records. Instead, the assisting nurses would insert their own initials next to the treatments administered by CHOMG physicians.

JESSICA RAMIREZ

29. Jessica Ramirez is CHOMG's office manager. After checking CHOMG's time-keeping records, she determined RN Wales did not work at CHOMG on November 8, 2019. During her testimony, Ms. Ramirez initially stated respondent's initials next to patient treatments indicated respondent had administered their medications but then changed her testimony, stating the notes reflecting patients treated at CHOMG on November 8, 2019 at Exhibit 13 were "appointment notes, not nurse's notes" and therefore were not intended to reflect whom amongst CHOMG's staff administered treatment.

RESPONDENT

30. At the hearing, respondent testified on her own behalf. She has worked at CHOMG since 2002, initially in a largely clerical capacity and then, after completing her LVN degree and obtaining licensure in July 2019, as a nurse. Once she became an LVN, respondent stated that, as part of a small private practice, she worked at CHOMG under physicians' close supervision and that this work included administering injections and IVs. She stated Dr. Nishimoto directly treated the patients seen on November 8, 2019, and she stood by to assist and even took notes for her own edification but did not retain them.

31. Respondent presented three letters of recommendation, one from CHOMG office manager, Jessica Ramirez and the other two from CHOMG physicians,

Frank Mori and Xiuqing (Jenny) Ru. (Exhs. B, C, and D.) These letters are uniformly complimentary of respondent's skills and commitment to vocational nursing; however, in light of CHOMG's close association and involvement with the circumstances underlying this matter, they were afforded limited weight. Respondent also presented certificates of completion for continuing education courses in prescription medication abuse, the illicit drug crisis, communication and team building, disorders of the gastrointestinal system, and sexual harassment prevention. (Exhs. F-L.)

Analysis of Evidence

32. RN Wales's testimony was persuasive and credible in establishing the significant dangers and challenges of reconstituting and administering medications to cancer patients and the reasons why such work requires the higher level of education and skills of RNs certified and specializing in oncology. Her testimony on that score was well-reasoned and detailed. RN Wales's testimony also credibly established respondent's encroaching role in work formerly undertaken solely by RNs. To the extent RN Wales's memory was compromised, she candidly admitted to any deficiencies and gaps. RN Wales's statement submitted to the Board in connection with her complaint supplemented her testimony by providing details she did not remember during her testimony.

33. RN Wales is not a percipient witness to the events occurring on November 8, 2019. She testified she could not recall whether she worked then, her complaint identifies the last day she worked at CHOMG as the day before, November 7, 2019, and CHOMG's records, as reported by CHOMG Office Manager Jessica Ramirez, do not reflect she worked that day.

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34. A reasonable inference to be drawn from RN Wales's testimony is that respondent took over RN Wales's duties after RN Wales left CHOMG's employ. Multiple factors support this inference: (i) RN Wales's credible, detailed testimony setting out respondent's increasing encroachment into RN Wales's areas of responsibility before RN Wales was terminated; (ii) statements in response to Analyst Vierra's inquiries from respondent and other staff confirming respondent does perform this work, without noting exceptions, particularly any assumption of these duties by CHOMG physicians; (iii) the records produced by CHOMG with respondent's initials entered next to some of the treatments; and (iv) the list CHOMG produced in response to Investigator Chavez's subpoena seeking production of documents recording the patients treated by respondent on November 8, 2019. At any point in the production of this information, RN Wales or CHOMG staff, including respondent, could have noted that even if respondent was present for patients' treatments, CHOMG physicians, and not her, were or may have been the ones directly administering treatment.

35. RN Wales expressly testified to the contrary, stating that, in her many years there, CHOMG physicians not only did not administer treatments themselves, but they avoided even entering the chemo rooms. Investigator Chavez's very specifically worded subpoena seeking documentation for the patients respondent treated on November 8, 2019, includes instructions not to remove identifying information of any other medical providers, a statement which certainly should have prompted disclosure of Dr. Nishimoto's participation that day, yet did not.

36. The evidence presented of Dr. Nishimoto's actions was primarily his own testimony, as corroborated by respondent's testimony. According to Dr. Nishimoto, he not only administered all the treatments given to patients on November 8, 2019, all

CHOMG physicians did so from time to time. And none of them chart their work under their own names.

37. Testimony by Dr. Nishimoto and respondent on this point is not credible and is not credited. Accurate charting of medical treatment is standard procedure for virtually all practitioners in the healing arts. It defies credulity that an established practice, treating seriously ill patients with dangerous drugs, would fail to adhere to these standard record-keeping practices. Respondent's testimony corroborating that of Dr. Nishimoto contradicts her earlier statements made during the Board's investigation, eroding both her credibility and Dr. Nishimoto's.

Enforcement Costs

38. The Justice Department billed the Board $22,318.75 for legal services related to the enforcement of this matter. These costs are deemed reasonable for the size and scope of the matter. Respondent did not produce evidence of financial hardship if she were to be ordered to pay these costs, or otherwise challenge the cost request.

LEGAL CONCLUSIONS

General Provisions

1. The Board has the authority to discipline a licensed vocational nurse for unprofessional conduct and for violating any provision of the Vocational Nursing Practice Act (Bus. & Prof. Code, §§ 2875, 2878, subd (a) and (d).) (Further statutory citations are to the Business and Professions Code unless otherwise indicated.)

2. The standard of proof in an administrative disciplinary action against a professional license is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The California Legislature has declared the practice of licensed vocational nursing to be a profession. (§ 2840.5.) The clear and convincing evidence standard requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

3. Section 2860.5, subdivision (a) provides in part:

> A licensed vocational nurse when directed by a licensed physician and surgeon may do all of the following:
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> (1) Administer medications by hypodermic injection.
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> (2) Withdraw blood from a patient if the licensed vocation nurse has been instructed by a licensed physician and surgeon and has demonstrated competence to the license physician and surgeon in the proper procedure to be employed when withdrawing blood or has satisfactorily completed a prescribed course of instruction approved by the Board, or has demonstrated competence to the satisfaction of the Board.
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> (3) Start and superimpose intravenous fluids if all of the following additional conditions exist:

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(A) The licensed vocational nurse has satisfactorily completed a prescribed course of instruction approved by the Board or has demonstrated competence to the satisfaction of the Board.

(B) The procedure is performed in an organized health care system in accordance with the written standardized procedures adopted by the organized health care system as formulated by a committee which includes representatives of the medical, nursing, and administrative staff. "Organized health care system," as used in this section, includes . . . clinics, . . . [and] physician's offices. Standardized procedures so adopted will be reproduced in writing and made available to total medical and nursing staff.

Causes for Discipline

GROSS NEGLIGENCE

4. As a first cause for discipline, complainant alleged respondent committed gross negligence when, on November 8, 2019, she administered chemotherapy and immunotherapy to patients. This cause for discipline was established based on Factual Findings 4-26 and 32-37.

5. Section 2878, subdivision (a)(1), provides in part:

The Board may suspend or revoke a license issued under [the Vocational Nursing Practice Act] 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

6. California Code of Regulations, title 16 (Regulation) section 2519 states:

> As set forth in [s]ection 2878 . . . gross negligence is deemed unprofessional conduct and is a ground for disciplinary action. As used in [s]ection 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.

7. In this case, respondent reconstituted and administered toxic and dangerous medications both by injection and intravenously on November 8, 2019. She was not yet certified to perform IV's and even if she was, such certification would not have qualified her to do so except to use IV's to infuse supplements and blood products. Her actions therefore constituted gross negligence.

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UNPROFESSIONAL CONDUCT

8. As a second cause for discipline, complainant alleged respondent committed unprofessional conduct. Under section 2878, "unprofessional conduct" is partially defined by an enumerated list of exemplars, none of which are cited by complainant as the basis for this cause for discipline. When not otherwise defined, case law provides "unprofessional conduct" defines as "conduct which breaches the rules or ethical code of a profession or which is unbecoming of a member in good standing of a profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

9. In evaluating whether respondent engaged in unprofessional conduct, RN Wales's account of the challenges of cancer medication preparation and administration as well as Ms. Jewell's expert opinion confirming RN Wales's contention that such work requires not only RN level credentials and experience but specialized certifications and training, must play a prominent role. Respondent may have had the best of intentions in meeting the expectations and direction of CHOMG, her employer and benefactor in becoming an LVN but, in doing so, she disregarded the needs of her patients, a vulnerable group, who trusted her to treat them appropriately when, in fact, she was not equipped to do so. As such, respondent's conduct is unbecoming of her profession. Therefore, this second cause for discipline is upheld.

Level of Discipline

10. In reaching a decision on the appropriate level of discipline, the Board must consider the guidelines entitled Disciplinary Guidelines and Uniform Standards Related to Substance Abuse, revised June 20, 2011, and incorporated by reference at Regulation section 2524 (the Guidelines). The Guidelines set out factors to be

considered when imposing discipline on a licensee. The factors relevant to this matter are: the nature and severity of the acts, the actual or potential harm to the public, the actual or potential harm to any patient, any prior disciplinary record, the number and/or variety of current violations, any evidence in mitigation, evidence of rehabilitation, and the time that has passed since the acts occurred. (Guidelines, p. iv.) Under the Guidelines, the recommended disciplinary actions for gross negligence and unprofessional conduct are the same: stayed revocation with two years' probation as a minimum discipline; stayed revocation with three years' probation as intermediate discipline; and outright revocation as the maximum discipline.

11. Respondent's actions are serious. Given the vulnerability of the patient population she was treating and their condition as cancer patients, the severity of her transgressions is manifest. Although nothing in the record supports a finding of actual harm to the patients, there was potential for harm. Respondent has no prior record of discipline and there are just two causes for discipline in the instant matter, both arising from the same factual allegations. In mitigation, respondent was new to the LVN profession when the circumstances giving rise to this matter came about. She was under the influence and authority of her employer, CHOMG, whose management played an active role in causing these circumstances. By way of rehabilitation, respondent obtained her certification in IV and blood withdrawal procedures during the Board's investigation. Considering the Guidelines' disciplinary factors as a whole, outright revocation of respondent's license is not necessary to protect the public. Respondent's license will be placed on probation for three years under appropriate terms and conditions as set out in the Order below.

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Cost Recovery

12. Section 125.3 authorizes the Board to recover its reasonable costs of investigation and enforcement. In *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, the California Supreme Court set out standards by which a licensing board must exercise its discretion to reduce or eliminate cost awards to ensure that licensees with potentially meritorious claims are not deterred from exercising their right to an administrative hearing. Those standards include whether the licensee has been successful at hearing in getting the charges dismissed or reduced, the licensee's good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate to the alleged misconduct. The costs requested by complainant are reasonable for the size and scope of the matter and respondent has not presented any evidence to otherwise reduce them.

ORDER

Vocational Nurse License number VN 706038 issued to Renee Ann Lazcano is revoked. However, the revocation is stayed, and respondent is placed on probation for a period of three years under the following terms and conditions:

1. OBEY ALL LAWS

Respondent shall obey all federal, state, and local laws, 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. 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 the 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. If respondent is under a criminal court order, including probation or parole, and the order is violated, it shall be deemed a violation of these probation conditions. Respondent shall submit proof of satisfactory completion of any criminal probation or parole that ends after the effective date of the Board's Decision. Respondent shall submit certified copies of court documents related to the expungement of any conviction(s) if not previously submitted.

2. COMPLIANCE WITH PROBATION PROGRAM

Respondent shall fully comply with the conditions of probation established by the Board and shall cooperate with its representatives in monitoring and investigation of her compliance with the Probation Program. Upon successful completion of probation, respondent's license shall be fully restored.

3. SUBMIT WRITTEN REPORTS

Respondent shall submit or cause to be submitted, under penalty of perjury, any written reports, declarations, and verification 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 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 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 vocational nurse license during the probation period. Respondent shall provide a copy of the Board's decision to the regulatory agency in every state and territory in which she has applied for or holds a vocational 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 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 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 his return to California.

6. MEETINGS WITH BOARD REPRESENTATIVES

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

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7. NOTIFICATION TO EMPLOYER(S)

Whether currently employed or applying for employment in any capacity in any health care profession, respondent shall notify her employer of her license's probationary status. 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 and Disciplinary Decision. 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 the 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 a course(s) 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 the respondent of the course content and number of contact hours required. Within thirty 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 course, respondent shall submit "original" completion certificates to the Board within thirty (30) days of course completion.

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11. MAINTENANCE OF VALID LICENSE

Respondent shall, at all times, maintain an active current license with the Board, including any period of suspension. Should respondent's license expire, by operation of law or otherwise, upon renewal or reinstatement, her license shall be subject to any and all conditions of this probation not previously satisfied.

12. 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 $22,318.75. 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 period. The filing of bankruptcy by respondent shall not relieve respondent of her responsibility to reimburse the Board for its enforcement 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 she presents sufficient documentation of good faith effort to comply with this condition and 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 shall apply. Except as provided above, the Board shall not renew or reinstate the license for any respondent who has failed to pay all the costs as directed in a Decision.

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13. LICENSE SURRENDER

During probation, if respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the conditions of probation, she 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 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.

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14. VIOLATION OF PROBATION

If respondent violates the conditions of her probation, the Board, after giving her notice and an opportunity to be heard, may set aside the stay order and revoke 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.

DATE: 11/16/2023

Deena R. Ghaly

Deena R. Ghaly (Nov 16, 2023 10:22 PST)

DEENA R. GHALY

Administrative Law Judge

Office of Administrative Hearings