

**FILED**

SEP 1 2010

**ACUPUNCTURE BOARD**

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7  
8 **BEFORE THE**  
**ACUPUNCTURE BOARD**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
**STATE OF CALIFORNIA**

10 In the Matter of the Accusation Against:

Case No. 1A-2010-56

11 **JANE DONG REN**  
12 **6029 Monterey Ave.**  
13 **Richmond, CA 94805**

**ACCUSATION**

14 **Acupuncture License No. AC 12543**

15 Respondent.

16  
17 Complainant alleges:

18 **PARTIES**

19 1. Janelle Wedge (Complainant) brings this Accusation solely in her official capacity as  
20 the Executive Officer of the Acupuncture Board, Department of Consumer Affairs.

21 2. On or about September 5, 2008, the Acupuncture Board issued Acupuncture License  
22 Number AC 12543 to Jane Dong Ren (Respondent). The Acupuncture License was in full force  
23 and effect at all times relevant to the charges brought herein and will expire on January 31, 2012,  
24 unless renewed.

25 **JURISDICTION**

26 3. This Accusation is brought before the Acupuncture Board (Board), Department of  
27 Consumer Affairs, under the authority of the following laws. All section references are to the  
28 Business and Professions Code unless otherwise indicated.

1           4.    Section 4955 of the Code states:

2           "The board may deny, suspend, or revoke, or impose probationary conditions upon, the  
3 license of any acupuncturist if he or she is guilty of unprofessional conduct.

4           "Unprofessional conduct shall include, but not be limited to, the following:

5                 "(h) Disciplinary action taken by any public agency for any act substantially  
6 related to the qualifications, functions, or duties of an acupuncturist or any  
7 professional health care licensee."

8           5.    Section 4959 of the Code states:

9                 "(a) The board may request the administrative law judge, under his or her  
10 proposed decision in resolution of a disciplinary proceeding before the board, to  
11 direct any licensee found guilty of unprofessional conduct to pay to the board a sum  
12 not to exceed actual and reasonable costs of the investigation and prosecution of the  
13 case.

14                 "(b) The costs to be assessed shall be fixed by the administrative law judge and  
15 shall not in any event be increased by the board. When the board does not adopt a  
16 proposed decision and remands the case to an administrative law judge, the  
17 administrative law judge shall not increase the amount of any costs assessed in the  
18 proposed decision.

19                 "(c) When the payment directed in the board's order for payment of costs is not  
20 made by the licensee, the board may enforce the order for payment in the superior  
21 court in the county where the administrative hearing was held. This right of  
22 enforcement shall be in addition to any other rights the board may have as to any  
23 licensee directed to pay costs.

24                 "(d) In any judicial action for the recovery of costs, proof of the board's  
25 decision shall be conclusive proof of the validity of the order of payment and the  
26 terms for payment.

27                 "(e) All costs recovered under this section shall be considered a reimbursement  
28 for costs incurred and shall be deposited in the Acupuncture Fund."

1 FIRST CAUSE FOR DISCIPLINE

2 (Disciplinary action by another licensing board)

3 6. Respondent is subject to disciplinary action under code section 4955(h) [disciplinary  
4 action by another healthcare agency] in that respondent's license to work as a registered nurse  
5 (hereinafter "RN") was disciplined by the California Board of Registered Nursing (hereinafter  
6 "RN Board.")

7 7. Respondent entered into a stipulation which placed her RN license on probation for  
8 three years subject to terms and conditions. Respondent admitted the truth of each and every  
9 charge and allegation in Accusation no. 2008-266 filed March 18, 2008. A true and correct copy  
10 of the Decision and Order in RN Case no. 2008-266 is attached hereto as Exhibit 1. The  
11 circumstances are as follows:

12 8. On or about October 24, 1995, the RN Board issued RN License number 517162 to  
13 Respondent. On or about March 18, 2008, the RN Board filed Accusation no. 2008-266 against  
14 Respondent's license.

15 9. On or about December 30, 2008, the RN Board issued a Decision and Order in case  
16 no. 2008-266 with an effective date of January 29, 2009. Respondent's license was revoked,  
17 revocation stayed, and her license was placed on three years probation subject to terms and  
18 conditions.

19 10. Accusation no. 2008-266 alleged that on July 7, 2004, while respondent was working  
20 as a registered nurse in the General Acute Care Unit (GACU) at Sonoma Developmental Center  
21 (SDC) in Eldridge, California, Respondent administered the wrong medication to a 23-year old  
22 patient by improper means, failed to properly document her medication errors, and failed to  
23 recognize and appropriately respond to the signs and symptoms of the patient's illness.

24 A. The patient, Patient A<sup>1</sup>, was a life long resident at SDC with a diagnosis including  
25 cerebral palsy, seizure disorder, and episodic pneumonia secondary to severe dysphagia  
26 (swallowing syndrome) . During the 18 months prior to his death, he had developed an

27 \_\_\_\_\_  
28 <sup>1</sup> Initial "A" is used to protect patient privacy.

1 increasing number of pneumonias. On or about July 5, 2004, he developed a fever with  
2 respiratory distress and dangerously abnormal vital signs; he was thereafter transferred to the  
3 GACU to receive a higher level of nursing and medical care. Respondent did not recognize the  
4 gross abnormality of the patient's vital signs, and did not properly assess, track and document his  
5 status.

6 B. At approximately 8:00 p.m. on July 7, 2004, Patient A. was scheduled to receive his  
7 standing 60 milligram (mg) dose of Phenobarbital<sup>2</sup>. Instead, Respondent administered 60 mg of  
8 morphine sulfate.<sup>3</sup> Patient A. had a brief seizure approximately two hours after missing his  
9 Phenobarbital.

10 C. The morphine sulfate was an extended release preparation. Extended release tablets  
11 should be administered whole and intact and not broken or crushed.<sup>4</sup> Respondent crushed the  
12 morphine sulfate extended release tablets and administered them through Patient A.'s  
13 gastrostomy tube.

14 11. Respondent's medication errors were not recognized until a routine medication count  
15 was performed during the evening shift change, approximately three hours later. Upon learning  
16 of her errors, Respondent did not correct the medical record, as required by facility procedures, to  
17 reflect that Patient A. received morphine sulfate extended-release tablets, crushed through his  
18 gastrostomy tube, rather than his regular phenobarbital dose.

19 12. Accusation no. 2008-266 charged respondent with gross negligence in that she  
20 administered the wrong medication to Patient A.; incompetence in that she crushed and  
21 administered medication that should only have been administered intact and unbroken;  
22 incompetence in that she failed to recognize that the patient's vital signs were grossly abnormal  
23

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24 <sup>2</sup> Phenobarbital is an anticonvulsant, commonly used in the management of seizure  
25 disorders.

26 <sup>3</sup> Morphine sulfate is a powerful analgesic used for preoperative sedation, as a supplement  
27 to anesthesia, or to relieve severe pain. Respiratory depression is the chief hazard of all morphine  
28 preparations. Respiratory depression occurs most frequently in elderly and debilitated patients,  
and those already suffering from respiratory ailments.

<sup>4</sup> Intake of broken or crushed morphine sulfate extended release tablets may result in too  
rapid a release of the drug and absorption of a potentially toxic dose of morphine sulfate.

1 and failed to respond accordingly; unprofessional conduct in that she failed to follow the facility's  
2 medication administration documentation procedures; and general unprofessional conduct.

3 13. Therefore, Respondent's acupuncture license is subject to discipline pursuant to code  
4 section 4955(h) in that the California Registered Nursing Board's discipline of her license to  
5 practice as a registered nurse constitutes grounds for discipline of her acupuncture license.

6 PRAYER

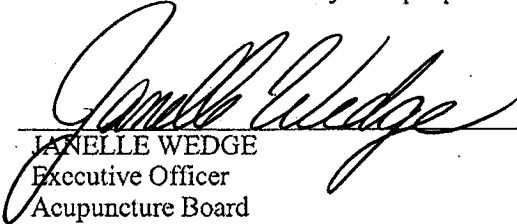
7 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
8 and that following the hearing, the Acupuncture Board issue a decision:

9 1. Revoking or suspending Acupuncture License Number AC 12543, issued to Jane  
10 Dong Ren;

11 2. Ordering Jane Dong Ren to pay to the Acupuncture Board the reasonable costs of the  
12 investigation and enforcement of this case, pursuant to Business and Professions Code section  
13 4959;

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

15 DATED: **SEP 01 2010**

16   
17 JANELLE WEDGE  
18 Executive Officer  
19 Acupuncture Board  
20 Department of Consumer Affairs  
21 State of California  
22 Complainant

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