EDMUND G. BROWN JR.
Attorney General of California
JANICE K. LACHMAN
Supervising Deputy Attorney General
LORRIE M. YOST
Deputy Attorney General
State Bar No. 119088
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-2271
Facsimile: (916) 327-8643

*Attorneys for Complainant*

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

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| In the Matter of the Accusation Against:<br><br>**RICHARD ALABA CALLUENG**<br>**1451 Rocky Ridge Drive, Apt. 2004**<br>**Roseville, CA 95661**<br><br>**Registered Nurse License No. 695159**<br><br>Respondent. | Case No. 2010- 512<br><br>**ACCUSATION** |

Complainant alleges:

**PARTIES**

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

**License History**

2. On or about January 10, 2007, the Board of Registered Nursing issued Registered Nurse License Number 695159 to Richard Alaba Callueng ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2010, unless renewed.

## JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing ("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.

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

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Code section 118, subdivision (b), provides that the suspension, expiration, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or

7. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, . . . .

8. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

## COST RECOVERY

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

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12. **DRUGS**

"Dilaudid," a brand name for Hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

"Ativan" is a brand of Lorazepam, and is a Schedule IV controlled substance, as designated by Health and Safety Code section 11057, subdivision (d)(13).

"Methadone", is a Schedule II controlled substance, as designated by Health and Safety Code section 11055, subdivision (c)(14).

"Morphine (MS)" is a Schedule II controlled substance, as designed by Health and Safety Code section 11055, subdivision (b)(1)(M).

"Restoril," a brand of Temazepam, is a Schedule IV controlled substance, as designated by H&S Code section 11057, subdivision (d)(29).

"Tylenol with Codeine," is a compound consisting of not more than 90 mg. of codeine, a Schedule III controlled substance, as designated by Health and Safety Code section 11056, subdivision (e)(2), and 300 mg. of acetaminophen per tablet.

"Xanax," a brand of Alprazolam, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(1).

## CAUSE FOR DISCIPLINE

**(Incorrect and/or Inconsistent Entries in Hospital and/or Patient Records)**

12. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that between May 6, 2007, through May 30, 2007, while employed at Mercy San Juan Medical Center in Carmichael, California, Respondent made grossly incorrect or grossly inconsistent entries in hospital and/or patient records. Respondent withdrew controlled substances from the hospital's Omnicell machine[1] without physician's orders therefore, and/or failed to chart the

[1] Omnicell is a trade name for the automated single-unit dose medication dispensing system that records information, including the patient name, physician orders, date and time the medication was withdrawn, and the name of the individual who withdrew the drug.

administration of the drugs in the patient's Medical Administration Record, or otherwise account for the wastage or disposition of the drugs, as more particularly set forth below:

Patient A

a. On May 13, 2007, at 0114 hours Respondent withdrew a 15 mg. cap of Restoril from the Omnicell for this patient. Respondent failed to chart the administration of the drug in the patient's Medication Administration Record or otherwise account for the wastage or disposition of the 15 mgs. of Restoril in any patient or hospital record.

b. On May 13, 2007, at 0114 hours Respondent withdrew a 2 mg./1 ml. syringe of Dilaudid from the Omnicell for this patient, without a physician's order therefore. However, Respondent failed to chart the administration of the drug in the patient's Medication Administration Record, or otherwise account for the wastage or disposition of the 2 mgs. of Dilaudid in any patient or hospital record.

c. On May 13, 2007, at 0118 hours Respondent withdrew a 2 mg./1 ml. syringe of Morphine from the Omnicell for this patient, without a physician's order therefore. Furthermore, Respondent failed to chart the administration of the drug in the patient's Medication Administration Record, or otherwise account for the wastage or disposition of the 2 mgs. of Morphine in any patient or hospital record.

Patient B

d. On May 19, 2007, at 0351 hours, Respondent withdrew 2 tablets of Tylenol with Codeine from the Omnicell for this patient without a physician's order therefore. However, Respondent failed to chart the administration of the drug in the patient's Medication Administration Record, or otherwise account for the wastage or disposition in any patient or hospital record.

e. On May 19, 2007, at 0701 hours, Respondent withdrew a 1 mg./1 ml. syringe of Dilaudid from the Omnicell for this patient. At 0702 hours, Respondent wasted .5 mgs. of the Dilaudid. However, Respondent failed to chart the administration of the remaining .5 mgs. in the patient's Medication Administration Record or otherwise account for the wastage or disposition of the remaining .5 mgs. of Dilaudid in any patient or hospital record.

Patient C

f. On May 30, 2007, at 0122 hours, Respondent withdrew a 2 mg./1 ml. vial of Ativan from the Omnicell for this patient. At 0130 hours, Respondent charted the administration of 1 mg. of Ativan in the patient's Medication Administration Records. However, Respondent failed to account for the wastage or disposition of the remaining 1 mg. of Ativan in any patient or hospital record.

Patient D

g. On May 8, 2007, at 0423 and 0709 hours, each time, Respondent withdrew a 1 mg/1 ml syringe of Dilaudid for this patient. However, Respondent failed to chart the administration of the drug in the patient's Medication Administration Record or account for the wastage or disposition of the 2 mgs. of Dilaudid in any patient or hospital record.

Patient E

h. On May 22, 2007, at 0615 hours, Respondent withdrew a 1 mg./1 ml. syringe of Dilaudid for this patient. However, Respondent failed to chart the administration of the drug in the patient's Medication Administration Record or account for the wastage or disposition of the 1 mg. of Dilaudid in any patient or hospital record.

Patient F

i. On May 12, 2007, at 1203 and 0423 hours, each time, Respondent withdrew a 2 mg./1 ml. syringe of Morphine for this patient. However, Respondent failed to chart the administration of the drug in the patient's Medication Administration Record or account for the wastage or disposition of the 4 mgs. of Morphine in any patient or hospital record.

Patient H

j. On May 6, 2007, at 2437 hours, Respondent withdrew 1 mg./1 ml. syringe of Dilaudid for this patient. However, Respondent failed to chart the administration of the drug in the patient's Medication Administration Record or account for the wastage or disposition of the 1 mg. Dilaudid in any patient or hospital record.

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k. On May 6, 2007, at 0250 hours, Respondent withdrew one 10 mg. tablet of Methadone for this patient. However, Respondent failed to chart the administration of the drug in the patient's Medication Administration Record or account for the wastage or disposition of the 10 mg. tablet of Methadone in any patient or hospital record.

l. On May 6, 2007, at 0345 hours, Respondent withdrew one .25 mg. tablet of Xanax for this patient. However, Respondent failed to chart the administration of the drug in the patient's Medication Administration Record or account for the wastage or disposition of the .25 mg. tablet of Xanax in any patient or hospital record.

Patient I

m. On May 9, 2007, at 0434 hours, Respondent withdrew 1 mg./1 ml. syringe of Dilaudid for this patient. However, Respondent failed to chart the administration of the drug in the patient's Medication Administration Record or account for the wastage or disposition of the 1 mg. Dilaudid in any patient or hospital record.

**PRAYER**

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

1. Revoking or suspending Registered Nurse License Number 695159 issued to Richard Alaba Callueng;

2. Ordering Richard Alaba Callueng to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

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

DATED: 4/15/10

Louise R. Bailey

LOUISE R. BAILEY, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
*Complainant*

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