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License Number: 832090

Current Date: 09/25/2017 09:59 PM

Name:	LIN, VICKI
License Type:	Registered Nurse
License Status:	Current
Secondary Status:	Accusation Filed
Expiration Date:	10/31/2018
Original Issuance Date:	11/07/2012

Disciplinary Actions

There are NO disciplinary actions against the license.

Public Record Actions

Administrative Disciplinary Actions	Found (1)
Court Order	None found
License Issued with Public Letter of Reprimand	None found
Auto Disclosure	None found
Public Documents	Found (1)

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8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No.

2017-923

13 **VICKI LIN**
2018 Camwood Ave.
Rowland Heights, CA 91748

ACCUSATION

14 **Registered Nurse License No. 832090**

15 Respondent.

16
17 Complainant alleges:

18 **PARTIES**

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

22 2. On or about November 7, 2012, the Board of Registered Nursing issued Registered
23 Nurse License Number 832090 to Vicki Lin (Respondent). The Registered Nurse License was in
24 full force and effect at all times relevant to the charges brought herein and will expire on October
25 31, 2018, unless renewed.

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1 **JURISDICTION**

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

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

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

13 **STATUTORY PROVISIONS**

14 6. Section 2761 of the Code states:

15 "The board may take disciplinary action against a certified or licensed nurse or deny an
16 application for a certificate or license for any of the following:

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

18 "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing
19 functions.

20 "...

21 "(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the
22 violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice
23 Act] or regulations adopted pursuant to it."

24 **REGULATORY PROVISIONS**

25 7. California Code of Regulations, title 16, section 1443, states:

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

1 8. California Code of Regulations, title 16, section 1443.5 states:

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

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

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

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

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

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

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

24 **COST RECOVERY**

25 9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
26 administrative law judge to direct a licentiate found to have committed a violation or violations of
27 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
28 enforcement of the case, with failure of the licentiate to comply subjecting the license to not being

1 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
2 included in a stipulated settlement.

3 **STATEMENT OF FACTS**

4 10. From August 5, 2013 through August 20, 2015, Respondent was employed as a
5 registered nurse in the Intensive Care Unit of Huntington Memorial Hospital in Pasadena, CA.
6 On October 12, 2015, the Board of Registered Nursing received a letter of complaint from
7 Huntington Memorial Hospital, alleging that Respondent obtained and used the identification and
8 password of another nurse in order to “make it appear as though [RN A.A.] had verified that the
9 insulin drip had been properly titrated by [Respondent].”

10 11. On July 16, 2013, Respondent signed a “Confidentiality, Computer Usage and
11 Accountability Agreement” (Confidentiality Agreement). In pertinent part, paragraph 5 of the
12 Agreement provides that Respondent “will not attempt to gain unauthorized access to any
13 information system or go beyond my authorized access. *This includes attempting to gain access*
14 *using another’s user ID and password....”*

15 12. Huntington Memorial Hospital’s Clinical Policy & Procedure provides, in pertinent
16 part, that insulin is designated as a “High Risk/High Alert Double Check Medication.” It further
17 provides: “Double-checking of specific medications is required to reduce the risk of error. The
18 process of double-checking involves two RNs, RN and a pharmacist, or RN and a physician.
19 Subcutaneous insulin may be checked by an LVN.”

20 13. The patients in the Coronary Care Unit are on certain IV medications, which must be
21 checked and monitored on a regular basis. Every hour on the hour, the Intensive Care Unit RN
22 must check the patient’s blood sugar, and make calculations as to the patient’s blood sugar value.
23 Then the RN calls a second RN to verify the calculations so that the correct dose of insulin is
24 administered. An incorrect dose could be fatal to the patient.

25 14. On July 13, 2015, RN T.G. handed off Patient 1 to Respondent for the evening shift.
26 On July 14, 2015, RN T.G. started her day shift with Patient 1 and found a piece of paper called
27 the “Off Bypass Call” sheet on the Computer on Wheels bearing the username and password of
28 RN A.A.

1 15. On July 14, 2015, RN T.G. reported the incident to the Critical Care Unit Manager
2 and the hospital's Compliance Hotline.

3 16. A review of Patient 1's medical record indicate entries by Respondent and reflect that
4 insulin was ordered and completed on July 13, 2015 at 19:10 hours, performed and verified by
5 Respondent at 20:00 hours. Then allegedly witnessed by RN A.A. at 20:00 hours.

6 17. On August 7, 2015, during a meeting with the Critical Care Unit Manager and Senior
7 Human Resources Business Partner, Respondent eventually admitted that RN A.A. did not
8 witness the drip for Patient 1. On August 7, 2015, Respondent was then suspended from work
9 pending further investigation regarding falsification of documentation, violations of the
10 Confidentiality Agreement, and failure to comply with the double-check process for
11 administering insulin.

12 **FIRST CAUSE FOR DISCIPLINE**

13 **(Unprofessional Conduct - Incompetence)**

14 18. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), as
15 defined in California Code of Regulations, title 16, sections 1443 and 1443.5(2), on the grounds
16 of incompetence in that Respondent breached the Confidentiality Agreement, violated hospital
17 policy by falsifying medical documentation and failing to comply with the double-check process
18 for administering insulin. Complainant refers to and incorporates all the facts and allegations
19 contained in Paragraphs 10 through 17, as though set forth fully.

20 **SECOND CAUSE FOR DISCIPLINE**

21 **(Unprofessional Conduct - Violations of Nursing Practice Act)**

22 19. Respondent is subject to disciplinary action under section 2761, subdivisions (a) and
23 (d), as defined in California Code of Regulations, title 16, sections 1443 and 1443.5(2), for
24 general unprofessional conduct and/or violating or attempting to violate, any provision or term of
25 the Nursing Practice Act. Complainant refers to and incorporates all the facts and allegations
26 contained in Paragraphs 10 through 17, as though set forth fully.

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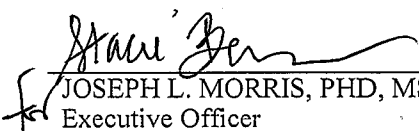
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PRAYER

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 832090, issued to Vicki Lin;
2. Ordering Vicki Lin to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,
3. Taking such other and further action as deemed necessary and proper.

DATED: May 23, 2017


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

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