1 ROB BONTA I hereby certify the foregoing to be a true copy Attorney General of California of the documents on file in our office. 2 MARICHELLE S. TAHIMIC Supervising Deputy Attorney General BOARD OF REGISTERED NURSING 3 DIANE VON DER AHE Deputy Attorney General 4 State Bar No. 294767 600 West Broadway, Suite 1800 Loretta Melby, RN, MSN 5 **Executive Officer** San Diego, CA 92101 P.O. Box 85266 6 San Diego, CA 92186-5266 Telephone: (619) 738-9463 7 Facsimile: (619) 645-2012 E-mail: Diane.VonDerAhe@doj.ca.gov 8 Attorneys for Complainant 9 **BEFORE THE** 10 **BOARD OF REGISTERED NURSING** DEPARTMENT OF CONSUMER AFFAIRS 11 STATE OF CALIFORNIA 12 13 In the Matter of the Accusation Against: Case No. 4002022000621 14 DANALEE DELOSSANTOS PASCUA. AKA DANALEE SOLIS DELOSSANTOS 15 7180 Woodshawn Drive ACCUSATION San Diego, CA 92114 16 Registered Nurse License No. 95071002 17 Public Health Nurse Certificate No. 552854 18 Respondent. 19 20 **PARTIES** 21 1. Loretta Melby, R.N., M.S.N. (Complainant) brings this Accusation solely in her 22 official capacity as the Executive Officer of the Board of Registered Nursing (Board), 23 Department of Consumer Affairs. 24 On or about September 3, 2015, the Board of Registered Nursing issued Registered 25 Nurse License Number 95071002 to Danalee Delossantos Pascua, aka Danalee Solis Delossantos 26 (Respondent). The Registered Nurse License was in full force and effect at all times relevant to 27 the charges brought herein and will expire on March 31, 2025, unless renewed. 28

FACTUAL ALLEGATIONS

- 12. Respondent was working as a registered nurse for the County of San Diego and assigned to Las Colinas Detention and Re-Entry Facility (Las Colinas) at all times relevant to this Accusation. On November 11, 2019, Respondent was assigned to the Medical Observation Unit (MOB) at Las Colinas. Inmate E.S. was in an isolation cell in the MOB. E.S. had been vomiting, was pregnant, was withdrawing from drugs and alcohol, and had possibly been experiencing seizures or seizure-like activity.
- 13. On November 11, 2019, Respondent reported to work at approximately 6:04 p.m. and conducted rounds. Respondent arrived at E.S.'s cell at approximately 7:06 p.m. A custodial deputy accompanied Respondent and ordered E.S. to come to the cell door. E.S. put her arm through the food flap, and Respondent attempted to take her blood pressure through the food flap. E.S.'s arm retracted back through the food flap with the blood pressure cuff still on it before Respondent could obtain a reading. Respondent and the custodial officer entered the cell to retrieve the cuff and try again. Respondent noted that E.S. "kind of slid down" the wall and sat with her eyes closed, which Respondent perceived as a "behavior" to avoid returning to the general population. Respondent attempted to obtain a blood pressure reading but was unable to due to E.S.'s arm stiffening. Respondent attempted to obtain E.S.'s oxygen level, which had been low earlier in the day, but was unable. Respondent charted that E.S.'s respiratory rate was "slow," without charting what the rate was or notifying a doctor.
- 14. Despite not obtaining vitals for E.S., Respondent informed the deputy the vitals were good and E.S. was okay. Respondent and the deputy left E.S.'s cell at approximately 7:11 p.m, with E.S. laying on the floor, her neck bent forward. Surveillance video showed E.S. appeared to be twitching. Her last movement occurred at 7:14 p.m.
- 15. At some point after leaving E.S.'s cell, Respondent learned that E.S. had urinated on herself, but Respondent did not think anything of it or check on E.S. at that time.
- 16. At approximately 8:05 p.m., Respondent walked past E.S.'s cell, noticed E.S. to be pale, and called for assistance. Respondent attempted to take E.S.'s pulse but, unsure if she was

| 1 | feeling the patient's pulse or her own pulse, asked the deputy to do it. The deputy could not find |
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| 2 | a pulse. Life saving measures were attempted but did not resuscitate E.S. |
| 3 | FIRST CAUSE FOR DISCIPLINE |
| 4 | (Gross Negligence – Failure to Obtain Vitals) |
| 5 | 17. Respondent is subject to disciplinary action under Code section 2761, subdivisions |
| 6 | (a)(1) and (a)(2), in conjunction with Regulation 1442, in that she left a critically ill patient |
| 7 | without obtaining her vital signs, and in a potentially dangerous position, as more fully set forth |
| 8 | in paragraphs 12 through 16, above, and incorporated herein by reference. |
| 9 | SECOND CAUSE FOR DISCIPLINE |
| 10 | (Incompetence - Failure to Obtain Vitals) |
| 11 | 18. Respondent is subject to disciplinary action under Code section 2761, subdivisions |
| 12 | (a)(1) and (a)(2), in conjunction with Regulation 1443, in that she left a critically ill patient |
| 13 | without obtaining her vital signs, and in a potentially dangerous position, as more fully set forth |
| 14 | in paragraphs 12 through 16, above, and incorporated herein by reference. |
| 15 | THIRD CAUSE FOR DISCIPLINE |
| 16 | (Incompetence - Failure to Recognize Changes in Condition) |
| 17 | 19. Respondent is subject to disciplinary action under Code section 2761, subdivisions |
| 1 / | 17. Respondent is subject to disciplinary action under code section 2701, subdivisions |
| 18 | (a)(1) and (a)(2), in conjunction with Regulation 1443, in that Respondent failed to recognize the |
| | |
| 18 | (a)(1) and (a)(2), in conjunction with Regulation 1443, in that Respondent failed to recognize the |
| 18 19 | (a)(1) and (a)(2), in conjunction with Regulation 1443, in that Respondent failed to recognize the patient's "slid[e] down" the wall or the patient's incontinence as a change in condition requiring a |
| 18 19 20 | (a)(1) and (a)(2), in conjunction with Regulation 1443, in that Respondent failed to recognize the patient's "slid[e] down" the wall or the patient's incontinence as a change in condition requiring a full nursing assessment, as more fully set forth in paragraphs 12 through 16, above, and |
| 18 19 20 21 | (a)(1) and (a)(2), in conjunction with Regulation 1443, in that Respondent failed to recognize the patient's "slid[e] down" the wall or the patient's incontinence as a change in condition requiring a full nursing assessment, as more fully set forth in paragraphs 12 through 16, above, and incorporated herein by reference. |
| 18 19 20 21 22 | (a)(1) and (a)(2), in conjunction with Regulation 1443, in that Respondent failed to recognize the patient's "slid[e] down" the wall or the patient's incontinence as a change in condition requiring a full nursing assessment, as more fully set forth in paragraphs 12 through 16, above, and incorporated herein by reference. FOURTH CAUSE FOR DISCIPLINE |
| 18 19 20 21 22 23 | (a)(1) and (a)(2), in conjunction with Regulation 1443, in that Respondent failed to recognize the patient's "slid[e] down" the wall or the patient's incontinence as a change in condition requiring a full nursing assessment, as more fully set forth in paragraphs 12 through 16, above, and incorporated herein by reference. FOURTH CAUSE FOR DISCIPLINE (General Unprofessional Conduct) |
| 18 19 20 21 22 23 24 | (a)(1) and (a)(2), in conjunction with Regulation 1443, in that Respondent failed to recognize the patient's "slid[e] down" the wall or the patient's incontinence as a change in condition requiring a full nursing assessment, as more fully set forth in paragraphs 12 through 16, above, and incorporated herein by reference. FOURTH CAUSE FOR DISCIPLINE (General Unprofessional Conduct) 20. Respondent is subject to disciplinary action under Code section 2761(a)(1) based on |
| 18 19 20 21 22 23 24 25 | (a)(1) and (a)(2), in conjunction with Regulation 1443, in that Respondent failed to recognize the patient's "slid[e] down" the wall or the patient's incontinence as a change in condition requiring a full nursing assessment, as more fully set forth in paragraphs 12 through 16, above, and incorporated herein by reference. FOURTH CAUSE FOR DISCIPLINE (General Unprofessional Conduct) 20. Respondent is subject to disciplinary action under Code section 2761(a)(1) based on the conduct more fully set forth in paragraphs 12 through 16, above, and incorporated herein by |

PRAYER 1 2 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: 3 1. Revoking or suspending Registered Nurse License Number 95071002, issued to 4 5 Danalee Delossantos Pascua, aka Danalee Solis Delossantos; 2. Revoking or suspending Public Health Nurse Certificate Number 552854, issued to 6 7 Danalee Delossantos Pascua, aka Danalee Solis Delossantos; 3. Ordering Danalee Delossantos Pascua to pay the Board of Registered Nursing the 8 9 reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and, if placed on probation, the costs of probation monitoring; 10 11 and, 4. Taking such other and further action as deemed necessary and proper. 12 13 14 15 DATED: May 8, 2024 16 **Executive Officer** 17 Board of Registered Nursing Department of Consumer Affairs 18 State of California **Complainant** 19 20 SD2022803128 21 84501093.docx 22 23 24 25 26 27 28