BEFORE THE TEXAS BOARD OF NURSING

****

In the Matter of Nurse Anesthetist &	§	AGREED
Registered Nurse License Number 719462	§	
issued to JOHN CLIFFORD ALLEN	§	ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of JOHN CLIFFORD ALLEN, Nurse Anesthetist and Registered Nurse License Number 719462, hereinafter referred to as Respondent. This action was taken in accordance with Section 301.453(c), Texas Occupations Code.

Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.

The Board makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was provided to Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived representation by counsel, informal proceedings, notice and hearing, and agreed to the entry of this Order.

3. Respondent received an Associate Degree in Nursing from Samford University-AD, Birmingham, Alabama, on May 24, 1997. Respondent received a Baccalaureate Degree in Nursing from Samford University-AD, Birmingham, Alabama, on May 23, 1998. Respondent received a Master's of Science Degree with a Focus in Nurse Anesthesia from Middle Tennessee School of Anesthesia, Madison, Tennessee, on November 3, 2011. Respondent was licensed to practice professional nursing in the State of Texas on August 1, 2005, and became Board recognized in the State of Texas as a Nurse Anesthetist on August 19, 2005.

4. Respondent's authorization to practice as a Nurse Anesthetist in the State of Texas and Respondent's license to practice professional nursing in the State of Texas are currently in delinquent status.

5. Respondent's nursing employment history is unknown.

6. On or about September 22, 2011, Respondent was issued a Finding of Public Emergency and Order by the Arizona State Board of Nursing wherein Respondent's license to practice professional nursing and Certificate to practice as a Certified Registered Nurse Anesthetist in the State of Arizona was Summarily Suspended pending a hearing. A copy of the Finding of Public Emergency and Order issued by the Arizona State Board of Nursing, dated September 22, 2011, is attached and incorporated by reference as part of this order.

7. On or about January 26, 2012, Respondent was issued a Findings of Fact, Conclusions of Law and Order by the Arizona State Board of Nursing wherein Respondent's license to practice as a professional nurse and Certificate to practice as a Certified Registered Nurse Anesthetist in the State of Arizona was Revoked. A copy of the Findings of Fact, Conclusions of Law and Order issued by the Arizona State Board of Nursing, dated January 26, 2012, is attached and incorporated by reference as part of this order.

8. On or about February 15, 2013, Respondent was issued a Default Decision and Order by the California Board of Registered Nursing wherein Respondent's license to practice as a Nurse Anesthetist and as a Registered Nurse in the State of California were Revoked. A copy of the Default Decision and Order issued by the California Board of Registered Nursing, dated February 15, 2013, is attached and incorporated by reference as part of this order.

9. Respondent, by his signature to this Order, expresses his desire to voluntarily surrender his license(s) to practice nursing in the State of Texas.

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.

3. The evidence received is sufficient cause pursuant to Section 301.452(b)(8), Texas Occupations Code, to take disciplinary action against Nurse Anesthetist and Registered Nurse License Number 719462, heretofore issued to JOHN CLIFFORD ALLEN, including revocation of Respondent's license(s) to practice nursing in the State of Texas.

4. Under Section 301.453(c), Texas Occupations Code, the Board has the authority to accept the voluntary surrender of a license.

5. Under Section 301.453(d), Texas Occupations Code, as amended, the Board may impose conditions for reinstatement of licensure.

6. Any subsequent reinstatement of this license will be controlled by Section 301.453(d), Texas Occupations Code, and 22 TEX. ADMIN. CODE §213.26-.29, and any amendments thereof in effect at the time of the reinstatement.

ORDER

NOW, THEREFORE, IT IS AGREED and ORDERED that the VOLUNTARY SURRENDER of Nurse Anesthetist and Registered Nurse License Number 719462, heretofore issued to JOHN CLIFFORD ALLEN, to practice nursing in the State of Texas, is accepted by the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice as a nurse anesthetist or professional nurse, use the title "nurse anesthetist or registered nurse" or the abbreviation "RN" or "CRNA" or wear any insignia identifying himself as a nurse anesthetist or registered nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a nurse anesthetist or registered nurse during the period in which the license is surrendered.

2. RESPONDENT SHALL NOT petition for reinstatement of licensure until: one (1) year has elapsed from the date of this Order.

3. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

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RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Agreed Order. I waive representation by counsel. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the Findings of Fact, Conclusions of Law, Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes final when accepted by the Executive Director at which time the terms of this Order become effective and a copy will be mailed to me.

Signed this 6TH day of February, 2014.

JOHN CLIFFORD ALLEN, Respondent

Sworn to and subscribed before me this 6th day of February, 2014.

RHONDA SCHLAUTMAN NOTARY PUBLIC ALABAMA STATE AT LARGE

Notary Public in and for the State of AL

My Commission Expires 08/09/2017

WHEREFORE, PREMISES CONSIDERED, the Executive Director on behalf of the Texas Board of Nursing does hereby accept the voluntary surrender of Nurse Anesthetist and Registered Nurse License Number 719462, previously issued to JOHN CLIFFORD ALLEN.

Effective this 6th day of February, 2014.

Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf
of said Board

ARIZONA STATE BOARD OF NURSING
4747 N. 7TH STREET, SUITE 200
PHOENIX ARIZONA 85014-3655

IN THE MATTER OF REGISTERED NURSE LICENSE NO. RN159804; CERTIFICATE NO. CERTIFIED REGISTERED NURSE ANESTHETIST NO. CRNA0632 ISSUED TO: JOHN CLIFFORD ALLEN Respondent.	**FINDINGS OF PUBLIC EMERGENCY AND ORDER OF SUMMARY SUSPENSION NO. 1010034**

On September 22, 2011, the Arizona State Board of Nursing ("Board") met at 4747 North 7th Street, Ste. 200, Phoenix, Arizona 85014-3655, to consider complaints filed against John Clifford Allen's ("Respondent's"), RN nurse license number RN159804 and Certificate Number CRNA0632. Information was presented to the Board and, as a result, the Board made the following Preliminary Findings of Fact, Conclusions of Law and Order.

PRELIMINARY FINDINGS OF FACT

1. On or about July 9, 2009 Respondent was issued RN license number RN159804 and certificate number CRNA0632.

2. On or about August 2009, Respondent began work at Sunrise Anesthesia & Pain Management in Springerville, Arizona.

3. On or about October 21, 2010, the Board received a complaint alleging Respondent independently prescribed schedule II controlled substances for chronic pain management after the Board informed him in person that he did not have such independent prescribing authority on or about March 23, 2010. The complaint contained additional allegations of misrepresentation of credentials, by advertising and/or failing to correct advertising as a doctor in Springerville, AZ.

4. On September 24, 2009, the Board opined that it believed Respondent could lawfully prescribe medications for chronic pain management under R4-19-516 (C) (8). On March 23, 2010, with Respondent and his attorneys present, the Board voted to rescind the prior Board opinion regarding Respondent's scope of practice and explicitly directed Respondent to cease prescribing medications for chronic pain, as the Board determined that this was beyond Respondent's scope of practice as a CRNA. Nevertheless, after the Board meeting on March 24, 2010, and through June 2011, Respondent continued to prescribe in excess of **2730** controlled medications, for which the majority are indicated for chronic pain management. The prescriptions also included powder cocaine, Suboxone (indicated for opioid withdraw), and Methadone. Allen has never been issued a prescribing and dispensing certificate from the Arizona State Board of Nursing.

5. On or about April 25, 2011, the Board received a complaint from patient L.T. alleging that Respondent assumed her medical care in February (2010) but after her March 2010 visit she has been unable to get an appointment with Respondent and the office refuses to let her speak with Respondent. She feels he has abandoned her as a patient.

6. On or about June 30, 2011, the Board received an inquiry from Robert Mangold, M.D., alleging that on June 30, 2011, Respondent sent him an email in which Respondent claimed he was, "authorized by the Arizona State Board of Nursing to prescribe for chronic pain management conditions," in contradiction to the Board's March 2010 direction to Respondent to the contrary. Based on these allegations, the Board opened an additional investigation.

7. On June 30, 2011, Dr. William Mangold, Contractor and Medical Director for Medicare (Noridian), informed Board staff that he received several emails from Respondent requesting credentialing with Medicare for the purposes of compensation for patient visits. In Respondent's June 29, 2011, email to Mr. Mangold, Respondent misrepresented the Board's position regarding his ability to prescribe, stating, "I have been authorized by the Arizona State

Board of Nursing to prescribe for chronic pain management conditions". Dr. Mangold reported to Board staff that Respondent never informed him that the Board had rescinded its prior opinion over a year earlier, on March 23, 2010.

8. Respondent failed to maintain a patient record for patient L.T. that accurately reflected the nursing assessment, care, treatment, and other nursing services provided to L.T. Specifically, Respondent failed to produce any progress notes or office visits for L.T.

9. From on or about 3/24/2011 - 9/3/2011, Allen exceeded his scope of practice by prescribing medications that were not anesthetics, and while he was not under the direction of and in the presence of a licensed physician or surgeon, such as Phentermine, Amphetamine salts, Alprazolam, Androgel, Suboxone, and methadone, etc.

10. From on or about 3/24/2011 - 9/3/2011, Allen exceeded his scope of practice when he prescribed medications that were not administered by a licensed, certified or registered health care provider pre-operatively, post-operatively, or as part of a procedure performed in a health care facility; the office of a health care provider licensed pursuant to A.R.S. Title 32, Chapters 7, 11, 13, and 17; or in an ambulance, such as cocaine, Phentermine, Amphetamine salts, Alprazolam, Androgel, Suboxone, and methadone, etc.

11. On 11/5/2010, 4/27/2011, and 7/13/2011, Board staff sent Respondent and his attorney investigative questionnaires. Respondent partially responded by email on 11/19/2010, 4/28/2011, 4/29/2011, 5/1/2011, 5/4/2011, 7/2/2011, 7/5/2011, and email responses from his attorney were received on 7/7/2011, 7/14/2011, 7/22/2011, 8/18/2011. However, Respondent failed to substantially respond to the complaints, return completed Investigative Questionnaires for all four complaints, and failed to provide complete patient files.

12. On 11/5/2010, and 4/27/2011, as part of the Board's investigation, Board staff issued subpoenas to Respondent for patient records. On February 11, 2011, at 4:45pm without an appointment or prior notice, Respondent appeared at the Board, stating he had 14 charts in his car that he expected to be copied by Board Staff immediately. Staff informed him they could not

copy all files in 15 minutes before the Board office closed at 5pm. Respondent would not leave the charts, and did not bring the charts back for copying, or forward the files even after Board staff sent a second subpoena on April 27, 2011. Thus, Respondent failed to respond to the Board subpoenas for complete patient records for 35 patient charts.

13. As stated above, Respondent failed to respond to the investigative questionnaires for Complaints 1, 3 and 4. Respondent partially responded to the Investigative Questionnaire for complaint #2, but failed to provide the complete medical record. Due to his failure to cooperate with relevant portions of the Boards investigation, Board staff is unable to determine if Respondent has complied with the Arizona Nurse Practice Act, related state and federal law, or whether the care he provided to his patients otherwise met the standard of care, aside from his ability to prescribe.

14. On or about 7/14/2009, Respondent received DEA license number FA1519098. On 8/20/2009, Respondent notified the DEA that FA159098 was issued in error and requested that it be retired. A new DEA number was issued the same day. Despite being instructed by the DEA to discontinue the use of DEA#FA1519098, Respondent wrote approximately 71 controlled substance prescriptions between 9/2009 – 9/2011 using the retired DEA #FA1519098.

15. On 10/13/2010, 10/20/2010, 11/15/2010, 1/14/2011, Respondent used DEA#MA2014455 to prescribe Cocaine HCL Powder #270 "For Office use Only", despite DEA regulations stating that a DEA registrant (practitioner – i.e. M.D., mid-level practitioner – i.e. NP) should not obtain Schedule 2-5 controlled substances for the purposes of dispensing or administering these controlled substances in an office setting. Specifically, if a practitioner or mid-level practitioner wishes to administer or dispense a controlled substance in their office they must obtain these controlled substances using one of two methods outlined by the DEA: 1) Schedule 2 controlled substance – must be obtained using a DEA Form 222 (Official Order Form). Used when obtaining Schedule 2 controlled substances for dispensation. Likewise, a pharmacy should not fill a prescription for a practitioner to obtain controlled substances "for

office use only" in order for the practitioner to dispense a Schedule 2 controlled substance in an office/clinic/hospital. 2) Schedule 3-5 controlled substances can be ordered using some type of sales invoice or document created either by the purchaser (the individual receiving the controlled substance) or by the supplier (the business selling the controlled substance to the purchaser).

16. Respondent was not licensed by the DEA to use controlled substances such as cocaine for the purposes of dispensing or administering these controlled substances in an office setting, nor was he ever authorized by the Board to dispense or independently administer these medications.

17. From on or about March 24, 2011 to September 3, 2011, Respondent exceeded his scope of practice when he prescribed medications that were not administered by a licensed, certified or registered health care provider pre-operatively, post-operatively, or as part of a procedure performed in a health care facility; the office of a health care provider licensed pursuant to A.R.S. Title 32, Chapters 7, 11, 13, and 17; or in an ambulance. For example, Allen prescribed medications such as cocaine, Phentermine, Amphetamine salts, Alprazolam, Androgel, Suboxone, and methadone, etc.

PRELIMINARY CONCLUSIONS OF LAW

1. The Arizona State Board of Nursing ("Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§ 32-1606, 32,-1661(a) and (b), 32-1663, 32-1664, and 41-1092.11(B). The Board also has the authority, pursuant to A.R.S. § 32-1663 and A.R.S. § 32-1664, to impose disciplinary sanctions against the holders of nursing licenses/certified nursing assistants for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 through 1669, A.A.C. R4-19-101 to R-19-815, R4-19-515(a) and (c), and R4-19-516.

2. The conduct and circumstances described in the Preliminary Findings of Fact constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. § 32-1663 (D) as described in A.R.S. §32-1601(18) (adopted effective September 30, 2009) 18."Unprofessional conduct" includes the following whether occurring in this state or elsewhere: (d) Any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public; (g) Willfully or repeatedly violating a provision of this chapter or a rule adopted pursuant to this chapter; (h) Committing an act that deceives, defrauds or harms the public; and (j) Violating a rule that is adopted by the board pursuant to this chapter, specifically, A.A.C. § R4-19-403 (adopted effective January 31, 2009). 1. A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice; 7. Failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient; 8. Falsifying or making a materially incorrect, inconsistent, or unintelligible entry in any record: (b) Pertaining to obtaining, possessing, or administering any controlled substance as defined in the federal Uniform Controlled Substances Act, 21 U.S.C. 801 et seq., or Arizona's Uniform Controlled Substances Act, A.R.S. Title 36, Chapter 27; 9. Failing to take appropriate action to safeguard a patient's welfare or follow policies and procedures of the nurse's employer designed to safeguard the patient; 12. Assuming patient care responsibilities that the nurse lacks the education to perform, for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse; 25. Failing to: a. Furnish in writing a full and complete explanation of a matter reported pursuant to A.R.S. § 32-1664, or b. Respond to a subpoena issued by the Board; 27. Making a false or misleading statement on a nursing or health care related employment or credential application concerning previous employment, employment experience, education, or credentials; and 31.Practicing in

any other manner that gives the Board reasonable cause to believe the health of a patient or the public may be harmed.

FINDING OF PUBLIC EMERGENCY AND ORDER

Based upon the facts and circumstances set forth in the Preliminary Findings of Fact and Preliminary Conclusions of Law, the Board finds that the public health safety and welfare imperatively requires emergency action.

IT IS THEREFORE ORDERED, pursuant to A.R.S. § 41-1092.11(B) and effective immediately, that registered nurse license number RN159804 and certificate number CRNA0632 held by John Clifford Allen is **SUMMARILY SUSPENDED** pending proceedings for revocation and other action by the Board. A hearing in this matter shall be promptly instituted and determined.

Dated this 22nd day of September, 2011.

SEAL

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

COPIES mailed this 22nd day of September, 2011, by First Class Mail and Certified Mail Receipt No. 7009 0080 0000 0430 2878 to:

R. John Lee
P.O. Box 2280
St. Johns, Arizona 85936

COPIES hand- delivered this 22nd day of September, 2011, to:

Emma Lehner Mamaluy
Assistant Attorney General
1275 W Washington LES Section
Phoenix AZ 85007

By: Llysia Gauntt

THE ARIZONA STATE BOARD OF NURSING

AT THE OFFICE OF ADMINISTRATIVE HEARINGS

IN THE MATTER OF REGISTERED NURSE LICENSE NO. RN159804; CERTIFICATE NO. CERTIFIED REGISTERED NURSE ANESTHETIST NO. CRNA0632 ISSUED TO: **JOHN CLIFFORD ALLEN,** Respondent.	**COMPLAINT NO. 1010034** **DOCKET NO. 11A-1010034-NUR** **COMPLAINT AND NOTICE OF HEARING**

I.

JURISDICTION

The Arizona State Board of Nursing issues this Complaint and Notice of Hearing pursuant to A.R.S. §§ 32-1606, -1646, -1663, -1664 and §§ 41-1092 through 41-1092.12.

II.

NOTICE OF HEARING

For the reasons contained in this Complaint, the Arizona State Board of Nursing has requested that an Administrative Law Judge from the Office of Administrative Hearings conduct a formal hearing at 1400 West Washington, Suite 101, Phoenix, Arizona 85007, (602-542-9826) on **October 20 and 21, 2011, at 8:00 a.m.** to determine whether grounds exist to take disciplinary action, including suspension or revocation against John Clifford Allen, who holds

registered license number RN159804 and CRNA0632 for the practice of nursing in the State of Arizona. At the hearing the Administrative Law Judge will hear testimony, take evidence and produce, for the Board's consideration, recommended findings of fact, conclusions of law and a recommended decision in this case.

III.

PARTIES

1. The Arizona State Board of Nursing ("Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664. The Board also has the authority to impose disciplinary sanctions against the holders of nursing licenses/nursing assistant certificates for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 to -1669.

2. John Clifford Allen ("Respondent") holds Board issued registered nurse license number RN159804 and CRNA0632 in the State of Arizona.

IV.

FACTUAL ALLEGATIONS

1. On or about July 9, 2009 Respondent was issued RN license number RN159804 and certificate number CRNA0632.
2. On or about August 2009, Respondent began work at Sunrise Anesthesia & Pain Management in Springerville, Arizona.

3. Respondent has never been issued a prescribing and dispensing certificate by the Arizona State Board of Nursing, nor is certified in Arizona as an advanced practice nurse/nurse practitioner.

COMPLAINT #1

4. On or about October 21, 2010, the Board initiated an investigation into Respondent's practice after it received a complaint from Snell & Wilmer Law Office, on behalf of the Arizona Society of Anesthesiologists, alleging that Respondent independently prescribed (Drug Enforcement Agency ("DEA")) Schedule II controlled substances for chronic pain management after the Board, at its March 23-24 Board meeting, informed Respondent in person and with his attorney present, that he did not have such independent prescribing authority. The complaint contained additional allegations of misrepresentation of credentials, alleging that Respondent advertised and/or failed to correct advertising in which he was listed as a doctor in Springerville, AZ.

5. The Board previously opined, on September 24, 2009, that it believed Respondent could lawfully prescribe medications for chronic pain management under R4-19-516 (C) (8). However, on March 23, 2010, with Respondent and his attorneys present, the Board voted to rescind the prior Board opinion regarding Respondent's scope of practice and explicitly directed Respondent to cease prescribing medications for chronic pain, since the Board had determined that this was beyond

Respondent's scope of practice as a certified registered nurse anesthetist ("CRNA").

6. Nevertheless, Board staff determined that, after the Board meeting on March 24, 2010, and through June 2011 (and beyond), Respondent continued to prescribe in excess of **2730** controlled medications, the majority of which are indicated for chronic pain management. The prescriptions included powder cocaine, Suboxone (indicated for opioid withdraw), and Methadone. (See, also, Complaint #4, below.)
7. From on or about 3/24/2011 - 9/3/2011, Allen exceeded his scope of practice by prescribing medications that were not anesthetics, and while he was not under the direction of or in the presence of a licensed physician or surgeon, such as Phentermine, Amphetamine salts, Alprazolam, Androgel, Suboxone, and methadone, etc.
8. From on or about 3/24/2011 - 9/3/2011, Allen exceeded his scope of practice when he prescribed medications that were not administered by a licensed, certified or registered health care provider pre-operatively, post-operatively, or as part of a procedure performed in a health care facility; the office of a health care provider, licensed pursuant to A.R.S. Title 32, Chapters 7, 11, 13, and 17; or in an ambulance, such as cocaine, Phentermine, Amphetamine salts, Alprazolam, Androgel, Suboxone, and methadone, etc.

COMPLAINT #2

9. On or about April 25, 2011, the Board received a complaint from patient L.T. alleging that Respondent assumed her medical care in February (2010) but after her March 2010 visit, she has been unable to get an

appointment with Respondent and the office refuses to let her speak with Respondent. She feels he has abandoned her as a patient.

10. Board staff found that Respondent failed to maintain a patient record for patient L.T. that accurately reflected the nursing assessment, care, treatment, and other nursing services provided to L.T. Specifically, Respondent failed to produce any progress notes that included a physical assessment or plan of care for L.T.

COMPLAINT #3

11. On or about June 30, 2011, the Board received an inquiry from Robert Mangold, M.D., alleging that on June 30, 2011, Respondent sent him an email in which Respondent claimed he was, "authorized by the Arizona State Board of Nursing to prescribe for chronic pain management conditions," despite the fact that the Board, on March 23, 2010, (over a year earlier) had directed Respondent to cease prescribing for chronic pain management conditions. Based on these allegations, the Board opened an additional investigation.

12. On June 30, 2011, Dr. William Mangold, Contractor and Medical Director for Medicare (Noridian), informed Board staff that he received several emails from Respondent requesting credentialing with Medicare for the purposes of compensation for patient visits. Mr. Mangold provided an email from Respondent, dated June 29, 2011, in which Respondent misrepresented the Board's position regarding his ability to prescribe; stating, "I have been authorized by the Arizona State Board of Nursing to prescribe for chronic pain management conditions". Dr. Mangold reported to Board staff that Respondent never informed him that the Board had rescinded its prior opinion more than a year earlier, on March 23, 2010.

COMPLAINT #4

13. On or about 7/14/2009, Respondent received DEA license number FA1519098, which is a number that is designated only for physicians. On 8/20/2009, Respondent notified the DEA that #FA159098 was issued to him in error and requested that it be retired. A new and correct DEA number (DEA#MA2014455) was issued the same day. Despite being instructed by the DEA to discontinue the use of DEA#FA1519098, Respondent wrote approximately 67 controlled substance prescriptions between 9/2009 – 9/2011 that were filled using the retired DEA #FA1519098.

14. On 10/13/2010, 10/20/2010, 11/15/2010, 1/14/2011, Respondent used DEA#MA2014455 to order Cocaine HCL Powder #270 "For Office use Only."

15. Respondent had no authorization from the DEA to use controlled substances such as cocaine for the purposes of dispensing or administering these controlled substances in an office setting, nor was he ever authorized by the Board to dispense or independently administer these medications.

16. From on or about March 24, 2011 to September 3, 2011, Respondent exceeded his scope of practice when he prescribed medications that were not administered by a licensed, certified or registered health care provider pre-operatively, post-operatively, or as part of a procedure performed in a health care facility; the office of a health care provider licensed pursuant to A.R.S. Title 32, Chapters 7, 11, 13, and 17; or in an ambulance. For example, Allen prescribed medications such

as cocaine, Phentermine, Amphetamine salts, Alprazolam, Androgel, Suboxone, and methadone.

FAILURE TO COOPERATE WITH THE BOARD INVESTIGATION

17. Board staff sent Respondent and his attorney investigative questionnaires on 11/5/2010 (Complaint #1), 4/27/2011 (Complaint #2), 7/13/2011 (Complaint #3), and 9/13/2011 (Complaint #4). Respondent partially responded to the questionnaire for Complaint #2 by email on 11/19/2010, 4/28/2011, 4/29/2011, 5/1/2011, 5/4/2011, 7/2/2011, 7/5/2011, and email responses from his attorney were received on 7/7/2011, 7/14/2011, 7/22/2011, and 8/18/2011. However, Respondent failed to substantively respond to the questionnaires for Complaints #1, 3 and 4, failed to return completed Investigative Questionnaires for all four complaints, and failed to provide complete patient records (Respondent provided only one, incomplete record for patient L.T.).

18. On 11/5/2010, and 4/27/2011, as part of the Board's investigation, Board staff issued subpoenas to Respondent for 35 patient records. On February 11, 2011, at approximately 4:45 p.m., without an appointment or prior notice, Respondent appeared at the Board, stating he had 14 charts (patient records) in his car that he expected to be copied by Board Staff immediately. Staff informed him they could not copy all of the files in the 15 minutes before the Board office closed at 5pm. Respondent refused to leave the charts with Board staff, and did not bring the charts back for copying, or otherwise produce the records, even after Board staff sent Respondent a second subpoena, on April 27, 2011. Thus, Respondent failed to respond to the Board subpoenas for complete patient records for the 35 subpoenaed patient charts.

19. As stated above, Respondent failed to respond to the investigative questionnaires for Complaints #1, 3 and 4. Respondent partially responded to the Investigative Questionnaire for complaint #2, but failed to provide a complete medical record for patient L.T. Due to Respondent's failure to cooperate with relevant portions of the Boards investigation, Board staff is unable to determine whether Respondent complied with certain provisions of the Arizona Nurse Practice Act, related state and federal law, and whether the care he provided to his patients otherwise met the standard of care, aside from Respondent's inability to prescribe as he did.

V.

ALLEGED LEGAL VIOLATIONS

1. The Arizona State Board of Nursing ("Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to the Nurse Practice Act, A.R.S. §§ 32-1601 – 1669, and specifically 32-1606, 32,-1661(a) and (b) (CRNA statute), 32-1663, 32-1664; and 41-1092.11(B). The Board also has the authority, pursuant to A.R.S. § 32-1663 and A.R.S. § 32-1664, to impose disciplinary sanctions against the holders of nursing licenses/certified nursing assistants for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 through 1669, and A.A.C. R4-19-101 to R-19-815, specifically R4-19-515(a) and (c), and R4-19-516.
2. The scope of practice for Certified Registered Nurse Anesthetists, such as Respondent, is delineated in A.R.S. §32-1661 and A.A.C. 4-19-515 and 516 (see, below). Respondent violated the CRNA scope of practice, as

delineated in paragraphs 1 – 16 of the Factual Allegations contained within this Complaint. Respondent's conduct constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. §§ 32-1663 and 1664.

3. A.R.S. §32-1661 states:

   a. A licensed registered nurse may administer anesthetics under the direction of and in the presence of a licensed physician or surgeon if the nurse has completed a nationally accredited program in the science of anesthesia
   b. As used in subsection A, "presence" means within the same room or an adjoining room or within the same surgical or obstetrical suite.

4. A.A.C. 4-19-515(C) states:

   A CRNA granted prescribing authority may prescribe drugs or medication to be administered by a licensed, certified or registered health care provider pre-operatively, post-operatively, or as part of a procedure performed in a health care facility; the office of a health care provider licensed pursuant to A.R.S. Title 32, Chapters 7, 11, 13, and 17; or in an ambulance.

5. A.A.C. 4-19-516(C) states:

   In addition to the scope of practice permitted a registered nurse under A.R.S. §32-1601, a registered nurse governed by this Section may perform one or more of the following acts:
   1. Assess the health status of an individual as that status related to the relative risks associated with anesthetic management of an individual;
   2. Obtain informed consent;
   3. Order and interpret laboratory and other diagnostic tests and perform those tests that the nurse is qualified to perform;
   4. Order and interpret radiographic imaging studies that the nurse is qualified to order and interpret;
   5. Identify, develop, implement, and evaluate an anesthetic plan of care for a patient to promote,

maintain, and restore health;
6. Take action necessary in response to an emergency situation;
7. Perform therapeutic procedures that the nurse is qualified to perform; or
8. Perform additional acts that the nurse is qualified to perform

6. The conduct and circumstances described in the Factual Allegations (specified below) also constitutes unprofessional conduct and grounds to take disciplinary action pursuant to A.R.S. §§ 32-1663 and 1664, specifically 1663(D), as described in A.R.S. §32-1601(18) ("Unprofessional conduct" includes the following whether occurring in this state or elsewhere)(adopted effective September 30, 2009):

   a. Paragraphs 1 through 19 of the Factual Allegations constitute unprofessional conduct pursuant to A.R.S. § 32-1601(18)(d), (any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public).

   b. Paragraphs 6 through 8, 11-19 of the Factual Allegations constitute unprofessional conduct pursuant to A.R.S. § 32-1601(18)(g), (willfully or repeatedly violating a provision of this chapter or a rule adopted pursuant to this chapter).

   c. Paragraphs 1 through 19 of the Factual Allegations constitute unprofessional conduct pursuant to A.R.S. § 32-1601(18)(h), (committing an act that deceives, defrauds or harms the public).

d. Paragraphs 1 through 19 of the Factual Allegations constitute unprofessional conduct pursuant to A.R.S. § 32-1601(18)(j), (violating a rule that is adopted by the board pursuant to this chapter), specifically:

i. (Paragraphs 10, 17-19): A.A.C. R4-19-403(7), (Failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient

ii. (Paragraphs 1 through 16): A.A.C. R4-19-403(8), (Falsifying or making a materially incorrect, inconsistent, or unintelligible entry in any record: a. Regarding a patient, health care facility, school, institution, or other work place location; or b. Pertaining to obtaining, possessing, or administering any controlled substance as defined in the federal Uniform Controlled Substance Act, 21 U.S.C. 801 *et seq.,* or Arizona Uniform Controlled Substances Act, A.R.S. Title 36, Chapter 27).

iii. (Paragraphs 1 through 16): A.A.C. R4-19-403(9), (Failing to take appropriate action to safeguard a patient's welfare policies and procedures of the nurse's employer designed to safeguard the patient).

iv. (Paragraphs 1 through 16): A.A.C. R4-19-403(12), (Assuming

patient care responsibilities that the nurse lacks the education to perform, for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse).

v. (Paragraphs 10, 17 through 19): A.A.C. R4-19-403(25)(a), (Failing to: a. Furnish in writing a full and complete explanation of a matter reported pursuant to A.R.S. § 32-1664, or b. Respond to a subpoena issued by the Board).

vi. (Paragraphs 11 through 12): A.A.C. R4-19-403(27), (Making a false or misleading statement on a nursing or health care related employment or credential application concerning previous employment, employment experience, education, or credentials).

vii. (Paragraphs 1 through 16): A.A.C. R4-19-403(31), (Practicing in any manner that gives the Board reasonable cause to believe the health of a patient or the public may be harmed).

RESPONDENT IS HEREBY NOTIFIED that pursuant to A.R.S. § 32-1664(I), you shall submit to the Board a written answer to the allegations contained in this Complaint and Notice of Hearing within thirty (30) days of its service. When notice is served by certified mail, service begins the date the notice was placed in the mail. Your written answer shall be made to the

attention of Llysia Gauntt, Arizona State Board of Nursing, 4747 North 7th Street, Suite 200, Phoenix AZ 85014-3655. **EVEN IF YOU PREVIOUSLY RESPONDED TO A BOARD ISSUED NOTICE OF CHARGES, YOU MUST STILL RESPOND TO THIS COMPLAINT AND NOTICE OF HEARING. THE BOARD MAY CONSIDER YOUR FAILURE TO RESPOND TO THE COMPLAINT AND NOTICE OF HEARING WITHIN THIS TIME AS YOUR ADMISSION BY DEFAULT TO THE ALLEGATIONS STATED IN THE COMPLAINT.** The Board may then take any of the actions allowed pursuant to A.R.S. § 32-1663 without conducting a hearing. The Board may take whatever action is deemed appropriate, including suspension, revocation, probation, restitution, refusal to renew, decree of censure and/or impose an administrative or civil penalty pursuant to A.R.S. §§ 32-1601(8), -1606, -1646, -1663, -1663.01 and -1664. For answers to questions regarding this Complaint and Notice of Hearing, contact Llysia Gauntt at (602) 771-7852. For answers to questions regarding this Complaint and Notice of Hearing, contact Llysia Gauntt at (602) 771-7852.

RESPONDENT IS FURTHER NOTIFIED that you may appear with or without the assistance of an attorney, on the date and at the place specified in this Notice of Hearing, and may present testimony and argument in your defense with respect to the alleged violations contained in this Complaint and Notice of Hearing. A.R.S. §§ 32-1664 and 41-1092.07 GIVE EVERY PERSON WHO IS A PARTY IN THIS MATTER THE RIGHT TO BE REPRESENTED BY

COUNSEL, TO SUBMIT EVIDENCE IN OPEN HEARING ON THEIR OWN BEHALF, TO EXAMINE AND CROSS-EXAMINE WITNESSES, AND TO HAVE SUBPOENAS ISSUED TO COMPEL ATTENDANCE OF WITNESSES AND PRODUCTION OF EVIDENCE.

RESPONDENT IS FURTHER NOTIFIED that if you fail to appear at the hearing, the Arizona State Board of Nursing may proceed and determine this matter in your absence. After the hearing, the Administrative Law Judge will submit the written report of his or her findings of fact and conclusions of law to the Arizona State Board of Nursing for its consideration in determining an appropriate disposition.

Dated this 28th day of September, 2011.

SEAL

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

In accordance with Title II of the Americans with Disabilities Act (ADA), this Board does not discriminate on the basis of disability in admission to and participation in hearings. People with a disability may request reasonable accommodation, such as a sign language interpreter, by contacting Joey Ridenour, Executive Director, at 602-771-7801. Requests should be made as early as possible to allow time to arrange the accommodation.

COPIES mailed this 28th day of September, 2011, by First Class Mail and Certified Mail Receipt No. 7009 0080 0000 0430 2946 to:

R. John Lee
P.O. Box 2280
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COPIES mailed this 28th day of September, 2011, to:

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Attorneys for Complainant

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

In the Matter of the Accusation Against: JOHN CLIFFORD ALLEN PMB 183 4319 Atlanta Highway Montgomery, AL 36109 Registered Nurse License No. 603395 Nurse Anesthetist Certificate No. 2874 Respondent.	Case No. 2013-148 ACCUSATION

Complainant alleges;

PARTIES

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

2. On or about August 2, 2002 the Board issued Registered Nurse License Number 603395 to John Clifford Allen ("Respondent"). The Registered Nurse License expired on February 29, 2008 and has not been renewed.

3. On or about August 8, 2002 the Board issued Nurse Anesthetist Certificate No. 2874 to Respondent. The Nurse Anesthetist Certificate also expired on February 29, 2008 and has not been renewed.

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JURISDICTION AND STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (all section references are to the Business and Professions Code unless otherwise indicated) 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 Code section 2750) of the Nursing Practice Act.

5. 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. Under subdivision (b) of Section 2811 of the Code the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118 subdivision (b) also grants the Board jurisdiction over suspended, expired, forfeited, cancelled, or surrendered licenses:

> "The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground."

7. In pertinent part, Section 2761 authorizes the Board to discipline licensees for license revocations or restrictions in other states:

> "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, which includes, but is not limited to, the following:
>
> ...
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action."

COST RECOVERY

8. Section 125.3 of the Code 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.

CAUSE FOR DISCIPLINE

(Disciplinary Action by the Arizona State Board of Nursing)

9. Respondent is subject to discipline pursuant to Code section 2761 subdivision (a)(4) on the grounds of unprofessional conduct, because his Arizona registered nursing license and his Arizona certified registered nurse anesthetist certificate were revoked by the Arizona State Board of Nursing ("Arizona Board"), as follows:

10. On or about January 26, 2012, the Arizona Board issued an order revoking Respondent's Arizona nursing license and Arizona certified registered nurse anesthetist certificate in the disciplinary action entitled, *In the Matter of Registered Nurse License No. RN159804; Certificate No. Certified Registered Nurse Anesthetist No. CRNA0632 Issued to: John Clifford Allen.*

11. In its January 26, 2012 order, the Arizona Board found as follows:

a. On or about 1992, Respondent was licensed as a registered nurse in Alabama. He then completed a program to be a certified registered nurse anesthetist. He practiced as a certified registered nurse anesthetist in Alabama for five or six years before moving to Arizona.

b. At a date unspecified, Respondent began running a chronic pain management clinic in Springerville, Arizona, a rural area.

c. While running the clinic in Springerville, Respondent asked the Arizona Board whether he could legally independently prescribe medication to his chronic pain management patients.

d. The Arizona Board surveyed the practices of other states and found that some states allowed certified registered nurse anesthetists to prescribe medication in pain management clinics outside of hospital settings.

e. At a meeting in September 2009, the Arizona Board passed a motion allowing Respondent to independently prescribe medication to his patients at the pain management clinic. He became the only certified registered nurse anesthetist to whom the Arizona Board granted independent prescription-writing authority.

f. In September 2009, Respondent began writing pain medication prescriptions to his patients unsupervised by any doctor.

g. The Arizona Society of Anesthesiologists complained to the Arizona Board about Respondent's prescription writing authority.

h. On March 23, 2010, the Arizona Board met again to consider Respondent's prescription writing authority. Respondent and his attorney testified at the meeting. After meeting in executive session, the Arizona Board passed a motion rescinding Respondent's independent prescription-writing authority. It then informed him that he would be officially notified of its action. But it failed to mail him or his attorney official notification of its decision until July 12, 2011. In the meantime, he continued independently writing prescriptions to his patients.

i. From March 23, 2010 to September 22, 2011, when the Arizona Board issued an emergency order suspending his Arizona license, Respondent wrote thousands of prescriptions for controlled substances, most of which were for pain management. These included prescriptions for powder cocaine, amphetamine salts, and opioid withdrawal medications.

j. On October 20-21, 2011, the Arizona Board held a hearing on four complaints against Respondent's Arizona nursing license and certified registered nurse anesthetist certificate.

k. After the hearing, the Arizona Board concluded that Respondent had committed unprofessional conduct by continuing to write prescriptions after the Arizona Board rescinded his authority to do so at its meeting on March 23, 2010.

l. It also concluded Respondent had committed unprofessional conduct by failing to properly respond to an inquiry and subpoenas it issued for his patient records.

m. And it concluded that he had committed unprofessional conduct by representing to a physician responsible for the state's Medicare reimbursements that he was still authorized to

prescribe medications (and therefore qualified to receive Medicare payments) after the date the Arizona Board had rescinded his prescribing authority.

12. Based on these violations, the Arizona Board revoked Respondent's Arizona nursing license and certified registered nurse anesthetist certificate.

13. Under Code Section 2761, subdivision (a)(4), the revocation of Respondent's nursing license and certified registered nurse anesthetists certificate by the Arizona Board in 2011 is ground for the California Board to take disciplinary action.

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 603395, issued to John Clifford Allen;

2. Revoking or suspending Nurse Anesthetist Certificate Number 2874, issued to John Clifford Allen;

3 Ordering John Clifford Allen 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,

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

DATED: September 04, 2012

for LOUISE R. BAILEY, M.Ed., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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