DOCKET NUMBER 507-15-2425

IN THE MATTER OF	**§**	**BEFORE THE STATE OFFICE**
ADVANCED PRACTICE	**§**	
REGISTERED NURSE	**§**	
LICENSE NUMBER AP119040 WITH	**§**	
PRESCRIPTION AUTHORIZATION	**§**	
NUMBER 10237 AND	**§**	**OF**
REGISTERED NURSE	**§**	
LICENSE NUMBER 784525,	**§**	
ISSUED TO	**§**	
PRIANGLAM BROOKS	**§**	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: PRIANGLAM BROOKS
C/O MARC MEYER, ATTORNEY
33300 EGYPT LANE, SUITE C600
MAGNOLIA, TX 77354

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
300 WEST 15TH STREET
AUSTIN, TEXAS 78701

At the regularly scheduled public meeting on October 27-28, 2016, the Texas Board of Nursing (Board) considered the following items: (1) the Proposal for Decision (PFD) regarding the above cited matter; (2) Respondent's exceptions to the PFD; (3) Staff's response to Respondent's exceptions to the PFD; (4) the ALJ's final letter ruling of July 8, 2016; (5) Staff's recommendation that the Board adopt the PFD with changes; and (7) Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. The Respondent filed exceptions to the PFD on June 10, 2016. Staff filed a response to Respondent's exceptions to the PFD on June 23, 2016. The ALJ issued her final letter ruling on July 8, 2016, in which she declined to make any changes to the PFD.

The Board, after review and due consideration of the PFD; Respondent's exceptions to the PFD; Staff's response to Respondent's exceptions to the PFD; the ALJ's final letter ruling of July 8, 2016; Staff's recommendations; and the presentation by the Respondent during the open meeting, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD as if fully set out and separately stated herein, except for proposed Conclusion of Law Number 6, which is modified and adopted as set out herein, and proposed Conclusions of Law Numbers 14 and 15, which are hereby re-designated as recommendations. All proposed findings of fact and conclusions of law filed by any party

not specifically adopted herein are hereby denied.

Modification of PFD

The Board has authority to review and modify a PFD in accordance with the Government Code §2001.058(e). Section 2001.058(e)(1) authorizes the Board to change a finding of fact or conclusion of law made by the ALJ or to vacate or modify an order issued by the ALJ if the Board determines that the ALJ did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions.

Proposed Conclusion of Law Number 6

Proposed Conclusion of Law Number 6 provides that the Board is authorized to take disciplinary action against the Respondent pursuant to several provisions of the Board's rules. While the Board does not necessarily disagree that the Board is authorized to take such action against the Respondent's license based on all of the provisions cited by the ALJ, the Board finds it appropriate to adopt a conclusion of law that only references the specific citations of violations contained in the Board's First Amended Notice of Hearing and First Amended Formal Charges that are supported by evidence in the record.

Therefore, under the authority of §2001.058(e)(1), IT IS, THEREFORE ORDERED THAT CONCLUSION OF LAW NUMBER 6 is MODIFIED and ADOPTED as follows:

6. The preponderance of the evidence established that Respondent's treatment of patients at both Ultimate Choice (Staff's First Amended Formal Charge IV) and at Prillennium (Staff's First Amended Formal Charge I) constituted a failure to meet minimum standards of nursing and advanced practice nursing, in violation of the Board's rules, specifically, rules found in 22 Texas Administrative Code §§217.11 (1)(A)-(C) and (4); 221.13(a) and (d); and 222.8 (for the period beginning November 20, 2013).

Proposed Conclusions of Law Numbers 14 and 15

Although labeled as proposed conclusions of law, proposed Conclusions of Law Numbers 14 and 15 are part of the ALJ's ultimate sanction recommendation and are related to the ALJ's recommended sanction in this matter. A recommendation for sanction is not a proper conclusion of law. As such, the Board re-designates proposed Conclusions of Law Numbers 14 and 15 as part of the ALJ's recommendation and declines to adopt them as conclusions of law.

Recommendation for Sanction

Although the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact or conclusions of law[1], the Board agrees with the ALJ that the most appropriate sanction in

[1] The Board, not the ALJ, is the final decision maker concerning sanctions. Once it has been determined that a violation of the law has occurred, the sanction is a matter for the agency's discretion. Further, the mere labeling of a recommended sanction as a conclusion of law or as a finding of fact does not change the effect of the ALJ's

this matter is revocation of the Respondent's licenses and prescriptive authority[2].

The ALJ found, and the Board agrees, that the Respondent's conduct warrants a second tier, level II sanction, for her violations of §301.452(b)(10)[3]. For a second tier, sanction level II sanction, the Board's Disciplinary Matrix authorizes either licensure suspension or revocation. The Board also agrees with the ALJ that the Respondent's conduct warrants a third tier, sanction level I sanction, for her violations of §301.452(b)(13)[4], for which licensure suspension or revocation is authorized.

The Board views an individual's violations of the Nursing Practice Act (NPA) and/or Board rules collectively. If multiple violations of the NPA and/or Board rules are present in a single case, the Board considers the most severe sanction recommended for anyone of the individual violations[5]. Additionally, when an individual has been previously disciplined or is being disciplined for more than one violation of the NPA and/or Board rules, the Board is statutorily required[6] to consider taking a more severe action than it would otherwise impose.

In determining the appropriate sanction in this case, the Board must consider the aggravating and mitigating factors. The Respondent's conduct, as outlined in adopted Findings of Fact Numbers 2-16 and Conclusions of Law Numbers 5-11 raise serious concerns about the Respondent 's ability to practice nursing safely. First, the Respondent's behavior encompasses multiple violations of the Nursing Practice Act and Board rules and cannot be considered isolated or minor incidents[7]. On the contrary, the Respondent repeatedly failed to meet the minimum standards of nursing practice over the course of several years[8]. Second, the Respondent's conduct posed a serious risk of harm, including

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recommendation. As such, the Board is not required to give presumptively binding effect to an ALJ's recommendation regarding sanctions in the same manner as with other findings of fact and conclusions of law. The choice of penalty is vested in the agency, not in the courts. An agency has broad discretion in determining which sanction best serves the statutory policies committed to the agency's oversight. The propriety of a particular disciplinary measure is a matter of internal administration with which the courts should not interfere. See *Texas State Board of Dental Examiners vs. Brown*, 281 S.W. 3d 692 (Tex. App. - Corpus Christi 2009, pet. filed); *Sears vs. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751 (Tex.App. - Austin 1988, no pet); *Firemen's & Policemen's Civil Serv. Comm'n vs. Brinkmeyer*, 662 S.W.2d 953, 956 (Tex. 1984); *Granek vs. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 781 (Tex.App. - Austin 2005, pet. denied); *Fay-Ray Corp. vs. Tex. Alcoholic Beverage Comm'n*, 959 S.W.2d 362, 369 (Tex.App. - Austin 1998, no pet.).

[2] See page 56 of the PFD.

[3] See page 46 of the PFD.

[4] See pages 46-47 of the PFD.

[5] 22 Tex. Admin. Code §213.33(b).

[6] See Tex. Occ. Code §301.4531.

[7] The Respondent is subject to discipline for multiple violations of the Nursing Practice Act and Board rules involving 8,614 prescriptions and practice at two separate clinics. See adopted Findings of Fact Numbers 2-16 and Conclusions of Law Numbers 5-11 and page 45 of the PFD.

[8] The Respondent treated patients from February to April 2011 at Ultimate Choice Medical & Rehab Clinic, LLC, Houston, Texas, and from December 2013 to January 2015 at Prillennium Healthcare, Houston, Texas. See adopted Findings of Fact Numbers 2-3.

death, to her patients[9]. Such risks are well-known to practitioners in the field of pain management and should have been known to the Respondent[10]. Yet, she did not follow the standard of care and prescribed dangerous controlled substances without conducting adequate patient assessments; failed to prepare treatment plans properly tailored to each patient's needs; failed to adequately collaborate with her delegating physician; and maintained inadequate and incomplete medical records[11]. Further, there is insufficient evidence that Respondent has learned from her past mistakes in a way that would assure the Board that future misconduct will not occur[12] and little mitigating evidence was presented during the hearing. The Board acknowledges that the Respondent has no prior disciplinary history with the Board[13]. As noted by the ALJ, this is a factor in the Respondent's favor[14].

Therefore, after carefully reviewing and considering the aggravating and mitigating factors in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix[15] and the Board's rules, including 22 Tex. Admin. Code §213.27 and §213.33(e), that the Respondent's licenses and prescriptive authority should be revoked. When weighed against the aggravating factors, the Board finds the mitigation shown by the Respondent in this case to be insufficient to warrant a lesser sanction. The Board also agrees with the ALJ that the administrative costs of the hearing and an administrative penalty should be imposed against the Respondent[16].

IT IS, THEREFORE, ORDERED THAT **Advanced Practice Registered Nurse License Number AP119040, Prescription Authorization Number 10237, and Registered Nurse License Number 784525,** previously issued to PRIANGLAM BROOKS, to practice nursing in the State of Texas be, and the same are hereby, REVOKED.

IT IS FURTHER ORDERED THAT RESPONDENT SHALL be assessed administrative costs in the amount of two thousand five hundred and sixty five dollars and twenty cents ($2,565.20), which shall be paid in full prior to Respondent petitioning for reinstatement of licensure or prescription authorization.

IT IS FURTHER ORDERED THAT RESPONDENT SHALL be assessed an administrative penalty in the amount of twenty seven thousand five hundred dollars ($27,500.00), which shall be paid in full prior to Respondent petitioning for reinstatement

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[9] See pages 46-48 of the PFD.

[10] See page 47 of the PFD.

[11] See adopted Finding of Fact Number 7.

[12] See page 50 of the PFD.

[13] See page 49 of the PFD.

[14] See *id.*

[15] 22 Tex. Admin. Code §213.33(b).

[16] See pages 51 and 56 of the PFD.

of licensure or prescription authorization

IT IS FURTHER ORDERED that this Order SHALL be applicable to Respondent's multi-state privileges, if any, to practice nursing in the State of Texas.

FURTHER, pursuant to the Occupations Code §301.467, RESPONDENT is not eligible to petition for reinstatement of licensure or prescription authorization until at least one (1) year has elapsed from the date of this Order. Further, upon petitioning for reinstatement, RESPONDENT must satisfy all then existing requirements for relicensure/prescription authorization, including any applicable requirements of this Order.

Entered this 28th day of October, 2016.

TEXAS BOARD OF NURSING

KATHERINE A. THOMAS, MN, RN, FAAN
EXECUTIVE DIRECTOR FOR THE BOARD

Attachment: Proposal for Decision; Docket No. 507-15-2425 (May 23 2016).

State Office of Administrative Hearings

Lesli G. Ginn
Chief Administrative Law Judge

May 23, 2016

Katherine A. Thomas, M.N., R.N.
Executive Director
Texas Board of Nursing
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701

VIA INTERAGENCY

RE: Docket No. 507-15-2425; Texas Board of Nursing v. Prianglam Brooks

Dear Ms. Thomas:

Please find enclosed a Proposal for Decision in this case. It contains my recommendation and underlying rationale.

Exceptions and replies may be filed by any party in accordance with 1 Tex. Admin. Code § 155.507(c), a SOAH rule which may be found at www.soah.state.tx.us.

Sincerely,

Pratibha J. Shenoy
Administrative Law Judge

PJS/mle
Enclosures
xc: John R. Griffith, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – VIA INTERAGENCY
Kathy A. Hoffman, Legal Assistant Supervisor, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 (with 1 CD; Certified Evidentiary Record) – VIA INTERAGENCY
Marc Meyer, Attorney at Law, 33300 Egypt Lane, Ste. C600, Magnolia, TX 77354 – VIA REGULAR MAIL

SOAH DOCKET NO. 507-15-2425

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
PRIANGLAM BROOKS, LICENSE NOS. AP119040 & 784525, Respondent	§	ADMINISTRATIVE HEARINGS

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SOAH DOCKET NO. 507-15-2425

TEXAS BOARD OF NURSING, Petitioner	§	BEFORE THE STATE OFFICE
v.	§	OF
PRIANGLAM BROOKS, LICENSE NOS. AP119040 & 784525, Respondent	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to revoke the nursing licenses[1] (Licenses) of Prianglam Brooks (Respondent) because she allegedly violated the minimum standards of nursing practice and failed to meet the standard of care by continually prescribing a combination of controlled substances without therapeutic benefit; prescribing certain opioids after she no longer held prescriptive authority to do so; and improperly owning and operating a pain management clinic. The Administrative Law Judge (ALJ) concludes that Staff met its burden of proof by a preponderance of the evidence. Accordingly, the ALJ recommends that the Board revoke Respondent's Licenses, and require her to pay the administrative costs of the hearing and an administrative penalty of $27,500.

I. PROCEDURAL HISTORY, JURISDICTION, AND NOTICE

The Board issued an Order of Temporary Suspension of Respondent's Licenses on February 17, 2015, pursuant to Texas Occupations Code (Code) § 301.455. The same day, the Board filed Formal Charges against Respondent and sent her notice of a probable cause hearing scheduled to convene on March 5, 2015.[2] After a continuance requested by Respondent was

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[1] Respondent holds Permanent Advanced Practice Registered Nurse License No. AP119040 (APRN License) and Permanent Registered Nurse License No. 784525 (RN License). Respondent was also granted prescriptive authority by the Board. Among nurses, only an APRN may hold prescriptive authority, but not all APRNs apply for it. Probable Cause Hearing Transcript (PC Tr.) at 128-27. Where a distinction is not required, "Licenses" is used to refer collectively to Respondent's licenses and prescriptive authority.

[2] Staff Exs. 4-5. Texas Occupations Code (Code) § 301.455(c) requires that the State Office of Administrative Hearings (SOAH) hold a hearing "not later than the 17th day after the date of the temporary suspension or restriction to determine whether probable cause exists that a continuing and imminent threat to the public welfare exists." Respondent agreed to waive the 17-day requirement.

granted, the probable cause hearing convened on March 11, 2015. An order was issued on April 7, 2015, upholding the temporary suspension of Respondent's Licenses.[3]

The hearing on the merits convened on January 26, 2016,[4] before ALJ Pratibha J. Shenoy at the State Office of Administrative Hearings (SOAH) facilities located at 300 West 15th Street, Fourth Floor, Austin, Texas. Assistant General Counsel John R. Griffith represented Staff and attorney Mark M. Meyer represented Respondent. Although the hearing concluded the same day, the record did not close until April 1, 2016,[5] after the parties submitted written closing arguments and Staff submitted an affidavit in support of its request for administrative costs.

By agreement of the parties, the exhibits and testimony presented at the probable cause hearing were admitted into evidence at the hearing on the merits. Although a court reporter was not present at the probable cause hearing, Staff obtained a certified transcript of the digital audio recording, which was admitted into evidence.[6]

Matters of notice and jurisdiction were undisputed and are therefore set out in the Findings of Fact and Conclusions of Law without further discussion.

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[3] At the probable cause hearing, Respondent argued that the temporary suspension should be dissolved on the basis that Staff had failed to establish probable cause to believe that continued practice by Respondent constituted a continuing and imminent threat to the public welfare. In the alternative, Respondent argued that any temporary suspension should be limited to her prescriptive authority as an APRN, rather than her ability to practice as an APRN or as an RN. The parties and the ALJ agreed that this argument appeared to be a matter of first impression. Respondent agreed to extend the temporary suspension until the parties could file briefs and the ALJ could issue a ruling concerning whether and on what basis an ALJ may modify a temporary suspension issued under Code § 301.455 in the manner requested by Respondent. The ALJ issued an order continuing the temporary suspension in full of Respondent's Licenses after considering the evidence submitted at the probable cause hearing, the briefing, and applicable law. *See* Order No. 4.

[4] The hearing originally was scheduled to convene in June 2015, but was continued due to witness availability issues and Respondent's attempts to locate additional records. *See* Order Nos. 5-7.

[5] The record was scheduled to close on March 31, 2016, but the deadline for filing closing briefs was extended at Respondent's request. The ALJ's administrative assistant verbally communicated the extended deadline to the parties because there was insufficient time to issue an order. The motion and grant thereof are mentioned here by way of memorializing them for the record.

[6] Staff Ex. 37.

II. STAFF'S FORMAL CHARGES

Staff's First Amended Formal Charges (Charges) concern Respondent's practice as an APRN with prescriptive authority, as well as her nursing practice more generally. Charges I-III were presented at the probable cause hearing, and Charge IV was added after additional patient records were located by Staff.

A. Charges I and IV

Charges I and IV address two periods of time: January 1 to August 31, 2011, when Respondent practiced at Ultimate Choice Medical & Rehab Clinic, L.L.C., in Houston, Texas (Ultimate Choice) (Charge IV); and December 1, 2013, to December 19, 2014, during which time Respondent practiced at her wholly-owned clinic, Prillennium Healthcare, in Houston, Texas (Prillennium) (Charge I).

Charges I and IV allege that Respondent, at both clinics and during both periods of time at issue, continually prescribed dangerous cocktails of controlled substances without regard to therapeutic benefit. The Charges also allege that Respondent repeatedly prescribed the same strength, dose, and quantity of hydrocodone,[7] Soma,[8] and/or alprazolam (Xanax)[9] to patients without: individually assessing each patient; developing an appropriate treatment plan for each patient; collaborating concerning the treatment and/or completing and accurately documenting such collaboration with a delegating physician in the patient's medical records; monitoring patients for abusive and/or drug-seeking behavior; and completely and accurately maintaining patient records.

While Charge I was not made as to specific patients, Staff alleged that Respondent prescribed 8,614 controlled substances in dangerous combinations during the December 1, 2013, to December 19, 2014 period. Charge IV listed 20 patients whose medical records were

[7] Hydrocodone is an opioid used to treat pain. PC Tr. at 57, 65-66.

[8] Soma (carisoprodol) is a muscle relaxant. PC Tr. at 57; Hearing on the Merits Transcript (HOM Tr.) at 113.

[9] Alprazolam (brand name Xanax) is a benzodiazepine used to treat anxiety. HOM Tr. at 46, 99, 108.

provided by Staff to its expert witness, who identified examples in 10 of those files of what he described as an overall pattern of failure to meet the standard of care.

B. Charge II

Staff alleged that Respondent exceeded her prescriptive authority in prescribing hydrocodone after the drug was reclassified from a Schedule III controlled substance to Schedule II.[10] While a physician may delegate to an APRN the authority to prescribe drugs in Schedules III through V as classified in the Texas Controlled Substances Act, APRNs may prescribe Schedule II drugs only in very limited circumstances (as discussed further below, these circumstances include certain patients in a hospital setting or receiving hospice care).

The reclassification of hydrocodone took effect on October 6, 2014.[11] Staff alleged that, between October 7 and December 12, 2014, Respondent wrote 410 prescriptions for hydrocodone when she did not have the authority to do so.

C. Charge III

Staff alleged that between September 2013 and January 2015, Respondent violated state laws, rules, and regulations because she owned and operated a pain management clinic without qualifying for an exemption permitting an APRN to own such a clinic. Staff alleged further that Respondent wrote prescriptions from a location not registered with the Texas Medical Board (TMB) as required.

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[10] The classification of a drug within one of five schedules is based on its potential for abuse or dependence and its currently accepted medical use in treatment in the United States. Schedule I includes drugs that carry an extremely high risk of abuse and have no legitimate medical use, and Schedule V includes drugs that have the lowest abuse or dependence risk and are currently accepted for medical use in the United States. Tex. Health & Safety Code § 481.035.

[11] Schedules of Controlled Substances: Rescheduling of Hydrocodone Combination Products From Schedule III to Schedule II, 79 Fed. Reg. 49661 (Aug. 22, 2014) (amending 24 C.F.R. § 1308.12).

III. APPLICABLE LAW

Staff asserted that Respondent should be disciplined for violating numerous provisions of the Board's rules,[12] which are found in title 22, part 11, chapters[13] 211-228 of the Texas Administrative Code. Specifically, Staff alleged violations of Board Rules 217.11(1)(A)-(C) and (4); 217.12(1)(A)-(B) and (4); 221.13(a), (b), and (d); 222.8(a), (b)(2)-(3), and (c); 228.1(i)(5); and, with respect to the time period at issue in Charge IV, 222.6(b)-(c).[14] According to Staff, Respondent's conduct subjects her to discipline by the Board pursuant to Code § 301.452(b)(1), (10), and (13).

The Board is authorized by the Nursing Practice Act (Act)[15] to discipline a nurse who violates the Act or a rule that is not inconsistent with the Act.[16] More specifically, the Board may discipline a licensee who engaged in "unprofessional or dishonorable conduct that, in the [B]oard's opinion, is likely to deceive, defraud, or injure a patient or the public."[17] Board rules define "unprofessional conduct" to include:

- Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice as set out in Board Rule 217.11;[18]

- Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings;[19] and

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[12] For ease of reference, a Board rule may be cited simply as "Board Rule ____."

[13] A chapter of Board rules (*i.e.*, one or more of chapters 211-228 of title 22, part 11 of the Texas Administrative Code) may be cited as "Board Rules Chapter___."

[14] In its Notice of Hearing, Staff also asserted violations of Board Rules 222.4(a), .10(a)(1), and, for Charge IV, Board Rule 222.12(a). Those rules were not discussed in Staff's written closing argument and the related allegations are presumed to be abandoned.

[15] The Nursing Practice Act (Act) is codified in Texas Occupations Code chapter 301.

[16] Tex. Occ. Code § 301.452(b)(1).

[17] Tex. Occ. Code § 301.452(b)(10).

[18] 22 Tex. Admin. Code § 217.12(1)(A).

[19] 22 Tex. Admin. Code § 217.12(1)(B).

- Careless or repetitive conduct that may endanger a client's life, health or safety, without requiring a showing of actual injury.[20]

The Act permits the Board to take disciplinary action against a nurse who has failed to "care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the [B]oard's opinion, exposes a patient or other person unnecessarily to risk of harm."[21] The Board has enacted rules that define standards of nursing practice to require that every nurse must, among other things:

- Know and conform to the Act and the Board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;[22]
- Implement measures to promote a safe environment for clients and others;[23] and
- Know the rationale for and the effects of medications and treatments and how to correctly administer them.[24]

Specific standards of nursing care apply to APRNs, as promulgated in Board rules. The Board requires that APRNs:

- Practice in an advanced nursing practice role and specialty in accordance with authorization granted under Board Rules Chapter 221 (relating to practicing in an APRN role) and standards set out in that chapter;[25]
- Prescribe medications in accordance with prescriptive authority granted under Board Rules Chapter 222 (relating to prescribing by APRNs), and standards set out in that chapter and in compliance with state and federal laws and regulations relating to prescription of dangerous drugs and controlled substances;[26] and

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[20] 22 Tex. Admin. Code § 217.12(4).

[21] Tex. Occ. Code § 301.452(b)(13).

[22] 22 Tex. Admin. Code § 217.11(1)(A).

[23] 22 Tex. Admin. Code § 217.11(1)(B).

[24] 22 Tex. Admin. Code § 217.11(1)(C).

[25] 22 Tex. Admin. Code § 217.11(4)(A).

[26] 22 Tex. Admin. Code § 217.11(4)(B).

- Know and conform to the Act, Board rules, standards of professional nursing, and all federal and state laws, rules, and regulations affecting the advanced practice role and specialty area; practice both independently and in collaboration with other health care professionals; and provide medical aspects of care in accordance with protocols or other written authorization.[27]

As noted above, Board rules regulating prescriptive authority prohibit APRNs from prescribing Schedule II medications outside certain hospital and hospice settings. An APRN with delegated authority from a physician may prescribe a Schedule II drug in a hospital-based facility to a patient who has been admitted for an intended stay of 24 hours or more, or who is receiving services in a hospital emergency department.[28] The APRN may also prescribe Schedule II drugs to a person who is terminally ill and is receiving hospice care from a qualified hospice provider.[29]

These provisions permitting prescriptions of Schedule II medications by APRNs took effect November 20, 2013.[30] At all times relevant to this case (*i.e.*, from 2011 onward), APRNs were required to consult with the delegating physician and note the consultation in the patient's chart before prescribing a controlled substance beyond an initial 90-day period.[31]

Code § 168.101 requires a pain management clinic to have a certificate before it may operate in Texas.[32] A pain management clinic is "a publicly or privately owned facility for which a majority of patients are issued on a monthly basis a prescription for opioids, benzodiazepines, barbiturates, or carisoprodol, but not including suboxone."[33]

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[27] 22 Tex. Admin. Code § 221.13(a), (b), and (d).

[28] 22 Tex. Admin. Code § 222.8(c)(1).

[29] 22 Tex. Admin. Code § 222.8(c)(2).

[30] 22 Tex. Admin. Code § 222.8 (effective Nov. 20, 2013).

[31] 22 Tex. Admin. Code §§ 222.6 (repealed Nov. 20, 2013), 222.8 (effective Nov. 20, 2013).

[32] Code § 168.101 (eff. Sept. 1, 2011), formerly Code § 167.101.

[33] Code § 168.001 (eff. Sept. 1, 2011). Amendments effective September 1, 2015, did not substantively change this language. Suboxone is a drug used for the treatment of opioid addiction. PC Tr. at 74.

An exemption for the certification requirement is available for a "clinic owned or operated by an advanced practice nurse licensed in this state who treats patients in the nurse's area of specialty and who personally uses other forms of treatment with the issuance of a prescription for a majority of the patients."[34] The TMB's rules reiterate the statutory language.[35] While the TMB has authority over the regulation of pain management clinics, the Board in February 2014 promulgated rules that prohibit an APRN from owning a pain management clinic unless the clinic is exempt from the certification requirement of Code chapter 168. The rules specify that the exemption for an APRN who "personally uses other forms of treatment with the issuance of a prescription" applies only if the treatments used are "within the current standard of care, supported by evidence based research, and consistent with the treatment plan."[36]

IV. EVIDENCE

As noted above, the testimony and evidence presented at the probable cause hearing were admitted into evidence at the hearing on the merits. In total, Staff called five witnesses (including Respondent) and offered 37 exhibits, all of which were admitted. Respondent testified on her own behalf, and did not offer any documentary evidence.

A. Testimony of Jami Cole

Jami Cole is a Diversion Investigator with the federal Drug Enforcement Administration (DEA). Her duties include investigating the diversion of licit pharmaceuticals for illicit purposes.[37] Ms. Cole testified that the TMB requested DEA assistance to serve a subpoena at Prillennium on January 22, 2015. Ms. Cole accompanied TMB staff on that visit and interviewed Respondent.

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[34] Code § 168.002(8) (eff. Sept. 1, 2011). An amendment effective January 1, 2014, added the words "who personally" in the above-quoted language.

[35] *See* 22 Tex. Admin. Code § 195.4(b)(8) (exempting from certification as a pain management clinic a "clinic owned or operated by an advanced practice nurse licensed in this state who treats patients in the nurse's area of specialty and personally uses other forms of treatment with the issuance of a prescription for a majority of the patients.")

[36] 22 Tex. Admin. Code § 228.1(i)(4)(B) (effective Feb. 23, 2014).

[37] PC Tr. at 14-15.

Ms. Cole noted that after DEA reclassified hydrocodone from Schedule III to Schedule II (effective October 6, 2014), Respondent did not appear to meet any of the exceptions permitting an APRN to prescribe Schedule II.[38] Ms. Cole testified that DEA had received complaints from pharmacies in Houston concerning Respondent's prescriptions for Schedule II controlled substances after the October 2014 reclassification, and that Respondent continued prescribing Schedule II drugs well into November 2014.[39]

Specifically, Ms. Cole said that DEA's database indicated Respondent was notified that she could not continue prescribing Schedule II controlled substances by DEA Registration Specialist Cheryl Walker on November 18, 2014.[40] After November 18, 2014, the prescriptions written by Respondent were still written on a prescription pad labeled with Respondent's name and prescribing information, but were being signed by Katherine Blanchette, M.D., according to Ms. Cole.[41] Ms. Cole said that the use of Respondent's prescription pad by Dr. Blanchette is not permitted.[42]

Because TMB staff had initiated the investigation of Respondent, they were in charge of the interviews during the serving of the subpoena on January 22, 2015, Ms. Cole said. She noted that she introduced herself to Respondent before the investigators began their interview, and was present for all of Respondent's interview.

According to Ms. Cole, Respondent stated during the interview that she was the sole owner of Prillennium and that 100% of Prillennium's patients were treated for pain.[43] Respondent also said that Prillennium was not registered with the TMB as a pain management clinic, and that she believed it did not need to be registered because it was owned by an APRN, not a physician.[44] Respondent said that she referred her patients to other providers for treatment

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[38] PC Tr. at 17.

[39] PC Tr. at 16.

[40] PC Tr. at 18, 20-21.

[41] PC Tr. at 20-21.

[42] PC Tr. at 21.

[43] PC Tr. at 16.

[44] PC Tr. at 14-15.

with alternative modalities (*i.e.*, other than prescriptions) but noted that about 1% of her patients received steroid shots, which she administered directly.[45] Ms. Cole agreed that during the interview, Respondent mentioned speaking to Ms. Walker (the DEA Registration Specialist) concerning the reclassification of hydrocodone into Schedule II.[46]

Ms. Cole said she requested that Respondent surrender her DEA license, which would have prevented Respondent from issuing prescriptions for controlled substances. According to Ms. Cole, Respondent refused to do so.[47]

B. Testimony of Karen Lawler

Ms. Lawler is a Case Support Specialist for the Texas Department of Public Safety (DPS). She testified that one of her job functions is to prepare reports requested by law enforcement agencies, including reports of prescription records. DPS maintains the Prescription Access Texas (PAT) database, which contains data on prescriptions of drugs in Schedules II-V. Pharmacies make electronic reports to DPS when prescriptions are filled, and that information is entered into the PAT database.[48]

The PAT system retains prescription records for one year, after which the data is purged, Ms. Lawler said. According to Ms. Lawler, a PAT report reflects that Respondent wrote 8,614 prescriptions for scheduled drugs between December 1, 2013, and December 19, 2014.[49] She provided this report and the underlying raw data to the Board during its investigation (prior to the probable cause hearing).

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[45] PC Tr. at 16-17.

[46] PC Tr. at 23-24.

[47] PC Tr. at 21.

[48] PC Tr. at 31.

[49] Staff Ex. 7.

C. Testimony of Graves T. Owen, M.D.

1. Pain Management Standard of Care

Dr. Graves T. Owen is board-certified in anesthesiology, and from 1995 to 2011 he operated an interdisciplinary pain management clinic.[50] He testified as an expert on the standard of care in pain management, which is what a reasonable and prudent medical professional would do in the same or similar circumstances, based on the evolving body of evidence-based literature in the field.[51] Although Respondent is a nurse, Dr. Owen testified that the standard of care applicable to Respondent is no different than would apply to a doctor or other professional prescribing medications for the treatment of pain.[52]

Pain, according to Dr. Owen, is a physical and emotional experience, and can be affected by a person's life circumstances, whether positive (for example, winning the lottery) or negative (such as stress from other life challenges).[53] Chronic pain is pain that persists after tissue has healed, usually measured as persisting after three months.[54]

Dr. Owen explained that in his pain management practice, he followed certain steps to ensure that his treatment of chronic pain patients met the standard of care. First, he requested any new patient's prior treatment records and reviewed them before the first appointment. During the first appointment, Dr. Owen conducted a problem-focused physical examination to identify the location, duration, and characteristics of the pain. If indicated, he administered basic psychological assessment tools to identify whether the patient required referrals for treatment for any comorbid conditions, such as depression. Based on his findings, he developed a treatment plan. Dr. Owen said that he would expect every pain management practitioner to maintain

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[50] Dr. Owen's *curriculum vitae* reflects his extensive experience in the field of pain management, including in treating patients, conducting research, publishing academic papers, and speaking to professional organizations.

[51] PC Tr. at 44.

[52] PC Tr. at 44-45.

[53] PC Tr. at 41-42.

[54] PC Tr. at 44.

records that reflect a review of patient history, document reliable examinations and findings, and set out a treatment plan.[55]

Dr. Owen testified that the standard of care in pain management requires that the practitioner explore evidence-based and low-risk approaches first.[56] Such treatment modalities include psychotherapy and physical therapy, both of which he said are supported by credible evidence and pose low risk to the patient. He explained that chronic treatment with opioid medications such as hydrocodone is not evidence-based, and also poses considerable risks.[57] He noted that there is no reliable study in the literature that examines the efficacy of opioid use for a period longer than six months, and most studies monitored patients for only six to twelve weeks.[58] Importantly, he said, it is well known among health professionals and law enforcement that there is a problem with abuse of hydrocodone in combination with other drugs, especially the muscle relaxant Soma (carisoprodol) and the anti-anxiety benzodiazepine Xanax (alprazolam).[59] Soma is known to have "especially potentiating euphoric effects with opioids," meaning that it enhances the "high" or the relief achieved from opioids.[60]

Mixtures of drugs that Dr. Owen has seen used illicitly include the Vegas Cocktail (hydrocodone plus Soma); the Soma Coma (Soma plus Tylenol III or IV); the Houston Cocktail (hydrocodone, Soma, and a benzodiazepine, usually Xanax); and the Florida Cocktail (oxycodone, Soma, and a benzodiazepine).[61] He said that these drug combinations have been identified by the federal Centers for Disease Control as the cause of more than half of all accidental lethal drug overdoses in the United States.[62] Most of these deaths are from central sleep apnea, which is a significant side effect of the drugs in question and is magnified when the drugs are taken in combination, Dr. Owen said.

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[55] PC Tr. at 45-46.

[56] PC Tr. at 44, 47.

[57] PC Tr. at 48.

[58] PC Tr. at 97.

[59] PC Tr. at 51-53.

[60] HOM Tr. at 113.

[61] PC Tr. at 51.

[62] PC Tr. at 48-49.

There is a serious problem, according to Dr. Owen, with medical professionals running "pill mills," which he said are clinics that exchange drugs for economic incentive without therapeutic benefit.[63] He stated that a generally-accepted definition of pill mills has been created by the North American Model State Drug Law Agency, a nonprofit organization. The definition describes a pill mill as being characterized by: operation by a provider who has not been trained formally in pain management; a high volume practice; the absence of pertinent medical records of patients' prior treatments; the failure to exhaust conservative approaches before resorting to chronic opioid therapy; inadequate documentation; unreliable exams and diagnoses; prescriptions of drug cocktails to the vast majority of patients; and cash-only practices. Another attribute of a pill mill, Dr. Owen commented, is that patients will often travel great distances to be treated at that facility rather than seeking care closer to home.[64]

These pill mill attributes indicate practice below the standard of care that would not be seen at a legitimate clinic, Dr. Owen said. He noted that he has consulted and/or testified regarding pill mill operations for the Board, the TMB, DEA, and the Department of Justice.[65]

2. Dr. Owen's Record Review and Expert Reports

Before the probable cause hearing, Dr. Owen reviewed the PAT report generated by Ms. Lawler; medical records for a sample of patients treated by Respondent at Prillennium from December 2013 to December 2014; and records produced by Xpress Pharmacy in Houston, Texas, for prescriptions written for Prillennium patients between October and December 2014. Based on his review, Dr. Owen prepared a report for Staff that set out his general findings concerning Respondent's pain management practice (Expert Report – Prillennium).[66]

After the probable cause hearing, Dr. Owen said, Staff gave him files for 20 patients treated by Respondent at Ultimate Choice in 2011. He reviewed 10 of those files in detail, and

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[63] PC Tr. at 52-53.

[64] PC Tr. at 56.

[65] PC Tr. at 53.

[66] Staff Ex. 8.

reiterated the same overall findings with respect to Respondent's practice, as he made concerning her practice in 2013-2014 at Prillennium. In reaching those conclusions, he again prepared a report, this time listing significant findings for a sample of the 20 patients (Expert Report – Ultimate Choice).[67]

In both Expert Reports, Dr. Owen provided the ultimate opinion that Respondent failed to meet the standard of care in pain management. At the probable cause hearing, Dr. Owen supported his opinion by pointing out examples from various patient files, though these details were not specifically listed in the Expert Report – Prillennium. The Expert Report – Ultimate Choice includes a list of items Dr. Owen identified in his review of 10 patient files, and states that the other 10 files contain the same features. At the hearing on the merits, Dr. Owen's testimony highlighted examples from the 10 patient files discussed in the Expert Report – Ultimate Choice, but he did not provide a visit-by-visit, patient-by-patient review and analysis.

Respondent did not provide patient-specific testimony except with respect to one lab result for one patient. Respondent also submitted no documentary evidence. As discussed in the Analysis section below, the ALJ finds that Staff produced evidence sufficient to meet its burden of proof. The highlights of Dr. Owen's testimony at the probable cause hearing (concerning Prillennium) and at the hearing on the merits (concerning Ultimate Choice) are set forth below.

3. Testimony Concerning Patients Treated at Prillennium, December 1, 2013, to December 19, 2014 (Charge I)

Based on his review of the prescription data report generated by Ms. Lawler, Dr. Owen said Respondent's practice at Prillennium was consistent with features of a pill mill. The vast majority of the 8,614 prescriptions written by Respondent and captured in the PAT report were for combinations of hydrocodone, Soma, and/or other drugs, often Xanax. Dr. Owen noted that in addition to the strikingly uniform combinations of drugs across the patient population, Respondent's prescriptions were primarily for the highest available doses of each drug

[67] Staff Ex. 34.

(10 milligrams (mg) for hydrocodone, 350 mg for Soma, and 2 mg for Xanax).[68] The 2 mg Xanax pills are known in the illicit drug trade as "bars" and have the highest street value for that drug, Dr. Owen added.[69]

Given that patients will vary as to their age, gender, other health issues, life circumstances, genetic makeup, and individual reactions to given medications (or combinations of medications), he said it is statistically highly unlikely that so many of Respondent's patients would need the same high doses of the same medications at the same intervals as prescribed by Respondent.[70] Also, he noted, a number of patients traveled for long distances (50 to 200 miles) to obtain medications at Prillennium, including from places outside Texas.[71]

Dr. Owen testified that he reviewed medical records for a sample of patients treated by Respondent to see whether the records indicated treatment meeting the standard of care. The records he reviewed showed substandard care in several respects, he opined.

For example, Patient FH's medical record from a November 4, 2014 visit states that his chief complaint was "low back pain" but there was no history of prior treatments or description of whether the pain radiated or presented in a particular pattern.[72] Dr. Owen said that the records showed no indication that FH had pain below the knee, which was inconsistent with Respondent's notation that she diagnosed radiculopathy, and Respondent's note of a "40/40" result for the straight leg raise (SLR) test did not state whether the result was positive or negative and had "no clinical significance."[73] A record in FH's file indicated that he obtained an x-ray of his lumbar spine at Respondent's request, and Respondent made a check mark next to "facet hypertrophic changes at L5-S1" on the radiology report. However, this finding is "non-specific," according to Dr. Owen, and is seen even in patients who have no complaints of back pain.[74]

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[68] PC Tr. at 57-58.

[69] PC Tr. at 55-56.

[70] PC Tr. at 47-48.

[71] PC Tr. at 56.

[72] PC Tr. at 59; Staff Ex. 10 at 2-3.

[73] PC Tr. at 62-63.

[74] PC Tr. at 63-64.

Similar problems were present in records of other patients, Dr. Owen asserted. For Patient AC, Respondent prepared medical records for visits on August 20, September 7, October 27, and November 24, 2014, all of which appeared to give the patient roughly the same instructions regarding her care, accompanied by prescriptions for hydrocodone, Soma, and other medications.[75] AC was 26 years old, and youth (under age 45) is a known risk factor for aberrant drug-taking behavior, but the potential for drug abuse apparently was not considered by Respondent in her treatment of AC, Dr. Owen said.[76]

On one visit, Respondent made a note that AC should be referred for a psychological evaluation to determine whether Xanax was appropriate. Dr. Owen found it troubling that there was no documentation of why the referral was being made, such as reports of anxiety or distress. Also, Dr. Owen noted, AC reported that her un-medicated pain level on a 1-10 scale was between 6 and 8, and with medications it would go down to 3 or 4. A reduction in pain symptoms of greater than 30% is unusual, Dr. Owen said, and would merit an explanation, which he did not find in the records. He distinguished opioid medications, which are analgesics and can "take the edge off the pain so that you can function better," from anesthetics, which actually cause a loss of consciousness.[77] He emphasized that analgesics do not typically produce the dramatic results that Respondent's patients appeared to report in the medical records.

For Patient AH, seen in September, October, and November 2014, Dr. Owen mentioned the same problem of Respondent's notations regarding "lower back pain" without any detail.[78] The SLR test result of "45/45" was clinically meaningless in Dr. Owen's view. He added that Respondent diagnosed radiculopathy but did not document it in the drawings where she should

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[75] PC Tr. at 64-65; Staff Ex. 10 at 29-33. Patient CM was also seen every month between August and November 2014 and received prescriptions for hydrocodone and Soma at every visit. Staff Ex. 10 at 41-45. Patient JS was seen every month from August to December 2014, and received prescriptions for hydrocodone and Xanax, or for hydrocodone and Soma, at every visit. Staff Ex. 10 at 52-56.

[76] PC Tr. at 64. Other risk factors, according to Dr. Owen, include post-traumatic stress disorder (PTSD), a history of emotional or sexual abuse, attention deficit disorder, depression, anxiety, or other mental illness, and a history of alcoholism or nicotine addiction (either the patient or in the patient's family). PC Tr. at 64-65.

[77] PC Tr. at 65-66.

[78] PC Tr. at 71.

have marked areas the patient reported were painful.[79] Dr. Owen found issues similar to those he identified for Patients FH, AC, and AH in the records for other patients.

Dr. Owen pointed out that for Patient JS, his age of 25 was not addressed as a risk factor, he reported an unrealistic 75% reduction in pain with medications, and a "negative straight leg raise" result was documented with a contradictory diagnosis of radiculopathy.[80] JS was referred for a psychiatric evaluation for Xanax use, Dr. Owen said, but the referral was made in his record *after* Respondent had already started prescribing Xanax to him. This conduct was "well below the standard of care," in Dr. Owen's opinion.[81]

After reviewing the Xpress Pharmacy records (for prescriptions written for Prillennium patients between October and December 2014), Dr. Owen noted that Respondent seemed to switch from prescribing hydrocodone to prescribing acetaminophen with codeine between October 7-27, 2014.[82] He explained that acetaminophen (Tylenol) with codeine is a Schedule III drug and was unaffected by the reclassification of hydrocodone, so an APRN could continue to prescribe it.[83] Nonetheless, he pointed out, codeine metabolizes to morphine and gives "most people" the same results as other opioids.[84]

After this interlude when she prescribed acetaminophen with codeine, Respondent resumed prescribing hydrocodone, Dr. Owen said. He cited hydrocodone prescriptions she wrote for Patient JFM on October 30, 2014,[85] Patients MJ and LC on October 31, 2014,[86] Patients FH, VR, and JH on November 4, 2014,[87] and Patient OK on November 11, 2014.[88]

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[79] PC Tr. at 72-73; Staff Ex. 10 at 36-40.

[80] PC Tr. at 76.

[81] PC Tr. at 77.

[82] HOM Tr. at 128.

[83] HOM Tr. at 128.

[84] HOM Tr. at 128.

[85] PC Ex. 82-83; Staff Ex. 11 at 7.

[86] PC Tr. at 81-82; Staff Ex. 11 at 3, 5.

[87] PC Tr. at 84-85; Staff Ex. 10 at 9, 11, 13.

[88] Staff Ex. 11 at 15.

Dr. Owen said that at some point, Respondent began having prescriptions for hydrocodone signed by her delegating physician, Dr. Blanchette, on a triplicate prescription pad.[89] He explained that, since the 1980s, medical professionals have been required to use a triplicate prescription pad for Schedule II drug prescriptions.[90] A physician who is prescribing both Schedule II drugs and other drugs may write all of the prescriptions on the triplicate pad. However, writing a prescription for a Schedule II drug on an ordinary prescription pad is prohibited.[91]

Respondent's triplicate pad listed both Respondent and Dr. Blanchette at the top, but included only Respondent's DEA registration number. The signature at the bottom, however, appeared to be Dr. Blanchette's, and someone wrote Dr. Blanchette's DEA registration number by hand on the pad. On the same date that Dr. Blanchette's signature appeared on the triplicate pad for hydrocodone prescriptions, Respondent signed prescriptions on an ordinary prescription pad for non-Schedule II drugs for the same patient.[92]

When he prescribed Schedule II medications at his own clinic, only his name appeared on the triplicate pad, and his midlevel providers did not have one, Dr. Owen said. That was because Dr. Owen's practice was not in a hospital or hospice where an APRN could prescribe Schedule II drugs.[93] Given that Prillennium was a stand-alone, non-hospice clinic, Dr. Owen questioned why Respondent would have a triplicate pad with her own name on it in the first instance.[94] Also, since prescriptions were signed by Dr. Blanchette (on the triplicate pad) and by Respondent (on an ordinary pad) for the same patients on the same visit, Dr. Owen questioned how this collaboration was managed.[95]

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[89] PC Tr. at 86-87; Staff Ex. 11 at 17.

[90] PC Tr. at 104.

[91] PC Tr. at 103-05.

[92] PC Tr. at 86-87; Staff Ex. 11 at 17.

[93] HOM Tr. at 127-28.

[94] HOM Tr. at 127.

[95] PC Tr. at 86-87; Staff Ex. 11 at 17.

He noted that it is impermissible for a delegating physician such as Dr. Blanchette to sign prescriptions in advance for Respondent to complete.[96] Rather, he said, Dr. Blanchette had to be physically present when the patient was present, meaning that either Dr. Blanchette was spending considerable time at Prillennium, or patients would return at the end of the day to have prescriptions signed by Dr. Blanchette.[97] Dr. Owen acknowledged that he did not know Prillennium's procedures, but he commented that both scenarios were impractical, inefficient, and unrealistic.

His review of the DPS prescription report, the patient medical record sample, and the Xpress Pharmacy prescription records led Dr. Owen to conclude that Respondent's treatment fell below the standard of care for pain management and was more consistent with a pill mill than with a legitimate medical clinic.[98] Dr. Owen conceded that he was not aware of any of Respondent's patients having serious adverse effects or overdoses from her prescriptions. He also agreed that his opinion of Respondent's practice was formed with respect to her treatment of pain management patients, and said he had no opinion concerning her practice as an RN. However, he said he was confident in the following conclusions:

- Respondent was performing superficial assessments and failing to prepare adequate treatment plans for patients at Prillennium;[99]
- Respondent's practice at Prillennium reflected a pattern of continually and repeatedly prescribing the same dangerous combinations of hydrocodone, Xanax, and/or Soma, at the maximum dosages available, to the vast majority of patients,[100] which was statistically incompatible with a legitimate pain management practice;[101]

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[96] PC Tr. at 87; Staff Ex. 11 at 17.

[97] PC Tr. at 87-88; Staff Ex. 11 at 17.

[98] Staff Ex. 8.

[99] PC Tr. at 80; Staff Ex. 11 at 17.

[100] The parties disputed whether the majority of patients were seen at Prillennium for complaints of pain. As discussed in the Analysis section, the ALJ finds that the credible evidence clearly preponderates in favor of a finding that Prillennium was a pain management clinic where the significant majority (if not all) of the patients were treated with prescriptions for opioids.

[101] PC Tr. at 88-89; Staff Ex. 8 at 1.

- The drug cocktails prescribed by Respondent were known to pose a risk of overdose or death, and did not have support in the evidence-based literature;[102] and

- The records indicated Respondent was resorting to opioid therapy on a chronic basis before first considering and exhausting lower-risk evidence-based modalities such as cognitive behavioral therapy, exercise, or physical therapy.[103]

4. Testimony Concerning Patients Treated at Ultimate Choice from January 1 to August 31, 2011 (Charge IV)

During his testimony at the hearing on the merits, Dr. Owen stated that he had been asked by Staff to review additional records, this time for patients treated by Respondent in 2011 at Ultimate Choice, a clinic where she was a healthcare provider but not the owner. While he reviewed all of the 20 patient files he received, Dr. Owen discussed 10 of those files in his second report (Expert Report – Ultimate Choice), and highlighted examples from those 10 files in his testimony at hearing. All of the patients in the files reviewed were given prescriptions for a combination of opioids and Xanax and/or Soma.

For patient AHi,[104] a 35-year-old man, Dr. Owen said the first concern was his relative youth, which is a risk factor for aberrant drug-taking behavior.[105] At a visit on March 14, 2011, AHi was seen by Respondent.[106] Dr. Owen pointed out that AHi reported a 50% reduction in pain with medications, an unreliable result; the drawing on which the areas of pain should have been indicated was blank; and the lack of detail on the form reflected a superficial evaluation without a problem-focused assessment.[107] Dr. Owen said he also saw no evidence that Respondent monitored AHi for side effects of chronic opioid therapy, such as central sleep apnea and impaired liver function.[108] Importantly, Dr. Owen said, there was no sign Respondent

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[102] PC Tr. at 88; Staff Ex. 8 at 1-2.

[103] PC Tr. at 88-89, 98.

[104] Because there were two patients with the initials "AH," Staff referred to them as AHi and AHo.

[105] HOM Tr. at 82.

[106] HOM Tr. at 82; Staff Ex. 14 at 31.

[107] HOM Tr. at 83-84.

[108] HOM Tr. at 87.

recommended lower-risk modalities, such as exercise or cognitive behavioral therapy, before prescribing opioids.[109] This was true of all 10 of the patients whose files he reviewed in-depth, Dr. Owen said.

As with many other patients in the sample, AHi's records showed no indication that Respondent administered a drug screen to determine what drugs AHi was already taking, or to ascertain that AHi was taking the drugs prescribed.[110] Urine drug testing (UDT) is an important monitoring tool, Dr. Owen said, especially because Respondent prescribed hydrocodone and Xanax at the highest available doses.[111] In addition, AHi received prescriptions for oxycodone, which in 2011 was classified as a Schedule II drug. Those prescriptions were signed by Edward Ramsey, M.D., who appeared to Dr. Owen to be Respondent's delegating physician.[112]

To illustrate the importance of UDT, Dr. Owen called attention to a drug test result for patient JG, who tested positive for cocaine, marijuana, and PCP, though not for the prescribed hydrocodone.[113] JG gave the urine sample on February 16, 2011, and results were reported to Ultimate Choice four days later. The next visit by JG to the clinic was on March 16, 2011, when he was seen by Respondent.[114] Dr. Owen described the lack of reference to the UDT results in Respondent's medical records as a failure to act on an "opportunity to take corrective action."[115]

Patient AHo raised a red flag, Dr. Owen said, because he reported being treated with opioids for chronic pain in the past. The standard of care required that Respondent obtain (or at least attempt to obtain) prior medical records, determine whether AHo benefitted in the past from the medications, rule out past drug abuse, and determine whether more conservative treatments could be utilized first.[116] Dr. Owen did not see evidence that Respondent did any of these things.

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[109] HOM Tr. at 88.

[110] HOM Tr. at 86-97.

[111] HOM Tr. at 83-84.

[112] HOM Tr. at 83-84, 103-04.

[113] HOM Tr. at 124-25.

[114] HOM Tr. at 125; Staff Ex. 24 at 31.

[115] HOM Tr. at 125.

[116] HOM Tr. at 88-89; Staff Ex. 15 at 5.

Patient BB reflected another pattern in the patient sample, Dr. Owen remarked, because Respondent prescribed Xanax without evidence that even a basic anxiety questionnaire had been used.[117] At subsequent visits, BB continued to report anxiety, which Dr. Owen said could indicate that the patient was not taking the medication as prescribed, or was obtaining inadequate therapeutic benefit. Dr. Owens saw no evidence that Respondent addressed this issue.[118]

For patient CT, Dr. Owen pointed out that the medical file contained consent forms for the use of benzodiazepines and for treatment with opioids, but the forms were blank.[119] The same problem was seen in a number of files in the sample (for example, patients AHi and GC).[120] CT reported what Dr. Owen described as a more reasonable reduction in pain from opioids, stating that his pain went from 8-9/10 to 6-7/10. Nonetheless, that raised another question, Dr. Owen said. Two patients could describe their pain as being 6/10, but could mean entirely different things because the reports are inherently subjective. In none of the patient files did he see an objective measure of function measured over time, such as whether the patient was able to increase hours of work or other activities at successive appointments.[121]

Patient DG drove about 272 miles each way from his home in Louisiana to obtain treatment at Ultimate Choice. That is a red flag for potential drug abuse, Dr. Owen said, because there is no explanation for why DG could not obtain adequate care closer to home.[122]

Patient HS complained of pain in his neck, low back, and right shoulder, hip, and leg, which would call for a multisite pain evaluation, in Dr. Owen's opinion.[123] With widespread pain, he said, it is important to rule out autoimmune disorders or thyroid imbalances.[124] That was not documented in the file for HS, or for AHi and DG, who also reported multisite pain.

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[117] HOM Tr. at 95.

[118] HOM Tr. at 96-97.

[119] HOM Tr. at 98-100.

[120] PC Tr. at 88-89, 98.

[121] HOM Tr. at 100-01.

[122] HOM Tr. at 104.

[123] HOM Tr. at 120.

[124] HOM Tr. at 107.

One outlier in the patient sample was patient GT, according to Dr. Owen. GT had a commercial driver's license, which requires the holder to obtain a letter of medical necessity for controlled substances that represents that the person is still safe to drive commercially.[125] Dr. Owen said he saw no evidence that this special consideration was discussed with GT or addressed with the appropriate letter.[126]

Dr. Owen testified that another pain medication (such as naproxen) may be prescribed alongside a short-acting opioid for breakthrough pain the patient experiences in between doses of the opioid.[127] There is no reason, however, to prescribe two short-acting opioids, he opined. Dr. Owen said he saw this unexplained redundancy in Ultimate Choice patients who received both oxycodone and hydrocodone (such as AHi, AHo, and DG), as well as patient GT, who received hydrocodone along with Morphine Sulfate Immediate Release, another short-acting opioid.[128]

In some of the patient files, Dr. Owen reported seeing separate prescriptions signed by Dr. Ramsey for oxycodone (which, as discussed previously, was a Schedule II drug in 2011). However, for appointments at which Respondent performed the assessments, it would have been incumbent on Dr. Ramsey to collaborate with Respondent in ensuring that the patient was an appropriate candidate for the medication, and incumbent on Respondent to ensure that the collaboration occurred and it was documented. Citing patient CT as an example, Dr. Owen said that some, but not all, records of visits at which CT received an oxycodone prescription had Dr. Ramsey's signature on the actual medical record as an indicator that some discussion took place. No details of any consultations were included.[129]

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[125] HOM Tr. at 116-17; Staff Ex. 22 at 1.

[126] HOM Tr. at 116-17.

[127] HOM Tr. at 119.

[128] HOM Tr. at 118-19.

[129] HOM Tr. at 103.

D. Testimony of Respondent

Respondent completed three degrees at schools in Tennessee: a two-year undergraduate degree from Jackson State Community College, a four-year degree from Union University, and in 2002, a degree in nursing from Baptist Memorial College.[130] She obtained a Master's of Science in nursing from Arkansas State University in 2006.[131] Her Master's degree qualified her as an APRN with a specialization as a family nurse practitioner.[132] Respondent noted that the Board does not recognize a specialization in pain management and said she developed expertise in the field through work experience and continuing education.[133] She could not recall specific courses or when she had taken them, noting that she takes many classes yearly.[134] Respondent said she has certificates of completion for these courses, but did not bring them with her.[135]

After obtaining her APRN degree, Respondent worked for two years at a hospital in Fort Smith, Arkansas, in three departments: rehabilitation, pain management, and hospice.[136] Respondent next worked in Oklahoma for Select Care of Oklahoma, serving as the nurse practitioner managing care for patients at four nursing homes. In 2010, she moved to Houston and began working at a practice called My Family Clinic.[137] Staff's records reflect that Respondent applied for and was granted prescriptive authority by the Board in May 2010.[138]

At some point in 2010 or 2011, Respondent began working at a clinic where Dr. Ramsey was the supervising physician. Dr. Ramsey became Respondent's delegating physician and the relationship was registered with the TMB, Respondent said.[139] She said she could not recall

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[130] HOM Tr. at 22-23.

[131] HOM Tr. at 23, 62.

[132] HOM Tr. at 23.

[133] HOM Tr. at 23-24, 61.

[134] HOM Tr. at 24-26.

[135] HOM Tr. at 24.

[136] HOM Tr. at 62.

[137] HOM Tr. at 64-65.

[138] Staff Ex. 1 at 2.

[139] HOM Tr. at 25.

exactly, but the clinic had "Primary" as part of its name (Primary Clinic).[140] Dr. Ramsey was also the supervising physician at Ultimate Choice, and Respondent began going to Ultimate Choice to "help out" in approximately March 2011, at Dr. Ramsey's request.[141] According to Respondent, Dr. Ramsey's specialization was in anesthesia, so Ultimate Choice was a pain management clinic, although Primary Clinic patients were treated for a variety of conditions.[142] Respondent was paid on an hourly basis, but she could not recall how much she earned.

Respondent said she was dissatisfied with how business was handled at Ultimate Choice and stopped working there after a few months. Specifically, Respondent would request the records for a patient's prior visits, but generally did not receive them until much later, usually after the patient had left.[143] She agreed that a health care provider has a duty to review records before continuing or changing a patient's treatment, but she reiterated that she could not review records that she did not have.[144] She added that, even without the records, she wrote refill prescriptions for drugs prescribed by Dr. Ramsey because the patients were "already established patient[s] of Dr. Ramsey."[145] Also, Respondent said, Dr. Ramsey was present and available to answer questions she had.[146] Although Dr. Ramsey supervised both clinics, Respondent said Primary Clinic was better managed and she did not encounter the same issues there.

Respondent did not testify concerning any of the specific shortcomings identified by Dr. Owen in the patient files from Ultimate Choice, except for the drug test of patient JG. Respondent said it was her practice to write her initials on lab results when she reviewed them, and the absence of her initials on the drug test result would mean that—even though she was the provider who saw JG at his next visit to Ultimate Choice—she did not have the results available

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[140] HOM Tr. at 188-89.

[141] HOM Tr. at 189.

[142] HOM Tr. at 26, 191.

[143] HOM Tr. at 189-90.

[144] HOM Tr. at 205-06.

[145] HOM Tr. at 205.

[146] HOM Tr. at 207.

to her.[147] Since the time she stopped working at Ultimate Choice, she has become aware, Respondent said, that the clinic was raided by the DEA.[148]

In December 2013, Respondent opened Prillennium as its sole owner.[149] She said she treated patients "for a variety of things" including hypertension, diabetes, and sinus infections, and stated that she could not recall what percentage of her patients were seen for complaints of pain.[150] She agreed that the PAT report prepared by DPS reflected the prescribing practices asserted by Staff, where the majority of patients received prescriptions for opioids and Xanax and/or Soma in combination, but she insisted that what was shown "on paper" did not reflect the entirety of her practice. Respondent denied telling Ms. Cole or the TMB investigators that 100% of Prillennium patients were treated for pain.[151] After the TMB investigation on January 22, 2015, Respondent did not see any more patients at Prillennium.[152] Respondent noted that she had been "in the process" of becoming eligible to accept insurance, but acknowledged that all Prillennium patients paid cash.[153] Respondent paid herself a salary of approximately $5,000 per month.[154]

With respect to the October 6, 2014 reclassification of hydrocodone, Respondent said she only received "bits and pieces" of information and made numerous unsuccessful efforts to find out what she needed to do.[155] She agreed that she did not stop prescribing hydrocodone until after that date. Respondent was asked to review the portion of the PAT report reflecting that she wrote prescriptions for hydrocodone until October 6, 2014; wrote prescriptions for acetaminophen with codeine between October 7 and 27, 2014; and once again began prescribing

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[147] HOM Tr. at 187-88; Staff Ex. 24 at 22-25.

[148] HOM Tr. at 193.

[149] HOM Tr. at 29-30.

[150] HOM Tr. at 30-32.

[151] HOM Tr. at 30-31.

[152] HOM Tr. at 49. The Board issued the temporary suspension of Respondent's Licenses on February 17, 2015.

[153] HOM Tr. at 33-34.

[154] HOM Tr. at 34.

[155] HOM Tr. at 35.

hydrocodone after October 27, 2014.[156] Acetaminophen with codeine is a Schedule III drug, and thus within an APRN's prescriptive scope, Respondent acknowledged. She reiterated that, without having access to her records, she could not elaborate further on why so patients received the same combinations and doses of medications.[157]

Staff questioned Respondent extensively about how she obtained a triplicate prescription pad from DPS in her own name, with Dr. Blanchette's name also printed on it, but only Respondent's DEA number preprinted. According to Respondent, she called DPS in November 2014 and spoke to an employee named John Crawford. Based on the conversation, Respondent's understanding was that she "could write for Schedule IIs [even] after that date [October 6, 2014]."[158] She filled out paperwork that DPS sent her, and DPS "switched [her] DPS and DEA certificate over to say Schedule II."[159] Though Respondent could not recall exactly when she received the Schedule II pads, she said it would have been after this paperwork was completed.[160]

When she received a call from Ms. Walker (the DEA Registration Specialist) in November 2014, Respondent said, she became confused because she was hearing contradictory things from Mr. Crawford at DPS. Respondent said she tried unsuccessfully to have Mr. Crawford and Ms. Walker speak to each other to resolve the discrepancy.[161] Respondent agreed that the period when she prescribed acetaminophen with codeine was likely when she felt she was having the most difficulty finding out from DPS and DEA exactly what she needed to do with respect to hydrocodone.[162]

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[156] HOM Tr. at 38-46.

[157] As memorialized in Order Nos. 5-7, the hearing on the merits was delayed at Respondent's request because she was attempting to obtain records from Prillennium that she believed were in the possession of the new owner. As noted previously, Respondent offered no documentary evidence at either hearing.

[158] HOM Tr. at 71.

[159] HOM Tr. at 71.

[160] HOM Tr. at 71.

[161] HOM Tr. at 77-78.

[162] HOM Tr. at 201.

Finally, after she was unable to get clarification, Respondent "asked [Dr. Blanchette] to come into the office to sign the prescription pads, . . . to be safe."[163] Later during her testimony, Respondent said that Dr. Blanchette was the one who suggested coming to Prillennium to sign prescriptions.[164] Per Respondent, Dr. Blanchette did not bring her own triplicate pad to Prillennium because Respondent's pads had both their names listed.[165]

Respondent admitted that the handwriting on the triplicate prescriptions in the Prillennium patient records (listing the hydrocodone strength and number of pills) was hers, but said the signature was Dr. Blanchette's. Respondent denied that Dr. Blanchette ever pre-signed prescriptions and left them for Respondent to complete. She insisted that Dr. Blanchette was in the office at Prillennium. Respondent said she would go into the exam room, examine and talk to the patient, and then come out to discuss the patient with Dr. Blanchette before Dr. Blanchette signed the prescriptions.[166] Respondent noted that Dr. Blanchette "had two other offices she was still with" but the doctor must have "neglected [the other offices] to come over to be with [Respondent]" at Prillennium.[167]

E. Testimony of Dr. Jolene Zych

Dr. Jolene Zych is an RN and an APRN, and holds a Ph.D. in public policy and administration. She has been a licensed nurse in Texas for 16 years and serves as a Nurse Consultant for Advanced Practice to the Board. Dr. Zych was deemed qualified by the ALJ to give expert testimony on the standards of practice applicable generally to nursing and specifically to APRNs.

After reviewing the evidence and hearing Respondent's testimony, Dr. Zych opined that Respondent failed to meet a number of standards applicable to all nurses. Specifically, Dr. Zych

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[163] HOM Tr. at 72-73.

[164] HOM Tr. at 192-93.

[165] HOM Tr. at 192.

[166] HOM Tr. at 51-53.

[167] HOM Tr. at 205-06.

said, all nurses perform patient assessments, which must be sufficiently thorough, and they document those assessments, which they must do with accuracy and completeness.[168] Any nurse who receives orders to administer drugs that may be contraindicated and/or in dangerous combinations has a duty to question the ordering physician before administering the drugs to a patient. Dr. Zych stated that Respondent did not appear to think carefully about prescribing dangerous combinations of controlled substances (in her role as an APRN), so it was unlikely that Respondent would question the same prescriptions written by a doctor if Respondent was working as an RN.[169] That indicated to Dr. Zych a fundamental deficit of critical thinking ability that pervaded Respondent's practice.[170]

As an APRN with prescriptive authority, Respondent was practicing in areas that overlapped with the scope of medical practice by physicians, Dr. Zych said.[171] This included formulating diagnoses, determining a plan of care, and writing prescriptions. She said the patient population was vulnerable because pain sufferers are very eager to get relief, but they also need careful monitoring for the side effects of the powerful medications Respondent was prescribing.[172] These patients also needed to be evaluated for possible comorbid conditions (such as anxiety, PTSD, or addiction issues) that could affect their treatment.

Hearing Respondent's testimony about the confusion she experienced in understanding the reclassification of hydrocodone, Dr. Zych expressed several concerns. First, if Respondent was unsure if she had authority to prescribe a drug, she had an obligation to refrain from prescribing it until she was certain.[173] Given that Respondent is licensed by the Board, she should have consulted the Board regarding whether her prescriptive authority (also granted by the Board) had been affected, and she did not do so.[174]

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[168] PC Tr. at 116, 118-19.

[169] PC Tr. at 117, 120-21.

[170] PC Tr. at 120.

[171] HOM Tr. at 150.

[172] HOM Tr. at 165-66.

[173] HOM Tr. at 171-72.

[174] HOM Tr. at 171.

Dr. Zych noted that Respondent appeared at first to understand that she could no longer prescribe hydrocodone, based on the roughly 20-day period in October 2014 when she issued prescriptions for acetaminophen with codeine instead of hydrocodone.[175] When Respondent resumed prescribing hydrocodone (between October and December 2014), she could have been misinformed about or deliberately ignoring her lack of authority to do so, either of which would show questionable competence and poor professional judgment, in Dr. Zych's opinion.[176]

The switch in late November 2014 when Dr. Blanchette began signing Schedule II prescriptions on Respondent's triplicate pad was also a source of concern to Dr. Zych. As an initial matter, Dr. Zych said that an APRN has to declare to DPS that she is qualified for an exemption to prescribe Schedule II drugs (*i.e.*, hospital or hospice setting) in order to obtain a Schedule II pad in her own name. Thus it was unclear, Dr. Zych said, how Respondent obtained the triplicate pad without wrongly claiming an exemption.[177] Further, Dr. Zych expressed her belief that APRNs cannot share a triplicate prescription pad with any other provider.[178]

If Respondent and Dr. Blanchette were truly collaborating and consulting on patients at Prillennium (whether before or after the reclassification of hydrocodone), Dr. Zych said there was minimal documentation of any discussion in the records.[179] The same was true, Dr. Zych added, of Respondent's collaboration with Dr. Ramsey, as evidenced by the lack of details concerning collaboration (or even Dr. Ramsey's signature) on some medical records prepared by Respondent for patients to whom Dr. Ramsey prescribed Schedule II medications.[180]

In Dr. Zych's view, Respondent was failing to adequately treat a large number of patients, from a subset of the population (pain sufferers) that is particularly vulnerable.[181] The lack of proper assessment with respect to possible comorbid conditions, aberrant drug use, and

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[175] HOM Tr. at 171-72.

[176] HOM Tr. at 179-80.

[177] HOM Tr. at 156-57.

[178] PC Tr. at 124; HOM Tr. at 173-74.

[179] HOM Tr. at 163-64.

[180] HOM Tr. at 212-13.

[181] HOM Tr. at 165.

potential side effects of opioids (such as liver impairment and central sleep apnea) enhanced the risk of harm posed by Respondent's practice, Dr. Zych said.[182] Dr. Zych also asserted that, at least as of February 2014 (when Board Rule 228.1 took effect) Respondent was operating a pain management clinic in violation of certification requirements because Respondent did not personally offer any other treatment and, based on all the available evidence, at least half of her patients received prescriptions for opioids.[183]

Given the numerous problems with Respondent's practice, Dr. Zych opined that at this time, remediation would not be a viable option for Respondent.[184] In particular, Dr. Zych noted, Respondent had shown no improvement in her practice between 2011 (at Ultimate Choice) and 2014 (at Prillennium), which indicated that she had not benefitted much from the work experience and any continuing education courses she had taken.[185]

Dr. Zych also testified as to the appropriate sanction(s) in this case. Since this testimony was offered as an interpretation of the legal provisions that the ALJ must independently apply, the ALJ will not detail it. To the extent Dr. Zych's opinions were useful to and/or accepted by the ALJ, they are reflected in the Analysis section without further comment here.[186]

F. Affidavit of Costs

Staff requested that it be awarded costs if it prevails in this case, pursuant to Code § 301.461. After the hearing, Staff filed an affidavit, admitted into the record, establishing the following costs: [187]

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[182] HOM Tr. at 165, 213.

[183] HOM Tr. at 154-56. As noted above, Board Rule 228.1 prohibits an APRN from owning a pain management clinic unless the clinic is exempt from the TMB's certification requirements.

[184] HOM Tr. at 177-78.

[185] HOM Tr. at 166-67.

[186] Dr. Zych's testimony may be found at pages 113-33 of the probable cause hearing transcript, and at pages 150-81 and 212-16 of the hearing on the merits transcript.

[187] Staff Ex. 38.

Court Reporter's Fees, Probable Cause Hearing:	
147 pages at $6.50 per page:	$ 955.50
Administrative Fee:	$ 65.00
Delivery:	$ 9.00
E-Transcript	$ 30.00
Court Reporter's Fees, Hearing on the Merits:	
218 pages at $3.90 per page:	$ 850.20
Hours – 7.25 hours at $75.00	$ 543.75
Administrative Fee:	$ 65.00
Delivery:	$ 16.75
E-Transcript	$ 30.00
Grand Total	**$ 2,565.20**

Staff's evidence related to costs was not contested by Respondent. The ALJ finds that the costs are reasonable administrative expenses related to the presentation of Staff's case, and that Staff is entitled to recover those expenses because, as set forth below, it prevailed in this case.

V. ANALYSIS

After considering the evidence and arguments, the ALJ finds that Respondent committed the violations attributed to her in Staff's four Charges. The ALJ concludes (as set forth in the discussion of Charge III, below) that, based on the credible evidence, the vast majority of patients at Prillennium were seen for complaints of pain. That conclusion is treated as established for purposes of the discussion (immediately below) of Charges I, II, and IV.

A. Charges I and IV

Charges I and IV address two separate periods of time, and two distinct practice settings. However, whether Respondent was working as an employee in a physician's clinic (as she did at Ultimate Choice in 2011) or as the owner of a free-standing clinic (as she did in 2013-2014 at Prillennium), she exhibited the same approach to her practice. That approach, as demonstrated by the preponderant evidence, did not meet the standard of care for pain management. Though Dr. Owen did not provide a patient-by-patient, visit-by-visit breakdown for every patient he mentioned at hearing or discussed in his Expert Reports, his testimony and Staff's documentary

evidence met Staff's burden to show by a preponderance of the evidence that Respondent committed violations of the Act and Board Rules that can subject her to discipline by the Board.

Dr. Owen's expertise and experience in pain management were unchallenged. He testified credibly that the standard of care is the same for any provider engaged in medical aspects of pain management, such as diagnosing conditions, developing treatments, and prescribing medications. The ALJ concludes that the standard of care includes (though it may not be limited to) the following elements, and discusses facts that establish that Respondent did not meet each of these elements. Respondent's conduct is a failure to meet minimum standards of nursing practice, and constituted unprofessional conduct.

1. Proper Assessment of Each Patient

Dr. Owen testified that in his own pain management practice, he made a point of obtaining the patient's prior medical records and reviewing them before the first appointment. At that appointment, he would conduct a problem-focused assessment of the patient's pain complaints, including an inquiry into whether the patient required referral for treatment of comorbid conditions.

The evidence illustrates that Respondent's patient assessments were inadequate. For example, she did not have prior medical records in the file for Prillennium patient FH, or Ultimate Choice patient AHo, among others. Respondent did not include in the record a description of how and where the pain presented for Prillennium patient FH and Ultimate Choice patients AHi and DG.

Respondent's records contained inconsistent and contradictory information, such as diagnoses of radiculopathy with no indication of below-the-knee pain for Prillennium patients FH and AH. Ultimate Choice patients HS, AHi, and DG reported pain in multiple locations, but Respondent did not document that she conducted multisite evaluations or that she ruled out (or even considered) alternative causes such as autoimmune disorders or thyroid imbalances. Many patients reported more than a 30% decrease in pain from medication, which is an unreliable

result and should have caused Respondent to inquire further. These include Prillennium patients AC and JS, and Ultimate Choice patient AHi. These same three patients were in the 18-45 age group at highest risk for aberrant drug-seeking behavior, but that concern was not addressed by Respondent.

The evidence produced by Staff, together with Dr. Owen's uncontroverted and persuasive expert testimony, indicates that Respondent failed to meet the standard of care for assessment of patients who presented for pain management treatment. Per Dr. Zych's testimony, the ability to perform quality assessments is a requirement for minimum standards of nursing practice.

2. Developing Individual Treatment Plan for Each Patient

One of the clearest indicators that Respondent failed to formulate adequate treatment plans for her patients at Prillennium is found in the markedly consistent prescriptions she wrote for the maximum doses of hydrocodone, Xanax, and/or Soma to the vast majority of patients. Respondent's prescription pattern would require all of these patients to have very similar needs for and responses to the same medications, which is statistically highly unlikely per Dr. Owen.

At Ultimate Choice, Respondent showed the same pattern of writing prescriptions for high dosages of medications for almost every patient. She demurred that she was seeing Dr. Ramsey's established patients and thus was justified in continuing his treatment plans. At the same time, she agreed that each health care provider has an obligation to review a patient's records before continuing or changing a treatment plan. Her complaint that she could not review records if Ultimate Choice did not provide them in a timely fashion does not excuse her from this obligation and demonstrates her failure to develop and implement treatment plans that were tailored to meet each patient's needs.

Respondent resorted to prescribing opioids on a chronic basis without considering and exhausting lower-risk evidence-based modalities such as cognitive behavioral therapy, exercise, or physical therapy. This was apparent throughout the patient files at both clinics, according to Dr. Owen, and demonstrated the shortcomings of her approach to treatment. In addition, the

evidence indicates Respondent did not ensure that her patients were adequately informed about and consented to the risks and benefits of treatment, as shown by the blank and unsigned consent forms in a number of patient files (for example, Ultimate Choice patients CT, AHi, and GC).

3. Collaborating Adequately with Delegating Physician and Documenting Collaboration

The Board has the discretion to grant prescriptive authority to an APRN who is qualified and applies for it. The exercise of that prescriptive authority requires delegation from a physician, so collaboration between the APRN and doctor is vital to ensure quality of care. Documenting that collaboration captures the thought process behind the treatment and preserves a medical record that a future provider can use to ensure continuity of care for the patient. As Dr. Owen noted, Dr. Ramsey signed prescriptions for Schedule II drugs for Ultimate Choice patients who were seen and assessed by Respondent, such as patient CT. The Ultimate Choice records do not reflect that Respondent and Dr. Ramsey collaborated, except for the presence of Dr. Ramsey's signature on some (but not all) medical records. The content of the collaboration (if any) is not included in the records.

Respondent's ability to meaningfully collaborate with Dr. Ramsey was curtailed because she could not obtain the patient's prior records before she saw and assessed the patient. Respondent agreed that as a nurse, she had a responsibility to question a doctor's orders if they appeared inconsistent or potentially harmful to a patient. Her practice at Ultimate Choice put her in a position of prescribing drugs to patients without having the information required to make her own assessment and/or question Dr. Ramsey's orders if necessary.

Respondent testified that Dr. Ramsey was present at the clinic and available for questions. But, Respondent apparently did not make the necessary inquiries, such as asking for procedural changes so records were supplied on a timely basis, and questioning dangerous redundancies in cases where patients (such as Ultimate Choice patients GT, AHi, AHo, and DG) received two short-acting opioids at the same time. This conduct, as Dr. Zych put it, indicates a deficit in critical thinking.

Respondent related that in late 2014 she began a procedure at Prillennium of seeing each patient and stepping out from the exam room to the office, where she would discuss the patient with Dr. Blanchette and the doctor would sign hydrocodone prescriptions. Other than the prescription signatures from Dr. Blanchette, the records do not document that Respondent and Dr. Blanchette had any collaboration. It also is difficult to credit Respondent's explanation that Dr. Blanchette chose to spend all day at Prillennium to the detriment of her own clinic and her own patients. The evidence supports Staff's assertion that proper collaboration did not occur at either clinic, and, in instances where it did take place, was not sufficiently documented.

While she was at Prillennium, Respondent prescribed opioids for more than an initial 90-day period without consulting with the delegating physician and documenting the collaboration in the medical record. Patient AC was seen monthly by Respondent from August to November 2014, and received prescriptions for hydrocodone and Soma at every visit without any collaboration between Respondent and Dr. Blanchette documented in the medical records. Patient CM was also seen every month between August and November 2014 and received prescriptions for hydrocodone and Soma at every visit. Patient JS was seen every month from August to December 2014, and received prescriptions for hydrocodone and Xanax, or for hydrocodone and Soma, at every visit.

The same prescriptive practice (prescribing more than an initial 90-day period without collaborating and documenting the collaboration) is not reflected in the Ultimate Choice records in evidence. Staff alleged in Charge IV that Respondent worked at Ultimate Choice from January to August 2011. Based on the records, however, the earliest document on which Respondent's signature appears is dated February 2, 2011,[188] and the last is April 28, 2011.[189] If Respondent only worked at Ultimate Choice for three months, the evidence does not show she exceeded the 90-day initial limit on prescriptions of controlled substances.

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[188] Patient JP was seen on February 2, 2011. Staff Ex. 25 at 15.

[189] Patient AHo was seen on April 28, 2011. Staff Ex. 25 at 15.

4. Monitoring Patients for Aberrant Behavior

Dr. Owen noted that opioid medications in combination with Soma and/or Xanax are known to present a significant risk of central sleep apnea and death from overdose. Therefore, a provider must exercise caution in prescribing these drugs, and the standard of care requires monitoring the patient for adverse effects and identifying any comorbid conditions such as PTSD, a history of emotional or sexual abuse, attention deficit disorder, depression or anxiety, and a history of alcoholism or nicotine addiction. Dr. Owen criticized Respondent's decision to prescribe Xanax to a large majority of patients without documenting reasons for the prescriptions and the therapeutic benefit.

For example, Prillennium patient JS was referred for evaluation of mental illness issues *after* Respondent had already begun prescribing Xanax to him. Ultimate Choice patient BB repeatedly complained of anxiety despite having a Xanax prescription, but Respondent failed to determine why BB was not obtaining adequate relief.

Urine drug screens are an important monitoring tool but were almost entirely absent from the patient files at both clinics, according to Dr. Owen. He cited the example of Ultimate Choice patient JG, who tested positive for cocaine, marijuana, and PCP, though not for the prescribed hydrocodone. Respondent was the provider who saw JG after the results were received, but she did not address the aberrant drug test.

At hearing, Respondent said she was certain she had never seen JG's test results before, because she always put her initials on lab results that she reviewed and the document was not initialed. Again, that may be an explanation of the circumstances, but it is not an excuse for failing to meet the standard of care. The fact that Respondent kept practicing for several months at a clinic whose operations were potentially dangerous for clients indicates a failure of judgment. At her own clinic, where she had control over the records and could have implemented urine drug screens, the evidence indicates Respondent neglected to do so.

5. Maintaining Complete and Accurate Medical Records

While at Ultimate Choice, Respondent did not receive requested copies of patient records, so she could not be sure that a complete and accurate file was being kept for each patient and that her contribution documented the continuing delivery of care. Even the records she personally prepared were lacking, however. There were blank consent forms in the files (patients CT, AHi, and GC, for example), and incomplete physical examination records that did not depict where the patient reported pain (patients AHi and DG, among others).

At Prillennium, Respondent personally saw patients and prepared the medical records, and her pattern of deficient recordkeeping continued. Respondent's records reflected unresolved inconsistencies, such as a diagnosis of radiculopathy without an indication of below-the-knee pain (patients FH and AH); a lack of documentation of the basis for prescribing Xanax (patients AC and JS); and unrealistic reports of greater than 30% reduction in pain with medication, which Respondent wrote down without questioning (patients AC and JS, among others).

As previously discussed, collaboration was sparsely documented, if at all, in files from both clinics. Respondent also failed to document that patients at either of the clinics were being monitored for adverse effects and were benefitting from using the drugs. The ALJ finds that Respondent failed to meet the standard of care with respect to keeping an accurate and complete medical record for each patient.

6. Violations Established

The ALJ finds that Respondent's treatment of patients at both Ultimate Choice (Charge IV) and Prillennium (Charge I) fell below the standards of care for pain management. In failing to meet the standard of care, Respondent did not meet minimum standards of nursing practice for either an RN (such as taking proper patient histories and performing appropriate assessments) or an APRN (practicing in accordance with laws governing the prescription of hydrocodone, collaborating adequately with other health professionals, and choosing evidence-based, low-risk treatments before resorting to high-risk controlled substance combinations on a

repetitive basis that are not supported by evidence). It is clear that Respondent's continuing education and work experience in pain management did not suffice to enable her to practice safely in the APRN specialty role she chose. Respondent also did not collaborate meaningfully, and failed to document any collaboration that did take place, with her delegating physicians at both Ultimate Choice and Prillennium.

Specifically, Respondent's conduct is subject to sanction under the following provisions of the Code because of violations of the Board rules listed below.

a. Code § 301.452(b)(1) (Violation of Act or Board Rule)

Code § 301.452(b)(1) subjects a nurse to discipline for any violation of the Act, a Board rule "not inconsistent with" the Act, or a Board order. As discussed below, Respondent violated provisions of several Board Rules, making her generally subject to sanction by the Board.

b. Code § 301.452(b)(10) (Prohibiting Unprofessional Conduct)

Respondent is subject to sanction because she violated:

i. **Board Rule 217.12(1)(A)** by carelessly failing, repeatedly failing, or exhibiting an inability to perform her nursing duties in conformity with the minimum acceptable level of nursing practice set out in Rule 217.11 (see below);

ii. **Board Rule 217.12(1)(B)** because by performing substandard assessments, keeping inadequate records, and prescribing medications without adequate evaluation, she carelessly or repeatedly failed to conform to generally accepted nursing standards; and

iii. **Board Rule 217.12(4)** because her routine practice of prescribing high doses of controlled substances in dangerous combinations constituted careless or repetitive conduct that could endanger a client's life, health or safety.

c. Code § 301.452(b)(13) (Minimum Standards of Nursing Practice)

Respondent is subject to sanction because she violated basic standards of nursing practice, specifically:

i. **Board Rule 217.11(1)(A)** by practicing in a manner that indicated a lack of knowledge about the applicable rules and laws (such as the reclassification of hydrocodone, discussed under Charge II, below);

ii. **Board Rule 217.11(1)(B)** by repeatedly prescribing controlled substances without proper assessments and treatment plans, thereby failing to promote a safe environment for clients and others; and

iii. **Board Rule 217.11(1)(C)** because she repeatedly prescribed high doses of controlled substances in potentially dangerous combinations, which is conduct that demonstrated a lack of knowledge or failure to correctly apply knowledge of the rationale for and effects of medications.

Respondent also violated standards of practice specific to APRNs:

iv. **Board Rule 221.13(a)** by practicing in a manner that indicated a lack of knowledge about the rules and laws applicable to her APRN role (such as documentation of collaboration);

v. **Board Rule 221.13(b)** because by failing to meet the standard of care in pain management, she failed to practice within the advanced specialty and role appropriate to her advanced educational preparation;

vi. **Board Rule 221.13(d)** by not properly using protocols or other written authorization evidenced in the records when delivering medical aspects of care;

vii. **Board Rule 222.8** while at Prillennium, by prescribing a controlled substance beyond an initial 90-day period without consulting with the delegating physician and documenting the collaboration in the medical record;[190]

[190] As discussed above, the evidence does not show Respondent saw patients at Ultimate Choice for more than three months. Therefore, the ALJ does not find a violation of prior Board Rule 222.6.

viii. **Board Rule 217.11(4)(A)** by practicing in an advanced practice role in a fashion inconsistent with Board Rules Chapter 221; and

ix. **Board Rule 217.11(4)(B)** by practicing in an advanced practice role in a fashion inconsistent with Board Rules Chapter 222.

B. Charge II

Staff proved by a preponderance of the evidence that Respondent prescribed hydrocodone after it was reclassified from Schedule III to Schedule II on October 6, 2014. Although Staff's formal Charge alleged that these prescriptions were issued from October 7 to December 12, 2014, this period was narrowed at hearing to October 27 to December 12, 2014. Staff established that in the 20-day period from October 7-27, 2014, Respondent stopped prescribing hydrocodone in favor of prescribing acetaminophen with codeine.[191] On October 27, 2014, Respondent resumed writing prescriptions for hydrocodone.

Respondent testified at hearing about her confusion regarding conflicting information from DEA and DPS. She did not contact her own licensing Board for more information, however. Also, the abrupt cessation of hydrocodone prescriptions on October 7, and resumption on October 27, 2014, indicates either that Respondent misinterpreted the law or that she chose deliberately to ignore it. Either way, Respondent exceeded her prescriptive authority. She did not qualify for an exemption to prescribe Schedule II drugs because Prillennium was not a hospital or hospice. Respondent began having Dr. Blanchette sign Schedule II prescriptions on November 18, 2014, but Respondent was the one who formulated the treatment plans and no collaboration with Dr. Blanchette was documented in the records.

Respondent's conduct reflects a failure, inability, or unwillingness to understand and conform to the law applicable to prescriptions of controlled substances, which is a failure to meet minimum standards of practice for RNs and APRNs, thereby violating Board Rules 217.11(1)(A)

[191] Staff Ex. 7a at 153-57.

and 221.13(a). These rule violations subject Respondent to discipline pursuant to Code § 301.452(b)(1) and (13).[192]

C. Charge III

Staff charged that Respondent owned and operated a pain management clinic without authorization between September 2013 and January 2015. It appears from Respondent's testimony at hearing that she actually opened Prillennium in December 2013.

Throughout the December 2013 to January 2015 period, the TMB defined a pain management clinic as a facility at which a majority of patients receive monthly prescriptions for opioids, benzodiazepines, barbiturates, or carisoprodol. Code § 168.101, enforced by the TMB, requires pain management clinics to hold a certificate before operating in Texas.

Respondent made vague claims that the prescription records obtained by Staff from DPS did not reflect the entirety of her practice, and she alluded to patients she treated for hypertension, diabetes, and other ailments. She denied telling Ms. Cole and the TMB investigators that 100% of Prillennium patients were treated for pain. However, she did not explicitly deny that more than half of her patients received monthly prescriptions for opioids, Xanax, and/or Soma. She agreed that the PAT report reflected 8,614 prescriptions for controlled substances between December 1, 2013, and December 19, 2014, almost all for combinations of hydrocodone, Xanax, and/or Soma.

The evidence produced by Staff is credible and persuasive. Ms. Cole is a federal employee who has no personal connection to this case and no reason to falsify her testimony. Respondent's admissions, the pharmacy records, and the PAT report establish by a preponderance that the vast majority of patients seen at Prillennium were pain patients who received monthly prescriptions for an opioid and/or Xanax and/or Soma. The evidence established that Prillennium was a pain management clinic.

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[192] Staff alleged violations of a number of other rules and of Code § 301.452(b)(10). The clearest link between the facts and the law establishes the violations discussed above. The other provisions overlap, or do not directly address the conduct in a distinct manner, so the ALJ finds a separate analysis is not warranted.

An exemption from the TMB's certification requirement applied to an APRN who "treats patients in her area of specialty and uses other forms of treatment with the issuance of a prescription." There is some slippage in the applicable language, because in January 2014, the TMB added the words "who personally" before "uses." Also, in February 2014, the Board promulgated Board Rule 228.1, prohibiting an APRN from owning a pain management clinic unless it was exempt from the certification requirement of Code § 168, and specifying that the "other forms of treatment" had to be evidence-based, within the standard of care, and consistent with the treatment plan.

The changes in language do not affect the outcome in this case. Respondent told Ms. Cole that 1% of Prillennium patients received steroid injections that she administered directly. Otherwise, there is no evidence that Respondent provided alternative forms of treatment, whether personally or through other professionals at Prillennium. Therefore, the evidence established that Prillennium was not exempt from the certification requirements of Code § 168.101, because Respondent did not provide any treatment apart from writing prescriptions.

The ALJ concludes that Staff met its burden to show by a preponderance of the evidence that, between December 2013 and January 2015, Respondent owned and operated a pain management clinic without authorization to do so as an APRN. Respondent violated Board Rules 217.11(1)(A)-(B) and 228.1(i)(5). These rule violations subject Respondent to discipline pursuant to Code § 301.452(b)(1).[193]

D. Potential Sanctions

Code § 301.453 sets forth disciplinary options for the Board if it finds a licensee violated a provision of Code § 301.452(b). Code § 301.4531 requires the Board to adopt a schedule of disciplinary sanctions. The Board has done that through its Disciplinary Matrix (Matrix), found at Board Rule 213.33. The Matrix classifies offenses as first-, second-, third-, or fourth-tier, and

[193] Staff alleged that Respondent is subject to discipline pursuant to Code § 168.202. However, that provision is part of the enabling statute for the TMB, not the Board. Staff did not pursue the contention in its written closing arguments and the allegation is presumed to have been abandoned.

as sanction level I or II within each tier. The classification is based on the seriousness of the violation, the risk of harm, and any aggravating or mitigating factors. Administrative penalties are also available pursuant to Code §§ 301.501 and .502, and Board Rule 213.32.

In its written closing argument, Staff contended that revocation of all of Respondent's Licenses is the appropriate sanction. Staff also argued for an administrative penalty of $85,000. Staff arrived at that number by taking the salary Respondent testified she paid herself at Prillennium ($5,000) and multiplying it by the 17 months (September 2013 to January 2015) that Staff alleged Respondent operated Prillennium. The issue of an administrative penalty is discussed separately below.

Respondent, in her written closing argument, submitted that at most, any violations established by the evidence were traceable to deficiencies in her documentation of assessments and/or her mistaken but sincere attempts to comply with the change in classification of hydrocodone. She denied that she was operating a pain management clinic and asserted that she therefore had no requirement to obtain a certificate. On that basis, Respondent requested that no more than a Reprimand be issued with stipulations pertaining to her APRN License. She proposed that her prescriptive authority be revoked, but that she be permitted to continue working as an APRN. In the alternative, Respondent argued that only her APRN License should be revoked and she should be allowed to continue practicing with her RN License.

1. Sanctions under Code § 301.452(b)(1) (Violation of Act or Board Rules)

Staff met its burden to show that Respondent, with respect to all four Charges, violated a number of Board Rules. The Matrix is focused on violations of Code § 301.452(b)(1) that relate to prior Board orders, but the provision also applies to any violation of the Act or Board rules. Given the lack of specificity in the Matrix for this section, however, the ALJ focuses on analysis of the appropriate sanctions under Code § 301.452(b)(10) and (13).

2. Sanctions under Code § 301.452(b)(10) (Unprofessional Conduct)

Respondent's conduct was not an "isolated violation," so it is not within the first tier of offenses under Code § 301.452(b)(10). At hearing, Dr. Zych noted that sanction level II for a third tier offense is emergency suspension of a nurse's license(s), which was already imposed in Respondent's case. Therefore, Dr. Zych opined that Respondent should be treated as having committed a third tier, sanction level I offense meriting the sanction of revocation.

Third tier offenses include a failure to comply with a substantive Board rule regarding unprofessional conduct "resulting in serious patient harm." No patient harm was shown in this case. The third tier also encompasses sexual or sexualized contact with, physical abuse of, or financial exploitation of a patient, none of which was established. It is a closer question as to whether Respondent's conduct constitutes "[r]epeated acts of unethical behavior or unethical behavior which results in harm to the patient or public" or is "unethical conduct resulting in a material or financial loss to a patient [or] public in excess of $4,999.99."

Dr. Zych pointed out that Respondent was paid (an unknown amount) by Dr. Ramsey to work at Ultimate Choice, and at Prillennium, Respondent had financial gain in an amount of at least $5,000 per month (the salary that Respondent said she paid herself). That enrichment was a financial loss to patients and/or the public and thus merits a third tier classification, Dr. Zych said. She admitted, however, that there was no direct evidence of financial exploitation of, or losses to, patients or the public. In the alternative, Dr. Zych suggested a second tier, sanction level II classification, for which the sanction of revocation is still available.

The ALJ interprets "[r]epeated acts of unethical behavior or unethical behavior which results in harm to the patient or public" to mean that the conduct included either repeated acts of unethical behavior or unethical behavior that results in harm. This would cover Respondent's actions, which consisted of repeated acts of unprofessional prescribing. However, the first sentence in the Matrix under third tier offenses is "[f]ailure to comply with a substantive Board rule regarding unprofessional conduct resulting in serious patient harm." That sentence implies that serious harm must be shown.

In the absence of clarity, the ALJ finds that the second tier, which covers "unprofessional conduct resulting in serious risk to patient or public safety," is appropriate. The evidence indicates that Respondent prescribed dangerous cocktails of controlled substances at the maximum doses to a majority of patients, putting them at risk of liver damage, overdose, central sleep apnea, and even death. The risk of harm was clear.

Within a given tier, sanction level is determined by reference to aggravating and mitigating factors. The mitigating factors listed in the Matrix do not apply.[194] The ALJ finds that the large number of events and patient vulnerability are aggravating factors in this case.[195] The presence of these aggravating factors supports a sanction level II punishment, which includes license denial, suspension, or revocation.

In addition, the Board has included in Board Rule 213.33(c) a list of factors that the Board and SOAH shall consider in conjunction with the Matrix. That list is applicable to all of the offenses established by the evidence, so the ALJ will discuss it in a separate section below.

3. Sanctions under Code § 301.452(b)(13) (Minimum Practice Standards)

The most appropriate classification for Respondent's conduct under the Matrix for Code § 301.452(b)(13) is tier three. The first tier covers below-standard practice with a "low risk" of patient harm, and the second tier includes substandard practice with "patient harm or risk of patient harm." The third tier applies to substandard practice "with a serious risk of harm or death that is known or should be known" and acts or omissions that demonstrate a "level of incompetence such that the person should not practice without remediation and subsequent demonstration of competency."

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[194] The mitigating factors listed are "[v]oluntary participation in established or approved remediation or rehabilitation program and demonstrated competency, full restitution paid."

[195] The other possible aggravating factors are "level of material or financial gain, actual harm, severity of harm, prior complaints or discipline for similar conduct, involvement of or impairment by alcohol, illegal drugs, or controlled substances or prescription medications, criminal conduct."

Respondent's practice was striking in the uniformity of powerful controlled substances that she prescribed at the maximum strengths and dosages, both at Ultimate Choice and at Prillennium. As an APRN practicing in an area with a vulnerable population and prescribing potentially deadly medications, Respondent should have known of the serious risk of harm to her patients. If she did not understand that risk, the incompetence displayed would require that she be prevented from practicing until she demonstrates her fitness. If Respondent understood the risk but deliberately prescribed the medications, her conduct would be an "intentional act or omission that risks or results in serious harm," also a third tier offense.

The mitigating factors listed in the Matrix do not apply.[196] Although Respondent cited systemic issues (failure to promptly provide patient files) as an impediment at Ultimate Choice, she continued working there for at least three months. Systemic issues cannot be claimed as a problem at Prillennium, where Respondent had control of service delivery. Of the aggravating factors in the Matrix, the ALJ finds that the large number of events and patient vulnerability apply in this case.[197] Sanction level II under tier three is emergency suspension of license(s), which has already been instituted. Therefore, the ALJ finds that sanction level I applies, and the possible sanctions include license denial, suspension, revocation, or request for voluntary surrender.

4. Application of Factors in Board Rule 213.33(c)

The Board has listed factors in Board Rule 213.33(c) that the Board and the ALJ shall consider in conjunction with the Matrix when determining tier and sanction level of an offense as

[196] The mitigating factors listed are "[o]utcome not a result of care, participation in established or approved remediation or rehabilitation program and demonstrated competency, systems issues."

[197] The full list is "[n]umber of events, actual harm, impairment at time of incident, severity of harm, prior complaints or discipline for similar conduct, patient vulnerability, failure to demonstrate competent nursing practice consistently during nursing career."

well as in determining the appropriate penalty and/or sanction in disciplinary matters.[198] Of those factors, the ALJ finds relevant the following:

a. Evidence of Actual or Potential Harm to Patients, Clients, or the Public

Respondent's conduct posed a risk of substantial harm to patients and possibly to the general public if the medications she prescribed were diverted for illicit sale.

b. Evidence of a Lack of Truthfulness or Trustworthiness

Respondent's testimony in several areas was vague, evasive, and difficult to credit. She made claims about treating patients for conditions other than pain, which the evidence simply does not support. She would not agree that the DPS prescription report reflected her prescribing history, saying that was only what was shown "on paper." And, it is hard to accept Respondent's assertion that Dr. Blanchette had two other clinics but neglected her own patients in favor of being available full-time to sign prescriptions at Prillennium.

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[198] The full list of factors is as follows: "(1) evidence of actual or potential harm to patients, clients, or the public; (2) evidence of a lack of truthfulness or trustworthiness; (3) evidence of misrepresentation(s) of knowledge, education, experience, credentials, or skills which would lead a member of the public, an employer, a member of the health-care team, or a patient to rely on the fact(s) misrepresented where such reliance could be unsafe; (4) evidence of practice history; (5) evidence of present fitness to practice; (6) whether the person has been subject to previous disciplinary action by the Board or any other health care licensing agency in Texas or another jurisdiction and, if so, the history of compliance with those actions; (7) the length of time the person has practiced; (8) the actual damages, physical, economic, or otherwise, resulting from the violation; (9) the deterrent effect of the penalty imposed; (10) attempts by the licensee to correct or stop the violation; (11) any mitigating or aggravating circumstances, including those specified in the Disciplinary Matrix; (12) the extent to which system dynamics in the practice setting contributed to the problem; (13) whether the person is being disciplined for multiple violations of the [Act] or its derivative rules and orders; (14) the seriousness of the violation; (15) the threat to public safety; (16) evidence of good professional character as set forth and required by [Board Rule] 213.27 of this chapter (relating to Good Professional Character); (17) participation in a continuing education course described in [Board Rule] 216.3(f) of this title (relating to Requirements) completed not more than two years before the start of the Board's investigation, if the nurse is being investigated by the Board regarding the nurse's selection of clinical care for the treatment of tick-borne diseases; and (18) any other matter that justice may require."

c. Evidence of Practice History

The evidence indicates a consistently substandard level of practice in pain management from 2011 through January 2015, when Respondent's Licenses were suspended.

d. Evidence of Present Fitness to Practice

Respondent should not be permitted to continue her dangerous prescribing practices as an APRN. Her fitness to practice as either an APRN or as an RN is also in question, given her substandard assessments and patient histories.

e. Previous Disciplinary Action by the Board or Other Jurisdiction

It is a point in Respondent's favor that there is no evidence that the Board (or any other authority with jurisdiction over Respondent's Licenses) has disciplined her in the past.

f. Deterrent Effect of the Penalty Imposed; Multiple Violations of the Act and Board Rules; Serious Violations; Risk to Public Safety

These factors are discussed below, in the analysis of an appropriate administrative penalty.

Based on the applicable (overwhelmingly negative) factors from Board Rule 213.33(c), the ALJ finds that a significant sanction is appropriate and recommends revocation of Respondent's Licenses.

5. Administrative Penalty

As discussed above, Staff requested an administrative penalty, and suggested a fine of $85,000, based on Respondent's monthly salary at Prillennium ($5,000) multiplied by the

17 months that Staff alleged Respondent operated Prillennium.[199] Staff noted that there are multiple ways of deriving an administrative penalty, given that Code § 301.501 permits a penalty of up to $5,000 per violation and Code § 301.502 permits each day a violation continues or occurs to be treated as a separate violation.[200] Other possibilities proposed by Staff include basing the penalty on the number of patients in the sample reviewed by Dr. Owen; the 410 hydrocodone prescriptions issued by Respondent and/or Dr. Blanchette from Prillennium after October 6, 2014; or each day that Respondent operated an uncertified pain management clinic. Regardless of how the fine is calculated, Staff requested imposition of a substantial penalty for a deterrent effect on Respondent as well as other nurses.

Respondent's violations were serious, presented a significant risk to public safety, and were numerous. There is no indication of sincere attempts to correct the violations. The ALJ agrees that a significant fine is appropriate for these reasons, as well as for the deterrent effect it can have. The ALJ does not, however, endorse the use of Respondent's claimed salary as a basis for calculating the fine. Although Respondent's practice did have many features of what Dr. Owen would deem a pill mill, it is not possible based on the available evidence to determine that the full $5,000 of Respondent's profit per month constituted unjust enrichment.

Also, even though Respondent's conduct posed a high risk of harm to patients and (if the drugs were illicitly distributed) to public safety, no actual physical harm was shown, and any financial harm is not quantifiable. Staff did not provide any indication of the Board's prior practice or written policies with respect specifically to administrative fines in the context of this type of case, and the ALJ is unaware of such. For those reasons, the ALJ does not recommend the maximum fine of $5,000 per violation.

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[199] Based on Respondent's testimony that she opened Prillennium in December 2013, this fine would be $70,000 rather than $85,000 as calculated by Staff.

[200] Code § 301.502 states that the amount of the penalty shall be based on "(1) the seriousness of the violation, including: (A) the nature, circumstances, extent, and gravity of any prohibited acts; and (B) the hazard or potential hazard created to the health, safety, or economic welfare of the public; (2) the economic harm to property or the environment caused by the violation; (3) the history of previous violations; (4) the amount necessary to deter a future violation; (5) efforts made to correct the violation; and (6) any other matter that justice may require."

The ALJ proposes instead that the Board fine Respondent $2,500 for every month that she operated Prillennium after Board Rule 228.1 was promulgated (prohibiting APRNs from owning pain management clinics unless exempt from certification). The rule took effect February 23, 2014, and Respondent testified that she no longer saw patients at Prillennium after the TMB investigation on January 22, 2015. A fine of $2,500 per month for the 11-month period would total $27,500, which is a substantial administrative penalty.

E. Conclusion and Recommendation

For the reasons set forth above, the ALJ finds that Staff established by a preponderance of the evidence that Respondent committed the acts alleged in Charges I-IV. The conduct constitutes violation of Board Rules 217.11(1)(A)-(C) and (4); 217.12(1)(A)-(B) and (4); 221.13(a), (b), and (d); 222.8; and 228.1(i)(5). The rule violations subject Respondent to discipline pursuant to Code § 301.452(b)(1), (10), and (13). As discussed above, the ALJ recommends that the Board find a second tier, sanction level II violation of Code § 301.452(b)(10), and a third tier, sanction level I violation of Code § 301.452(b)(13). The ALJ recommends revocation of Respondent's Licenses; an award of administrative costs of the hearing against Respondent in the amount of $2,565.20; and imposition of an administrative penalty against Respondent in the amount of $27,500.

VI. FINDINGS OF FACT

1. Prianglam Brooks (Respondent) holds two licenses issued by the Texas Board of Nursing (Board): Permanent Advanced Practice Registered Nurse License No. AP119040 (APRN License) and Permanent Registered Nurse License No. 784525 (RN License). Respondent was granted prescriptive authority by the Board in May 2010 (together with the APRN License and the RN License, the Licenses).

2. From February to April 2011, Respondent worked at Ultimate Choice Medical & Rehab Clinic, L.L.C. in Houston, Texas (Ultimate Choice), where her delegating physician was Edward Ramsey, M.D.

3. From December 2013 to January 2015, Respondent treated patients at her wholly-owned clinic, Prillennium Healthcare, in Houston, Texas (Prillennium). During this period, Respondent's delegating physician was Katherine Blanchette, M.D.

4. At Ultimate Choice, Respondent repeatedly prescribed high doses of hydrocodone, Soma (carisoprodol), and/or Xanax (alprazolam) in combinations, to the majority of patients she saw.

5. Between December 1, 2013, and December 19, 2014, while practicing at Prillennium, Respondent wrote prescriptions for 8,614 controlled substances, almost uniformly combinations of hydrocodone, Soma, and/or Xanax, and almost always at the highest strength, dose, and quantity available for such drugs.

6. Combinations of hydrocodone, Soma, and/or Xanax account for over half of the accidental lethal drug overdoses in the United States, as measured by federal authorities.

7. In her practice at both Ultimate Choice and Prillennium, Respondent's actions with respect to numerous patients reflected that Respondent:

   a. failed to conduct adequate patient assessments, including obtaining prior medical records and conducting problem-focused examinations appropriate to the complaints of pain;

   b. did not prepare treatment plans properly tailored to each patient's needs and clinical presentation;

   c. did not adequately collaborate with her delegating physician and/or properly document that collaboration in the medical records;

   d. neglected to monitor patients for side effects of chronic treatment with opioid medications, rule out comorbid conditions, and implement urine drug testing to monitor compliance with treatment plans; and

   e. maintained inadequate and incomplete medical records as shown by diagnoses that were unsupported by the physical findings, prescriptions for Xanax without findings of anxiety, and unrealistic reports of pain relief from medication that were not questioned.

8. On October 6, 2014, hydrocodone, formerly a Schedule III controlled substance, was reclassified as a Schedule II drug.

9. APRNs do not have authority to prescribe Schedule II drugs except in specific practice settings that did not apply to Respondent.

10. From October 7-27, 2014, Respondent ceased writing prescriptions for hydrocodone, indicating that she understood the change in the law.

11. Between October 27 and November 18, 2014, Respondent again wrote and signed prescriptions for hydrocodone.

12. Between November 18 and December 12, 2014, Respondent wrote prescriptions for hydrocodone that were signed by Dr. Blanchette on a triplicate prescription pad that is required to be used for Schedule II drugs, but on which only Respondent's Drug Enforcement Administration (DEA) registration was preprinted.

13. No collaboration between Respondent and Dr. Blanchette was documented in the medical records for patients seen between November 18 and December 12, 2014.

14. The vast majority of patients at Prillennium were treated for pain and received prescriptions for hydrocodone and/or Soma and/or Xanax. Those patients did not receive alternative treatments at Prillennium.

15. Prillennium was a pain management clinic.

16. Respondent operated Prillennium between December 2013 and January 22, 2015, without obtaining certification as a pain management clinic from the Texas Medical Board (TMB).

17. The TMB and DEA served a subpoena at Prillennium on January 22, 2015, after which date Respondent did not see any more patients at Prillennium.

18. On February 17, 2015, the Board issued an Order of Temporary Suspension of Respondent's Licenses, pursuant to Texas Occupations Code § 301.455.

19. Also on February 17, 2015, the Board referred this matter to the State Office of Administrative Hearings (SOAH). The staff (Staff) of the Board filed Formal Charges against Respondent and sent her a Notice of Probable Cause Hearing scheduled to convene on March 5, 2015.

20. The Notice of Probable Cause Hearing and the Formal Charges contained a statement of the time, place, and nature of the probable cause hearing; a statement of the legal authority and jurisdiction under which the probable cause hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

21. After a continuance was granted at Respondent's request, the probable cause hearing convened on March 11, 2015.

22. On April 7, 2015, after written briefing by the parties, the Administrative Law Judge (ALJ) issued an order upholding the temporary suspension of Respondent's Licenses.

23. On November 13, 2015, Staff issued a Notice of Hearing on the Merits to Respondent, together with First Amended Formal Charges.

24. The Notice of Hearing on the Merits and the First Amended Formal Charges contained a statement of the time, place, and nature of the hearing on the merits; a statement of the

legal authority and jurisdiction under which the hearing on the merits was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

25. On January 26, 2016, ALJ Pratibha J. Shenoy convened the hearing on the merits at SOAH's Austin hearings facility, 300 West 15th Street, Fourth Floor, Austin, Texas. Assistant General Counsel John R. Griffith represented Staff, and Respondent was represented by attorney Mark M. Meyer. The record closed on April 1, 2016, after the parties submitted written closing arguments.

26. The administrative costs of conducting this contested case proceeding are $2,565.20.

VII. CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter. Tex. Occ. Code ch. 301.

2. SOAH has jurisdiction over the hearing in this proceeding, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Tex. Gov't Code ch. 2003.

3. Respondent received proper notice of the hearing on the merits. Tex. Occ. Code § 301.454; Tex. Gov't Code §§ 2001.051-.052.

4. Staff had the burden of proof by a preponderance of the evidence. 1 Tex. Admin. Code § 155.427.

5. The preponderance of the evidence established that Respondent's treatment of patients at both Ultimate Choice (Staff's First Amended Formal Charge IV) and at Prillennium (Staff's First Amended Formal Charge I) constituted unprofessional conduct in violation of the Board's rules, specifically, rules found in 22 Texas Administrative Code § 217.12(1)(A)-(B) and (4).

6. The preponderance of the evidence established that Respondent's treatment of patients at both Ultimate Choice (Staff's First Amended Formal Charge IV) and at Prillennium (Staff's First Amended Formal Charge I) constituted a failure to meet minimum standards of nursing and advanced practice nursing, in violation of the Board's rules, specifically, rules found in 22 Texas Administrative Code §§ 217.11(1)(A)-(C) and (4); 221.13(a), (b), and (d); and 222.8 (for the period beginning November 20, 2013).

7. The preponderance of the evidence established that, while practicing at Prillennium between October 27 and November 18, 2014, Respondent exceeded her prescriptive authority by writing and signing prescriptions for hydrocodone. The preponderance of the evidence also established that, while practicing at Prillennium between November 18 and December 12, 2014, Respondent wrote prescriptions for hydrocodone that were signed by Dr. Blanchette, but Respondent did not document collaboration with Dr. Blanchette in the medical records for this period. Respondent's conduct during the

October 27 to December 12, 2014 period (Staff's First Amended Formal Charge II) exceeded her prescriptive authority with respect to hydrocodone. Respondent violated Board rules found at 22 Texas Administrative Code §§ 217.11(1)(A) and 221.13(a).

8. The preponderance of the evidence established that between December 2013 and January 2015, Respondent owned and operated a pain management clinic without certification from the TMB and without authorization to do so as an APRN (Staff's First Amended Formal Charge III). Respondent's conduct violated Board rules found at 22 Texas Administrative Code §§ 217.11(1)(A)-(B) and 228.1(i)(5).

9. Respondent's conduct with respect to Staff's First Amended Formal Charges I-IV violated Texas Occupations Code chapter 301 or a rule or regulation not inconsistent with that chapter, thereby subjecting Respondent to potential disciplinary action pursuant to Texas Occupations Code § 301.452(b)(1).

10. With respect to Staff's First Amended Formal Charges I, II, and IV, Respondent engaged in unprofessional or dishonorable conduct that was likely to deceive, defraud, or injure a patient, thereby subjecting Respondent to potential disciplinary action pursuant to Texas Occupations Code § 301.452(b)(10).

11. With respect to Staff's First Amended Formal Charges I, II, and IV, Respondent failed to adequately care for patients or to conform to the minimum standards of acceptable nursing practice in a manner that exposed her patients unnecessarily to a risk of harm, thereby subjecting Respondent to potential disciplinary action pursuant to Texas Occupations Code § 301.452(b)(13).

12. The Board is authorized to recover costs of a contested case proceeding pursuant to Texas Occupations Code § 301.461.

13. The Board may impose an administrative penalty on a licensee who violates Texas Occupations Code chapter 301 or a rule or order adopted under that chapter, pursuant to Texas Occupations Code § 301.501. The amount of the penalty is determined in accordance with Texas Occupations Code § 301.502.

14. Based on the factors set out in the Board's disciplinary matrix found at 22 Texas Administrative Code § 213.33, revocation of Respondent's Licenses is an appropriate sanction for her conduct.

15. Based on Texas Occupations Code §§ 301.501-.502 and the factors set out in the Board's disciplinary matrix found at 22 Texas Administrative Code § 213.33, an administrative penalty is an appropriate sanction in this case.

VIII. RECOMMENDATION

Based on the above Findings of Fact and Conclusions of Law, the ALJ recommends that the Board revoke Respondent's Licenses, assess contested case hearing costs of $2,565.20 against her, and require her to pay an administrative penalty of $27,500.

SIGNED May 23, 2016.

Pratibha J. Shenoy

PRATIBHA J. SHENOY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

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Law Office of Marc Meyer, PLLC

Texas Nursing & EMS Lawyer

Marc M. Meyer, RN, LP, MS, JD Principal Office, Magnolia, TX

June 10th, 2016

To: Docketing, State Office of Administrative Hearings

Re: In the Matter of Advanced Practice Nurse Prianglam Brooks

Please see the attached excpetions to the proposal for decision in this matter. If you have any questions, call me at (281) 259-7575. Thank you,

Marc M. Meyer, RN, JD
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DOCKET NO. 507-15-2425

IN THE MATTER OF	§	
PERMANENT CERTIFICATE NUMBERS	§	**BEFORE THE TEXAS STATE**
AP119040 & 784525	§	
ISSUED TO PRIANGLAM BROOKS,	§	**OFFICE OF ADMINISTRATIVE HEARINGS**
RESPONDENT	§	

RESPONDENT'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

TO THE HONORABLE ADMINISTRATIVE LAW JUDGE:

NOW COMES the Respondent, Prianglam Brooks, through his attorney, to file these Exceptions to the Proposal for Decision.

EXCEPTIONS

Findings of Fact Nos. Fourteen (14) and Fifteen (15): The Respondent excepts to Finding of Fact Nos. Fourteen (14) AND Fifteen (15) as not supported by the evidence in the record. Finding of Fact No. Fourteen (14) states that "[t]he vast majority of patients at Prillennium were treated for pain and received prescriptions for hydrocodone and/or Soma and/or Xanax. Those patients did not receive alternative treatments at Prillennium."[1] Finding of Fact No. Fifteen (5) ostensibly follows, holding that "Prillennium was a pain management clinic."[2] As support for these findings, Administrative Law Judge Shenoy discussed the testimony from Ms. Cole, the DEA investigator, the testimony of the Respondent and the prescription reports.[3] However, what the testimony did not directly address, nor did any documentary evidence show, was how many patients were seen at Prillennium, a necessary component to determine if more than half of the patients seen were prescribed medications that would require the certification as a pain management clinic.

In the absence of the denominator in this equation, any finding that a "vast majority" of patients seem at Prillennium were treated for pain is wildly speculative, at best. Staff's argument

[1] Proposal for Decision (PFD), at 53.

[2] *Id.*

[3] *Id.*, at 42.

that the practice treated over 50% of patients for pain was based on the alleged admission to Ms. Cole, which the Respondent adamantly denied making.[4] Staff attempts to argue that the DPS profile supposedly indicates that more than half of the patients at Prillennium were treated for pain, but again that is only based on the prescriptions written for those controlled substances and not prescriptions written for other conditions, which would not show up on the DPS reports. And any arguments that the Respondent did not provide alternative therapies for pain directly is irrelevant unless that 50% threshold is met. Keeping in mind that the agency has the burden of proof to provide evidence which shows that more that the practice treated more than 50% of the patients for pain,[5] Respondent argues that Staff failed to provide the most basic of evidence related the actual numbers of patients treated at Prillennium, and thus any finding of fact that indicates a majority of patients were prescribed controlled substances is incorrect, as is any finding of fact which relies on that fact. Therefore, the Respondent argues that Findings of Fact Nos. Fourteen (14) and Fifteen (15) should be deleted from the PFD.

Conclusion of Law No. Eight (8): The Respondent excepts to Conclusion of Law No. Eight (8) as not supported by a preponderance of the evidence. Conclusion of Law rests on Findings of Fact Nos. Fourteen (14) and Fifteen (15) to conclude that the Respondent operated a pain management clinic without certification from the Texas Medical Board in violation of 22 TEXAS ADMINISTRATIVE CODE §§217.11(1)(A) – (B) and 228.1(i)(5).[6] The Respondent argues that based on the arguments above that Findings of Fact Nos. Fourteen (14) and Fifteen (15) should be deleted from the PFD, Conclusion of Law No. Eight (8) is also incorrect and should be deleted from the PFD.

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[4] Final Hearing Transcript ("Hearing Tr."), at 31. While the Respondent admitted that she could not recall if more or less than 50% of the patients were seen for pain, she denied even speaking with Ms. Cole about that issue. *Id.*, at 33. There is also no tape of the alleged interview because apparently either the DEA or the Texas Medical Board don't make it a practice to tape these interviews. Probable Cause Hearing Transcript ("PC Tr."), at 23.

[5] See PFD, at 54, Conclusion of Law No. Four (4); 1 TEXAS ADMINISTRATIVE CODE §155.427.

[6] PFD, at 55.

Finding of Fact No. Thirteen (13): The Respondent excepts to Finding of Fact No. Thirteen (13) as not supported by the evidence in the record. Finding of Fact No. Thirteen (13) asserts that there was no collaboration documented in the medical records between November 18th and December 12th, 2014. What is unclear about this is where this is required by statute, Board Rule or policy position. Nor was there any specific testimonial evidence from Dr. Zych related to where this documentation of collaboration was required to be in the medical record specifically, and not in other documents that may or may not have been entered into evidence. Therefore, the Respondent argues that Finding of Fact No. Thirteen (13) as not supported by the evidence in the record and should be deleted.

Conclusion of Law No. Seven (7): The Respondent excepts to Conclusion of Law No. Seven (7) as not supported by a preponderance of the evidence. Conclusion of Law No. Seven (7) holds in part that the Respondent wrote prescriptions that were signed by Dr. Blanchette, but there was no collaboration documented with Dr. Blanchette in the medical record. Based on the arguments above with regards to Finding of Fact No. Thirteen (13), the Respondent argues that this requirement for documentation of collaboration in the medical record was not supported by the evidence and that to the extent that this supports a finding of a violation of 22 TEXAS ADMINISTRATIVE CODE §§217.11(1)(A) and 221.13(a), Conclusion of Law No. Seven should be modified to delete such references to Finding of Fact No. Thirteen (13).

Further, the Respondent argues that the prescriptions written between October 27th and November 18th, 2014 reflect a confusion over the status of the law surrounding her ability to write prescriptions for hydrocodone, which was newly rescheduled in Schedule II. The Respondent testified to the lack of guidance she was given by DPS[7] and the DEA[8] when she attempted to clear up her understanding of her authority to prescribe schedule II drugs. The Respondent asserts that she was making good faith efforts to understand the new rules and that once she understood that she was not authorized to sign prescriptions for Schedule II

[7] Hearing Tr., at 69–71.

[8] *Id.*, at 71.

medications, she stopped writing those prescriptions.[9] Therefore, the Respondent asserts that any violations related to prescribing hydrocodone after October 6th, 2016 should be considered in light of this confusion and Conclusion of Law No. Seven (7) should reflect that fact.

Recommended Sanction: The Respondent excepts to the Sanction Recommendation asserted by the Administrative Law Judge (ALJ) in that a sanction of a Revocation of all of her nursing licenses is not justified as all of the evidence presented relates to the advanced practice of the Respondent and not at all to the basic nursing license functions. The only mention of issues related to the Respondent's RN license are scattered sentences stating that the Respondent failed to meet the standards of nursing practice,[10] but there was little or no discussion regarding how the alleged failures related to basic nursing practice outside of assessment and documentation. Specifically, the Respondent asserts that all of the findings of fact relate directly to the prescription of certain controlled substances.[11] There is little evidence, none really beyond the speculation of Dr. Zych,[12] that the Respondent's practice as an APRN is a problem beyond the allegations in this case. Even Dr. Owen declined to offer an opinion as to the APRN standard for patients other than pain management patients.[13]

In addition, there was no discussion of the disciplinary matrix factors in relation to the Respondent's RN license, which the Respondent asserts would lead to a different conclusion. And given the presence of certain mitigating factors, such as the facts there was no evidence of actual harm to patients, no evidence of prior disciplinary actions or other evidence of continuing practice issues, and the length of the Respondent's practice history, the Respondent asserts that a proper sanction for her RN license is no greater than a reprimand with stipulations, consistent with a tier two, sanction level I offense and with stipulations to include no more than indirect supervision and other stipulations to be determined by the Board of Nursing.

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[9] *Id.*, at 72–73.

[10] See e.g. PFD, at 54, Conclusion of Law No. Six (6).

[11] *Id.*, at 51–54.

[12] PC Tr., at 115–16.

[13] *Id.*, at 102.

PRAYER FOR RELIEF

Respondent, Prianglam Brooks prays that the honorable Administrative Law Judge:

1. Delete Findings of Fact Nos. Thirteen (13), Fourteen (14) and Fifteen (15);
2. Delete Conclusion of Law No. Eight (8);
3. Change Conclusion of Law No. Seven (7) consistent with the arguments contained above;
4. Change the Sanction Recommendation from a revocation to a Reprimand with Stipulations, supervision not to exceed indirect supervision, and with other stipulations to be determined by the Texas Board of Nursing; AND
5. Propose to the Texas Board of Nursing in a Decision all relief at law or in equity to which Respondent is entitled.

Respectfully submitted,

By: Marc M Meyer

Marc M. Meyer
State Bar No. 24070266
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CERTIFICATE OF SERVICE

This is to certify that on the 10th day of June, 2016, a true and correct copy of the above and foregoing document was served on the following individual(s) at the location(s) and in the manner indicated below:

Docketing Division
State Office of Administrative Hearings
William P. Clements Building
300 W. 15th Street, Suite 504
Austin, TX 78701-1649
VIA FACSIMILE AT 512-322-2061

John Griffith, Assistant General Counsel
Texas Board of Nursing
333 Guadalupe, Suite 3-460
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VIA FACSIMILE AT 512-305-8101

Marc M Meyer
Marc M. Meyer

Texas Board of Nursing

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Phone: (512) 305 7400 Fax: (512) 305-7401 www.bon.texas.gov

Katherine A. Thomas, MN, RN, FAAN
Executive Director

June 23, 2016

Administrative Law Judge
State Office of Administrative Hearings
P.O. Box 13025
Austin, TX 78711-3025

Via Electronic Filing

RE: In the Matter of Permanent Certificate Nos. **AP119040 & 784525**
Issued to **PRIANGLAM BROOKS**
SOAH Docket No. **507-15-2425**

Dear Judge:

Enclosed please find ***Staff's Response to Respondent's Exceptions to the Proposal for Decision.***

By copy of this letter, I am forwarding a copy of this document to Respondent's counsel.

Please feel free to contact me at (512) 305-8658, should you have any questions and/or concerns regarding this case.

Thank you in advance for your time and assistance with this matter.

Very truly yours,

John R. Griffith
Assistant General Counsel

JRG/cp
Enclosure

cc: Prianglam Brooks
c/o Marc Meyer, Attorney
33300 Egypt Lane, Suite C600
Magnolia, Texas 77354

Via Fax: (866) 839-6920

DOCKET NO. 507-15-2425

In the Matter of	§	BEFORE THE
Permanent Advanced Practice	§	
Registered Nurse License No. AP119040	§	
With Prescription Authorization No. 10237	§	STATE OFFICE OF
and Permanent Registered Nurse	§	
License No. **784525**	§	
Issued to **PRIANGLAM BROOKS,**	§	ADMINISTRATIVE
Respondent	§	HEARINGS

STAFF'S RESPONSE TO RESPONDENT'S EXCEPTIONS TO THE PROPOSAL FOR DECISION

COMES NOW, the Staff of the Texas Board of Nursing (hereinafter "Staff" or "Board") submits its response to Respondent's exceptions, as follows:

Response to Respondent's Exception to Findings of Fact Nos. Fourteen (14) and Fifteen (15), and Conclusion of Law No. Eight (8)

Staff agrees with the Administrative Law Judge's (ALJ) original Findings of Fact and Conclusion of Law. Finding of Fact No. Fourteen (14), as the ALJ notes in the PFD,[1] is framed by Occupations Code § 168.101, which requires pain management clinics to be certified. First, Respondent's clinic was not registered, and when interview, DEA Diversion Investigator Jami Cole testified that Respondent admitted that 100% of her patients were being treated for pain.[2]

Second, besides Respondent's admission, the Prescription Access Texas (PAT) report produced by the Texas Department of Public Safety (DPS) reflected 8,614 prescriptions between December 1, 2013, and December 19, 2014, almost all of which were hydrocodone, Xanax, and/or Soma combinations. Dr. Owen's testimony and report, the pharmacy records, and the PAT report, all support the same cocktail prescribing pattern for the majority of patients. And while Respondent denied making an admission to Ms. Cole, the ALJ considered the truthfulness of Ms. Cole's testimony, and found it credible.

Further, Respondent was not exempt from having her clinic certified with TMB, as she admitted to Ms. Cole that only 1% of patients received steroid injections that Respondent personally administered.[3] And Respondent admitted at hearing that if her clinic was open in the Fall of 2014, she was more than likely prescribing combinations of hydrocodone and Soma.[4] Nothing in the medical records reviewed by Dr. Owen, or Respondent's own testimony, suggests

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[1] Proposal for Decision (PFD), at 42.

[2] Transcript, Probable Cause Hearing, at 16.

[3] PFD, at 43.

[4] Transcript, Final Hearing, page 200, lines 3-24.

she personally performed other modalities that might exempt her from having her pain management practiced certified with TMB. The evidence at hearing demonstrated Respondent was the owner and operator of an uncertified pain management clinic.

Therefore, Staff respectfully asks that Respondent's Exceptions to Findings of Fact Nos. Fourteen (14) and Fifteen (15), and the corresponding Conclusion of Law No. Eight (8), be denied.

Response to Respondent's Exception to Findings of Fact Nos. Thirteen (13) and Conclusion of Law No. Seven (7)

Staff agrees with the Administrative Law Judge's (ALJ) original Finding of Fact and corresponding Conclusion of Law. At both the Probable Cause and Final Hearings, Dr. Owen and Dr. Zych testified about the necessity for documentation in the medical record. Documentation in the medical record is required to establish and meet the standard of care. Respondent claims there is a lack of specificity regarding where the documentation of collaboration is required, but at no point during either proceeding, either by Staff's experts or Respondent, was anything beyond the medical records discussed. The experts testified that the medical record is where a provider documents, and any evidence of collaboration should be in the medical record itself.

Finding of Fact No. Thirteen (13) correctly states that no evidence of collaboration between Respondent and Dr. Blanchette was documented in the medical records for patients seen between November 18 and December 12, 2014. That Finding itself does not appear to actually be in dispute. Respondent seems to suggest there was other documentation outside of the medical record, but there was no evidence of that presented at hearing, and no explanation for why such documentation would have been excluded. Given that Respondent provided the medical records herself, there is little reason to believe the medical records were incomplete.

Conclusion of Law No. Seven (7) concerns Respondent exceeding her prescriptive authority between October 27 and November 18, 2014, by writing and signing hydrocodone prescriptions, then a Schedule II narcotic, after October 6, 2014, and in violation of state and federal law. Conclusion of Law No. Seven (7) also finds Respondent exceeded her prescriptive authority by having her delegating physician sign prescriptions without any documentation of collaboration/consultation. At both hearings, Dr. Owen failed to find any evidence of collaboration between Respondent and her delegating physician. At the Probable Cause Hearing, Dr. Zych found it concerning that a physician would sign a prescription without discussing the patient or seeing the patient.[5] Dr. Zych's opinion was based on the complete lack of documentation in the medical record of any discussion by Respondent with her delegating physician.[6] There was no documentation that the delegating physician even reviewed the records or signed off on the records.[7] This is compounded by the fact that Respondent allowed her delegating physician to use Respondent's triplicate prescription pad, regardless of whether Respondent's mere possession of such a pad was lawful.

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[5] Transcript, Probable Cause Hearing, at 123-124.

[6] *Id.*

[7] *Id.*

The standard of care is to document collaboration, which was established by Drs. Owen and Zych, and Respondent failed to meet that standard with her delegating physician between October 27 to December 12, 2014. Respondent also exceeded of her prescriptive authority between October 27 and November 18, 2014, by writing hydrocodone prescriptions after October 6, 2014, in violation of state and federal law. Respondent's misconduct constitutes violations of Board Rules §§ 217.11(1)(A) and 221.13(a).

Staff addressed the issue of Respondent's alleged confusion regarding her prescriptive authority in Staff's Closing Argument, and concurs with the ALJ's analysis.

Therefore, Staff respectfully asks that Respondent's Exceptions to Finding of Fact No. Thirteen (13) and Conclusion of Law No. Seven (7), be denied.

Response to Respondent's Exception Regarding the Recommended Sanction

Staff fully outlined the reasoning, based on Dr. Zych's recommendation at hearing, for the revocation Respondent's nursing licenses. Respondent argues a lesser sanction is appropriate for Respondent's Registered Nurse license. Dr. Zych fully outlined the risks associated with Respondent's RN license at both the Probable Cause Hearing,[8] and at the hearing on the merits.[9] Both Dr. Owen and Dr. Zych found the same practice concerns, but it was Dr. Zych that applied those errors to Respondent's RN practice, as well as her APRN practice. Dr. Zych's application of the Board's disciplinary matrix applied to all of Respondent's licenses, as she explained.

Staff concurs with the ALJ's analysis and recommended sanction.

Therefore, Staff respectfully asks that Respondent's Exception to the Recommended Sanction be denied.

Respectfully submitted,

TEXAS BOARD OF NURSING

John R. Griffith, Assistant General Counsel
State Bar No. 24079751
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701
P: (512) 305-8658; F: (512) 305-8101

[8] Transcript, Probable Cause Hearing, at 116-123.

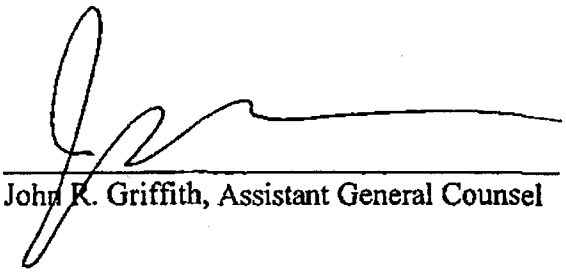
[9] Transcript, Final Hearing, at 157-161

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing ***Staff's Response to Respondent's Exceptions to the Proposal for Decision*** was sent by Fax, on June 23, 2016, to:

Prianglam Brooks
c/o Marc Meyer, Attorney
33300 Egypt Lane, Suite C600
Magnolia, Texas 77354

Via Fax: (866) 839-6920



John R. Griffith, Assistant General Counsel

State Office of Administrative Hearings

Lesli G. Ginn
Chief Administrative Law Judge

July 8, 2016

Katherine A. Thomas, M.N., R.N.
Executive Director
Texas Board of Nursing
333 Guadalupe, Tower III, Suite 460
Austin, Texas 78701

VIA FACSIMILE (512) 305-8101

RE: SOAH Docket No. 507-15-2425; Texas Board of Nursing v. Prianglam Brooks

Dear Ms. Thomas:

On June 10, 2016, Respondent Prianglam Brooks filed exceptions to the Proposal for Decision (PFD) issued on May 23, 2016. Staff filed a timely response to Respondent's exceptions, requesting that they all be denied.

Respondent objects to Findings of Fact Nos. 14-15 and corresponding Conclusion of Law No. 8; Finding of Fact No. 13 and corresponding Conclusion of Law No. 7; and to the recommended sanction.

Findings of Fact Nos. 14-15 and Conclusion of Law No. 8

Finding of Fact No. 14 states in relevant part that the "vast majority of patients at Prillennium were treated for pain and received prescriptions for hydrocodone and/or Soma and/or Xanax," and Finding of Fact No. 15 states, "Prillennium was a pain management clinic." Conclusion of Law No. 8 concludes that Respondent operated a pain management clinic without certification from the Texas Medical Board.

The record contains ample factual support for finding that 100% of Respondent's patients were treated for pain, as she admitted to DEA Investigator Jami Cole (whose testimony is in the record). The pharmacy records, DPS records, expert testimony, and Respondent's own hearing testimony also indicated Prillennium was a pain management clinic. Respondent relies primarily on her denial that she made any admission to Investigator Cole.

However, as the Third Court of Appeals held, "[i]n a contested case hearing, the ALJ is the sole judge of witness credibility and is free to accept or reject the testimony of any witness or even accept part of the testimony of one witness and disregard the remainder."[1] The ALJ considered and weighed the testimony, and explained at pages 35-36 and 42-43 of the PFD the reasons for Findings of Fact Nos. 14 and 15, which directly support Conclusion of Law No. 8. Therefore, the changes requested by Respondent are denied.

Finding of Fact No. 13 and Conclusion of Law No. 7

Finding of Fact No. 13 states, "No collaboration between Respondent and Dr. Blanchette was documented in the medical records for patients seen between November 18 and December 12, 2014." Conclusion of Law No. 7 states in part that the preponderance of the evidence established that between October 27 and November 18, 2014, Respondent exceeded her prescriptive authority by writing and signing prescriptions for hydrocodone. Conclusion of Law No. 7 goes on to state that, between November 18 and December 12, 2014, Respondent wrote prescriptions for hydrocodone signed by Dr. Blanchette, but Respondent did not document collaboration in the medical records as required.

With respect to prescriptions written between October 27 and November 18, 2014, Respondent argues that she was confused about the change in classification of hydrocodone from Schedule III to Schedule II and that her "good faith efforts" to comply should be taken into account. The ALJ addressed the matter on pages 41-42 of the PFD, and Respondent's exceptions do not alter that analysis.

Respondent also claims that evidence of collaboration may have been "in other documents that may or may not have been entered into evidence." The Administrative Procedure Act requires that findings of fact "be based only on the evidence and on matters that are officially noticed," and the ALJ cannot consider what may be contained in documents outside the record.[2] Nothing in the evidence contradicts Finding of Fact No. 13; the medical records are devoid of documentation of collaboration, which is required to meet the standard of care. Accordingly, the ALJ declines to change Finding of Fact No. 13 and Conclusion of Law No. 7.

Recommended Sanction

Respondent reiterates a position she took at hearing and in written closing arguments, namely that if she is sanctioned, only her APRN license should be subject to disciplinary action, and her RN license should be spared. The sanction suggested by Respondent, as well as Staff's reasoning for recommending revocation of all licenses, is discussed exhaustively at pages 43-51 of the PFD and that discussion is incorporated herein by reference.

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[1] *Granek v. Tex. State Bd. of Med. Exam.*, 172 S.W.3d 761, 778 (Tex. App.—Austin 2005, pet. denied) (internal citations and quotation omitted).

[2] Tex. Gov't Code § 2001.141(c).

The Board has the ultimate authority on matters of sanction, and the ALJ does not see any reason to change the recommendation made in the PFD.

Therefore, the PFD is ready for your consideration.

Sincerely,

Pratibha J. Shenoy
Administrative Law Judge

xc: John R. Griffith, Assistant General Counsel, Texas Board of Nursing, 333 Guadalupe, Tower III, Ste. 460, Austin, TX 78701 – **VIA FACSIMILE (512) 305-8101**
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