

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Cynthia Bowling, NP** ) **REPRIMAND OF CERTIFICATE**  
)  
**License No. 200950043NP** ) **Reference No. 16-00490**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Nurse Practitioners. Cynthia Bowling (Licensee) was issued a Nurse Practitioner Certificate by the Board on April 16, 2009.

On or about September 2, 2015, the Board received information that Licensee had failed to properly assess JO, an adult patient seen intermittently in her practice prior to prescribing medications to treat mental illness. There was no report of patient harm. The Board opened an investigation into the matter.

During the course of the investigation, Board staff obtained additional information regarding Licensee's prescribing practices, failure to properly terminate JO from her care and failure to maintain original treatment records for JO, which did not meet the community standard of care.

Licensee acknowledged she had provided care to JO for a period of time during which she did not personally assess JO prior to prescribing medications to treat her mental health symptoms, instead relying on information from JO's mother during periods of crisis.

Licensee stated she had attempted to discharge JO from care after JO moved further from her practice, but never formally terminated care or transferred care to another provider. Licensee acknowledged failing to formally terminate care of JO, created a patient provider relationship which impeded JO's mental health treatment and continuity of care.

As a means of remediation Licensee completed coursework on Professional Boundaries, Medical/Legal Ethics and Medical Record Documentation and submitted certificates of successful completion.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111 (1) (f) and (g) and OAR 851-045-0070 (1) (a), (d) and (n); (3) (a), (b),(e) and (h); and (4) (b) which reads as follows:

678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be

placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

- (f) Conduct derogatory to the standards of nursing.
- (g) Violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder.

**851-045-0070**

**Conduct Derogatory to the Standards of Nursing Defined**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(1) Conduct related to the client's safety and integrity:

(a) Developing, modifying, or implementing standards of nursing practice/care which jeopardize patient safety.

(d) Failing to modify, or failing to attempt to modify the plan of care as needed based on nursing assessment and judgment, either directly or through proper channels.

(n) Failing to maintain professional boundaries with a client.

(3) Conduct related to communication:

(a) Inaccurate recordkeeping in client or agency records.

(b) Incomplete recordkeeping regarding client care; including, but not limited, to failure to document care given or other information important to the client's care or documentation which is inconsistent with the care given.

(e) Destroying a client or agency record or records prepared for an accrediting or credentialing entity.

(h) Failing to communicate information regarding the client's status to members of the health care team (physician, nurse practitioner, nursing supervisor, nurse co-worker) in an ongoing and timely manner; and

(4) Conduct related to achieving and maintaining clinical competency:

(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the Nurse Practitioner Certificate of Cynthia Bowling be reprimanded.**

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Nurse Practitioner.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

\_\_\_\_\_  
Cynthia Bowling, NP

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

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Bonnie Kostelecky, MS, MPA, RN  
Board President

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Date

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Charles Cole, CNA** ) **PROBATION OF NURSING ASSISTANT**  
 ) **CERTIFICATE**  
 )  
**Certificate No. 201506592CNA** ) **Reference No. 16-00813**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Certified Nursing Assistants. Charles Cole (CNA) was issued a Nursing Assistant certificate by the Oregon State Board of Nursing (Board) on September 03, 2015.

In November 2015, the Board received a complaint alleging CNA Cole recently diverted and/or failed to properly administer narcotic medication at West Hills Village in Portland, OR. The Board opened an investigation and found that in September/October 2015, CNA had logged out multiple patients' narcotic medications which he subsequently failed to document as administered, returned, or wasted on their medication administration record (MAR). CNA subsequently informed the Board that he did not divert medication; however, he failed to properly document his medication administration.

By the above actions, CNA is subject to discipline pursuant to ORS 678.442(2)(d) and (f) and OAR 851-063-0080(4) and (6) and OAR 851-063-0090(4)(c)(B) and (D) which provide as follows:

**ORS 678.442 Certification of nursing assistants; rules.**

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

- (d) Violation of any provisions of ORS 678.010 to 678.445 or rules adopted thereunder.
- (f) Conduct unbecoming a nursing assistant in the performance of duties.

**OAR 851-063-0080 Causes for Denial, Reprimand, Suspension, Probation or Revocation of CNA Certificate**

Under the contested case procedure in ORS 183.310 to 183.550 the Board may impose a range of disciplinary sanctions including, but not limited to deny, reprimand, suspend, place on probation or revoke the certificate to perform duties as a CNA for the following causes:

- (4) Violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder;
- (6) Conduct unbecoming a nursing assistant.

**OAR 851-063-0090 Conduct Unbecoming a Nursing Assistant**

A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant

profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to:

(4) Conduct related to communication:

(c) Entering inaccurate, incomplete, falsified or altered documentation into a health record or into agency records. This includes but is not limited to:

- (B) Failing to document information pertinent to the person's care;
- (D) Falsifying data

CNA admits that the above allegations occurred and constitute violations of the Nurse Practice Act. CNA wishes to cooperate with the Board in resolving the present disciplinary matter. The following will be proposed to the Oregon State Board of Nursing and is agreed to by CNA:

CNA shall be placed on probation effective the date the Board approves this Stipulated Order for Probation. CNA's compliance with this Stipulated Order will be monitored by the Oregon State Board of Nursing. CNA must complete a twenty-four (24) month period of probation to begin upon CNA's return to work, monitored as outlined below. CNA must work a minimum of sixteen (16) hours per week, and no more than a maximum of one (1.0) FTE. CNA must work in a setting where CNA can exercise the full extent of CNA's scope of duties, in order to demonstrate CNA's competence. Limited overtime may be approved on occasion, at the discretion of Board staff.

CNA shall comply with the following terms and conditions of probation:

1. CNA shall not violate the Nurse Practice Act (ORS 678) or the rules adopted thereunder.
2. CNA shall have thirty-six (36) months from Board's acceptance of this Stipulated Order to complete twenty-four (24) months of monitored practice.
3. CNA shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
4. CNA shall maintain active certification.
5. CNA shall inform Board staff in advance of any absences from Oregon and/or any move from Oregon to another licensing jurisdiction. If CNA leaves the state and is unable to work in the state of Oregon, CNA's probationary status will be re-evaluated.
6. CNA shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.
7. CNA shall notify Board staff of any citations, arrests, or convictions for any offense, whether felony, misdemeanor, violation, or citation within seven (7) days of the occurrence.

8. CNA will not look for, accept, or begin a new nursing assistant position without prior approval of the Board. This includes changes of the employer itself or changes within the facility or institution.
9. CNA shall inform current and prospective employers, including any Nurse Executive, of the probationary status of CNA's certification, the reasons for probation, and terms and conditions of probation. If CNA's employer has a Nurse Executive, CNA shall inform Board staff of the name of the Nurse Executive and Board staff will provide the Nurse Executive with a copy this Stipulated Order.
10. CNA shall work under the direct supervision of another licensed healthcare professional, functioning at the same or higher level of licensure, who is working in the same physical location and readily available to observe CNA's work and provide assistance. CNA shall be employed in a setting where CNA's nursing assistant supervisor agrees to submit written evaluations of work performance (on forms provided by the Board) every three (3) months during the probationary period. The quarterly evaluation is expected to be received by Board staff within ten (10) days of the due date. If the evaluation is not timely received, Board staff will contact the employer with a reminder. If Board staff is not in receipt of the report within five (5) business days from the reminder date, CNA may be restricted from performing the duties of a nursing assistant.
11. Between quarterly reporting periods, the Nurse Executive or a person designated by CNA's employer shall inform Board staff of any instance of CNA's non-compliance with the terms and conditions of this Stipulated Order or of any other concern regarding CNA's work-related conduct or personal behavior that may affect CNA's ability to perform the duties of a nursing assistant.
12. CNA shall notify Board staff when there is a change in status of employment, including resignations and terminations.
13. CNA shall not have access to narcotics, carry the keys to narcotics storage, or administer narcotics at any time or under any circumstances or until CNA receives written approval from Board staff.
14. CNA shall not work in any work setting when on-site supervision is not available. This generally includes home health agencies, traveling agencies, float pools, temporary agencies, assisted living facilities, adult foster care, independent consulting contracts, home hospice, and night shifts outside of acute care settings.
15. CNA shall not be allowed to participate in the CNA2 training pursuant to Division 62 of the Oregon Administrative Rules.
16. CNA shall participate in and comply with any treatment recommendations set forth by a third party evaluator approved by the Board. Within fourteen (14) days of completing treatment, CNA shall submit to Board staff a copy of CNA's completion certificate or discharge summary. CNA shall sign any release of information necessary

to allow Board staff to communicate with CNA's treatment provider and release CNA's treatment records to the Board.

17. CNA shall participate in the Board's random urine drug testing program. Failure to comply with random urine or any other requested drug test shall result in CNA's immediate removal from working as a nursing assistant. CNA shall submit to tests to determine the presence of unauthorized substances immediately upon request by Board staff or CNA's employer. CNA shall sign any release of information necessary to ensure the Board will receive the results of such testing. The presence of unauthorized substances may be considered a violation of the terms and conditions of this Stipulated Order. Upon request of Board staff, CNA shall obtain an evaluation by a Board approved chemical abuse or dependence evaluator. CNA understands that CNA is financially responsible for any and all costs related to testing and evaluating. CNA's failure to maintain an account in good standing with the Board's laboratory vendor may be considered a violation of this Stipulated Order.
18. CNA shall abstain from using alcohol and/or other intoxicating, mind altering, or potentially addictive drugs, including over-the-counter or prescription drugs while on probation, except as provided in Section 19 below. CNA shall avoid any over-the-counter products and food items containing alcohol and/or poppy seeds.
19. CNA may take medication for a documented medical condition provided that the medication is from a valid prescription prescribed by a person authorized by law to write such a prescription for the documented medical condition. CNA shall notify Board staff of any prescription within seventy-two (72) hours of its issuance. CNA shall sign any release of information necessary to allow Board staff to communicate with the prescribing person and release CNA's records to the Board. CNA shall discard any unused prescription medication when no longer needed or when expired.
20. CNA shall cease performing the duties of a nursing assistant upon the occurrence of a relapse, or at the request of Board staff because of a relapse or relapse behavior. The performance of nursing assistant duties may resume only when approved in writing by Board staff, in consultation with CNA's employer.
21. CNA shall notify any and all healthcare providers of the nature of CNA's chemical dependency to ensure that CNA's health history is complete before receiving any treatment, including medical and dental. CNA shall provide a copy of this Stipulated Order to CNA's healthcare providers. CNA shall provide Board staff with the names and contact information of any and all health care providers. CNA shall sign any release of information necessary to allow Board staff to communicate with CNA's healthcare providers and release CNA's medical and treatment records to the Board. CNA is financially responsible for any costs incurred for compliance with the terms and conditions of this Stipulated Order.
22. CNA shall notify Board staff at least three (3) business days prior to leaving town or going on vacation, with the exception of a family emergency.

23. CNA shall cooperate fully with Board staff in the supervision and investigation of CNA's compliance with the terms and conditions of this Stipulated Order.

CNA understands that the conduct resulting in the violations of law described in this Stipulated Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

CNA understands that in the event CNA engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against CNA's certificate, up to and including revocation of CNA's certification to perform the duties of a nursing assistant.

CNA understands that this Stipulated Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

CNA understands that by signing this Stipulated Order, CNA waives the right to an administrative hearing under ORS 183.310 to 183.540. CNA acknowledges that no promises, representations, duress or coercion have been used to induce CNA to sign this Stipulated Order.

CNA understands that this Stipulated Order is a document of public record.

CNA has read this Stipulated Order, understands this Stipulated Order completely, and freely signs this Stipulated Order for Probation.

IT IS SO AGREED:

\_\_\_\_\_  
Charles Cole, CNA

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR PROBATION OF**  
**Kara Del Curto, NP** ) **REGISTERED NURSE LICENSE AND**  
 ) **NURSE PRACTITIONER CERTIFICATE**  
**License No. 201408399NP-PP,** ) **Reference No. 16-01033**  
**201408398RN**

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Kara Del Curto (Licensee) was issued a Registered Nurse (RN) license and Nurse Practitioner (NP) certificate by the Oregon State Board of Nursing (Board) on December 6, 2014.

On or about December 22, 2015, Licensee self-reported to the Board that she was in treatment for substance abuse issues. On or about November 12 and November 20, 2015, Licensee wrote two prescriptions for Oxycodone-Acetaminophen 10-325 for her own use. At Licensee's request, her Medical Assistant created a false patient medical record, picked up both prescriptions (20 tabs on November 12 and 40 tabs on November 20, 2015) and delivered them to Licensee. The Board opened an investigation.

Licensee was assigned chemical dependency diagnoses and is active in her recovery.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f), OAR 851-045-0070(2)(f)(i)(j) and (5)(d).

**ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee.** In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(f) Conduct derogatory to the standards of nursing.

**OAR 851-045-0070**

**Conduct Derogatory to the Standards of Nursing Defined.** Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(2) Conduct related to other federal or state statute/rule violations:

(f) Unauthorized removal or attempted removal of narcotics, other drugs, supplies, property, or money from clients, the work place, or any person.

(i) Possessing, obtaining, attempting to obtain, furnishing, or administering prescription or controlled drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs.

(j) Aiding, abetting, or assisting an individual to violate or circumvent any law, rule or regulation intended to guide the conduct of nurses or other health care providers.

(5) Conduct related to impaired function:

(d) Use of drugs, alcohol or mind-altering substances to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice for which the licensee is licensed.

Licensee admits that the above allegations occurred and constitute violations of the Nurse Practice Act. Licensee wishes to cooperate with the Board in resolving the present disciplinary matter. The following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**Licensee shall be placed on probation effective the date the Board approves this Stipulated Order for Probation. Licensee's compliance with this Order will be monitored by the Oregon State Board of Nursing. Licensee must complete a twenty-four (24) month period of probation to begin upon Licensee's return to practice, monitored as outlined below. Licensee must practice a minimum of sixteen (16) hours per week, and no more than a maximum of one (1.0) FTE. Licensee must practice in a setting where Licensee can exercise the full extent of Licensee's scope of practice, in order to demonstrate Licensee's competence. Limited overtime may be approved on occasion, at the discretion of Board staff. Any period in which Licensee does not practice in the state of Oregon will not count toward the probationary period.**

Licensee shall comply with the following terms and conditions of probation:

1. Licensee shall not violate the Nurse Practice Act (ORS 678) or the rules adopted thereunder.
2. Licensee shall have thirty-six (36) months from Board's acceptance of this Order to complete twenty-four (24) months of monitored practice.
3. Licensee shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
4. Licensee shall maintain active licensure.
5. Licensee shall inform Board staff in advance of any absences from Oregon and/or any move from Oregon to another licensing jurisdiction. If Licensee leaves the state and is unable to practice in the state of Oregon, Licensee's probationary status will be re-evaluated.
6. Licensee shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.

7. Licensee shall notify Board staff of any citations, arrests, or convictions for any offense, whether felony, misdemeanor, violation, or citation within seven (7) days of the occurrence.
8. Licensee will not look for, accept, or begin a new nursing position without prior approval of the Board. This includes changes of the employer itself or changes within the facility or institution.
9. Licensee shall inform current and prospective employers, including any Nurse Executive, of the probationary status of Licensee's license, the reasons for probation, and terms and conditions of probation. If Licensee's employer has a Nurse Executive, Licensee shall inform Board staff of the name of the Nurse Executive and Board staff will provide the Nurse Executive with a copy this Order.
10. Licensee shall work under the direct supervision of another licensed healthcare professional, functioning at the same or higher level of licensure, who is working in the same physical location and readily available to observe Licensee's practice and provide assistance. Licensee shall be employed in a setting where Licensee's nursing supervisor agrees to submit written evaluations of work performance (on forms provided by the Board) every three (3) months during the probationary period. The quarterly evaluation is expected to be received by Board staff within ten (10) days of the due date. If the evaluation is not timely received, Board staff will contact the employer with a reminder. If Board staff is not in receipt of the report within five (5) business days from the reminder date, Licensee may be restricted from practicing as a nurse.
11. Between quarterly reporting periods, the Nurse Executive or a person designated by Licensee's employer shall inform Board staff of any instance of Licensee's non-compliance with the terms and conditions of this Order or of any other concern regarding Licensee's work-related conduct or personal behavior that may affect Licensee's ability to perform the duties of a nurse.
12. Licensee shall notify Board staff when there is a change in status of employment, including resignations and terminations.
13. Licensee shall not have access to narcotics, prescribe narcotics, carry the keys to narcotics storage, or administer narcotics at any time or under any circumstances or until Licensee receives written approval from Board staff.
14. Licensee's practice shall be monitored by a nurse practitioner or physician for appropriate practice to include, but not limited to, chart review and prescription audits.
15. Licensee shall not work in any practice setting when on-site supervision is not available. This generally includes home health agencies, traveling agencies, float pools, temporary agencies, assisted living facilities, adult foster care, independent consulting contracts, home hospice, and night shifts outside of acute care settings.

16. Licensee shall participate in and comply with any treatment recommendations set forth by a third party evaluator approved by the Board. Within fourteen (14) days of completing treatment, Licensee shall submit to Board staff a copy of Licensee's completion certificate or discharge summary. Licensee shall attend Narcotics Anonymous (NA), Alcoholics Anonymous (AA) or similar recovery program on a weekly basis and provide proof of attendance to Board staff. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's treatment provider and release Licensee's treatment records to the Board.
17. Licensee shall participate in the Board's random urine drug testing program. Failure to comply with random urine or any other requested drug test shall result in Licensee's immediate removal from nursing practice. Licensee shall submit to tests to determine the presence of unauthorized substances immediately upon request by Board staff or Licensee's employer. Licensee shall sign any release of information necessary to ensure the Board will receive the results of such testing. The presence of unauthorized substances may be considered a violation of the terms and conditions of this Order. Upon request of Board staff, Licensee shall obtain an evaluation by a Board approved chemical abuse or dependence evaluator. Licensee understands that Licensee is financially responsible for any and all costs related to testing and evaluating. Licensee's failure to maintain an account in good standing with the Board's laboratory vendor shall be considered a violation of this Order.
18. Licensee shall abstain from using alcohol and/or other intoxicating, mind altering, or potentially addictive drugs, including over-the-counter or prescription drugs while on probation, except as provided in Section 18 below. Licensee shall avoid any over-the-counter products and food items containing alcohol and/or poppy seeds.
19. Licensee may take medication for a documented medical condition provided that the medication is from a valid prescription prescribed by a person authorized by law to write such a prescription for the documented medical condition. Licensee shall notify Board staff of any prescription within seventy-two (72) hours of its issuance. Licensee shall sign any release of information necessary to allow Board staff to communicate with the prescribing person and release Licensee's records to the Board. Licensee shall discard any unused prescription medication when no longer needed or when expired.
20. Licensee shall cease practicing as a nurse upon the occurrence of a relapse, or at the request of Board staff because of a relapse or relapse behavior. Practice may resume only when approved in writing by Board staff, in consultation with Licensee's employer.
21. Licensee shall notify any and all healthcare providers of the nature of Licensee's chemical dependency to ensure that Licensee's health history is complete before receiving any treatment, including medical and dental. Licensee shall provide a copy of this Order to Licensee's healthcare providers. Licensee shall provide Board staff with the names and contact information of any and all health care providers. Licensee shall sign any release of information necessary to allow Board staff to communicate

with Licensee's healthcare providers and release Licensee's medical and treatment records to the Board. Licensee is financially responsible for any costs incurred for compliance with the terms and conditions of this Order.

- 22. Licensee shall notify Board staff at least three (3) business days prior to leaving town or going on vacation, with the exception of a family emergency.
- 23. Licensee shall cooperate fully with Board staff in the supervision and investigation of Licensee's compliance with the terms and conditions of this Order.

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event Licensee engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against Licensee's license, up to and including revocation of Licensee's licensure.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, Licensee waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce Licensee to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Probation.

IT IS SO AGREED:

\_\_\_\_\_  
Kara Del Curto, RN, NP

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF OREGON  
for the  
OREGON STATE BOARD OF NURSING**

In the Matter of: ) **FINAL ORDER**  
)  
**TAMARA DIXON** )  
) OAH Case No. 1504258  
) Agency Case No. 15-01446

**HISTORY OF THE CASE**

On June 29, 2015, the Oregon State Board of Nursing (Board) issued a Notice of Proposed Revocation of Nurse Practitioner (N.P.) Certificate and Registered Nurse (R.N.) License (Notice) to Tamara Dixon. On June 30, 2015, Ms. Dixon, through counsel, requested an administrative hearing.

On July 20, 2015, the Board referred the hearing request to the Office of Administrative Hearings (OAH). Senior Administrative Law Judge (ALJ) Jennifer H. Rackstraw of the OAH was assigned to preside over the matter.

On September 14, 2015, ALJ Rackstraw convened a telephone prehearing conference. At the conference, Senior Assistant Attorney General Lori H. Lindley represented the Board and attorney Kevin Keaney represented Ms. Dixon. Ms. Lindley agreed to provide Mr. Keaney with previously requested discovery by September 18, 2015. A hearing was scheduled for five days, commencing on December 28, 2015. The parties agreed to submit exhibits and witness lists by December 11, 2015.

On March 14, 2016, ALJ Rackstraw issued a Proposed Order revoking Licensee's Nurse Practitioner Certificate and her Registered Nurse License. In that order, ALJ Rackstraw provided exceptions instructions that they were to be filed within 10 days following the date of service of the Proposed Order. The Board received timely filed written exceptions and reviewed them. The Board found that the exceptions reiterated arguments made during the hearing and did not find them to be persuasive.

*Request for Order Compelling Discovery*

On September 21, 2015, Mr. Keaney notified the ALJ that he had not yet received the requested discovery. He therefore requested that the ALJ issue an order compelling the Board to produce the discovery by September 23, 2015. The ALJ, in response, requested that Mr. Keaney file a motion for an order compelling discovery, pursuant to OAR 137-003-0568(2) and (3), if Ms. Dixon was in fact seeking such an order. Mr. Keaney responded on September 21, 2015, and included in his email a description of his previous attempts to obtain the requested

discovery.<sup>1</sup> On September 22, 2015, Ms. Lindley provided Mr. Keaney and the ALJ with a copy of a letter that Ms. Lindley had mailed to Mr. Keaney—along with the requested discovery—on September 18, 2015. The ALJ thereafter determined that the request for an order compelling discovery was moot.

#### *Request for Admissions Nos. 1 and 2*

On September 8, 2015, Ms. Dixon, through Mr. Keaney, filed a Request for Admissions Nos. 1 and 2. On September 22, 2015, the Board filed a Reply to Request for Admissions. On September 29, 2015, Mr. Keaney requested that the ALJ order the Board to admit or deny two requests for admissions “without equivocation or evasion.” On September 30, 2015, Ms. Lindley requested a telephone conference in the event the ALJ planned to “entertain an order for the Board to answer [the requests for admissions] ‘without equivocation or evasion.’” Also on September 30, 2015, Mr. Keaney provided additional argument, via email, in support of the request for an order regarding the two requests for admissions. Later, on September 30, 2015, Ms. Lindley provided Mr. Keaney and the ALJ with a copy of a letter to the ALJ, dated September 29, 2015. The letter objected to the form of Mr. Keaney’s request for an order compelling the Board to admit or deny the two requests for admissions.

On October 5, 2015, the ALJ issued a Ruling on Request for Discovery Order to Compel Additional Responses to Request for Admissions Nos. 1 and 2. The ALJ ruled that Ms. Dixon had properly filed the request for a discovery order, but that all future motions or requests for relief must be filed by facsimile or regular mail (as opposed to email). The ALJ also denied Ms. Dixon’s request for a discovery order compelling the Board to submit additional responses to the requests for admissions, finding that the Board’s answers were sufficiently responsive. Pleading P21.

#### *Qualified Protective Order*

On September 22, 2015, the Board filed a Motion for Qualified Protective Order, along with a draft Qualified Protective Order Limiting Use and Disclosure. On September 27, 2015, Mr. Keaney objected to the Protective Order and requested a telephone conference. The ALJ denied the request for a telephone conference and requested that Mr. Keaney specify the bases of Ms. Dixon’s objections to the Board’s motion and the draft protective order. On September 29, 2015, Mr. Keaney clarified the basis of Ms. Dixon’s objection; Ms. Lindley responded to the objection; and Mr. Keaney subsequently withdrew the objection. The ALJ thereafter granted the Board’s motion and, on September 29, 2015, signed the Qualified Protective Order Limiting Use and Disclosure. Pleading P14.

#### *Request for Admissions Nos. 3 and 4*

On or about September 29, 2015, Ms. Dixon, through counsel, filed a Request for Admissions Nos. 3 and 4. On October 12, 2015, the Board filed its Reply to Request for Admissions Nos. 3 and 4. On October 16, 2015, Ms. Dixon, through counsel, filed a discovery

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<sup>1</sup> The relevance of the requested discovery was never at issue.

motion, requesting “an order compelling the Board to admit” Request for Admissions Nos. 3 and 4. On October 20, 2015, the Board filed its Response to Licensee’s Second Motion to Compel Discovery. On October 23, 2015, Ms. Dixon filed a Reply to OSBN’s Response to Second Motion to Compel. On November 4, 2015, ALJ Rackstraw issued a Ruling on Request for Discovery Order to Compel Board to Admit Request for Admissions Nos. 3 and 4. The ALJ denied Ms. Dixon’s request, concluding that the Board’s answers were sufficiently responsive. Pleading P42.

#### *Request for Transmittal of Questions*

On October 19, 2015, Ms. Dixon, through counsel, requested that ALJ Rackstraw transmit “question[s]” to the Board, pursuant to OAR 137-003-0635, pertaining to the burdens and standards of proof applicable in her case. On October 20, 2015, the Board, through Ms. Lindley, filed a response to the transmittal request. In its response, the Board asserted that Ms. Dixon’s “questions” were not appropriate for transmittal to the Board under OAR 137-003-0635. Notwithstanding that objection, the Board cited to *Staats v. Newman*, 164 Or App 18 (1999) to support its position that the standard of proof in this matter is a preponderance of evidence. The Board then cited to ORS 678.111 and *Olson v. State Mortuary and Cemetery Board*, 230 Or App 376, 396 (2009) to support its position that the Board has the discretion to suspend or revoke a nursing license for any causes listed in ORS 678.111.

On October 21, 2015, Ms. Dixon, through counsel, replied to the Board’s response and, in so doing, made an additional request that ALJ Rackstraw transmit certain additional “questions” to the Board. On that same date, Ms. Lindley notified ALJ Rackstraw that the Board was awaiting a ruling and that Ms. Lindley was available for oral argument if necessary. In response, on October 21, 2015, Mr. Keaney submitted the following argument:

The ALJ does not “rule” on the agency response under OAR 137-003-0635. Counsel needs to review the rule. There is no provision under the rule for the ALJ to decide any question of law. A ruling comes after the hearing when the ALJ issues proposed findings[]and[]conclusions.

On October 23, 2015, ALJ Rackstraw issued a Ruling on Licensee’s Request for Transmittal of Questions. The ALJ concluded that the four “questions” posed by Licensee were not appropriate for transmittal to the Board under OAR 137-003-0635(1). However, the ALJ gave the parties the opportunity to file briefs regarding which standard of proof applies to the proceeding, and whether the standard of proof might differ with respect to the Board’s allegations of “[f]raud or deceit of the licensee in the practice of nursing,” under ORS 678.111(1)(d). Pleading P34. On November 12, 2015, the Board and Ms. Dixon each filed a brief with respect to those issues. The ALJ thereafter informed the parties that they would have an opportunity to provide oral argument in support of their briefs at the hearing.

#### *Motion for Summary Determination / Motion to Strike Amended Notice*

On November 30, 2015, Ms. Dixon, through counsel, filed a Motion for Summary Determination, pursuant to OAR 137-003-0580, alleging that the Board’s June 29, 2015 Notice

did not provide her with constitutionally adequate notice. On December 2, 2015, the Board issued an Amended Notice of Proposed Revocation of Nurse Practitioner Certificate and Registered Nurse License (Amended Notice) to Ms. Dixon.

On December 7, 2015, ALJ Rackstraw notified the parties that because the Board had issued an Amended Notice, the June 29, 2015 Notice was no longer at issue and, as a result, Ms. Dixon could not prevail on her Motion for Summary Determination as a matter of law. ALJ Rackstraw informed the parties that she intended to issue a ruling denying the Motion for Summary Determination by December 11, 2015, and that if either party objected to the process, they could do so by December 9, 2015. That day, Ms. Lindley informed the ALJ that the Board intended to file a response to the Motion for Summary Determination. Also that day, Mr. Keaney informed the ALJ that he and his client “object to the ALJ, in effect, ruling on our motion and expressing the reason therefor even before the OSBN has responded with what the OSBN believes to be any alleged reasons for denying the motion.” Mr. Keaney further stated that Ms. Dixon planned to file a motion to dismiss the Amended Notice, and he disagreed that the June 29, 2015 Notice had been superseded by the Amended Notice. Later that day, ALJ Rackstraw informed the parties that she would await the Board’s response to the Motion for Summary Determination before issuing a written ruling on the motion.

On December 8, 2015, the Board filed a Response to Licensee’s Motion for Summary Determination. On December 9, 2015, Ms. Dixon filed a Motion to Strike Amended Notice (Motion to Strike). That same day, the Board filed a Response to Licensee’s Motion to Strike Amended Notice. Later that same day, Ms. Dixon filed a Reply on Motion to Strike Amended Notice.

On December 11, 2015, the Board provided a copy of Amended Emergency Board Meeting Minutes from December 10, 2015 to ALJ Rackstraw and Mr. Keaney. That same day, Mr. Keaney requested leave to address issues raised by the meeting minutes more thoroughly. He also informed the ALJ that he might require additional time “to include exhibits and witnesses on my lists in light of this new information.”

On December 21, 2015, ALJ Rackstraw issued Rulings on Motion to Strike Amended Notice and Motion for Summary Determination, denying both motions. The ALJ denied the Motion to Strike on the following bases: 1) the Board was authorized, under OAR 137-003-0530(4), to issue the Amended Notice; 2) to the extent there was any question as to Board staff’s authority to issue the Amended Notice, any defect was cured by the Board’s approval of the Amended Notice on December 10, 2015; and 3) Ms. Dixon failed to establish that the Amended Notice is constitutionally defective. The ALJ informed the parties, however, that she would allow Ms. Dixon the opportunity to develop the record more fully on these issues at hearing. Pleading P53.

### *Hearing*

On December 28 through 31, 2015 and January 8, 2016, ALJ Rackstraw convened a contested case hearing at the Board’s offices in Portland, Oregon. Ms. Lindley represented the Board. Mr. Keaney represented Ms. Dixon. Board Investigator Jessica Van Horn, the agency

representative, and Elana Patel, the agency's expert witness, attended the hearing all five days. Ms. Dixon attended the hearing in person on the first four days, and via telephone on the last day. Board Investigator Wendy Bigelow and Cathy Keaney, Mr. Keaney's legal assistant, each attended a portion of the hearing.

The Board called the following witnesses: Ms. Dixon; JDB, an R.N. at Rogue Regional; TF, KG's son; James A. Green, a forensic document examiner; Jeanette Holmes, Director of Employee and Labor Relations with Asante; Elizabeth McOmer, a Medford police officer; Glendora Raby, a privacy information security officer at Asante; Timothy Reeder, a security officer at Rogue Regional; Paul Rimov, R.Ph., a Safeway pharmacist; Ms. Van Horn; and Ms. Patel.

Ms. Dixon called the following witnesses: Tom Espinosa, an R.N. at Rogue Regional; Jamie Hazlett, Ms. Dixon's attorney in another matter; KE,<sup>2</sup> an R.N. at Rogue Regional and a Private Transformations client; LSJ, an R.N. at Rogue Regional and a Private Transformations client; Stephanie Labrash; Christy Cowgill, a Board policy analyst; and Ms. Van Horn. Ms. Dixon also testified on her own behalf.

The record closed at the conclusion of the hearing on January 8, 2016.

## ISSUES

1. Whether the preponderance of evidence standard is the applicable standard of proof as to all allegations in this proceeding.
2. Whether on or about October 3, 2013, Ms. Dixon prescribed Iopidine Ophthalmic Solution (0.5%) to herself, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(10)(b), and OAR 851-056-0016(2)(d) (effective October 6, 2011).<sup>3</sup>
3. Whether between January 1, 2012 and May 7, 2015, Ms. Dixon deviated from the standard of care by utilizing prescription pads from her previous employer, Creekside Family Medicine, and her hospital employer, Asante Rogue Regional Medical Center, to write prescriptions, in violation of ORS 678.111(1)(d), (f), and (g), OAR 851-056-0010(1) (effective May 6, 2011 and January 1, 2015),<sup>4</sup> OAR 851-056-0016(2)(f) and (h) (effective October 6, 2011) and OAR 851-056-0016(2)(g) and (i) (effective January 1, 2015).<sup>5</sup>

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<sup>2</sup> Client initials are used throughout the Proposed Order.

<sup>3</sup> The version of OAR 851-056-0016(2)(d) that was in effect at the time of the alleged violation is not materially different from the current version that became effective on January 1, 2015. The only difference between the two versions is that subsection (2)(d) became (2)(e) in the current version.

<sup>4</sup> The only difference between the 2011 and 2015 versions of OAR 851-056-0010(1) is that the former version references "the prescribing nurse practitioner or clinical nurse specialist" and the current version references "the prescribing APRN." Otherwise, the requirements in section (1) of the rule are identical.

4. Whether Ms. Dixon violated KG's right to privacy and confidentiality of information by reviewing KG's and EG's private health records without a medical reason, in violation of ORS 678.111(1)(d), (f), and (g) and OAR 851-045-0070(2)(l) and (m).

5. Whether in 2014, Ms. Dixon violated ORS 678.111(1)(d), (f), and (g) and OAR 851-045-0070(1)(h) and (2)(f), (i), and (j) and (3)(b) and (f) when she requested that a coworker, JCB, remove medication from the Omnicell so that Ms. Dixon could provide the medication to KG.

6. Whether on or about July 23, 2014, Ms. Dixon failed to maintain professional boundaries with clients and abused the nurse/client relationship by requesting that a client's family member, TF, obtain Norco (hydrocodone) prescribed to the client, KG, from the pharmacy and deliver the medication to Ms. Dixon, in violation of ORS 678.111(1)(f) and (g) and OAR 851-045-0070(1)(n) and (2)(h).

7. Whether on or about April 2, 2015, Ms. Dixon violated ORS 678.111(1)(f) and (g) and OAR 851-045-0070(9) when she was involved in a physical altercation with KG at the Rogue Regional Medical Center.

8. Whether between April 16, 2015 and May 13, 2015, Ms. Dixon falsified records associated with her client, KG, at Private Transformations, in violation of ORS 678.111(1)(d), (f), and (g) and OAR 851-045-0070(3)(d) and (g).

9. Whether between January 1, 2012 and May 7, 2015, Ms. Dixon deviated from the standard of care by prescribing medication to individuals without having a patient/provider relationship with the individuals, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(c), (3)(b), and (4)(b), OAR 851-056-0016(2)(c), (f) and (h) (2011), OAR 851-056-0016(2)(c),<sup>6</sup> (g), and (i) (2015) and OAR 851-050-0005(4)(a), (b), (c), (d), and (e).<sup>7</sup>

10. Whether between January 1, 2012 and May 7, 2015, Ms. Dixon failed to maintain client records, failed to properly assess individuals and document the assessments, and improperly prescribed medications to non-Private Transformations clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(c), (3)(b), and (4)(b), OAR 851-056-0016(2)(c), (f) and (h) (2011), and OAR 851-056-0016(2)(c), (g), and (i) (2015).

11. Whether between January 1, 2012 and May 7, 2015, Ms. Dixon failed to properly assess clients and document the assessments when prescribing medication to Private

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<sup>5</sup> The only difference between the two rule versions in effect when the alleged violations occurred is that subsections (2)(f) and (h) became (2)(g) and (i) in the current version. The language in those subsections is identical.

<sup>6</sup> OAR 851-056-0016(2)(c) is identical in both the former and current versions of the rule.

<sup>7</sup> The current version of OAR 851-050-0005(4)(a)-(e) (effective November 1, 2014) is identical to the previous versions (effective January 1, 2010 and June 1, 2013) that are relevant to the alleged violations. Going forward, it is therefore unnecessary to specify a particular version of the rule.

Transformation clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(a), (c), (d), and (n), (3)(a) and (b), and (4)(b), OAR 851-056-0016(2)(c), (f) and (h) (2011), and OAR 851-056-0016(2)(c), (g), and (i) (2015).

12. Whether between January 1, 2012 and May 7, 2015, Ms. Dixon deviated from the standard of care while treating Private Transformation clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(a), (c), (d), and (n), (3)(a) and (b), and (4)(b), OAR 851-056-0016(2)(c), (f) and (h) (2011), OAR 851-056-0016(2)(c), (g), and (i) (2015), and OAR 851-050-0005(4)(a), (b), (c), (d), and (e).

13. Whether between January 1, 2012 and May 7, 2015, Ms. Dixon improperly prescribed medication to Private Transformation clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(a), (c), (d), and (n), (3)(a) and (b), and (4)(b), OAR 851-056-0016(2)(c), (f) and (h) (2011), and OAR 851-056-0016(2)(c), (g), and (i) (2015).

14. Whether Ms. Dixon failed to answer truthfully and completely during the Board's investigation, including in a written statement submitted to the Board on April 22, 2015, and during a personal interview with Board staff on May 20, 2015, in violation of ORS 678.111(1)(d), (f), and (g) and OAR 851-045-0070(7)(b).

15. If the Board proves one or more violations, whether revocation of Ms. Dixon's R.N. license and N.P. certificate is the appropriate sanction.

## **MOTIONS AT HEARING**

### *Renewal of Previous Motion to Strike Amended Notice*

At hearing, Ms. Dixon, through counsel, renewed her Motion to Strike the Board's Amended Notice, and offered the same arguments she previously made in her Motion to Strike and Reply to Motion to Strike. Given that no new evidence was introduced at hearing relevant to the motion, and no new arguments were advanced on behalf of the renewed motion, the ALJ's December 21, 2015 Ruling on Motion to Strike Amended Notice remains unchanged, and Ms. Dixon's renewed motion is denied for the same reasons set forth in that written ruling.

### *Motion to Dismiss Contested Case on Constitutional Grounds*

At hearing, Ms. Dixon, through counsel, moved to dismiss the entire contested case on constitutional grounds.

First, she contended that the Board is inherently biased in this matter, as evidenced by the Board calling an emergency Board meeting on December 10, 2015 to try and "save" the Amended Notice. She asserted that a fundamental guarantee of due process is an unbiased decision-maker, and that this contested case process does not afford that because, after receiving the ALJ's proposed order, the Board retains final decision-making authority. She also contended that the assistant attorney general's dual role of advising the Board while also prosecuting the

case against her violates due process. She concluded that the entire contested case process “fails” for lack of due process.

Ms. Dixon’s contention that the Board is biased against her is not supported by the record. And, to the extent she contends that Oregon’s Administrative Procedure Act (APA) is unconstitutional by virtue of allowing agencies to retain final-decision-making authority,<sup>8</sup> the contention is without merit. Similar administrative processes are utilized in all 50 states, as well as at the federal level, and the ALJ did not know of no persuasive authority that has deemed such procedures unconstitutional.

Moreover, Ms. Dixon’s contention that the combination of functions exercised by the Board’s counsel violates due process is unpersuasive. The U.S. Supreme Court held, in *Withrow v. Larkin*, 421 US 35, 46, 58 (1975), that a state medical board’s combination of investigatory and adjudicatory functions, which ultimately resulted in a physician’s license suspension, did not raise constitutional concerns. Similarly, the Court found no due process violation where ALJs determine Social Security disability benefits and, at the preliminary stage, “investigate facts and develop the arguments both for and against granting benefits,” *Sims v. Apfel*, 530 U.S. 103, 111 (2000), and “act[] as an examiner charged with developing the facts.” *Richardson v. Perales*, 402 US 389, 410 (1971). Indeed, the U.S. Court of Appeals for the Federal Circuit noted that “[t]he Supreme Court has never held a system of combined functions to be a violation of due process, and it has upheld several such systems.” See *Ethicon Endo-Surgery, Inc. v. Covidien LP* at 10 (Fed Cir January 13, 2016), citing 2 Richard J. Pierce, Jr., *Administrative Law Treatise* § 9.9, 892 (5th ed 2010). Lower courts have also rejected due process challenges to systems of adjudication that combine functions in an agency. See, e.g., *NLRB v. Aaron Bros. Corp.*, 563 F2d 409, 413 (9th Cir 1977) (finding no due process violation when the NLRB’s regional director “exercised both investigative and adjudicative responsibilities in connection with the issuance and resolution of [an] unfair labor practice complaint”); *Riggins v. Goodman*, 572 F3d 1101, 1112 (10th Cir 2009) (no due process concerns in a system for deciding whether to terminate public employees that combined investigative and adjudicatory functions); *In re Seidman*, 37 F3d 911, 924-26 (3d Cir 1994) (finding no due process violation in combining functions involving investigation, prosecution, and adjudication in the Director of the Office of Thrift).

Second, Ms. Dixon contended that it is unconstitutional not to know how the Board structures its discretion when deciding on an appropriate sanction in a given case. However, she pointed to no authority to support that contention. The Board, on the other hand, cited to *Olsen v. State Mortuary and Cemetery Bd*, 230 Or App 376 (Or App 2009) for the proposition that,

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<sup>8</sup> See, e.g., ORS 183.464(1) (“unless a hearing officer is authorized or required by law or agency rule to issue a final order, the hearing officer shall prepare and serve on the agency and all parties to a contested case hearing a proposed order”); see also OAR 137-003-0645(1) (“Unless the administrative law judge is authorized or required to issue a final order without first issuing a proposed order, the administrative law judge shall prepare a proposed order.”); OAR 137-003-0655(6) (“The agency or, if authorized, the administrative law judge shall issue a final order in accordance with OAR 137-003-0665. The agency may adopt the proposed order as the final order, or modify the proposed order and issue the modified order as the final order.”)

once an agency is statutorily authorized to impose a range of sanctions, the choice of which sanction to impose is a matter within that agency's discretion. In *Olson*, the Mortuary and Cemetery Board revoked the petitioners' licenses and imposed a civil penalty of \$500 for each of 88 proven violations (for a total of \$44,000).<sup>9</sup> *Olson*, 230 Or App 386-387.

In rejecting the petitioners' assertion that the Mortuary and Cemetery Board erred in imposing a \$500 fine for each violation and revoking the petitioners' licenses, the Court of Appeals held that "[t]he imposition and choice of penalty for violation of laws governing funeral service providers and funeral homes is a matter within the board's discretion." *Id.* at 393-394. The Board then noted that the petitioners had identified no basis for asserting that the Mortuary and Cemetery Board had abused its discretion when deciding on the appropriate sanction.<sup>10</sup>

More recently, the Court of Appeals held in a disciplinary case involving the Board of Accountancy that when selecting an appropriate sanction in a given case, "[n]othing precludes the board from relying on its own knowledge of its prior decisions without placing those prior decisions in the evidentiary record." *Gustafson v. Bd of Accountancy*, 270 Or App 447, 457 (2015). The court rejected the petitioner's argument that the Board of Accountancy had abused its discretion.

In sum, Oregon case law does not support Ms. Dixon's contention that an agency must provide a licensee with a specific, structured analysis of how it utilizes its discretion in choosing a sanction.

For the reasons set forth above, Ms. Dixon's motion to dismiss the contested case based upon constitutional grounds is denied.

*Motion to Exclude Exhibits A102 through A105 and Dismiss Allegation of Standard of Care Violation pertaining to Ms. Dixon's Treatment of KG on June 30, 2014.*

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<sup>9</sup> At that time, ORS 692.180(1) provided, in part:

If the board finds any of the causes described in this section in regard to any person, licensee or applicant \* \* \*, the board may impose a civil penalty of not more than \$1,000 for each violation, suspend or revoke a license to practice or to operate under this chapter[.]

<sup>10</sup> ORS 183.482 pertains to judicial review of contested cases and states, in part:

(8)(b) The court shall remand the order to the agency if the court finds the agency's exercise of discretion to be:

- (A) Outside the range of discretion delegated to the agency by law;
- (B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or
- (C) Otherwise in violation of a constitutional or statutory provision.

At hearing, the Board offered Exhibits A102 through A105 for impeachment purposes, and also to establish that Ms. Dixon deviated from the standard of care when providing emergency medical treatment to KG on June 30, 2014. The ALJ admitted the exhibits for impeachment purposes, but reserved ruling on whether to admit the exhibits to establish a standard of care violation pertaining to Ms. Dixon's treatment of KG on June 30, 2014.

Ms. Dixon asserted, through counsel, that the Board failed to provide constitutionally adequate notice that any emergency treatment that Ms. Dixon provided to KG on June 30, 2014 could be considered a violation. The Board contended, however, that any standard of care violation pertaining to the June 30, 2014 incident falls under Paragraph VII of the Amended Notice. That paragraph states:

The Board alleges that between January 1, 2012 and May 7, 2015 Licensee deviated from the standard of care while treating clients at Private Transformations including but not limited to, \* \* \* (KG) \* \* \*. This is in violation of: ORS 678.111(1)(f) and (g) and OAR 851-045-0070(1)(a), (c), (d), and (n) and (3)(a) and (b) and (4)(b) and OAR 851-056-0016(2)(c), (g), and (i) and OAR 851-050-0005(4)(a), (b), (c), (d), and (e).

Amended Notice at 2.

ORS 183.415 sets forth the requirements for adequate notice under the APA and provides, in pertinent part:

(2) In a contested case, all parties shall be afforded an opportunity for hearing after reasonable notice[.]

(3) Notice under this section must include:

\* \* \* \* \*

(d) A short and plain statement of the matters asserted or charged[.]

The Board contends that it provided adequate notice to Ms. Dixon, via Paragraph VII of the Amended Notice, for the following three reasons: 1) Ms. Dixon's provision of emergency medical treatment to KG on June 30, 2014 occurred between the time period specified in the paragraph; 2) KG was one of Ms. Dixon's Private Transformations clients; and 3) KG is listed as one of the clients regarding whom there is a standard of care violation.

It is correct that the June 30, 2014 incident falls within the time frame referenced in Paragraph VII, that KG was a Private Transformations client, and that KG is listed in Paragraph VII. However, the Board's contention that those things placed Ms. Dixon on notice that her emergency treatment of KG on June 30, 2014 could constitute a standard of care violation under that paragraph is unpersuasive. The Amended Notice does not mention the June 30, 2014

incident, nor provide any factual allegations relating specifically to the incident. A plain reading of Paragraph VII reasonably leads to the conclusion that any standard of care violations referenced therein relate to Ms. Dixon's provision of care to clients in the context of her Private Transformations practice. The emergency medical care that Ms. Dixon provided to KG on June 30, 2014 falls outside of that practice. Therefore, the Board's Amended Notice does not comply with ORS 183.415(3)(d) with respect to an alleged standard of care violation involving Ms. Dixon's treatment of KG on June 30, 2014. The Board may not proceed with that allegation in this matter.<sup>11</sup>

The Board agrees with ALJ Rackstraw's rulings on the preceding motions.

### **EVIDENTIARY RULINGS**

At hearing, the Board offered Exhibits A1 through A105. Exhibits A1 through A60, A62, A64 through A78, and A81 through A101 were admitted into the record without objection.<sup>12</sup> Exhibits A61, A63, A79, and A80 were admitted into the record over Ms. Dixon's objections. Exhibits A102 through A105 were admitted into the record for impeachment purposes over Ms. Dixon's objections. For the reasons discussed in the previous section titled "Ms. Dixon's Motions at Hearing," Exhibits A102 through A105 are excluded for the purpose of establishing any standard of care violations pertaining to Ms. Dixon's treatment of KG on June 30, 2014.

At hearing, Ms. Dixon offered Exhibits R1 through R43. Exhibits R1 through R26, R28 through R32, R34 through R36, and R41 through R43 were admitted into the record without objection. Exhibits R27, R33, R37, R39, and R40 were admitted into the record over the Board's objections. Exhibit R38 was excluded based on the Board's relevancy objection.

### **EXPERT OPINION OF JAMES A. GREEN**

The Board hired forensic document examiner James A. Green<sup>13</sup> to determine whether, in his expert opinion, Ms. Dixon wrote Norco prescriptions to KG dated November 20, 2014

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<sup>11</sup> The Oregon Court of Appeals has held that an appellant need not demonstrate actual prejudice due to adequate notice under ORS 183.415(3) because "the absence of adequate notice is prejudicial in and of itself." See *Villanueva v. Board of Psychologist Examiners*, 179 Or App 134, 138 (2002); *Drayton v. Department of Transportation*, 186 Or App 1, 11-13 (2003).

<sup>12</sup> Exhibits A97 and A101 were admitted as demonstrative exhibits only.

<sup>13</sup> Mr. Green was a forensic document examiner for the Eugene Police Department from 1988 to 2000. Since 2000, he has continued that work in private practice. He is a member and the president-elect of the American Society of Questioned Document Examiners, a fellow of the American Academy of Forensic Sciences – Questioned Document Section, and a member of the Southwest Association of Forensic Document Examiners. He is certified by the American Board of Forensic Document Examiners, for whom he currently serves as treasurer. He is qualified in federal courts in California, Montana, Oregon, and Washington and in state courts in Alaska, Idaho, Oregon, Texas, Minnesota, Washington, and Montana. He has provided testimony in more than 100 cases, presented at several conferences, and been published in the *Journal of Forensic Sciences*. (Ex. A92 at 1-2.)

(Exhibit A91 at 5) and January 16, 2015 (Exhibit A91 at 10). *See* Exhibit R37; testimony of Green.

Ms. Dixon has repeatedly denied writing the two suspect prescriptions. On or about April 16, 2015, she informed Paul Rimov, R.Ph, the manager of the Medford Safeway Pharmacy, that she did not authorize the suspect prescriptions. Test. of Rimov. In a written statement provided to the Medford Police Department (titled “Discovery of Prescription Fraud”), Ms. Dixon asserted that six controlled substances prescriptions that named her as the prescriber were filled for KG from May 27, 2014 to January 30, 2015, without Ms. Dixon’s authorization or knowledge.<sup>14</sup> *See* Exhibit A74 at 1, 3, 11. Ms. Dixon suggested in the written statement that KG was using Ms. Dixon’s license number and name to illegally obtain the prescriptions. Ms. Dixon also noted in the statement that KG previously had access to Ms. Dixon’s hospital office, her home, and her home office. *Id.* at 11. On April 22, 2015, Ms. Dixon, through counsel, provided a copy of the same written statement to the Board. *See* Exhibit A83 at 1, 8-10. On April 30, 2015, Ms. Dixon spoke with Medford police officer Elizabeth McOmber and denied that she had written the prescriptions at issue. She also informed Officer McOmber that she believed KG had possibly traced the suspect prescriptions from old prescriptions. Exhibit A74 at 6. On May 20, 2015, Ms. Dixon informed Board investigators Jessica Van Horn and Suzanne Meadows that she did not write any narcotics prescriptions to KG after June 23, 2014. Exhibit A86 at 7, 11-12; testimony of Van Horn. Finally, at hearing, she testified that she did not write the two suspect prescriptions. Testimony of Dixon.

On October 6, 2015, at the Medford Safeway Pharmacy, Mr. Green examined the originals of the two suspect prescriptions, as well as an original November 13, 2014 prescription known to have been written by Ms. Dixon. Testimony of Green; Exhibit A90 at 5; *see also* Exhibit R38. In addition, he reviewed approximately 35 samples of known writing of Ms. Dixon’s, as well as six of KG’s known writings. Testimony of Green; *see* Exhibits A90, A91.

Mr. Green first looked for evidence that the two suspect prescriptions were originals, and not the products of a copying or duplicating instrument. He confirmed that both suspect prescriptions were, in fact, written in ink. Testimony of Green.

Mr. Green knew that Mr. Dixon had suggested that the suspect prescriptions were traced. He therefore examined the suspect prescriptions under magnification for indications of a tracing process, specifically looking for an outline in the form of an indented outline or a pencil or carbon outline. He found “no evidence of any form of outline” on either suspect prescription. Testimony of Green; Exhibit A90 at 5. Mr. Green also looked for evidence of a slowly drawn writing process, which is commonly seen with tracings. When a person writes slowly, as when tracing, there will typically be no variation in pen pressure. He determined that the two prescriptions in question “were written with speed,” and he noted that that there were several indications that they were “fluently written” and not drawn products. Testimony of Green; Exhibit A90 at 5.

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<sup>14</sup> Ms. Dixon has subsequently admitted that she was mistaken with regard to the May 27, 2014 and June 23, 2014 Norco prescriptions, and that she did authorize those two prescriptions for KG. (*See* Ex. A86 at 7, 9-10; test. of Dixon.)

Mr. Green next examined the suspect prescriptions for evidence of a simulation process. When trying to simulate a signature (or text), there is typically evidence of hesitation points, as well as shakiness or tremor to the line quality. Mr. Green found no evidence of hesitation points, shakiness, or tremor in the two suspect prescriptions. Testimony of Green; Exhibit A90 at 5.

Given the above, Mr. Green ruled out that the two suspect prescriptions were tracings or simulations. Testimony of Green; Exhibit A90 at 5.

Mr. Green then compared the two suspect prescriptions to the November 13, 2014 prescription and several of Ms. Dixon's other known writings. Testimony of Green; *see* Exhibit A90 at 5-11. When he compared signatures between the November 13, 2014 known sample and the two suspect prescriptions, he observed that the height relationships and connecting strokes matched. Testimony of Green; Exhibit A90 at 8. He noted a number of similarities between the two suspect prescriptions and Ms. Dixon's known writings. For example, the upper stroke of the "K" in KG's name was higher on the right side than the left; the "i" in KG's name was shorter than the other letters; the "i-dot" was positioned slightly to the right of the staff; the crossing of the "t" in KG's name was low on the vertical staff; the right side of the "N" in "F.N.P." extended above the other letters; the "N" in "Norco" had a sweeping right leg that extended below the imaginary baseline; the "D" in "Disp[ense]" had a well-arched termination stroke; the number 3 had a slight retracing at the bottom; the number 2 was not looped; the number 4 was written in an open block style; the top of the "G" extended beyond the letter; and the cursive "T" in "Take" began with a very short approach stroke and had a loop at the bottom. Testimony of Green; Exhibit A90 at 5-8.

Every writer has natural variations in his or her writing. Testimony of Green. For example, in Ms. Dixon's known writings, the "s" at the end of KG's name was sometimes written in cursive and sometimes in print. Exhibit A90 at 7; *see, e.g.*, Exhibit A91 at 11,<sup>15</sup> 12, 15. Similarly, in one of the suspect prescriptions (Exhibit A91 at 5), the "s" at the end of KG's name appears in print, and in the other suspect prescription (Exhibit A91 at 10), the "s" appears in cursive. Exhibit A90 at 7. Taking into consideration Ms. Dixon's natural writing variations, Mr. Green discerned no significant differences between her known writings and the two suspect prescriptions. Testimony of Green.

Forensic document examiners do not use percentages or degrees of scientific certainty. *Id.* Instead, the Scientific Working Group for Forensic Document Examination has defined specific terms to express the possible range of opinions. "Identification of the writer" is the highest standard of certainty in forensic document examination. Exhibit A90 at 13; testimony of Green. In descending order of certainty, the other terms are as follows: highly probable (did write); probable (did write); indications (did write); inconclusive; indications (did not write); probable (did not write); highly probable (did not write); and elimination of the writer. Forensic document examiners, when rendering opinions using the above terms, consider such things as whether originals or machine copies were provided and reviewed, the quantity and quality of any machine copies provided, whether the known samples were closely dated to the suspect

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<sup>15</sup> A better (*i.e.* more readable) copy of this prescription is found at Exhibit A90 at 11.

writing[s], the amount of writing at issue, and whether the writing was in cursive, printed, or restricted to initials or numerals. Exhibit A90 at 13.

In his written report, Mr. Green stated the following regarding the November 20, 2014 and January 16, 2015 suspect prescriptions:

As [a] result of the examination, Ms. Dixon was identified as the writer of both prescriptions in question[.] The numerous features in common with the printed text as well as the signatures, with no apparent significant differences, compelled the opinion stated.

*Id.* at 11. At hearing, when the Board's counsel asked whether there was any question in Mr. Green's mind that Ms. Dixon wrote the two suspect prescriptions, Mr. Green answered, "No." Testimony of Green. He then testified, "I'm confident [Ms. Dixon] wrote both prescriptions in question." *Id.* Mr. Green's expert opinion is entitled to significant weight.

At hearing, counsel for Ms. Dixon questioned Mr. Green about an opinion that Mr. Green expressed on his internet blog that stated, "The reality is a well simulated signature, or tracing, rarely contains identifying features of the writer." See Exhibit R40 at 2. Counsel seemed to insinuate that the stated opinion contradicts Mr. Green's conclusions pertaining to the two suspect prescriptions. There is no contradiction, however, because Mr. Green ruled out that the two suspect prescriptions were either tracings or simulations. Thus, the opinion expressed on Mr. Green's blog does not apply to the two prescriptions at issue. Ms. Dixon did not otherwise offer any evidence that called into question Mr. Green's expertise, forensic examination methodology, or the basis for his conclusions in this matter. Aside from her repeated denials, and claims that KG is dishonest and manipulative, Ms. Dixon presented no evidence to refute Mr. Green's opinion that Ms. Dixon wrote the two suspect prescriptions.

As discussed in greater detail in subsequent subsections of the Proposed Order, Ms. Dixon's written and verbal assertions to the Board and the ALJ regarding certain matters were not always plausible, consistent, reliable, logical, or credible.

For example, Ms. Dixon's hearing testimony was inconsistent as to what she believed, or knew to be true, about KG's medication status when KG overdosed on June 30, 2014.<sup>16</sup> At the hearing on December 28, 2015, Ms. Dixon testified that on June 30, she knew KG was on an antidepressant, taking Norco, and had consumed alcohol "excessively" the previous night. Testimony of Dixon. However, on January 8, 2016, she insinuated through additional testimony that she had been unaware that prescription medications might be involved with KG's intoxicated, incoherent state on June 30. She testified that when SG first called her on June 30, he only reported that KG had consumed too much alcohol the previous evening and did not mention any medications, and that when she arrived at KG's home, she believed KG had merely consumed too much alcohol. She testified that it was after KG's symptoms started to worsen,

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<sup>16</sup> In addition, Ms. Dixon provided inconsistent statements to the 911 operator, Board investigators, and this ALJ as to the timing of her arrival at KG's home and the subsequent 911 call.

SG suggested that KG may have taken medications, and he produced bottles of a benzodiazepine and an antidepressant that she then called 911.

In addition to those inconsistencies, it is unlikely, and bordering on implausible, that Ms. Dixon would not immediately realize or remember that she had been prescribing Norco to KG, in significant amounts, for several months leading up to June 30. On March 11, 2014, she prescribed 90 tablets of Norco to KG; on April 7, 2014, she prescribed 90 tablets, with five refills (which if filled, would make 540 tablets available to KG); and on May 27, 2014, she prescribed 120 tablets, with four refills (which if filled, would make 600 additional Norco tablets available to KG). Given that, it is highly suspicious that Ms. Dixon did not report to the 911 operator, or to any of the emergency responders on June 30, that KG had been taking Norco since March and currently had an active prescription. The most plausible explanation for her omission is that, as the prescriber of the Norco, Ms. Dixon was attempting to shield herself from any potential liability or other negative repercussions.

Ms. Dixon's hearing testimony was also inconsistent as to whether she conferred with Dr. Binette regarding KG. At the hearing on December 28, 2014, Ms. Dixon testified that she did not confer with Dr. Binette, or any other providers, regarding KG's dysmenorrhea and pain issues. However, on January 8, 2016, she testified that she *had* discussed KG with Dr. Binette, because he was also Ms. Dixon's physician. The later, inconsistent testimony was unconvincing.

In addition, and as explained in greater detail later, Ms. Dixon made several untruthful statements to Board investigators during a May 20, 2015 Board interview. The statements included, among others, whether she had altered KG's Botox treatment records (which she had, in four instances), whether the Botox treatment records she provided to the Board were complete and reflected all client prescriptions (they did not), and whether she had prescribed medication to individuals with whom she did not have a provider/client relationship (she admitted to two; there were actually 22).

Given all of the above, the record persuasively establishes that Ms. Dixon wrote the Norco prescriptions to KG dated November 20, 2014 and January 16, 2015.<sup>17</sup>

## FINDINGS OF FACT

### *Professional History*

1. The Board has licensed Ms. Dixon as an R.N. (082011895RN) since 1984. Since 2008, the Board has certified Ms. Dixon as an N.P. (200850050NP).<sup>18</sup> (Ex. R1 at 1; *see* Ex. A78 at 1.)

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<sup>17</sup> The record establishes this fact by both a preponderance of the evidence (*i.e.* more likely than not) and by clear and convincing evidence (*i.e.* highly probable).

<sup>18</sup> She is specifically certified as a Family Nurse Practitioner (F.N.P). (*See* Ex. A78 at 1.)

2. From 1985 to 1986, Ms. Dixon was a staff nurse at Ashland Community Hospital. From 1986 to 1989, she was an R.N. in the critical care float pool and intensive care unit (ICU) at Rogue Valley Medical Center. From 1989 to 1993, she performed medical sales for Kinetic Concepts, Inc. From 1994 to 1997, she was a staff nurse and clinical nurse manager in the combined ICU/coronary care unit (CCU) at Tuality Community Hospital. (Exs. A1 at 1-2, R2 at 1-2; test. of Dixon.)

3. In May 1997, Ms. Dixon began working at Asante Rogue Regional Medical Center (Rogue Regional).<sup>19</sup> Until June 2008, she worked as an R.N. in the CCU. As of June 2008, she worked as a Critical Care N.P. in the ICU. She also periodically worked as an Interim Nurse Manager for the ICU and CCU. (Exs. A1 at 2, R3 at 2, A86 at 4, 13; test. of Dixon.) On August 10, 2015, the employer terminated her employment for failure to maintain an unrestricted license to practice.<sup>20</sup> (Exs. A89 at 1, R5 at 1.)

4. Meanwhile, from January 2010 to February 2013, Ms. Dixon also worked as an F.N.P. at Creekside Family Practice (Creekside). She worked on a part-time basis, one day per week, providing primary care and episodic care management. Although she did not see patients after December 10, 2012, she stayed on-call staff until February 2013, during which time she continued to field some questions through the medical assistant. (Exs. A1 at 2, R3 at 2, A86 at 3-4, 16; test. of Dixon.)

#### *Private Transformations Practice*

5. On April 1, 2011, Ms. Dixon began her Private Transformations esthetic skin care practice. She primarily performed skin care consultations, and provided Botox, dermal fillers, and collagen to clients. (Exs. A1 at 3, R3 at 3, A86 at 19-20; test. of Dixon.)

6. Ms. Dixon primarily performed Private Transformations procedures out of her home office. However, she also sometimes performed Botox procedures at private residences, sometimes during so-called “Botox parties.” (Ex. A86 at 30, 54.) She also occasionally performed Botox procedures at the Blue Giraffe Spa and the Element Salon/Spa. (*Id.*; test. of Dixon.) By 2015, her practice had grown to approximately 414 Botox clients. (Test. of Dixon.)

7. After signing the Interim Consent Order in May 2015, Ms. Dixon ceased operating her Private Transformations practice. (Test. of Dixon.)

#### *Standards of Care Pertaining to N.P. Practice*

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<sup>19</sup> Asante is a corporation that owns several hospitals, including Rogue Regional. (Test. of Holmes.)

<sup>20</sup> On May 7, 2015, Ms. Dixon signed an Interim Order by Consent, agreeing not to practice as an R.N. or N.P. pending further order of the Board. (See Pl. P1 at 1, Exs. R2 at 1, A84 at 1-3.)

8. Standards of care for N.P.s are the same throughout Oregon. The standards are not specific to particular communities, cities, or regions in the state. (Test. of Patel.<sup>21</sup>)

9. An N.P. can independently provide primary care and prescribe and dispense medications to patients. The standard of care for prescribing medication requires that an N.P. conduct and document an assessment. An assessment is vital for determining whether a medication (or other treatment) is necessary and appropriate. An assessment requires taking a careful clinical history; conducting a physical examination, if indicated; making a diagnosis; and

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<sup>21</sup> Given Ms. Patel's education and experience (a summary of which follows), the ALJ concluded that her opinions on the standards of care pertaining to N.P.s were entitled to significant weight.

Ms. Patel has been an F.N.P. since 2001. Since 2002, she has been licensed in both Oregon and Washington. In 1995, she received a Bachelor of Science in Nursing. From 1995 to 1998, she was a staff nurse in the sub-acute skilled nursing unit at Legacy Good Samaritan Hospital. From 1999 to 2001, she was a staff nurse involved with hematology, oncology, and bone marrow transplant patients at the University of Michigan Medical Center. In April 2001, she received a Master of Science in Community Health Nursing. During the 2001-2002 academic year, she was a clinical teaching associate at the Oregon Health Sciences University Hospital (OHSU) School of Nursing. Until 2002, she worked with hematology, oncology, and bone marrow transplant patients at OHSU. From 2002 to 2004, she worked as an F.N.P., providing primary care for adults, children, and infants.

From 2004 to 2008, she worked as a Board Investigator and Advisor. In her investigatory role, she investigated complaints against N.P.s, R.N.s, and certified nursing assistants (C.N.A.s) to determine whether violations of the Oregon Nurse Practice Act had occurred. In her advisory role, she provided advice regarding the scope of nursing practice to N.P.s, R.N.s, C.N.A.s, employers, and the public.

From 2008 to 2009, she worked as an FN.P. for adults and children at the Minute Clinic. From 2009 to 2010, she was the R.N. Care Manager in the InteR.N.al Medicine Clinic at OHSU. Her primary responsibilities included developing ways to better manage chronically ill patients, developing ways for providers to improve preventive health maintenance, performing phone triage, and nursing duties such as dressing changes, patient education, and facilitation of necessary treatment recommendations and follow-up care. From 2010 to 2011, she worked as an F.N.P. at the Camas Family Doctor clinic, providing primary care for men, women, children, and infants.

From 2011 to 2012, she worked as an F.N.P. Research Assistant for RS Medical, a company involved with neuromuscular stimulator products. Her primary responsibilities included researching current recommended treatments for low back pain, compiling guidelines for the evaluation of back pain, and compiling a comprehensive list of current pain grading scales.

From 2012 to 2013, she worked as an F.N.P., on an independent contractor basis, for EMSI. She primarily performed in-home assessments of specifically identified patients enrolled in the Medicare Advantage program, to ensure compliance with the Centers for Medicare and Medicaid Services (CMS). Her specific duties included identifying health risks, performing comprehensive assessments, identifying diagnoses, making appropriate referrals, and educating patients. From 2013 to the present, she has continued to perform in-home assessments of patients enrolled in the Medicaid Advantage program, as an F.N.P. for Optum Health.

developing a plan of care. The scope and precise components of an assessment can be complaint-specific and patient-specific. (Test. of Patel.)

10. The Board has a publication titled “Prescriptive Authority in Oregon for Advanced Practice Nurses.”<sup>22</sup> (Ex. A94.) The section “Prescribing for Family, Friends, Peers or Self” states:

[An N.P.] \* \* \* may not prescribe for themselves. [An N.P.] \* \* \* may prescribe for family, friends, or peers, provided the client/provider relationship is established and documented. All prescribed drugs require establishment of the client/provider relationship, assessment, and documentation of such to produce upon request by the [Board.] \* \* \* [The Board] and DEA strongly discourage prescription of controlled substances to family, friends or coworkers. The \* \* \* N.P. practicing in mental health is ethically bound to avoid boundary conflicts by not treating or diagnosing friends and family.

(*Id.* at 10.)

11. Although the Board and the federal Drug Enforcement Administration (DEA) discourage the prescribing of narcotics to family, friends, and coworkers, the Board does not prohibit the practice. The community standard for N.P.s is that if you prescribe to family, friends, and/or coworkers, you must conduct assessments and document them. (Test. of Patel; Ex. R32 at 1-2.)

12. There is a large illicit market for controlled substances, and they carry a high potential for abuse. As such, N.P.s must be diligent when prescribing controlled substances. An N.P. should optimize alternatives to controlled substances; conduct patient risk assessments; take careful client histories; conduct follow-ups with patients to look for evidence of withdrawal, intoxication, and/or sedation; require regular urinalyses (UAs) for ongoing narcotics patients; and limit the dosages, quantities, and refills of controlled substances. (Test. of Patel.)

13. If an N.P. prescribes narcotics to a patient with known substance abuse issues, the N.P. should prescribe only the minimum amount of narcotics necessary, have the patient enter into a contract agreeing to submit to UAs and not to seek narcotics from other providers, and closely follow up with the patient. The best practice in such a situation would be for the N.P. to refer the patient to a pain specialist or pain clinic. (Test. of Patel.)

14. A nurse/client relationship is not established merely because an N.P. prescribes a medication for a person. However, when an N.P. prescribes a medication to someone, regardless of whether there is an established nurse/client relationship, the N.P. nonetheless has an obligation to determine whether the prescription is appropriate and whether the person has any co-morbid

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<sup>22</sup> N.P.s are considered advanced practice registered nurses (A.P.R.N.s). (Test. of Cowgill; *see* OAR 851-056-0000(3).)

conditions that could be adversely affected by the medication. The N.P. must also document the assessment. (Test. of Patel, Cowgill.)

15. Providers write prescriptions for finite amounts of medication to encourage patients to return for reevaluation. In Ms. Patel's opinion, an N.P. provides a disservice to a person by giving the person refills on a prescription instead of requiring the person to go back to the original prescribing provider so that provider can assess the propriety of continuing the prescription, potentially adjusting the dosage, *etc.* (Test. of Patel.)

16. Patient documentation (*i.e.* treatment notes) must be accurate and thorough so that another provider could review the documentation and take over care of the patient. Failure to accurately and thoroughly document patient care carries a potential risk of harm to the patient because it could negatively affect continuity of care with a new provider. (Test. of Patel.)

17. If a nurse or N.P. makes a late entry in a patient record, the nurse or N.P. must write "late entry" next to the late entry, along with the date he or she is making the late entry, and his or her signature. (Test. of Patel.) It is contrary to the standard of care for an N.P. or a nurse to change numbers on a patient record. The acceptable practice is to cross out the incorrect number, write "error" next to it, write the correct number, and then write the date the correction was made and the nurse or N.P.'s signature. (*Id.*)

18. Honesty and trustworthiness are vital components to nursing practice. An R.N. or N.P. must be able to admit when he or she makes a mistake, especially when it relates to the provision of patient care. (Test. of Patel.)

#### *Prescription for Iopidine Ophthalmic Solution*

19. Ms. Dixon maintains certain supplies, such as needles and Lidocaine, as "office stock" for her Private Transformations practice. (Test. of Dixon; *see* Ex. R41.) She has an account with Black Oak Pharmacy, and she typically purchases office stock through that pharmacy. (Test. of Dixon; *see* Ex. R41.)

20. Ptosis is a temporary condition, resulting in a droopy eye that can occur following a Botox procedure. Ms. Dixon learned during her Botox training that it was a good practice to have Iopidine Ophthalmic Solution (0.5%) available in a Botox clinic for treating ptosis. (Test. of Dixon.)

21. Black Oak Pharmacy does not carry Iopidine Ophthalmic Solution (0.5%). On October 3, 2013, Ms. Dixon called in a prescription to Rogue Valley Rx for one bottle of Iopidine Ophthalmic Solution (0.5%). (Test. of Dixon; Exs. A73 at 1, R25 at 1.) She intended to utilize the bottle of medication as office stock. She did not intend to personally use the medication. (Test. of Dixon.) On the prescription form, Ms. Dixon is listed as both the provider and the patient. The prescription form does not indicate that the medication is intended for use as office stock. (*See* Exs. A73 at 1, R25 at 1.)

22. During her Board interview, Ms. Dixon denied prescribing the medication for her own use, she explained that it was intended strictly for use as office stock, and she insisted that she never used the medication personally. (Ex. A86 at 49-50.)

*Alleged Violations Involving Treatment of GB, JB, JDB, LLB, WB, SKC, SMC, SD, TD, PE, KF, AF, LF, NF, TLK, SL, ML, DM, AR, HS, BT, LW and JW*

23. On January 30, 2014, Ms. Dixon prescribed Retin-A (tretinoin) to GB. (Exs. A16 at 1, A86 at 43.) There are no Rogue Regional records showing that GB was a patient of Ms. Dixon's. There are no patient records at Creekside for GB. (See Ex. A16 at 2-4.) Ms. Dixon has no Private Transformations treatment records for GB. (See Evidentiary Record.)

24. On July 23, 2014, Ms. Dixon prescribed Effexor ER (37.5 mg, #90) to her "close friend," JB.<sup>23</sup> (Test. of Dixon; Ex. A17 at 1-3.) JB had been taking Effexor for approximately two years, but he did not have a current provider because he had recently relocated. Ms. Dixon did not want him to abruptly stop the medication. (Test. of Dixon.) JB filled the prescription on July 23, 2014, August 20, 2014, and September 19, 2014.<sup>24</sup> (Ex. A17 at 1-3; test. of Dixon.) Ms. Dixon did not document the prescription. (Test. of Dixon.) There are no patient records at Creekside or Rogue Regional for JB. (See Ex. A17 at 4-8.) Ms. Dixon has no Private Transformations treatment records for JB. (See Evidentiary Record.)

25. To meet the standard of care for diagnosing depression, an N.P. must take a careful client history, including a substance abuse history and a history of present illness; utilize some type of depression scale (*e.g.* Beck Inventory Scale); question the client about suicidal ideation; and rule out any medical causes for depression. (Test. of Patel.)

26. On December 31, 2013, Ms. Dixon prescribed lisinopril (20 mg), a blood pressure medication, to JDB, an R.N. at Rogue Regional. The prescription allowed for three refills. (Exs. A20 at 1, A86 at 31-32; test. of JDB, Dixon.) Prior to prescribing it, Ms. Dixon questioned JDB about the medication and asked him to take his own blood pressure. (Test. of JDB.) During her Board interview, Ms. Dixon stated, in part:

[W]ith [JDB], \* \* \* he and I are very good friends, and he said, "Tamara, I'm out of my lisinopril, I have a very strong family history, I've been on it for three years, I ran out of it, I don't get in with my primary care

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<sup>23</sup> In correspondence submitted to the Board on June 15, 2015, Ms. Dixon indicated that she did not recall JB. (See Ex. A87 at 1.) At hearing, however, she testified with great specificity as to the circumstances surrounding JB's Effexor prescription and she provided details of the "very thorough" depression assessment she performed on him. (Test. of Dixon.)

<sup>24</sup> Ms. Dixon testified at hearing that JB was only taking 37.5 mg of Effexor per day, which would make the 90-tablet prescription a three-month supply of medication. With the addition of the two refills, this would make a nine-month supply of medication in total. However, because JB filled the prescriptions monthly (*i.e.* in July, August, and September), more likely than not, he was taking *three* 37.5 mg tablets per day, and each prescription was merely a one-month supply. This makes the original prescription, plus the two refills, a three-month supply in total.

provider for a month, will you write me a prescription for one month?" Lisinopril, I said, what are you on? He said Lisinopril 20 mg. Have you always been on it? Yes I have. Any known allergies? No. And I wrote the prescription.

(Ex. A86 at 32.) JCB refilled the lisinopril prescription on April 24, 2014, June 27, 2014, and November 1, 2014. (Ex. A95 at 1.)

27. To meet the minimum standard of care when prescribing blood pressure medication, an N.P. should check vital signs—including blood pressure, heart rate, and respiration—because a person's condition can change over time. The N.P. should also examine the person's feet to ensure there is no swelling. (Test. of Patel.)

28. On June 26, 2014, Ms. Dixon prescribed acyclovir (400 mg), an anti-viral medication, and propranolol (20 mg), a medication to treat tremors, to JDB. (Ex. A20 at 2-3; test. of JDB.) JDB's only known medical history was provided verbally to Ms. Dixon by JDB himself. Ms. Dixon did not document any of JDB's prescriptions in treatment records or chart notes. (Ex. A86 at 32, 45.) There are no Rogue Regional records showing that JDB was a patient of Ms. Dixon's. There are no patient records at Creekside for JDB. (See Ex. A20 at 4-6.) Ms. Dixon has no Private Transformations treatment records for JDB. (See Evidentiary Record.)

29. To meet the minimum standard of care when prescribing medication for tremors, an N.P. must evaluate whether the tremors are benign or not. It is the N.P.'s responsibility to take a careful client history (including family history), conduct a physical examination (including heart and lungs), conduct a neurological examination,<sup>25</sup> make a diagnosis, inform the client of side effects and the "black-box" warning regarding abrupt discontinuation of the medication, and document the assessment. (Test. of Patel.)

30. On August 24, 2012, Ms. Dixon prescribed Cymbalta (duloxetine) (60 mg) and trazadone (100 mg) to LLB. (Exs. A21 at 1, A86 at 46.) Each prescription allowed for 11 refills. (See Ex. A21 at 1.) During her Board interview, Ms. Dixon had no recollection of LLB, or of prescribing medications to her. (Ex. A86 at 46.) There are no Rogue Regional records showing that LLB was a patient of Ms. Dixon's. There are no patient records at Creekside for LLB. (See *id.* at 2-5.) Ms. Dixon has no Private Transformations treatment records for LLB. (See Evidentiary Record.)

31. Cymbalta is used to treat depression. Trazodone is an antidepressant that is often used for insomnia treatment. Both medications have black-box warnings regarding suicidal ideation. To meet the standard of care when prescribing those medications, an N.P. must monitor the patient for signs of suicide and/or a worsening of depressive symptoms. (Test. of Patel.)

32. WB is a CNA at Rogue Regional. (Ex. A86 at 46.) On September 24, 2013, Ms. Dixon prescribed a transdermal scopolamine patch to WB, after he approached her in the

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<sup>25</sup> Ms. Patel explained that it is important to rule out Parkinson's disease, for example. (Test. of Patel.)

workplace and requested it for motion sickness for an upcoming cruise. (Exs. A18 at 1, A86 at 45-46.) There are no Rogue Regional records showing that WB was a patient of Ms. Dixon's. There are no patient records at Creekside for WB. (*See* Ex. A18 at 2-4.) Ms. Dixon has no Private Transformations treatment records for WB. (*See* Evidentiary Record.)

33. On January 28, 2015, Ms. Dixon prescribed Tamiflu (25 mg) to SKC. (Ex. A22 at 1.) There are no Rogue Regional records showing that SKC was a patient of Ms. Dixon's. There are no patient records at Creekside for SKC. (*See id.* at 2-4.) Ms. Dixon has no Private Transformations treatment records for SKC. (*See* Evidentiary Record.)

34. On February 6, 2013, Ms. Dixon prescribed propranolol (20 mg) to SMC. The prescription allowed for one refill. (Ex. A23 at 1.) There are no Rogue Regional records showing that SMC was a patient of Ms. Dixon's. There are no patient records at Creekside for SMC. (*See id.* at 2-4.) Ms. Dixon has no Private Transformations treatment records for SMC. (*See* Evidentiary Record.)

35. On March 11, 2014, Ms. Dixon prescribed Yaz, an oral contraceptive, to her 16-year-old daughter, SD. The prescription allowed for a one-year supply of the medication. (Ex. A24 at 1-12; test. of Dixon.) There are no Rogue Regional records showing that SD was a patient of Ms. Dixon's. There are no patient records at Creekside for SD. (*See* Ex. A24 at 13-15.) Ms. Dixon has no Private Transformations treatment records for SD. (*See* Evidentiary Record.)

36. To meet the standard of care when prescribing oral contraceptives to a minor, an N.P. must take a careful client history (including sexual history, substance abuse history, and gynecological history) and should discuss the issue of sexually transmitted diseases. (Test. of Patel.)

37. Ms. Dixon's ex-husband, TD, had recurrent issues with swollen, actively inflamed eyelids. (Test. of Dixon.) On May 7, 2013, Ms. Dixon prescribed erythromycin to TD. The prescription allowed for six refills. On September 11, 2013, Ms. Dixon prescribed doxycycline (100 mg), 30 tabs, to TD. That prescription allowed for one refill. (Exs. A25 at 1-2, A86 at 49.) TD refilled the doxycycline prescription on January 5, 2014. (Ex. A95 at 2.) On February 4, 2014, Ms. Dixon again prescribed doxycycline to TD. (Ex. A25 at 3.) Ms. Dixon did not maintain a chart on TD, or otherwise document any care she provided to him. (Ex. A86 at 49.) There are no Rogue Regional records showing that TD was a patient of Ms. Dixon's. There are no patient records at Creekside for TD. (*See* Ex. A25 at 4-6.)

38. Blepharitis is inflammation of the eyelid. The condition can be either anterior or posterior (a myopia gland dysfunction). To meet the standard of care when prescribing medication for blepharitis, an N.P. must obtain a careful client history, ask about current symptoms, conduct a physical examination, document a diagnosis, and establish a plan of care. In treating the condition, lid hygiene is crucial, and topical antibiotics are appropriate. If the condition is persistent or chronic, an oral antibiotic (such as doxycycline) may be appropriate. Due to the risk of corneal inflammation in chronic cases, the best practice is to refer such a patient to a specialist. (Test. of Patel.)

39. On December 18, 2013, Ms. Dixon prescribed Augmentin (875/125 mg) to a Rogue Regional coworker, PE. (Ex. A26 at 1.) PE was having symptoms of bronchitis, so Ms. Dixon listened to her lungs and gave her the antibiotic prescription. (Ex. A86 at 51.) On September 22, 2014, Ms. Dixon prescribed Ciprofloxacin (250 mg) to PE. (Ex. A26 at 2.) Ms. Dixon did not chart any care for PE. (Ex. A86 at 51.) There are no Rogue Regional records showing that PE was a patient of Ms. Dixon's. There are no patient records at Creekside for PE. (See Ex. A26 at 3-5.)

40. On January 26, 2014, Ms. Dixon prescribed Augmentin (875/125 mg) to a coworker, KF. At the time, KF was not a Private Transformations client.<sup>26</sup> (Exs. A27 at 1, A86 at 54.) There are no patient records at Creekside or Rogue Regional for KF. (See Ex. A27 at 2-5.)

41. On January 12, 2014, Ms. Dixon prescribed benzonatate (200 mg), a cough suppressant, to AF. (Ex. A28 at 1.) There are no patient records at Creekside or Rogue Regional for AF. (See *id.* at 2-6.) Ms. Dixon has no Private Transformations treatment records for AF. (See Evidentiary Record.)

42. On April 4, 2014, Ms. Dixon wrote a tanning prescription for KG's daughter, LF. (Exs. A29 at 1, A68 at 53.) At the time, LF was 15 years old. (See Ex. A29 at 1.) During her Board interview, Ms. Dixon had the following exchange with Board investigators regarding the tanning prescription:

Van Horn: Does she have a medical condition that would have required tanning?

Dixon: No, it was for prom, or it was for something like that.

\* \* \* \* \*

Meadows: She didn't have psoriasis?

Van Horn: She didn't have psoriasis and acne?

Dixon: She did have acne.

Van Horn: What about psoriasis?

\* \* \* \* \*

Dixon: I know she has acne. I recall acne.

(Ex. A86 at 53.) There are no Rogue Regional records showing that LF was a patient of Ms. Dixon's. There are no patient records at Creekside for LF. (See Ex. A29 at 2-4.) Ms. Dixon has no Private Transformations treatment records for LF. (See Evidentiary Record.) A letter dated

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<sup>26</sup> Sometime later in 2014, KF did become a Botox client of Ms. Dixon's. (Ex. A86 at 54.)

October 13, 2015, from Southern Oregon Pediatrics, states that “[t]here are no records regarding skin conditions in the time frame being requested regarding [LF].” (Ex. A29 at 5.)

43. The U.S. Department of Health & Human Services and the World Health Organization have determined that ultraviolet radiation (such as that from indoor tanning beds) is a carcinogen and causes cancer. Tanning beds are not recommended for individuals under the age of 18. In Oregon, persons under age 18 need a prescription to use a tanning bed. (Test. of Patel.)

44. If Ms. Dixon was intending to treat acne by prescribing tanning for LF, then a thorough assessment was required. The standard treatments for acne include topical creams and oral antibiotics. Current literature shows that tanning beds are not a treatment choice for acne. (Test. of Patel.)

45. On September 11, 2013, Ms. Dixon prescribed valacyclovir (500 mg) to NF. (Ex. A30 at 1.) There are no patient records at Creekside or Rogue Regional for NF. (*See id.* at 2-4.) Ms. Dixon has no Private Transformations treatment records for NF. (*See* Evidentiary Record.)

46. On January 1, 2013, Ms. Dixon prescribed Lunesta (3 mg) to a Rogue Regional coworker, TLK. The prescription allowed for one refill. (Exs. A31 at 1, A86 at 31-32.) During her Board interview, Ms. Dixon stated, in part:

In the nursing break room, [TLK] said, “Tamara I cannot sleep; I’ve used Lunesta before, I can’t get into my primary care provider, would you write me a prescription for Lunesta?” I said, have you been on it before?” “I have, it worked great for me, it’s the only thing that works for me.” Do you have any known allergies? “No.” And I wrote [the prescription] for Lunesta.

(Ex. A86 at 32.) Ms. Dixon did not document the encounter with TLK. (*Id.*) There are no Rogue Regional records showing that TLK was a patient of Ms. Dixon’s. There are no patient records at Creekside for TLK. (*See* Ex. A31 at 2-4.) Ms. Dixon has no Private Transformations treatment records for TLK. (*See* Evidentiary Record.)

47. On June 15, 2013 and May 28, 2014, Ms. Dixon prescribed acyclovir to SL. The May 28, 2014 prescription allowed for one refill. On July 16, 2013, Ms. Dixon prescribed valacyclovir to SL, with one refill allowed. (Ex. A32 at 1-3.) There are no patient records at Creekside or Rogue Regional for SL. (*See id.* at 4-6.) Ms. Dixon has no Private Transformations treatment records for SL. (*See* Evidentiary Record.)

48. On January 16, 2014, Ms. Dixon prescribed acyclovir to ML. (Ex. A33 at 1.) There are no Rogue Regional records for ML reflecting a patient encounter on January 16, 2014. (*See id.* at 2.) Ms. Dixon has no Private Transformations treatment records for ML. (*See* Evidentiary Record.)

49. On January 16, 2014, Ms. Dixon prescribed acyclovir for DM. (Ex. A34 at 1.) There are no Rogue Regional records showing that DM was a patient of Ms. Dixon's. There are no patient records at Creekside for DM. (*See id.* at 2-4.) Ms. Dixon has no Private Transformations treatment records for DM. (*See Evidentiary Record.*) During her Board interview, Ms. Dixon could not recall this individual. (Ex. A86 at 62.)

50. On May 5, 2014, Ms. Dixon prescribed acyclovir to AR, with one refill allowed. On January 27, 2015, Ms. Dixon prescribed azithromycin to AR. (Ex. A35 at 1-2.) There are no Rogue Regional records showing that AR was a patient of Ms. Dixon's. (*See id.* at 3.) Ms. Dixon has no Private Transformations treatment records for AR. (*See Evidentiary Record.*)

51. On June 7, 2013, Ms. Dixon prescribed doxycycline to HS, a friend of Ms. Dixon's daughter. (Ex. A36 at 1; test. of Dixon.) There are no Rogue Regional records for HS reflecting a patient encounter on June 7, 2013. (*See Ex. A36 at 2.*) There are no patient records at Creekside for HS. (*See id.* at 3.) Ms. Dixon has no Private Transformations treatment records for HS. (*See Evidentiary Record.*)

52. On August 25, 2013, Ms. Dixon prescribed Silvadene cream to BT, a friend of Ms. Dixon's daughter. (Ex. A37 at 1; test. of Dixon.) There are no Rogue Regional records for BT reflecting a patient encounter on August 25, 2013. (*See Ex. A37 at 2.*) There are no patient records at Creekside for BT. (*See id.* at 3-4.) Ms. Dixon has no Private Transformations treatment records for BT. (*See Evidentiary Record.*)

53. On October 18, 2013, Ms. Dixon prescribed Cipro to LW. (Ex. A38 at 1.) There are no Rogue Regional records for LW reflecting a patient encounter on October 18, 2013. (*See id.* at 2.) There are no patient records at Creekside for LW. (*See id.* at 3-4.) Ms. Dixon has no Private Transformations treatment records for LW. (*See Evidentiary Record.*)

54. On August 11, 2014, Ms. Dixon prescribed albuterol (a bronchodilator), montelukast (Singulair, used for allergies or asthma), prednisone (a steroid often used for wheezing/shortness of breath), and levofloxacin (Levaquin, a strong antibiotic) to JW. (Ex. A39 at 1-3; test. of Patel.) At that time, JW was eight years old. (*See Ex. A39 at 1.*) During her Board interview, Ms. Dixon did not recall this individual. (Ex. A86 at 64.) There are no Rogue Regional records showing that JW was a patient of Ms. Dixon's. (Ex. A39 at 4.) During her Board interview, Ms. Dixon stated that JW's records could have been listed under the Rogue Regional ICU physician's name, even if Ms. Dixon was the one who called in prescriptions for the patient upon his discharge. (Ex. A86 at 65.) There are no patient records at Creekside for JW. (*See Ex. A39 at 5-6.*) Ms. Dixon has no Private Transformations treatment records for JW. (*See Evidentiary Record.*) In Ms. Patel's opinion, JW was a very ill patient, given that he received multiple breathing medications and an antibiotic. (Test. of Patel.)

*Alleged Violations Involving Treatment of SB, LB, DB, HC, ED, KE, TE, KH, LSJ, LLJ, KJ, TK, TL, DLM, MS, KS, DT, MW, PW, and SZ*

55. SB has been a Private Transformations client since at least May 2, 2011. (*See Ex. A40 at 3-4.*) On April 8, 2014, Ms. Dixon prescribed Miracle Mouthwash (containing Benadryl,

lidocaine, and Maalox) to SB, with one refill allowed. On December 23, 2014, Ms. Dixon prescribed 10 tablets of Cipro to SB. (*Id.* at 1-2.) The prescriptions are not documented in SB's Botox treatment records. (*See id.* at 3-9.)

56. LB has been a Private Transformations client since at least October 20, 2013. (*See* Ex. A41 at 3.) On June 18, 2014, Ms. Dixon prescribed acyclovir to LB, with one refill allowed. (*Id.* at 1.) The prescription is not documented in LB's Botox treatment records. (*See id.* at 2-4.)

57. DB is a nurse practitioner with whom Ms. Dixon previously worked at Creekside. (Ex. A86 at 42.) DB became a Private Transformations client on or about July 9, 2012. On July 10, 2012, DB received her only Botox treatment from Ms. Dixon. (*See* Ex. A42 at 9-10.) Ms. Dixon prescribed multiple medications for DB. (*See id.* at 1-8.) None of the prescriptions are documented in the Botox treatment records. (Ex. A86 at 42.) During a Board interview, Investigator Van Horn and Ms. Dixon had the following exchange regarding DB:

Van Horn: So it looks like there [are] eight scripts in the packet [for DB].

\* \* \* \* \*

Dixon: [T]hey were all collegial, and it was, people do it, and we're not supposed to, she said, would you write me a script of Singulair, would you write me a script for Phentermine? And I did.

Van Horn: [A]nd you didn't do any assessments on her? No documentation? No charting? You just gave her scripts?

Dixon: Yes.<sup>27</sup>

(*Id.* at 43.)

58. On April 15, 2013, Ms. Dixon authorized a refill of Singulair for DB. On July 11, 2013, Ms. Dixon prescribed Singulair for DB. On January 6, 2014, Ms. Dixon prescribed promethazine (with codeine) to DB. (Ex. A42 at 2, 6, 8.)

59. On June 14, 2013 and July 11, 2013, Ms. Dixon prescribed Soma (carisoprodol), a muscle relaxant and central nervous system depressant, to DB. The July 11, 2013 prescription allowed for two refills. (Ex. A42 at 3, 5; test. of Patel.)

60. Soma has the potential for drug dependency, so it is important for a prescribing N.P. to determine whether the patient has a history of substance abuse. When prescribing Soma, an N.P. would want to know the nature of the patient's muscle pain and conduct a muscle

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<sup>27</sup> On August 21, 2015, DB signed a Stipulated Order for Reprimand of Practitioner Certificate with regard to obtaining prescriptions from Ms. Dixon without have a patient/provider relationship. The Order became final on September 17, 2015. (Ex. A42 at 13.)

evaluation to assess strength, movement, and weakness. Labs and other diagnostics are not necessary when prescribing Soma for the first time. (Test. of Patel.)

61. On February 12, 2013, Ms. Dixon prescribed a three-month supply of phentermine (30 mg) to DB. The prescription was for 180 tablets, and directed DB to take one tablet twice per day.<sup>28</sup> (Ex. A42 at 1; test. of Patel.) On July 2, 2013, Ms. Dixon prescribed another three-month supply of phentermine (30 mg) to DB. (Ex. A42 at 4; test. of Patel.) On September 21, 2013, Ms. Dixon prescribed phentermine (15 mg) to DB. This prescription was for 60 tablets, and directed DB to take one tablet “qAM” (*i.e.* every morning). (Ex. A42 at 7; test. of Patel.)

62. Phentermine is a Schedule IV controlled substance. (21 C.F.R. §1308.14(e)(9).) As a stimulant medication, phentermine has a potential for abuse. It is typically prescribed for persons with body mass indexes (BMIs) greater than 30. It has been FDA-approved for short-term use. The typical dose is 15 to 37.5 mg per day.<sup>29</sup> To meet the standard of care when prescribing phentermine for weight reduction, an N.P. should initially monitor the patient’s weight, blood pressure, and heart rate on a weekly basis. (Test. of Patel.)

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<sup>28</sup> BID = twice per day. (Test. of Patel.)

<sup>29</sup> Notably, the Oregon Medical Board has, via OAR 847-015-0010, restricted Oregon physicians from prescribing phentermine for weight reduction purposes, except as follows:

(2) A physician may utilize a Schedule III or IV controlled substance for purposes of weight reduction in the treatment of Exogenous Obesity in a regimen of weight reduction based on caloric restriction, behavior modification and prescribed exercise, provided that all of the following conditions are met:

(a) Before initiating treatment utilizing a Schedule III or IV controlled substance, the physician determines through review of the physician’s own records of prior treatment, or through review of the records of prior treatment which another treating physician or weight-loss program has provided to the physician, that one of the following conditions exist:

(A) Patient’s body mass index exceeds 30 Kg/M sq; or

(B) Patient’s body mass index exceeds 27 Kg/M sq and the excess weight represents a threat to the patient’s health (as with hypertension, diabetes, or hypercholesterolemia.)

(b) Before initiating treatment utilizing a Schedule III or IV controlled substance, the physician obtains a thorough history, performs a thorough physical examination of the patient, and rules out the existence of any recognized contraindications to the use of the controlled substance to be utilized.

(3) Continuation of Schedule III or IV designated as FDA short term use controlled substances beyond three (3) months requires documentation of an average two (2) pound per month weight loss during active weight reduction treatment, or documentation of maintenance of goal weight[.]

63. HC has been a Private Transformations client since at least August 8, 2011. (See Ex. A43 at 3-4.) On April 8, 2015, Ms. Dixon prescribed a five-day course of the antibiotic Cipro (250 mg, #10) to HC. On April 15, 2015, Ms. Dixon prescribed another five-day course of Cipro (500 mg, #10) to HC. (*Id.* at 1-2; test. of Patel.) The prescriptions are not documented in the Botox treatment records.<sup>30</sup> (See Ex. A43 at 3-7; test. of Patel.)

64. The standard dosage for treating an uncomplicated urinary tract infection (UTI) with Cipro is 250 mg, every twelve hours for three days, or 500 mg, once a day for three days. (Test. of Patel.) Cipro has a black-box warning for tendonitis. (Test. of Patel.)

65. To meet the standard of care when prescribing medication to treat a UTI, an N.P. must take a careful clinical history and a history of current symptoms, including when the symptoms started; whether the person has experienced urgency, abdominal/flank pain, or fever; and whether there has been any blood in the urine. It is not necessary to perform a UA for an uncomplicated UTI, as long as the N.P. performs a careful assessment (including an abdominal and pelvic exam, if indicated). If a patient is taking Cipro to treat an uncomplicated UTI and symptoms persist after 7 or 8 days, the assumption is that the Cipro is not working to treat the infection. The standard of care in this circumstance is for the N.P. to prescribe a different medication and/or have the patient evaluated for a complicated UTI. (Test. of Patel.)

66. ED has been a Private Transformations client since at least November 29, 2011. (See Ex. A44 at 3-4.) On February 14, 2013, Ms. Dixon prescribed Xanax (0.25 mg, #30) and Retin-A to ED. (*Id.* at 1-2.) Ms. Dixon documented the prescriptions in a Botox treatment note dated February 14, 2013. With regard to the Xanax, the note indicates that ED complained of anxiety and difficulty sleeping and that she had taken Xanax in the past. Ms. Dixon also wrote that ED should follow up with her primary care physician (PCP). (*Id.* at 5.)

67. Insomnia can be secondary to other medical issues. Anxiety is typically a persistent problem. An N.P. should evaluate whether there are any physical causes of the anxiety, whether the person has any psychiatric disorders, whether the person has a family history of psychological issues, and whether the person has a history of substance abuse issues. (Test. of Patel.)

68. Ms. Dixon eventually learned by “word of mouth” that ED had substance abuse issues. (Test. of Dixon.)

69. KE was a Rogue Regional coworker of Ms. Dixon’s. (Ex. A86 at 51-52; test. of KE, Dixon.) She has been a Private Transformations client since at least May 13, 2011. (See Ex. A45 at 2-4.)

70. KE has been using progesterone cream since 1981. Her N.P. had been prescribing it for her, until the N.P. passed away. Because KE had not yet secured a new PCP or N.P., in

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<sup>30</sup> However, Ms. Dixon did note that HC had a UTI, for which Ms. Dixon prescribed Cipro (400 mg, #10), in a treatment note dated August 6, 2014. (Ex. A43 at 6.)

February 2013, she asked Ms. Dixon to write a progesterone cream prescription for her. Prior to prescribing the cream, Ms. Dixon conducted a “verbal assessment” of KE while they were working at Rogue Regional. (Test. of KE.) She asked KE about her symptoms, her blood pressure, her last mammogram, any incidences of bleeding, and whether KE was looking for a new PCP/N.P. Ms. Dixon did not make any notes of KE’s responses. In KE’s opinion, Ms. Dixon’s assessment was thorough. (*Id.*) There is no evidence that Ms. Dixon checked KE’s vitals. (*See Evidentiary Record.*)

71. On February 14, 2013, KE filled a prescription for progesterone 25% cream, which Ms. Dixon prescribed for her. (Exs. A45 at 1; A86 at 51; test. of KE.) The prescription is not noted in KE’s Botox treatment records. (*See Ex. A45 at 4-5.*)

72. TE is a monitor tech at Rogue Regional. (Ex. A86 at 52.) She was formerly a patient of Ms. Dixon’s at Creekside. (*See Ex. A46 at 13-15; test. of Dixon.*) She has been a Private Transformations client since at least May 13, 2011. (*See Ex. A46 at 10.*) The only Creekside records pertaining to Ms. Dixon’s care of TE at Creekside consist of a chart note dated March 4, 2010 and laboratory records dated April 28 and May 6, 2010. (*See id. at 13-15.*) TE is a single mother and Ms. Dixon tried to “help her out” by writing prescriptions for her. (Ex. A86 at 52.)

73. On December 24, 2010, TE was arrested for DUII (alcohol) and Reckless Endangering. (Ex. A79 at 1, 4.)

74. On January 11, 2013, Ms. Dixon prescribed Ativan (1 mg, #40), one tablet every eight hours for anxiety, to TE. The prescription allowed for one refill. Also on January 11, 2013, Ms. Dixon prescribed Phentermine (15 mg, #30) to TE. (Ex. A46 at 4-5.) Neither prescription is documented in TE’s Botox treatment records. (*See id. at 10-12.*)

75. On October 13, 2013, TE was arrested and cited for DUII (alcohol and methamphetamine) and Driving While Suspended (DWS). (Ex. A80 at 1-2.) TE admitted to an Oregon State Police officer that she had used methamphetamine and consumed alcohol before crashing her vehicle that day. (*Id. at 6.*) A blood test confirmed the presence of methamphetamine, and its metabolite amphetamine, in TE’s system on October 13, 2013. (*Id. at 21.*)

76. There is a handwritten note in TE’s Botox treatment records that states, “1/11/14 Sudafed 60 mg (#30) MR x 4.” (*See Ex. A46 at 12.*) However, there is no corresponding prescription in the record. (*See Evidentiary Record.*)

77. On February 26, 2014, Ms. Dixon prescribed Percocet 5/325 (oxycodone), a narcotic used to treat severe pain, to TE. (Ex. A46 at 6.) Ms. Dixon prescribed the Percocet for TE’s tooth pain. (Ex. A86 at 52.) For unknown reasons, the prescription is documented in the Botox treatment record on February 14, 2014. The note contains no information regarding why Ms. Dixon prescribed the medication. (*See Ex. A46 at 11.*)

78. On October 8, 2014, Ms. Dixon prescribed Augmentin (an antibiotic) to TE. (Ex. A46 at 7.) The prescription is not documented in TE's Botox treatment record. (*See id.* at 10-12.)

79. On January 8, 2015, Ms. Dixon prescribed pseudoephedrine (60 mg, #20) to TE. (Ex. A46 at 8.) Pseudoephedrine is a CNS stimulant that is used to make methamphetamine. It is not a drug treatment of choice for allergies. When prescribing this medication, it requires a careful clinical history, including a drug/alcohol history. (Test. of Patel.)

80. Also on January 8, 2015, Ms. Dixon prescribed clindamycin (an antibiotic) to TE. (Ex. A46 at 9; test. of Patel.) The prescription is not documented in TE's Botox treatment record. (*See Ex. A46 at 10-12.*)

81. KH is an R.N. and former colleague of Ms. Dixon's. (Ex. A86 at 57-58.) She has been a Private Transformations client since at least October 31, 2012. (*See Ex. A48 at 6.*) On November 6, 2013, at Rogue Regional, Ms. Dixon ordered a "stat" (*i.e.* emergent) blood pregnancy test for KH, at KH's request. (*Id.* at 13; test. of Dixon.) From a medical standpoint, it was not an actual emergent situation. However, KH did not want to wait the usual two to three days for results. (Test. of Dixon.) Ms. Dixon listed the condition "dysmenorrhea" on the pregnancy test order. (Ex. A40 at 12.) She did not perform a vaginal examination on KH. (Test. of Dixon.)

82. On November 20, 2013, Ms. Dixon prescribed a 90-day supply of the oral contraceptive Yasmin for KH. (Ex. A48 at 1.) KH had recently experienced a miscarriage, which had disrupted her menstrual cycle. (Test. of Dixon.) On August 26, 2014, Ms. Dixon prescribed azithromycin to KH. (Ex. A48 at 3.) Neither prescription is documented in KH's Botox treatment records. (*See id.* at 4-6.)

83. On January 3, 2015, Ms. Dixon prescribed azithromycin and Ativan (lorazepam) to KH. (Ex. A48 at 3.) Ms. Dixon prescribed the Ativan because KH was travelling and had difficulty with flying and sleeping. (*Id.* at 5, Ex. A86 at 58.) In a Botox treatment note dated January 3, 2015, Ms. Dixon noted the Ativan prescription and the reason for prescribing it. The azithromycin prescription is not documented in the records. (*See Ex. A48 at 5.*)

84. LSJ was a Rogue Regional colleague of Ms. Dixon's. (Ex. A86 at 58.) She has been a Private Transformations client since at least May 12, 2012. (*See Ex. A49 at 5.*) On September 9, 2013, Ms. Dixon prescribed Cipro to LSJ. (*Id.* at 1.) The prescription is not noted in LSJ's Botox treatment records. (*See id.* at 4-7.) On March 2, 2015, Ms. Dixon prescribed Phenergan (with codeine) and Augmentin to LSJ. (*Id.* at 2-3.) Those two prescriptions are documented in the Botox treatment records with the notation that LSJ was experiencing cough, congestion, and green nasal discharge. (*See id.* at 6.) Prior to writing prescriptions for LSJ, Ms. Dixon would do a "head to toe" assessment and, in LSJ's opinion, ask "appropriate" questions. (Test. of LSJ.)

85. LLJ was a Rogue Regional colleague of Ms. Dixon's. (Ex. A86 at 59.) On January 25, 2014, Ms. Dixon prescribed Atenolol and Norvasc, blood pressure medications, to LLJ. (Exs. A50 at 1, A86 at 59.) LLJ had run out of her long-term prescriptions for those

medications, and she told Ms. Dixon she would follow up with her usual provider after receiving the prescriptions from Ms. Dixon. (Test. of Dixon.) The prescriptions are not documented in any patient records for LLJ. (See Evidentiary Record.) LLJ did not become a Private Transformations client until April 8, 2014. None of her Botox treatment records document that she has high blood pressure. (See Ex. A50 at 4-5.)

86. On April 8, 2014, Ms. Dixon prescribed Norco and Soma to LLJ. (Ex. A50 at 2-3.) The medications were for LLJ's hip pain, until she could undergo hip replacement surgery. (Ex. A86 at 59; see also Ex. A50 at 4-5.) The two prescriptions are documented in LLJ's Botox treatment records. (See Ex. A50 at 5.)

87. KJ has been a Private Transformations client since at least August 12, 2011. (See Ex. A51 at 13-14.) On October 15, 2012, Ms. Dixon prescribed acyclovir, a medication to treat oral and genital herpes, to KJ. The prescription authorized two refills. On April 23, 2013, Ms. Dixon authorized a prescription refill of acyclovir for KJ, with six additional refills. KJ filled all of the prescriptions. On April 29, 2014, Ms. Dixon authorized additional refills, as needed, for up to one year. (*Id.* at 1-12; test. of Patel.) KJ's Botox treatment records do not document any of the acyclovir prescriptions. (See Ex. A51 at 13-21.)

88. TK is the owner of the Blue Giraffe Spa. (Ex. A52 at 2.) On March 5, 2013, Ms. Dixon prescribed lidocaine cream to TK. (*Id.* at 1.) TK's Botox treatment records show that she did not become a Private Transformations client until November 7, 2014. (See *id.* at 2-3.)

89. TL is an R.N. and former colleague of Ms. Dixon's. (Ex. A86 at 59.) She has been a Private Transformations client since at least April 24, 2011. (See Ex. A53 at 5-6.) On a Botox Patient Information sheet, Ms. Dixon noted that TL had no significant medical history and no current medications. (*Id.* at 5.)

90. On February 28, 2013, Ms. Dixon prescribed Lunesta (2 mg, #20) to TL for insomnia. The prescription allowed for one refill. (Exs. A53 at 1, A86 at 59-60.) In TL's Botox treatment record, a note dated February 28, 2013 states that TL complained of chronic insomnia, that TL had taken Xanax previously but wanted something different, and that Ms. Dixon was prescribing 20 tablets of Lunesta (2 mg). (Ex. A53 at 7.) Ms. Dixon did not document a careful client history, a diagnosis, or a plan of care. (See *id.*; test. of Patel.)

91. In TL's Botox treatment record, a note dated April 22, 2013 states that TL liked Lunesta, her insurance was covering it, and Ms. Dixon was prescribing 30 tablets of Lunesta (3 mg). (Ex. A53 at 8.) On April 23, 2013, Ms. Dixon again prescribed Lunesta to TL, with three refills. (*Id.* at 2.) A note dated October 15, 2013 states, "Trial of Lunesta 3 mg tabs #30 (x2) – refills OK'd – working well." (*Id.* at 8.)

92. On October 3, 2013, Ms. Dixon prescribed Iopidine Ophthalmic drops (0.5%) for TL because TL called Ms. Dixon after a Botox treatment and complained of a droopy eye. (Exs. A53 at 3, A86 at 60.) Ms. Dixon did not document TL's complaint or the Iopidine prescription in TL's Botox treatment records. (See Ex. A53 at 5-12.)

93. On November 5, 2014, Ms. Dixon prescribed Xanax for TL after TL reported that her insurance was no longer covering Lunesta. (Exs. A53 at 4, A86 at 59-60.) TL's Botox treatment records do not note the Xanax prescription until November 14, 2014, when Ms. Dixon noted that she would prescribe Xanax because the pharmacy was no longer covering Lunesta and TL had used Xanax in the past "well." (See Ex. A53 at 7; test. of Patel.) There is no documentation of an assessment, diagnosis, or plan of care with regard to the Xanax. (See Ex. A53 at 7; test. of Patel.)

94. On June 1, 2014, Ms. Dixon prescribed doxycycline to DLM. (Ex. A54 at 1.) DLM's Botox treatment records show that she did not become a Private Transformations client until November 21, 2014. (See *id.* at 2-3.)

95. MS has been a Private Transformations client since at least June 21, 2014. (Ex. A55 at 2-3.) On June 26, 2014, December 3, 2014, and January 23, 2015, MS filled prescriptions for Chantix, all of which Ms. Dixon prescribed to her. (*Id.* at 1.) MS's Botox treatment records contain no documentation of the Chantix prescriptions. (See *id.* at 2-3; test. of Patel.)

96. Chantix is a smoking cessation medication that is typically prescribed for no longer than 12 weeks. It is most beneficial to combine Chantix with cognitive behavioral therapy. Chantix has a black-box warning for depression, suicidal ideation, suicide attempts, behavioral changes, and hostility. Those events have occurred even in patients who have no prior history of psychological or psychiatric issues. To meet the standard of care for prescribing Chantix, an N.P. should perform a depression screen so that any behavioral changes (caused by the medication) can be tracked over time. (Test. of Patel.)

97. On October 25, 2014, MS filled prescriptions for Proair (albuterol), levofloxacin (an antibiotic), and Phenergan (promethazine) with codeine, all of which Ms. Dixon prescribed to her. (Ex. A55 at 1.) MS's Botox treatment records contain no documentation of those prescriptions. (See *id.* at 2-3.)

98. KS is an R.N. and former Rogue Regional colleague of Ms. Dixon's. (Exs. A56 at 3, A86 at 62.) She has been a Private Transformations client since at least April 29, 2011. (See Ex. A56 at 3.) On November 14, 2013, and January 24, 2014, Ms. Dixon prescribed Flexeril to KS for a shoulder issue. (*Id.* at 1-2, Ex. A86 at 62.) KS's Botox treatment records contain no documentation of the prescriptions. (See A56 at 3-7.)

99. DT is Ms. Dixon's sister. (Ex. A86 at 63.) She has been a Private Transformations client since at least April 24, 2011. (See Ex. A57 at 6-7.) On May 12, 2013, Ms. Dixon prescribed Ambien to DT, with refills as needed for one year. (*Id.* at 1.) In a Botox treatment note dated May 10, 2013, Ms. Dixon documented a one-year Ambien prescription and noted that it "works well" and that DT had no problems with it. (*Id.* at 8; test. of Patel.) DT's treatment records do not contain a careful client history, listed symptoms, evidence that Ms. Dixon ruled out secondary causes for insomnia, a diagnosis, or a plan of care. (See Ex. A57 at 6-9; test. of Patel.)

100. On June 21, 2014, Ms. Dixon again prescribed Ambien to DT, and authorized four refills. (Ex. A57 at 4.) In a Botox treatment note dated June 21, 2014, there is no documentation of the June 21, 2014 prescription. However, there is a note in that area of the chart that states, “11/12/14 Ambien 10 mg #90 (MR x 3) – OK to refill x 1 year.” (*Id.* at 9.)

101. On April 26, 2013, Ms. Dixon prescribed trazadone to MW. (Ex. A58 at 1.) On May 3, 2013, she prescribed Flonase to MW. (*Id.* at 2.) MW’s Botox treatment records show that she did not become a Private Transformations client until November 21, 2013. (*See id.* at 3-4.)

102. PW has been a Private Transformations client since at least August 12, 2011. (*See* Ex. A59 at 3.) On September 29, 2013, Ms. Dixon prescribed Ambien to PW for insomnia. The prescription allowed for five refills. (*Id.* at 1, Ex. A86 at 64.) In a Botox treatment note dated September 28, 2013, Ms. Dixon documented the prescription and stated that PW was stressed and not sleeping well after the recent death of her husband. (Ex. A59 at 6.) Subsequent treatment notes contain no documentation as to the efficacy of the medication or whether PW experienced any side effects. (*See id.* at 6-9.)

103. SZ has been a Private Transformations client since at least August 12, 2011. (*See* Ex. A60 at 8-9.) On May 5, 2013, Ms. Dixon prescribed Xanax (0.5 mg, #30) to SZ for “anxiety/sleep.” (*Id.* at 1, Ex. A86 at 65.) Ms. Dixon documented the prescription in a treatment note dated May 10, 2013, but she did not note that it was a late entry. The entry states that SZ complained of difficulty sleeping and that she had no insurance. (*See* Ex. A60 at 11; test. of Patel.)

104. On May 10, 2013, Ms. Dixon prescribed a one-year supply of Temovate (clobetasol) 0.05% cream and scalp solution and triamcinolone 0.1% cream to treat SZ’s psoriasis. (Ex. A60 at 2-4.) Ms. Dixon did not document those prescriptions in SZ’s Botox treatment record. (*See id.* at 8-13.) In a treatment note dated September 16, 2013, there is documentation of a one-year prescription for Temovate 0.5% cream for “plaque scalp/facial psoriasis.” (*Id.* at 11.) There is no corresponding prescription for that date, and no notation that it is a late entry for the May 10, 2013 prescription. (*See id.*, *see also* Evidentiary Record.)

105. On May 4, 2014, Ms. Dixon prescribed another one-year supply of triamcinolone 0.1% cream to SZ. On May 30, 2014, she prescribed another one-year supply of Temovate 0.05% cream and scalp solution to SZ. (Ex. A60 at 2-7.) Ms. Dixon did not document those prescriptions in SZ’s Botox treatment notes. (*See id.* at 8-13.) In a treatment note dated September 11, 2014, there is documentation of a one-year prescription for Temovate 0.5% cream. (*Id.* at 11.) There is no corresponding prescription for that date, and no notation that it is a late entry for the May 30, 2014 prescription. (*See id.*, *see also* Evidentiary Record.)

#### *Use of Creekside and Asante/Rogue Regional Prescription Pads*

106. As an N.P. at Rogue Regional, Ms. Dixon’s job duties included writing prescriptions for her patients. During the latter part of her employment, Rogue Regional utilized

electronic prescriptions only. However, there were prescription pads available in the event of printer malfunctions. (Ex. A86 at 13-14.)

107. Ms. Dixon did not have prescription pads for her Private Transformations practice. If she wrote a paper prescription (as opposed to calling in a prescription) for a Private Transformations client, she used either a Creekside prescription pad or an Asante/Rogue Regional prescription pad. After her employment ended at Creekside, she sometimes wrote prescriptions for coworkers and friends using Creekside prescription pads. She also sometimes wrote prescriptions for coworkers and friends using Asante/Rogue Regional prescription pads. (Ex. A86 at 17-18; *see, e.g.*, Exs. A18 through A22, A26 through A29, A31, A42, A44, A46, A49, A50, A53, A54, A56, A57, A60, A62, A62A, A64, A64A; test. of Dixon.)

108. The Creekside prescription pads that Ms. Dixon used for Private Transformations patients, coworkers, and friends contained the physical address, phone number, and fax number of the Creekside Family Medicine clinic, as well as the following names: Stephen L. Nelson, M.D.; Deborah Boles, F.N.P.; and Tamara Dixon, F.N.P. (*See, e.g.*, Ex. A64 at 1.) When Ms. Dixon used those pads to write prescriptions to non-Creekside patients after her Creekside employment ended, she did not include her own phone number or the physical address of her Private Transformations practice on the prescriptions. (*See, e.g., id.* at 1-2, 6, Ex. A64A at 1-7.)

109. The Asante/Rogue Regional prescription pads that Ms. Dixon used for Private Transformations patients, coworkers, and friends contained the physical address of the Rogue Regional Medical Center and spaces for the prescriber to put his or her address, DEA number, and office phone number. (*See, e.g.*, Ex. A62 at 1.) With very limited exception, when Ms. Dixon used those pads to write prescriptions to Private Transformations clients and other individuals for purposes unrelated to her Rogue Regional employment, she did not include her printed name, her own phone number, or the physical address of her Private Transformations practice on the prescriptions.<sup>31</sup> (*See, e.g., id.* at 1, 5-7, 9, 11, 13, 15-16, 37, 41, 51-53, Ex. A62A at 1-7, 9, 11.)

110. Ms. Dixon did not obtain authorization from either Creekside or Asante/Rogue Regional to use the prescription pads for purposes unrelated to her employment. (Test. of Dixon; *see* Exs. A61, A63.) Nonetheless, she did not believe she was doing anything wrong by using the prescription pads for non-employment purposes. (Test. of Dixon.)

111. In a written declaration, James Grebosky, M.D., stated, in part:

[I] am the Vice President of Medical Affairs for Asante Rogue Regional Medical Center[.]

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<sup>31</sup> One exception is an August 26, 2014 prescription, where Ms. Dixon's printed name does appear on the prescription. (*See* Ex. A62 at 29.) Another exception is a May 3, 2013 prescription, where Ms. Dixon included her Rogue Regional office phone number. (*See id.* at 47, Ex. A86 at 3.)

[I]t is not consistent with Asante practice to use an Asante prescription pad for an individual with whom a licensed provider does not have a provider/patient relationship.

[A]sante did not authorize Tamara Dixon, N.P., to use an Asante prescription pad for her home business.

(Ex. A61 at 1.)

112. In a written declaration, William J. Sloan stated, in part:

[I] am the Chief Financial Officer for Rogue Valley Physicians, PC, located in Medford[.]

[T]amara Dixon was hired on January 26, 2010, to work at our Creekside Family Practice clinic. While employed by Rogue Valley Physicians, she only worked at the Creekside Family Practice clinic.

[M]s. Dixon's last day of work in which she saw patients was on December 10, 2012. Ms. Dixon then was on call, but she did not come back into the clinic after December 10, 2012. [Her employment ended] on February 28, 2013.

[T]he prescription pads labeled "Creekside Family Medicine" are only used in the Creekside Family Practice clinic for clinic patients.

[M]s. Dixon was not authorized to use clinic prescription pads outside of the Creekside Family Practice clinic while not seeing clinic patients.

[T]here was no reason for Ms. Dixon to take the prescription pads offsite. Because Ms. Dixon did not return to the clinic after December 10, 2012, there was no reason for her to use the prescription pads after December 10, 2012.

(Ex. A63 at 1-2.)

*Ms. Dixon's Relationship with and Treatment of KG*

113. Ms. Dixon met KG in approximately 2012 when KG began working as an R.N. in the ICU at Rogue Regional. (Ex. A86 at 4; test. of Dixon.) In late 2013, KG and her young child lived at Ms. Dixon's home for approximately one month. (Test. of Dixon.) Ms. Dixon and KG became close friends. (Test. of Dixon; *see, e.g.*, Ex. A82 at 1-2.)

114. On July 27, 2013, Ms. Dixon first treated KG as a Botox client through her Private Transformations practice. (*See* Ex. A47 at 14-15.) In the Botox treatment records, Ms. Dixon noted that KG is "healthy," but that she has dysmenorrhea, needs a hysterectomy, and sees Dr.

Binette.” (*Id.* at 14.) A treatment note dated April 7, 2014, states that KG has fibroids. (*Id.* at 16.)

115. KG frequently complained of chronic pain from dysmenorrhea. (Ex. A86 at 54.) On January 28, 2014, Ms. Dixon prescribed Soma (350 mg, #30) to KG for her dysmenorrhea. (Ex. A47 at 1; test. of Dixon.) The prescription does not show that Ms. Dixon authorized any refills. (*See* Ex. A47 at 1.) In KG’s Botox treatment records that Ms. Dixon provided to the Medford Police, a treatment note dated January 28, 2014 lists a prescription for Soma, 350 mg, with “2 refills.” (Ex. A14 at 2.) In KG’s Botox treatment records that Ms. Dixon provided to the Board, a treatment note dated January 28, 2014 lists a prescription for Soma, 350 mg, with “4 refills.” (Ex. A15 at 2.) The number “4” is written over a “2.” (*Id.*)

116. Narcotics are not generally the first-line treatment for dysmenorrhea, but they may be appropriate if other treatments have been tried and failed. (Test. of Patel.)

117. On January 28, 2014, Ms. Dixon also prescribed azithromycin to KG. (Ex. A47 at 1.) On February 8, 2014, she prescribed the antibiotic Levaquin (levofloxacin) to KG. (*Id.* at 2.) Ms. Dixon documented those prescriptions in KG’s Botox treatment record. (*See id.* at 15-16.)

118. On March 11, 2014, Ms. Dixon prescribed Soma (350 mg, #30), with one refill, and 90 tablets of Norco (hydrocodone 10-325) to KG. (Ex. A47 at 3.) Norco is a controlled substance that may be appropriate for treating pain associated with dysmenorrhea. To meet the standard of care for prescribing Norco, an N.P. must obtain a careful client history. (Test. of Patel.) A Botox treatment note dated March 9, 2014 states that KG complained of low back pain from dysmenorrhea, that KG was to see Dr. Binette to discuss a hysterectomy, that Ms. Dixon was prescribing 60 tablets of Norco, and that KG still had one refill of Soma. (Ex. A47 at 16.)

119. Ms. Dixon wrote Norco prescriptions to KG that allowed for refills. (Ex. A86 at 10.) For example, on April 7, 2014, she prescribed 90 tablets of Norco, with five refills, to KG. (Ex. A47 at 4.) In a Botox treatment note dated April 7, 2014, Ms. Dixon stated that KG complained of severe dysmenorrhea, pain, and bleeding; that KG stated she was scheduled to see Dr. Binette; that KG wants a hysterectomy for “fibroids;” that a prescription was called into Safeway for 90 tablets of Norco with one refill; and that KG “still has Soma refill.” (*Id.* at 16.)

120. On May 2, 2014, KG refilled the Norco prescription. (*See* Ex. R22 at 2.) On May 5, 2014, Ms. Dixon prescribed Augmentin to KG. (Ex. A47 at 5.) On May 6, 2014, KG refilled the Soma prescription. (*See* Ex. R22 at 2.)

121. On May 27, 2014, Ms. Dixon prescribed 120 tablets of Norco, with four refills, to KG. (Ex. A47 at 6; test. of Rimov.) In KG’s Botox treatment records that Ms. Dixon provided to the Medford Police, there is no documentation of the May 27, 2014 Norco prescription. (*See* Ex. A14 at 3.) In the treatment records Ms. Dixon provided to the Board, she documented a “Late Entry” for the May 27, 2014 Norco prescription. (*See* Ex. A15 at 3.) On June 23, 2014, KG refilled the Norco prescription. (*See* Ex. R22 at 2.)

122. Ms. Dixon never conferred with Dr. Binette, or any other providers regarding KG's dysmenorrhea and pain issues. Ms. Dixon trusted that KG was providing her with accurate and truthful information about her conditions and the care she was receiving from other providers. (Test. of Dixon.)

123. According to Verizon phone records, at 4:26 a.m. on June 30, 2014, Ms. Dixon received an incoming call (lasting one minute) on her cell phone<sup>32</sup> from SG, KG's husband. She then received subsequent calls from SG at 4:27 a.m. (seven minutes duration), 4:40 a.m. (13 minutes duration), 5:00 a.m. (five minutes duration), 7:19 a.m. (three minutes duration), and 8:07 a.m. (one minute duration). (Ex. A100 at 5.) During one of the earlier calls, SG told Ms. Dixon that KG was awake and talking, but not acting "normal" and he wanted Ms. Dixon to come over and see her. (Test. of Dixon.) Ms. Dixon told him to watch her closely, but she did not agree to come over at that time. During a subsequent phone call to Ms. Dixon, SG informed her that KG was not "making sense." (*Id.*) At that time, Ms. Dixon told SG to call 911, and stated that she would come over. (*Id.*)

124. Ms. Dixon lives only a few blocks away from KG. It would have taken Ms. Dixon no longer than approximately 15 minutes to drive to KG's home that morning. When she arrived at the home, SG stated that he had not called 911 because he did not want to jeopardize KG's nursing license. Ms. Dixon found KG to be initially coherent, but then not coherent. Ms. Dixon told SG to call 911 a couple more times. KG did not initially appear to be in respiratory distress. (Test. of Dixon.)

125. At 9:31 a.m., Ms. Dixon called 911. (Ex. A102 at 1-2, 4.) She reported to the 911 operator that KG was unresponsive and unarousable, and had agonal respiration. Ms. Dixon told the 911 operator that she believed KG had "some alcohol intoxication" and a few seconds later stated, "I think it's an inadvertent mixture of alcohol and Xanax." (*Id.* at 1.) When the 911 operator asked how long KG had been unresponsive, Ms. Dixon replied, "Well, she, I just got here" and then Ms. Dixon told the operator that KG had been unresponsive for "about an hour." (*Id.* at 2.)

126. The 911 operator notified emergency responders of the situation at KG's home at 9:32 a.m. By 9:33 a.m., the responders were enroute to KG's home. The responders arrived at KG's home at 9:36 a.m. They found KG unconscious, with Ms. Dixon administering mouth-to-mouth. KG was subsequently intubated, given intravenous therapy and oxygen, and transported to a hospital emergency department. (Ex. A102 at 4-5, 8, 12.)

127. It is a breach of the minimum standard of care for an R.N. or N.P. to wait one hour to call 911 when a person is unresponsive to painful stimuli. (Test. of Patel.)

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<sup>32</sup> Although the cell phone number is actually registered to Todd Dixon, Ms. Dixon represented to Ms. Van Horn during a Board interview that this was the cell phone number she used. (Test. of Van Horn; see Ex. A86 at 3.)

128. Ms. Dixon did not inform the 911 operator (or the first responders) that KG had been prescribed Norco, and that Norco was available to her.<sup>33</sup> (See Ex. A102 at 1-16.) If Ms. Dixon had informed the 911 operator or the first responders that KG had active Norco prescriptions, KG's overdose may have been reduced more quickly by the administration of Narcan (naloxone) (a medication that can reverse an opiate overdose), if the overdose actually involved Norco. (Test. of Patel; see Ex. A102 at 20.)

129. KG's Botox treatment records do not show any evidence that Ms. Dixon obtained a careful substance abuse history from KG. (See Ex. A47 at 14-18; test. of Patel.) Regardless of whether KG would have been honest about her substance abuse history, the standard of care dictates that an N.P. must nonetheless ask the relevant questions when prescribing narcotics to a patient. (Test. of Patel.)

130. In Ms. Patel's opinion, Ms. Dixon caused harm to KG by repeatedly prescribing narcotics to her instead of insisting that KG follow up with Dr. Binette for a hysterectomy. By Ms. Dixon continuing to prescribe the narcotics that KG was requesting from her, KG had little to no reason to see Dr. Binette. (Test. of Patel.)

131. After KG's overdose on June 30, 2014, Ms. Dixon continued to see KG as a Botox client. (Ex. A86 at 7, 11.) On November 3, 2014, Ms. Dixon prescribed mupirocin 2% cream to KG. (Ex. A47 at 12.) That prescription is not documented in KG's Botox treatment records. (See *id.* at 14-18.) Documentation of mupirocin prescriptions does appear, in treatment notes dated August 25, 2014<sup>34</sup> and November 24, 2014. (See *id.* at 17-18.) The record contains no evidence of any mupirocin prescriptions for KG on either August 25, 2014 or November 24, 2014. (See Evidentiary Record.)

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<sup>33</sup> An Out of Hospital Care Report written by first responder Kevin Christopher Watt states, in part, "Family and friends not sure if [patient] took any other med[ications], did find her Xanax bottle empty, bottle was filled 30 days ago, no other substance that family knew of[.]" (Ex. A102 at 5.)

A Patient Care Report signed by paramedic Rachele Fain and EMT Kalah Hilliker states, in part:

Arrived on scene to have bystander who was a nurse practitioner state that the patient was last seen awake at 0600. Bystander stated that there was some heavy drinking yesterday and last night[.] \* \* \* \* \*. Bystander on scene stated that the patient was sad last night but stated that she did not make any suicide threats. Family member on scene stated that there were empty pill bottles. Family brought a[n] empty Xanax bottle and a[n] empty Lexapro bottle. No other empty bottles are [sic] medication w[ere] found. Family and bystander denied any other medications available to patient.

(*Id.* at 12-16.)

<sup>34</sup> While this Mupirocin notation was not present in KG's Botox treatment records that Ms. Dixon provided to the Medford Police (see Ex. A14 at 4), it appeared in the treatment records Ms. Dixon subsequently provided to the Board. (See Ex. A15 at 4.)

132. On November 26, 2014, Ms. Dixon prescribed azithromycin to KG. (Ex. A47 at 11.) A Botox treatment note dated November 24, 2014 lists the azithromycin prescription. (*See id.* at 18.)

#### *Omnicell Incident*

133. Rogue Regional utilizes an Omnicell machine to dispense medications. The medications are assigned to specific patients, and each R.N. has his or her own access code for the machine. Rogue Regional staff persons audit the Omnicell every four hours. (Test. of JDB.)

134. While working as an N.P. (*i.e.* a “mid-level” practitioner) at Rogue Regional, Ms. Dixon was not authorized to obtain medication from the Omnicell.<sup>35</sup> (Ex. A86 at 14.)

135. In approximately June 2014, KG complained to Ms. Dixon about having a painful migraine. She asked Ms. Dixon to get her the medication Toradol (an NSAID). When Ms. Dixon told KG she could not get the medication, KG told Ms. Dixon to ask someone else to get it. In response, Ms. Dixon asked JDB, an R.N. with whom she worked, to get the medication for KG. (Exs. A86 at 14, A11 at 3; test. of Dixon, JDB.)

136. JDB subsequently accessed the Omnicell, obtained a vial of intravenous Toredal as “floor stock,” and gave the medication to Ms. Dixon. (Test. of JDB; Ex. A86 at 15.) Ms. Dixon subsequently provided it to KG. (Test. of Dixon; Ex. A86 at 15.) There is no documentation of the Toredal medication in KG’s Botox treatment records. (*See* Ex. A47 at 14-18.)

137. On June 1, 2015, the employer questioned JDB about pulling medication from the Omnicell for someone who was not his patient. JDB admitted that he obtained Toredal from the Omnicell, at Ms. Dixon’s request, so that she could give it to KG. The employer gave JDB a Written Corrective Action for his conduct. (Ex. A11 at 1, 3; test. of JDB.) JDB self-reported his conduct to the Board and subsequently stipulated to a Board reprimand. (Ex. A12 at 1-2; test. of JDB.)

#### *Viewing of KG’s and EG’s Health Records*

138. On November 28, 2014, Ms. Dixon, while in her office at Rogue Regional, accessed KG’s medical record. On February 10, 2015, Ms. Dixon accessed EG’s<sup>36</sup> medical record, also from her Rogue Regional office. (Test. of Dixon.)

139. Asante prohibits an employee from accessing medical records outside of that employee’s work duties. (Test. of Raby.) Asante’s written confidentiality policy states, in part:

Asante staff is not allowed to access their own [protected health information], or that of family or friends, unless required to perform their job, even if they have the access to do so. All individuals, including

<sup>35</sup> When she previously worked as an R.N., she was authorized to use the Omnicell. (Ex. A86 at 14.)

<sup>36</sup> EG is KG’s minor son. (Test. of Raby, Dixon.)

employees whose friends or relatives are treated at Asante, must request patient information through Health Information Services. Accessing any patient information other than what is needed to do one's job is not allowed.

(Ex. R35 at 1-2; test. of Raby.)

140. On June 12, 2015, KG called Glendora Raby, a privacy information security officer with Asante, and reported that she had concerns about Ms. Dixon inappropriately accessing medical records for her and EG. (Test. of Raby; Ex. A66 at 1.) In response, Ms. Raby ran an audit report for the period 2013 to 2015. The audit report showed that Ms. Dixon viewed clinical notes and other medical records for KG on November 28, 2014, and for EG on February 10, 2015. (Test. of Raby; Ex. A65 at 1-2; *see also* Ex. R16 at 1-2, A66 at 2.) Ms. Raby reported the matter to Jacque Sites, in the employer's human resources department. (Test. of Raby; Ex. A66 at 1.)

141. On June 30, 2015, Ms. Dixon met with Ms. Sites and three other individuals regarding the medical record access issue. (Exs. A66 at 1, A67 at 1; test. of Raby.) Ms. Dixon stated during the meeting that KG had asked Ms. Dixon to access her records, as well as EG's records. Ms. Dixon further reported that during both instances, KG was standing right there with Ms. Dixon and provided necessary information for the access to occur (*e.g.* EG's full name). (Exs. A67 at 1, R15 at 1.)

142. Even with authorization from KG (written or otherwise), accessing patient records outside of work duties is a violation of Asante's written policy. (Test. of Raby.)

#### *Workplace Altercation Involving KG*

143. On or about March 22, 2015, KG got arrested for DUII, Possession of a Controlled Substance, and Reckless Driving.<sup>37</sup> (*See* Ex. R27 at 1; test. of Dixon.)

144. The next morning, Ms. Dixon was waiting at KG's house when KG returned home from jail. KG became very upset when Ms. Dixon refused to give her \$400 so she could pay to have her mugshot removed from "Medford Mugshots." (Ex. A86 at 33; test. of Dixon.) While at KG's home, Ms. Dixon saw that KG had a bottle of Norco, with pills contained therein, that listed a provider named Dr. Sandra Dixon. (Test. of Dixon; *see* Ex. R34 at 3, 5-6.) The bottle was dated January 30, 2015, and the prescription label listed a quantity of 120, with no refills. (Ex. R34 at 3; test. of Dixon.) Ms. Dixon took the bottle of medication from KG, placed it in a plastic baggie, and subsequently turned it over to attorney Jamie Hazlett. Ms. Hazlett subsequently turned the bottle over to Attorney Keaney, who then submitted the bottle as

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<sup>37</sup> On September 16, 2015, the Board took final disciplinary action against KG by placing her R.N. license on probation for 24 months for using intoxicants to an extent that was injurious to herself or others. (Ex. R28 at 1.)

evidence in this contested case proceeding. (Test. of Dixon; *see* Ex. R34 at 2-7.) There were 17 tablets in the bottle at the time of the hearing.<sup>38</sup> (*See* Ex. R34 at 7.)

145. Ms. Dixon was then out of town for approximately one week. April 2, 2015 was her first day back at work after KG's DUII arrest. (Ex. A86 at 33-34.) That day, KG was working with LSJ in the unit. KG told LSJ that she and Ms. Dixon had recently had a "heated argument" outside of the workplace and that KG had kicked Ms. Dixon out of her home. (Test. of LSJ.)

146. When Ms. Dixon got to the workplace on April 2, 2015, she heard from coworkers that KG was making accusations about various individuals, and telling people that she had not been drunk the night of the DUII arrest, that the drugs were not hers, and that she planned to "take everybody down" with her. (Exs. A86 at 34, A74 at 8.) Ms. Dixon approached KG and told her that she needed to stop lying and quit talking at work about the arrest. (Exs. A86 at 34, A74 at 8.) A short time later, LSJ and Ms. Dixon had a short conversation regarding KG. LSJ told Ms. Dixon that KG appeared to be very angry that day and she suggested that Ms. Dixon avoid KG. (Test. of LSJ, Dixon.) After their discussion, Ms. Dixon walked away. LSJ then had contact with KG, and KG "spanked" LSJ on the buttocks approximately three times. (Test. of LSJ.) LSJ assumed that KG's action were because KG was upset after likely overhearing the conversation between LSJ and Ms. Dixon. (*Id.*)

147. A short time later, on April 2, 2015, Ms. Dixon left the unit on a break to meet with a coworker near the coffee cart in the lower level of the hospital. (Test. of Dixon.) KG saw Ms. Dixon leaving the unit and began following her. The two women began arguing with one another, primarily about KG's substance abuse issues. By the time they got on the elevator to go down to the lower level, things were "very heated" between them. (Exs. A86 at 34, A74 at 8-9; test. of Dixon.) KG pushed Ms. Dixon's right shoulder with her finger and told her "it will be on your fucking head when I kill myself." (Exs. A86 at 34, A74 at 9; *see also* Ex. A6 at 2; test. of Dixon.) After exiting the elevator, they continued their heated verbal exchange. (Ex. A86 at 35.) At one point, Ms. Dixon pushed KG's arm and called KG a "liar." (*Id.*; Ex. A74 at 9.) Ms. Dixon then used her hand to hold KG towards a wall and stated, "I'm making you go to rehab." (Exs. A74 at 9, A86 at 35.) Meanwhile, Rogue Regional security guard Timothy Reeder heard a woman yelling and then observed that KG was up against a wall (and appeared to be somewhat sliding down the wall) while Ms. Dixon yelled at her that she was a "liar" and a "piece of shit." (Test. of Reeder, Dixon; Ex. A2 at 1.) In Mr. Reeder's opinion, KG appeared frightened and Ms. Dixon appeared aggressive. Because Mr. Reeder was carrying food items in his hands, he did not physically separate the two women. (Test. of Reeder; Ex. A2 at 2.)

148. Mr. Reeder observed that Ms. Dixon continued to yell at KG while they walked towards the coffee cart. The two women then stopped and Ms. Dixon raised her hand and pushed the palm of her hand into KG's left shoulder. KG yelled "Don't touch me!" and Mr.

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<sup>38</sup> During the contested case hearing, it was agreed by all parties that the medication bottle, and its contents, would be photographed, the photographs marked as an evidentiary exhibit, and the medication surrendered to the Tualatin Police Department for disposal. The Board's Executive Director, Ruby R. Jason, oversaw the surrender of the medication. (*See* Ex. R34 at 1.)

Reeder then yelled “Stop!” (Test. of Reeder; Ex. A2 at 2.) Ms. Dixon then exclaimed that she could not put up with the “craziness” of KG’s situation anymore and that if KG did not stop trying to engage her, she would get a restraining order. (Exs. A74 at 9, A86 at 35.) Ms. Dixon then walked away, returned to the unit, and resumed working. (Exs. A74 at 9, A86 at 35.) Mr. Reeder did not speak with Ms. Dixon. (Test. of Reeder.)

149. Mr. Reeder spoke with KG and encouraged her to report the incident to the employer. (Test. of Reeder; Ex. A2 at 2.) He then went to report the incident to his supervisor, Tom Ellis. Because Mr. Ellis was not available, Mr. Reeder reported the incident to Julie Hale. She advised him to write an incident report. He wrote an incident report that day. (Test. of Reeder; *see* Ex. A2 at 1-2.)

150. Mr. Reeder only observed the portion of the altercation that occurred once KG and Ms. Dixon were downstairs near the coffee cart. He did not witness how the altercation started. Given the portion of the altercation he saw, he believes that Ms. Dixon was the aggressor. (Test. of Reeder.)

151. The employer’s director of employee and labor relations, Jeanette Holmes, investigated the incident. She first spoke with Ms. Dixon, who admitted that an altercation had occurred between her and KG. Ms. Dixon explained that she was trying to do an intervention with KG. Ms. Holmes next spoke with Mr. Reeder. She then attempted to speak with KG, but KG stated that she was too upset to discuss the incident at that time. KG did not perform any additional patient care for the rest of that day. (Test. of Holmes, LSJ.) Ms. Holmes subsequently returned to Ms. Dixon, sent her home for the day, and instructed her not to speak with KG. (Test. of Holmes.)

152. Because KG did not perform any patient care that day, after having the altercation with Ms. Dixon, LSJ had to take care of KG’s two patients, in addition to her own two patients, until another nurse could be brought in to replace KG for the remainder of the nursing shift. Another nurse arrived approximately one to two hours later. In the interim, the charge nurse assisted LSJ with some patient care, but the patients received less nursing time than they would have received if KG had completed her shift. (Test. of LSJ; Ex. A9 at 2.)

153. On the morning of April 3, 2015, Ms. Dixon met with Ms. Holmes. Ms. Dixon was late for the meeting and explained that it was due to her emailing KG to see if they could work out their issues between themselves. Ms. Holmes observed that Ms. Dixon appeared very remorseful about the situation. Ms. Holmes also reviewed a written statement from Ms. Dixon, dated April 2, 2015. (Test. of Holmes; Ex. A2 at 3-4.) The written statement did not mention that KG pushed Ms. Dixon’s right shoulder with her finger while they were on the elevator. (*See* Ex. A2 at 3-4.)

154. Later in the day on April 3, 2015, Ms. Holmes spoke with KG. KG informed Ms. Holmes that she was afraid of Ms. Dixon and did not want to continue working with her. KG also reported that Ms. Dixon was to blame for KG’s problems because Ms. Dixon had been writing prescriptions to KG. (Test. of Holmes; Ex. A2 at 5-6.)

155. KG requested that the employer perform drug testing on her that day to prove that she was not impaired when the altercation with Ms. Dixon occurred. The result of the drug test was negative. (Test. of Holmes; *see* Exs. A3 at 2-4, A4 at 5, R9 at 2.) KG requested, and subsequently took, one week off work. (Test. of Holmes; *see* Ex. A2 at 8.)

156. On April 6, 2015, Ms. Holmes spoke with LSJ via telephone. LSJ informed Ms. Holmes that KG appeared increasingly agitated on April 2, 2015 after Ms. Dixon arrived at work. LSJ further stated that she believed that KG followed Ms. Dixon downstairs that day. (Test. of Holmes; Exs. A2 at 7, R17 at 1.) LSJ subsequently drafted a written statement, dated May 18, 2015, regarding the events of April 2, 2015. (Exs. A9 at 1-2, R10 at 1-2.) In the written statement, LSJ described how KG left the unit on April 2, 2015, very soon after Ms. Dixon had stated that she was leaving the unit to go and get breakfast:

[KG] asked if I would watch her patients, she had to run down[]stairs. I said, "sure." [KG] had a half smile, I'm hiding something look on her face. It wasn't till [*sic*] she had walked away did it dawn on me that she had just left, right after Tamara. About 30 minutes into watching her patients for her, since our breaks are only 15 minutes long[,] \* \* \* I began to wonder where she was. A few minutes later Sharon came into the unit looking for Dr. Ghosh, in a frantic manner. It was about 30 minutes later that Sharon called our charge R.N. for the day[,] Karen Brown[,] to tell her [KG] would not be back to care for her patients [and that] a replacement R.N. was being called in. I was then responsible for [KG]'s 2 patients and my own 2 patients till [*sic*] a replacement R.N. could arrive.

(Exs. A9 at 2, R10 at 2.)

157. On April 13, 2015, Ms. Holmes met with KG and assured her that she would not be assigned to work the same work shifts as Ms. Dixon. (Test. of Holmes; *see* Ex. A2 at 8.) KG returned to work, but then took a leave of absence starting on April 30, 2015. She eventually resigned without returning to work. (Test. of Holmes.)

158. In Ms. Holmes' opinion, both Ms. Dixon and KG were at fault regarding the altercation because they both brought their personal issues into the workplace. (Test. of Holmes.)

159. During her investigation of the altercation, Ms. Holmes received information that Ms. Dixon had been writing prescriptions to coworkers. As a result, the employer asked nurses in the CCU to answer questionnaires regarding the prescription issue, in general. However, once Ms. Dixon's employment ended, the employer ceased its investigation into that matter. (Test. of Holmes.)

160. KG subsequently reported the incident to the Medford police. (Ex. A5 at 2-3.) Medford police took statements from KG and Mr. Reeder, and also reviewed written statements from each of them. (*Id.* at 3; *see* Exs. A2 at 1-2, A4 at 2-5.) On April 7, 2015, Officer Josh Schilder spoke with Ms. Dixon at her home. She provided him with a written statement. (Ex.

A5 at 3-4; *see* Ex. A2 at 3-4.) Ms. Dixon was ultimately cited for Harassment, and the case was forwarded to the Medford Municipal Court. (Exs. A5 at 1, 4, 6; R7 at 1.)

161. Ms. Dixon subsequently amended her written statement regarding the events of April 2, 2015. (*See* Ex. A6 at 1-2.) The amended statement, dated April 16, 2015, includes the following information not contained in her original written statement:

While in the elevator, [KG] \* \* \* did aggressively push my right shoulder with her finger. She definitely initiated the body contact between us[.]

\* \* \* \* \*

[T]here were terrible accusations and minimal physical contact that occurred between BOTH parties. [KG] \* \* \* was the first to make physical contact against me while in the elevator[.]

(*Id.* at 2.)

162. On April 27, 2015, Officer Schilder met with Ms. Dixon. At that time, Ms. Dixon provided him with her amended written statement and informed him that she wished to press charges against KG for Harassment. (Ex. A7 at 2.) KG was ultimately cited for Harassment, and the case was forwarded to the Medford Municipal Court. (*Id.* at 1-2, 5; *see also* Exs. A5 at 5, R6 at 1.) The Medford City Attorney's Office declined to prosecute KG for Harassment due to a lack of facts regarding the incident. (Ex. A8 at 1.)

163. On June 2, 2015, Ms. Dixon pled "no contest" to the Harassment charge as a "violation." (Exs. A10 at 1, R12 at 1, R13 at 1-2.) She entered into a deferred sentencing agreement, whereby upon paying a \$160 fine and completing a six-month probationary period with no further violations or charges, the Harassment violation would be dismissed. (Exs. A10 at 1-5, R12 at 1, R13 at 1-2.) Ms. Dixon subsequently met the required conditions, and the violation was dismissed in December 2015. (Ex. R29.)

#### *KG's Questionable Norco Prescriptions*

164. When someone calls in a prescription to the Safeway pharmacy, a pharmacist records the information. The pharmacist asks for and writes down the patient's name and date of birth; the prescription name, quantity, directions, and whether refills are available; the name of the person calling in the prescription; the national provider identification (N.P.I) number; and the provider's DEA number, if the medication is a controlled substance. If a pharmacist questions the authenticity of a prescription, he or she will put a "?" and a "/" before the provider's name and call the provider to make sure the prescription is valid. (Test. of Rimov.)

165. If a provider so chooses, the provider may call the Safeway pharmacy and request that a prescription that has been filled under that provider's name, but not yet picked up, be discontinued. (Test. of Rimov.)

166. In a Botox treatment note dated July 18, 2014, Ms. Dixon stated that because of KG's drug and alcohol overdose, she would no longer be giving prescriptions to KG and that KG was following up with Dr. Binette. (Ex. A47 at 17.) The note was a late entry that Ms. Dixon made after KG went to Hazelden Betty Ford (Hazelden) for drug and alcohol treatment. (Test. of Dixon; *see* Exs. A72 at 1, R26 at 1.) Ms. Dixon did not note that it was a late entry. (*See* Ex. A47 at 17.) KG's Botox treatment records do not note any substance abuse issues prior to that entry. (*See id.* at 14-17.)

167. From July 20, 2014 to August 6, 2014, KG participated in a drug and alcohol treatment program at Hazelden. She completed the program CWSA – Conditional with Staff Approval. (Exs. A72 at 1, R26 at 1.)

168. On July 22, 2014, the Safeway pharmacy received a prescription via telephone for 110 tablets of Norco for KG. (*See* Ex. A69 at 1.) The caller left the prescription request on the pharmacy's interactive voice recorder (IVR).<sup>39</sup> Pharmacy Manager Rimov listened to the recording and wrote down the prescription so it could be filled. (Test. of Rimov; *see* Exs. A47 at 7, R18 at 1.) He recognized the voice as someone who had previously called in prescriptions. He discontinued the May 27, 2014 prescription that still had four refills available, and filled the July 22, 2014 prescription as a "new" prescription. (Test. of Rimov.)

169. The Safeway pharmacy has the following phone numbers: (541) 608-3686 (main); (541) 608-3680; (541) 608-3682; and (541) 608-3684. (Test. of Rimov.) Verizon phone records show that a call was made from Ms. Dixon's cell phone to the Safeway pharmacy on July 22, 2014, at 12:51 p.m. The call lasted three minutes. (Ex. A100 at 10.)

170. During the Board's investigation, KG denied to Board Investigator Jessica Van Horn that she called the Safeway pharmacy on July 22, 2014. A representative from Hazelden, where KG was on July 22, 2014, informed Investigator Van Horn that patients undergoing treatment there were only allowed to use a phone during evening hours. (Test. of Van Horn.)

171. On July 22 or 23, 2014, TF, KG's adult son, received several texts from Ms. Dixon. Ms. Dixon asked TF to go pick up the July 22, 2014 Norco prescription at Safeway so that KG would not have access to the medication when she got out of Hazelden. (Test. of TF; Ex. A71 at 1.)

172. TF agreed to pick up the Norco prescription and bring the medication to Ms. Dixon at her home. On July 23, 2014, TF signed for and received the prescription medication from Safeway. (Test. of TF; Exs. A70 at 1, A71 at 1, R20 at 1.) He took the medication to Ms. Dixon at her home. Ms. Dixon, in turn, provided TF with approximately \$20 to compensate him for his fuel costs.<sup>40</sup> (Test. of TF.)

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<sup>39</sup> Safeway pharmacy deletes the IVR recordings each day. Thus, no recording from July 22, 2014 currently exists. (Test. of Rimov.)

<sup>40</sup> The record contains no evidence regarding what Ms. Dixon did with the Norco once she gained possession of it.

173. On September 17, 2014, the Safeway pharmacy received a prescription on its IVR for 120 tablets of Norco for KG. Mr. Rimov listened to the recording and wrote down the prescription so it could be filled. (Test. of Rimov; *see* Ex. A47 at 8.) KG picked up the prescription that same day. (*See* Ex. A47 at 8.)

174. A paper prescription, dated November 20, 2014, was presented to the Safeway pharmacy for 180 tablets of Norco for KG. Ms. Dixon was the listed provider on the prescription. (Ex. A47 at 10; *see also* Ex. A91 at 5; test. of Rimov.) On November 26, 2014, Ms. Dixon prescribed Mupirocin and Erythromycin to KG. (Ex. A47 at 11-12.) On that same date, KG picked up those two prescriptions, as well as the November 20, 2014 Norco prescription. (Ex. A86 at 11; *see* Ex. A47 at 10-12.) During a Board interview on May 20, 2015, Ms. Dixon denied to investigators that she prescribed Norco to KG on November 20, 2014. (Ex. A86 at 11.)

175. A paper prescription, dated January 16, 2015, was presented to the Safeway pharmacy for 120 tabs of Norco for KG. Ms. Dixon was the listed provider on the prescription. (Exs. A47 at 13, R24 at 1; *see also* Ex. A91 at 10; test. of Rimov.) On January 30, 2015, KG picked up the prescription. (*See* Ex. A47 at 13; test. of Rimov.)

176. The Board subpoenaed records from Dr. Sandra Dixon and learned that no patient/provider relationship existed between Dr. Dixon and KG. (Test. of Van Horn.) Mr. Rimov believes that when the prescription dated January 16, 2015, which listed Tamara Dixon as the provider (*see* Ex. A47 at 13) was filled at Safeway pharmacy, the pharmacist or pharmacy technician inadvertently listed Dr. Sandra Dixon as the provider instead of correctly listing Tamara Dixon. Mr. Rimov believes that a pharmacist then caught that it was the incorrect provider listed on the bottle before the medication was dispensed and the pharmacist corrected the information in the computer system, but not on the medication bottle itself. (Test. of Rimov.)

177. On April 16, 2015, Ms. Dixon met with the employer to discuss the physical altercation with KG. During the meeting, Ms. Dixon learned that KG was alleging that Ms. Dixon contributed to her substance abuse issues. This made Ms. Dixon suspect that KG might be obtaining narcotic prescriptions with Ms. Dixon's name. (Ex. A86 at 6; test. of Dixon.)

178. On or about April 16, 2015, Ms. Dixon called Mr. Rimov and informed him that she had not prescribed narcotics to KG since KG's overdose on June 30, 2014. She asked Mr. Rimov to pull KG's records to see whether there had been narcotics prescriptions filled by KG after that date. Mr. Rimov confirmed to Ms. Dixon that the records showed that KG had been filling narcotics prescriptions that listed Ms. Dixon as the prescriber. He provided Ms. Dixon with the dates of those prescriptions. Ms. Dixon told him that she believed KG was filling the prescriptions without her authorization or knowledge. (Ex. A86 at 6; test. of Rimov, Dixon.) At Ms. Dixon's request, Mr. Rimov discontinued all active prescription orders for KG prescribed by Ms. Dixon. (Test. of Rimov.)

179. Mr. Rimov subsequently faxed Ms. Dixon a printout of medications that KG had filled at the Safeway pharmacy that listed Ms. Dixon as the prescriber.<sup>41</sup> (Ex. A86 at 9-10; *see* Ex. A75 at 1-2.) Sometime later, in mid to late April 2015, Ms. Dixon accessed KG's prescription history through the Prescription Drug Monitoring Program (PMDP). (Test. of Dixon; Ex. A86 at 31.) She printed out the prescription history and used it to compare the information contained therein with what was in her Botox treatment records. (Test. of Dixon.)

180. On April 22, 2015, Mr. Rimov reported to the Medford Police Department that he received a report that KG had submitted fraudulent prescriptions starting in May 2014. (Ex. A74 at 1-2; test. of Rimov, McOmber.) That day, Officer McOmber called Mr. Rimov to obtain a statement. Mr. Rimov informed Officer McOmber that Ms. Dixon had recently contacted him regarding allegedly fraudulent prescriptions filled for her patient, KG. He reported that he faxed Ms. Dixon a copy of prescriptions that KG had filled under Ms. Dixon's name, and that Ms. Dixon later informed him that there were multiple fraudulent narcotics prescriptions that she did not authorize for KG. (Ex. A74 at 2-3; test. of McOmber.)

181. Officer McOmber attempted to reach Ms. Dixon via telephone, but was unsuccessful. Officer McOmber eventually spoke with Attorney Hazlett (who was representing Ms. Dixon at the time). Ms. Hazlett stated that Ms. Dixon had recently been made aware of the prescription fraud and that Ms. Dixon had a written statement regarding the fraud. Ms. Hazlett agreed to fax the statement, and other documentation, to Officer McOmber. By April 25, 2015, Officer McOmber had not received the faxed statement and other documents. She contacted Ms. Hazlett, who then faxed them over that day. The faxed documents included Ms. Dixon's written statement, KG's treatment records from Private Transformations, KG's prescription record from Safeway pharmacy, Ms. Dixon's Private Transformations business license, and two training certificates. (Ex. A74 at 3; test. of McOmber; *see* Exs. A74 at 10-28, A14.)

182. Ms. Dixon's written statement, titled "Discovery of Prescription Fraud," states, in part:

I first met [KG] in October 2012 through our work at Rogue Regional[.]  
\* \* \*. We subsequently became close friends.

Completely separate from our friendship, [KG] and I entered into a patient-client relationship at Private Transformation, my private esthetic practice. She was seen as a patient in my office at home from July 27, 2013, through November 24, 2014. \* \* \*. I have documentation of all treatments provided, as well as any prescriptions that were provided during our professional relationship.

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<sup>41</sup> During the early part of her Board interview, Ms. Dixon twice told Investigator Van Horn that she did not obtain any pharmacy records from Safeway regarding KG. (Ex. A86 at 6, 8.) After a recess with her attorney, the interview resumed and Ms. Dixon then reported that she had, in fact, received faxed pharmacy records from Mr. Rimov. (*See id.* at 8-9.)

On June 28, 2014, [KG] attempted suicide with an overdose of alcohol and drugs[.] \* \* \*. Treatment records at Private Transformations dated July 18, 2014, indicate that no further prescriptions would be written for her by me. She was asked to see her primary care provider for any issues not related to my esthetic care for her.

Treatment records at Private Transformations on August 25, 2014, indicates that [KG] complained of “anxiety and severe back and menstrual cramps” and stated she had fibroids and was attempting to arrange for a hysterectomy. She requested medications for those symptoms during that visit but was denied them[.]

\* \* \* \* \*

On April 16, 2015, I met with my employer, Asante Physician Partners, to discuss the incident that occurred on April 2 between [KG] and myself. They informed me that [KG] was alleging that I “contributed to her substance abuse problems by prescribing for her[.]” I immediately became very concerned because I knew this was not true and became suspicious that [KG] had been using my name and license number to illegally obtain prescriptions. She had previously had access to my home, as well as my office at Private Transformations and my office at Rogue Regional[.]

After that meeting on April 16, 2015, I contacted Safeway Pharmacy[.] I spoke to the pharmacist there and asked if there were any prescriptions filled under my name in the last year. He informed me that [KG] had filled several prescriptions from multiple providers for opioids, anxiolytics, and anti-depressants, including myself. I received a faxed copy of [KG]’s prescriptions from January 2014 through April 2015. The prescriptions that were filled by me from January 28, 2014 through May 6, 2014 were done with my authority and were clearly documented on her treatment records at Private Transformations. However, medications for controlled substances that [KG] obtained from May 27, 2014 through January 30, 2015 were NOT authorized by me, were NOT documented in her treatment records, and were filled WITHOUT my knowledge. This included prescriptions on May 27, 2014, June 23, 2014, July 22, 2014, September 27, 2014, November 26, 2014, and January 30, 2015.

On April 17, 2015, I called Paul Rimov \* \* \* to report my discovery. \* \* \*. I informed him that I had just become aware that she had been filling prescriptions without my authority. \* \* \*. [I] requested that no further prescriptions be filled for her under my name. I then notified my nursing profession attorney so that we could report [KG]’s unprofessional and illegal activity.

(Ex. A74 at 10-12.) Based on that written statement, Officer McOmber determined that there was probable cause to arrest KG for Forgery II, Tampering with Drug Records, and ID Theft. (*Id.* at 4; test. of McOmber.)

183. On April 30, 2015, Medford Police arrested KG and transported her to police headquarters for an interview with Officer McOmber. (Ex. A74 at 5; test. of McOmber.) Officer McOmber's written narrative of that interview states, in part:

[KG] told me that she was recently arrested on unrelated charges and was in possession of prescription medication. [KG] said that after she was arrested Dixon confronted her regarding having a "pill problem[.]" [KG] told me that Dixon had been prescribing her medication. [KG] said that she was going to Dixon for [B]otox. She said that they did not have any other patient relationship besides the [B]otox. [KG] said that Dixon was prescribing her controlled substance[s] for [B]otox[,] which typically is not normal practice.

[KG] said that after the previous case there was an altercation at work \* \* \* [involving Ms. Dixon]. She said that Dixon was cited for Harassment[.] [KG] told me she believes this is why Dixon is filing this case[.]

\* \* \* \* \*

[KG] told me that Dixon wrote all the prescriptions to her. [KG] said that Dixon knows she can be in trouble for writing the prescriptions and is trying to cover herself now.

\* \* \* \* \*

I reviewed over the prescriptions with [KG]. She pointed out on 11/26/14 Dixon was claiming she wrote a fraudulent prescription for hydrocodone. She said that Dixon also prescribed her Azithromysn [*sic*] and was not claiming that was fraudulent. She pointed out the same thing on 3/11/14. She showed me that she was prescribed the carisoprodol and hydrocodone by Dixon.

(Ex. A74 at 5-6; test. of McOmber.) During the interview, Officer McOmber observed KG's handwriting on some documents and noted that the handwriting differed significantly from that on the prescriptions at issue. (Test. of McOmber.)

184. On April 30, 2015, Ms. Dixon came to the Medford Police headquarters on a matter unrelated to the alleged prescription fraud. Officer McOmber met with her regarding that unrelated matter. During their meeting, Officer McOmber observed some handwriting of Ms. Dixon's that she believed looked identical to the handwriting on the allegedly fraudulent prescriptions. When she questioned Ms. Dixon about the handwriting, Ms. Dixon stated that she

did not write the prescriptions at issue and that she thinks KG possibly traced her handwriting from an old prescription. Officer McOmber informed Ms. Dixon that she had some concerns regarding Ms. Dixon's fraud report. (Ex. A74 at 6-7; test. of McOmber.)

185. Officer McOmber subsequently obtained from Board Investigator Van Horn some known copies of prescriptions that Ms. Dixon wrote. Officer McOmber compared the known writings to the prescriptions at issue and opined that the handwriting matched. The Medford Police subsequently dropped the charges against KG. Officer McOmber referred the matter to the District Attorney for the potential filing of false report charges against Ms. Dixon. (Ex. A74 at 7; test. of McOmber.) As of December 2015, when Ms. McOmber testified in this contested case hearing, the matter of false report charges against Ms. Dixon was still under review. (Test. of McOmber.)

#### *Board Involvement*

186. In early April 2015, the Board received a complaint regarding the workplace altercation between Ms. Dixon and KG. Board Investigator Jessica Van Horn interviewed the complainant and issued multiple subpoenas for various employers, Safeway pharmacy, and the Medford Police Department. As Investigator Van Horn received more information, the scope of her investigation regarding Ms. Dixon considerably broadened to include issues regarding Private Transformations, and conduct such as prescribing medications to coworkers and asking a coworker to obtain medication from the Omnicell. (Test. of Van Horn.)

187. By letter dated April 8, 2015, Investigator Van Horn requested that Ms. Dixon contact the Board by April 22, 2015 to schedule a Board interview. The letter also instructed Ms. Dixon to provide a copy of her work history and a written statement regarding the workplace altercation by April 22. (Ex. R4 at 1.) On April 19, 2015, Attorney Keaney sent Ms. Van Horn a copy of Ms. Dixon's work history and a written statement regarding the April 2, 2015 workplace altercation.<sup>42</sup> (Ex. A83 at 1-5.)

188. On April 22, 2015, Attorney Keaney sent Ms. Van Horn a copy of Ms. Dixon's written statement titled "Discovery of Prescription Fraud" and a copy of an undated letter Ms. Dixon submitted to Asante Human Resources regarding her concerns that KG was practicing while impaired by mental health and substance abuse issues. (Ex. A83 at 6-10.)

189. On May 7, 2015, Investigator Van Horn sent Mr. Keaney an Interim Order by Consent, requesting that Ms. Dixon voluntarily agree not to work as an R.N. or N.P. in Oregon pending further order of the Board. Investigator Van Horn explained in her correspondence that the Interim Order was not a disciplinary action, but was intended merely to address the Board's concerns until the matter involving Ms. Dixon could be fully investigated. (Ex. A84 at 1-3.) On May 7, 2015, Ms. Dixon signed the Interim Order by Consent. (See Pl. P1 at 1, Ex. R2 at 1.)

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<sup>42</sup> This version of the written statement included the allegation that KG initiated physical contact with Ms. Dixon in the elevator. (See Ex. A83 at 5.)

190. On or prior to May 7, 2015, Investigator Van Horn requested records from Ms. Dixon for certain Private Transformations clients. On or about May 7, 2015, Attorney Keaney provided the requested records to the Board. (See Ex. A84 at 3-4; test of Van Horn.)

191. On May 20, 2015, Ms. Dixon participated in a face-to-face interview with Investigator Van Horn and Board Investigator Suzanne Meadows, RN. Attorney Keaney was also present. (Ex. A86 at 1.)

192. During the interview, Ms. Dixon informed the Board investigators that when SG called her to tell her that KG would not wake up and that she was “breathing funny,” Ms. Dixon told SG to call 911 and then she went to their home. (Ex. A86 at 34.) She told the investigators that when she got to their home, she asked SG if the emergency responders were on their way, and he told her that he had not called them. She further reported that once SG told her that KG’s condition had deteriorated, she made him call 911. (*Id.* at 34.)

193. During the interview, Ms. Dixon informed the Board investigators that the Private Transformations records she provided to the Board were the complete medical records for the requested clients. (Ex. A86 at 19.)

194. During the interview, Ms. Dixon informed the Board investigators that she believed the July 22, 2014 Norco prescription was a refill of a prescription she had previously provided to KG. (Ex. A86 at 10.) However, the July 22 prescription was for 110 tablets, and the previous prescription (from May 27, 2014, which authorized four refills) was for 120 tablets. (Exs. A47 at 6, A75 at 1; see Ex. A86 at 10.) Upon further questioning by the investigators, Ms. Dixon stated that she “most likely” did authorize the July 22, 2014 prescription, but then stated that she did not recall authorizing it. (Ex. A86 at 11.)

195. During the interview, Ms. Dixon denied authorizing Norco prescriptions to KG after her overdose on June 30, 2014. (Ex. A86 at 7, 11-12.) When the investigators asked Ms. Dixon to look at some disputed prescriptions for KG, the following exchange occurred:

Dixon: You know what? It looked [*sic*] like they are my signature.

\* \* \* \* \*

Dixon: They really look like my signature, and I do know that I can tell you my suspicion, but it’s just my word against hers.

\* \* \* \* \*

Dixon: That I had given her \* \* \* prescriptions before, she lived in my home, and my suspicion is that she put the prescription over it, and copied my signature completely. It looks just like it you guys.

Van Horn: [S]ame with your handwriting as well? It all looks the same.

Dixon: And, yeah, I think that she put the, she kept the original copy, she put it over, traced it[.]

\* \* \* \* \*

Meadows: So you're saying before she took it to the pharmacist...

Van Horn: She made a copy?

Meadows: In these cases? Only in these cases?

Van Horn: Ok.

Dixon: That would be my solemn swear.

(*Id.* at 65-66.)

196. During the interview, Investigator Van Horn asked Ms. Dixon if she added anything to her Private Transformations medical records after accessing the PDMP. This verbal exchange followed that question:

Dixon: The only thing I would have, on [KG] there was a late entry.

Van Horn: Mmhmm.

Dixon: Because I got the dates wrong, so there was one late entry. [B]ut no other clients.

Van Horn: Ok. So just one late entry. Was that the 5/27 one that you already spoke [of]?

Dixon: Yeah.

Van Horn: Ok. So you saw that was on the PDMP, it wasn't in your medical records so you went ahead and added it?

Dixon: Correct.

Van Horn: Ok. And just that one time?

Dixon: Yes.

(Ex. A86 at 31; *see also id.* at 66.) Investigator Van Horn later asked Ms. Dixon whether all medications she prescribed to her Private Transformation clients would be reflected in their Private Transformations records. Ms. Dixon responded in the affirmative, but noted that there was one exception, TE. Ms. Dixon explained that TE was a single mother with no insurance,

and that if she needed an antibiotic or some other medication, Ms. Dixon would write a prescription for her and not necessarily document it. (*Id.* at 39-40, 52.) Investigator Van Horn then asked Ms. Dixon, “[W]ere any of your records updated, altered or changed before sending them to us?” (*Id.* at 40.) Ms. Dixon responded that the only change she made to the records was the May 27 late entry in KG’s records. (*Id.*) When Investigator Van Horn asked if there was anything else Ms. Dixon added to KG’s records, Ms. Dixon responded, “No.” (*Id.*)

197. During the interview, Investigator Van Horn asked if Ms. Dixon had ever prescribed to anyone without a patient provider relationship. In response, Ms. Dixon stated that she prescribed lisinopril to her coworker and friend, JDB, until he could get in to see his primary care provider and that she prescribed Lunesta to a coworker, TLK, until he could see his primary care provider. (Ex. A86 at 31-32.) She then stated, “To my knowledge, anybody else that I have ever prescribed to \* \* \* had already entered into a patient/client relationship either at Creekside or at Private Transformations.” (*Id.* at 32.) When Ms. Van Horn asked how Ms. Dixon determined what medications the two men needed and whether she performed assessments on them, Ms. Dixon responded as follows:

[W]ith [JDB], the conversation went, he and I are very good friends, and he said, “Tamara, I’m out of my lisinopril, I have a very strong family history, I’ve been on it for three years, I ran out of it, I don’t get in with my primary care provider for a month, will you write me a prescription for one month?”

\* \* \* \* \*

Lisinopril, I said, what are you on? He said lisinopril 20 mg. Have you always been on it? Yes I have. Any known allergies? No. And I wrote the prescription.

\* \* \* \* \*

[With regard to [TLK,] the conversation was, I recall; it was in the nursing break room, he said, “Tamara I cannot sleep; I’ve used Lunesta before, I can’t get into my primary care provider, would you write me a prescription for Lunesta?” I said, have you been on it before?” “I have, it worked great for me, it’s the only thing that works for me.” Do you have any known allergies? “No.” And I wrote [the prescription] for Lunesta.

(*Id.*)

198. During the latter part of the Board interview, Ms. Dixon stated, in part, the following with respect to whether she performed assessments before prescribing medications:

[I] would not \* \* \* indiscriminately write prescriptions. I have always felt that I was doing what was right for the person, they would ask me for, they would state a complaint, I would go through my assessment of

questions. \* \* \*. Have you used it before? Yes, it worked very well. Do you have any allergies? No, you don't. [What are] you using it for? He would tell me. So I would thoroughly assess them, I would just not say, what drug do you want? I would never do that, I would never want to cause harm to anybody. So I would thoroughly assess, I would assess them and I would try to ask all the right, the questions so that I would do no harm. \* \* \*. Another nurse comes to me and she goes, I have been coughing, you know, I'm not getting any better, can I have an antibiotic? And I would [say], can I listen to your lungs? Can I look at your ears? Come into my office. I'd look at their ears. Your ears are not bulging, your lungs are you know? [sic] I would assess them. And I would feel very comfortable with the medications that I was prescribing. \* \* \*. I would say, have you taken anything? What is your discharge like? How long has it been? You know? And then, I would write the prescription.

(Ex. A86 at 55.)

199. On June 12, 2015, Investigator Van Horn sent an email to Attorney Keaney. The email listed three individuals to whom Ms. Dixon prescribed medications prior to their becoming her Private Transformation clients. Investigator Van Horn requested that Ms. Dixon indicate, in response, whether she had a patient/provider relationship with any of them prior to them becoming Botox clients. The email also listed 22 other individuals to whom Ms. Dixon prescribed medications. Investigator Van Horn stated that no medical records substantiated a patient/provider relationship between Ms. Dixon and any of them through Asante, Creekside, or Private Transformations. Investigator Van Horn requested that Ms. Dixon provide documentation to support otherwise, if applicable. (Ex. A87 at 1-2.)

200. By email dated June 15, 2015, Attorney Keaney responded to Investigator Van Horn's June 12, 2015 email with Ms. Dixon's responses. The email stated, in part:

[TK]. Owner of Blue Giraffe Spa. Documented client-provider relationship starting in September 2011. Documents would be those from Private Transformations. [TK] was seen at both Blue Giraffe Spa and Private Transformations.

[DLM]. Documented client-provider relationship. Seen at Private Transformations.

[].<sup>43</sup> Do not recall.

[]. Was seen as a patient at Creekside[.]

[JB]. Do not recall.

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<sup>43</sup> The ALJ elected not to provide the names or initials of individuals that the Board subsequently determined are not involved in the current allegations against Ms. Dixon.

[SKC]. Do not recall.

[SMC]. Documented client-provider relationship starting 30 September 2011. Seen at Blue Giraffe Spa.

[SD]. Ms. Dixon's daughter.

[]. Was seen as a patient at Creekside[.]

[AF]. Do not recall.

[NF]. Do not recall.

[]. Do not recall.

[]. Do not recall.

[]. Was seen as a patient at Creekside[.]

[SL]. Was seen as a patient at Creekside[.]

[ML]. Do not recall.

[]. Was seen as a patient at Creekside[.]

[]. Do not recall.

[]. Was seen as a patient at Creekside[.]

[HS]. Prescribed as close family friend; no controlled substances.

[BT]. Prescribed as a close family friend; no controlled substances.

[]. Do not recall.

[LW]. Do not recall.

[JW]. Do not recall.

[GB]. Documented client-provider relationship starting in February 2012. Was seen at Blue Giraffe Spa.

\* \* \* \* \*

[B]e advised that every patient seen at Asante must have his or her medical records (including prescriptions) co-signed by an attending ICU physician. Although Ms. Dixon might have seen a patient, written a progress note, and/or prescribed medications, she still may not show as “the provider” in the medical records because “the provider” would be listed under the attending physician.

(Ex. A88 at 1-2.)

201. On June 17, 2015, a Board Meeting occurred. Prior to the meeting, Investigator Van Horn provided Board members with an Investigator Report and a Supplemental Investigator Report that she drafted with regard to Ms. Dixon. (Test. of Van Horn; Exs. R42, R43.) On June 29, 2015, the Board issued a Notice of Proposed Revocation of Nurse Practitioner Certificate and Registered Nurse License to Ms. Dixon. (Pl. P2 at 1-11.)

#### *KG’s Private Transformations Records*

202. The Private Transformations records for KG that Ms. Dixon provided to the Medford Police Department on April 25, 2015 (Ex. A14), through Attorney Hazlett, differ in certain respects from the records Ms. Dixon provided to the Board on or about May 7, 2015 (Ex. A15), through Attorney Keaney. (Test. of Van Horn.)

203. The copy of KG’s Private Transformations records that Ms. Dixon provided to the Board contains notes that were not present in the records she provided to the Medford Police Department. (*Compare* Exs. A14, A15; test. of Van Horn.) The following entries (which are in quotations below) appear in the records provided to the Board (Ex. A15), but not in the records provided to the Medford Police (Ex. A14):

- Under a treatment note dated January 6, 2014, “Rx Mupirocin 2% topical cream” appears. (Ex. A15 at 2; *compare* A14 at 2.) There are no initials and no date next to the entry. (Ex. A15 at 2.)
- A treatment note dated January 28, 2014 lists a prescription for Soma, 350 mg, with “4 refills.” (Ex. A15 at 2.) The “4” is written over a “2.” (*Id.*; *see* Ex. A14 at 2.) There are no initials and no date next to the change from “2” to “4.” (Ex. A15 at 2.)
- Under a section for additional comments on KG’s treatment record (between treatment notes dated April 7, 2014 and July 18, 2014), the following appears: “5/27 Late Entry OK’d for Norco 10/325 #120 (MR x 4) — Planning for hysterectomy late summer [w/] Binette (needs PTO).” (Ex. A15 at 3; *compare* A14 at 3.) There are no initials next to the entry. (Ex. A15 at 3.)

- Under a treatment note dated August 25, 2014, “Rx Mupirocin 2% cream” appears. (Ex. A15 at 4; *compare* A14 at 4.) There are no initials and no date next to the entry. (Ex. A15 at 4.)

*Statements of Professional Support*

204. KE is an R.N. in the CCU at Rogue Regional. She has worked with Ms. Dixon since approximately 1987. She considers Ms. Dixon to be dependable, honest, compassionate, and well-respected professionally. (Test. of KE.)

205. LSJ is an R.N. in the ICU at Rogue Regional. She has worked with Ms. Dixon since approximately 2008. She considers Ms. Dixon to be an honest, dependable, and compassionate person who is “highly regarded” by physicians and clinical staff. (Test. of LSJ.)

206. Thomas Espinosa is an R.N. in the ICU at Rogue Regional. He has known Ms. Dixon for approximately 20 years. In his opinion, Ms. Dixon has “incredible” clinical skills, she is thorough in her work, and she is dedicated to the well-being of her patients. (Test. of Espinosa.) Mr. Espinosa has also written a letter of support for Ms. Dixon. (*See* Ex. R33 at 4-5.)

207. JDB is an R.N. at Rogue Regional. He considers Ms. Dixon to be a “fantastic practitioner” who is able to handle stressful situations calmly. (Test. of JDB.)

208. In addition, the following persons have written letters of support, attesting to Ms. Dixon’s clinical skills, knowledge, competence, professionalism, integrity, diligence, and/or compassionate demeanor in the clinical setting:

- Dani Thomas, DO, Pulmonary & Critical Care Medicine at Rogue Regional. (Ex. R33 at 1.)
- Elizabeth Manuwal, R.N., Intensivist Team at Rogue Regional. (*Id.* at 2.)
- Melanie Stranahan, R.N., Nursing Supervisor, Rogue Regional. (*Id.* at 3.)
- Justin McCoy, R.N., Intensivist Team, Rogue Regional. (*Id.* at 6.)
- Dale Tollefson, R.N., ICU, Rogue Regional. (*Id.* at 7.)
- Jennifer Cooney, ICU, Rogue Regional. (*Id.* at 8.)
- Laure Trickel, R.N., CCU, Rogue Regional. (*Id.* at 9, 19.)
- Radek Dutkiewicz, MD, Rogue Regional. (*Id.* at 10.)

- Petey Laohaburanakit, MD, Rogue Regional (formerly). (*Id.* at 11.)
- Somnath Ghosh, MD, ICU Medical Director, Rogue Regional. (*Id.* at 12.)
- Karen Brown, R.N., Rogue Regional. (*Id.* at 13.)
- Francisco Paz, MD, ICU, Rogue Regional (formerly). (*Id.* at 15.)
- James Stubenrauch, Physician Assistant (PA), Rogue Regional. (*Id.* at 16, 18.)
- Theresa Mershon, R.N., CCU, Rogue Regional. (*Id.* at 20.)
- Karen Person, R.N., CCU, Rogue Regional. (*Id.* at 21.)
- Denise Workman, R.N., Rogue Regional. (*Id.* at 22.)

### CONCLUSIONS OF LAW

1. The preponderance of evidence standard is the applicable standard of proof as to all allegations in this proceeding, including those involving fraud and deceit.
2. On or about October 3, 2013, Ms. Dixon did not prescribe Iopidine Ophthalmic Solution (0.5%) to herself, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(10)(b), and OAR 851-056-0016(2)(d) (2011).
3. Between January 1, 2012 and May 7, 2015, Ms. Dixon deviated from the standard of care by utilizing prescription pads from her previous employer, Creekside Family Medicine, and her hospital employer, Asante Rogue Regional Medical Center, to write prescriptions to individuals, in violation of ORS 678.111(1)(g) and OAR 851-056-0010(1) (2011 and 2015).
4. Ms. Dixon did not violate KG's right to privacy and confidentiality of information by reviewing KG's and EG's private health records without a medical reason, in violation of ORS 678.111(1)(d), (f), and (g) and OAR 851-045-0070(2)(l) and (m).
5. In 2014, Ms. Dixon violated ORS 678.111(1)(d), (f), and (g) and OAR 851-045-0070(2)(f), (i), and (j) and (3)(b) when she requested that a coworker, JCB, remove medication from the Omnicell so that Ms. Dixon could provide the medication to KG.
6. On or about July 23, 2014, Ms. Dixon failed to maintain professional boundaries with a client by requesting that a client's family member, TF, obtain Norco (hydrocodone) prescribed to the client, KG, from the pharmacy and deliver the medication to Ms. Dixon, in violation of ORS 678.111(1)(f) and (g) and OAR 851-045-0070(1)(n).

7. On or about April 2, 2015, Ms. Dixon violated ORS 678.111(1)(f) and (g) and OAR 851-045-0070(9) when she was involved in a physical altercation with KG at the Rogue Regional Medical Center.

8. Between April 16, 2015 and May 13, 2015, Ms. Dixon falsified records associated with her client, KG, at Private Transformations, in violation of ORS 678.111(1)(d), (f), and (g) and OAR 851-045-0070(3)(d) and (g).

9. Between January 1, 2012 and May 7, 2015, Ms. Dixon deviated from the standard of care by prescribing medication to individuals without having a patient/provider relationship with the individuals, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(4)(b), OAR 851-056-0016(2)(c) (2011 and 2015) and (f) (2011) and (g) (2015).

10. Between January 1, 2012 and May 7, 2015, Ms. Dixon failed to maintain client records, failed to document assessments when prescribing medications, and improperly prescribed medications to non-Private Transformations clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(3)(b) and (4)(b), OAR 851-056-0016(2)(f) and (h) (2011), and OAR 851-056-0016(2)(g), and (i) (2015).

11. Between January 1, 2012 and May 7, 2015, Ms. Dixon failed to properly assess a client, DB, and failed to document any client assessments when prescribing medication to multiple Private Transformation clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(3)(b) and (4)(b), OAR 851-056-0016(2)(f) and (h) (2011), and OAR 851-056-0016(2)(g) and (i) (2015).

12. Between January 1, 2012 and May 7, 2015, Ms. Dixon deviated from the standard of care while treating Private Transformation clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(3)(a) and (b), and (4)(b), and OAR 851-056-0016(2)(c), (f) (2011) and (c), (g) (2015).

13. Between January 1, 2012 and May 7, 2015, Ms. Dixon improperly prescribed medication to Private Transformation clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(c) and (d), and (4)(b), and OAR 851-056-0016(2)(f) (2011) and (g) (2015).

14. Ms. Dixon failed to answer truthfully and completely during the Board's investigation, including in a written statement submitted to the Board on April 22, 2015, and during a personal interview with Board staff on May 20, 2015, in violation of ORS 678.111(1)(d), (f), and (g) and OAR 851-045-0070(7)(b).

15. Revocation of Ms. Dixon's N.P. certificate and R.N. license is the appropriate sanction for the proven violations.

### OPINION

The Board seeks to revoke Ms. Dixon's N.P. certificate and R.N. license, pursuant to ORS 678.111(1)(d), (f) and (g), which states:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(d) Fraud or deceit of the licensee in the practice of nursing or in admission to such practice.

\* \* \* \* \*

(f) Conduct derogatory to the standards of nursing.

(g) Violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder.

OAR 851-045-0070 defines conduct derogatory to the standards of nursing, in part, as follows:

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following \* \* \* [.]

The Board has alleged that Ms. Dixon engaged in conduct derogatory to the standard of nursing, as per the following provisions of OAR 851-045-0070:

(1)(a) Developing, modifying, or implementing standards of nursing practice/care which jeopardize patient safety.

\* \* \* \* \*

(c) Failing to develop, implement and/or follow through with the plan of care.

(d) Failing to modify, or failing to attempt to modify the plan of care as needed based on nursing assessment and judgment, either directly or through proper channels.

\* \* \* \* \*

(h) Failing to teach and supervise unlicensed persons to whom nursing tasks have been delegated.

\* \* \* \* \*

(n) Failing to maintain professional boundaries with a client.

\* \* \* \* \*

(2)(f) Unauthorized removal or attempted removal of narcotics, other drugs, supplies, property, or money from clients, the work place, or any person.

\* \* \* \* \*

(h) Using the nurse client relationship to exploit the client by gaining property or other items of value from the client either for personal gain or sale, beyond the compensation for nursing services.

(i) Possessing, obtaining, attempting to obtain, furnishing, or administering prescription or controlled drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs.

(j) Aiding, abetting, or assisting an individual to violate or circumvent any law, rule or regulation intended to guide the conduct of nurses or other health care providers.

\* \* \* \* \*

(3)(a) Inaccurate recordkeeping in client or agency records.

(b) Incomplete recordkeeping regarding client care; including, but not limited, to failure to document care given or other information important to the client's care or documentation which is inconsistent with the care given.

\* \* \* \* \*

(d) Altering a client or agency record or records prepared for an accrediting or credentialing entity; including, but not limited to, changing words/letters/numbers from the original document to mislead the reader of the record, adding to the record after the original time/date without indicating a late entry.

\* \* \* \* \*

(f) Directing another person to falsify, alter or destroy client or agency records or records prepared for an accrediting or credentialing entity.

(g) Failing to maintain client records in a timely manner which accurately reflects management of client care, including failure to make a late entry within a reasonable time period.

\* \* \* \* \*

(4)(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

\* \* \* \* \*

(7)(b) Failing to answer truthfully and completely any question asked by the Board \* \* \* during the course of an investigation or any other question asked by the Board.

\* \* \* \* \*

(9) Conduct related to co-workers: Violent, abusive or threatening behavior towards a co-worker which either occurs in the presence of clients or otherwise relates to the delivery of safe care to clients.

\* \* \* \* \*

(10)(b) Prescribing for or dispensing medications to one's self.

The Board also contends that Ms. Dixon engaged in conduct derogatory to the standards of nursing, pursuant to the following provisions of OAR 851-056-0016 (2015):

(2) The abuse of the prescriptive or dispensing authority constitutes conduct derogatory to nursing standards and is defined as:

\* \* \* \* \*

(c) Prescribing, dispensing, or distributing drugs to an individual who is not the APRN's<sup>44</sup> client unless written under Expedited Partner Therapy guidelines from the Department of Human Services; or under the Oregon Health Authority Programs to Treat Allergic Response OR Hypoglycemia and Opiate Overdose in ORS 433.800–433.830.

\* \* \* \* \*

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<sup>44</sup> “APRN” includes Board licensed or certified clinical nurse specialists, certified registered nurse anesthetists, and N.P.s. See OAR 851-056-0000(3).

(e) Prescribing, dispensing, or distributing drugs for personal use;

\* \* \* \* \*

(g) Prescribing, dispensing, administering, or distributing drugs in an unsafe or unlawful manner or without adequate instructions to the client according to acceptable and prevailing standards or practice;

\* \* \* \* \*

(i) Failure to properly assess and document client assessment when prescribing, dispensing, administering, or distributing drugs[.]

OAR 851-056-0016 (2011) similarly provides:

(2) The abuse of the prescriptive or dispensing authority constitutes conduct derogatory to nursing standards and is defined as:

\* \* \* \* \*

(c) Prescribing, dispensing, or distributing drugs to an individual who is not the clinical nurse specialist's or nurse practitioner's client unless written under Expedited Partner Therapy guidelines from the Department of Human Services or is not within the scope of practice or type of client population served;

(d) Prescribing, dispensing, or distributing drugs for personal use;

\* \* \* \* \*

(f) Prescribing, dispensing, administering, or distributing drugs in an unsafe or unlawful manner or without adequate instructions to the client according to acceptable and prevailing standards or practice;

\* \* \* \* \*

(h) Failure to properly assess and document client assessment when prescribing, dispensing, administering, or distributing drugs[.]

The Board has the burden of proving its allegations against Ms. Dixon. In addition, the evidence must establish that the proposed sanction is appropriate under the facts of the case. *See* ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position"); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position).

## 1. Standard of Proof

The parties agree that the preponderance of evidence standard is the applicable standard of proof as to all non-fraud and non-deceit allegations in this proceeding. Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

Ms. Dixon contends that the Board must prove all allegations involving fraud or deceit by clear and convincing evidence. To be “clear and convincing,” evidence must establish that the truth of the facts asserted is “highly probable.” *Riley Hill General Contractor*, 303 Or at 402, citing to *Cook v. Michael*, 214 Or 513, 526-527 (1958).

The Board contends that the general preponderance of the evidence standard controls in administrative cases, absent some indication from the legislature that the Board should use a different standard of proof. The Board further contends that nothing in ORS 678.111 suggests that the legislature intended that the Board use a clear and convincing standard of proof with respect to “fraud or deceit” in subsection (1)(d) of the statute.

To assist with this issue, it is helpful to review Oregon case law pertaining to standards of proof in the administrative context.

First, in *Bernard v. Board of Dental Examiners*, 2 Or App 22 (1970), the Board of Dental Examiners sought license revocation based on alleged fraud and misrepresentation in obtaining fees for dental services. The court stated:

It is elementary that fraud or misrepresentation is never presumed and that even in a civil action the burden is on the person claiming it to establish its existence by clear, satisfactory and convincing evidence. \* \* \*. The rule in license revocation proceedings requires at least this standard[.]

*Bernard*, 2 Or App at 36. The Court of Appeals analogized the revocation of a dentist’s license to attorney disciplinary proceedings that require clear and convincing evidence, and held that in a dental license revocation proceeding, the Board of Dental Examiners must prove fraud by clear and convincing evidence. *Id.*

In 1980, in *Cook v. Employment Division*, 47 Or App 437 (1980), the Court of Appeals cited to ORS 183.482(8)(c),<sup>45</sup> and concluded that the definition of “substantial evidence” in

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<sup>45</sup> ORS 183.482(8)(c) states:

The court shall set aside or remand the order if the court finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding.

*Wilton v. Employment Division*, 26 Or App 549, 551, 553 (1976) (“any reasonable evidence or such proof as a reasonable mind would employ to support a conclusion”) adequately establishes that “the burden of proof in these [Employment Division] cases is by a preponderance of the evidence, and not by some higher standard.” *Cook*, 47 Or App at 441.

In 1981, the Court of Appeals considered another Board of Dental Examiners case, *Van Gordon v. Board of Dental Examiners*, 52 Or App 749 (1981). There, the Board of Dental Examiners sought license revocation, based in part on allegations that the licensee had obtained fees by misrepresentation or fraud. *Van Gordon*, 52 Or App at 751-752. The court cited to *Bernard* for the proposition that “[i]n a license revocation proceeding based on fraud or misrepresentation, the Board has the burden of establishing the existence of fraud by clear, satisfactory and convincing evidence.” *Id.* at 766.

In 1983, citing to no authority, the Court of Appeals held that the standard of proof in an administrative proceeding “is by a preponderance of the evidence in the absence of some legislative adoption of a different standard.” *Metcalfe v. AFSD*, 65 Or App 761, 765 (1983).<sup>46</sup>

Eleven years later, in 1994, the Court of Appeals noted that the Oregon Administrative Procedures Act (APA) “does not expressly prescribe a standard of proof applicable to administrative proceedings,” but that it had previously held in *Metcalfe* that the standard in an administrative proceeding “is by a preponderance of the evidence in the absence of some legislative adoption of a different standard.” *Sobel v. Board of Pharmacy*, 130 Or App 374, 379 (1994)

*Sobel* involved the denial of a license application based on fraud and intentional misrepresentation. The licensee argued that the court should recognize an exception to the preponderance of evidence standard, as it did in *Bernard* and *Van Gordon*, and require the Board of Pharmacy to prove fraud/intentional misrepresentation by clear and convincing evidence. *Sobel*, 130 Or App at 379-380.

The court stated that it “need not decide whether those cases remain viable in the light of subsequent APA cases” that have applied the preponderance standard because *Bernard* and *Van Gordon* are distinguishable because they involved license revocations, and the current case [merely] involves denial of a license application.” *Id.* at 380. The court reasoned that the factors supporting a higher standard of proof for license revocations are not present with regard to application denials. The court ultimately held that “absent legislative adoption of a different standard, an applicant’s fraud in attempting to secure a license to practice pharmacy may be established by the same preponderance of evidence standard generally applicable to contested cases under the APA.” *Id.* at 380-381.

In March of 1999, the Court of Appeals considered a case involving the suspension of a physician’s license for alleged unprofessional or dishonorable conduct relating to the treatment

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<sup>46</sup> *Metcalfe* was unrelated to professional licensing, and instead involved the termination of general assistance benefits based on a claim of employability. See *Metcalfe v. AFSD*, 65 Or App at 763.

of a patient.<sup>47</sup> *Gallant v. Board of Medical Examiners*, 159 Or App 175 (1999). The court noted that in previously holding (in *Sobel, Metcalf, etc.*) that the standard of proof in an administrative proceeding “is by a preponderance of the evidence in the absence of some legislative adoption of a different standard,” the court “did not interpret directly, or rely on, any statutory or constitutional provision, apparently assuming that the legislature intended the usual civil standard to apply in the absence of legislation to the contrary.” *Gallant*, 159 Or App at 180.

The court noted that ORS 183.450(5)<sup>48</sup> describes the necessary quantity of proof as “substantial evidence,” which does not correspond clearly to the usual terms of preponderance, clear and convincing, or reasonable doubt. The court therefore looked to legislative intent to determine the corresponding standard. And, after analyzing the text, context, and legislative history, the court determined that “if the legislature had wanted a burden of proof higher than the preponderance standard to apply, it would have said so.” *Id.* at 180-183. The court concluded that, because the legislature was silent as to that matter, in enacting ORS 183.450(5), the legislature “intended to prescribe a standard of proof that corresponded to the preponderance standard.” *Id.* at 183.

The licensee in that case argued that due process requires a clear and convincing standard of proof in disciplinary proceedings involving health care professionals. In analyzing that argument, the court specifically stated, “we express no opinion as to whether due process concerns require allegations of fraud in the license revocation or suspension context to be proved by that higher standard of proof.” *Id.* at 183-184. The court then considered the *Matthews v. Eldridge*, 424 US 319 (1976) factors, and ultimately concluded that due process required no more than the preponderance of the evidence standard of proof in the instant case. *Id.* at 184-185.

With regard to *Bernard* and *Van Gordon*, the court stated:

With respect to the burden of proof issue, the analysis of those cases is questionable because we did not in either case purport to base our decision on either statutory or constitutional grounds. Rather, we derived the clear and convincing standard of proof by analogizing the administrative proceeding to a civil action concerning fraud and to an attorney disciplinary proceeding. [citations omitted.] Furthermore, the rationale in *Bernard* for a higher standard of proof relied in part on the allegation of fraud, which is not present here[.]

*Id.* at 185-186.

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<sup>47</sup> *Gallant* contained no allegations of fraud or misrepresentation.

<sup>48</sup> ORS 183.450(5):

No sanction shall be imposed or order be issued except upon consideration of the whole record or such portions thereof as may be cited by any party, and as supported by, and in accordance with, reliable, probative and substantial evidence.

In November 1999, in a Water Resources Department case involving the alleged forfeiture of water rights via non-use, the Court of Appeals cited to *Gallant* and noted, “We have consistently held that, in the absence of an expressly contrary legislative objective, a preponderance standard of proof satisfies the requirements of ORS 183.450(5).” *Staats v. Newman*, 988 P2d 439, 441, 164 Or App 18 (1999).

The petitioners argued, however, that the Department must prove non-use by clear and convincing evidence because forfeiture in civil proceedings must generally be shown by that higher standard of proof. Petitioners cited to dictum in *Rencken v. Young*, 300 Or 352, 365 n 12 (1985), another water rights case, where, after citing ORS 183.450(3) as describing the applicable standard of proof in the proceeding, the court observed in a footnote that “[i]n the circuit court, the burden of proving the forfeiture of a vested property right is by clear and convincing evidence.” *See Staats*, 988 P2d at 441.

The court rejected Petitioners’ reliance on the dictum in *Rencken* and stated:

[T]he [*Rencken*] court was not describing the burden that applies to a water rights proceeding that is controlled by ORS 183.450(3), but, rather, was establishing a contrasting burden that applies, “[i]n the circuit court,” where, in the absence of a statutory standard of proof, the traditional equitable antipathy to forfeiture results in a more demanding standard.

*Id.* (emphasis in original). The court concluded that the clear and convincing evidence standard does not apply in water rights cancellation proceedings. *Id.*

To summarize, in *Gallant*, the Court of Appeals states that “the analysis of [*Van Gordon* and *Bernard*] is questionable,” noting that, in those cases, the court “derived the clear and convincing standard of proof by analogizing the administrative proceeding to a civil action concerning fraud and to an attorney disciplinary proceeding.” *Gallant*, 159 Or App at 185-86; *see also Sobel*, 130 Or App at 380 (questioning the viability of *Van Gordon* and *Bernard* but not reaching the issue). *Gallant* and *Staats* both demonstrate that the court is moving away from simply analogizing administrative proceedings to civil actions with regard to matters such as fraud or water rights cancellation. Instead, with regard to the applicable standard[s] of proof in administrative proceedings, the court has narrowed its focus to statutory and constitutional grounds.

Here, Ms. Dixon has not identified an “expressly contrary legislative directive” requiring a clear and convincing standard of proof as to the Board’s allegations involving fraud or deceit. Instead, Ms. Dixon simply relies on the standard of proof for common law fraud, citing to *OPERB v. Simat, Helliesen & Eichner*, 191 Or App 408 (2004), a civil case. However, *Staats* suggests that court cases establishing the standard of proof for matters arising in circuit court are not dispositive as to the standard of proof required by the APA in a contested case proceeding. *See Staats* at 22. Rather, the *Staats* court notes that what matters is the standard of proof imposed by the legislature. *Id.* To date, the legislature has not specified that a clear and convincing standard of proof applies in professional licensing cases involving fraud or deceit.

Consequently, the ALJ concluded that the applicable standard of proof for all allegations in this proceeding is preponderance of evidence.<sup>49</sup> The Board agrees.

## 2. Prescription for Iopidine Ophthalmic Solution (0.5%)

The Board contends that on or about October 3, 2013, Ms. Dixon prescribed Iopidine Ophthalmic Solution (0.5%) to herself, in violation of ORS 678.111(f) and (g), OAR 851-045-0070(10)(b), and OAR 851-056-0016(2)(e).

Under OAR 851-045-0070(10)(b), conduct derogatory to the standards of nursing includes “[p]rescribing for or dispensing medications to one’s self.”

Similarly, OAR 851-056-0016(2)(d) (2011)<sup>50</sup> provides:

(2) The abuse of the prescriptive or dispensing authority constitutes conduct derogatory to nursing standards and is defined as:

\* \* \* \* \*

(d) Prescribing, dispensing, or distributing drugs for personal use[.]

The record establishes the following facts by a preponderance of the evidence: Ms. Dixon maintains certain supplies as office stock for her Botox practice; she typically purchases her office stock through Black Oak Pharmacy, with whom she has an account; Black Oak Pharmacy does not carry Iopidine Ophthalmic Solution (0.5%); on October 3, 2013, she called in a prescription to Rogue Valley Rx for one bottle of the medication; on the prescription form, she is listed as both the provider and the patient; and the prescription form does not indicate that the medication is intended for use as office stock.

The Board contends that Ms. Dixon prescribed the medication at issue for herself, for her own personal use, in violation of the above-cited rules. Ms. Dixon, on the other hand, asserts that, consistent with her Botox training, she decided to obtain a bottle of Iopidine Ophthalmic Solution (0.5%) strictly for use as office stock, she never intended to personally use the medication, and she did not, in fact, ever personally use it. Ms. Dixon’s assertions are persuasive.<sup>51</sup>

Despite the fact that the prescription form for the Iopidine Ophthalmic Solution (0.5%) lists Ms. Dixon as the patient, the Board has not proven, more likely than not, that she prescribed

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<sup>49</sup> Ms. Dixon did not argue that the Due Process Clause of the Fourteenth Amendment requires the Board to prove its allegations involving fraud or deceit by clear and convincing evidence. Thus, the ALJ did not address that constitutional issue.

<sup>50</sup> This was the version of the rule in effect at the time of the alleged violation.

<sup>51</sup> By contrast, as discussed elsewhere in the Proposed Order, her assertions regarding certain *other* matters pertaining to her N.P. practice were not always plausible, consistent, reliable, logical, or credible.

the medication for herself or dispensed the medication to herself, as per OAR 851-045-0070(10)(b). The Board has also failed to establish that Ms. Dixon prescribed or dispensed the medication for “personal use,” as per OAR 851-056-0016(2)(d) (2011).

In sum, the Board has not proven, more likely than not, that Ms. Dixon engaged in conduct derogatory to the standards of nursing, pursuant to OAR 851-045-0070(10)(b), and OAR 851-056-0016(2)(e) (2011), with regard to the Iopidine Ophthalmic Solution (0.5%).

### 3. Use of Prescription Pads from Creekside and Asante/Rogue Regional

The Board contends that between January 1, 2012 and May 7, 2015, Ms. Dixon deviated from the standard of care by using prescription pads from Creekside and Asante/Rogue Regional to write prescriptions for Private Transformations clients and other individuals for purposes unrelated to her Creekside and Rogue Regional employment, in violation of ORS 678.111(1)(d), (f), and (g), OAR 851-056-0010(1), and OAR 851-056-0016(2)(g) and (i).

OAR 851-056-0010(1) (2015) states:

A written prescription shall include the date, printed name, legal signature, specialty category/title, business address, and telephone number of the prescribing APRN, in addition to the required patient and drug information.<sup>52</sup>

OAR 851-056-0016(2) (2015) states, in relevant part:

(2) The abuse of the prescriptive or dispensing authority constitutes conduct derogatory to nursing standards and is defined as:

\* \* \* \* \*

(g) Prescribing, dispensing, administering, or distributing drugs in an unsafe or unlawful manner or without adequate instructions to the client according to acceptable and prevailing standards or practice; [or]

\* \* \* \* \*

(i) Failure to properly assess and document client assessment when prescribing, dispensing, administering, or distributing drugs[.]

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<sup>52</sup> OAR 851-056-0010(1) (2011) contains no material differences, and states:

A written prescription shall include the date, printed name, legal signature, specialty category/title, business address, and telephone number of the prescribing nurse practitioner or clinical nurse specialist, in addition to the required patient and drug information.

Similarly, OAR 851-056-0016(2) (2011) states, in relevant part:

(2) The abuse of the prescriptive or dispensing authority constitutes conduct derogatory to nursing standards and is defined as:

\* \* \* \* \*

(f) Prescribing, dispensing, administering, or distributing drugs in an unsafe or unlawful manner or without adequate instructions to the client according to acceptable and prevailing standards or practice;

\* \* \* \* \*

(h) Failure to properly assess and document client assessment when prescribing, dispensing, administering, or distributing drugs[.]<sup>53</sup>

Ms. Dixon admitted at hearing to using Creekside and Asante/Rogue Regional prescription pads to write prescriptions to Private Transformations clients and other individuals for purposes not related to either her Creekside or Rogue Regional employment. *See also* Exhibits A86 at 17-18, A18 through A22, A26 through A29, A31, A42, A44, A46, A49, A50, A53, A54, A56, A57, A60, A62, A62A, A64, A64A. She also admitted at hearing that she lacked approval from Creekside and Asante/Rogue Regional to use the pads in that manner. She disputes, however, that her conduct violated the above-cited rules.

Both the current and former versions of OAR 851-056-0010(1) require that a written prescription contain, among other things, the printed name, business address, and telephone number of the prescribing N.P.

The Creekside prescription pads that Ms. Dixon used for Private Transformations patients, coworkers, and friends (for purposes unrelated to Creekside) contained the physical address, phone number, and fax number of the Creekside Family Medicine clinic, as well as the following names: Stephen L. Nelson, M.D.; Deborah Boles, F.N.P.; and Tamara Dixon, F.N.P. When Ms. Dixon used those pads to write prescriptions to non-Creekside patients after she was no longer employed at Creekside, she did not include her own phone number or the business address of her Private Transformations practice on the prescriptions. At hearing, Ms. Dixon asserted that the recipient of such a prescription could have called Creekside and someone at that clinic could have contacted her or otherwise put the caller in contact with her. Regardless of whether someone could have eventually tracked down Ms. Dixon through a clinic at which she was no longer employed, the current and former versions of OAR 851-056-0010(1) explicitly require that a written prescription contain the business address and phone number of the *prescriber herself*. The Board has established that Ms. Dixon violated OAR 851-056-0010(1) on multiple occasions by using the Creekside prescription pads.

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<sup>53</sup> As previously noted, the only difference between the current and former version is with regard to the subsection numbering.

The Asante/Rogue Regional prescription pads that Ms. Dixon used for Private Transformations patients, coworkers, and friends contained the physical address of the Rogue Regional Medical Center and spaces for the prescriber to put his or her address, DEA number, and office phone number. With very limited exception, when Ms. Dixon used those pads to write prescriptions to Private Transformations clients and other individuals for purposes unrelated to her Rogue Regional employment, she did not include her printed name, own phone number, or the physical address of her Private Transformations practice on the prescriptions. For the same reasons discussed above, Ms. Dixon violated OAR 851-056-0010(1) multiple times via this conduct.

As previously stated, conduct derogatory to the standards of nursing under OAR 851-056-0016(2)(g) (2015) and (f) (2011) includes prescribing drugs “in an unsafe or unlawful manner or without adequate instructions to the client according to acceptable and prevailing standards of practice.” The Board did not establish, more likely than not, that Ms. Dixon’s use of the Creekside and Asante/Rogue Regional prescription pads in the manner already discussed was unsafe or unlawful. Moreover, the ALJ concluded that failing to have information such as the business address and prescriber phone number on a paper prescription is distinguishable from prescribing drugs “without adequate instructions.” OAR 851-056-0016(2). The Board has not proven that Ms. Dixon’s use of the Creekside and Asante/Rogue Regional prescription pads constitutes conduct derogatory to the standards of nursing under OAR 851-056-0016(2)(g) (2015) and (f) (2011). The Board agrees.

Finally, the Board’s contention that Ms. Dixon engaged in conduct derogatory to the standards of nursing pursuant to OAR 851-056-0016(2)(i) (2015) and OAR 851-056-0016(2)(h) (2011) by using the Creekside and Asante/Rogue Regional prescription pads for purposes unrelated to her employment with those entities is not persuasive. Rather, the issue of whether she failed to properly assess and document client assessments when prescribing medications is thoroughly discussed in later subsections of the Proposed Order.

In conclusion, the Board has established that Ms. Dixon violated OAR 851-056-0010(1) (2011 and 2015) on multiple occasions via her use of the Creekside and Asante/Rogue Regional prescription pads. Thus, the Board may discipline Ms. Dixon pursuant to ORS 678.111(1)(g), for violating “any provision of ORS 678.010 to 678.445 or rules adopted thereunder.”<sup>54</sup> Ms. Dixon is not, however, subject to discipline under ORS 678.111(1)(f) because the Board did not establish that her actions involving the prescription pads amounted to “[c]onduct derogatory to the standards of nursing.”

The only remaining issue is whether Ms. Dixon is subject to discipline pursuant to ORS 678.111(1)(d), for “[f]raud or deceit of the licensee in the practice of nursing[.]” The phrase “fraud or deceit,” as used in ORS 678.111(1)(d), is not defined by statute or rule, and nothing in the statute suggests that the legislature intended for the Board to treat the phrase as importing the

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<sup>54</sup> The Board adopted OAR 851-056-0010 pursuant to the statutory authority in ORS 678.150 and 678.285.

elements for a civil fraud claim. It is therefore appropriate to construe the terms “fraud” and “deceit” using the ordinary meanings derived from their dictionary definitions.<sup>55</sup>

“Fraud” is defined, in relevant part, as “an instance or an act of trickery or deceit esp. when involving misrepresentation: an act of deluding.” *Webster’s Third New International Dictionary* 904 (unabridged ed 2002). “Deceit” is defined, in relevant part, as follows:

1: the act or practice of deceiving (as by falsification, concealment, or cheating) \* \* \* 2a: an attempt to deceive: a declaration, artifice, or practice designed to mislead another[.]

DECEIT implies the intent to mislead and can cover misrepresentation, falsification, fraud, or trickery of any kind[.]

*Id.* at 584. From those definitions, the ALJ concluded that a finding of “fraud or deceit” under ORS 678.111(1)(d) requires a misrepresentation or falsification made for the purpose of misleading another. The Board agrees.

Here, the record does not establish, more likely than not, that Ms. Dixon used the Creekside and Asante/Rogue Regional prescription pads to write prescriptions to Private Transformations clients, friends, and coworkers with the intent of *misleading* those individuals, pharmacies, or the Board into believing that she was writing the prescriptions on behalf of those employers. Rather, Ms. Dixon’s use of the pads appears motivated by mere convenience, and her mistaken belief that such conduct was allowable. Thus, the Board has not established fraud or deceit with respect to this conduct, and Ms. Dixon is not subject to discipline pursuant to ORS 678.111(1)(d) based on the conduct.

#### **4. Violation of KG’s Right to Privacy and Confidentiality of Information**

The Board contends that Ms. Dixon violated KG’s right to privacy and confidentiality of information when Ms. Dixon viewed KG’s and EG’s private health records without a medical reason to do so, in violation of ORS 678.111(1)(d), (f), and (g) and OAR 851-045-0070(2)(l) and (m).

Ms. Dixon admits to accessing KG’s medical record at Rogue Regional on November 28, 2014, and EG’s medical record on February 10, 2015. However, Ms. Dixon contends that KG requested that she access the records on both occasions, that KG gave her verbal permission for the access, and that KG was present on both occasions when the access occurred.

On June 12, 2015, KG reported to an Asante privacy information security officer that she had concerns about Ms. Dixon inappropriately accessing medical records for her and her son,

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<sup>55</sup> A statute is generally construed by giving words their ordinary meaning. *Stuart v. Pittman*, 350 Or 410, 418-419 (2011). In determining the ordinary meaning of words in a statute, it is appropriate to consider dictionary definitions. *See Department of Revenue v. Faris*, 345 Or 97, 101 (2008) (looking to dictionary definition of an ordinary word not defined in statute).

EG. The record contains no evidence as to what prompted KG to report her alleged concerns on that date, when the access to her records occurred nearly seven months earlier and the access to her son's records occurred more than four months earlier. It is suspicious that KG would wait to voice concerns about the medical records access until after the workplace altercation with Ms. Dixon in April 2015, the subsequent filing of harassment charges by each of the women against the other, and the demise of their once close friendship.

Ms. Dixon admitted at hearing that there were times when the lines between her close friendship with KG and their provider/client relationship became blurred. The record demonstrates that Ms. Dixon has willingly acted for KG's benefit even if her actions could have proven detrimental to Ms. Dixon professionally, or even legally (*e.g.*, asking a coworker to remove medication from the Omnicell so Ms. Dixon could give it to KG). The ALJ concluded that, more likely than not, Ms. Dixon accessed KG's and EG's medical records at KG's request, with KG's verbal permission, and in the presence of KG. Although the Board does not agree, the Board allows this finding to stand as recommended by the ALJ. The issue is whether the access of those records, *under those circumstances*, constitutes conduct derogatory to the standards of nursing as per OAR 851-045-0070(2)(l) and/or (m).<sup>56</sup>

Under OAR 851-045-0070, conduct derogatory to the standards of nursing includes:

(2)(l) Violating the rights of privacy, confidentiality of information, or knowledge concerning the client, unless required by law to disclose such information or unless there is a "need to know."

(m) Violating the rights of privacy, confidentiality of information, or knowledge concerning the client by obtaining the information without proper authorization or when there is no "need to know."

Ms. Dixon was not required by law to disclose the health information at issue to KG, and Ms. Dixon did not have a "need to know" the information contained in the medical records. The question thus becomes whether it is possible for Ms. Dixon to violate KG's right to privacy and confidentiality of information by accessing the records when KG expressly requested that Ms. Dixon access the records on KG's behalf. The ALJ concluded that answering this question in the affirmative would be illogical.<sup>57</sup> Thus, the Board has not established that Ms. Dixon engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(2)(l) and/or (m) when she accessed the records, and Ms. Dixon is not subject to discipline pursuant to ORS 678.111(1)(d), (f), and (g) for that conduct.

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<sup>56</sup> While it is clear that Ms. Dixon's conduct violates the employer's written confidentiality policy, the Board has not alleged a violation against Ms. Dixon for violating a workplace policy.

<sup>57</sup> In addition, the Board did not explain how Ms. Dixon's conduct of accessing EG's medical record would constitute a violation of KG's right to privacy and confidentiality of information, even if there had hypothetically been no consent or authorization from KG. It may well be that KG has some right to privacy or confidentiality of EG's information by virtue of being the minor child's parent, but the Board offered no authority to support that proposition. It is, however, unnecessary to resolve the issue, given that KG verbally authorized Ms. Dixon to access KG's and EG's records.

**5. Asking JCB to Take Medication from the Omnicell for Use by KG**

The Board contends that Ms. Dixon violated ORS 678.111(1)(d), (f), and (g) by engaging in conduct derogatory to the standards of nursing, pursuant to the provisions of OAR 851-045-0070 set forth below, when she requested that JDB remove medication from Rogue Regional's Omnicell medication dispenser so that Ms. Dixon could give the medication to KG, who was ill at home at the time.

Under OAR 851-045-0070, conduct derogatory to the standards of nursing includes the following:

(1)(h) Failing to teach and supervise unlicensed persons to whom nursing tasks have been delegated.

\* \* \* \* \*

(2)(f) Unauthorized removal or attempted removal of narcotics, other drugs, supplies, property, or money from clients, the work place, or any person.

\* \* \* \* \*

(i) Possessing, obtaining, attempting to obtain, furnishing, or administering prescription or controlled drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs.

(j) Aiding, abetting, or assisting an individual to violate or circumvent any law, rule or regulation intended to guide the conduct of nurses or other health care providers.

\* \* \* \* \*

(3)(b) Incomplete recordkeeping regarding client care; including, but not limited, to failure to document care given or other information important to the client's care or documentation which is inconsistent with the care given.

\* \* \* \* \*

(f) Directing another person to falsify, alter or destroy client or agency records or records prepared for an accrediting or credentialing entity.

The record establishes that in approximately June 2014, KG persuaded Ms. Dixon to obtain a vial of Toredal medication for her from the workplace. Ms. Dixon subsequently asked JDB, an R.N. with whom she worked, to get the medication for KG. JDB agreed, accessed the

Omnicell, obtained a vial of intravenous Toreadal as “floor stock,” and then gave the medication to Ms. Dixon. Ms. Dixon subsequently provided it to KG. Both Ms. Dixon and JCB admit to the above conduct.

The ALJ did not find that Ms. Dixon’s conduct constitutes a failure “to teach and supervise unlicensed persons to whom nursing tasks have been delegated” and there is no evidence that she directed JDB to “falsify, alter or destroy client or agency records or records prepared for an accrediting or credentialing entity.” Thus, she did not engage in conduct derogatory to the standards of nursing under OAR 851-045-0070(1)(h) or (3)(f). However, by requesting that a coworker improperly obtain medication for KG, personally removing the improperly obtained medication from the workplace, furnishing the medication to KG, and failing to document the medication in KG’s treatment records, Ms. Dixon engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(2)(f), (i), and (j) and (3)(b).

Ms. Dixon’s conduct in asking JDB to improperly obtain medication from the workplace was deceitful and fraudulent towards Asante/Rogue Regional. The Board has proven that, based on this conduct, Ms. Dixon is subject to discipline pursuant to ORS 678.111(1)(d) (fraud or deceit), (f) (conduct derogatory to nursing standards), and (g) (violation of a Board rule).

#### **6. Asking TF to Obtain KG’s Norco from the Pharmacy and Deliver it to Ms. Dixon**

The Board contends that on or about July 23, 2014, Ms. Dixon failed to maintain professional boundaries with clients and abused the nurse/client relationship by requesting that KG’s adult son, TF, pick up Norco prescribed to KG from the pharmacy and deliver it to Ms. Dixon, in violation of ORS 678.111(1)(f) and (g) and OAR 851-045-0070(1)(n) and (2)(h).

Under OAR 851-045-0070, conduct derogatory to the standards of nursing includes:

(1)(n) Failing to maintain professional boundaries with a client.

\* \* \* \* \*

(2)(h) Using the nurse client relationship to exploit the client by gaining property or other items of value from the client either for personal gain or sale, beyond the compensation for nursing services.

Ms. Dixon admits that on or about July 22 or 23, 2014, she asked KG’s son, TF, to retrieve a filled Norco prescription for KG from the Safeway pharmacy and bring the medication to Ms. Dixon. Ms. Dixon told TF that she wanted the medication so that KG, who was in a substance abuse treatment program at Hazelden at the time, would not have access to the medication once she left Hazelden. TF agreed to Ms. Dixon’s request, and on July 23, 2014, he signed for and received the Norco from the pharmacy, took the medication to Ms. Dixon at her home, and received approximately \$20 from Ms. Dixon to compensate him for his fuel costs.

The first issue is whether Ms. Dixon failed to “maintain professional boundaries with a client,” as per OAR 851-045-0070(1)(n). If Ms. Dixon had concerns that KG would have Norco

available to her once she left her substance abuse treatment program (from prescriptions or refills that Ms. Dixon herself had authorized), Ms. Dixon could have simply instructed the pharmacy to “unfill” any Norco prescriptions waiting for KG and to discontinue any active Norco prescription orders prescribed by Ms. Dixon.<sup>58</sup> But rather than take those reasonable actions, Ms. Dixon instead asked KG’s son to retrieve a filled Norco prescription for KG from the pharmacy and turn the Norco over to Ms. Dixon. Ms. Dixon’s conduct in contacting the son of a client, asking the son to retrieve the client’s filled narcotic medication, and having the son place the medication in Ms. Dixon’s possession so the client would not have access to it demonstrates a significant breach of professional provider/client boundaries. The Board has therefore proven that Ms. Dixon engaged in conduct derogatory to the standards of nursing, under OAR 851-045-0070(1)(n). For this conduct, Ms. Dixon is subject to discipline pursuant to ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

The next issue is whether Ms. Dixon used the provider/client relationship to exploit KG “by gaining property or other items of value from [KG] either for personal gain or sale, beyond the compensation for nursing services,” as per OAR 851-045-0070(2)(h). To determine whether Ms. Dixon engaged in conduct derogatory to the standards of nursing under that rule provision, it is necessary to determine Ms. Dixon’s intent in having TF retrieve KG’s Norco from the pharmacy and turn it over to Ms. Dixon. Back in July 2014, she told TF that she wanted the Norco so that KG would not have access to it after returning home from a substance abuse treatment program. Ms. Dixon testified at hearing as to that same intent. However, certain circumstances surrounding the April 22, 2014 Norco prescription raises serious questions about Ms. Dixon’s conduct and motivations.

On July 22, 2014, the Safeway pharmacy received a prescription request on its interactive voice recorder for 110 tablets of Norco for KG. Pharmacy Manager Rimov listened to the recording, recognized the voice as someone who had previously called in prescriptions, and wrote down the prescription so it could be filled. He discontinued the May 27, 2014 Norco prescription that still had four refills available, and filled the July 22, 2014 prescription as a new prescription.

During her Board interview, Ms. Dixon informed Board investigators that she believed the July 22, 2014 Norco prescription was a refill of a prescription she had previously provided to KG. However, the July 22 prescription was for 110 tablets, and the previous prescription (from May 27, 2014) was for 120 tablets. Upon further questioning from the investigators, Ms. Dixon stated that she “most likely” did authorize the July 22, 2014 prescription, but then stated that she did not recall authorizing it.

At the hearing, Ms. Dixon insisted that she did not call in the July 22, 2014 Norco prescription for KG. When the Board’s counsel questioned Ms. Dixon about Verizon phone records showing that a three-minute phone call was made from her cell phone to the Safeway pharmacy on July 22, 2014, at 12:51 p.m., she admitted to calling the pharmacy that day, but insisted that she merely called to ask whether there was a filled prescription of Norco waiting for

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<sup>58</sup> Incidentally, in April 2015, Ms. Dixon did request that the Safeway pharmacy discontinue all active prescription orders for KG prescribed by Ms. Dixon. (Test. of Rimov.)

KG. If Ms. Dixon did not call in the Norco prescription on July 22, it is strangely coincidental that she would choose to call the pharmacy that very day merely to ask whether there was a filled Norco prescription waiting for KG.

Given the above, and the fact that Ms. Dixon has been untruthful with regard to whether she wrote Norco prescriptions to KG dated November 20, 2014 and January 16, 2015,<sup>59</sup> the ALJ found that more likely than not, Ms. Dixon did call and authorize the July 22, 2014 Norco prescription. Her motivation for doing so, however, remains unknown. And, the record contains no evidence regarding what Ms. Dixon did with the Norco once she obtained possession of it from TF on July 23, 2014. The Board agrees.

In sum, although Ms. Dixon's conduct with regard to the July 22, 2014 Norco prescription is cause for serious concern for the Board (and subjects her to discipline via other administrative provisions), it does not constitute conduct derogatory to the standards of nursing under OAR 851-045-0070(2)(h). The ALJ was not persuaded that the filled Norco prescription was an item of value or property that actually belonged to KG. Moreover, the Board has not established by a preponderance of the evidence *why* Ms. Dixon chose to gain possession of the Norco. In other words, the Board has not proven, more likely than not, that she did so "for personal gain or sale," as set forth under OAR 851-045-0070(2)(h). The Board agrees.

## **7. Physical Altercation in the Workplace**

The Board contends that on or about April 2, 2015, Ms. Dixon engaged in conduct derogatory to the standards of nursing, pursuant to OAR 851-045-0070(9), when she was involved in a physical altercation with KG in the workplace.

Under OAR 851-045-0070(9), conduct derogatory to the standards of nursing includes:

[V]iolent, abusive or threatening behavior towards a co-worker which either occurs in the presence of clients or otherwise relates to the delivery of safe care to clients.

The morning after KG's March 22, 2015 arrest for DUII, Possession of a Controlled Substance, and Reckless Driving, Ms. Dixon and KG had a heated argument at KG's home. Their friendship thereafter became strained. On April 2, 2015, KG and Ms. Dixon were both working on the same unit at Rogue Regional. KG appeared angry that day, and once Ms. Dixon arrived at work and heard from coworkers that KG had been making accusations about various individuals and denying fault for her arrest, Ms. Dixon approached KG and told her that she needed to stop lying and quit talking at work about the arrest.

A short time later, Ms. Dixon left the unit on a break to meet with a coworker near the coffee cart in the lower level of the hospital. KG followed Ms. Dixon and they began arguing with one another, primarily about KG's substance abuse issues. KG was not on an authorized break at the time. When KG and Ms. Dixon got on the elevator to go down to the lower level,

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<sup>59</sup> See the previous section of the Proposed Order titled "Expert Opinion of James A. Green."

their exchange had become very heated. On the elevator, KG pushed Ms. Dixon's right shoulder with her finger and told Ms. Dixon that it would be her fault when KG killed herself. After exiting the elevator, they continued their heated verbal exchange, and Ms. Dixon subsequently pushed KG's arm and called her a liar. Ms. Dixon then used her hand to hold KG towards a wall and asserted that she was going to make KG go to rehab. Rogue Regional security guard Timothy Reeder observed that KG was up against the wall (and appeared to be somewhat sliding down the wall) while Ms. Dixon yelled at her that she was a liar and a "piece of shit." Testimony of Reeder, Dixon; Exhibit A2 at 1. In Mr. Reeder's opinion, KG appeared frightened and Ms. Dixon appeared aggressive.

Ms. Dixon continued to yell at KG while they walked towards the coffee cart. The two women then stopped and Ms. Dixon raised her hand and pushed the palm of her hand into KG's left shoulder. At that point, KG yelled "Don't touch me!" and Mr. Reeder yelled "Stop!" Testimony of Reeder; Exhibit A2 at 2. Ms. Dixon then walked away, returned to the unit, and resumed working. Although Mr. Reeder did not witness the entire altercation (including how it started), from the portion of it that he observed, he believes that Ms. Dixon was the aggressor.

Ms. Dixon does not dispute that a heated verbal exchange and physical altercation with KG occurred in the lower level of Rogue Regional.<sup>60</sup> The ALJ was persuaded that, at certain points during the altercation, Ms. Dixon engaged in threatening behavior towards KG. Ms. Dixon contends, however, that the altercation did not occur in the presence of clients and that it did not relate to the "delivery of safe care to clients" as per OAR 851-045-0070(9). The Board agrees.

Ms. Dixon is correct that there is no evidence to establish that any Rogue Regional clients witnessed the physical altercation on April 2, 2015. However, Ms. Dixon is incorrect to assert that the altercation did not relate to the delivery of safe care to clients. During the altercation, KG (who was not on an authorized break) was not on the unit performing patient care as she was supposed to be doing at that time. Moreover, KG did not resume her work shift after the altercation and did not perform any additional patient care for the rest of that day. This resulted in a coworker having to take care of KG's two patients on the unit, in addition to the coworker's own two patients, until another nurse could be brought in to replace KG for the remainder of the nursing shift. Another nurse arrived approximately one to two hours later, and in the interim, the charge nurse assisted KG's coworker with some patient care. However, the patients received less nursing time than they would have received if KG had completed her shift. For this reason, the ALJ was persuaded that the altercation between KG and Ms. Dixon related to the delivery of safe care to clients on April 2, 2015. The Board agrees.

The Board has proven that Ms. Dixon engaged in conduct derogatory to the standards of nursing, under OAR 851-045-0070(9). For this conduct, Ms. Dixon is subject to discipline pursuant to ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

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<sup>60</sup> There is some factual dispute as to certain minor details involving the physical altercation, but they are not material to the determination of whether Ms. Dixon engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(9).

## 8. Falsification of KG's Private Transformations Records

The Board contends that between April 16, 2015 and May 13, 2015, Ms. Dixon engaged in conduct derogatory to the standards of nursing, pursuant to OAR 851-045-0070(3)(d) and (g), by falsifying KG's Private Transformations records before providing them to the Board.

Under OAR 851-045-0070(3), conduct derogatory to the standards of nursing includes:

(d) Altering a client or agency record or records prepared for an accrediting or credentialing entity; including, but not limited to, changing words/letters/numbers from the original document to mislead the reader of the record, adding to the record after the original time/date without indicating a late entry.

\* \* \* \* \*

(g) Failing to maintain client records in a timely manner which accurately reflects [*sic*] management of client care, including failure to make a late entry within a reasonable time period.

In approximately mid to late April 2015, Ms. Dixon accessed KG's prescription history through the PMDP, printed out the prescription history, and used it to compare the information contained therein with what was in KG's Botox treatment records. On April 25, 2015, she provided a copy of KG's Private Transformations records to the Medford Police Department. *See* Exhibit A14. On or about May 7, 2015, she provided a copy of KG's Private Transformations records to the Board.<sup>61</sup> *See* Exhibit A15.

The records Ms. Dixon provided to the Board list three prescriptions that were not present in the records provided to the Medford Police Department: a Mupirocin prescription under a treatment note dated January 6, 2014; a Norco prescription in a section for additional comments between treatment notes dated April 7, 2014 and July 18, 2014; and another Mupirocin prescription under a treatment note dated August 25, 2014. Also, in a treatment note dated January 28, 2014, the records Ms. Dixon provided to the Board show that the number of Soma refills was changed from a "2" to a "4." *See* Exhibits A14 at 2, A15 at 2. Ms. Dixon wrote that the Norco prescription was a late entry ("5/27 Late Entry OK'd for Norco 10/325 #120 (MR x 4) — Planning for hysterectomy late summer [w/] Binette (needs PTO).")<sup>62</sup> She

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<sup>61</sup> The records provided to the Board were pursuant to Ms. Van Horn's request for Botox treatment records for certain named clients, including KG. (*See* Ex. A84 at 3-4; test of Van Horn.)

<sup>62</sup> It is highly unlikely that Ms. Dixon actually made that late entry on May 27, 2014, because the entry was not in the records she provided to the Medford Police on May 1, 2015. (*See* Ex. A14 at 3.) Moreover, the "5/27" cannot refer to May 27, 2015 because Ms. Dixon provided this record to the Board

did not, however, indicate that the Mupirocin additions and the change to the amount of Soma refills were late entries.

At hearing, Ms. Dixon denied using the information from the PMDP to falsify KG's treatment records. She testified that after discussing KG's suspect prescriptions with Officer McOmber, on April 30, 2015, she added the additional entries to KG's records in an attempt to make the records as complete and accurate as possible. She insisted that she did not falsify the records, but merely added information as it became available to her, and that her failure to document the entries as late was inadvertent.

To constitute conduct derogatory to the standards of nursing under OAR 851-045-0070(3)(d) and (g), there is no requirement that the licensee or applicant intend to mislead the Board. Rather, OAR 851-045-0070(3)(d) merely requires a finding that Ms. Dixon altered a client record before providing it to the Board by, for example, "adding to the record after the original time/date without indicating a late entry." The record establishes three instances where Ms. Dixon added to KG's records before providing them to the Board and did not indicate late entries—the Mupirocin note at Exhibit A15 at 2; the Soma note at Exhibit A15 at 2; and the Mupirocin note at Exhibit A15 at 4. Thus, the Board has established that Ms. Dixon engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(3)(d), and she is subject to discipline for that conduct under ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

Conduct derogatory to the standards of nursing under OAR 851-045-0070(3)(g) requires a finding that Ms. Dixon failed to maintain KG's records in a timely manner to accurately reflect management of her care, such as by failing to make a late entry "within a reasonable time period." Ms. Dixon made the additional entries and the Soma refill alteration to KG's records sometime between April 25, 2015, when she provided a copy to the Medford Police Department, and approximately May 7, 2015, when the Board received its copy. The first Mupirocin addition appears under a treatment note dated January 6, 2014; the Soma refill alteration appears in a treatment note dated January 28, 2014; the late Norco entry appears between treatment notes dated April 7, 2014 and July 18, 2014; and the second Mupirocin addition appears under a treatment note dated August 25, 2014. The phrases "timely manner" and "reasonable time" are not defined in OAR 851-045-0070(3)(g). Nonetheless, given how important it is for an N.P. to maintain accurate and complete client records, making late entries and alterations to a patient record 10 to 16 months after the provision of care cannot realistically be construed as timely or reasonable. The Board has therefore proven that Ms. Dixon engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(3)(g), and she is subject to discipline for that conduct under ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

The final issue is whether Ms. Dixon's conduct in altering KG's medical records before providing them to the Board constitutes fraud or deceit, thus subjecting her to discipline under ORS 678.111(1)(d).

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*before* that date. More likely than not, Ms. Dixon's notation that the late entry was made on May 27 is inaccurate.

During Ms. Dixon's May 20, 2015 Board interview, Investigator Van Horn asked if Ms. Dixon added anything to KG's records after accessing the PDMP. In response, Ms. Dixon admitted to only the 5/27 late entry. Sometime later during the interview, Investigator Van Horn asked Ms. Dixon if any of the Private Transformations records were updated, altered, or changed before sending them to the Board. Ms. Dixon responded that the only change she made to the records was the May 27 late entry in KG's records. When Investigator Van Horn asked if there was anything else Ms. Dixon added to KG's records, Ms. Dixon responded in the negative.

As previously discussed, Ms. Dixon made the four alterations to KG's records sometime between April 25 and approximately May 7, 2015. It strains credulity to believe that, during the May 20, 2015 interview (just weeks after making those alterations), Ms. Dixon remembered the one late entry that she had marked as such, but not the other three alterations that were not marked as being late entries. The ALJ was not persuaded that Ms. Dixon intended to mark those three entries as late, but inadvertently did not, and that she forgot about them when asked multiple times during her Board interview if she made any additions, alterations, and/or changes to the records aside from the May 27 late entry. Rather, more likely than not, Ms. Dixon made those alterations to KG's records prior to providing them to the Board in an attempt to mislead the Board into believing that the records presented a complete and accurate picture of the treatment Ms. Dixon had provided to KG. Ms. Dixon's conduct was fraudulent and deceitful, and she is therefore subject to discipline under ORS 678.111(1)(d). The Board agrees.

#### **9. Prescribing Medications for Individuals without Provider/Client Relationship**

The Board contends that between January 1, 2012 and May 7, 2015, Ms. Dixon deviated from the standard of care by prescribing medication to multiple individuals without having a provider/client relationship with those individuals, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(c), (3)(b), and (4)(b), OAR 851-056-0016(2)(c), (f) and (h) (2011), OAR 851-056-0016(2)(c), (g), and (i) (2015) and OAR 851-050-0005(4)(a), (b), (c), (d), and (e).

The ALJ found that any violations alleged pursuant to OAR 851-045-0070(1)(c) and (3)(b), OAR 851-056-0016(2)(h) (2011) and (i) (2015), and OAR 851-050-0005(4)(a)-(e) are inapplicable to the specific issue of whether Ms. Dixon prescribed medication to multiple individuals without having a provider/client relationship. Instead, violations alleged pursuant to those provisions more appropriately fall under the next subsection, titled "Failure to Properly Assess, Document, and/or Maintain Client Record when Prescribing to Individuals Who Were Not Private Transformations Clients and Improperly Prescribing Medication." Those particular provisions are therefore discussed in the next subsection, and not the current one.

Under OAR 851-045-0070, conduct derogatory to the standards of nursing includes:

- (4)(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

Under OAR 851-056-0016(2) (2015),<sup>63</sup> the abuse of the prescriptive or dispensing authority constitutes conduct derogatory to nursing standards and includes:

(c) Prescribing, dispensing, or distributing drugs to an individual who is not the APRN's client unless written under Expedited Partner Therapy guidelines from the Department of Human Services; or under the Oregon Health Authority Programs to Treat Allergic Response OR Hypoglycemia and Opiate Overdose in ORS 433.800–433.830.

\* \* \* \* \*

(g) Prescribing, dispensing, administering, or distributing drugs in an unsafe or unlawful manner or without adequate instructions to the client according to acceptable and prevailing standards or practice[.]

OAR 851-050-0000(3) defines “client(s)” or “patient(s)” as “a family, group or individual who has been assessed by and has a client/patient record established by the nurse practitioner.”<sup>64</sup>

The Board asserts that Ms. Dixon prescribed medication to the following individuals with whom she had no provider/client relationship: GB, JB, JDB, LLB, WB, SKC, SMC, SD, TD, PE, KF, AF, LF, NF, TLK, SL, ML, DM, AR, HS, BT, LW, and JW. As previously noted, the issue of whether assessments occurred with respect to those individuals will be discussed in the next subsection. Thus, the ALJ focused on the portion of the definition of “client” that requires an N.P. to establish a client record, because without such a record, the individual is not a client and there is no provider/client relationship between the N.P. and the individual.

<sup>63</sup> Similarly, OAR 851-056-0016(2) (2011) provides, in relevant part:

(2) The abuse of the prescriptive or dispensing authority constitutes conduct derogatory to nursing standards and is defined as:

\* \* \* \* \*

(c) Prescribing, dispensing, or distributing drugs to an individual who is not the clinical nurse specialist's or nurse practitioner's client unless written under Expedited Partner Therapy guidelines from the Department of Human Services or is not within the scope of practice or type of client population served;

\* \* \* \* \*

(f) Prescribing, dispensing, administering, or distributing drugs in an unsafe or unlawful manner or without adequate instructions to the client according to acceptable and prevailing standards or practice[.]

<sup>64</sup> OAR Chapter 851, Division 50 relates to N.P.s generally, whereas Division 56 relates specifically to an A.P.R.N.'s authority to prescribe and dispense medication. OAR 851-056-0000(5) contains the same definition of “client” and “patient” as OAR 851-050-0000(3).

On January 30, 2014, Ms. Dixon prescribed Retin-A (tretinoin) to GB. There are no Rogue Regional records showing that GB was a patient of Ms. Dixon's, and there are no Creekside or Private Transformations treatment records for GB. Ms. Dixon asserted in email correspondence sent by Attorney Keaney to Investigator Van Horn on June 15, 2015 that GB was seen at the Blue Giraffe Spa and that Ms. Dixon has had a documented provider/client relationship with GB since February 2012. However, Ms. Dixon produced no treatment records to substantiate her assertion. The ALJ concluded, more likely than not, that GB had no established client record with Ms. Dixon, and that Ms. Dixon therefore prescribed medication to GB without a provider/client relationship. The Board agrees.

On July 23, 2014, Ms. Dixon prescribed Effexor ER to JB, a close friend of hers. Ms. Dixon did not document the prescription. There are no patient records at Creekside or Rogue Regional for JB, and Ms. Dixon has no Private Transformations treatment records for him. On December 31, 2013, Ms. Dixon prescribed lisinopril to JDB, an R.N. with whom she worked and had a friendship. On June 26, 2014, she prescribed acyclovir and propranolol to JDB. She did not document any of JDB's prescriptions in treatment records or chart notes. There are no Rogue Regional records showing that JDB was a patient of Ms. Dixon's, and there are no Creekside or Private Transformations treatment records for him. On August 24, 2012, Ms. Dixon prescribed Cymbalta and trazadone to LLB. There are no Rogue Regional records showing that LLB was a patient of Ms. Dixon's, and there are no Creekside or Private Transformations treatment records for LLB. On September 24, 2013, Ms. Dixon prescribed a transdermal scopolamine patch to WB, a CNA at Rogue Regional. There are no Rogue Regional records showing that WB was a patient of Ms. Dixon's, and there are no Creekside or Private Transformations treatment records for him. On January 28, 2015, Ms. Dixon prescribed Tamiflu to SKC. There are no Rogue Regional records showing that SKC was a patient of Ms. Dixon's, and there are no Creekside or Private Transformations treatment records for SKC. The ALJ concluded, more likely than not, that JB, JDB, LLB, WB, and SKC had no established client records with Ms. Dixon. Consequently, the Board has proven that she prescribed medications to those individuals without a provider/client relationship.

On February 6, 2013, Ms. Dixon prescribed propranolol to SMC. There are no Rogue Regional records showing that SMC was a patient of Ms. Dixon's, and there are no Creekside or Private Transformations treatment records for SMC. Ms. Dixon asserted in Attorney Keaney's email correspondence dated June 15, 2015 that SMC was seen at the Blue Giraffe Spa and that Ms. Dixon has had a documented provider/client relationship with SMC since September 30, 2011. However, Ms. Dixon produced no treatment records to substantiate her assertion. The ALJ concluded, more likely than not, that SMC did not have an established client record with Ms. Dixon. Thus, Ms. Dixon prescribed medication to SMC without a provider/client relationship.

On March 11, 2014, Ms. Dixon prescribed Yaz, an oral contraceptive, to her 16-year-old daughter, SD. There are no Rogue Regional records showing that SD was a patient of Ms. Dixon's, and there are no Creekside or Private Transformations treatment records for SD. On May 7, 2013, Ms. Dixon prescribed erythromycin to TD, her ex-husband. On September 11, 2013 and February 4, 2014, she prescribed doxycycline to TD. Ms. Dixon did not maintain a

chart on TD, or otherwise document any care she provided to him. There are no Rogue Regional records showing that TD was a patient of Ms. Dixon's, and there are no patient records at Creekside for TD. On December 18, 2013, Ms. Dixon prescribed Augmentin to a Rogue Regional coworker, PE. On September 22, 2014, Ms. Dixon prescribed Ciprofloxacin to PE. Ms. Dixon did not chart any care for PE. There are no Rogue Regional records showing that PE was a patient of Ms. Dixon's, and there are no patient records at Creekside for PE. On January 26, 2014, Ms. Dixon prescribed Augmentin to a coworker, KF. At the time, KF was not a Private Transformations client, and there are no Botox treatment records for KF on or before January 26, 2014. There are also no patient records at Creekside or Rogue Regional for KF. On January 12, 2014, Ms. Dixon prescribed benzonatate to AF. There are no patient records at Creekside or Rogue Regional for AF, and Ms. Dixon has no Private Transformations treatment records for AF. On April 4, 2014, Ms. Dixon wrote a tanning prescription for KG's daughter, LF. There are no Rogue Regional records showing that LF was a patient of Ms. Dixon's, and there are no Creekside or Private Transformations treatment records for LF. On September 11, 2013, Ms. Dixon prescribed valacyclovir to NF. There are no patient records at Creekside or Rogue Regional for NF, and Ms. Dixon has no Private Transformations treatment records for NF. On January 1, 2013, Ms. Dixon prescribed Lunesta to a Rogue Regional coworker, TLK. Ms. Dixon did not document the prescription. There are no Rogue Regional records showing that TLK was a patient of Ms. Dixon's. There are no Creekside or Private Transformations treatment records for TLK. The ALJ concluded, more likely than not, that SD, TD, PE, KF, AF, LF, NF, and TLK did not have established client records with Ms. Dixon. The Board has therefore proven that she prescribed medications to those individuals without a provider/client relationship.

On June 15, 2013 and May 28, 2014, Ms. Dixon prescribed acyclovir to SL. Although Ms. Dixon asserted in Attorney Keaney's June 15, 2015 email correspondence that SL was a patient at Creekside, Ms. Dixon ceased all employment at Creekside in February 2013, and, in any event, there are no patient records for SL at Creekside. There are also no Rogue Regional or Private Transformations treatment records for SL. The Board has proven, more likely than not, that SL did not have an established client record with Ms. Dixon, and that Ms. Dixon therefore prescribed medication to SL without a provider/client relationship.

On January 16, 2014, Ms. Dixon prescribed acyclovir to ML. There are no Rogue Regional records for ML reflecting a patient encounter on January 16, 2014, and Ms. Dixon has no Private Transformations treatment records for ML. On January 16, 2014, Ms. Dixon prescribed acyclovir for DM. There are no Rogue Regional records showing that DM was a patient of Ms. Dixon's. There are no patient records at Creekside for DM. Ms. Dixon has no Private Transformations treatment records for DM. On May 5, 2014, she prescribed acyclovir to AR. There are no Rogue Regional records showing that AR was a patient of Ms. Dixon's, and Ms. Dixon has no Private Transformations treatment records for AR. On June 7, 2013, Ms. Dixon prescribed doxycycline to HS, a friend of Ms. Dixon's daughter. There are no Rogue Regional records for HS reflecting a patient encounter on June 7, 2013, and there are no Creekside or Private Transformations treatment records for HS. On August 25, 2013, Ms. Dixon prescribed Silvadene cream to BT, a friend of Ms. Dixon's daughter. There are no Rogue Regional records for BT reflecting a patient encounter on August 25, 2013, and there are no Creekside or Private Transformations treatment records for BT. On October 18, 2013, Ms.

Dixon prescribed Cipro to LW. There are no Rogue Regional records for LW reflecting a patient encounter on October 18, 2013, and there are no Creekside or Private Transformations treatment records for LW. The ALJ concluded, more likely than not, that ML, DM, AR, HS, BT, and LW did not have established client records with Ms. Dixon. The Board has therefore proven that she prescribed medications to those individuals without a provider/client relationship.

On August 11, 2014, Ms. Dixon prescribed albuterol, montelukast, prednisone, and levofloxacin to JW. There are no patient records at Creekside for JW, and Ms. Dixon has no Private Transformations treatment records for him. Although there are no Rogue Regional records showing that JW was Ms. Dixon's patient, Ms. Dixon contends that his records could be listed under a Rogue Regional ICU physician's name, even if Ms. Dixon was the one who called in prescriptions for JW upon his discharge from the hospital. In Attorney Keaney's email correspondence to Investigator Van Horn dated June 15, 2015, the following appears:

[B]e advised that every patient seen at Asante must have his or her medical records (including prescriptions) co-signed by an attending ICU physician. Although Ms. Dixon might have seen a patient, written a progress note, and/or prescribed medications, she still may not show as "the provider" in the medical records because "the provider" would be listed under the attending physician.

Exhibit A88 at 1-2. After weighing the evidence, the ALJ concluded, more likely than not, that JW was a patient at Rogue Regional and that Ms. Dixon prescribed the four medications to him in the course of her employment. The Board has not established, therefore, that Ms. Dixon prescribed to JW without a provider/client relationship. The Board agrees.

The Board has proven by a preponderance of the evidence that Ms. Dixon prescribed medication to the following individuals with whom she had no provider/client relationship: GB, JB, JDB, LLB, WB, SKC, SMC, SD, TD, PE, KF, AF, LF, NF, TLK, SL, ML, DM, AR, HS, BT, and LW. Ms. Dixon's conduct demonstrates an abuse of her prescriptive authority and constitutes conduct derogatory to the standards of nursing under OAR 851-056-0016(2)(c) (2011 and 2015).<sup>65</sup> Moreover, the ALJ was persuaded that Ms. Dixon prescribed drugs in an unsafe manner, as per OAR 851-056-0016(2)(f) (2011) and (g) (2015), when she prescribed medication to 22 individuals without a client record to document the medications. It is imperative that patient records exist, and that such records accurately and thoroughly document patient care (including prescriptions), so that another provider could review the records and be able to competently and safely take over care of the patient. Failure to establish any sort of patient record carries a potential risk of harm to the patient because it could negatively affect continuity of care with a new provider. Finally, Ms. Dixon engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(4)(b) because prescribing medication when no client record has been established and no provider/client relationship exists is contrary to the essential standards of acceptable and prevailing nursing practice. Ms. Dixon is subject to discipline for

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<sup>65</sup> The exceptions set forth in OAR 851-056-0016(2)(c) are inapplicable.

that conduct under ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule). The Board agrees.

**10. Failure to Properly Assess, Document, and/or Maintain Client Records when Prescribing to Individuals Who Were Not Private Transformations Clients and Improperly Prescribing Medications**

The Board contends that between January 1, 2012 and May 7, 2015, Ms. Dixon failed to maintain a client record for multiple individuals, failed to properly assess and document client assessments when prescribing medication to multiple individuals, and improperly prescribed medications to multiple individuals, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(c), (3)(b), and (4)(b), and OAR 851-056-0016(2)(c), (f), and (h) (2011) and (2)(c), (g), and (i) (2015).<sup>66</sup>

Under OAR 851-045-0070, conduct derogatory to the standards of nursing includes the following:

(1)(c) Failing to develop, implement and/or follow through with the plan of care.

\* \* \* \* \*

(3)(b) Incomplete recordkeeping regarding client care; including, but not limited, to failure to document care given or other information important to the client's care or documentation which is inconsistent with the care given.

\* \* \* \* \*

(4)(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

Under OAR 851-056-0016(2) (2015),<sup>67</sup> the abuse of the prescriptive or dispensing authority constitutes conduct derogatory to nursing standards and includes:

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<sup>66</sup> The previous subsection fully discussed Ms. Dixon's violations under OAR 851-056-0016(2)(c) (2011 and 2015), and the provision is inapplicable to the violations asserted in this subsection.

<sup>67</sup> OAR 851-056-0016(2) (2011) similarly provides:

(2) The abuse of the prescriptive or dispensing authority constitutes conduct derogatory to nursing standards and is defined as:

\* \* \* \* \*

(f) Prescribing, dispensing, administering, or distributing drugs in an unsafe or unlawful manner or without adequate instructions to the client according to acceptable and prevailing standards or practice;

\* \* \* \* \*

(g) Prescribing, dispensing, administering, or distributing drugs in an unsafe or unlawful manner or without adequate instructions to the client according to acceptable and prevailing standards or practice;

\* \* \* \* \*

(i) Failure to properly assess and document client assessment when prescribing, dispensing, administering, or distributing drugs[.]

*A. Failure to maintain client records*

As discussed in the previous subsection, Ms. Dixon failed to maintain a client record for the following individuals to whom she prescribed medications: GB, JB, JDB, LLB, WB, SKC, SMC, SD, TD, PE, KF, AF, LF, NF, TLK, SL, ML, DM, AR, HS, BT, and LW. For the reasons already discussed, such conduct constitutes conduct derogatory to the standards of nursing under OAR 851-056-0016(2)(f) (2011) and (g) (2015) and OAR 851-045-0070(4)(b). In addition, the failure to maintain a client record constitutes conduct derogatory to the standards of nursing under OAR 851-045-0070(3)(b) because it is a “failure to document care given.” For this conduct, Ms. Dixon is subject to discipline under ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

*B. Failure to properly assess and document assessments when prescribing medication*

1. Failure to document assessments

As previously discussed, the preponderance of the evidence establishes that Ms. Dixon failed to document any assessments for the 22 individuals for whom she prescribed medication without client records. Her failure to do so constitutes conduct derogatory to the standards of nursing under OAR 851-056-0016(2)(h) (2011) and (i) (2015).

The standard of care for prescribing medication requires that an N.P. conduct and document an assessment. Because Ms. Dixon did not document assessments for any of the 22 individuals to whom she prescribed medications (and, in fact, maintained no client records or documentation at all with regard to those individuals), her conduct failed to conform to the essential standards of acceptable and prevailing nursing practice, as per OAR 851-045-0070(4)(b). In addition, her conduct constitutes “[i]ncomplete recordkeeping regarding client

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\* \* \* \* \*

(h) Failure to properly assess and document client assessment when prescribing, dispensing, administering, or distributing drugs[.]

care” under OAR 851-045-0070(3)(b). She is therefore subject to discipline under ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

## 2. Failure to conduct assessments

OAR 851-050-0000(1)<sup>68</sup> defines an “assessment” as follows:

“Assessment” means a process of collecting information regarding a client’s health status including, but not limited to, illness; response to illness; health risks of individuals, families and groups; resources; strengths and weaknesses, coping behaviors; and the environment. The skills employed during the assessment process may include, but are not limited to: obtaining client histories, conducting physical examinations, ordering, interpreting and conducting a broad range of diagnostic procedures (e.g., laboratory studies, EKGs, and x rays).

The scope and precise components of an assessment can be complaint-specific and patient-specific.

The primary evidence the Board offered to show that Ms. Dixon did not perform assessments prior to prescribing medications is the absence of any documentation showing that assessments occurred. However, the absence of documentation is not, in and of itself, sufficient to prove the lack of an assessment.

During the Board interview, Ms. Van Horn asked Ms. Dixon how she determined what medications JDB and TLK needed and whether she performed assessments on them. With respect to JDB, Ms. Dixon stated that he told her he had run out of his lisinopril, that he had been on that medication for three years, and that he had a strong family history of blood pressure issues. She further stated that she asked JDB about the dosage of the medication, whether he had always been on that dosage, and whether he had any known allergies. With regard to TLK, Ms. Dixon stated that he reported that he could not sleep, that he has used Lunesta before, that it was the only medication that worked for him, and that he could not get in to see his primary care provider. Ms. Dixon further stated that she asked TLK about his prior use of the medication and whether he had any known allergies.

Later during the Board interview, Ms. Dixon stated the following with respect to whether she performed assessments before prescribing medications:

[I] would not \* \* \* indiscriminately write prescriptions. I have always felt that I was doing what was right for the person, they would ask me for, they would state a complaint, I would go through my assessment of questions. \* \* \*. Have you used it before? Yes, it worked very well. Do you have any allergies? No, you don’t. [What are] you using it for? He would tell me. So I would thoroughly assess them, I would just not say,

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<sup>68</sup> OAR 851-056-0000(4) contains the same definition of “Assessment.”

what drug do you want? I would never do that, I would never want to cause harm to anybody. So I would thoroughly assess, I would assess them and I would try to ask all the right, the questions so that I would do no harm. \* \* \*. Another nurse comes to me and she goes, I have been coughing, you know, I'm not getting any better, can I have an antibiotic? And I would [say], can I listen to your lungs? Can I look at your ears? Come into my office. I'd look at their ears. Your ears are not bulging, your lungs are you know? [sic] I would assess them. And I would feel very comfortable with the medications that I was prescribing. \* \* \*. I would say, have you taken anything? What is your discharge like? How long has it been? You know? And then, I would write the prescription.

*Id.* at 55. The only exception to Ms. Dixon's insistence that she always performed assessments prior to prescribing medications was with regard to DB. During the Board interview, Investigator Van Horn and Ms. Dixon had the following exchange regarding DB:

Van Horn: So it looks like there [are] eight scripts in the packet [for DB].

\* \* \* \* \*

Dixon: [T]hey were all collegial, and it was, people do it, and we're not supposed to, she said, would you write me a script of Singulair, would you write me a script for Phentermine? And I did.

Van Horn: [A]nd you didn't do any assessments on her? No documentation? No charting? You just gave her scripts?

Dixon: Yes.

*Id.* at 43.

When the Board's counsel questioned Ms. Dixon on the first day of the hearing regarding her treatment of certain Private Transformations clients and other individuals to whom she prescribed medications, Ms. Dixon did not provide much detail regarding assessments she conducted. On the third day of the hearing, the Board's expert, Ms. Patel, provided extensive client-specific testimony as to what Ms. Dixon's assessments needed to include to meet the standard of care for an N.P. On the fifth and final day of the hearing, Ms. Dixon testified that she performed client assessments just as Ms. Patel had described for the specific patients mentioned, and she remarked that her N.P. training appears to have been the same as that of Ms. Patel. With regard to assessing depression, in particular, Ms. Dixon testified that she asks clients questions that include the following: have you had trouble sleeping; have you had any appetite changes; are you feeling down (if so, what does that feel like to you); do you have little interest in things; do you have low energy; do you have a slow affect; and do you feel suicidal or homicidal. She also testified that she asks clients whether they have tried any non-medication treatments, such as cognitive-behavioral therapy.

LSJ, a Rogue Regional colleague for whom Ms. Dixon authorized three prescriptions, testified at hearing that Ms. Dixon did a “head to toe” assessment on her and, in LSJ’s opinion, asked “appropriate” questions prior to prescribing the medications. (Testimony of LSJ.) KE, a Rogue Regional colleague to whom Ms. Dixon prescribed progesterone cream (which KE had been using for years), testified that prior to prescribing the cream, Ms. Dixon conducted a “verbal assessment” that included asking KE about her symptoms, her blood pressure, her last mammogram, any incidences of bleeding, and whether KE was looking for a new PCP. Testimony of KE. In KE’s opinion, Ms. Dixon’s assessment was thorough.

In weighing the above evidence, the ALJ concluded that—with the exception of DB—the Board has not proven, more likely than not, that Ms. Dixon failed to perform assessments prior to prescribing medications to the individuals at issue in this matter. The Board agrees.

### *C. Improperly prescribing medication*

#### 1. JB

When Ms. Dixon prescribed 90 tablets of Effexor ER (37.5 mg) with two refills to JB, he had been taking Effexor for approximately two years. At the time, he did not have a provider because he had recently relocated, and Ms. Dixon did not want him to abruptly stop the medication. The Board has not established that Ms. Dixon, more likely than not, improperly prescribed Effexor ER to JB.

#### 2. JDB

Ms. Dixon prescribed the blood pressure medication lisinopril (20 mg), with three refills, to her colleague, JDB. He had been taking the medication for three years, run out of it, and was not seeing his primary care provider for another month. He informed Ms. Dixon that he had a strong family history of high blood pressure, that he had been taking 20 mg of the medication, and that he had no known allergies.

To meet the minimum standard of care when prescribing blood pressure medication, a N.P. should check vital signs—including blood pressure, heart rate, and respiration—because a person’s condition can change over time. The N.P. should also examine the person’s feet to ensure there is no swelling. Although Ms. Dixon had JDB check his blood pressure before she prescribed the medication, there is no evidence that she checked JDB’s heart rate, respiration, or feet for swelling. Thus, more likely than not, Ms. Dixon improperly prescribed the lisinopril to JDB.

Ms. Dixon also prescribed propranolol (20 mg), a medication to treat tremors, to JDB. JDB’s only known medical history was provided verbally to Ms. Dixon by JDB himself. To meet the minimum standard of care when prescribing medication for tremors, a N.P. must evaluate whether the tremors are benign or not. It is the N.P.’s responsibility to take a careful client history (including family history), conduct a physical examination (including heart and lungs), conduct a neurological examination, make a diagnosis, inform the client of side effects and the “black-box” warning regarding abrupt discontinuation of the medication, and document

the assessment. At a minimum, there is no evidence that Ms. Dixon checked JDB's heart and lungs or conducted a neurological examination prior to providing the propranolol to JDB. Thus, more likely than not, Ms. Dixon improperly prescribed that medication to JDB.

### 3. LLB

Ms. Dixon prescribed Cymbalta (duloxetine) (60 mg) and trazadone (100 mg) to LLB. Each prescription allowed for 11 refills. Cymbalta is used to treat depression, and trazadone is an antidepressant that is often used for insomnia treatment. Both medications have black-box warnings regarding suicidal ideation. To meet the standard of care when prescribing those medications, an N.P. must monitor the client for signs of suicide and/or a worsening of depressive symptoms. Ms. Dixon prescribed an entire year's worth of the medication, and there is no evidence that she conducted any follow-up to evaluate the efficacy of the medications or to monitor for signs of suicide and/or a worsening of LLB's depressive symptoms. Thus, more likely than not, Ms. Dixon improperly prescribed those medications to LLB.

### 4. TD

Ms. Dixon's ex-husband, TD, had recurrent issues with swollen, actively inflamed eyelids (*i.e.* blepharitis). For his condition, Ms. Dixon prescribed erythromycin, with six refills, and she twice prescribed doxycycline to him, with one of the doxycycline prescriptions allowing for one refill.

To meet the standard of care when prescribing medication for blepharitis, an N.P. must obtain a careful client history, inquire about current symptoms, conduct a physical examination, document a diagnosis, and establish a plan of care. Due to the risk of corneal inflammation in chronic cases, the best practice is to refer such a client to a specialist. There is no evidence that Ms. Dixon established any plan of care for TD's blepharitis condition, and by continuing to prescribe medications for his condition, with refills, she significantly reduced the incentive for TD to follow up with an eye specialist. The ALJ concluded that, more likely than not, Ms. Dixon improperly prescribed medications to treat TD's eyelid condition.

### 5. LF

Ms. Dixon prescribed indoor tanning for 15-year-old LF. The written prescription authorized tanning two to three times per week for one year, and the listed diagnoses were psoriasis and acne. During the Board interview, Ms. Dixon informed Board staff that LF did not have a medical condition that required tanning, and that LF wanted to tan for prom. When prompted as to whether LF had psoriasis or acne, Ms. Dixon then stated that she recalled that LF did, in fact, have acne. If Ms. Dixon prescribed tanning for LF simply because LF wished to tan for prom, then Ms. Dixon improperly prescribed that treatment.

At hearing, Ms. Dixon testified that she prescribed the tanning primarily to treat LF's back acne. If LF had acne for which she sought treatment from Ms. Dixon, then the standard treatment would have been topical creams and/or oral antibiotics. Current literature does not support tanning beds as a treatment choice for acne. Moreover, the U.S. Department of Health &

Human Services and the World Health Organization have determined that ultraviolet radiation (such as that from indoor tanning beds) is a carcinogen, and tanning beds are not recommended for individuals under the age of 18. Thus, to the extent Ms. Dixon prescribed tanning for LF in an attempt to treat acne, she improperly prescribed that treatment.

By improperly prescribing the above medications (and the tanning treatment), Ms. Dixon engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(4)(b) (Failing to conform to the essential standards of acceptable and prevailing nursing practice). In addition, with respect to JDB, LLB, and TD, she prescribed medication in an unsafe manner, as per OAR 851-056-0016(2)(f) (2011) and (g) (2015). For this conduct, Ms. Dixon is subject to discipline under ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

### **11. Failure to Properly Assess and Document Assessments when Prescribing to Private Transformations Clients**

The Board contends that between January 1, 2012 and May 7, 2015, Ms. Dixon failed to properly assess and document client assessments when prescribing medication to multiple Private Transformation clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(a), (c), (d), and (n), (3)(a) and (b), and (4)(b), and OAR 851-056-0016(2)(c), (f), and (h) (2011) and (2)(c), (g), and (i) (2015).

#### *A. Failure to conduct assessments*

As previously discussed, with the exception of DB, the Board has not proven by a preponderance of the evidence that Ms. Dixon failed to perform assessments prior to prescribing medications to Private Transformations clients. Because an assessment is vital for determining whether a medication is necessary and appropriate, Ms. Dixon's failure to perform assessments when prescribing multiple medications to DB constitutes conduct derogatory to the standards of nursing under OAR 851-045-0070(4)(b) (failure to conform to the essential standards of acceptable and prevailing nursing practice) and OAR 851-056-0016(2)(f) (2011) and (g) (2015) (prescribing drugs in an unsafe manner) and (h) (2011) and (i) (2015) (failure to properly assess when prescribing drugs). For this conduct, Ms. Dixon is subject to discipline under ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

#### *B. Failure to document assessments*

The record establishes that Ms. Dixon failed to document one or more prescriptions, and any assessments for those prescriptions, for the following Private Transformations clients: SB, LB, DB, KE, HC, KG, KH, KJ, LSL, TL, KS, MS, LLJ, TK, DLM, DT, MW, TE, SZ.<sup>69</sup>

Her failure to document assessments when prescribing one or more medications to those individuals constitutes conduct derogatory to the standards of nursing under OAR 851-056-0016(2)(h) (2011) and (i) (2015). In addition, her conduct failed to conform to the essential

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<sup>69</sup> This lack of documentation is explained in greater detail in a later subsection.

standards of acceptable and prevailing nursing practice, as per OAR 851-045-0070(4)(b) and constitutes “[i]ncomplete recordkeeping regarding client care” under OAR 851-045-0070(3)(b). Ms. Dixon is therefore subject to discipline under ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

## **12. Deviation from Standards of Care While Treating Private Transformations Clients**

The Board contends that between January 1, 2012 and May 7, 2015, Ms. Dixon deviated from the standard of care while treating multiple Private Transformation clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(a), (c), (d), and (n), (3)(a) and (b), and (4)(b), OAR 851-056-0016(2)(c), (f) and (h) (2011), OAR 851-056-0016(2)(c), (g), and (i) (2015), and OAR 851-050-0005(4)(a), (b), (c), (d), and (e).

### *A. Prescribing medication to Private Transformations clients prior to the existence of a provider/client relationship*

On January 25, 2014, Ms. Dixon prescribed Atenolol and Norvasc to LLJ. LLJ did not become a Private Transformations client until April 8, 2014, and the prescriptions are not documented in any of Ms. Dixon’s records for LLJ. On March 5, 2013, Ms. Dixon prescribed lidocaine cream to TK. TK did not become a Private Transformations client until November 7, 2014, and the prescription is not documented in any of Ms. Dixon’s records for TK. On June 1, 2014, Ms. Dixon prescribed doxycycline to DLM. DLM did not become a Private Transformations client until November 21, 2014, and the prescription is not documented in any of Ms. Dixon’s records for DLM. On April 26, 2013, Ms. Dixon prescribed trazadone to MW, and on May 3, 2013, she prescribed Flonase to MW. MW did not become a Private Transformations client until November 21, 2013, and the prescriptions are not documented in any of Ms. Dixon’s records for MW.

The Board has proven by a preponderance of the evidence that Ms. Dixon prescribed medication to the above individuals prior to the existence of any provider/client relationship and without any client records in existence at the time. This conduct demonstrates an abuse of Ms. Dixon’s prescriptive authority and constitutes conduct derogatory to the standards of nursing under OAR 851-056-0016(2)(c) (2011 and 2015).<sup>70</sup> The absence of any client records to document the prescribed medications had the potential to negatively affect continuity of care with new providers. As such, the ALJ was persuaded that Ms. Dixon prescribed drugs to those clients in an unsafe manner, as per OAR 851-056-0016(2)(f) (2011) and (g) (2015). Finally, Ms. Dixon engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(4)(b) because prescribing medication when no client record has been established and no provider/client relationship exists is contrary to the essential standards of acceptable and prevailing nursing practice. Ms. Dixon is subject to discipline for this conduct under ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule). The Board agrees.

### *B. Inaccurate recordkeeping and failure to document prescriptions and care provided*

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<sup>70</sup> The exceptions set forth in OAR 851-056-0016(2)(c) are inapplicable.

The Botox treatment records for the following Private Transformations clients either fail to list one or more medications that Ms. Dixon prescribed, list the medications on dates different than when prescribed, list the wrong quantity of medication or refills, and/or contain late entries without noting that the entries are late.

Ms. Dixon prescribed Miracle Mouthwash and Cipro to SB, but neither prescription is documented in SB's Botox treatment records. She prescribed acyclovir (with one refill) to LB, and the prescription is not documented in LB's Botox treatment records. She prescribed Singulair, promethazine with codeine, Soma (with two refills), and phentermine on three separate occasions for DB. None of those prescriptions are documented in DB's Botox treatment records. She prescribed progesterone 25% cream to KE, but the prescription is not documented in KE's Botox treatment records. On April 8 and 15, 2015, she prescribed Cipro (250 mg and 500 mg, respectively) to HC, but neither prescription is documented in HC's Botox treatment records. Ms. Dixon prescribed Cipro to LSJ, and the prescription is not noted in LSJ's Botox treatment records. Ms. Dixon twice prescribed Flexeril to KS, but did not document those prescriptions in KS's Botox treatment records.

On January 11, 2013, Ms. Dixon prescribed Ativan (with one refill) and phentermine to TE. On October 8, 2014, she prescribed Augmentin to TE, and on January 8, 2015, she prescribed pseudoephedrine (60 mg, #20) and clindamycin to TE. None of those prescriptions are documented in TE's Botox treatment records. There is a handwritten note in TE's Botox treatment records that states, "1/11/14 Sudafed 60 mg (#30) MR x 4," but there is no corresponding prescription in the record. *See* Exhibit A46 at 12. On February 26, 2014, Ms. Dixon prescribed Percocet 5/325 (oxycodone) to TE. For unknown reasons, the prescription is documented in the Botox treatment record on February 14, 2014, and the note contains no information regarding why Ms. Dixon prescribed the medication.

On November 20, 2013, Ms. Dixon prescribed a 90-day supply of Yasmin for KH, and on August 26, 2014, she prescribed azithromycin to KH. Neither prescription is documented in KH's Botox treatment records. On January 3, 2015, Ms. Dixon prescribed azithromycin and Ativan (lorazepam) to KH. A Botox treatment note dated January 3, 2015, lists the Ativan prescription and the reason for prescribing it, but does not list the azithromycin prescription.

On October 15, 2012, Ms. Dixon prescribed acyclovir (with two refills) to KJ. On April 23, 2013, she authorized a prescription refill of acyclovir for KJ, with six additional refills. On April 29, 2014, she authorized additional refills, as needed, for up to one year. KJ's Botox treatment records do not document any of those prescriptions.

On October 3, 2013, Ms. Dixon prescribed Iopidine Ophthalmic drops (0.5%) for TL, but did not note the prescription in TL's Botox treatment records. On November 5, 2014, Ms. Dixon prescribed Xanax for TL. However, TL's Botox treatment records do not note the Xanax prescription until November 14, 2014, and there is no notation that it is a late entry.

On June 26, 2014, December 3, 2014, and January 23, 2015, MS filled prescriptions for Chantix, all of which Ms. Dixon prescribed to her. MS's Botox treatment records contain no

documentation of the Chantix prescriptions. On October 25, 2014, MS filled prescriptions for albuterol, levofloxacin, and Phenergan with codeine, all of which Ms. Dixon prescribed to her. MS's Botox treatment records contain no documentation of those prescriptions.

On June 21, 2014, Ms. Dixon prescribed Ambien to DT (with four refills). In a Botox treatment note dated June 21, 2014, there is no documentation of the June 21, 2014 prescription. However, there is a note in that area of the chart that states, "11/12/14 Ambien 10 mg #90 (MR x 3) – OK to refill x 1 year." Exhibit A57 at 9.

On May 5, 2013, Ms. Dixon prescribed Xanax to SZ. Ms. Dixon documented the prescription in a treatment note dated May 10, 2013, but she did not note that it was a late entry. On May 10, 2013, Ms. Dixon prescribed a one-year supply of Temovate (clobetasol) 0.05% cream and scalp solution and triamcinolone 0.1% cream to SZ. Ms. Dixon did not document those prescriptions in SZ's Botox treatment record. In a treatment note dated September 16, 2013, there is documentation of a one-year prescription for Temovate 0.5% cream, but there is no corresponding prescription for that date, and no notation that it is a late entry for the May 10, 2013 prescription. On May 4, 2014, Ms. Dixon prescribed another one-year supply of triamcinolone 0.1% cream to SZ, and on May 30, 2014, she prescribed another one-year supply of Temovate 0.05% cream and scalp solution to SZ. She did not document those prescriptions in SZ's Botox treatment records. In a treatment note dated September 11, 2014, there is documentation of a one-year prescription for Temovate 0.5% cream, but there is no corresponding prescription for that date, and no notation that it is a late entry for the May 30, 2014 prescription.

On March 11, 2014, Ms. Dixon prescribed Soma (350 mg, #30), with one refill, and 90 tablets of Norco (hydrocodone 10-325) to KG. A Botox treatment note dated March 9, 2014 inaccurately states that Ms. Dixon was prescribing 60 tablets of Norco, and that KG still had one refill of Soma. The note does not indicate that Ms. Dixon prescribed Soma on March 11. On April 7, 2014, Ms. Dixon prescribed 90 tablets of Norco, with five refills, to KG. In a Botox treatment note dated April 7, 2014, Ms. Dixon inaccurately stated that the Norco prescription was for 90 tablets with one refill. On November 3, 2014, Ms. Dixon prescribed mupirocin 2% cream to KG, but the prescription is not documented in KG's Botox treatment records. As previously discussed, the record establishes that Ms. Dixon authorized Norco prescriptions for KG on July 22, 2014, November 20, 2014, and January 16, 2015. None of those prescriptions are documented in KG's Botox treatment records.

The above conduct constitutes conduct derogatory to the standards of nursing under OAR 851-045-0070(3)(a) (inaccurate recordkeeping in client records) and (b) (incomplete recordkeeping regarding client care) and (4)(b) (failure to conform to the essential standards of acceptable and prevailing nursing practice). In addition, it demonstrates an abuse of Ms. Dixon's prescriptive authority under OAR 851-056-0016(2)(f) (2011) and (g) (2015) (prescribing drugs in an unsafe manner).

### **13. Improperly Prescribing to Private Transformations Clients**

The Board contends that between January 1, 2012 and May 7, 2015, Ms. Dixon improperly prescribed medication to multiple Private Transformation clients, in violation of ORS 678.111(1)(f) and (g), OAR 851-045-0070(1)(a), (c), (d), and (n), (3)(a) and (b), and (4)(b), OAR 851-056-0016(2)(c), (f) and (h) (2011), and OAR 851-056-0016(2)(c), (g), and (i) (2015).

OAR 851-050-0005(4) provides:

Within his or her specialty, the nurse practitioner is responsible for managing health problems encountered by the client and is accountable for health outcomes. This process includes:

- (a) Assessment;
- (b) Diagnosis;
- (c) Development of a plan;
- (d) Intervention;
- (e) Evaluation.

OAR 851-050-0000 provides the following relevant definitions:

(10) "Diagnosis" means identification of actual or potential health problems or need for intervention, based on analysis of the data collected.

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(13) "Evaluation" means the determination of the effectiveness of the intervention(s) on the client's health status.

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(17) "Intervention" means measures to promote health, to protect against disease, to treat illness in its earliest stages, and to manage acute and chronic conditions and/or illness. Interventions may include, but are not limited to: issuance of orders, direct nursing care, prescribing or administering medications or other therapies, and consultation or referral.

**A. DB**

DB is a nurse practitioner with whom Ms. Dixon worked at Creekside. Ms. Dixon prescribed multiple medications to DB, and none of them are documented in the Botox treatment records. Ms. Dixon admitted during her Board interview that she did not conduct any assessments on DB prior to prescribing medications to her.

Ms. Dixon twice prescribed Soma, a muscle relaxant and central nervous system depressant, to DB. The second prescription allowed for two refills. Soma has the potential for drug dependency, so it is important for a prescribing N.P. to determine whether the patient has a history of substance abuse. When prescribing Soma, an N.P. would want to know the nature of the patient's muscle pain and conduct a muscle evaluation to assess strength, movement, and weakness. Because Ms. Dixon conducted no assessment on DB prior to prescribing Soma, she did not obtain a patient history (including a substance abuse history), she did not conduct a muscle evaluation, and she did not make a diagnosis or develop a plan of care. More likely than not, Ms. Dixon improperly prescribed Soma to DB.

On February 12, 2013, Ms. Dixon prescribed a three-month supply of phentermine (30 mg) to DB; on July 2, 2013, she prescribed another three-month supply of phentermine (30 mg) to DB; and on September 21, 2013, she prescribed a two-month supply of phentermine (15 mg) to DB. Phentermine is a Schedule IV controlled substance and, as a stimulant medication, it has a potential for abuse. It is typically prescribed for persons with BMIs greater than 30. To meet the standard of care when prescribing phentermine for weight reduction, an N.P. should initially monitor the patient's weight, blood pressure, and heart rate on a weekly basis. Because Ms. Dixon conducted no assessment on DB prior to prescribing phentermine, she did not determine whether phentermine was appropriate for DB and she did not develop a plan of care for the medication. In addition, there is no evidence that Ms. Dixon conducted any follow-up with DB to evaluate and monitor her weight, blood pressure, and heart rate. More likely than not, Ms. Dixon improperly prescribed phentermine to DB.

#### *B. HC*

On April 8, 2015, Ms. Dixon prescribed a five-day course of the antibiotic Cipro (250 mg, #10) to HC to treat an uncomplicated UTI. Ms. Dixon did not physically examine HC, but she asked her questions about her symptoms, including the onset, duration, and characteristics of the symptoms, and whether she had any back pain. Approximately one week later, HC informed her that she felt better but was unsure that her symptoms were completely gone. In response, on April 15, 2015, Ms. Dixon prescribed another five-day course of Cipro (500 mg, #10).

It is not necessary to perform a UA for an uncomplicated UTI, as long as the N.P. performs a careful assessment. If a patient is taking Cipro to treat an uncomplicated UTI and symptoms persist after 7 or 8 days, the assumption is that the Cipro is not working to treat the infection. The standard of care in this circumstance is for the N.P. to prescribe a different medication and/or have the patient evaluated for a complicated UTI. Ms. Dixon's conduct in continuing to prescribe Cipro to HC after learning that Cipro may have been ineffective in treating HC's UTI is inconsistent with the standard of care for an N.P. Thus, more likely than not, Ms. Dixon improperly prescribed Cipro to HC on April 15, 2015.

#### *C. TE*

TE was formerly a patient of Ms. Dixon's at Creekside, and she has been a Private Transformations client since at least May 13, 2011. Ms. Dixon prescribed multiple medications to TE, and none are documented in her Botox treatment records.

On January 11, 2013, Ms. Dixon prescribed 40 tablets of Ativan and 30 tablets of phentermine (15 mg) to TE. The Ativan prescription stated that it was prescribed for anxiety. Anxiety is typically a persistent problem, and an N.P. should evaluate whether there are any physical causes of the anxiety, whether the person has any psychiatric disorders, whether the person has a family history of psychological issues, and whether the person has a history of substance abuse issues.<sup>71</sup> As to the phentermine, there is no evidence that Ms. Dixon conducted any follow-up with TE to evaluate and monitor her weight, blood pressure, and heart rate after prescribing the phentermine. The ALJ concluded, more likely than not, that Ms. Dixon improperly prescribed that medication to TE. The Board agrees.

*D. TL, DT, and SZ*

On February 28, 2013, Ms. Dixon prescribed 20 tablets of Lunesta (2 mg) to TL for insomnia. The prescription allowed for one refill. A corresponding treatment note states that TL complained of chronic insomnia, that TL had taken Xanax previously but wanted something different, and that Ms. Dixon was prescribing 20 tablets of Lunesta (2 mg). An April 22, 2013 treatment note states that TL liked Lunesta, her insurance was covering it, and Ms. Dixon was prescribing 30 tablets of Lunesta (3 mg). On April 23, 2013, she prescribed Lunesta to TL, with three refills. A note dated October 15, 2013 states that Ms. Dixon authorized more refills of Lunesta and that it was working well for TL. On November 5, 2014, Ms. Dixon prescribed Xanax for TL after TL reported that her insurance was no longer covering Lunesta. In a November 14, 2014 treatment note, Ms. Dixon wrote that she was prescribing Xanax because the pharmacy was no longer covering Lunesta and TL had used Xanax successfully in the past.

On May 12, 2013, Ms. Dixon prescribed Ambien to her sister, DT, with refills as needed for one year. A treatment note dated May 10, 2013 notes the one-year Ambien prescription and indicates that it works well for DT and that she has no problems taking it. On June 21, 2014, Ms. Dixon again prescribed Ambien to DT, and authorized four refills. A note dated November 12, 2014 mentions an Ambien prescription (10 mg, #90) and notes that refills are authorized for one year.

On May 5, 2013, Ms. Dixon prescribed 30 tablets of Xanax (0.5 mg) to SZ. A treatment note dated May 10, 2013 states that SZ had complained of difficulty sleeping.

Insomnia can be secondary to other medical issues. There is no evidence that Ms. Dixon assessed TL, DT, or SZ for medical conditions that might have been contributing to, or causing, their insomnia. Her failure to do so falls below the minimum standard of care for an N.P. Thus, it is more likely than not, that Ms. Dixon improperly prescribed Lunesta and Xanax to TL, Lunesta to DT, and Xanax to SZ.

*E. MS*

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<sup>71</sup> It is curious that Ms. Dixon would prescribe a stimulant medication (phentermine) and an anxiolytic medication (Ativan) simultaneously.

On June 26, 2014, December 3, 2014, and January 23, 2015, MS filled prescriptions for Chantix, all of which Ms. Dixon prescribed to her. Chantix is a smoking cessation medication that is typically prescribed for no longer than 12 weeks. It has a black-box warning for depression, suicidal ideation, suicide attempts, behavioral changes, and hostility. Those events have occurred even in patients who have no prior history of psychological or psychiatric issues. To meet the standard of care for prescribing Chantix, an N.P. should perform a depression screen so that any behavioral changes caused by the medication can be tracked over time.

At hearing, Ms. Dixon testified that she provided MS with all relevant warnings for Chantix. However, there is no evidence that she performed a depression screen on MS, or that she followed-up with MS to evaluate the effectiveness of the medication and ascertain whether MS was experiencing any behavioral changes or other side effects associated with the medication. Therefore, it is more likely than not, Ms. Dixon improperly prescribed that medication to MS.

*F. PW*

On September 29, 2013, Ms. Dixon prescribed Ambien (with five refills) to PW for insomnia. A treatment note dated September 28, 2013 mentions the prescription and states that PW was stressed and not sleeping well after the recent death of her husband. There is no evidence that Ms. Dixon conducted any follow-up with PW to evaluate the efficacy of the medication and to determine whether PW was experiencing any side effects. Consequently, it is more likely than not, Ms. Dixon improperly prescribed that medication to PW.

*G. KG*

KG frequently complained of chronic pain from dysmenorrhea. It was Ms. Dixon's understanding that KG also had fibroids, that she required a hysterectomy, and that she was seeing Dr. Binette for her gynecological issues.

On January 28, 2014, Ms. Dixon prescribed 30 tablets of Soma (350 mg) to KG for that condition. On March 11, 2014, Ms. Dixon prescribed 30 tablets of Soma (350 mg), with one refill, and 90 tablets of Norco to KG. On April 7, 2014, Ms. Dixon prescribed 90 tablets of Norco, with five refills, to KG. On May 2, 2014, KG refilled the Norco prescription. On May 6, 2014, KG refilled the Soma prescription. On May 27, 2014, Ms. Dixon prescribed 120 tablets of Norco, with four refills, to KG. On June 23, 2014, KG refilled the Norco prescription.

Narcotics are not generally the first-line treatment for dysmenorrhea, but they may be appropriate if other treatments have been tried and failed. There is no evidence that KG had unsuccessfully tried other treatments for her dysmenorrhea before Ms. Dixon prescribed Soma and Norco to her for that condition.

There is a large illicit market for controlled substances, and they carry a high potential for abuse. N.P.s must therefore be diligent when prescribing controlled substances. An N.P. should optimize alternatives to controlled substances; conduct patient risk assessments; take careful client histories; conduct follow-ups with patients to look for evidence of withdrawal,

intoxication, and/or sedation; require regular UAs for ongoing narcotics patients; and limit the dosages, quantities, and refills of controlled substances.

There is no evidence that Ms. Dixon ever required KG to submit to UAs or that she conducted follow-ups with KG to evaluate whether KG was exhibiting signs of withdrawal, intoxication, or sedation. Moreover, the quantities and refills of Norco that Ms. Dixon prescribed to KG within relatively short time periods were significant. As previously noted, on March 11, 2014, she prescribed 90 tablets of Norco; on April 7, 2014, she prescribed 90 tablets, with five refills (which if filled, would make 540 tablets available to KG); and on May 27, 2014, she prescribed 120 tablets, with four refills (which if filled, would make 600 additional Norco tablets available to KG).

On June 30, 2014, KG overdosed on alcohol and one or more unspecified substances.<sup>72</sup> From July 20, 2014 to August 6, 2014, KG participated in a drug and alcohol treatment program. After KG's overdose on June 30, 2014, Ms. Dixon continued to see KG as a Botox client, and she prescribed medications to her such mupirocin 2% cream and azithromycin. In addition, the record establishes that on July 22, 2014, Ms. Dixon authorized a prescription for 110 tablets of Norco for KG, and she had KG's adult son pick up the medication and bring it to her (*i.e.* to Ms. Dixon). Moreover, the record establishes that she prescribed Norco for KG on at least two more occasions after KG's overdose—on November 20, 2014 and January 16, 2015.

If an N.P. prescribes narcotics to a patient with known substance abuse issues, the N.P. should prescribe only the minimum amount of narcotics necessary, have the patient enter into a contact agreeing to submit to UAs and not to seek narcotics from other providers, and closely follow up with the patient. The best practice in such a situation, however, would be for the N.P. to refer the patient to a pain specialist or pain clinic.

At hearing, Ms. Dixon admitted that she became aware that KG was abusing controlled substances when KG overdosed on June 30, 2014. Despite that awareness, the record establishes that Ms. Dixon continued to prescribe Norco to KG after June 30, 2014 (*e.g.*, on November 20, 2014 and January 15, 2015). There is no evidence that KG had a pain contract with Ms. Dixon, that Ms. Dixon closely followed up with KG to evaluate whether KG was abusing the medication, or that Ms. Dixon ever referred KG to a pain specialist.

In addition, Ms. Dixon never conferred with Dr. Binette, or any other providers regarding KG's dysmenorrhea and pain issues. In Ms. Patel's expert opinion, Ms. Dixon caused harm to KG by repeatedly prescribing narcotics to her instead of insisting that she follow up with Dr. Binette for a hysterectomy. By Ms. Dixon continuing to prescribe the narcotics that KG was requesting from her, KG had little to no incentive to follow up with Dr. Binette.

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<sup>72</sup> Although KG reported to the Medford Police Department that her overdose involved medication that Ms. Dixon had prescribed to her (*see* Ex. A74 at 6), there is no evidence in the record to substantiate that claim. Without corroborating evidence, the ALJ and Board cannot conclude more likely than not that the overdose involved medications Ms. Dixon prescribed.

For the above reasons, the record establishes, more likely than not, that Ms. Dixon improperly prescribed Norco to KG.

By improperly prescribing medications to DB, HC, TE, TL, DT, SZ, MS, PW, KG as detailed above, Ms. Dixon engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(4)(b) (failure to conform to the essential standards of acceptable and prevailing nursing practice). In addition, with respect to DB, TE, MS, and KG, she prescribed medication in an unsafe manner, as per OAR 851-056-0016(2)(f) (2011) and (g) (2015). With respect to DB, HC, TE, MS, PW, and KG, she also failed to develop, implement, and/or follow through with a plan of care, as per OAR 851-045-0070(1)(c), and/or failed to modify the plan of care as needed based on nursing assessment and judgment, as per OAR 851-045-0070(1)(d). For this conduct, Ms. Dixon is subject to discipline under ORS 678.111(1)(f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

#### **14. Failure to Answer Truthfully and Completely during the Board's Investigation**

The Board contends that Ms. Dixon failed to answer truthfully and completely during its investigation, including in a written statement submitted to the Board on April 22, 2015, and during an interview with Board staff on May 20, 2015, in violation of ORS 678.111(1)(d), (f), and (g) and OAR 851-045-0070(7)(b).

Under OAR 851-045-0070(7), conduct derogatory to the standards of nursing includes the following:

(7) Conduct related to the licensee's relationship with the Board:

(b) Failing to answer truthfully and completely any question asked by the Board on an application for licensure or during the course of an investigation or any other question asked by the Board.

The Board asserts that Ms. Dixon failed to answer truthfully and completely with regard to the following: (A) whether the Botox treatment records she provided to the Board were the complete medical records for the requested clients and reflected all the medications prescribed for those clients; (B) the number of people for whom she prescribed medications when no provider/client relationship existed; (C) whether she prescribed KG's Norco prescriptions dated July 22, 2014, November 20, 2014, and January 16, 2015; and (D) whether she made any changes to KG's Botox treatment records aside from the late entry dated May 27.

##### *A. Whether Botox treatment records were complete and reflected all client prescriptions*

During the Board interview, Ms. Dixon stated that the Botox treatment records she provided to the Board were the complete medical records for each of the requested clients. When Investigator Van Horn later asked Ms. Dixon whether all medications she prescribed to her Botox clients would be reflected in their treatment records, Ms. Dixon responded in the affirmative, but with one exception (TE).

As discussed in significant detail in a previous subsection, Ms. Dixon's Botox treatment records for the majority of the 21 clients reviewed were severely incomplete and deficient with regard to documenting treatment provided and medications prescribed to the clients. If, hypothetically, the records had merely lacked *some* documentation of treatment provided and neglected to include *just a few* prescriptions authorized for the 21 clients, then Ms. Dixon's verbal assertion that the records she provided to the Board were complete and reflected all prescribed medications might be credible. However, those are not the circumstances of this case, and it is implausible that Ms. Dixon could have prescribed so many medications to various clients and not documented them in the treatment records, yet nonetheless held a good faith belief that her assertion to Board staff about the completeness of those records was honest and accurate. Rather, more likely than not, her statements to the Board investigators regarding the completeness of her Botox treatment records were untruthful.

*B. Number of persons prescribed medication with no provider/client relationship*

During the Board interview, Investigator Van Horn asked if Ms. Dixon had ever prescribed medication to anyone without having a provider/client (or provider/patient) relationship. Ms. Dixon replied that she had prescribed lisinopril to her coworker and friend, JDB, and that she prescribed Lunesta to a coworker, TLK. She then stated, "To my knowledge, anybody else that I have ever prescribed to \* \* \* had already entered into a patient/client relationship either at Creekside or at Private Transformations." Exhibit A86 at 32.

As discussed in a previous subsection, the record establishes that between January 1, 2012 and May 7, 2015, Ms. Dixon prescribed medication to 22 individuals with whom she had no provider/client relationship. Given the stark contrast between admitting to certain conduct on two occasions versus having engaged in that conduct 22 times, the ALJ concluded that Ms. Dixon's verbal assertion to the Board that she had only prescribed to two individuals without a provider/client relationship was untruthful. The Board agrees.

*C. Norco prescriptions dated July 22, 2014, November 20, 2014, and January 16, 2015*

In her written statement submitted to the Board on April 22, 2015, Ms. Dixon denied authorizing any Norco prescriptions for KG after June 30, 2014. During the Board interview, she repeated her denial. See Exhibit A86 at 7, 11-12. When the Board investigators asked Ms. Dixon to look at some disputed post-July 30 prescriptions for KG, the following exchange occurred:

Dixon: You know what? It looked [*sic*] like they are my signature.

\* \* \* \* \*

Dixon: They really look like my signature, and I do know that I can tell you my suspicion, but it's just my word against hers.

\* \* \* \* \*

Dixon: That I had given her \* \* \* prescriptions before, she lived in my home, and my suspicion is that she put the prescription over it, and copied my signature completely. It looks just like it you guys.

Van Horn: [S]ame with your handwriting as well? It all looks the same.

Dixon: And, yeah, I think that she put the, she kept the original copy, she put it over, traced it[.]

\* \* \* \* \*

Meadows: So you're saying before she took it to the pharmacist...

Van Horn: She made a copy?

\* \* \* \* \*

Dixon: That would be my solemn swear.

*Id.* at 65-66.

As discussed in a previous subsection, the record establishes by a preponderance of the evidence that Ms. Dixon called the Safeway pharmacy and authorized the July 22, 2014 Norco prescription for KG. Thus, her written statement to the Board, in which she denied authorizing any Norco prescriptions for KG after June 30, 2014, was untruthful.

Moreover, the record persuasively establishes that Ms. Dixon wrote the November 20, 2014 and January 16, 2015 Norco prescriptions for KG. Ms. Dixon's assertions to the contrary in her written statement to the Board and during the Board interview were therefore untruthful.

*D. Extent of changes made to KG's Botox treatment records*

As discussed in a previous subsection, Ms. Dixon made four changes to KG's Botox treatment records before providing a copy of the records to the Board on or about May 7, 2015. During her Board interview, she admitted to making one change—a late entry dated May 27. She otherwise denied, three separate times during the interview, that she made any other changes to the treatment records. Ms. Dixon's verbal denials were untruthful.

*E. Conclusion*

The Board has established that Ms. Dixon engaged in conduct derogatory to the standards of nursing under OAR 851-045-0070(7)(b). Ms. Dixon is therefore subject to discipline for that

conduct pursuant to ORS 678.111(1)(d) (fraud or deceit),<sup>73</sup> (f) (conduct derogatory to nursing standards) and (g) (violation of a Board rule).

## 15. Sanction

The Board has proven that, on multiple occasions and with regard to multiple individuals, Ms. Dixon abused her prescription authority, engaged in conduct derogatory to the standards of nursing, and engaged in fraud and deceit in the practice of nursing. Under ORS 678.111(1)(d), (f), and (g), the Board may sanction Ms. Dixon for those violations, and the possibilities include reprimand, suspension, probation, or revocation of her N.P. certificate and/or R.N. license.

The Board has proposed to revoke Ms. Dixon's N.P. certificate and R.N. license. She contends that the proposed sanction is unduly harsh, given the length of her nursing career, her professional reputation, and the fact that she has never been previously disciplined by the Board. She asserts that because the most serious violations (or at least *alleged* violations) relate to her prescriptive authority as an N.P., a more appropriate sanction would be to revoke the N.P. certificate, but allow her to retain her R.N. license.

It is true that Ms. Dixon has had a lengthy nursing career, she is highly regarded by her professional colleagues, and this matter marks the first time she has come before the Board for discipline. However, the violations proven herein are numerous and serious, and some of them go well beyond her prescriptive authority.

The proven violations that involve Ms. Dixon's prescriptive authority include prescribing drugs in an unsafe manner; failing to properly assess and document client assessments when prescribing drugs; failing to modify the plan of care as needed based on nursing assessment and judgment; failing to develop, implement and/or follow through with the plan of care; failing to keep accurate, complete, and timely records of client care and medications prescribed; and failing to conform to the essential standards of acceptable and prevailing nursing practice.

The record reflects that Ms. Dixon seemed to have an almost complete disregard for the importance of documentation and record-keeping when treating and prescribing to Private Transformations clients and individuals with whom she had no provider/client relationship. Her failure to document the majority of the medications she prescribed and care she provided to those individuals placed them at risk of harm. Aside from the documentation issues, Ms. Dixon otherwise failed to meet multiple standards of care for N.P.s when prescribing medication, and her improper prescribing placed many individuals at risk of harm. The Board is justifiably troubled by this conduct.

Without diminishing the seriousness of the violations relating to Ms. Dixon's prescriptive authority, the ALJ nonetheless found that the greatest barrier to her continued Board certification and licensure is the fact that she cannot be trusted. She asked a coworker to take medication

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<sup>73</sup> The record establishes, more likely than not, that Ms. Dixon made the untruthful written and verbal statements with the intent to minimize any misconduct on her behalf and/or otherwise mislead the Board during its investigation.

from the employer without authorization so she could give it to KG; she falsified KG's Botox treatment records in an attempt to mislead the Board; she made false statements to Board staff, and otherwise attempted to minimize certain conduct, during the May 20, 2015 Board interview; and she was untruthful to the police, the Board, and this ALJ regarding the July 22, 2014, November 20, 2014, and January 16, 2015 Norco prescriptions for KG. She has repeatedly demonstrated a willingness to place her self-interests above the truth.

Honesty and trustworthiness are integral to nursing practice, both from a patient care perspective and from a regulatory perspective. An R.N. or N.P. must be willing to admit when he or she makes a mistake that relates to patient care. The R.N. or N.P. must also be willing to fully cooperate with the Board as to licensing matters, and that cooperation includes being forthright and honest in both written and verbal communications. On this record, Ms. Dixon has not demonstrated such willingness.

It is within the Board's discretion to revoke Ms. Dixon's N.P. certificate and R.N. license, and the Board has provided sufficient justification to do so. The ALJ concluded that revocation of Ms. Dixon's certificate and license is consistent with the Board's interest in protecting the health, safety, and welfare of patients and that it is the appropriate sanction in this case. The Board agrees.

### **ORDER**

*The Board of Nursing issues the following order:*

Tamara Dixon's Nurse Practitioner Certificate (200850050NP) and Registered Nurse License (082011895RN) are REVOKED.

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Bonnie Kostecky, MS, MPA, RN  
Oregon Board of Nursing, Board President

### **APPEAL**

If you wish to appeal the Final Order, you must file a petition for review with the Oregon Court of Appeals within 60 days after the Final Order is served upon you. *See* ORS 183.480 *et seq.*

**CERTIFICATE OF MAILING**

On March 14, 2016, I mailed the foregoing PROPOSED ORDER issued on this date in OAH Case No. 1504258.

By: First Class Mail

Kevin Keaney  
Attorney at Law  
Kevin Keaney PC  
1631 NE Broadway Street #540  
Portland OR 97232

Patricia Harmon  
Board of Nursing  
17938 SW Upper Boones Ferry Rd  
Portland OR 97224-7012

Lori Lindley  
Senior Assistant Attorney General  
Department of Justice  
1162 Court St NE  
Salem OR 97301-4096

Alesia Vella for Lucy Garcia  
Administrative Specialist  
Hearing Coordinator

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**John Elder, CNA** ) **VOLUNTARY SURRENDER**  
)  
**Certificate No. 201212653CNA** ) **Reference No. 16-01336**

---

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Certified Nursing Assistants. John Elder (CNA) was issued a Nursing Assistant Certificate by the Board on November 27, 2012.

On or about February 12, 2016, the Board received information alleging that CNA physically abused a patient. The Board opened an investigation.

On or about March 18, 2016, the Board received information that a Finding of Abuse was substantiated against CNA by the Oregon Department of Human Services, Office of Licensing and Regulatory Oversight.

On or about March 18, 2016, CNA was placed on the Abuse Registry.

On March 23, 2016, CNA informed Board staff that he no longer wished to work as a Nursing Assistant and desired to voluntarily surrender his certification.

By the above actions, CNA is subject to discipline pursuant to ORS 678.442(2)(d)(f) and OAR 851-063-0090(8)(d), which read as follows:

**ORS 678.442 Certification of nursing assistants; rules.**

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

- (d) Violation of any provisions of ORS 678.010 to 678.448 or rules adopted thereunder.
- (f) Conduct unbecoming a nursing assistant in the performance of duties.

**OAR 851-063-0090 Conduct Unbecoming a Nursing Assistant.** A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to:

- (8) Conduct related to other federal or state statutes/rule violations:
  - (d) Abusing a person.

CNA wishes to cooperate with the Board in this matter and voluntarily surrender his Certified Nursing Assistant certificate.

Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by CNA:

**That the voluntary surrender of the Certified Nursing Assistant certificate of John Elder be accepted. If, after a minimum of three years, Mr. Elder wishes to reinstate his Certified Nursing Assistant certificate, he may submit an application to the Board to request reinstatement.**

CNA agrees that he will not practice as a Certified Nursing Assistant from the date he signs this Order.

CNA understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

CNA understands that by signing this Stipulated Order, he waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. CNA acknowledges that no promises, representations, duress or coercion have been used to induce him to sign this Order.

CNA understands that this Order is a document of public record.

CNA has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

\_\_\_\_\_  
John Elder, CNA

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Benjamin Farlow, RN** ) **VOLUNTARY SURRENDER**  
)  
**License No. 201043373RN** ) **Reference No. 16-01387**

---

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Benjamin Farlow (Licensee) was issued a Registered Nurse License by the Board on November 24, 2010.

Licensee was approved entry in the Health Professional Services Program on June 17, 2015. On or about February 23, 2016, the Board received a non-compliance report that Licensee tested positive for alcohol on a toxicology test on February 18, 2016. Licensee attended a third party evaluation on February 26, 2016. Licensee is not able to meet the treatment requirements from that evaluation or the HPSP program requirements and has requested his RN license be surrendered.

By the above actions, Licensee is subject to discipline pursuant to

**STATUTES AND RULES RELATED TO THIS CASE**

**IMPAIRED HEALTH PROFESSIONAL PROGRAM**

ORS 676.200 Board participation in program; rules

(3) A board that participates in the impaired health professional program shall review reports received from the program. If the board finds that a licensee is substantially noncompliant with a diversion agreement entered into under ORS 676.190, the board may suspend, restrict, modify or revoke the licensee's license or end the licensee's participation in the impaired health professional program.

**PROFESSIONAL NURSES**

(Generally)

(Discipline of Nurses)

ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:

(e) Impairment as defined in ORS 676.303.

(f) Conduct derogatory to the standards of nursing.

(g) Violation of any provision of ORS 678.010 to 678.448 or rules adopted thereunder.

ORS 678.112 Impaired health professional program. Persons licensed to practice nursing who elect not to participate in the impaired health professional program established under ORS 676.190 or who fail to comply with the terms of participation shall be reported to the Oregon State Board of Nursing for formal disciplinary action under ORS 678.111. [1991 c.193 §2; 2007 c.335 §1; 2009 c.697 §7; 2009 c.756 §§32,94]

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined  
Nurses, regardless of role, whose behavior fails to conform to the legal standard and

accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(5) Conduct related to impaired function:

(d) Use of drugs, alcohol or mind-altering substances to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice for which the licensee is licensed.

OAR 851-070-0080 Licensee Responsibilities:

(1) All licensees must:

(c) Abstain from mind-altering or intoxicating substances or potentially addictive drugs, unless prescribed for a documented medical condition by a person authorized by law to prescribe the drug to the licensee. The Board does not authorize the vendor to approve or disapprove medications prescribed to the Licensee for a documented medical condition;

OAR 851-070-0100 Substantial Non-Compliance Criteria

(1) The HPSP will report substantial non-compliance within one business day after the HPSP learns of non-compliance, including but not limited to information that a licensee:

(d) Received a positive toxicology test result as determined by federal regulations pertaining to drug testing;

(k) Violated any provisions of OAR 851-070-0080;

(l) Violated any terms of the diversion agreement;

(2) The Board, upon being notified of a licensee's substantial non-compliance will investigate and determine the appropriate sanction, which may include a limitation of licensee's practice and any other sanction, up to and including termination from the HPSP and formal discipline.

Licensee wishes to cooperate with the Board in this matter and voluntarily surrender his Registered Nurse license.

Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the voluntary surrender of the Registered Nurse license of Benjamin Farlow be accepted. If, after a minimum of three years, Mr. Farlow wishes to reinstate his Registered Nurse license, he may submit an application to the Board to request reinstatement.**

Licensee agrees that he will not practice as a Registered Nurse from the date he signs this Order.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, he waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce him to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

\_\_\_\_\_  
Benjamin Farlow, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Patty Holmes, RN** ) **VOLUNTARY SURRENDER**  
 )  
**License No. 201401453RN** ) **Reference No. 16-01312**

---

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Patty Holmes (Licensee) was issued a Registered Nurse License/Certificate by the Board on March 18, 2014.

On or about, September 2012, the Board received an RN License endorsement application in which Licensee disclosed a history of substance abuse that ended in 2010. Licensee also disclosed a history of treatment for chemical dependency and mental health issues. Evaluations confirmed a diagnosis of chemical dependence in remission and major depressive disorder in remission for which monitored practice was indicated.

On July 17, 2013, the Board agreed to issue Licensee a RN Limited License for the purposes of completing a reentry program and agreed to 24 months of Probation. Licensee complied with her stipulated agreement and urinalysis testing, (UA), but found it a challenge to obtain employment. Licensee has recently gotten married, moved to a home in the country and accompanies her husband on frequent work-related trips. For these reasons Licensee wishes to voluntarily surrender her license at this time.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111 - Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:

- 1) Issuance of the license to practice nursing, whether by examination or by endorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the Board may impose or may be issued a limited license or may be reprimanded or censured by the Board, for any of the following causes:
- (f) Conduct derogatory to the standards of nursing.

OAR 851-045-0070 Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to the following:

- (7) Conduct related to the licensee's relationship with the Board  
(d) Violating the terms and conditions of a Board order.

Licensee wishes to cooperate with the Board in this matter and voluntarily surrender her Registered Nurse license.

Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the voluntary surrender of the Registered Nurse license of Patty Holmes be accepted. If, after a minimum of three years, Ms. Holmes wishes to reinstate her Registered Nurse license, she may submit an application to the Board to request reinstatement.**

Licensee agrees that she will not practice as a Registered Nurse from the date she signs this Order.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

\_\_\_\_\_  
Patty Holmes, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Julianne Hunter, RN** ) **REPRIMAND OF LICENSE**  
)  
**License No. 200940434RN** ) **Reference No. 16-01205**

---

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Julianne Hunter (Licensee) was issued a Registered Nurse License by the Board on March 5, 2009.

On or about January 29, 2016, Licensee self-reported to the Board that she had practiced outside her scope by administering a narcotic without an order. The Board opened an investigation into the matter.

On March 9, 2016, Licensee admitted to Board staff that she had in fact administered a narcotic without an order.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f)(g) and OAR 851-045-0070(1)(a)(4)(a) which read as follows:

**ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee.**

In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(f) Conduct derogatory to the standards of nursing.

(g) Violation of any provision of ORS 678.010 to 678.448 or rules adopted thereunder.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(1) Conduct related to the client's safety and integrity:

(a) Developing, modifying, or implementing standards of nursing practice/care which jeopardize patient safety.

(4) Conduct related to achieving and maintaining clinical competency:

(a) Performing acts beyond the authorized scope or the level of nursing for which the individual is licensed.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the Registered Nurse license of Julianne Hunter be reprimanded.**

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Registered Nurse.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

\_\_\_\_\_  
Julianne Hunter, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Barbara Irving, LPN** ) **REPRIMAND OF LICENSE**  
)  
**License No. 090005015LPN** ) **Reference No. 15-02058**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Licensed Practical Nurses. Barbara Irving (Licensee) was issued a Licensed Practical Nurse License/Certificate by the Board on February 07, 1990.

On or about June 30, 2015, the Board received information that Licensee had failed to follow the plan of care for patient AM, a medically fragile infant under her care while working as a nurse under contract to provide in home services and care. The Board opened an investigation into the matter.

On or about June 24, 2015, Licensee assumed care of AM, and began providing routine care as specified by the care plan. During the course of the day, Licensee took AM for an extended walk in his stroller without bringing the designated emergency medical equipment to provide interventions related to AM's tracheostomy and breathing if necessary to address any changes in AM's respiratory status. While away from the home, AM did not experience any respiratory distress which required the use of the equipment.

Additionally, Licensee failed to document care provided to AM after the time she left the home with AM, through the end of her shift. Although Licensee was asked to leave the home upon her return from her walk with AM and did not have access to the records, Licensee was provided with an opportunity to complete the charting by her employer at a later date and failed to do so.

Licensee acknowledged she had forgotten the emergency equipment when she left the home. Licensee explained she had lost track of time and when she realized she did not have the emergency equipment she believed she was close enough to the home to access the supplies if needed.

Licensee acknowledged by her actions she did not follow the plan of care or complete her documentation of the care she provided to AM during her entire shift. Licensee expressed remorse for her actions and completed continuing education coursework on Sharpening Critical Thinking Skills and Ethics and Professionalism in Nursing. Licensee provided certificates of completion of the coursework.

By the above actions, Licensee is subject to discipline pursuant to

**ORS 678.111 Causes for denial, revocation or suspension of license or probation,**

**reprimand or censure of licensee.**

In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(f) Conduct derogatory to the standards of nursing.

(g) Violation of any provision of ORS 678.010 to 678.448 or rules adopted thereunder.

**851-045-0070**

**Conduct Derogatory to the Standards of Nursing Defined**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(1) Conduct related to the client's safety and integrity:

(a) Developing, modifying, or implementing standards of nursing practice/care which jeopardize patient safety.

(b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment.

(c) Failing to develop, implement and/or follow through with the plan of care.

(3) Conduct related to communication:

(a) Inaccurate recordkeeping in client or agency records.

(b) Incomplete recordkeeping regarding client care; including, but not limited, to failure to document care given or other information important to the client's care or documentation which is inconsistent with the care given.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the Licensed Practical Nurse license of Barbara Irving be reprimanded.**

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious

danger to public health and safety.

Licensee understands that in the event she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Licensed Practical Nurse.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

---

Barbara Irving, LPN

---

Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

---

Bonnie Kostelecky, MS, MPA, RN  
Board President

---

Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of  
Barbara Jaques, RN**

)  
) **FINAL ORDER OF REVOCATION**  
) **OF REGISTERED NURSE LICENSE**  
) **BY DEFAULT**  
)

**License No. 000007868RN**

) **Reference No. 16-00740**

---

The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Barbara Jaques (Licensee) was issued a Registered Nurse License by the Board on August 25, 1986.

This matter was considered by the Board at its meeting on April 13, 2016.

On March 29, 2016, a Notice stating that the Board intended to revoke the Registered Nurse License of Barbara Jaques was sent to her via certified and first-class mail to her address of record. The Notice alleged that Licensee engaged in conduct derogatory to the standards of nursing.

The Notice granted Licensee an opportunity for hearing if requested within twenty (20) days of the mailing of the Notice. No such request for hearing has been received by the Board. The Notice designated the Board's file on this matter as the record for purposes of default.

NOW THEREFORE, after consideration of its records and files related to this matter, the Board enters the following Order:

**-I-**

**FINDINGS OF FACT**

Based on the evidence submitted through the Notice and the agency file in this case, the Board finds the following:

1. Licensee was issued a Registered Nurse License in the state of Oregon on August 25, 1986.
2. On or about October 28, 2015, Licensee was reported to the Board for allegations she was using alcohol in a manner injurious to herself or others. The Board opened an investigation into the matter.
3. On or about on or about January 9, 2016 the Board received a second complaint alleging that Licensee was intoxicated at work and tested positive for alcohol.

4. On or about February 17, 2016, the Board issued a Final Order suspending Licensee's Registered Nurse license for failing to cooperate with the Board's investigation.
5. On March 29, 2016, Board staff mailed a Notice of Proposed Revocation to Licensee via first-class and certified mail. The Notice granted Licensee twenty (20) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.

**-II-**

### **CONCLUSIONS OF LAW**

1. That the Board has jurisdiction over the Licensee, Barbara Jaques, and over the subject matter of this proceeding.
2. That Licensee's conduct is in violation of ORS 678.111 (1)(e) and (f) and OAR 851-045-0070 (5)(c) and (d) and (7)(a) and (c).
3. That Licensee defaulted on the Notice by not requesting a hearing within the allotted twenty (20) days and, as a result, pursuant to ORS 183.417(3), the Board may enter a Final Order by Default.

**-III-**

### **ORDER**

Based on the foregoing Findings of Fact and Conclusions of Law, and the Board being fully advised in the premises, it is hereby:

ORDERED that the Registered Nurse License of Barbara Jaques is REVOKED.

DATED this \_\_\_\_\_ day of April, 2016

**FOR THE BOARD OF NURSING OF THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

TO: BARBARA JAQUES:

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within (sixty) 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within sixty (60) days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482.

If, after a minimum of three (3) years, you wish to reinstate your Registered Nurse License, you may submit an application to the Board to request reinstatement.

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **FINAL ORDER OF SUSPENSION**  
**Lisa Jones, CNA** ) **BY DEFAULT FOR**  
 ) **FAILURE TO COOPERATE**  
 )  
**Certificate No. 200710868CNA** ) **Reference No. 16-00055**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Certified Nursing Assistants. Lisa Jones (Certificate Holder) was issued a Nursing Assistant certificate by the Board on May 2, 2007.

This matter was considered by the Board at its meeting on April 13, 2016.

On March 23, 2016, a notice stating that the Board intended to suspend the Nursing Assistant certificate of Certificate Holder was sent to her via certified and first-class mail to her address of record. The Notice alleged that Lisa Jones failed to cooperate with the Board during the course of an investigation.

The Notice granted Certificate Holder an opportunity for hearing if requested within twenty (20) days of the mailing of the Notice. No such request for hearing has been received by the Board. The Notice designated the Board's file on this matter as the record for purposes of default.

NOW THEREFORE, after consideration of its records and files related to this matter, the Board enters the following Order:

-I-

**FINDINGS OF FACT**

Based on the evidence submitted through the Notice and the agency file in this case, the Board finds the following:

1. On or about June 25, 2015, Certificate Holder submitted a Certification Renewal Application to the Board. On her application, Certificate Holder marked "yes" to the following question: "Are you being investigated currently, or have you been investigated since the 'date of your last renewal' (regardless of whether the investigation was substantiated), for any type of abuse or mistreatment in any state?" The Board opened an investigation into the matter.

2. On February 25, 2016, Board staff mailed a letter to Certificate Holder's address of record requesting that Certificate Holder supplement her renewal application by providing the Board with additional documents and information. Certificate Holder failed to provide the requested documents and information.
3. On March 11, 2016, a second letter was sent to Certificate Holder's address of record requesting that Certificate Holder provide the requested documents and information within five (5) business days. Certificate Holder failed to provide the requested documents and information.
4. On March 23, 2016, Board staff mailed a Notice of Proposed Suspension to Certificate Holder via first-class and certified mail. The Notice granted Certificate Holder twenty (20) days from the date of the mailing of the Notice to request a hearing. The Notice also designated that the agency file would be the record for purposes of default.
5. Certificate Holder failed to respond to the Notice of Proposed Suspension within the required twenty (20) days. Consequently, Certificate Holder's opportunity to request a hearing has expired and she is in default.

-II-

### CONCLUSIONS OF LAW

1. That the Board has jurisdiction over the Certificate Holder, Lisa Jones, and over the subject matter of this proceeding.
2. That Certificate Holder's failure to cooperate with the Board during the course of an investigation is grounds for disciplinary action pursuant to ORS 678.442(2)(f), OAR 851-063-0080(6) and OAR 851-063-0090(10)(a) and (c).
3. That Certificate Holder defaulted on the Notice by not requesting a hearing within the allotted twenty (20) days and, as a result, pursuant to ORS 183.417(3), the Board may enter a Final Order by Default.

-III-

### ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, and the Board being fully advised in the premises, it is hereby:

ORDERED that the Nursing Assistant Certificate of Lisa Jones is SUSPENDED for a minimum of two weeks, commencing five business days from the date this Order is signed, and shall continue until such time as Lisa Jones has fully cooperated with the

Board's investigation. Should the Board reinstate the Nursing Assistant Certificate of Lisa Jones, she would be subject to whatever terms and conditions the Board may impose.

DATED this \_\_\_\_ day of April, 2016

**FOR THE BOARD OF NURSING OF THE STATE OF OREGON**

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Bonnie Kostelecky, MS, MPA, RN  
Board President

TO: LISA JONES:

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within (sixty) 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within sixty (60) days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482.

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Kay Kastrava, CNA Applicant** ) **PROBATION**  
)  
**Certificate No. 200212369CNA** ) **Reference No. 16-01261**

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Kay Kastrava (Applicant) was issued a Nursing Assistant certificate by the Oregon State Board of Nursing (Board) on September 13, 2002. In her application, Applicant had disclosed two 1999 arrests related to illegal substances, her substance use history and substance abuse treatment. Applicant was issued a Nursing Assistant certificate and placed on probation.

On or about October 14, 2004, Applicant successfully completed probation.

On or about February 12, 2013, Applicant's Nursing Assistant certificate lapsed.

On or about January 5, 2016, Applicant made application to the Board for reactivation of her CNA certificate. In her application, Applicant disclosed two arrests and convictions in 2012/2013 related to illegal substances, her most recent substance use history and substance abuse treatment.

Applicant has provided evidence of rehabilitation, including treatment for substance abuse, ongoing participation in recovery support programs and documented abstinence from mind-altering substances since October 24, 2014.

By the above actions, Applicant is subject to discipline pursuant to ORS 678.442(2)(a), OAR 851-063-0090(7)(c) and OAR 851-063-0110(3), which read as follows:

**ORS 678.442 Certification of nursing assistants; rules.**

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

(a) Conviction of the certificate holder of a crime where such crime bears demonstrable relationship to the duties of a nursing assistant. A copy of the record of such conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence of the conviction.

**OAR 851-063-0090 Conduct Unbecoming a Nursing Assistant.** A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to:

(7) Conduct related to safe performance of authorized duties:

(c) Using a prescription or non-prescription drug, alcohol, or a mind-altering substance to

an extent or in a manner dangerous or injurious to the nursing assistant or others, or to an extent that such use impairs the ability to perform the authorized duties safely.

**OAR 851-063-0110 Criminal Conviction History/Falsification of Application — Denial of Certification — Grounds for Discipline.**

(3) All other applicants or individuals with current nursing assistant certification, with conviction histories, other than those listed above, including crimes which are drug and alcohol related, will be considered on an individual basis. . . .

Applicant admits that the above allegations occurred and constitute violations of the Nurse Practice Act. Applicant wishes to cooperate with the Board in resolving the present disciplinary matter. The following will be proposed to the Oregon State Board of Nursing and is agreed to by Applicant:

**Applicant shall be placed on probation effective the date the Board approves this Stipulated Order for Probation. Applicant's compliance with this Order will be monitored by the Oregon State Board of Nursing. Applicant must complete a twenty-four (24) month period of probation to begin upon Applicant's return to work, monitored as outlined below. Applicant must work a minimum of sixteen (16) hours per week, and no more than a maximum of one (1.0) FTE. Applicant must work in a setting where Applicant can exercise the full extent of Applicant's scope of duties, in order to demonstrate Applicant's competence. Limited overtime may be approved on occasion, at the discretion of Board staff.**

Applicant shall comply with the following terms and conditions of probation:

1. Applicant shall not violate the Nurse Practice Act (ORS 678) or the rules adopted thereunder.
2. Applicant shall have thirty-six (36) months from Board's acceptance of this Order to complete twenty-four (24) months of monitored practice.
3. Applicant shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
4. Applicant shall maintain active certification.
5. Applicant shall inform Board staff in advance of any absences from Oregon and/or any move from Oregon to another licensing jurisdiction. If Applicant leaves the state and is unable to work in the state of Oregon, Applicant's probationary status will be re-evaluated.
6. Applicant shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.
7. Applicant shall notify Board staff of any citations, arrests, or convictions for any

offense, whether felony, misdemeanor, violation, or citation within seven (7) days of the occurrence.

8. Applicant will not look for, accept, or begin a new nursing assistant position without prior approval of the Board. This includes changes of the employer itself or changes within the facility or institution.
9. Applicant shall inform current and prospective employers, including any Nurse Executive, of the probationary status of Applicant's certification, the reasons for probation, and terms and conditions of probation. If Applicant's employer has a Nurse Executive, Applicant shall inform Board staff of the name of the Nurse Executive and Board staff will provide the Nurse Executive with a copy this Order.
10. Applicant shall work under the direct supervision of another licensed healthcare professional, functioning at the same or higher level of licensure, who is working in the same physical location and readily available to observe Applicant's work and provide assistance. Applicant shall be employed in a setting where Applicant's nursing assistant supervisor agrees to submit written evaluations of work performance (on forms provided by the Board) every three (3) months during the probationary period. The quarterly evaluation is expected to be received by Board staff within ten (10) days of the due date. If the evaluation is not timely received, Board staff will contact the employer with a reminder. If Board staff is not in receipt of the report within five (5) business days from the reminder date, Applicant may be restricted from performing the duties of a nursing assistant.
11. Between quarterly reporting periods, the Nurse Executive or a person designated by Applicant's employer shall inform Board staff of any instance of Applicant's non-compliance with the terms and conditions of this Order or of any other concern regarding Applicant's work-related conduct or personal behavior that may affect Applicant's ability to perform the duties of a nursing assistant.
12. Applicant shall notify Board staff when there is a change in status of employment, including resignations and terminations.
13. Applicant shall not have access to narcotics.
14. Applicant shall not work in any work setting when on-site supervision is not available. This generally includes home health agencies, traveling agencies, float pools, temporary agencies, assisted living facilities, adult foster care, independent consulting contracts, home hospice, and night shifts outside of acute care settings.
15. Applicant shall not be allowed to participate in the CNA2 training pursuant to Division 62 of the Oregon Administrative Rules.
16. Applicant shall participate in and comply with any treatment recommendations set forth by a third party evaluator approved by the Board. Within fourteen (14) days of completing treatment, Applicant shall submit to Board staff a copy of Applicant's completion certificate or discharge summary. Applicant shall attend Narcotics

Anonymous (NA), Alcoholics Anonymous (AA) or similar recovery program on a weekly basis and provide proof of attendance to Board staff. Applicant shall sign any release of information necessary to allow Board staff to communicate with Applicant's treatment provider and release Applicant's treatment records to the Board.

17. Applicant shall participate in the Board's random urine drug testing program. Failure to comply with random urine or any other requested drug test shall result in Applicant's immediate removal from working as a nursing assistant. Applicant shall submit to tests to determine the presence of unauthorized substances immediately upon request by Board staff or Applicant's employer. Applicant shall sign any release of information necessary to ensure the Board will receive the results of such testing. The presence of unauthorized substances may be considered a violation of the terms and conditions of this Order. Upon request of Board staff, Applicant shall obtain an evaluation by a Board approved chemical abuse or dependence evaluator. Applicant understands that Applicant is financially responsible for any and all costs related to testing and evaluating. Applicant's failure to maintain an account in good standing with the Board's laboratory vendor may be considered a violation of this Order.
18. Applicant shall abstain from using alcohol and/or other intoxicating, mind altering, or potentially addictive drugs, including over-the-counter or prescription drugs while on probation, except as provided in Section 19 below. Applicant shall avoid any over-the-counter products and food items containing alcohol and/or poppy seeds.
19. Applicant may take medication for a documented medical condition provided that the medication is from a valid prescription prescribed by a person authorized by law to write such a prescription for the documented medical condition. Applicant shall notify Board staff of any prescription within seventy-two (72) hours of its issuance. Applicant shall sign any release of information necessary to allow Board staff to communicate with the prescribing person and release Applicant's records to the Board. Applicant shall discard any unused prescription medication when no longer needed or when expired.
20. Applicant shall cease performing the duties of a nursing assistant upon the occurrence of a relapse, or at the request of Board staff because of a relapse or relapse behavior. The performance of nursing assistant duties may resume only when approved in writing by Board staff, in consultation with Applicant's employer.
21. Applicant shall notify any and all healthcare providers of the nature of Applicant's chemical dependency to ensure that Applicant's health history is complete before receiving any treatment, including medical and dental. Applicant shall provide a copy of this Order to Applicant's healthcare providers. Applicant shall provide Board staff with the names and contact information of any and all health care providers. Applicant shall sign any release of information necessary to allow Board staff to communicate with Applicant's healthcare providers and release Applicant's medical and treatment records to the Board. Applicant is financially responsible for any costs incurred for compliance with the terms and conditions of this Order.

22. Applicant shall notify Board staff at least three (3) business days prior to leaving town or going on vacation, with the exception of a family emergency.
23. Applicant shall cooperate fully with Board staff in the supervision and investigation of Applicant's compliance with the terms and conditions of this Order.

Applicant understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Applicant understands that in the event Applicant engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against Applicant's certificate, up to and including revocation of Applicant's certification to perform the duties of a nursing assistant.

Applicant understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Applicant understands that by signing this Stipulated Order, Applicant waives the right to an administrative hearing under ORS 183.310 to 183.540. Applicant acknowledges that no promises, representations, duress or coercion have been used to induce Applicant to sign this Order.

Applicant understands that this Order is a document of public record.

Applicant has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Probation.

IT IS SO AGREED:

\_\_\_\_\_  
Kay Kastrava, Applicant

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Heather Lorenz, RN** ) **REPRIMAND OF LICENSE**  
)  
**License No. 200540521RN** ) **Reference No. 16-00865**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Heather Lorenz (Licensee) was issued a Registered Nurse License by the Board on April 14, 2005.

On or about November 20, 2015, the Board received information that Licensee had accessed a patients' personal health information without a medical need to do so. An investigation was opened into the matter.

On March 11, 2016, Licensee admitted to accessing a patient's personal health information without a medical need to do so.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f)(g) and OAR 851-045-0070(2)(m) which read as follows:

**ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee.** In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(f) Conduct derogatory to the standards of nursing.

(g) Violation of any provision of ORS 678.010 to 678.448 or rules adopted thereunder.

**ORS 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(2) Conduct related to other federal or state statute/rule violations:

(m) Violating the rights of privacy, confidentiality of information, or knowledge concerning the client by obtaining the information without proper authorization or when there is no "need to know."

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the Registered Nurse license of Heather Lorenz be reprimanded.**

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Registered Nurse.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

\_\_\_\_\_  
Heather Lorenz, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Anne Meeks, RN** ) **PROBATION**  
 )  
**License No. 200940236RN** ) **Reference No. 16-00441**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Anne Meeks (Licensee) was issued a Registered Nurse license by the Board on February 2, 2009.

On or about September 9, 2014, Licensee signed an agreement to enter the Health Professionals' Services Program (HPSP) after she voluntarily sought treatment for her alcohol use. On or about September 24, 2014, Board staff referred Licensee to the HPSP for enrollment in the program. In October 2014, Licensee signed a series of contracts with representatives of the HPSP agreeing to comply with the terms of the program, including agreeing to abstain from the use of intoxicating substances, to report any use of intoxicating substances within 24 hours, and to submit to random drug or alcohol testing.

During Licensee's participation in the HPSP, Licensee failed to comply with the terms of the program on multiple occasions. The incidents of non-compliance included Licensee continuing to drink alcohol during her participation, failing to complete required drug and alcohol testing, and testing positive for ethyl glucuronide (EtG - a metabolite of alcohol). In communications with Board staff, Licensee initially denied relapsing and offered alternative explanations for the non-compliance incidents. Ultimately, Licensee acknowledged she had relapsed and had been drinking alcohol. Licensee has re-engaged in treatment for alcohol use.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f) & (1)(g), ORS 678.112, OAR 851-045-0070(5)(d) & (7)(b), OAR 851-070-0080(1)(b), (1)(c), (1)(d) & (1)(i), and OAR 851-070-0100(1)(d), (1)(k), (1)(l) & (2), which provide as follows:

**ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee.** In the manner prescribed in ORS chapter 183 for a contested case:

- (1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:
  - (f) Conduct derogatory to the standards of nursing.
  - (g) Violation of any provision of ORS 678.010 to 678.448 or rules adopted thereunder.

**ORS 678.112 Impaired health professional program.** Persons licensed to practice nursing who elect not to participate in the impaired health professional program established under ORS 676.190 or who fail to comply with the terms of participation shall be reported to the Oregon State Board of Nursing for formal disciplinary action under ORS 678.111.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

- (5) Conduct related to impaired function:
  - (d) Use of drugs, alcohol or mind-altering substances to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice for which the licensee is licensed.
- (7) Conduct related to the licensee's relationship with the Board:
  - (b) Failing to answer truthfully and completely any question asked by the Board on an application for licensure or during the course of an investigation or any other question asked by the Board.

**OAR 851-070-0080 Licensee Responsibilities**

- (1) All licensees must:
  - (b) Comply continuously with his or her monitoring agreement, including any restrictions on his or her practice, for at least two years or longer, as specified by the Board by rule or order;
  - (c) Abstain from mind-altering or intoxicating substances or potentially addictive drugs, unless prescribed for a documented medical condition by a person authorized by law to prescribe the drug to the licensee. The Board does not authorize the vendor to approve or disapprove medications prescribed to the Licensee for a documented medical condition;
  - (d) Report use of mind-altering or intoxicating substances or potentially addictive drugs within 24 hours;
  - (i) Submit to random drug or alcohol testing.

**OAR 851-070-0100 Substantial Non-Compliance Criteria**

- (1) The HPSP will report substantial non-compliance within one business day after the HPSP learns of non-compliance, including but not limited to information that a licensee:
  - (d) Received a positive toxicology test result as determined by federal regulations pertaining to drug testing;
  - (k) Violated any provisions of OAR 851-070-0080;
  - (l) Violated any terms of the diversion agreement.
- (2) The Board, upon being notified of a licensee's substantial non-compliance will investigate and determine the appropriate sanction, which may include a limitation of licensee's practice and any other sanction, up to and including termination from the HPSP and formal discipline.

Licensee admits that the above allegations occurred and constitute violations of the Nurse Practice Act. Licensee wishes to cooperate with the Board in resolving the present disciplinary matter. The following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

Licensee shall be placed on probation effective the date the Board approves this Stipulated Order for Probation. Licensee's compliance with this Order will be monitored by the Oregon State Board of Nursing. Licensee must complete a thirty-six (36) month period of probation to begin upon Licensee's return to practice, monitored as outlined below. Licensee must practice a minimum of sixteen (16) hours per week, and no more than a maximum of one (1.0) FTE. Licensee must practice in a setting where Licensee can exercise the full extent of Licensee's scope of practice, in order to demonstrate Licensee's competence. Limited overtime may be approved on occasion, at the discretion of Board staff.

Licensee shall comply with the following terms and conditions of probation:

1. Licensee shall not violate the Nurse Practice Act (ORS 678) or the rules adopted thereunder.
2. Licensee shall have forty-eight (48) months from Board's acceptance of this Order to complete thirty-six (36) months of monitored practice.
3. Licensee shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
4. Licensee shall maintain an active license.
5. Licensee shall inform Board staff in advance of any absences from Oregon and/or any move from Oregon to another licensing jurisdiction. If Licensee leaves the state and is unable to practice in the state of Oregon, Licensee's probationary status will be re-evaluated.
6. Licensee shall appear in person or by phone to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.
7. Licensee shall notify Board staff of any citations, arrests, or convictions for any offense, whether felony, misdemeanor, violation, or citation within seven (7) days of the occurrence.
8. Licensee will not look for, accept, or begin a new nursing position without prior approval of the Board. This includes changes of the employer itself or changes within the facility or institution.
9. Licensee shall inform current and prospective employers, including any Nurse Executive, of the probationary status of Licensee's license, the reasons for probation,

and terms and conditions of probation. If Licensee's employer has a Nurse Executive, Licensee shall inform Board staff of the name of the Nurse Executive and Board staff will provide the Nurse Executive with a copy this Order.

10. Licensee shall work under the direct supervision of another licensed healthcare professional, functioning at the same or higher level of licensure, who is working in the same physical location and readily available to observe Licensee's practice and provide assistance. Licensee shall be employed in a setting where Licensee's nursing supervisor agrees to submit written evaluations of work performance (on forms provided by the Board) every three (3) months during the probationary period. The quarterly evaluation is expected to be received by Board staff within ten (10) days of the due date. If the evaluation is not timely received, Board staff will contact the employer with a reminder. If Board staff is not in receipt of the report within five (5) business days from the reminder date, Licensee may be restricted from practicing as a nurse.
11. Between quarterly reporting periods, the Nurse Executive or a person designated by Licensee's employer shall inform Board staff of any instance of Licensee's non-compliance with the terms and conditions of this Order or of any other concern regarding Licensee's work-related conduct or personal behavior that may affect Licensee's ability to perform the duties of a nurse.
12. Licensee shall notify Board staff when there is a change in status of employment, including resignations and terminations.
13. Licensee shall not work in any practice setting when on-site supervision is not available. This generally includes home health agencies, traveling agencies, float pools, temporary agencies, assisted living facilities, adult foster care, independent consulting contracts, home hospice, and night shifts outside of acute care settings.
14. Licensee shall participate in and comply with any treatment recommendations set forth by a third party evaluator approved by the Board. Within fourteen (14) days of completing treatment, Licensee shall submit to Board staff a copy of Licensee's completion certificate or discharge summary. Licensee shall attend Alcoholics Anonymous (AA) or a similar recovery program on a weekly basis and provide proof of attendance to Board staff. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's treatment provider and release Licensee's treatment records to the Board.
15. Licensee shall participate in the Board's random drug and alcohol testing program. Failure to comply with random urine or any other requested drug test shall result in Licensee's immediate removal from nursing practice. Licensee shall submit to tests to determine the presence of unauthorized substances immediately upon request by Board staff or Licensee's employer. Licensee shall sign any release of information necessary to ensure the Board will receive the results of such testing. The presence of unauthorized substances may be considered a violation of the terms and conditions of

this Order. Upon request of Board staff, Licensee shall obtain an evaluation by a Board-approved chemical dependence evaluator. Licensee understands that Licensee is financially responsible for any and all costs related to testing and evaluating. Licensee's failure to maintain an account in good standing with the Board's laboratory vendor shall be considered a violation of this Order.

16. Licensee shall abstain from using alcohol and/or other intoxicating, mind altering, or potentially addictive drugs, including over-the-counter or prescription drugs while on probation, except as provided in Section 17 below. Licensee shall avoid any over-the-counter products and food items containing alcohol and/or poppy seeds.
17. Licensee may take medication for a documented medical condition provided that the medication is from a valid prescription prescribed by a person authorized by law to write such a prescription for the documented medical condition. Licensee shall notify Board staff of any prescription within seventy-two (72) hours of its issuance. Licensee shall sign any release of information necessary to allow Board staff to communicate with the prescribing person and release Licensee's records to the Board. Licensee shall discard any unused prescription medication when no longer needed or when expired.
18. Licensee shall cease practicing as a nurse upon the occurrence of a relapse, or at the request of Board staff because of a relapse or relapse behavior. Practice may resume only when approved in writing by Board staff, in consultation with Licensee's employer.
19. Licensee shall notify any and all healthcare providers of the nature of Licensee's chemical dependency to ensure that Licensee's health history is complete before receiving any treatment, including medical and dental. Licensee shall provide a copy of this Order to Licensee's healthcare providers. Licensee shall provide Board staff with the names and contact information of any and all health care providers. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's healthcare providers and release Licensee's medical and treatment records to the Board. Licensee is financially responsible for any costs incurred for compliance with the terms and conditions of this Order.
20. Licensee shall notify Board staff at least three (3) business days prior to leaving town or going on vacation, with the exception of a family emergency.
21. Licensee shall cooperate fully with Board staff in the supervision and investigation of Licensee's compliance with the terms and conditions of this Order.

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event Licensee engages in future conduct resulting in

violations of law or the Nurse Practice Act, the Board may take further disciplinary action against Licensee's license, up to and including revocation of Licensee's license to practice as a Registered Nurse.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, Licensee waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce Licensee to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Probation.

IT IS SO AGREED:

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Anne Meeks, RN

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Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

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Bonnie Kostecky, MS, MPA, RN  
Board President

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Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of  
Terence Mitchell, RN**

) **STIPULATED ORDER FOR  
) PROBATION  
)**

**License No. 200040267RN**

) **Reference No. 16-00907**

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Terence Mitchell (Licensee) was issued a Registered Nurse license by the Oregon State Board of Nursing (Board) on July 6, 2000.

On or about November 23, 2015, Licensee was reported to the Board for diverting narcotics. The Board opened an investigation into the matter.

The Board alleges that on or about February 5, 2016, Licensee admitted to diverting narcotics from his employer for personal use and to altering agency records.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(d)(f)(g) and OAR 851-045-0070(2)(f)(i)(n)(3)(d)(5)(d) which read as follows:

**ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee.** In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

- (d) Fraud or deceit of the licensee in the practice of nursing or in admission to such practice.
- (f) Conduct derogatory to the standards of nursing.
- (g) Violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

- (2) Conduct related to other federal or state statute/rule violations:
  - (f) Unauthorized removal or attempted removal of narcotics, other drugs, supplies, property, or money from clients, the work place, or any person.
  - (i) Possessing, obtaining, attempting to obtain, furnishing, or administering prescription or controlled drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs.
  - (n) Unauthorized removal of client records, client information, facility property, policies or written standards from the work place;

(3) Conduct related to communication:

(d) Altering a client or agency record or records prepared for an accrediting or credentialing entity, including, but not limited to, changing words/letters/numbers from the original document to mislead the reader of the record, adding to the record after the original time/date without indicating a late entry

(5) Conduct related to impaired function:

(d) Use of drugs, alcohol or mind-altering substances to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice for which the licensee is licensed.

Licensee admits that the above allegations occurred and constitute violations of the Nurse Practice Act. Licensee wishes to cooperate with the Board in resolving the present disciplinary matter. The following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

Licensee shall be placed on probation effective the date the Board approves this Stipulated Order for Probation. Licensee's compliance with this Order will be monitored by the Oregon State Board of Nursing. Licensee must complete a twenty-four (24) month period of probation to begin upon Licensee's return to practice, monitored as outlined below. Licensee must practice a minimum of sixteen (16) hours per week, and no more than a maximum of one (1.0) FTE. Licensee must practice in a setting where Licensee can exercise the full extent of Licensee's scope of practice, in order to demonstrate Licensee's competence. Limited overtime may be approved on occasion, at the discretion of Board staff.

Licensee shall comply with the following terms and conditions of probation:

1. Licensee shall not violate the Nurse Practice Act (ORS 678) or the rules adopted thereunder.
2. Licensee shall have thirty-six (36) months from Board's acceptance of this Order to complete twenty-four (24) months of monitored practice.
3. Licensee shall notify Board staff, in writing, prior to any change of address or employment setting during the probation period.
4. Licensee shall maintain an active license.
5. Licensee shall inform Board staff in advance of any absences from Oregon and/or any move from Oregon to another licensing jurisdiction. If Licensee leaves the state and is unable to practice in the state of Oregon, Licensee's probationary status will be re-evaluated.
6. Licensee shall appear in person or by phone, to designated Board staff for interviews on a monthly basis during the probationary period. Frequency of contact may be reviewed and revised periodically at the discretion of Board staff.
7. Licensee shall notify Board staff of any citations, arrests, or convictions for any offense, whether felony, misdemeanor, violation, or citation within seven (7) days of the occurrence.
8. Licensee will not look for, accept, or begin a new nursing position without prior approval of the Board. This includes changes of the employer itself or changes within the facility or institution.

9. Licensee shall inform current and prospective employers, including any Nurse Executive, of the probationary status of Licensee's license, the reasons for probation, and terms and conditions of probation. If Licensee's employer has a Nurse Executive, Licensee shall inform Board staff of the name of the Nurse Executive and Board staff will provide the Nurse Executive with a copy this Order.
10. Licensee shall work under the direct supervision of another licensed healthcare professional, functioning at the same or higher level of licensure, who is working in the same physical location and readily available to observe Licensee's practice and provide assistance. Licensee shall be employed in a setting where Licensee's nursing supervisor agrees to submit written evaluations of work performance (on forms provided by the Board) every three (3) months during the probationary period. The quarterly evaluation is expected to be received by Board staff within ten (10) days of the due date. If the evaluation is not timely received, Board staff will contact the employer with a reminder. If Board staff is not in receipt of the report within five (5) business days from the reminder date, Licensee may be restricted from practicing as a nurse.
11. Between quarterly reporting periods, the Nurse Executive or a person designated by Licensee's employer shall inform Board staff of any instance of Licensee's non-compliance with the terms and conditions of this Order or of any other concern regarding Licensee's work-related conduct or personal behavior that may affect Licensee's ability to perform the duties of a nurse.
12. Licensee shall notify Board staff when there is a change in status of employment, including resignations and terminations.
13. Licensee shall not have access to narcotics, carry the keys to narcotics storage, or administer narcotics at any time or under any circumstances or until Licensee receives written approval from Board staff.
14. Licensee shall not work in any practice setting when on-site supervision is not available. This generally includes home health agencies, traveling agencies, float pools, temporary agencies, assisted living facilities, adult foster care, independent consulting contracts, home hospice, and night shifts outside of acute care settings.
15. Licensee shall participate in and comply with any treatment recommendations set forth by a third party evaluator approved by the Board. Within fourteen (14) days of completing treatment, Licensee shall submit to Board staff a copy of Licensee's completion certificate or discharge summary. Licensee shall attend Narcotics Anonymous (NA), Alcoholics Anonymous (AA) or similar recovery program on a weekly basis and provide proof of attendance to Board staff. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's treatment provider and release Licensee's treatment records to the Board.
16. Licensee shall participate in the Board's random urine drug testing program. Failure to comply with random urine or any other requested drug test shall result in Licensee's immediate removal from nursing practice. Licensee shall submit to tests to determine the presence of unauthorized substances immediately upon request by Board staff or Licensee's employer. Licensee shall sign any release of information necessary to ensure the Board will receive the results of such testing. The presence of unauthorized substances may be considered a violation of the terms and conditions of this Order. Upon request of Board staff, Licensee shall obtain an evaluation by a Board approved chemical abuse or dependence evaluator. Licensee understands that Licensee is financially responsible for any and all costs related to testing and evaluating. Licensee's failure to maintain an account in good standing with the Board's laboratory vendor shall be considered a violation of this Order.

17. Licensee shall abstain from using alcohol and/or other intoxicating, mind altering, or potentially addictive drugs, including over-the-counter or prescription drugs while on probation, except as provided in Section 18 below. Licensee shall avoid any over-the-counter products and food items containing alcohol and/or poppy seeds.
18. Licensee may take medication for a documented medical condition provided that the medication is from a valid prescription prescribed by a person authorized by law to write such a prescription for the documented medical condition. Licensee shall notify Board staff of any prescription within seventy-two (72) hours of its issuance. Licensee shall sign any release of information necessary to allow Board staff to communicate with the prescribing person and release Licensee's records to the Board. Licensee shall discard any unused prescription medication when no longer needed or when expired.
19. Licensee shall cease practicing as a nurse upon the occurrence of a relapse, or at the request of Board staff because of a relapse or relapse behavior. Practice may resume only when approved in writing by Board staff, in consultation with Licensee's employer.
20. Licensee shall notify any and all healthcare providers of the nature of Licensee's chemical dependency to ensure that Licensee's health history is complete before receiving any treatment, including medical and dental. Licensee shall provide a copy of this Order to Licensee's healthcare providers. Licensee shall provide Board staff with the names and contact information of any and all health care providers. Licensee shall sign any release of information necessary to allow Board staff to communicate with Licensee's healthcare providers and release Licensee's medical and treatment records to the Board. Licensee is financially responsible for any costs incurred for compliance with the terms and conditions of this Order.
21. Licensee shall notify Board staff at least three (3) business days prior to leaving town or going on vacation, with the exception of a family emergency.
22. Licensee shall cooperate fully with Board staff in the supervision and investigation of Licensee's compliance with the terms and conditions of this Order.

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event Licensee engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against Licensee's license, up to and including revocation of Licensee's license to practice as a Registered Nurse.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, Licensee waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce Licensee to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Probation.

IT IS SO AGREED:

\_\_\_\_\_  
Terence Mitchell, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Carol Oliver, NP** ) **REPRIMAND OF NP CERTIFICATE**  
 )  
**License No. 200650010NP** ) **Reference No. 15-02015**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Nurse Practitioners. Carol Oliver (Licensee) was issued a Registered Nurse License and a Nurse Practitioner Certificate by the Board on January 17, 2006.

On or about June 15, 2015, the Board received information that Licensee used offensive language in an unprofessional manner to a pharmacist while working at Beach Medical and Skin Care Center.

On or about November 19, 2015, the Board issued a Notice for a Mental Health Evaluation which the Licensee successfully completed on December 28, 2015.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f), OAR 851-045-0070(4)(b), and OAR 851-0050-0005(5)(g).

**ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee.** In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by endorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the Board may impose or may be issued a limited license or may be reprimanded or censured by the Board, or any of the following causes:

(f) Conduct derogatory to the standards of nursing

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined.**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(4) Conducted related to achieving and maintaining clinical competency:

(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established

**OAR 851-050-0005 Nurse Practitioner Scope of Practice**

(5) The nurse practitioner is independently responsible and accountable for the continuous and comprehensive management of a broad range of health care, which may include:

(g) Consultation and/or collaboration with other health care providers and community resources.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the Nurse Practitioner Certificate of Carol Oliver be reprimanded.**

**Licensee will also complete continuing education on Medical Ethics by April 12, 2016, at the request of the Board.**

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a serious nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Nurse Practitioner.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

\_\_\_\_\_  
Carol Oliver, NP

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date

SIGNATURES & DATED COPY ON FILE IN BOARD OFFICE

BEFORE THE  
BOARD OF NURSING  
STATE OF OREGON

In the Matter of: ) FINAL ORDER  
)  
GARY ROGERS, CNA, ) OAH Case No. 1504269  
Certificate No. 000028920CNA. ) Agency Case No. 15-01148  
\_\_\_\_\_ )

**HISTORY OF THE CASE**

On July 10, 2015, the Oregon State Board of Nursing (Board) issued a Notice of Proposed Suspension of Nursing Assistant Certificate to Gary Rogers. On July 20, 2015, Mr. Rogers requested a hearing.

On July 27, 2015, the Board referred the matter to the Office of Administrative Hearings (OAH). The OAH assigned Administrative Law Judge (ALJ) Joe Allen to preside at hearing. The OAH scheduled a prehearing conference for September 28, 2015. The prehearing conference was postponed at the Board's request. On October 13, 2015, Presiding ALJ John Mann convened a telephone prehearing conference. Mr. Rogers did not appear. The Board appeared and was represented by Senior Assistant Attorney General Thomas Cowan. Presiding ALJ Mann scheduled the hearing for July 19, 2016, and set deadlines for submission of motions, witness lists and exhibits.

On January 15, 2016, the Board filed a Motion for Summary Determination (Motion). On February 17, 2016, the OAH assigned ALJ Samantha Fair to rule on the Motion. The record closed on February 19, 2016, without receipt of any response from Mr. Rogers.

On February 22, 2016, ALJ Fair issued her Ruling on Motion for Summary Determination and Proposed Order. The ALJ found that no genuine issues as to any material facts existed and the Board was entitled to a favorable ruling as a matter of law. ALJ Fair recommended that the Board issue an order suspending Mr. Rogers' nursing assistant certificate, and canceled the hearing. Mr. Rogers was notified of his right to file exceptions within 10 days following the date of service of the Proposed Order. The Board did not receive any exceptions from Mr. Rogers within the timeframe allowed.

At its Board meeting on April 13, 2016, the Board deliberated the ALJ's Ruling on Motion for Summary Determination and Proposed Order. The Board voted to accept the Proposed Order and now issues this Final Order. The Board has not made any changes to this Final Order that substantially modifies the ALJ's proposed findings of historical fact or changes the ALJ's recommended outcome or basis therefor. The Board has made changes to the Proposed Order to correct spelling, grammar, and/or textual placement.

## ISSUE

Whether Mr. Rogers' certified nursing assistant certificate should be suspended. ORS 678.442(2); OAR 851-063-0080 and OAR 851-063-0090.

## EVIDENTIARY RULINGS

The Affidavit of Leslie Kilborn (Affidavit) and Exhibits 1 through 8, offered by the Board, were admitted into the record.

## FINDINGS OF FACT

1. In 2004 and 2008, Mr. Rogers was arrested for driving under the influence of intoxicants (DUII). (Ex. 6 at 3.)
2. On March 23, 2014, the Oregon State Police (OSP) received a report from Mr. Rogers' wife that he was driving while intoxicated. (Ex. 1 at 1.) Mr. Rogers' wife reported that Mr. Rogers had been drinking all morning, that he left the home about 2 p.m. after he backed his car into a fence, and had two prior DUII arrests. (*Id.* at 3.) Approximately 5 p.m. that day, an OSP trooper stopped Mr. Rogers while he was driving his car. Mr. Rogers indicated that he had not consumed any alcohol since 3 a.m. The OSP trooper observed signs of intoxication, including a strong odor of an alcoholic beverage, flushed cheeks and glassy eyes. The OSP trooper performed a horizontal gaze nystagmus (HGN) test. The results of the HGN test reflected the effects of intoxicants. Mr. Rogers refused to perform any additional field sobriety tests. The OSP trooper arrested Mr. Rogers for DUII. There were three opened cans of beer in Mr. Rogers' car. Two were empty and the third still contained some beer. After his arrival at the police station, Mr. Rogers admitted to drinking three beers at 7 a.m. Mr. Rogers provided a breath sample that showed a blood alcohol level of 0.05 percent. (*Id.* at 4-9.) The OSP trooper also cited Mr. Rogers for possession of an open container of alcohol. (*Id.* at 1.)
3. On March 24, 2014, the charge of DUII against Mr. Rogers was dismissed when no complaint was filed in court. (Ex. 2 at 1.) On April 17, 2014, Mr. Rogers was convicted of the open container violation following his no contest plea. (*Id.* at 2.)
4. On January 23, 2015, Mr. Rogers filed a renewal application for his nursing assistant certificate. (Ex. 6 at 3.) In his application, he responded "no" to questions about whether he had used alcohol in a way that could impair his ability to perform nursing assistant duties or whether he had been diagnosed with an alcohol condition since his last renewal. (Ex. 3 at 1.) He responded "yes" to a question about whether he had been arrested, cited or charged with an offense, other than a traffic ticket. (*Id.* at 2.) He elaborated that he had been arrested for DUII but "passed all test and complied with all laws no charges were made." (*Id.*)
5. On February 18, 2015, the Board sent Mr. Rogers a letter, instructing him to contact the Board's investigator no later than March 4, 2015 to schedule an appointment to discuss his DUII arrest. The letter further instructed Mr. Rogers to send a copy of his work history and a

written statement describing the DUII arrest to the Board no later than March 4, 2015. (Ex. 4 at 1.) Mr. Rogers did not contact the Board's investigator by March 4, 2015. (Affidavit at 1.)

6. On March 9, 2015, the Board sent Mr. Rogers a letter, advising him that he had failed to call the Board to schedule an appointment to discuss his DUII arrest. In the letter, the Board warned Mr. Rogers that he had an obligation to cooperate with the Board during an investigation and a failure to cooperate was grounds for disciplinary action. The Board instructed Mr. Rogers to contact its investigator within five business days of the letter to schedule an interview. The Board again reminded Mr. Rogers to provide his work history and written statement regarding the DUII arrest. (Ex. 4 at 3.)

7. On March 18, 2015, the Board sent Mr. Rogers a letter, advising him that he had again failed to call the Board to schedule an interview. In the letter, the Board instructed Mr. Rogers to call the investigations department within five business days of the letter and provide his work history and written statement regarding the DUII arrest. (Ex. 4 at 5.)

8. On March 29, 2015, Mr. Rogers emailed the Board's investigator a written statement regarding the DUII arrest and his work history. This email was his first response to the Board's letters. (Ex. 5 at 1; Affidavit at 1.) In his statement, Mr. Rogers indicated:

I stopped for lunch at a restaurant and ate lunch and had 2 beers with lunch. \* \* \* A state trooper pulled me over and asked for my license, he said he could smell alcohol and asked if I had been drinking. I said yes that I had 2 beers with my lunch. \* \* \*. He had me do a field sobriety test and I refused. I told him I did not feel safe parked on the freeway. He then arrested me for DUII \* \* \*. I took a breathalyzer test two times at the station and passed them both. He then told me he was taking me to jail and let the DA decide. I spent the weekend in jail and was released with no charges filed.

(Ex. 5 at 1.)

9. The Board's investigator interviewed Mr. Rogers on April 7, 2015. (Affidavit at 2.) During the interview, Mr. Rogers acknowledged that his wife did not like him drinking alcohol, that he usually consumed it when she was not present, that he used to binge drink alcoholic beverages, and that he believed his alcohol consumption was under control because he no longer engaged in binge drinking alcohol. (Ex. 6 at 3.) When the investigator mentioned a chemical dependency evaluation, Mr. Rogers responded that he did not have the time to comply with a chemical dependency evaluation or any potential requirements of a monitored practice or probation because of the recurrence of his cancer. (Ex. 6 at 3; Affidavit at 2.)

10. On April 28, 2015, the Board received confirmation from Mr. Rogers' oncologist that he was undergoing treatment for colon cancer. (Affidavit at 2.)

11. Based upon his history of DUII arrests and history of alcohol consumption, the Board issued Mr. Rogers an Order for Chemical Dependency Evaluation (Order) on June 22,

2015. The Order required Mr. Rogers to submit to a chemical dependency evaluation by requiring him to contact a Board-approved evaluator within 10 days of the Order's mailing date; to notify the Board of the name of the evaluator and the date and time of the appointment at least 7 days before the evaluation; and to complete the evaluation within 30 days of the Order's mailing date. (Ex. 6 at 1-3.) The Order further provided that "Failure to schedule and attend this evaluation within the allotted time is grounds for revocation of your certificate." (*Id.* at 1.) The Board mailed the Order to Mr. Rogers by certified mail on June 23, 2015. He signed the return receipt for the Order on June 24, 2015. (*Id.* at 4.)

12. On July 18, 2015, Mr. Rogers mailed a letter to the Board, informing it that he had failed to contact the Board to do an evaluation "since I am currently undergoing treatment for cancer and will not be able to attend any classes or treatment program while I am going through this." (Ex. 8 at 1-2.)

13. As of January 8, 2016, Mr. Rogers has not obtained or completed a chemical dependency evaluation. (Affidavit at 2.)

### **CONCLUSIONS OF LAW**

It is appropriate that the certified nursing assistant certificate of Gary Rogers should be suspended.

### **OPINION**

#### *Standard of Review for Motion for Summary Determination*

OAR 137-003-0580 addresses motions for summary determination. It provides, in relevant part:

(6) The administrative law judge shall grant the motion for a summary determination if:

(a) The pleadings, affidavits, supporting documents (including any interrogatories and admissions) and the record in the contested case show that there is no genuine issue as to any material fact that is relevant to resolution of the legal issue as to which a decision is sought; and

(b) The agency or party filing the motion is entitled to a favorable ruling as a matter of law.

(7) The administrative law judge shall consider all evidence in a manner most favorable to the non-moving party or non-moving agency.

(8) Each party or the agency has the burden of producing evidence on any issue relevant to the motion as to which that party or the agency would have the burden of persuasion at the contested case hearing.

\* \* \* \* \*

(12) If the administrative law judge's ruling on the motion resolves all issues in the contested case, the administrative law judge shall issue a proposed order in accordance with OAR 137-003-0645 incorporating that ruling \* \* \*.

Pursuant to OAR 137-003-0580(6)(a), in making her ruling, the ALJ considered the Board's Motion, the Affidavit, and Exhibits 1 through 8. Pursuant to OAR 137-003-0580(7), the ALJ reviewed the evidence in the light most favorable to Mr. Rogers, the non-moving party, and she determined there were no genuine issues as to the material facts of the Board's allegation that are relevant to resolution of the legal issues and the Board is entitled to a favorable ruling. Because the ruling on the Motion resolved all issues in this matter, the ALJ issued a proposed order and canceled the hearing.

Suspension of Nursing Assistant Certificate

The Board proposes to suspend Mr. Rogers' certified nursing assistant certificate, based on an allegation of conduct unbecoming a nursing assistant. As the proponent of the allegation, the Board has the burden to establish, by a preponderance of the evidence, that the allegations are correct and that it is entitled to assess the civil penalty. ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position"); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

ORS 678.442(2) provides, in part:

In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

\* \* \* \* \*

(f) Conduct unbecoming a nursing assistant in the performance of duties.

OAR 851-063-0080 provides, in part:

Under the contested case procedure in ORS 183.310 to 183.550 the Board may impose a range of disciplinary sanctions including, but not limited to deny, reprimand, suspend, place on probation or revoke the certificate to perform duties as a CNA for the following causes:

\* \* \* \* \*

(6) Conduct unbecoming a nursing assistant.

Pursuant to the authority granted by ORS 678.150 and ORS 678.442, the Board promulgated an administrative rule to define conduct unbecoming a nursing assistant. OAR 851-063-0090 provides, in part:

A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to:

\* \* \* \* \*

(10) Conduct related to the certification holder's relationship with the Board:

(a) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to waiver of confidentiality, except attorney-client privilege[.]

Based upon his acknowledgement of his March 2014 DUII arrest in his renewal application, the Board sought to investigate the circumstances of the arrest and sent Mr. Rogers three letters, all directing him to contact the Board's investigator to schedule an interview and provide details of the arrest. Mr. Rogers failed to comply with the Board's first two letters and was late complying with the Board's final letter.

Because of Mr. Rogers' history of DUII arrests and past alcohol consumption issues, pursuant to the authority granted by ORS 678.113(1), the Board issued Mr. Rogers the Order, requiring him to submit to a chemical dependency evaluation to be completed no later than 30 days after the June 22, 2015 issuance of the Order. As of January 8, 2016, Mr. Rogers had still not complied with the Order's requirement to complete a chemical dependency evaluation. Although Mr. Rogers was undergoing cancer treatment in early 2015, there is no evidence that his cancer treatment commitments prevented him from participating in a chemical dependency evaluation.

By his failures to timely respond to the Board's investigative communications and his failure to comply with the Order, Mr. Rogers failed to fully cooperate with the Board during the course of its investigation. Mr. Rogers engaged in conduct unbecoming a nursing assistant as defined by OAR 851-063-0090(1).

Because Mr. Rogers has engaged in conduct unbecoming a nursing assistant, the Board may revoke or suspend his certificate pursuant to ORS 678.442(2)(f). Without Mr. Rogers' completion of the chemical dependency evaluation, the Board is unable to evaluate whether Mr. Rogers suffers from a chemical dependency that may negatively impact his ability to practice as

a nursing assistant with reasonable skill and safety to patients. Therefore, it is appropriate for the Board to suspend Mr. Rogers' certified nursing assistant certificate until such time as he fully cooperates with the Board's investigation by complying with the Order.

### **ORDER**

Gary Rogers' certified nursing assistant certificate is suspended until such time as he fully cooperates with the Oregon State Board of Nursing's investigation by complying with the Order for Chemical Dependency Evaluation and completing a chemical dependency evaluation by a Board-approved evaluator.

The Oregon State Board of Nursing is not precluded from initiating further disciplinary action if an investigation determines that Gary Rogers has committed other violations of the Nurse Practice Act or any of the Board's administrative rules.

DATED this \_\_\_\_ day of April 2016.

FOR THE OREGON STATE BOARD OF NURSING

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Bonnie Kostelecky, MS, MPA, RN  
Board President

### **APPEAL**

If you wish to appeal the final order, you must file a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. *See* ORS 183.480 *et seq.*

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Karma Sammy, CNA** ) **VOLUNTARY SURRENDER**  
)  
**Certificate No. 000005377CNA** ) **Reference No. 16-01025**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Certified Nursing Assistants. Karma Sammy (CNA) was issued a Nursing Assistant certificate by the Board on August 08, 1991.

In November 2015 and/or December 2015, CNA removed money without authorization from a resident's room at Rose Villa Senior Living in Portland, Oregon and, as a result, she was subsequently arrested.

By the above actions, CNA is subject to discipline pursuant to ORS 678.442(2)(d) and (f) and OAR 851-063-0080(4) and (6) and OAR 851-063-0090(8)(j) which provide as follows:

**ORS 678.442 Certification of nursing assistants; rules.**

(2) In the manner prescribed in ORS chapter 183, the board may revoke or suspend a certificate issued under this section or may reprimand a nursing assistant for the following reasons:

- (d) Violation of any provisions of ORS 678.010 to 678.445 or rules adopted thereunder.
- (f) Conduct unbecoming a nursing assistant in the performance of duties.

**OAR 851-063-0080 Causes for Denial, Reprimand, Suspension, Probation or Revocation of CNA Certificate**

Under the contested case procedure in ORS 183.310 to 183.550 the Board may impose a range of disciplinary sanctions including, but not limited to deny, reprimand, suspend, place on probation or revoke the certificate to perform duties as a CNA for the following causes:

- (4) Violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder;
- (6) Conduct unbecoming a nursing assistant.

**OAR 851-063-0090 Conduct Unbecoming a Nursing Assistant**

A CNA, regardless of job location, responsibilities, or use of the title "CNA," whose behavior fails to conform to the legal standard and accepted standards of the nursing assistant profession, or who may adversely affect the health, safety or welfare of the public, may be found guilty of conduct unbecoming a nursing assistant. Such conduct includes but is not limited to:

- (8) Conduct related to other federal or state statutes/rule violations:
- (j) Unauthorized removal or attempted removal of any drugs, supplies, property, or money from any person or setting

CNA wishes to cooperate with the Board in this matter and voluntarily surrender her Nursing Assistant certificate.

Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by CNA:

**That the voluntary surrender of the Nursing Assistant certificate of Karma Sammy be accepted. If, after a minimum of three years, Ms. Sammy wishes to reinstate her Nursing Assistant certificate, she may submit an application to the Board to request reinstatement.**

CNA agrees that she will not practice as a Certified Nursing Assistant from the date she signs this Stipulated Order.

CNA understands that this Stipulated Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

CNA understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. CNA acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Stipulated Order.

CNA understands that this Stipulated Order is a document of public record.

CNA has read this Stipulated Order, understands this Stipulated Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

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Karma Sammy, CNA

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Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

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Bonnie Kostelecky, MS, MPA, RN  
Board President

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Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Deborah Sanders, RN** ) **REPRIMAND OF LICENSE**  
)  
**License No. 094003076RN** ) **Reference No. 15-00836**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Deborah Sanders (Licensee) was issued a Registered Nurse License by the Board on July 27, 1995.

I.

On or about December 4, 2014, Licensee was reported to the Board for failing to maintain professional boundaries with a patient. The Board opened an investigation into the matter.

II.

The Board alleges that on or about December 2010, while Licensee was employed as a Registered Nurse in a Neonatal Intensive Care Unit in Eugene, Oregon, she began to care for a premature infant patient (Child).

III.

The Board alleges that on or about March 2011, Licensee voluntarily agreed to the placement of Child in her home. The Child and birth mother (Mother) remained in Licensee's home until February 21, 2014.

IV.

The Board alleges that between March 2011 and February 2014, Mother paid Licensee approximately \$320.00 a month in rent.

V.

The Board alleges that on or about February 21, 2014, Mother and Child voluntarily moved out of Licensee's home. Licensee was concerned for Child's health and welfare and contacted Department of Human Services (DHS). DHS returned Child to Licensee's home until May 28, 2014 when Child was reunited with Mother.

VI.

The Board alleges that on or about November 26, 2014, Licensee and her husband (Husband) filed a Petition for Third Party Rights and Visitation Time with the Douglas County Circuit Court requesting visitation with Child and custody should the court find sufficient circumstances detrimental to Child. On July 24, 2015, the Petition for Third Party Rights and Visitation Time was withdrawn.

VII.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f)(g), OAR 851-045-0070(n) which read as follows:

**678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee.** In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(f) Conduct derogatory to the standards of nursing.

(g) Violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder.

**851-045-0070**

**Conduct Derogatory to the Standards of Nursing Defined**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(1) Conduct related to the client's safety and integrity:

(n) Failing to maintain professional boundaries with a client.

Licensee wishes to cooperate with the Board in this matter. Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the Registered Nurse license of Deborah Sanders be reprimanded.**

Licensee understands that the conduct resulting in the violations of law described in this Order are considered by the Board to be of a grave nature and, if continued, constitutes a serious danger to public health and safety.

Licensee understands that in the event she engages in future conduct resulting in violations of law or the Nurse Practice Act, the Board may take further disciplinary action against her license, up to and including revocation of her license to practice as a Registered Nurse.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval

and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Reprimand.

\_\_\_\_\_  
Deborah Sanders, RN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Gary Hickmann, RN  
Board President

\_\_\_\_\_  
Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Joshua Shepherd, RN** ) **VOLUNTARY SURRENDER**  
)  
**License No. 201141505RN** ) **Reference No. 15-00950**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Registered Nurses. Joshua Shepherd (Licensee) was issued a Registered Nurse License by the Board on June 29, 2011.

On or about January 5, 2015, Licensee was reported to the Board for allegations that he was arrested following an incident at Salem Hospital. The Board opened an investigation into the matter.

On or about December 31, 2014, Licensee was arrested for Driving Under the Influence of Intoxicants and Official Misconduct. Licensee was under the influence of a controlled substance and was on duty as a nurse at the time of his arrest.

Between February 6, 2015, and February 17, 2015, Licensee was charged with several crimes in multiple jurisdictions.

Licensee's Registered Nurse License was suspended by the Board on February 10, 2015.

On June 24, 2015, Licensee entered a no contest plea to DUII, Resisting Arrest, Failure to Perform the Duties of a Driver, Interfering with a Police Officer, and a second DUII in Marion County, Oregon. Multiple other charges were dismissed.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111 (1)(b),(e), and (f) and OAR 851-045-0070(1)(j) and (n) and (4)(b) and (5)(c) and (d) and (7)(a) and (c) which read as follows:

**ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee.** In the manner prescribed in ORS chapter 183 for a contested case:

- (1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:
  - (b) Gross incompetence or gross negligence of the licensee in the practice of nursing at the level for which the licensee is licensed.
  - (e) Impairment as defined in ORS 676.303.
  - (f) Conduct derogatory to the standards of nursing.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(1) Conduct related to the client's safety and integrity:

(j) Leaving or failing to complete any nursing assignment, including a supervisory assignment, without notifying the appropriate personnel and confirming that nursing assignment responsibilities will be met.

(n) Failing to maintain professional boundaries with a client.

(4) Conduct related to achieving and maintaining clinical competency:

(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

(5) Conduct related to impaired function:

(c) Practicing nursing when physical or mental ability to practice is impaired by use of drugs, alcohol or mind-altering substances.

(d) Use of drugs, alcohol or mind-altering substances to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice for which the licensee is licensed.

(7) Conduct related to the licensee's relationship with the Board:

(a) Failing to provide the Board with any documents requested by the Board.

(c) Failing to fully cooperate with the Board during the course of an investigation, including but not limited to, waiver of confidentiality privileges, except client-attorney privilege.

Licensee wishes to cooperate with the Board in this matter and voluntarily surrender his Registered Nurse license.

Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the voluntary surrender of the Registered Nurse license of Joshua Shepherd be accepted. If, after a minimum of three years, Mr. Shepherd wishes to reinstate his Registered Nurse license, he may submit an application to the Board to request reinstatement.**

**Upon application, Mr. Shepherd will be required to provide documentation of at least two years sobriety, obtain a chemical dependency evaluation and follow any treatment recommendations requested by the evaluator and/or any other requests by the Board.**

**The three year period referenced above shall begin February 10, 2015, the date the Emergency Suspension of Shepherd's Registered Nurse license was Ordered by the Board.**

Licensee agrees that he will not practice as a Registered Nurse from the date he signs this Order.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, he waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce him to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

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Joshua Shepherd, RN

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Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

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Bonnie Kostelecky, MS, MPA, RN  
Board President

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Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of** ) **STIPULATED ORDER FOR**  
**Lauri Kaye Wallace, LPN** ) **VOLUNTARY SURRENDER OF**  
**(A.K.A.: Lauri Kaye Sutton)** ) **PRACTICAL NURSE LICENSE**  
)  
**License No. 092005260LPN** ) **Reference No. 16-01046**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Licensed Practical Nurses. Lauri Wallace (Licensee) was issued a Practical Nurse license by the Board on April 21, 1993.

On or about December 23, 2015, Licensee practiced nursing while impaired by controlled substances.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(f) and (g) and OAR 851-045-0070(5)(c) and (d) which provide as follows:

**ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee.** In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

- (f) Conduct derogatory to the standards of nursing.
- (g) Violation of any provision of ORS 678.010 to 678.445 or rules adopted thereunder.

**OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined**

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

- (5) Conduct related to impaired function:
  - (c) Practicing nursing when physical or mental ability to practice is impaired by use of drugs, alcohol or mind-altering substances.
  - (d) Use of drugs, alcohol or mind-altering substances to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice for which the licensee is licensed.

Licensee wishes to cooperate with the Board in this matter and voluntarily surrender her Practical Nurse license.

Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the voluntary surrender of the Practical Nurse license of Lauri Wallace be accepted. If, after a minimum of three years, Ms. Wallace wishes to reinstate her Practical Nurse license, she may submit an application to the Board to request reinstatement.**

Licensee agrees that she will not practice as a Licensed Practical Nurse from the date she signs this Stipulated Order.

Licensee understands that this Stipulated Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Stipulated Order.

Licensee understands that this Stipulated Order is a document of public record.

Licensee has read this Stipulated Order, understands this Stipulated Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

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Lauri Kaye Wallace, LPN

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Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

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Bonnie Kostelecky, MS, MPA, RN  
Board President

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Date

**BEFORE THE OREGON  
STATE BOARD OF NURSING**

**In the Matter of  
Tracy Wilkinson, LPN**

) **STIPULATED ORDER FOR  
VOLUNTARY SURRENDER**

**License No. 000007791LPN**

) **Reference No. 15-00332**

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The Oregon State Board of Nursing (Board) is the state agency responsible for licensing, regulating and disciplining certain health care providers, including Licensed Practical Nurses. Tracy Wilkinson (Licensee) was issued a Licensed Practical Nurse License by the Board on December 2, 1974.

On or about September 8, 2014, Licensee self-reported that she had been arrested for criminal possession of dangerous drugs. An investigation was opened into the matter.

On or about September 25, 2014, the Board received information that Licensee entered into a deferred prosecution agreement for criminal possession of dangerous drugs.

On March 12, 2015, Licensee received a chemical dependency evaluation. The evaluator recommended intensive outpatient treatment and Licensee completed this treatment in September 2015.

On October 27, 2015, Licensee admitted to having a history of consuming large amounts of alcohol on a regular basis.

By the above actions, Licensee is subject to discipline pursuant to ORS 678.111(1)(a)(e)(f)(g) and OAR 851-045-0070(2)(i)(5)(d) which read as follows:

ORS 678.111 Causes for denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the manner prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:

(e) Impairment as defined in ORS 676.303.

(f) Conduct derogatory to the standards of nursing.

(g) Violation of any provision of ORS 678.010 to 678.448 or rules adopted thereunder.

OAR 851-045-0070 Conduct Derogatory to the Standards of Nursing Defined

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(2) Conduct related to other federal or state statute/rule violations:

(i) Possessing, obtaining, attempting to obtain, furnishing, or administering prescription or controlled drugs to any person, including self, except as directed by a person authorized by law to prescribe drugs.

(5) Conduct related to impaired function:

(d) Use of drugs, alcohol or mind-altering substances to an extent or in a manner dangerous or injurious to the licensee or others or to an extent that such use impairs the ability to conduct safely the practice for which the licensee is licensed.

Licensee wishes to cooperate with the Board in this matter and voluntarily surrender her Licensed Practical Nurse license.

Therefore, the following will be proposed to the Oregon State Board of Nursing and is agreed to by Licensee:

**That the voluntary surrender of the Licensed Practical Nurse license of Tracy Wilkinson be accepted. If, after a minimum of three years, Ms. Wilkinson wishes to reinstate her Licensed Practical Nurse license, she may submit an application to the Board to request reinstatement.**

Licensee agrees that she will not practice as a Licensed Practical Nurse from the date she signs this Order.

Licensee understands that this Order will be submitted to the Board of Nursing for its approval and is subject to the Board's confirmation.

Licensee understands that by signing this Stipulated Order, she waives the right to an administrative hearing under ORS 183.310 to 183.540, and to any judicial review or appeal thereof. Licensee acknowledges that no promises, representations, duress or coercion have been used to induce her to sign this Order.

Licensee understands that this Order is a document of public record.

Licensee has read this Stipulated Order, understands this Order completely, and freely signs this Stipulated Order for Voluntary Surrender.

\_\_\_\_\_  
Tracy Wilkinson, LPN

\_\_\_\_\_  
Date

**ORDER**

IT IS SO ORDERED:

**BOARD OF NURSING FOR THE STATE OF OREGON**

\_\_\_\_\_  
Bonnie Kostelecky, MS, MPA, RN  
Board President

\_\_\_\_\_  
Date