State Office of Administrative Hearings

Cathleen Parsley
Chief Administrative Law Judge

July 31, 2014

Nicole Oria
Executive Director
Texas State Board of Veterinary Medical Examiners
333 Guadalupe, Ste 3-810
Austin, Texas 78701-3942

RE: Docket No. 578-14-2551; Texas Board of Veterinary Medical Examiners v. Darrell Kinnard, D.V.M.

Dear Ms. Oria:

I issued the Proposal for Decision (PFD) in this case on June 20, 2014. The respondent, Darrell Kinnard, D.V.M., filed exceptions on July 7, 2014. The staff of the Texas Board of Veterinary Examiners (Board) did not file any reply to the exceptions. Having reviewed the respondent’s exceptions, I have determined that they do not require any amendment of the PFD.

As to the dispensing of Ureeze on December 12, 2011, Dr. Kinnard’s exceptions primarily reflect disagreement with how I weighed the evidence. However, Dr. Kinnard makes two assertions about the evidentiary record that are incorrect. First, he asserts, “Ms. Nabors testified that she could not remember getting a script for Ureeze on 12/11/12.” In fact, Ms. Nabors stated that, at that visit, “I received a prescription for Ureeze.” Further, Dr. Kinnard says, “[Ms. Nabors] could not remember whether she told Dr. Kinnard that she did not need Ureeze because she already had it.” Actually, Ms. Nabors was never asked about, and did not testify whether, she had declined the Ureeze. She was only asked whether she told Dr. Kinnard that she already had some Ureeze, and she testified that she did not remember if she had said that. She did not testify that she could not recall whether she had turned down Ureeze because she already had some.

1 Dr. Kinnard’s exceptions incorrectly identify the relevant date as “December 11, 2012.”
2 Respondent’s Exceptions to Proposal for Decision at 1.
3 Audio recording of hearing at approximately 10:40.
4 Respondent’s Exceptions to Proposal for Decision at 1.
5 Audio recording of hearing at approximately 12:30 to 17:30.
SOAH Docket No. S78-14-2551
Exceptions Letter
Page 2

With respect to the recordkeeping violations, Dr. Kinnard’s exceptions go to the significance, and not the fact, of his failure to comply with the applicable rule. The PFD takes the relative lack of seriousness of the violations into account in the discussion of sanction.6

The PFD is ready for the Board’s consideration.

Sincerely,

[Signature]

Shannon Kilgore
Administrative Law Judge

SK/eh
xo: Jonathan Crabtree, Texas State Board of Veterinary Medical Examiners, 333 Guadalupe, Ste. 3-810, Austin, TX 78701-3942 – VIA FACSIMILE NO. 512/305-7574
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6 PFD at 17.

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AGENCY: Veterinary Medical Examiners, Texas State Board of (TBVME)

STYLE/CASE: DARRELL KINNARD, DVM

SOAH DOCKET NUMBER: 578-14-2551

REFERRING AGENCY CASE:

<table>
<thead>
<tr>
<th>STATE OFFICE OF ADMINISTRATIVE HEARINGS</th>
<th>ADMINISTRATIVE LAW JUDGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>REPRESENTATIVE / ADDRESS</td>
<td>ALJ SHANON KILGORE</td>
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PARTIES

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<tr>
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DATE: 07/31/2014
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DOCKET NUMBER: 578-14-2551
JUDGE SHANNON KILGORE

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Cathleen Parsley
Chief Administrative Law Judge

June 20, 2014

Nicole Oria
Executive Director
Texas State Board of Veterinary Medical Examiners
333 Guadalupe, Ste 3-810
Austin, Texas 78701-3942

RE: Docket No. 578-14-2551; Texas Board of Veterinary Medical Examiners v. Darrell Kinnard, D.V.M.

Dear Ms. Oria:

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

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

Sincerely,

Shannon Kilgore
Administrative Law Judge

VIA INTERAGENCY

SK/mm
Enclosures (with 1 CD) – VIA INTERAGENCY
xc: Jonathan Crabtree, Texas State Board of Veterinary Medical Examiners, 333 Guadalupe, Ste. 3-810, Austin, TX 78701-3942 – VIA INTERAGENCY
Laura Moriarty, General Counsel, Texas State Board of Veterinary Medical Examiners, 333 Guadalupe, Ste. 3-810, Austin, TX 78701-3942 – VIA INTERAGENCY
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SOAH DOCKET NO. 578-14-2551

TEXAS BOARD OF VETERINARY MEDICAL EXAMINERS, Petitioner

v.

DARRELL KINNARD, D.V.M., Respondent

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Veterinary Medical Examiners (Board) seeks disciplinary sanctions against the respondent, Darrell Kinnard, D.V.M., a veterinarian licensed by the Board. Staff alleges that Dr. Kinnard violated the Board's rules with respect to one patient by inadequately labeling prescribed medications and maintaining insufficient medical records.

The Administrative Law Judge (ALJ) determines that Dr. Kinnard committed some, but not all, of the alleged violations. The ALJ recommends that he receive a formal reprimand, that he be required to undergo continuing education, and that he be assessed an administrative penalty of $500.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There are no contested issues of notice or jurisdiction in this proceeding. Therefore, those matters are addressed in the findings of fact and conclusions of law without further discussion here.

The hearing on the merits was held on April 15, 2014, before ALJ Shannon Kilgore at the hearing facilities of the State Office of Administrative Hearings (SOAH), 300 West 15th Street, Fourth Floor, Austin, Texas. Staff was represented by Jonathan Crabtree, Staff Attorney. Respondent was represented by attorney Donald A. Ferrill. After post-hearing closing arguments were filed by the parties, the record closed on May 9, 2014.
II. APPLICABLE STATUTES AND RULES

The Board is authorized to take disciplinary action against a Texas veterinarian who has engaged in conduct that violates the Board's rules of professional conduct.¹ Among the Board's disciplinary powers is the authority to revoke or suspend a license, reprimand a license holder, impose administrative penalties, and require license holders to participate in continuing education programs.²

In this case, Staff alleges that Dr. Kinnard violated two Board rules. Rule 573.40 provides:

(a) A veterinarian shall affix labels to all unlabeled containers containing any medication dispensed and to all factory labeled containers that contain prescription (legend) drugs and/or controlled substances dispensed. The label must be affixed to the immediate container and include:

   (1) the veterinarian's name, address, and telephone number (including area code);
   (2) date of delivery or dispensing;
   (3) patient/client name (and address if drug is a controlled substance);
   (4) species of the animal;
   (5) name, strength, and quantity of the drug dispensed;
   (6) directions for use; and
   (7) cautionary statements as required by law, i.e. not for human consumption, poisonous, withdrawal periods, etc.³

Rule 573.52, which sets the required standards for patient record keeping, provides in relevant part:

(a) Individual [patient] records will be maintained at the veterinarian's place of business, that are complete, contemporaneous and legible and include, but are not limited to:

² Id. §§ 801.401, 801.451.
(11) names, dosages, concentration, and routes of administration of each
drug prescribed, administered and/or dispensed.

(b) Maintenance of Patient Records.

(1) Patient records shall be current and readily available for a
minimum of five years from the anniversary date of the date of last
treatment by the veterinarian.

(2) A veterinarian may destroy medical records that relate to any
civil, criminal or administrative proceeding only if the veterinarian
knows the proceeding has been finally resolved.

(3) Veterinarians shall retain patient records for such longer
length of time than that imposed herein when mandated by other
federal or state statute or regulation.

(4) Patient records are the responsibility and property of the
veterinarian or veterinarians who own the veterinary practice,
provided however, the client is entitled to a copy of the patient
records pertaining to the client’s animals.

(5) If the veterinarian discontinues his or her practice, the
veterinarian may transfer ownership of records to another licensed
veterinarian or group of veterinarians only if the veterinarian
provides notice consistent with §573.55 of this title (relating to
Transfer and Disposal of Patient Records) and the veterinarian who
assumes ownership of the records shall maintain the records
consistent with this chapter.4

The Board’s Recommended Schedule of Sanctions, located at 22 Texas Administrative
Code § 575.25, establishes that violating a rule of professional conduct is a Class B violation if
the person has committed a prior violation. Maximum penalties for Class B violations include
(A) a one to ten-year license suspension with none, all, or part probated; (B) a penalty not
exceeding $5,000 for each violation per day; (C) continuing education in a specified field related
to the licensee’s practice that the Board deems relevant to the violation(s); (D) quarterly
reporting certifying compliance with board orders; and/or (E) taking specified exams.5

4 22 Tex. Admin. Code § 573.52. The quoted language from the rule has remained unchanged since the time of the
conduct at issue in this case. However, § 573.52(a)(11) has since been amended to include the following additional
language: “If a drug is approved by the United States Food and Drug Administration (FDA) in only one
concentration and the veterinarian is administering the FDA-approved drug at the FDA-approved concentration, the
veterinarian may omit recording the concentration of the drug administered[.]”

In assessing sanctions and penalties, consideration shall be given to: the seriousness of the violation, including the nature, circumstances, extent, and gravity of any prohibited acts; the hazard or potential hazard created to the health, safety, or economic welfare of the public; the economic harm to property or the environment caused by the violation; the history of previous violations; what is necessary to deter future violations; and any other matters that justice may require.\textsuperscript{6}

III. OVERVIEW OF EVIDENCE

This case concerns medications and recordkeeping in connection with the care of C.J., a fourteen-year-old male miniature Schnauzer dog, on December 12, 2011, and March 21, 2012, at the Mabank Animal Hospital, a veterinary clinic in Mabank, Texas. The Mabank Animal Hospital is owned by Dr. Kinnard. The evidence in this case consists of:

- Medical records from Dr. Kinnard’s clinic for the treatment of C.J. (Petitioner’s Exhibit 1).

- A dark brown glass bottle (with a dropper-top) bearing a label, dated March 21, 2012, from the Mabank Animal Hospital indicating, among other things, that the bottle contains a medication called Clavamox for C.J. (Petitioner’s Exhibit 3) (Clavamox bottle).

- An orange plastic pill container bearing a label, dated December 12, 2011, from the Mabank Animal Hospital indicating, among other things, that it contains a medication called Ureeze\textsuperscript{7} for C.J. (Petitioner’s Exhibit 4) (Ureeze container).

- Three prior agreed Board orders against Dr. Kinnard (Petitioner’s Exhibit 5).

- The testimony of Sharon Nabors, C.J.’s owner.

- The testimony of Dennis Barker, Jr., an investigator with the Board.

\textsuperscript{6} 22 Tex. Admin. Code § 575.25(b)(2).

\textsuperscript{7} The ALJ is unsure how to spell the name of this medication and uses the spelling employed in Staff’s pleadings and on the container, Petitioner’s Exhibit 4.
• The testimony of Don McLeod, D.V.M., an expert witness called by Staff. Dr. McLeod has been a veterinarian for 39 years and has been licensed in Texas since 1975. He has owned his own veterinary clinic in Austin since 1978.

• The testimony of Dr. Kinnard.

• The testimony of Tincey Crocker, the office manager for the Mabank Animal Hospital.

IV. ALLEGED VIOLATIONS ON DECEMBER 12, 2011

A. Evidence

It is undisputed that, on December 12, 2011, Ms. Nabors brought C.J. to the Mabank Animal Clinic because of urinary tract problems and that Dr. Kinnard examined him on that date.

Ms. Nabors testified that Dr. Kinnard prescribed Ureece and sent the medication home with her in a bottle that she later gave to Staff. She testified that she did not recall whether she already had some Ureece at home or whether she told Dr. Kinnard that she already had some. She did not see who filled out the label on the bottle.

The label on the Ureece container in evidence is pre-printed with the name, “Mabank Animal Hospital,” and the clinic’s address and telephone number (without the area code). There are also pre-printed words followed by spaces for handwritten entries, as follows:

**Patient**, filled in with “C.J.”;

**Drug**, filled in with “Ureece”;

**Size**, left blank;

**Date**, filled in with “12-12-11”;

**For**, filled in with “Acid [illegible]”;

**No.**, filled in with “30”;
Exp., left blank; and

Directions, filled in with “1 Tablet Once Daily.”

A handwritten notation in pencil (in contrast with the other handwriting on the label, which is in pen) reads, “kidney stones.” It does not appear to have been written by the same person who filled out the rest of the label. Also on the container are the notations: “For animal use only” and “Keep out of reach of children or pets. Not for human use.”

C.J.’s medical records include both computer-entered items and handwritten notes for each date of service at issue. For December 12, 2011, the computer records reference lab work, an x-ray, an antibiotic injection, and a bottle of Clavamox drops. The handwritten notes for that date are as follows:

18.9# Blood in urine T101.1 XRay
bladder – Dx cystitis CBC panel—good
Tx Pen 1 ½-⅔ Gen

There is no mention of Ureeze in the medical records for this date. There is also no mention of Ureeze having been dispensed to C.J. on any prior date of service.

Mr. Barker, the Board’s investigator, testified that “Pen” sometimes means Penicillin, an antibiotic, and “Gen” sometimes is an abbreviation for “Gentocin,” another antibiotic. He said that, usually, injection amounts are expressed in cubic centimeters (cc), or milliliters (ml). He further stated that he does not know who wrote the label on the Ureeze container.

Dr. Kinnard testified that Ms. Nabors brought C.J. to the clinic on December 12, 2011, because he was not urinating. Dr. Kinnard ordered lab work and radiographs to rule out kidney

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8 Petitioner’s Ex. 4.
9 Petitioner’s Ex. 1 at 1.
10 Id. at 2. Dr. Kinnard testified that he wrote the words “XRay” through “Gen.”
stones and other internal problems. In addition, he stated, C.J. was administered an antibiotic injection (1.5 cc Penicillin, .5 cc Gentocin) subcutaneously. The dosage for a small dog would have been in cc's, he said. He further testified that he prescribed two medications that day: Clavamox and Ureeze. He stated that Ms. Nabors declined the Ureeze, saying that she already had some at home. Therefore, according to Dr. Kinnard, he prescribed Uereeze that day, but he did not dispense any. Because he did not dispense that medication, he did not note it in the medical record for that day. Dr. Kinnard testified that the label on the Uereeze container was not filled out in the manner his clinic's personnel filled out labels in 2011 and 2012, in that information was missing on the label; his personnel always filled out all blanks, he said. Further, he said, the handwriting on the Uereeze container was not his and did not look like that of any of his employees. He added that, without information about medication quantity on the container, his staff would not be able to check a client out following the visit.

Ms. Crocker, who has been the clinic's office manager for five years, testified that, at the time of the events at issue in this case, the Mabank Animal Hospital used the pre-printed labels with blanks that are on the Uereeze container and the Clavamox bottle. The vet technicians filled in the blanks on the labels by hand.

Ms. Crocker testified that Ms. Nabors was her personal friend who later filed a complaint against Dr. Kinnard. For these reasons, said Ms. Crocker, she actually recalls the two visits at issue in this case, even though the clinic averages fifteen to twenty patients per day. She stated that she is the person who processes clients at the end of their visits, performing the billing and handing the clients their pets’ medications. Without the full information on the container, she said, she would have been unable to check C.J. out. According to Ms. Crocker, she worked full-time on December 12, 2011, and she checked Ms. Nabors and C.J out that day. Ms. Crocker said that no Uereeze was dispensed to C.J. that day, she did not hand Ms. Nabors the Uereeze container, and she did not see anyone else hand Ms. Nabors the Uereeze container. Ms. Crocker did not recall any conversation with Ms. Nabors about her already having Uereeze. Furthermore,

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11 Ms. Crocker and Dr. Kinnard testified that the Mabank Animal Hospital has since (at considerable expense, according to Dr. Kinnard) implemented a system of using electronic medical records and computer-generated labels for all medications dispensed.
Ms. Crocker stated, she is familiar with the handwriting of Dr. Kinnard and of all the vet technicians at the clinic, and she does not recognize the handwriting on the Ureeze container (and it did not appear to be that of Dr. Kinnard, who usually printed). When asked where the labels were kept, she said that they were kept in the clinic’s pharmacy, an area not open to the public. However, she added, other veterinarians, including one or more competitors of Dr. Kinnard, had visited that area on occasion.

Dr. McLeod, Staff’s expert witness, expressed some uncertainty about the medication administered to C.J. on December 12, 2011, but acknowledged that Penicillin could be “Pen.” He also stated that that veterinarians commonly abbreviate the antibiotic Gentocin as “Gen” and that Penicillin and Gentocin are often administered together. He said that he would interpret the “1½” in the note to reflect that 1.5 cc of Penicillin was given to C.J. Although Dr. McLeod testified that there have been many generations of Penicillin, he did not say that it is necessary or important to record what generation of Penicillin is administered.

According to Dr. McLeod, the antibiotic’s route of administration was not recorded, other than the term “injection.” There are various routes of administration by injection, he explained: intramuscular, intravenous, and subcutaneous. He acknowledged, however, that Penicillin typically is administered by subcutaneous or intramuscular injection only (although the only significance, if any, between those two methods of administration would have been the speed of absorption).

Dr. McLeod agreed that the Ureeze container was missing information, including the area code, veterinarian’s name, client’s name, patient’s species, and medication strength. However, he said that the lack of area code, species name, and veterinarian (so long as the clinic is identified) could cause little harm.

B. Alleged Medication Labeling Violations

Staff alleges that Dr. Kinnard violated Board Rule 573.40(a) by dispensing Ureeze in a container with a label missing the following required information: the veterinarian’s name, the
area code for the veterinarian’s telephone number, the species of the animal, the name of the client who owned the animal, and the strength and quantity of the drug dispensed. Dr. Kinnard asserts that neither he nor anyone in his clinic dispensed Ureeze to C.J. on December 12, 2011.

The ALJ finds the preponderance of the evidence supports a finding that Dr. Kinnard dispensed Ureeze to C.J. on December 12, 2011. The parties agree that Dr. Kinnard saw C.J. on that date for urinary problems. The evidence in this case includes a pill container bearing a label that, all parties agree, is one of the pre-printed labels used by the Mabank Animal Clinic in 2011. The container’s label, dated December 12, 2011, reflects that it contained Ureeze for C.J. Dr. Kinnard testified that the clinic did not dispense Ureeze to C.J. on that date because Ms. Nabors said that she already had some. Ms. Crocker stated that no one at the clinic gave Exhibit 4 to Ms. Nabors, and the handwriting on the container did not appear to be that of anyone employed at the clinic. The ALJ does not find their testimony persuasive, however, for two reasons. First, Ms. Nabors testified that she did receive Ureeze for C.J. that day, and that she gave the pill container to Staff. Second, if the Mabank Animal Clinic did not provide the container to Ms. Nabors, there is no credible explanation for the existence of Petitioner’s Exhibit 4. Hints by Dr. Kinnard and Ms. Crocker that Ms. Nabors and/or a rival veterinarian may have stolen labels and filled them out inadequately (presumably in an effort to discredit Dr. Kinnard) are too speculative to cast significant doubt on the authenticity of the pill container.12

Staff has shown by a preponderance of the evidence that:

- Dr. Kinnard prescribed Ureeze to C.J. on December 12, 2011;
- the Mabank Animal Clinic dispensed the Ureeze to Ms. Nabors; and
- Dr. Kinnard violated Board Rule 573.40(a) by failing to affix a label to the Ureeze that included the veterinarian’s name, the area code for the veterinarian’s telephone number,

12 Staff objected to testimony by Ms. Nabors about handwriting. The ALJ overruled the objection but took the objection under advisement in considering the weight of the evidence. In analyzing the evidence, the ALJ has considered this testimony but ultimately found it unpersuasive for the reasons stated above.
the species of the animal, the name of the client who owned the animal, and the strength of the drug dispensed.\textsuperscript{13}

C. Alleged Medical Recordkeeping Violations

Board Rule 573.52(a)(11) requires veterinarians to document the names, dosages, concentration, and routes of administration of each drug prescribed, administered and/or dispensed. Staff alleges that Dr. Kinnard violated this rule by failing to include any information whatsoever about Ureeze in the medical record for December 12, 2011, and by failing to note the name, concentration, route of administration, or dosage of the antibiotic administered to C.J. on that date. Dr. Kinnard argues that he did not dispense Ureeze on that date, and he points out that the medical record actually contains considerable information about the antibiotic administered.

For the reasons discussed above, the ALJ has determined that Staff has shown Dr. Kinnard dispensed Ureeze to C.J. on December 12, 2011. By failing to include any information about the Ureeze in the medical record for that date, Dr. Kinnard violated the Board’s rule.

As to the injection of antibiotics, the ALJ finds that medical record includes much of the required information in a shorthand form. Staff’s expert, Dr. McLeod, acknowledged that Penicillin can be abbreviated as “Pen,” that “Gen” is a common abbreviation for Gentocin, and that the two are often administered together. Further, Dr. McLeod testified that he assumed that the notation “Pen 1 ½” indicated 1.5 cc of Penicillin was administered; Dr. Kinnard testified that this was, in fact, the case, and that the “½ Gen” similarly referenced .5 cc of Gentocin administered. As the rule neither prohibits abbreviations nor specifies the level of detail required, the ALJ concludes that Staff failed to show Dr. Kinnard violated the recordkeeping rule with respect to the names and dosages of the antibiotics. However, there is no documentation of the concentration of the antibiotics, and this failure violated the rule.\textsuperscript{14}

\textsuperscript{13} The Ureeze container’s label did include the quantity of medication dispensed.

\textsuperscript{14} Even if there were a standard concentration for each of these medications (which is not clear from the record), the rule in effect at the time still required documentation of the concentration.
administration, the record indicates that the antibiotics were given by injection. However, Dr. McLeod testified that injections can be given in three ways—intravenous, intramuscular, or subcutaneous—and his testimony suggested that the specific kind of injection should be documented. He went on to say that Penicillin is typically administered by intramuscular or subcutaneous injection. Neither of these was noted in the medical record. Dr. Kinnard’s failure to specify the route of administration for the antibiotics, therefore, violated the rule.

D. Summary of December 12, 2011 Violations

Staff proved that Dr. Kinnard violated Board Rule 573.40(a) by failing to affix a label to the Ureeze dispensed on December 12, 2011, that included all the information required. Staff further proved that Dr. Kinnard’s medical records for C.J.’s December 12, 2011 visit violated Board Rule 573.52(a)(11) in that they failed to include any of the required information concerning the Ureeze dispensed on that date. And, Staff proved that Dr. Kinnard also violated Board Rule 573.52(a)(11) by failing to document the concentration and route of administration of the antibiotics administered during the visit.

V. ALLEGED VIOLATIONS ON MARCH 21, 2012

A. Evidence

Ms. Nabors took C.J. to the Mabank Animal Hospital on March 21, 2012. It is undisputed that C.J. was examined by Wesley Archer, D.V.M. Ms. Nabors testified that she was sent home with a bottle of liquid Clavamox that she later gave to Staff.

The label on the Clavamox bottle is similar to the one on the Ureeze container. The Clavamox bottle label is pre-printed with the name, “Mabank Animal Hospital,” and the clinic’s address and telephone number (without the area code). There are also pre-printed words followed by spaces for handwritten entries, as follows:
Patient, filled in with "C.J.";

Drug, filled in with "Clavamox";

Size, left blank;

Date, filled in with "3-21-12";

For, filled in with "Cystitis";

No., left blank;

Exp., left blank; and

Directions, filled in with "Give 1 dropper full twice daily."

Also on the container is the notation: "Keep out of reach of children or pets. Not for human use." The handwriting on the Clavamox bottle appears to be different from the handwriting on the Ureece container.

C.J.'s computer-entered medical record for the March 21, 2012 visit references one bottle of Clavamox drops. The handwritten entry says, "Rx Clavamox 1 dropper full twice a day."

Mr. Barker testified that he does not know who wrote the label on the Clavamox bottle or who gave the bottle to Ms. Nabors.

Dr. Kinnard stated that Dr. Archer was a relief veterinarian, and not a regular employee of the Mabank Animal Hospital, seeing patients on March 21, 2012, when Dr. Kinnard was out of the office. According to Dr. Kinnard, Dr. Archer was a licensed veterinarian practicing under his own license and responsible for the quality of his own work, including his records. Dr. Kinnard testified that, as owner of the clinic, he owns and must keep the medical records pertaining to the clinic's patients, but the content of the individual records is the responsibility of the treating veterinarians.

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15 Petitioner's Ex. 3.
As to the Clavamox bottle, Dr. Kinnard stated that it was not filled out in the manner his clinic’s personnel filled out labels in 2011 and 2012, in that information was missing on the label. However, he noted, Clavamox comes in a standard concentration. Further, he said, he did not fill out the label, and the handwriting on the label did not appear to be that of any of his employees.

Ms. Crocker testified that she was at work on March 21, 2012, and she charged out Ms. Nabors on that day. She said that she did not hand the Clavamox bottle to Ms. Nabors. Moreover, Ms. Crocker did not see anyone hand the bottle to Ms. Nabors.

Dr. McLeod testified that the Clavamox bottle label is missing the concentration and total amount. However, he acknowledged that Clavamox comes in a standard concentration, that one dropper is the standard dose, and that it would be possible to calculate the exact dosage. He further testified that each licensed veterinarian is responsible for his or her own conduct.

B. Alleged Labeling and Recordkeeping Violations

Staff alleges that Dr. Kinnard violated Board Rule 573.40(a) by dispensing Clavamox without labeling it with the name of the veterinarian, the area code of the clinic’s phone number, the species of the animal, the name of the client, and the strength of the drug. Staff further alleges that Dr. Kinnard violated Board Rule 573.52(a)(11) by failing to include the dosage and concentration of the Clavamox prescribed and dispensed.16

The ALJ finds, for reasons similar to those related to the Ureeze container, that a bottle of Clavamox was dispensed for C.J. from the Mabank Animal Hospital on March 21, 2012. It is undisputed that C.J. was seen at the clinic that day. The evidence in this case includes a bottle bearing a label that, all parties agree, is one of the pre-printed labels used by the Mabank Animal Clinic in early 2012. The container’s label, dated March 21, 2012, reflects that it contained

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16 Although the record reflects that Clavamox came in a standard concentration (and the dosage could be calculated from the concentration), and Board Rule 573.52(a)(11) has been amended to relax the requirement of documenting the concentration in such cases, the rule in effect on March 21, 2011, had no such exception.
Clavamox for C.J. C.J.’s medical records show that Clavamox was prescribed for him that day. Ms. Nabors testified that she received the Clavamox bottle for C.J. and that she gave the bottle to Staff. As with the Utreeze container, if the Mabank Animal Clinic did not provide the bottle to Ms. Nabors, there is no credible explanation for the existence of Petitioner’s Exhibit 3.

Further, the ALJ agrees with Staff that the label on the Clavamox bottle violated Board Rule 573.40(a) in that it lacked the name of the veterinarian, the area code of the clinic’s phone number, the species of the animal, the name of the client, and the strength and quantity of the drug. In addition, C.J.’s medical record for March 21, 2012, violated Board Rule 573.52(a)(11) in that it did not document the dosage and concentration of the Clavamox prescribed and dispensed.

However, although C.J. was seen at the Mabank Animal Hospital on March 21, 2012, and rule violations occurred in connection with his visit, the ALJ cannot conclude that Dr. Kinnard committed any act or omission in violation of the Board’s rules.

It is undisputed that Dr. Kinnard did not treat C.J. in his March 21, 2012 visit to the Mabank Animal Hospital. In fact, the evidence reflects that Dr. Kinnard was not at the clinic that day. The evidence further reflects that another veterinarian, Dr. Archer, practicing under his own license, treated C.J. that day. Rule 573.40(a) reads, “A veterinarian shall affix labels . . . .” The rule imposes the labeling responsibility on the veterinarian, not the clinic owner. It would be a considerable stretch to read this language to require the owner of a clinic to be responsible for the label of a medication prescribed by another, licensed veterinarian and dispensed in the owner’s absence. Staff argues that Dr. Kinnard is responsible for the label on every medication dispensed from his clinic, regardless of whether he or another licensed veterinarian prescribed it; however, Staff cites to no legal authority for this assertion.\textsuperscript{17} Even Staff’s own expert, Dr. McLeod, testified that every licensed veterinarian is responsible for his or her own conduct. The Board’s rules (those in effect in 2012 and those in effect now) include provisions addressing the responsibility of licensed veterinarians for actions by various licensed and non-licensed veterinarians.

\textsuperscript{17} Petitioner’s Closing Brief at 4.
employees, and nowhere do those provisions state that a veterinarian is responsible for the practice-related acts or omissions of other veterinarians practicing under their own licenses. To the contrary, the Board’s rules state, “A licensee shall be responsible for his or her own actions.”

Similarly, any violation of Board Rule 573.52’s recordkeeping requirements on March 21, 2012, was not Dr. Kinnard’s. Staff first points to subsection (a) of the rule, requiring a veterinarian to maintain complete medical records at the veterinarian’s place of business. Staff asserts that, because Dr. Archer was not a regular employee at Mabank Animal Hospital, this provision must somehow mean that Dr. Kinnard was responsible for the content of Dr. Archer’s medical record entries. But a far more reasonable reading of the provision is that a relief veterinarian’s “place of business” is wherever the relief veterinarian is employed to treat animals. Therefore, Dr. Archer was required to make complete and adequate medical entries in C.J.’s medical records at the Mabank Animal Hospital.

Staff also points to subsection (b) of Rule 573.52, which says that patient records are the responsibility and property of the veterinarian or veterinarians who own the veterinary practice. This language, argues Staff, makes any veterinarian who owns a clinic responsible for the content of the medical records created by other licensed veterinarians practicing at the clinic. However, this cited portion of the rule addresses—not the required content or quality of the records—but the ongoing physical upkeep and ownership of the records. Dr. Kinnard, as the owner of the clinic, was responsible under subsection (b) for preserving medical records for the requisite period of time, but the ALJ sees little support in the rule for the assertion that he was also responsible for the content of records created by another licensed veterinarian working in the clinic. As noted above, Dr. McLeod’s testimony and the Board’s rules concerning supervision indicate that each licensed veterinarian is responsible for his or her own practice-related acts.

18 22 Tex. Admin. Code ch. 573, subch. B (“Supervision of Personnel”). To the degree that Staff may be arguing that the Clavamox label was written by an employee of Mabank Animal Hospital, the argument fails because the record does not make clear who actually filled out the label.

For these reasons, the ALJ cannot conclude that Dr. Kinnard committed any violations in connection with C.J.'s March 21, 2012 visit.

VI. SUMMARY AND RECOMMENDED SANCTION

Dr. Kinnard committed the following violations:

- Dr. Kinnard violated Board Rule 573.40(a) by failing to affix a label to the Ureeze container that included the veterinarian's name, the area code for the veterinarian's telephone number, the species of the animal, the name of the client who owned the animal, and the strength of the drug dispensed.

- Dr. Kinnard violated Board Rule 573.52(a)(11) because his medical records for C.J.'s December 12, 2011 visit failed to include any of the required information concerning the Ureeze dispensed on that date.

- Dr. Kinnard also violated Board Rule 573.52(a)(11) by failing to document the concentration and route of administration of the antibiotics administered during the December 12, 2011 visit.

Staff seeks a formal reprimand, assessment of a $1,000 administrative penalty, and a requirement that Dr. Kinnard undergo three hours of continuing education in recordkeeping.

Under the Board's rule governing disciplinary sanctions, a violation of a Board rule by a licensee who has committed a prior violation of the Board's rules is deemed a Class B violation. Dr. Kinnard has been the subject of three prior agreed disciplinary orders issued by the Board, entered in 2004, 2005, and 2013, respectively.\(^{20}\) All of the orders were based on conclusions of law stating that Dr. Kinnard had violated the Board's rules.\(^{21}\) Therefore, all of Dr. Kinnard's violations in this case are considered Class B violations, the maximum penalties for which include a one to ten-year license suspension; a penalty not exceeding $5,000 for each violation

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\(^{20}\) The orders are at Petitioner's Ex. 5.

\(^{21}\) The 2004 order required Dr. Kinnard to take the Board's jurisprudence examination and to submit six patient records to the Board for review. The 2005 order required Dr. Kinnard to pay a penalty of $1,000. The 2013 order reprimanded Dr. Kinnard and required him to pay a $500 administrative penalty.
per day; continuing education; quarterly reporting certifying compliance with board orders; and taking specified exams.\textsuperscript{22}

In determining the exact sanction or sanctions to be imposed, the Board must consider the seriousness of the violation, the hazard or potential hazard created, the economic harm to property or the environment, the history of previous violations, what is necessary to deter future violations, and any other matters that justice may require.\textsuperscript{23}

The violations proven in this case are not the most serious imaginable. No actual harm to the patient was proven. With respect to the labeling of the Urkeeze container, Staff’s own expert testified that the lack of the area code, species name, and veterinarian (so long as the clinic is identified) could cause little harm. No economic harm was shown as to any of the violations. That Dr. Kinnard has had at least one prior violation has already been taken into account by the Board’s rule that subsequent violations fall into Class B; however, the fact that Dr. Kinnard has been the subject of \textit{three} prior orders is of further significance and suggests that a strong deterrent might be necessary. On the other hand, Dr. Kinnard and Ms. Crocker testified that the Mabank Animal Hospital has implemented an expensive new software system and training for employees to address labeling and recordkeeping issues. Finally, that Staff failed to prove several of its allegations must be considered in assessing the sanction.

Staff notes, correctly, that its recommended sanctions in this case are far less severe than the maximum penalties authorized under the statute and rules. The ALJ believes that the record supports the proposed formal reprimand, especially in light of Dr. Kinnard’s extensive history of prior Board orders. The continuing education requirement is also reasonably based on proven deficiencies in Dr. Kinnard’s medical records concerning medications. Dr. Kinnard’s steps to improve and update his clinic’s practices are a good sign, but he did not participate in the training to which he sent his employees. Lastly, given that Staff failed to prove several of the alleged violations, the ALJ recommends that Staff’s proposed penalty be reduced to $500.

\textsuperscript{22} 22 Tex. Admin. Code § 575.25(b)(3).
\textsuperscript{23} 22 Tex. Admin. Code § 575.25(b)(2).
VII. FINDINGS OF FACT

1. Darrell W. Kinnard, D.V.M. is licensed as a veterinarian by the Texas Board of Veterinary Medical Examiners (Board).

2. On March 5, 2014, the Board’s staff (Staff) issued a Notice of Hearing to Dr. Kinnard.

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

4. The hearing on the merits was held April 15, 2014, before Administrative Law Judge (ALJ) Shannon Kilgore at the hearing facilities of the State Office of Administrative Hearings (SOAH), 300 West 15th Street, Fourth Floor, Austin, Texas. The Board was represented by Staff Attorney Jonathan Crabtree. Respondent was represented by attorney Donald A. Ferrill. The record closed on May 9, 2014.

5. At all times relevant to this case, Dr. Kinnard owned the Mabank Animal Hospital in Mabank, Texas.

6. At the time of the events in this case, C.J. was a fourteen-year-old male miniature Schnauzer dog owned by Sharon Nabo.


8. Dr. Kinnard ordered that C.J. be administered an antibiotic shot.

9. Dr. Kinnard also prescribed and dispensed a medication called “Ureeze” to C.J.

10. The Ureeze was dispensed in a container with a label filled out at the Mabank Animal Hospital.

11. The label affixed to the Ureeze container failed to include the veterinarian’s name, the area code for the veterinarian’s telephone number, the species of the animal, the name of the client who owned the animal, and the strength of the drug dispensed.

12. The medical records for C.J.’s December 12, 2011 visit failed to include the name, dosage, concentration, and route of administration of the Ureeze prescribed and dispensed that day.

13. The medical records for C.J.’s December 12, 2011 visit failed to include the concentration and route of administration (intravenous, intramuscular, or subcutaneous injection) of the antibiotics administered to C.J. that day.
14. Ms. Nabors took C.J. to the Mabank Animal Hospital on March 21, 2012, and the animal was examined and treated by Wesley Archer, D.V.M., a relief veterinarian working under his own license.

15. Dr. Kinnard was not present at Mabank Animal Hospital on March 21, 2012.

16. Dr. Archer prescribed a medication called Clavamox to C.J. at the March 21, 2012 visit.

17. The label on the Clavamox bottle for C.J. lacked the name of the veterinarian, the area code of the clinic’s phone number, the species of the animal, the name of the client, and the quantity and strength of the drug.

18. The medical records for C.J.’s March 21, 2012 visit failed to document the dosage and concentration of the Clavamox prescribed and dispensed.

19. No actual harm (economic or otherwise) resulted from any labeling and recordkeeping deficiencies with respect to C.J.’s care.

20. The lack of the area code, species name, and veterinarian (so long as the clinic is identified) on a medication label has little potential to cause harm.

21. Dr. Kinnard has been the subject of three prior agreed disciplinary orders issued by the Board, entered in 2004, 2005, and 2013, respectively. All of the orders were based on conclusions of law stating that Dr. Kinnard had violated the Board’s rules.

22. The Mabank Animal Hospital has implemented an expensive new software system and training for employees to address labeling and recordkeeping issues. Dr. Kinnard did not personally participate in any of the training.

VIII. CONCLUSIONS OF LAW

1. The Board has jurisdiction and authority to take disciplinary action against a licensee who violates the Board’s rules of professional conduct. Tex. Occ. Code §§ 801.401, 801.402.

2. The State Office of Administrative Hearings has jurisdiction over all matters relating to the conduct of a hearing in this matter, including the preparation of a proposal for decision with findings of fact and conclusions of law. Tex. Gov’t Code Ch. 2003; Tex. Occ. Code § 801.407.


4. Staff had the burden of proving the case by a preponderance of the evidence. 1 Tex. Admin. Code § 155.427.
5. Dr. Kinnard violated Board Rule 573.40(a) by failing to affix a label to the container of Urechee he prescribed and dispensed to C.J. that included the veterinarian’s name, the area code for the veterinarian’s telephone number, the species of the animal, the name of the client who owned the animal, and the strength of the drug dispensed. 22 Tex. Admin. Code § 573.40(a).

6. Dr. Kinnard violated Board Rule 573.52(a)(11) because his medical records for C.J.’s December 12, 2011 visit failed to include the name, dosage, concentration, and route of administration concerning the Urechee dispensed on that date. 22 Tex. Admin. Code § 573.52(a)(11).

7. Dr. Kinnard violated Board Rule 573.52(a)(11) by failing to document the concentration and route of administration of the antibiotics administered during C.J.’s December 12, 2011 visit.

8. Dr. Kinnard committed no violations of the Board’s rules with respect to C.J.’s visit to the Mabank Animal Hospital on March 21, 2012.

9. Among the Board’s disciplinary powers is the authority to revoke or suspend a license, reprimand a license holder, impose administrative penalties, and require license holders to participate in continuing education programs. Tex. Occ. Code §§ 801.401, 801.451.

10. Under the Board’s schedule of recommended sanctions, Dr. Kinnard’s violations of the rules of professional conduct are properly characterized as Class B violations, for which the Board is authorized to impose up to a 10-year license suspension, an administrative penalty of up to $5,000.00 per violation per day, continuing education requirements relevant to violations, and/or quarterly reporting requirements. 22 Tex. Admin. Code § 575.25(b).

IX. RECOMMENDATION

The ALJ recommends that the Board formally reprimand Dr. Kinnard, impose a $500 administrative penalty, and require Dr. Kinnard to complete a three-hour continuing education class in recordkeeping.

SIGNED June 20, 2014.

[Signature]

SHANNON KILGORE
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS