

**BEFORE THE MINNESOTA
BOARD OF VETERINARY MEDICINE**

In the Matter of
Diane R. Hansen, D.V.M.
License No. 08291

**STIPULATION AND
CONSENT ORDER**

STIPULATION

Diane R. Hansen, D.V.M. ("Licensee"), and the Minnesota Board of Veterinary Medicine ("Board"), by its Complaint Review Committee ("Committee"), agree the above-referenced matter may be resolved without trial of any issue or fact as follows:

I.

JURISDICTION

1. The Board is authorized pursuant to Minnesota Statutes sections 156.001 to 156.20 to license and regulate veterinarians and to take disciplinary action as appropriate.
2. Licensee holds a license from the Board to practice veterinary medicine in the State of Minnesota and is subject to the jurisdiction of the Board with respect to the matters referred to in this Stipulation and Consent Order.

II.

3. Licensee was advised by the Board's representatives that she may choose to be represented by legal counsel in this matter. Licensee was represented by Jeanne E. Morris, Esq., Morris Law Firm, P.A. The Committee was represented by Benjamin R. Garbe, Assistant Attorney General.

III.

FACTS

4. For purposes of this proceeding only, and having no force, effect, or implication in any extraneous civil or criminal proceeding, and while Licensee makes no express admissions to the contents herein, this Stipulation and Consent Order is based upon the following facts:

a. Since 2002, Licensee has been the sole owner of a Veterinary Clinic ("Clinic") in Delano, Minnesota.

b. In September 2012, it was reported to the Board that Licensee had been diverting medications, including controlled substances, intended for the Clinic's veterinary practice. The report indicated that in March 2012, an employee of the Clinic had noticed discrepancies between what medications had been ordered and what had been administered to animals. When confronted with the discrepancies by an employee, Licensee admitted that she had been dependent on pain medications since returning to practice from a back surgery. The employee volunteered to assume responsibility for the medication handling at the Clinic.

c. On September 25, 2012, an employee discovered that three bottles of Hydromorphone (Schedule II Controlled Substance) had not been entered into the Clinic inventory because the package was intercepted by Licensee. The employee confirmed that Licensee had signed for the order of Hydromorphone.

d. On September 27, 2012, a second employee at the Clinic reported to the Board that they were aware of Licensee's diversion of medications and indicated that Licensee would be entering chemical dependency treatment on September 30, 2012.

e. On September 28, 2012, Licensee contacted the Board and acknowledged that there was a "problem" and that she would relinquish her DEA registration.

f. On October 20, 2012, Licensee entered into individual outpatient treatment for opioid abuse at Hazelden. In a December 28, 2012 letter, Licensee's counselor stated that Licensee's prognosis is good for prolonged sobriety.

g. On October 22, 2012, Licensee entered into a Stipulation to Cease Practice with the Committee, under which Licensee agreed not to engage in the practice of veterinary medicine until the proceeding had been resolved.

h. A subsequent investigation into Licensee's conduct by the Attorney General's Office revealed the following:

***Discrepancies Between Controlled Substance Reports,
Controlled Drug Logs, and Patient Records***

i. In response to a subpoena, Licensee provided copies of Controlled Drug Logs dating back to 2010. A comparison of the Controlled Drug Logs and the Controlled Substance Reports from the Clinic revealed approximately 45 incidents in which there were discrepancies regarding administration of Diazepam (commonly marketed as Valium), 30 discrepancies regarding Buprenorphine (semi-synthetic opioid used to treat opioid addiction or control pain in lower doses for non-opioid-tolerant individuals; commonly marketed as Subutex or Suboxone), and 51 discrepancies regarding Morphine (opioid pain reliever). Many of the discrepancies involved animals owned by Licensee.

j. For example, upon comparison of 18 patient charts and the Controlled Substance Reports with the Controlled Drug Logs obtained from Licensee, numerous discrepancies were discovered as follows:

- The patient record and reports indicate that "Cutter" received 1.1 ml of Diazepam on 12/22/11, while the logs from Licensee indicate the dog received 1.5 ml.

- The patient record and reports indicate "Bear" received 2.1 ml of Morphine on 1/17/12, while the logs from Licensee indicate the dog received three doses of 2.2 ml each.

- The logs from Licensee indicate "Bear" received two doses of Hydromorphone 1.2 ml each on 1/17/12. Bear's patient records contain no mention of Hydromorphone and the reports have no entries of Hydromorphone.

- The logs from Licensee indicate her dog "Queenie" received 3.2 ml and 3.5 ml of Morphine on 1/31/12. The patient records and reports contain no corresponding entries.

- The logs from Licensee indicate the dog "Annie" received 0.3 ml of Diazepam on 3/8/12. According to the patient chart, the dog was euthanized by Licensee five weeks earlier on 2/2/12. The reports contain no corresponding entry.

- The logs from Licensee indicate the dog "Katie" received two 2.5 cc of Diazepam on 3/8/12. The patient chart contains no records for 3/8/12. The last date of service documented in the chart is 8/8/11. The reports contain no corresponding entry.

- The logs from Licensee indicate her dog "Dusty" received doses of 1.5 ml, 1.0 ml and 2.0 ml Valium on 3/8/12. The patient chart contains no entries for this date. The reports contain no corresponding entries.

k. The Controlled Drug Logs list approximately 100 purported occurrences of controlled substance drugs being administered to dogs owned by Licensee. None of these occurrences are documented in the patient charts for those dogs. Additionally, in 30 of the 100 occurrences, a dog owned by Licensee is listed on the logs as having received the remaining amount of medication in a bottle.

Miscellaneous Medication/Narcotics Discrepancies

l. Most of the medication bottle numbers on the Controlled Substance Reports were different than the bottle numbers on corresponding entries on the Controlled Drug Logs.

m. Licensee failed to provide Controlled Drug Logs corresponding to drug order receipts. Examples are as follows:

- An invoice dated 11/9/11 indicates 30 bottles of Diazepam were received, but Licensee provided corresponding drug logs for only nine of the 30 bottles.

- A receipt indicates the clinic received five bottles of Hydromorphone on 7/12/11; Licensee provided logs for only three bottles.

n. An invoice dated August 22, 2012 identifies three bottles of Hydromorphone. A note on the invoice states, "No record in inventory. 3 bottles - signed by [Licensee] from UPS." Licensee did not provide a copy of this invoice, despite being subpoenaed for all invoices of controlled substance purchases.

o. Numerous Controlled Drug Logs fail to account for all of the drug in a bottle. For example, a bottle of Diazepam (Bottle 191) had a balance of 4 cc on in the log on March 1, 2012. The next line lists a zero balance with no indication as to what happened to the 4 cc.

p. Several drug logs from the Clinic indicate that counts of Diazepam, Buprenorphine, and Morphine were off by varying amounts between March and September 2012. For example, a note on a log for Tramadol indicates the count was off by 121 tablets (end of bottle 8/18/12). Notes on logs for Alprazolam indicate that one bottle was missing 38 tablets on 8/4/12 and another bottle was missing 17 tablets on 8/6/12.

q. Licensee had notified Clinic employees that a bottle of Diazepam, a bottle of Morphine, and three bottles of Hydromorphone were contaminated, and were presumably destroyed.

Fraudulent Prescriptions:

1. Purported Prescription for Solo, owned by T.P. #1

r. On December 5, 2012, an employee of the Clinic contacted the Board and indicated that the Clinic had received a call from a Byerly's pharmacy on 12/4/12 seeking to verify Licensee's DEA number for a prescription of Diazepam. The prescription had purportedly been written by Licensee on October 23, 2012 for a dog named "Solo," with an owner listed as [Third Party #1] ("T.P. #1). The employee indicated to the Board that T.P. #1 had not been seen at the Clinic for several years and there was no patient named "Solo" under T.P. #1's name in the Clinic database. The employee advised the Byerly's pharmacy not to fill the prescription.

s. On December 31, 2012, Licensee was served with a subpoena ordering the production of patient records for "Solo." Licensee indicated she could not locate any records for that animal.

t. During an interview, T.P. #1 said she had not spoken to Licensee since June 2012, and that if T.P. #1 had received a prescription from Licensee, it would have been before that time. T.P. #1 did not recall ever using a Byerly's pharmacy to fill a prescription.

u. The manager of the Byerly's store provided three still photos from video taken at the store on 12/4/12 of the woman who presented the 10/23/12 prescription for filling.

v. Licensee denied attempting to fill the prescription for Solo. When shown the still photographs, Licensee acknowledged she was the person depicted in them.

2. Purported Prescriptions for Dogs owned by T.P. #2

w. A pharmacy canvas revealed three other questionable Diazepam prescriptions filled under Licensee's name as prescriber. One was written on 9/29/12 and filled 10/1/12 at the Walgreens in Blaine, for another dog named Solo, purportedly owned by [Third

Party #2] ("T.P. #2). The second was written 10/9/12 for "Queen," purportedly owned by T.P. #2, and filled at the Byerly's in Wayzata on 10/11/12. The third was written on 10/20/12 for "Rose," purportedly owned by T.P. #2, and was filled at the Walgreens in Wayzata on 11/9/12. The prescriptions noted above list two different addresses for T.P. #2 and three slightly different phone numbers, which included the number (763) 567-XXXX.

x. Attempts at contacting T.P. #2 were unsuccessful. According to the Postal Service, the addresses listed for T.P. #2 on the prescriptions do not exist. Two of the phone numbers were incorrect, as they belonged to men named Jonathan and Steve. No answer was received when an investigator called the third number.

y. On December 31, 2012, Licensee was served with a subpoena ordering the production of patient records for Solo, Queen, and Rose, owned by T.P. #2. Licensee could not locate any records for that animal or owner.

z. Licensee identified (763) 567-XXXX as her cell phone number (the number on one of the T.P. #2 prescriptions). Licensee denied writing or attempting to fill any prescriptions after signing the Stipulation to Cease Practice.

aa. Licensee indicated she could not remember anyone named T.P. #2. Licensee acknowledged that she owns three dogs with the same names as the purported T.P. #2 dogs (Solo, Queen, and Rose).

Licensee's Chronic Pain and Chemical Dependency

bb. Licensee indicated that in mid-2011, she developed severe back pain and neurologic deficits to her legs. In October 2011, Licensee underwent back surgery. Following the surgery, Licensee was prescribed opioid narcotics - Oxycodone and OxyContin. Licensee had also been prescribed anxiety medications.

cc. Licensee admitted to using medications (Xanax) ordered for the Clinic for her personal use.

dd. Licensee admitted to an addiction to opioids that she had been prescribed for pain - Oxycodone and OxyContin. Licensee also indicated an addiction to Diazepam, and that she had taken more Xanax than was prescribed for her.

ee. The investigation did not obtain any evidence that Licensee practiced veterinary medicine while under the influence of controlled substances.

IV.

LAWS

5. Licensee acknowledges that if proven in a contested case the conduct described in section III. above constitutes a violation of Minnesota Statutes section 156.081, subdivision 2(3), (6), (8), (11), (12), and (17).

V.

DISCIPLINARY ACTION

The parties agree the Board may take the following disciplinary action and require compliance with the following terms:

Stayed Suspension

6. The Board hereby suspends Licensee's license to practice veterinary medicine. The suspension is **STAYED** so long as Licensee complies with the following requirements and upon the condition that Licensee participates in the Health Professionals Services Program ("HPSP") as follows:

a. Contact With the HPSP. Licensee shall contact the HPSP at (651) 643-2120 to initiate enrollment in the program within 14 days of the date of this Order.

b. Participation Agreement. Licensee shall enter into a Participation Agreement with the HPSP for monitoring of Licensee's chemical dependency and mental health within 60 days of the date of this Order. Licensee must comply with all terms of the Participation Agreement.

c. Abstinence From Mood-Altering Chemicals. At all times while this Stipulation and Consent Order is in effect, Licensee shall completely abstain from all mood-altering chemicals, including alcohol, unless expressly prescribed in writing by a physician, dentist, or other authorized health care professional who is providing care and treatment to Licensee. Within three (3) days of when a physician, dentist, or other authorized health care professional prescribes controlled substances for Licensee, Licensee must inform the HPSP in writing of the prescription and the condition being treated.

Removal of Stayed Suspension

7. Licensee may petition for removal of the stayed suspension at any regularly scheduled Board meeting following discharge from the HPSP after successful completion of the Participation Agreement. Licensee's stayed suspension shall be removed if the evidence dictates and provided there is no ongoing need to protect the public. The burden of proof shall be upon Licensee to demonstrate by a preponderance of the evidence that Licensee is capable of conducting herself in a fit and competent manner in the practice of veterinary medicine. Before petitioning for removal of the stayed suspension, Licensee shall meet with the Committee to review her petition and any evidence in support of the petition. The Board may, at any regularly scheduled meeting following Licensee's petition for removal of the stayed suspension, remove the stayed suspension, remove the stayed suspension with limitations placed upon the scope of

Licensee's practice and/or conditional upon further reports to the Board, or continue the stayed suspension of Licensee's license based upon Licensee's failure to meet the burden of proof.

VI.

CONSEQUENCES FOR NONCOMPLIANCE OR ADDITIONAL VIOLATIONS

8. It is Licensee's responsibility to ensure all payments, reports, evaluations, and documentation required to be filed with the HPSP pursuant to Licensee's Participation Agreement are timely filed by those preparing the report, evaluation, or documentation. Failure to file payments, reports, evaluations, and documentation on or before their due date is a violation of this Stipulation and Consent Order.

Noncompliance With Requirements for Stayed Suspension

9. If the Committee has probable cause to believe Licensee has failed to comply with or has violated any of the requirements for staying the suspension as outlined in paragraph 6 above or has failed to comply with the HPSP Participation Agreement, or is subject to a positive chemical screen, the Committee may remove the stayed suspension pursuant to the following procedures:

a. The removal of the stayed suspension shall take effect upon service of an Order of Removal of Stayed Suspension ("Order of Removal"). Licensee agrees that the Committee is authorized to issue an Order of Removal, which shall remain in effect and shall have the full force and effect of an order of the Board until the Board makes a final determination pursuant to the procedures outlined in paragraph 10 below. The Order of Removal shall confirm the Committee has probable cause to believe Licensee has failed to comply with or has violated one or more of the requirements for staying the suspension of Licensee's license. Licensee further agrees an Order of Removal issued pursuant to this paragraph shall be deemed a

public document under the Minnesota Government Data Practices Act. Licensee waives any right to a conference or hearing before removal of the stayed suspension.

c. The Committee shall schedule the hearing pursuant to paragraph 10 below to be held within 60 days of the date the Order of Removal was served.

Noncompliance With Stipulation and Consent Order

10. If Licensee fails to comply with or violates this Stipulation and Consent Order the Committee may, in its discretion, seek additional discipline either by initiating a contested case proceeding pursuant to Minnesota Statutes chapter 14 or by bringing the matter directly to the Board pursuant to the following procedure:

a. The Committee shall schedule a hearing before the Board. At least 20 days before the hearing, the Committee shall mail Licensee a notice of the violation(s) alleged by the Committee. In addition, the notice shall designate the time and place of the hearing. Within ten days after the notice is mailed, Licensee shall submit a written response to the allegations. If Licensee does not submit a timely response to the Board, the allegations may be deemed admitted.

b. The Committee, in its discretion, may schedule a conference with Licensee prior to the hearing before the Board to discuss the allegations and to attempt to resolve the allegations through agreement.

c. Prior to the hearing before the Board, the Committee and Licensee may submit affidavits and written argument in support of their positions. At the hearing, the Committee and Licensee may present oral argument. Argument shall not refer to matters outside the record. The evidentiary record shall be limited to the affidavits submitted prior to the hearing and this Stipulation and Consent Order. Unless stated otherwise in this Stipulation and Consent

Order, the Committee shall have the burden of proving by a preponderance of the evidence that a violation has occurred. Licensee waives a hearing before an administrative law judge, discovery, cross-examination of adverse witnesses, and other procedures governing hearings pursuant to Minnesota Statutes chapter 14.

d. If the HPSP discharges Licensee from the program for any reason other than Licensee's successful completion of the terms of the Participation Agreement, there will be a presumption of a preponderance of the evidence that Licensee has failed to comply with the requirements for staying the suspension. Licensee's correction of a violation prior to the conference, hearing, or meeting of the Board may be taken into account by the Board but shall not limit the Board's authority to impose discipline for the violation. A decision by the Committee not to seek discipline when it first learns of a violation will not waive the Committee's right to later seek discipline for that violation, either alone or in combination with other violations, at any time while Licensee's license is suspended or the suspension is stayed.

e. Following the hearing, the Board will deliberate confidentially. If the allegations are not proved, the Board will dismiss the allegations. If a violation is proved, the Board may impose additional discipline, including additional requirements for the stayed suspension, removal of the stayed suspension, an additional period of suspension, or revocation of Licensee's license.

f. Nothing herein shall limit the Committee's or the Board's right to temporarily suspend Licensee's license pursuant to Minnesota Statutes section 156.126, based on a violation of this Stipulation and Consent Order or based on conduct of Licensee not specifically referred to herein.

VII.

ADDITIONAL INFORMATION

11. In the event Licensee should leave Minnesota to reside or to practice outside of the state, Licensee shall give the Board written notification of the new location, as well as dates of departure and return. If Licensee leaves the state, the terms of this order continue to apply unless waived in writing.

12. Licensee waives the contested case hearing and all other procedures before the Board to which Licensee may be entitled under the Minnesota and United States constitutions, statutes, or rules.

13. Licensee waives any claims against the Board, the Minnesota Attorney General, the State of Minnesota, and their agents, employees, and representatives related to the investigation of the conduct herein, or the negotiation or execution of this Stipulation and Consent Order, which may otherwise be available to Licensee.

14. This Stipulation and Consent Order, the files, records, and proceedings associated with this matter shall constitute the entire record and may be reviewed by the Board in its consideration of this matter.

15. Either party may seek enforcement of this Stipulation and Consent Order in any appropriate civil court.

16. Licensee has read, understands, and agrees to this Stipulation and Consent Order and has voluntarily signed the Stipulation and Consent Order. Licensee is aware this Stipulation and Consent Order must be approved by the Board before it goes into effect. The Board may either approve the Stipulation and Consent Order as proposed, approve it subject to specified change, or reject it. If the changes are acceptable to Licensee, the Stipulation and Consent Order

will take effect and the order as modified will be issued. If the changes are unacceptable to Licensee or the Board rejects the Stipulation and Consent Order, it will be of no effect except as specified in the following paragraph.

17. Licensee agrees that if the Board rejects this Stipulation and Consent Order or a lesser remedy than indicated in this settlement, and this case comes again before the Board, Licensee will assert no claim that the Board was prejudiced by its review and discussion of this Stipulation and Consent Order or of any records relating to it.

18. This Stipulation and Consent Order shall not limit the Board's authority to proceed against Licensee by initiating a contested case hearing or by other appropriate means on the basis of any act, conduct, or admission of Licensee which constitutes grounds for disciplinary action and which is not directly related to the specific facts and circumstances set forth in this document.

VIII.

DATA PRACTICES NOTICES

19. This Stipulation and Consent Order constitutes disciplinary action by the Board and is classified as public data pursuant to Minnesota Statutes section 13.41, subdivision 5. Data regarding this action will be provided to all entities and data banks as required by Federal law or consistent with Board policy. While this Stipulation and Consent Order is in effect, information obtained by the Board pursuant to this Order is considered active investigative data on a licensed health professional, and as such, is classified as confidential data pursuant to Minnesota Statutes section 13.41, subdivision 4.

20. The parties consider this Stipulation and Consent Order a settlement document under Rule 408 of the Federal Rules of Evidence and Rule 408 of the Minnesota Rules of

Evidence. The parties contemplate that this Stipulation and Consent Order shall be inadmissible in any civil or criminal proceeding outside of this administrative health licensing proceeding.

21. This Stipulation contains the entire agreement between the parties, there being no other agreement of any kind, verbal or otherwise, which varies this Stipulation.

22. Licensee may immediately return to the practice of veterinary medicine in the state of Minnesota upon adoption of this Stipulation and Consent Order by the Board.

CONSENT:


DIANE R. HANSEN, D.V.M.
Licensee

BOARD OF VETERINARY MEDICINE
COMMITTEE


BARBARA S. FISCHLEY, D.V.M.
Committee Member

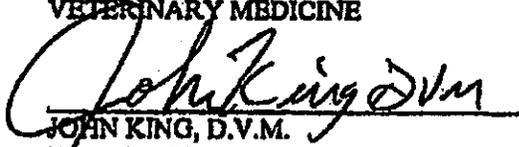
Dated: 2-26-13

Dated: 3-13-13

ORDER

Upon consideration of the Stipulation, the Board hereby suspends Licensee's license, but **STAYS** the suspension upon the condition that Licensee participates in the Health Professionals Services Program, and adopts all other terms of the Stipulation on this 13 day of March, 2013.

MINNESOTA BOARD OF
VETERINARY MEDICINE


JOHN KING, D.V.M.
Executive Director