

HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 503-
TEXAS MEDICAL LICENSE NO. D-6049

IN THE MATTER OF THE
COMPLAINT AGAINST

WAYNE CHARLES JONES, M.D.

BEFORE THE

TEXAS MEDICAL BOARD

COMPLAINT

TO THE HONORABLE TEXAS MEDICAL BOARD AND THE HONORABLE
ADMINISTRATIVE LAW JUDGE TO BE ASSIGNED:

COMES NOW, the Staff of the Texas Medical Board (the "Board"), and files this Complaint against Wayne Charles Jones, M.D., ("Respondent"), based on Respondent's alleged violations of the Medical Practice Act ("the Act"), Title 3, Subtitle B, Texas Occupations Code, and would show the following:

I. INTRODUCTION

The filing of this Complaint and the relief requested are necessary to protect the health and public interest of the citizens of the State of Texas, as provided in Section 151.003 of the Act.

II. LEGAL AUTHORITY AND JURISDICTION

1. Respondent is a Texas Physician and holds Texas Medical License No. D-6049, that was originally issued on August 27, 1969. Respondent's license was in full force and effect at all times material and relevant to this Complaint.

2. Respondent received notice of the Informal Settlement Conference ("ISC") and appeared at the ISC, which was conducted in accordance with §2001.054(c), GOV'T CODE and §164.004 of the Act. All procedural rules were complied with, including but not limited to, Board Rules 182 and 187, as applicable.

3. No agreement to settle this matter has been reached by the parties.

4. All jurisdictional requirements have been satisfied.

III. FACTUAL ALLEGATIONS

Board Staff has received information and on that information believes that Respondent has violated the Act. Based on such information and belief, Board Staff alleges:

Patient: [Board staff will provide the identification of the patient to the ALJ and Respondent by separate document confidential under seal.]

1. This case involves allegations that Respondent: non-therapeutically prescribed medication and failed to keep adequate medical records.
2. On February 1, 2007, Respondent gave the Patient prescriptions for: Adderall XR 30 mg, to be taken once a day (#30); Daytrana 30 mg patch, to be taken once daily (#30); and Tenex 1 mg (#30), with instructions to take one half to two tabs twice a day. There is no explanation in Respondent's medical record for why these multiple different medications were prescribed.
3. The Patient's medical record included an undated mental status exam for the initial visit on February 1, 2007. On the exam, Respondent failed to document necessary information including: appearance, motor activity, affect, mood, speech, attitude, thought process or thought content and diagnosis listed, Axis I – III, sleep problems, stressors, and school problems.
4. On February 8, 2007, Respondent prescribed the medication Adderall, 60 tablets, and gave the Patient samples of the medication Klonopin. Respondent documented the indication for the Klonopin was "for worry," but did not document the quantity given in the medical record.
5. On March 22, 2007, Respondent gave Patient a coupon for the medication Focalin XR, 20 mg #30, to be taken once daily. Respondent did not document an explanation for why the medication was prescribed.
6. Respondent documented an entry in the Patient's medical records noting that: the Patient had a better sleep schedule; Adderall made the Patient "snappy" with others, and the Patient did not like the patch, so the medication Abilify was added for anxiety. This entry was not dated.
7. On December 13, 2007, Respondent noted in the Patient's medical record that: the Patient should resume meds though not needing clonazepam; the Patient was attending grad school; and the Patient would pick up Adderall tabs.

8. On May 2, 2008, Respondent noted in Patient's medical record the following about the Patient: would pick up Adderall tabs; was looking for work; had moved from parents' home to live with cousin; had been very ill and dropped out of school; was planning to start mechanical engineering; and was sporadic with meds.

9. Overall, Respondent's documentation of symptoms to make a diagnosis relied on completing brief rating scales. Additionally, Respondent's documentation is scattered and unorganized and provides no explanation as to why medication dosing for the Patient exceeded recommended levels.

IV. GENERAL ALLEGATIONS

1. Respondent failed to practice in accordance with public health and welfare due to one or more of the following: failure to meet the standard of care; negligence in providing medical services; failure to use diligence; poor medical judgment; poor decision making; and non-therapeutic prescribing and/or treatment.

2. The actions of Respondent as specified above violate one or more of the following provisions of the Medical Practice Act ("the Act"):

- a. Respondent is subject to disciplinary action pursuant to Section 164.051(a)(1) of the Act based on Respondent's commission of an act prohibited under Section 164.052 of the Act.
- b. Respondent is subject to disciplinary action by the Board pursuant to Section 164.051(a)(6) of the Act by failing to practice medicine in an acceptable professional manner consistent with public health and welfare, and as further defined by Board Rule(s) 190.8(1)(A)-(C).
- c. Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's committing or attempting to commit a direct violation of a rule adopted under this subtitle, either as principal, accessory or accomplice. Specifically, Respondent violated of Board Rule 165, by failing to maintain adequate medical records.

- d. Section 164.052(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent's unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.
- e. Respondent has committed a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(5) of the Act by prescribing or administering a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed.

V. AGGRAVATING FACTORS

This case involves an aggravating factor in that Respondent has had prior similar violations in a previous Board order.

VI. APPLICABLE STATUTES, RULES, AND AGENCY POLICY

Respondent's conduct, as described above, constitutes grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any other authorized means of discipline upon the Respondent. The following statutes, rules, and agency policy are applicable to this matter:

1. Section 164.007(a) of the Act requires that the Board adopt procedures governing formal disposition of a contested case before the State Office of Administrative Hearings.
2. 22 TEX. ADMIN. CODE, Chapter 187 sets forth the procedures adopted by the Board under the requirement of Section 164.007(a) of the Act.
3. 1 TEX. ADMIN. CODE §155.3(c) provides that the procedural rules of the state agency on behalf of which the hearing is conducted govern procedural matters that relate to the hearing as required by law, to wit: Section 164.007(a) of the Act, as cited above.
4. 1 TEX. ADMIN. CODE, CHAPTER 155 sets forth the rules of procedure adopted by SOAH for contested case proceedings.

VII. NOTICE TO RESPONDENT

IF YOU DO NOT FILE A WRITTEN ANSWER TO THIS NOTICE WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS WITHIN 20 DAYS AFTER THE DATE OF SERVICE, A DEFAULT JUDGMENT MAY BE ENTERED AGAINST YOU, WHICH MAY INCLUDE THE DENIAL OF LICENSURE OR ANY OR ALL OF THE REQUESTED SANCTIONS INCLUDING THE REVOCATION OF YOUR LICENSE. IF YOU FILE A WRITTEN ANSWER, BUT THEN FAIL TO ATTEND THE HEARING, A DEFAULT JUDGMENT MAY BE ENTERED AGAINST YOU, WHICH MAY INCLUDE THE DENIAL OF LICENSURE OR ANY OR ALL OF THE REQUESTED SANCTIONS INCLUDING THE REVOCATION OF YOUR LICENSE. A COPY OF ANY RESPONSE YOU FILE WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS SHALL ALSO BE PROVIDED TO THE HEARINGS COORDINATOR OF THE TEXAS MEDICAL BOARD.

IF YOU FAIL TO ATTEND THE HEARING, THE ADMINISTRATIVE LAW JUDGE MAY PROCEED WITH THE HEARING AND ALL THE FACTUAL ALLEGATIONS LISTED IN THIS NOTICE CAN BE DEEMED ADMITTED, AND THE RELIEF SOUGHT IN THIS NOTICE MIGHT BE GRANTED.

WHEREFORE, PREMISES CONSIDERED, Board Staff requests that an administrative law judge employed by the State Office of Administrative Hearings conduct a contested case hearing on the merits of the Complaint, and issue a Proposal for Decision ("PFD") containing Findings of Fact and Conclusions of Law necessary to support a determination that Respondent violated the Act as set forth in this Complaint.

Respectfully submitted,

TEXAS MEDICAL BOARD



By:

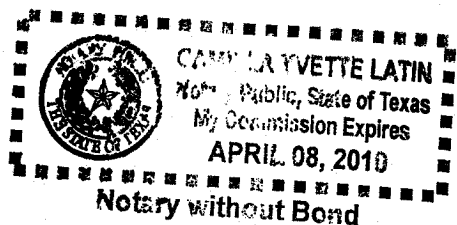
Claudia Kirk, Staff Attorney
Texas State Bar No. 24041087
Telephone: (512) 305-7082
FAX # (512) 305-7007
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701

THE STATE OF TEXAS

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COUNTY OF TRAVIS

SUBSCRIBED AND SWORN to before me by the said Claudia Kirk on
August 27, 2009, 2009.



Camille Yvette Latin
Notary Public, State of Texas

Filed with the Texas Medical Board on August 25, 2009.

Mari Robinson

Mari Robinson, J.D.
Executive Director
Texas Medical Board

SERVICE LIST

On this 27th day of August, 2009, I certify that a true and correct copy of this Complaint has been served on the following individuals at the locations and the manner indicated below, in accordance with TEX. GOV'T CODE §2001.052, 22 TEX. ADMIN. CODE §187.26, and 1 TEX. ADMIN. CODE §155.103:

BY CERTIFIED MAIL RETURN RECEIPT REQUESTED and FIRST CLASS MAIL

Wayne Charles Jones, M.D.
375 MUNICIPAL, #224
RICHARDSON MEDICAL PARK
Richardson, TX 75080

BY FAX TRANSMISSION TO:


Mark Hanna
LAW OFFICE OF MARK HANNA
900 CONGRESS, #250
Austin, TX 78701

BY FAX TRANSMISSION TO: 475-4994

Docket Clerk
State Office of Administrative Hearings
300 West 15th #504
Austin, Texas 78701

BY HAND DELIVERY:

Sonja Aurelius
Hearings Coordinator
Texas Medical Board
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701



Claudia Kirk