STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES
BOARD OF VETERINARY MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

ABOLARIN AGBONA, D.V.M.
License No. 69-01-008492
_____/

Complaint No. 69-14-132141
(Consolidated with 69-13-127998,
69-13-129829 and 69-13-129997)

ADMINISTRATIVE COMPLAINT

Attorney General Bill Schuette, through Assistant Attorney General Debra M. Gagliardi, on behalf of the Department of Licensing and Regulatory Affairs, Bureau of Health Care Services, (Complainant), files this complaint against Abolarin Agbona, D.V.M., (Respondent), alleging upon information and belief as follows:

1. The Board of Veterinary Medicine, an administrative agency established by the Public Health Code, 1978 PA 368, as amended, MCL 333.1101 *et seq*, is empowered to discipline licensees under the Public Health Code through its Disciplinary Subcommittee, (DSC).

2. Respondent is currently licensed as a Doctor of Veterinary Medicine (DVM) pursuant to the Public Health Code. At all times relevant to this Complaint, Respondent owned and operated Comprehensive Animal Hospital located in Lansing, Michigan.

3. Section 16221(a) of the Code provides the DSC with authority to take disciplinary action against Respondent for a violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to, or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition which impairs, or may impair, the ability to safely and skillfully practice the health profession.

4. Section 16221(b)(i) of the Code gives the Disciplinary Subcommittee the authority to discipline Respondent for incompetence. Incompetence is defined under MCL 333.16106(1) as, "a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, whether or not actual injury to an individual occurs."

5. 2011 AACS, R 338.4921(1) provides a veterinarian shall; in a timely fashion maintain a medical record that accurately reflects the veterinarian's evaluation and treatment of the patient. The patient record shall contain documentation of a valid veterinarian-client relationship.

6. 2011 AACS, R 338.4921(3) provides that a veterinary medical record for an individual patient shall document all of the following:

(a) Identification that may include, but is not limited to, a tattoo, tag number, lot number, pen name, age, name, markings, sex, and species of the patient, as available.
(b) Date of the last veterinary service.
(c) Name, address, and telephone number of the client.
(d) Location of patients, if not at the location of the veterinary practice.
(e) Reason for the contact including, but not limited to, the case history, problems and/or signs of a problem, and whether the contact was a routine health visit or an emergency call.

(f) Vaccination history, when appropriate and if known.
(g) Results of the physical examination and a list of abnormal findings.
(h) Laboratory reports and other reports, when appropriate.
(i) Diagnostic procedures utilized and the reports that pertain to these procedures.
(j) Procedures performed, including but not limited to, surgery and rectal palpitations.
(k) Daily progress notes, if hospitalized.
(l) Documentation of informed consent, if appropriate.
(m) Documentation of diagnostic options and treatment plans.
(n) Records of any client communication deemed relevant.
(o) Documentation of prescribed medication.

7. Section 16221(h) of the Code authorizes the Disciplinary Subcommittee to take disciplinary action against a licensee for violating, or aiding or abetting in a violation of, Article 15 or a rule promulgated under that article.

8. Section 16226 of the Code authorizes the DSC to impose sanctions against persons licensed by the Board, if after opportunity for a hearing, the DSC determines that a licensee violated one or more of the subdivisions contained in section 16221 of the Code.

FACTUAL ALLEGATIONS

Canine Patient Roxy

9. Patient Roxy, a female Labrador Retriever, presented to Respondent on February 22, 2013. At the time of presentation, Roxy had been sick and not eating for three days prior to the appointment.

10. Respondent's treatment records for February 22, 2013, state "all vital signs are within normal limits, cardiopulmonary auscultation is normal. Abdominal palpitation suggest possible foreign object in distal abdominal area."

Respondent ordered radiographs, on which he stated, "Radiographs show severe intestinal gas pattern. Possible intestinal foreign object." Respondent's treatment plan included exploratory surgery.

11. Respondent's chart entry for the February 22, 2013 exploratory surgery states, "stomach and intestines were examined, foreign objects (piece of bone) was located in the ileum. Area around the bone was discolored reddish-blue-black?"

12. A March 5, 2013, chart entry created by Comprehensive Animal Hospital states Roxy's condition as "not doing well, lethargic, diarrhea hasn't cleared, hasn't eaten today, vomiting white foam."

13. Roxy's condition did not improve, her owners elected to have her seen by another provider. Roxy was seen by Derek Nolan, D.V.M. of Cedar Creek Veterinary Clinic located in Williamston, Michigan, on March 7, 2013.

14. Dr. Nolan noted in Roxy's chart that her abdomen was distended, and a culture and sensitivity of all fluids showed no growth.

15. By March 11, 2013, Roxy's condition had not improved; Dr. Nolan elected to perform exploratory surgery the following day.

16. Dr. Nolan chartered regarding the exploratory surgery, "Entire GI tract adhesed to itself . . . . Many (>50) black dog hairs in abdominal cavity with granulation tissue around them. Entenotomy site dehisced with stool & granulation around it necrotic intestine (jejunum). Performed resection & an

anastomosis . . . . Also palpitated masses/objects in stomach . . . removed 2 halves of hoof."

17. Roxy's condition continued to deteriorate despite interventions. Roxy's owners and Dr. Nolan decided to euthanize Roxy. Roxy was euthanized on March 15, 2013.

18. Respondent failed to obtain pre-operative blood work on Roxy. Respondent also failed to chart in his initial examination of Roxy her temperature, pulse rate, and respiratory rate.

19. Respondent failed to chart what anesthetic was administered, and the route of administration. Respondent also failed to chart any post-operative progress notes or chart when Roxy as discharged and in what condition. Respondent charted dispensing the antibiotic Enrofloxacin, but failed to chart the number of doses or duration of administration.

20. Medications dispensed to Roxy's owners by Respondent were not appropriately labeled. The prescription bottles do not display the name of the prescription drug, the patient's name, and the quantity of the drug.

Canine Patient Cheeka

21. Patient Cheeka, a female Chihuahua-Pug mix, first presented to Respondent on April 28, 2013. Cheeka's owners brought her to Respondent after she had gone into labor and delivered puppies because, following the delivery, she was not eating.

22. Respondent's chart entry for the April 28, 2013, appointment reads "Cheeka is lethargic at presentation but all vital signs are within normal, cardiopulmonary auscultation is normal. Abdominal palpitation suggests likely two puppies in uetero. Foul odor from Cheeka. Dystocia[1]"

23. Respondent charted that radiographs taken of Cheeka on April 28, 2013 confirmed two puppies remained in Cheeka's uterus. Respondent performed a cesarean section the same day to remove the deceased puppies.

24. Respondent's notes for the April 28, 2013 Cesarean procedure state "Incision is made into uterus, two dead puppies are retrieved. Cheeka is then spayed."

25. Cheeka was discharged home by Respondent on April 29, 2013.

26. On May 15, 2013, Cheeka's owners brought her into Respondent's practice with complaints that she had been vomiting for 3-4 days.

27. Respondent's May 15, 2013 notes regarding Cheeka state "Cheeka is upright and alert, all vital signs are within normal limits, heart and lung sounds are normal, mucus membranes are pink/moist. Abdominal palpitation is unremarkable."

28. Respondent recommended and performed an exploratory laparotomy on Cheeka on May 15, 2013. Respondent's notes for the procedure state "The stomach and intestines are located and palpated, a section of proximal duodenum

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[1] *Dystocia* is the medical term used to diagnose a difficult birthing experience. This condition may occur as a result of maternal or fetal factors, and can occur during any stage of the labor. http://www.petmd.com/dog/conditions/reproductive/c_dg_dystocia

has some firm materials in the ileum. Incision is made into the location some material (possible sock or other clothing material was located and removed). Other section of the intestines appeared normal."

29. On May 16, 2013, Cheeka remained hospitalized at Respondent's practice. The morning of May 16, 2013, Cheeka was taken outside for a walk and managed to escape. Efforts by Respondent to locate Cheeka failed. On May 18, 2013, Cheeka's owners located her expired on the side of the road a few blocks from Respondent's practice. Cheeka appeared to have died after being hit by an automobile.

30. Respondent failed to fully assess Cheeka prior to performing surgeries on April 28 and May 15, 2013. Respondent failed to have any pre-surgical blood-work performed on Cheeka, to assess any co-morbidities. No anesthetic record is documented. Respondent also failed to chart Cheeka's temperature, pulse rate, respiration hydration status, and laboratory data assessing Cheeka's hematological and biochemical status during the surgeries.

31. Medications dispensed to Cheeka's owners by Respondent were not appropriately labeled. The medication bottles failed to include the strength of the prescribed medication, and failed to include the clinic's name, address, and phone number.

Feline Patient Toby

32. Patient Toby, a female shorthair cat, presented to Respondent on December 31, 2013. At the time of presentation, Toby was gasping, vomiting, and had not been eating.

33. Respondent performed an examination of Toby, the chart entry states, "Toby presented bright and alert, all vital signs are within normal, cardiopulmonary auscultation is normal. Hydration status is within normal limits, mucous membranes are pink/moist. Abdominal palpitation . . . .some firm fecal matter in lower intestines."

34. Respondent took radiographs of Toby and charted: "Radiographs – shows presence of firm fecal matter with tiny . . . objects in descending colon."

35. Based on his reading of the radiographs, Respondent administered an enema and briefly hospitalized Toby until the enema allowed Toby to void. Respondent charted "cat void some firm feces, fecal matter is blood stained." Respondent discharged Toby and prescribed a laxative to be used 2-3 times a day, along with metronidazole 65mg to be given twice a day."

36. Toby died on January 1, 2014. A necropsy was performed at Michigan State, which revealed a 12 cm string present in Toby's throat and stomach, and a 57 cm string present in Toby's intestines.

37. Respondent failed to conduct a thorough examination of patient Toby that included an examination of Toby's mouth, which would have revealed the string present in Toby's mouth.

DEA Registration

38. Respondent's DEA registration number FA4220896 expired on June 30, 2013.

39. Michigan Automated Prescription System (MAPS) reports for the period September 2013 through December 2013 establish Respondent continued to prescribe controlled substances to patients despite the fact that his DEA registration had expired.

40. Invoices from Penn Veterinary Supply, Inc., located in Lancaster, PA, indicate that beginning in August 2013, Respondent's expired DEA number was used to order controlled substances for his practice.

41. Invoices from Luea Pharmacy, located in Swartz Creek, MI, indicate that beginning in September 2013, Respondent's expired DEA number was used to order controlled substances for his practice.

COUNT I

42. Respondent's conduct as described above constitutes negligence or failure to exercise due care, in violation of 16221(a) of the Code.

COUNT II

43. Respondent's conduct as described above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

COUNT III

44. Respondent's conduct as described above constitutes a failure to maintain a medical record for each patient that accurately reflects the

veterinarian's evaluation and treatment of the patient in violation of 2011 AACS, R 338.4921(1) and contrary to Section 16221(h) of the Code.

COUNT IV

45. Respondent's conduct as described above constitutes a failure to maintain patient records that document all of the following: a) Identification that may include, but not be limited to, a tattoo, tag number, lot number, pen number, age, name, markings, sex, and species of the patient, as available; b) Date of the last veterinary service; c) Name, address, and telephone number of the client; d) Location of patients, if not at the location of the veterinary practice; e) Reason for the contact including, but not limited to, the case history, problem and/or signs of a problem, and whether the contact was a routine health visit or an emergency call; f) Vaccination history, when appropriate and if known; g) Results of the physical examination and a list of abnormal findings; h) Laboratory reports and other reports, when appropriate; i) Diagnostic procedures utilized and the reports that pertain to these procedures; j) Procedures performed including, but not limited to, surgery and rectal palpitations; k) Daily progress notes, if hospitalized; l) Documentation of informed consent, if appropriate; m) Documentation of diagnostic options and treatment plans; n) Records of any client communication deemed relevant; and o) Documentation of prescribed medication patient in violation of 2011 R 338.4921(3) and contrary to Section 16221(h) of the Code.

THEREFORE, Complainant requests that this complaint be served upon Respondent and that Respondent be offered an opportunity to show compliance with

all lawful requirements for retention of the aforesaid license. If compliance is not shown, Complainant further requests that formal proceedings be commenced pursuant to the Code, rules promulgated pursuant to it, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq.*

RESPONDENT IS NOTIFIED that, pursuant to section 16231(8) of the Code, Respondent has 30 days from the receipt of this complaint to submit a written response to the allegations contained in it. The written response shall be submitted to the Bureau of Health Care Services, Department of Licensing and Regulatory Affairs, P.O. Box 30670, Lansing, Michigan, 48909, with a copy to the undersigned assistant attorney general. Further, pursuant to section 16231(9), failure to submit a written response within 30 days shall be treated as an admission of the allegations contained in the complaint and shall result in the transmittal of the complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

Respectfully submitted,

BILL SCHUETTE
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Dated: December 17, 2014