BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE ALASKA STATE BOARD OF NURSING

In the Matter of	)	
	)	
PAULA KORN	)	OAH No. 20-0696-NUR
	)	Agency No. 2017-000045

DECISION

I. Introduction

Paula Korn holds a registered nursing license and a license as an Advanced Nurse Practitioner. The Division of Business, Corporations and Professional Licensing filed an accusation seeking disciplinary sanctions against Ms. Korn's licenses based on concerns with her charting and prescribing practices. This decision concludes that Ms. Korn's practice records reveal a practice that has, across a broad array of cases, fallen profoundly short of professional standards on charting and on the prescription of controlled substances, despite prior discipline from this Board on these same topics, and therefore recommends a short-term suspension of both nursing licenses, but a longer-term suspension of her APRN license.

II. Facts

A. Background

Paula Korn holds Nursing licenses 6075 (Registered Nurse) and U9 (Advanced Nurse Practitioner) and is nationally certified as a women's health nurse practitioner.[1] Because this case involves Ms. Korn's work as an Advanced Nurse Practitioner, the specialized requirements of that role are briefly addressed below.

An Advanced Nurse Practitioner (ANP) is a "licensed independent practitioner who is licensed to practice as a … a nurse practitioner[.] The individual must be licensed to practice in the role for which the individual has received specialized education."[2] The Board's regulations currently identify six population foci for advanced practice registered nursing, and provide that an ANP "must be licensed to practice in one or more" of these.[3] The six recognized foci are: "(1) family/individual across the lifespan; (2) adult/gerontology; (3) neonatal; (4) pediatric; (5)

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1 Korn testimony; Ex. A, Ex. B.
2 12 AAC 44.380(a).
3 12 AAC 44.380(b).

women's health/gender related; [and] (6) psychiatric/mental health."[4] Alaska does not recognize a "pain management" population focus for Advanced Nursing Practitioners.[5]

The requirements for obtaining licensure as an ANP include at least a year of additional graduate level schooling to prepare registered nurses to perform an expanded role in patient care, as well as a current certification in the chosen population focus from a national certifying body.[6]

Ms. Korn was first licensed as a nurse in Alaska in 1976, and first licensed as an ANP in 1980.[7] She has operated as an independent practitioner since 1982.

Ms. Korn has a small but busy practice with approximately 190 patients, most of whom she has been seeing for 8 – 15 years. She considers her "primary practice" to be "women's health," consistent with her national certification.[8]

B. 2009 Consent Agreement

In 2009, the Division received complaints about Ms. Korn that led to an accusation and, ultimately, to a consent agreement. At the time, her ANP authorized specialties were that of Nurse Midwife and Women's Health/OB-GYN.[9]

In the 2009 consent agreement, Ms. Korn admitted to "treating a female patient in her practice for an extended period of time for pain management," and further admitted that "the pain management care of this patient is not authorized under [her] ANP specialties and thus outside of her authorized scope of practice."[10] Ms. Korn also admitted her documentation and charting of this patient's care were "very sparse, incomplete, and lacked critical information that should have been present for pain management treatment and proper care of the patient."[11]

Ms. Korn acknowledged that her "care for this patient was negligent in that it involved long term care with opioids for ongoing pain without proper steps being taken and safeguards in place to prevent significant risks to the patient's health or safety."[12] She agreed to pay a fine and

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4 12 AAC 44.380(b). The regulations also recognize certain previously licensed population foci, and provide that an APRN licensed or certified in one of these areas by January 1, 2024 may continue to practice as long as the certification is maintained. They are: "(1) acute care/emergency; (2) adult health; (3) adult psychiatric/mental health; (4) family health; (5) family psychiatric/mental health; (6) geriatric nursing; [and] (7) women's health." 12 AAC 44.380(c).

5 12 AAC 44.380(b); Valentine testimony.

6 12 AAC 44.440.

7 Ex. B.

8 Korn testimony, Ex. A.

9 Ex. B, p. 3.

10 Ex. B, p. 3.

11 Ex. B, pp. 3-5.

12 Ex. B, p. 5

to complete certain continuing education courses.[13] The Board adopted the agreement, and Ms. Korn complied with her obligations under it.[14]

C. 2017 complaints and investigation

In January 2017, the Division again received complaints about Ms. Korn's prescribing practices. A complaint received January 24, 2017, alleged that Ms. Korn had been "over prescribing benzodiazepines to known addicted individuals for years."

> I work in substance abuse treatment. For the past 14 years, [Ms. Korn] has been over prescribing benzodiazepines to known addicted individuals. The addicted population know that she will write a prescription for benzodiazepines. They seek this ANP out in the community. I work as a nurse with administering methadone to opiate addicted patients. The combination of methadone and benzodiazepines is deadly. You can see the amount of benzodiazepines handed out is not therapeutic as evidenced by the AK PDMP. She is dangerous to the community.[15]

A second complaint submitted January 26, 2017, likewise raised concerns about patients receiving large volumes of benzodiazepines alongside opioids:

> Please examine prescribing practice of this practitioner who has dealt with several clients of mine over the years prescribing benzodiazepines to various individuals who abuse [them] and whose anxiety disorders should be managed by non-addicting substances. My most recent client with a mood disorder on a SSRI but still using methamphetamine was prescribed Xanax 1 mg (receiving 135 tablets in 12/2016) BUT simultaneously given a stimulant (Dextro-amphetamine) for "ADD." This client was also on Methadone at the time. Our client does not permit the combination of methadone and benzodiazepines. This client reports seeing Paula Korn for many years and has been a heroin user during the time she has been under P. Korn's care.[16]

Division began an investigation.

1. PDMP records

The Alaska prescription drug monitoring program (PDMP) collects and stores data on all controlled substance prescriptions filled within the state. Division investigators subpoenaed Ms. Korn's PDMP records for the first five months of 2017.[17] During this period, Ms. Korn wrote a total of 869 controlled substance prescriptions.[18]

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13 Ex. B, p. 9.
14 Ex. B, p. 13; Korn testimony.
15 R. 478.
16 R. 479.
17 Ex. C.
18 Ex. N.

Looking at specific (random) dates in the PDMP records reveals a high volume of controlled substance prescribing by Ms. Korn during this time period. On March 10, 2017, Ms. Korn wrote a total of sixteen controlled substance prescriptions to a total of seven patients.[19] On March 20, 2017, she wrote seventeen controlled substance prescriptions to a total of nine patients.[20] And on April 21, 2017, she prescribed eleven different patients a total of eighteen controlled substances on that day.[21]

The PDMP records also enable the user to sort by type of medication prescribed, or by medication types per patient. From January 3 to June 2, 2017, Ms. Korn wrote:

- 88 prescriptions for amphetamines
- 83 prescriptions for amphetamine derivatives
- 42 prescriptions for central nervous system muscle relaxants
- 287 prescriptions for Opiate agonists
- 400 prescriptions for benzodiazepines
- 52 prescriptions for sedatives/hypnotics[22]

Looked at another way, Ms. Korn's prescribing practices over this same five-month time frame reflect the following:[23]

Drug type	**Total number of patients**	**Total number of prescriptions**
Amphetamines	16 patients	88 prescriptions
Amphetamine derivatives	36 patients	83 prescriptions
Muscle relaxants	16 patients	42 prescriptions
Opiate agonists	51 patients	287 prescriptions
Benzodiazepines	79 patients	400 prescriptions
Sedatives/hypnotics	15 patients	52 prescriptions

19 Ex. N, pp. 25-26.
20 Ex. N, p. 25.
21 Valentine testimony; Ex. N, p. 14.
22 R. 486 – 528. (Ex. N)
23 R. 486 – 528. (Ex. N)

2. Appointment calendars

After the hearing in this matter, Ms. Korn submitted into evidence her appointment calendars for the months of January through May 2017. Neither party offered testimony or other interpretation of these records. It appears Ms. Korn offered the records to substantiate that she sees and spends time with as many patients as the PDMP prescribing records reflect. But a review of the records in concert with the PDMP records from the same dates shows a consistently high volume of controlled substance prescribing – particularly benzodiazepines but also pain medication. Some examples of these patterns follow. Of note, the examples provided are from randomly selected dates. While finite time and resources do not permit the undersigned to compare each day of Ms. Korn's calendar to the corresponding pages of the PDMP records, the randomly chosen dates summarized herein are ample evidence of the trends at issue.[24]

On January 3, 2017, Ms. Korn's schedule shows nine scheduled patients, but only six actually seen.[25] Of the six scheduled patients who were seen, four were prescribed controlled substances. In addition, however, seven other patients not on the schedule received controlled substance prescriptions dated January 3, 2017. Of the thirteen patients receiving controlled substances, eight (including 6 who were not on the schedule) were prescribed Xanax. The number of Xanax tablets prescribed per patient varied between 20 and 120, with an average of 65 tablets per patient, and a total of 518 Xanax tablets prescribed that day.

On January 4, 2017, the schedule shows 10 patients, one of whom was being seen for a TB test. Of the nine others, all nine received controlled substances – as did three patients not on the schedule. Six patients received benzodiazepines and five received opioids (one received both opioids and benzodiazepines). Of the five patients prescribed Xanax, the patients received prescriptions ranging from 30 to 90 tablets. Opioid prescriptions on this date ranged from 28 and 180 tablets, with an average of 72 tablets per prescription.

On January 6, 2017, four patients received prescriptions for a total of 750 tablets of controlled substances. Two patients on the schedule received a combined 540 tablets (clonazepam, Xanax, and tramadol for one; methadone and oxycodone for the other). Another two patience not on the schedule received controlled substance prescriptions: one being

[24] Unfortunately, neither the board's staff nor Ms. Korn synthesized this information, leaving the full range of potential violations unexplored.

[25] The calendar shows one no show, one reschedule, and one patient there for a TB test.

prescribed 30 tablets of morphine and 90 of oxycodone; the other being prescribed 90 tablets of Xanax.

Of eight patients seen on February 6, 2017, six were prescribed controlled substances, and three received combinations of opioids and benzodiazepines. The volume prescribed per patient is as follows:

- A.H.: 180 50-mg tramadol, 30 10-mg Ambien, and 90 1-mg Xanax.
- J.M.: 30 10-mg Ambien and 60 2-mg Xanax.
- B.L.: 30 each of 15-mg morphine ER, 6.5 mg Ambien ER, and 1-mg clonazepam; 60 20-mg dextroamphetamine; and 90 7.25/325-mg oxycodone-acetaminophen.
- B.H.: 90 10/325-mg hydrocodone-acetaminophen.
- C.D.: 30 each 10-mg Ambien and 37.5-mg phentermine.
- K.C.: 90 1-mg Xanax and 45 7.5/200-mg hydrocodone.

On April 7, 2017, Ms. Korn had nine patients on her schedule, one of whom did not keep her appointment. Of the eight patients she saw, five received one or more controlled substance prescriptions. Of these five, four received benzodiazepines, and three – each of whom had received a benzodiazepine – also received a prescription for oxycodone.

On April 11, 2017, Ms. Korn had three patients on her schedule. All of these, and one patient who was not on the schedule, received controlled substances. Three patients received prescriptions for Xanax (between 45 and 60 tablets) and the fourth received a prescription for 90 hydrocodone.

On April 17, 2017, 10 patients were on the calendar. Six of these, and one not on the schedule, received controlled substance prescriptions. Of these, four received opioids, five received benzodiazepines, and two received opioids and benzodiazepines together. The total number of individual tablets of controlled substances prescribed that day was 585 (285 Xanax, 255 opioids, 30 amphetamines and 15 Ambien).

On May 17, 2017, Ms. Korn had seven patients on her schedule, plus three for TB tests. Of the seven appointments, one was a no show and one rescheduled. Of the remaining five, three received controlled substance prescriptions – one for two types of oxycodone, one for Xanax, and one, patient H.G. discussed below, for methadone, oxycodone, Xanax, and tramadol. Additionally, three patients not on the schedule also received controlled substance prescriptions

– two for Xanax and one for phentermine. The total number of tablets of controlled substances prescribed that day was 676, including 250 Xanax, 336 Opioids, and 90 Methadone.[26]

3. Patient records

In August 2018, the Division subpoenaed full patient records of 17 patients from Ms. Korn's practice.[27] From these, the following four were discussed at hearing and/or in the Division's expert report in this matter.

a. Patient J.B.

J.B. was a patient of Ms. Korn's from approximately 1996 until her death in June 2017.[28] Her records reflect that she used IV drugs in early adulthood, later developed Hepatitis A, B, and C, and ultimately required a liver transplant. She received a liver transplant in late 2016, but died suddenly in June 2017.[29]

During the twenty years that she treated J.B., Ms. Korn grew to know a great deal of her personal history.[30] However, the records support the conclusion that, during the period at issue in the PDMP records and likely considerably longer, Ms. Korn treated J.B. for ongoing management of chronic pain and anxiety. The records also reflect that, perhaps due to Ms. Korn's personal familiarity with her patient's life story, Ms. Korn's chart notes for J.B. rarely included detailed documentation, particularly with regard to treatment plans and the efficacy of interventions.[31]

During the 5-month time frame at issue in the PDMP records, Ms. Korn prescribed Xanax, Ambien, Oxycodone HCL, Vicoprofen, and Trazadone to J.B.[32] Ms. B's chart reflects that she received Xanax from Ms. Korn from 1997 until 2010, and then again from mid-2011 until her death six years later, for most of the time receiving 60 1-mg tablets each month.[33]

Ms. Korn prescribed opioids to J.B. alongside benzodiazepines and/or CNS depressants. This is a dangerous prescription combination for which there is an FDA "black box warning" --

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[26] It appears that Ms. Korn wrote prescriptions for future dates for Ms. G. 45 Methadone, 50 Xanax, and 45 Oxycodone were written on this date and filled, while an identical set were written on this date but filled two weeks later. See Ex. N. pp. 19-20, 24; Ex. P, p. 23. The totals here include both sets of prescriptions.

[27] Ex. G.

[28] Ex. Q, pp. 5, 933.

[29] Ex. Q, pp. 74, 268

[30] Korn testimony; Ex. Q.

[31] See, e.g., Ex. Q, p. 270-274, 293, 321-324, 328, 333, 338, 340, 341 351-352, 346, 348, 356.

[32] Ex. N, pp. 3, 7, 8, 11, 16, 17, 23, 28; Ex. Q, p. 5.

[33] See, e.g., Ex. Q, p. 293, 321-324, 328, 333, 338, 340, 341 351-352, 346, 348, 356. During the gap in 2010 – mid-2011, she was prescribed Ativan, but believed it gave her headaches and restarted Xanax. Ex. Q, pp. 270-274.

the FDA's most serious cautionary label. That safety warning, instituted nearly a year prior to the prescriptions at issue in this case, cautions of the "serious risks" of this combination:

> Concomitant use of opioid pain or cough medicines and benzodiazepines, other central nervous system (CNS) depressants, or alcohol may result in profound sedation, respiratory depression, coma, and/or death.

The FDA warning therefore directs health care professionals to (1) "limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate;" (2) if prescribing these medications together, to "limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect;" and (3) to "[w]arn patients and caregivers" about both the risks and the associated signs and symptoms.[34] J.B.'s records are silent as to any discussion or consideration of these warnings.[35]

J.B.'s records also reflect prescriptions by Ms. Korn for both Ambien and Vicoprofen (a combination of Hydrocodone and Ibuprofen) in the months shortly following the liver transplant.

- Ms. B received a 4-day supply (12 tablets) of Hydrocodone-Ibuprofen (Vicoprofen) 7.5-200 on March 21, 2017, and then a 30-day supply (30 tablets) on April 14 and again on May 12.[36]
- She received a 15-day supply (15 10-mg tablets) of Ambien on February 28, 2017, and then a 30-day supply (30 10-mg tablets) of Ambien on March 20, April 17, May 5, and May 31, 2017.[37]

Neither Ibuprofen nor Ambien are recommended for use with hepatically impaired patients.[38] Post-transplant specialist records contained within Ms. Korn's chart for J.B. expressly advised J.B. to "avoid aspirin, ibuprofen, naproxen for pain relief."[39]

Ms. Korn's records for J.B. do not document a justification for prescribing these medications to this patient given her liver condition and given her specialist's express direction

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[34] https://www.fda.gov/media/99761/download (last accessed 4/6/2021). Official notice of the FDA safety warning is taken pursuant 2 AAC 64.300(a).

[35] Ex. Q. Ms. Korn testified that she is "sure at one time" she must have had such discussions, but also noted that J.B. "had drug knowledge," and had "never OD'd on them."

[36] Ex. N, p. 8, 17, 23; Ex. Q, p. 938.

[37] Ex. N, p. 3, 11, 16, 23, 28. (The May 5 prescription was for 30 5-mg tablets. J.B. then obtained 30 10-mg tablets on May 31, one week before her death).

[38] Valentine testimony; Ex. N, p. 23; Ex. L, p. 2. According to its FDA package insert, Ambien should be used with caution in patients with mild to moderate hepatic impairment, and should be avoided in patients with severe hepatic impairment. https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/019908s038lbl.pdf at 5.7. (last accessed 4/13/2021). Official notice of the 2017 FDA package insert for Ambien (zolpidem tartrate) is taken pursuant 2 AAC 64.300(a).

[39] Ex. Q, R. 1048.

to avoid these, nor do they document any discussion of these issues with either J.B. or her specialist.[40]

J.B. was found deceased in her home in early June 2017, about a week after her last visit with Ms. Korn.[41] According to Ms. Korn, there was no evidence J.B. had taken more medication than had been prescribed for her.[42] As noted above, however, the medications prescribed by Ms. Korn to J.B. at the time of her death included a combination of opioids and both benzodiazepines and a CNS depressant, as well as two different medications contraindicated for patients with severe liver damage.

b. Patient H.G.

H.G. was a patient of Ms. Korn's for roughly fifteen years.[43] Her medical history is significant for chronic orthopedic difficulties and stroke.[44] She also has a substance abuse history and participated in treatment at Clitheroe Center after arrests in 2006 and 2008.[45] Another provider's medical record in Ms. Korn's chart for H.G. reports that she participated in A.A. Pain Clinic for six months in 2009, but was terminated from the clinic after having a urinalysis that was negative for methadone.[46]

During the 5 months covered by the PDMP records, Ms. Korn prescribed four scheduled medications – Xanax, Methadone, Oxycodone, and Tramadol – to H.G.[47] During this time period H.G. received, every two weeks: 50 0.5-mg tablets of Xanax (classified as a 12-day supply), 45 5-325 tablets of oxycodone-acetaminophen (a 15-day supply), and 45 10-mg tablets of methadone HCL (a two-week supply).[48] As noted above, prescribing these combinations of opioids, benzodiazepines, and CNS depressants together poses risk for overdose, abuse, and death, and should be used with extreme caution.[49] On two occasions in a six-week period during

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40 Ms. Korn testified that at some unidentified point she discussed with J.B. "the fact that drugs metabolized in her liver was better than the effect of alcohol on her liver." If such conversation occurred, it is not documented in J.B.'s chart. Moreover, if such a conversation did occur, it would be further evidence of questionable judgment and prescribing practices with regard to her complex patients.

41 Ex. Q, pp. 4-5. Ms. Korn signed Ms. B's death certificate. Ex. Q, p. 268. She testified that she was instructed by an unknown individual to indicate that J.B. had died of a probable heart attack. Korn testimony. The death certificate in the record attributes J.B.'s death to a "probable blood clot." Ex. Q, R. 810.

42 Korn testimony; Ex. Q, p. 4.

43 Ex. R; Valentine testimony.

44 See, e.g., Ex. R, p. 343.

45 Ex. R, pp. 241-246, 255, 259.

46 Ex. R, p. 343. Ms. Korn disputes the accuracy of this information.

47 Ex. N, pp. 4, 8, 12-14, 19-20; 23-24; 28; 31; 35, 38; 42 (prescriptions 5/26/17; 5/12/17; 4/14/17; 4/20/17; 4/28/17; 3/31/17; 3/17/17; 3/3/17; 2/17/17; 2/3/17; 1/20/17; 1/3/17).

48 Ex. N, p. 4, 8, 12, 16, 20, 24, 28, 31 (January 20, February 2, February 17, March 3, March 17, March 31, April 14, April 28, May 12, and May 26).

49 Valentine testimony.

this same time, H.G. also received 180 50-mg tablets of another opioid, Tramadol (as a 30-day supply).[50]

A sampling of chart notes for this period shows monthly visits "for refills." For example:

- 2/17/17: *Discussed past history. Pt has no desire to use.*
  O 130/70. Herat rate 70 normal rhythm.
  A: Osteoperotic fx hx
  Sug menopause
  Hypertension
  High col.
  P. Premarin .3 #30 + 1 refill
  Sinvastin 20 mg #30 2 1qd
  Prenizide 20/12.5 #30 Tqd
  Methadone 10 MG #45 T tid + for pick up 3/3
  Xanax .5 #50 1½ tid + 1 refill
  Percocet 7.5/325 #45 + for pick up 3/3.[51]

- 3/17/17 *P. Methadone 10 MG #45 T tid + one for 3/31*
  Percocet 7.5/325 #45 T tid + one for 3/31.
  Xanax .5 #50 + 1 refill
  A Osteoportic Fx.
  Soc stress
  O 140/90. Recheck 138/86.[52]

- 4/14/17 *Here for refills.*
  P. Xanax .5 1½ tid #50 + 1 refill
  Percocet 5/325 #30 T bid + 1 for pick up 4/29.
  Methadone 10 MG 1 tid #45 + 1 for 4/29[53]

Of note, H.G.'s chart shows roughly the same combination of prescriptions over a period of years. This is so despite a January 4, 2016 chart note in which Ms. Korn wrote: "Uses Benadryl at bedtime. Gets up at 4:30 and is not pill headed the next day. I could tell by pts speech on the phone had taken something besides regular drugs."[54] Despite these observations and the patient's substance abuse history, and without a documented explanation, Ms. Korn prescribed H.G. 52 Xanax, 30 Percocet, and 45 Methadone at that appointment, and again two

50 Ex. N, p. 23, 35 (February 2, March 17).
51 Ex. P. p. 24
52 Ex. P. p. 23
53 Ex. P, p. 22.
54 Ex. P, p. 36.

weeks later.[55] H.G.'s chart notes do not offer documentation to explain why she is taking these medications, how they are working, or the overall treatment plan.[56]

A small number of notes make passing references to "back pain," "knee pain," and/or "social stress," and an even smaller few record a "pain level," but none appears to look at whether pain is improving with the opioids prescribed, let alone documenting what else might be considered to treat Ms. G's ongoing pain problems.[57] Ms. Korn's records similarly do not appear to reflect any consideration of how to treat H.G.'s "social stress" other than with benzodiazepines.[58]

The records plainly support the conclusion that, in addition to providing "women's health care," Ms. Korn was separately treating H.G. for pain management and anxiety. As to the opioid prescriptions, it is true, as Ms. Korn testified, that H.G.'s Percocet dosage has decreased over the years – it was 10/325-mg in 2012, then 7.5/325-mg in January 2014, and then reduced to 5/325-mg in March 2017. However, nothing in H.G.'s chart explains any of the reductions, nor the choice to stay on an opioid for nearly ten years, nor the choice to continuously prescribe Xanax and Methadone and without any apparent consideration of their efficacy or dangerous of the continued combination of medications.[59] Records throughout the remainder of 2017 reflect regular pain management visits for refills of these multiple pain medications.[60]

c. Patient M.M.

M.M. was a patient of Ms. Korn's from 2014 through August 2018.[61] Like H.G. and A.M., discussed below, her medical records reflect a history of intravenous drug use and Hepatitis C.[62] And like the other patients discussed herein, the records support the conclusion that Ms. Korn was seeing M.M. for ongoing chronic pain management and anxiety.

During the time period covered by the PDMP records, Ms. Korn routinely prescribed a combination of benzodiazepines and opioids, and without a clear description of why. For example, on April 7, 2017, M.M. was given 150 10-mg Methadone tablets, 90 30-mg Oxycodone

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55 Ex. P., pp. 35-36.
56 *See* R. 1678; Valentine testimony.
57 *See e.g.,* Ex. R, R. 1697-1699.
58 See R. 1680, 1699.
59 See Ex. R, R. 1690-1694. The chart is also silent as to why Ms. Korn added a third opioid – 100 50-mg tablets of Ultram – in September 2017, with no documentation of the decision-making process that led to this addition on top of the continued prescriptions for Xanax, Methadone, and Percocet. Ex. R, p. 1688.
60 Ex. R, pp. 1681, 1685. By May 2018, H.G. was apparently off the Ultram, but still on the other three, and still with no documentation of the decision-making process.
61 Ex. S, pp. 2-8.
62 See Ex. S, pp. 219, 223.

HCL tablets, and 30 5-mg Diazepam (valium) tablets.[63] She received the same combination on May 8, 2017.[64] Ms. Korn's chart notes for M.M. for that day read in full:

> *Sleeping too much. Doesn't have any ambition. Discussed some of past history. Doesn't see herself as ever having a different better life. No SI.*
>
> *P: Methadone 10 mg #150*
>
> *Premarin 45 #30 Tqd*
>
> *Valium 5 mg #30*
>
> *Roxicodone 30 mg #90.*[65]

M.M. received the same doses monthly throughout 2017, and similar doses in the 2018 records.[66]

Also of note, M.M.'s records include a June 2018 hospital admission for suicidal ideation.[67] Her hospital discharge summary notes that she sees Ms. Korn for chronic pain.[68] Ms. Korn continued to prescribe the same quantities and doses of opioids alongside benzodiazepines after this hospital admission.[69]

d. Patient A.M.

Lastly, A.M. was a patient of Ms. Korn's beginning in 2007.[70] She had a history of substance use, alcohol use, and significant depression with a history of suicide attempts, as well as having breast cancer in 2012 and chronic Hepatitis C. Ms. M. came to Ms. Korn's practice from a pain clinic, and was taking methadone when she first began seeing Ms. Korn.[71] Ms. Korn has apparently continued to prescribe methadone to her "for back pain" since that time.[72]

The PDMP records reflect that during the time period at issue in the Division's investigation, Ms. Korn prescribed Ms. M. between 480 and 720 methadone tablets per month.[73] Additionally, while the standard maintenance dose of methadone for opioid dependent patients is 80 -120 mg/day,[74] Ms. Korn's records for A.M. as well as the PDMP records reflect an ongoing

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63 Ex. S, p. 41-42 (R 3131-3132).
64 Ex. N, p. 10.
65 Ex. S, p. 41 (R 3131).
66 *See* Ex. S, pp. 32, 34-36, 39, 40, 150-153.
67 Ex. S, p. 169-171.
68 Ex. S, p. 171.
69 *See* Ex. S, p. 17.
70 Ex. T; Korn testimony.
71 Korn testimony.
72 Korn testimony.
73 Ex. L, p. 3; Ex. N, p. 3, 7, 12, 15, 22, 26, 31, 34 (240 tablets of 10-mg methadone on 5/2/17, 5/30/17, 5/16/17, 4/18/17, 4/4/17, 3/21/17, 3/7/17, 2/21/17, 2/7/17, 1/24/17)
74 Ex. L.

prescription of methadone at 160 mg per day.[75] The chart notes in the record – only spanning from late 2009 through 2013[76] – reflect a continuous pattern of prescribing 160 mg of Methadone per day for a period of years, with virtually no explanation beyond passing references to back pain, and no attempts to titrate down or stop it.[77]

D. Accusation

On August 4, 2020, the Division filed an Accusation seeking disciplinary sanctions against Ms. Korn's nursing licenses. The operative Accusation for purposes of this proceeding[78] alleges the following:

- Count 1 alleges that Ms. Korn violated AS 08.68.270(5) by engaging in conduct that resulted in a significant risk to client health or safety. Specifically, Count I alleges Ms. Korn prescribed medication that was contraindicated for certain patients given their surgical or prescriptive histories.
- Count II alleges that Ms. Korn violated AS 08.68.270(7) and 12 AAC 44.770(5) by engaging in unprofessional conduct. Specifically, Count II alleges a failure to take and document sufficient patient histories before prescribing medication, and the prescription of medication contraindicated by a patient's condition.
- Count III alleges Ms. Korn violated AS 08.68.270(7) and 12 AAC 44.770(10) by failing to maintain accurate records for clients that accurately reflect nursing problems and interventions.
- Count IV alleges Ms. Korn violated AS 08.68.270(7) and 12 AAC 44.770(39) by failing to check the PDMP when prescribing schedule II and III controlled substances.
- Count V (added at the close of testimony) alleges that Ms. Korn violated AS 08.68.270(7), (8), and (12), and 12 AAC 44.445(e) and .770(3) by delegating her PDMP access to an unlicensed staff member.

The Division requested a one-year suspension, five years' probation, a $2500 fine, a formal reprimand, practice monitoring, and 30-hours of additional CMEs on topics related to the alleged violations. Ms. Korn, through counsel, filed a notice of defense and requested a hearing.

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[75] Ex. T, pp. 16-52 (prescriptions for 40 mg of Methadone four times daily, 12/30/09 – 5/15/13); Valentine testimony.

[76] Unfortunately, the agency record does not appear to contain chart notes for A.M. from Ms. Korn's practice from after 2013.

[77] See generally, Ex. T, pp. 16-52. Ms. M's chart contains a few references to back pain and a desire to have back surgery in the future. Ex. T, pp. 25 (6/27/12: "Has had more back pain from chemo and more muscle pain in legs & sm spasms in arm. Methadone 10 mg #240 4qid."); 28 (5/16/12: "P. Refills.… Percocet 7.5/325 #60. Methadone 10mg #240 4qid. Can have back surgery after graduates in 1 yr."); 30 (4/4/12: "A. Breast Cancer Treatment. Backpain."), 33 (12/28/11: "Methadone 4qid #240. Ultimate goal surgery after graduation"). However, the records in the record do not reveal any actual attempts to titrate down the dose.

[78] The First Amended Accusation, filed January 27, 2021, is the operative accusation.

E. Hearing and post-hearing filings

The hearing in this matter was held on January 19 and February 2, 2021. Ms. Korn was represented by counsel, D. Scott Dattan; the Division was represented by AAG Harriet Milks.

1. Denise Valentine testimony

The Division's main witness was Advanced Practice Registered Nurse (APRN) Denise Valentine. Ms. Valentine has worked in nursing since 1984, became licensed as an APRN in 2005, and has held prescriptive authority since 2006. Ms. Valentine is experienced in primary care nursing, and is a former longtime member of the Board of Nursing. She was admitted as an expert in the practice of registered nursing, specifically the professional expectations for documentation, prescriptive practices, and scope of practice,[79] and offered her opinion that Ms. Korn overprescribes controlled substances beyond her scope of practice and inadequately documented.

Ms. Valentine opined that the PDMP records reflect unusually high numbers of controlled substances to be prescribed in a single day, particularly in the context of a "women's health" specialization. Ms. Valentine also noted that these records reflected multiple instances in which a single patient was prescribed both opioids and benzodiazepines, despite the black box warning cautioning against this combination.

Looking at the four patients highlighted in her report (and introduced briefly above),[80] Ms. Valentine opined that these patients' records reflected a pain and anxiety management practice, and clinical documentation that fell far below the minimum threshold of professional conduct.[81] Also, and noting the well-established risks to patient safety associated with prescribing benzodiazepines in concert with opioids, Ms. Valentine expressed concern that several patients were receiving this dangerous combination with no apparent acknowledgment or justification documented in the chart, and certainly no justification for ongoing regular prescriptions over a long period of time.[82] Additionally, as to J.B., Ms. Valentine expressed

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79 Division Investigator Joel Dolphin testified very briefly, only to describe his role in subpoenaing documents and drafting the accusation.

80 Although Ms. Valentine's report also discusses patient A.M., she did not offer direct testimony on this patient's care.

81 Valentine testimony, Ex. N, p. 16.

82 Ms. Valentine also testified that the records reflected an incident in which H.G. was discharged from AA Pain Clinic, but Ms. Korn denies that H.G. was seen at that facility, and the records do not appear to support Ms. Valentine's recollection as to that incident. But the record does support Ms. Valentine's observation that Ms. Korn prescribed H.G. "a high amount of benzodiazepines while prescribing methadone and oxycodone," which Ms. Valentine characterized as "a dangerous combination of medications that puts a client at risk for drug overdose." Ex. L, p. 2.

Ambien and Vicoprofen prescriptions for a hepatically impaired patient, and also about this post-transplant prescribing appearing to have occurred without consultation with the patient's specialist or any apparent discussion of risks with the patient.[83]

Ms. Valentine testified that Ms. Korn's practices fall below the standard of care in multiple areas. As a threshold matter, Ms. Valentine explained that the standard of care for controlled substance prescribing requires documentation of the reasons for prescribing, the long-term treatment plan, and education of the patient as to that plan. She further testified that the standard of care for safe patient practice when prescribing controlled substances with a high potential for addiction and abuse is to make sure that patients are on the lowest effective dose and titrated off the medication where possible.

As to charting, Ms. Valentine testified credibly that the information contained in Ms. Korn's clinical notes was significantly below the requirements set out in 12 AAC 44.445(f), which governs the charting requirements specific to controlled substance prescribing.[84] Explaining that documentation should include "pain rating before and after the given medication, side effects of the drug, [and] effect on function with the medication," Ms. Valentine observed that Ms. Korn's charting "consistently shows a lack of the standard documentation one would expect to see during a visit."[85]

As to prescribing practices, Ms. Valentine expressed serious concern about Ms. Korn's prescribing practices around controlled substances, noting ongoing prescriptions for dangerous combinations of benzodiazepines with opioids and without sufficient (if any) documentation of a justification for those prescriptions, particularly in concert. Ms. Valentine credibly testified that the amount "of controlled substances being prescribed, the frequency at which they are prescribed, the combinations of scheduled medications, and Ms. Korn's lack of documentation are sufficiently divergent from the standard of care as to "create a public safety issue."

Lastly, Ms. Valentine testified that APNs are expected to practice within their scope of specialty, but that Ms. Korn's records reflected more of a pain management practice than a

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[83] Valentine test. ("If I had a patient who had needed something that severe, I'd practice in consultation with the specialist to protect the longevity of the transplant. It stood out that the notes reflect no reaching out to the specialist.")

[84] *See* 12 AAC 44.445(f) ("When prescribing a drug that is a controlled substance, as defined in AS 11.71.900, the APRN shall create and maintain a complete, clear, and legible written record of care that includes (1) a patient history and evaluation sufficient to support a diagnosis; (2) a diagnosis and treatment plan for the diagnosis; (3) a plan for monitoring the patient for side effects of the drug and results of the drug; (4) a record of each drug prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills.").

[85] Korn testimony; Ex. L, p. 1.

general women's health care practice. This conclusion was based on the number of patients seen, the percentage of patients who received controlled substances, and the nature of the documentation. Given the extensive amount of prescribing for pain management and anxiety, and the chief focus of reviewed patient records relating to pain management, Ms. Valentine opined that Ms. Korn is practicing outside the scope of her authorized women's health care NP practice.

2. Paula Korn testimony

Ms. Korn testified in her own defense. She denied operating a pain management practice, saying that her "primary practice is women's health," and that most of her patients are long-term patients with multiple medical needs. She described the scope of problems for which she sees patients as including weight loss, hypertension, early dementia, "female problems," depression, and anxiety. She testified that only "about five percent" of her patients are on pain medication.

Ms. Korn explained that she has known most of her patients for more than a decade, and that her chart notes are sufficient for her own purposes of being able to look at the notes and recall what occurred. As to the level of detail in patient records, she stated that her patients' source of pain didn't change, so she did not feel the need to continuously repeat the same information in their records.

She appeared to concede that the documentation fell below expectations, stating (as to patient J.B.), that "at the time I thought I was adequately documenting," but "obviously people want a huge amount on there." Nonetheless, Ms. Korn explained that she doesn't "see the sense in writing the same thing every time if nothing's changing." Ms. Korn also noted that "you can't write down everything you talked to a patient about," and that patients don't like serial discussions "about their [past] use or bad choices." When asked if she was documenting enough, she responded that "you can always document more," but that, "[i]f I know the patient, my documentation was enough for me to know. I know all my patients; it's enough for me to look at the record." Ms. Korn was unable to say whether her documentation practices improved after the 2009 consent agreement.

As to her prescribing practices, she noted that her patients "have never OD'd" and also that many have a sophisticated knowledge of drugs. She said that she rarely gives refills, instead meeting with her patients ever two weeks or once a month. Her testimony on individual patients was sparse, but, as to the allegations in the accusation:

- As to patient J.B., she testified that J.B. began using Xanax in 2001 order to quit using alcohol, that she and J.B. had discussed that Xanax was better for her liver than alcohol, and that she was prescribing J.B. oxycodone for joint pain caused by Hepatitis C. When asked whether she had discussed with J.B. her use of benzodiazepines and opioids, Ms. Korn responded that J.B. "had drug knowledge and she never OD'd on them." She testified that she had discussed J.B.'s use of Ambien with J.B.'s specialist, but also admitted these events were "probably not" reflected in J.B.'s chart.
- She testified that she "monitored the risk" associated with patient H.G.'s cocktail of benzodiazepines and opioids by seeing "patients every month, sometimes every two weeks," and "spend[s] a whole half hour with them, not writing on anything." "She's never OD'd; she's well aware of drugs," and "her dosage has gradually decreased" over a period of years.
- She acknowledged that patient A.M. had been on methadone for back pain for at least 10 years without any adjustment to her dose, and that there appear to be no records showing any attempt to titrate down that dose. She noted that the patient had been seeing a counselor for twenty years, and saw a liver specialist who "knew what she was on."

Ms. Korn did not deny that the Ambien and ibuprofen were dangerous to her hepatically impaired patients. She likewise did not deny that the combination of opioids and benzodiazepines was dangerous. She testified that her patients are savvy about drugs and that she mitigates the risk by meeting with them every two to four weeks.

On efforts to keep her prescriptive practices knowledge up to date, Ms. Korn described having read two books in the past year about opioids, taken four hours of relevant continuing education practices in 2019, and taken an online course in 2002. When queried about the evolution in thinking about opioid use and abuse, she offered that alcohol kills more people than opioids, and that her patients – including the ones on benzodiazepines – hadn't seen their doses increase.

Lastly, Ms. Korn also testified that she didn't use to consult the PDMP because she was unclear about the requirements, but that PDMP records are now checked for each patient at each visit. However, in describing what those checks look like, she testified that her office manager was the one actually accessing her PDMP account.

3. Parties' post-hearing submissions

Both parties also submitted a large volume of additional documents after the hearing. Ms. Korn submitted her handwritten patient schedules for the months covered by the PDMP records. The Division, at the request of the ALJ, submitted an unredacted copy of its Exhibit N, the 45-page PDMP prescriber activity report. Ms. Korn then submitted, in response, 103

handwritten pages of newly-generated notes about the patients identified in the PDMP records.[86] Upon further request, the Division also submitted separate exhibits containing all records in the agency record for each of the four patients addressed in Ms. Valentine's report. Neither party requested to restrict the other party's post-hearing submissions or to reopen testimony to contextualize or otherwise address these submissions.

III. Discussion

A. General principles

The Board of Nursing has been charged by the legislature to develop reasonable and uniform standards for nursing practice.[87] Those standards, set out in the Board's regulations, establish the requirements for licensure, the standards for ongoing practice, and the scope of what constitutes unprofessional conduct.[88]

The legislature has also empowered the Board with disciplinary authority to enforce its standards, and AS 08.68.275 identifies the range of disciplinary sanctions that the Board may take, singly or in combination, in exercising those disciplinary powers.[89] These range from imposition of probation to permanent license revocation. The Board may suspend or revoke the license of a person who:

- "has intentionally or negligently engaged in conduct that has resulted in a significant risk to the health or safety of a client or in injury to a client;"[90]
- "is guilty of unprofessional conduct as defined by regulations adopted by the board."[91]
- "has willfully or repeatedly violated a provision of this chapter or regulations adopted under this chapter or AS 08.01;"[92] or
- "[has] prescribed … drugs in violation of a law, regardless of whether there has been a criminal action or harm to the patient."[93]

The Board may also terminate prescriptive authority if drugs are prescribed or dispensed outside an APRN's scope of practice for "other than therapeutic purposes."[94]

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86 Ex. 1.
87 AS 08.68.100(a)(8), (b).
88 *See* 12 AAC 44.400 (Requirements for licensure: APRN); 12 AAC 44.447 (APRN dispensing standards); 12 AAC 44.770 (Unprofessional conduct).
89 *See* AS 08.01.075 (Disciplinary Powers of Boards).
90 AS 08.68.270(5)
91 AS 08.68.270(7)
92 AS 08.68.270(8)
93 AS 08.68.270(12)
94 12 AAC 44.440(e)(2).

Alaska Statute 08.68.270(f) requires the Board to "seek consistency in the application of disciplinary sanctions." Accordingly, "a significant departure from prior decisions involving similar situations shall be explained in the findings of fact or order."

As the party seeking to invoke disciplinary sanctions, the Division has the burden of proving, by a preponderance of the evidence, that Ms. Korn committed the alleged violations.[95]

B. Allegations in the accusation

1. Did the Division prove that Ms. Korn created a significant risk to patient health or safety by prescribing medication contraindicated by surgical or prescriptive history? (Count I)

"The Board may suspend or revoke the license of a person who … has intentionally or negligently engaged in conduct that has resulted in a significant risk to the health or safety of a client or in injury to a client."[96] In the first count of its accusation, the Division argues that Ms. Korn engaged in such conduct by prescribing medications contraindicated by certain patients' surgical or prescription histories.

As to the allegation of prescribing medication contraindicated by a patient's surgical history, the Division here is referring to Patient J.B., a liver transplant recipient, to whom Ms. Korn prescribed both Vicoprofen and Ambien in the months after her transplant. Ms. Korn testified that when she began prescribing Ambien for J.B. it was in the context of J.B. having problems with alcohol and "deciding that Ambien was better than alcohol for her." Ms. Korn testified that she discussed the hepatic impact of Ambien with J.B., and also with her liver specialist, but concedes that such conversations are not documented in her chart.

Nonetheless, both ibuprofen and Ambien are dangerous choices for hepatically impaired patients, and the transplant discharge materials document that J.B. was expressly told to avoid ibuprofen.[97] And Ms. Korn's claim to have discussed various issues with her patient or J.B.'s specialist does not override the simple fact that there is no documentation of such discussions having occurred. From the perspective of a nurse's recordkeeping obligations, as Ms. Valentine observed, conversations "didn't happen" if not documented in a patient's chart. Ms. Korn did not offer evidence of ever documenting risk analysis or discussions of such risks with J.B. or her treatment team, nor did she offer any explanation for her choice to prescribe these medications to her hepatically impaired patient.

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95 AS 44.62.360; *Odom v. State*, 421 P.3d 1, 7 (Alaska 2018).
96 AS 08.68.270(5)
97 Valentine testimony; Ex. Q, p. 1048.

As to the allegation of medication prescribed in contraindication of a patient's prescriptive history, the evidence further supports a finding that Ms. Korn's practice of prescribing opioids in concert with benzodiazepines was outside the scope of practice for a women's health care ANP, and created a significant risk to her patients' safety.[98] The FDA's boxed warning on this practice – which predates all prescriptions in the PDMP records at issue here – warns of a heightened risk of overdose and death, and directs prescribers to avoid concomitant prescribing wherever possible and to limit both dosages and durations to the minimum required.[99] Patients J.B., H.G., and M.M. all received this dangerous combination during the time period covered by the PDMP records (as did other patients listed in those records) for a lengthy duration at high doses and in large volumes.

In the case of J.B., this patient received 60 30-mg Roxicodone tablets on March 1, March 20, April 14, and May 5 – all while also receiving other opioids and multiple CNS sedatives (Ambien and Xanax). Further, and beyond also prescribing hepatically challenging medications after J.B.'s liver transplant, Ms. Korn also continued to prescribe Xanax and Ambien to J.B. during this time despite noting in her chart that she was taking "more than prescribed," needing refills "about six days too early."[100] On the same day that she noted that J.B. was overusing Xanax and Ambien, Ms. Korn provided her a prescription for 60 more Xanax tablets and 15 more 10-mg Ambien, as well as 30 Percocet and 60 Roxicodone.[101]

In the case of M.M., the evidence again shows prescriptions for methadone, opioids, and sedatives, all given in high doses and large amounts. M.M. received 90 30-mg Roxicodone tablets on January 11, February 10, March 10, April 7, and May 8, 2017 – again while receiving other opioids (150 10-mg methadone) and a central nervous system depressant (30 5-mg diazepam) alongside each of the oxycodone refills.[102] This large volume of high dose medications carrying FDA cautions about co-prescribing, provided over lengthy periods of time

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98 Ex. L, p. 3; Valentine testimony. To the extent this count is also intended to refer to A.M., to whom the Division alleges Ms. Korn prescribed methadone for a number of years without explanation or justification in the patient's chart, the records presented as to A.M. do not include any records after 2013. It is therefore impossible on this record to substantiate an allegation about improper prescribing in 2017.

99 See https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/021011s006lbl.pdf (FDA prescribing packet for Roxicodone, prescribed to J.B.) (last accessed 4/9/2021) ("Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing for use in patients for whom alternative treatment options are inadequate; limit dosages and durations to the minimum required; and follow patients for signs and symptoms of respiratory depression and sedation.")

100 Ex. Q, p. 396.

101 Ex. Q, p. 396.

102 Ex. N, p. 10, 17-18, 25, 33, 40.

with no apparent awareness of or effort to ameliorate the dangers, placed this patient at an unreasonable risk of harm.[103]

Nothing in these patients' records for those time periods suggests any level of awareness or acknowledgement by Ms. Korn of the risks of combining these medications, nor any discussion of those risks with the patient, nor any implementation of a plan to reduce or ameliorate the risks. Considering the example of H.G., Ms. Korn testified that her prescribing practices are safe as H.G. "knows drugs" and "never OD'd." But Ms. Korn's generalized belief that her clients are immune to overdose is not evidence that these prescribing practices were appropriate. Her patient's charts are devoid of any analysis of the risks and benefits of these prescribing choices, and Ms. Korn did not offer any testimony beyond vague assurances to justify her dangerous prescribing practices.[104]

The combination of prescriptions provided to these patients – particularly in the doses and volume prescribed, placed Ms. Korn's patients at risk of significant adverse consequences.[105] The Division has met its burden of proving that Ms. Korn negligently engaged in conduct that created a significant risk to patient health or safety by prescribing medication contradicted by a patient's surgical history (J.B.) and prescriptive history (J.B., H.G., and M.M.).

2. Did the Division prove that Ms. Korn failed to take and document sufficient patient histories and prescribed medication that is contradicted by a patient's condition? (Count II)

Count II of the Accusation is brought under 12 AAC 44.770(5), which defines unprofessional nursing conduct to include "failing to perform acts within the nurse's scope of practice which are necessary to prevent substantial risk or harm to a client."[106] In Count II, the Division argues that Ms. Korn failed to perform such acts in her taking and documenting of patient histories, and in her prescribing practices.

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[103] Ex. L, p. 3 (noting "risky combination" that places a patient "at risk of death."). Additionally, in the case of patient A.M., Ms. Valentine pointed to methadone prescriptions "surpassing the recommended dose." In the month of April 2017, for example, she prescribed 480 tablets of methadone, an amount which Ms. Valentine characterized as "dangerous" given the possibility of overdose. Ex. L, p. 3. With a lack of contemporaneous medical records, however, the prescriptions to A.M. are not included in this finding.

[104] Nothing in this decision should be read to impose a blanket prohibition on prescribing opioids alongside benzodiazepines or CNS depressants. Such prescribing, however, must be undertaken with due observance of not only Board statutes and regulations but also the precautions set out in the FDA warning.

[105] Valentine testimony, Ex. L, p. 2 (noting, as to H.G., that prescription of "a high amount of benzodiazepines while prescribing methadone and oxycodone [is] a dangerous combination of medications that puts a client at risk for drug overdose.").

[106] 12 AAC 44.770(5) ("Nursing conduct that could adversely affect the health and welfare of the public constitutes unprofessional conduct under AS 08.68.270(7) and includes… failing to perform acts within the nurse's scope of practice which are necessary to prevent substantial risk or harm to a client.").

The allegations of prescribing practices in expressly linked to the prescription of Vicoprofen and Ambien to J.B. This decision has already found that the prescription of Ambien and Vicoprofen to J.B. in the months following her liver transplant violated professional standards and put J.B. at risk. For the same reasons as in Count I, Ms. Korn's prescription of these medications to Ms. B likewise establish a "failure to perform acts within the nurse's scope of practice which are necessary to prevent substantial risk or harm to a client."[107]

As to Count II's allegations of inadequate documentation, the APRN's duties with regard to taking and documenting patient history when prescribing controlled substances are set out in regulation:

> When prescribing a drug that is a controlled substance, as defined in AS 11.71.900, the APRN shall create and maintain a complete, clear, and legible written record of care that includes (1) a patient history and evaluation sufficient to support a diagnosis; (2) a diagnosis and treatment plan for the diagnosis; (3) a plan for monitoring the patient for side effects of the drug and results of the drug; (4) a record of each drug prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills.[108]

Ms. Korn's patient records for the period covered by the PDMP records do not provide anything close to the level of detail contemplated by the regulation.

The exhibits at hearing contain pages upon pages of sparse entries often documenting little if anything beyond that a patient is "here for refills" and listing the medications prescribed.[109] Thus a patient may be seen a dozen times and receive hundreds upon hundreds of tablets of controlled substances, without any revisiting of any topic identified in 12 AAC 44.445(f)(1)-(3).

Ms. Valentine testified, and this decision concludes, that the patient records for the time period in question were insufficient under the Board's regulations and the accepted professional standards applicable to controlled substance prescribing. Ms. Korn attempted to justify the paucity of information in her patient records by explaining that she had been treating these patients for many years prior and did not need to redocument information that remained unchanged over time. The statutory and regulatory requirements for detailed records contain no exception based on familiarity with a patient, or having treated the patient for a period of years. Ms. Korn made no attempt to offer testimony – other than her own vague assurances – or

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107 12 AAC 44.770(5).
108 12 AAC 44.445(f).
109 See, e.g., Ex. R, pp. 8-13; Ex. Q, pp. 393-395.

authority to support such a construction of the requirements. The Division has met its burden of showing that Ms. Korn failed to document sufficient patient history as required when prescribing controlled substances.

3. Did the Division prove that Ms. Korn failed to maintain accurate records for patients that accurately reflected the nursing problems and interventions? (Count III)

In Count III, the Division argues that Ms. Korn's patient records for the patients discussed above fell below the required standard of care. The Board's regulations provide that "failing to maintain a record for each client which accurately reflects the nursing problems and interventions for the client[.]" constitutes unprofessional nursing conduct.[110] As noted above, when prescribing a controlled substance, APRNs are required to maintain a clear and legible written record of care that includes:

> (1) a patient history and evaluation sufficient to support a diagnosis; (2) a diagnosis and treatment plan for the diagnosis; (3) a plan for monitoring the patient for side effects of the drug and results of the drug; (4) a record of each drug prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills.[111]

The Division argues and Ms. Valentine testified that Ms. Korn's chart notes do not satisfy this standard. The evidence does permit a contrary finding.

As to J.B., M.M., and H.G., Ms. Korn's chart notes for the time period surrounding the PDMP records fall significantly short of the requirements set out in 12 AAC 44.445(f). Virtually none of the chart notes include anything resembling a treatment plan, and none identify a plan for monitoring side effects or results of the treatment.

As described in detail above, Ms. Korn engaged in very frequent prescribing of controlled substances – most frequently, medication for pain and anxiety, and in large volumes over long periods of time – but paid little if any attention to the associated requirements of documentation, including clearly documenting the need for and response to these substances.[112] Further, and as noted above, several of the patients addressed in Ms. Valentine's report and testimony also received a dangerous cocktail of controlled substances on a regular basis over a

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110 12 AAC 44.770(10) ("Nursing conduct that could adversely affect the health and welfare of the public constitutes unprofessional conduct under AS 08.68.270(7) and includes… failing to maintain a record for each client which accurately reflects the nursing problems and interventions for the client[.]").

111 12 AAC 44.445(f).

112 Valentine testimony.

lengthy period of time and with little to no documentation about why these medications were prescribed, let alone any serious attempt to justify the dangers or titrate down doses.

Ms. Korn made no serious effort to show compliance with the regulation on controlled substance prescribing documentation nor with professional standards for documentation generally as described by Ms. Valentine, instead arguing that her records were sufficient for her own purposes. But regardless of how personally informative Ms. Korn finds her chart notes, the regulations plainly require significantly more. The Division has met its burden of showing that Ms. Korn committed unprofessional conduct by failing to maintain adequate records to document and justify her diagnosis, treatment plan, and monitoring plan.

4. Did the Division prove both PDMP violations? (Counts IV and V)

The original Accusation in this case contained one count pertaining to the Prescription Drug Monitoring Program (PDMP) – failing to check the PDMP before prescribing controlled substances (Count IV). After the close of testimony, the Division amended the accusation to add a second PDMP count – delegating PDMP access to an unlicensed employee (Count V).

As to Count IV, the Board's regulation on APRN controlled substance prescribing requires the following:

> The APRN shall check the controlled substance prescription database, established under AS 17.30.200, before a controlled substance designated schedule II or III under federal law is initially dispensed, prescribed, or administered to a patient, at least once every 30 days for up to 90 days, and at least once every three months if a course of treatment continues for more than 90 days.[113]

The Board's regulations on unprofessional conduct, in turn, provide that failing to check the PDMP when prescribing or dispensing a schedule II or III controlled substance constitutes unprofessional conduct.[114]

None of the medical records in the 3,000+ page agency record appear to document checking of the PDMP in association with controlled substance prescribing. In her testimony, Ms. Korn admitted that there was an undefined period of time when she was not checking the PDMP because she was unaware that she was required to do so. She explained that the PDMP is now checked for each patient at each visit. Ms. Korn, through counsel, has admitted this violation.

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113 12 AAC 44.445(g)

114 12 AAC 44.770(39).

As to Count V, the Division alleges, and Ms. Korn admits, that she violated the PDMP regulations by improperly delegating access to her PDMP account. Access to the PDMP database is strictly limited.[115] Concerning access to the PDMP by prescribing practitioners and their staff, AS 17.30.200(d)(3) provides that the database may only be accessed by:

> [A] licensed practitioner having authority to prescribe controlled substances or an agent or employee of the practitioner whom the practitioner has authorized to access the database on the practitioner's behalf, to the extent the information relates specifically to a current patient to whom the practitioner is prescribing or considering prescribing a controlled substance; the agent or employee must be licensed or registered under AS 08.

The Board's regulations, in turn, provide that "an advanced practice registered nurse with authority to prescribe controlled substances may only delegate to a registered nurse or licensed practical nurse to access the database on the practitioner's behalf."[116]

The Board's regulation on unprofessional conduct expressly include in such conduct a nurse "knowingly delegating a nursing care function, task, or responsibility to another who is not licensed under AS 08.68 to perform that function, task, or responsibility, when the delegation is contrary to AS 08.68 or 12 AAC 44 or involves a substantial risk or harm to a client."[117] Ms. Korn, through counsel, has admitted this violation.

C. What discipline is appropriate under the facts of this case?

Having found that Ms. Korn committed the above violations, the question remains what disciplinary sanctions, if any, are appropriate for these violations. The disciplinary powers of this Board range from reprimand to permanent reprimand, and include the power to suspend for an identified period of time, to impose practice conditions or limitations, probation, peer review, fines, and educational requirements.[118] The Board must seek consistency in the application of disciplinary sanctions, and must explain significant departures from prior decisions involving similar facts.[119]

Alaska Statute 08.68.270(7) authorizes the Board to suspend or revoke the license of a person who "is guilty of unprofessional conduct as defined by regulations adopted by the

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115 *See* AS 17.30.200(d).
116 12 AAC 44.445(e).
117 12 AAC 44.770(3).
118 AS 08.68.275(a)(2), (5)-(9); AS 08.01.075(a).
119 AS 08.01.075(f); AS 08.68.275(f) ("The board shall seek consistency in the application of disciplinary sanctions. A significant departure from prior decisions involving similar situations shall be explained in the findings of fact or order.").

board."[120] The Board may also suspend or revoke a license of a person who "has willfully or repeatedly violated a provision of this chapter or regulations adopted under this chapter or AS 08.01,"[121] or a person who "[has] prescribed … drugs in violation of a law, regardless of whether there has been a criminal action or harm to the patient."[122]

The Board's disciplinary guidelines give it discretion to suspend a license for up to one year, with another year of probation, for unprofessional conduct.[123] The guidelines give the Board discretion to suspend a license for up to two years, with at least two years of probation to follow, if a licenses willfully or repeatedly violates a nursing statute or board regulation.[124] And the guidelines give the Board discretion to revoke a license for a repeat offense, or for unprofessional conduct that places another person's health at risk.[125]

Ms. Korn, through counsel, suggests that any violations are, at most, technical recordkeeping matters for which guidance and monitoring, rather than discipline, are appropriate. The Division, noting Ms. Korn's prior disciplinary history for a markedly similar violation as well as the broad scope of her prescribing practices, urges more severe discipline, including at least one year of APRN license suspension, practice monitoring, and five years of probation.

Here, as to the unprofessional conduct violations, the Division has proved through Counts I, II, and III of the Accusation that Ms. Korn:

- Prescribed pain medications that were contraindicated for her hepatically challenged patient J.B. (Counts I and II);
- Prescribed to multiple patients – including specifically J.B., H.G., and M.M. – a "dangerous combination" of medications that, when prescribed together and in large amounts over long periods of time, placed these patients at risk of overdose or death (Counts I and III);
- Prescribed controlled substances – specifically, to J.B., H.G., M.M. – without documenting patient histories and without setting out in the patient's records a plan related to the use of these substances as required by 12 AAC 44.445(f); (Counts II and III);
- When prescribing to multiple patients over lengthy time periods combinations of benzodiazepines and opioids, failed to document any awareness or justification of the risks of these combinations (and likewise

120 AS 08.68.270(7)
121 AS 08.68.270(8)
122 AS 08.68.270(12)
123 12 AAC 44.720(c)(1).
124 12 AAC 44.720(b)(2).
125 12 AAC 44.720(a)(1), (7).

failed to document that those risks had been conveyed to her patients) (Count III); and

- In treating patients – specifically including J.B., A.G., M.M., and H.G. – failed to maintain sufficient clinical records, particularly in light of the heavy volumes of controlled substances being prescribed (Count III).

As an underlying concern, while the Division did not include a separate count in the Accusation expressly charging Ms. Korn with practicing outside the scope of her women's health care certification, her having done so is implicated in each of the violations identified above. All of the violations identified above involve the prescription of controlled substances for pain or mood disorders or both. The records presented in this case demonstrate that the four patients whose records were discussed in depth at the hearing were in no way exceptions but were rather examples of a larger pattern of prescribing. The PDMP records admitted without objection reflect the scope and scale of Ms. Korn's prescribing practices. Ms. Korn's decision to practice outside her identified population focus – or to treat her identified population focus for problems outside her area of training and specialization – is in turn reflected in the unsafe prescribing practices described above. Thus, while not a separate "count" of the accusation, Ms. Korn's de facto operation of a pain management practice informs the inquiry into what discipline is appropriate in this case.

The appropriate discipline in this case is also informed by this being Ms. Korn's second disciplinary accusation for strikingly similar conduct. In the 2009 case, Ms. Korn admitted to:

- practicing outside her authorized scope of practice by engaging in long term pain management of a patient;
- engaging in sparse, incomplete, and substandard documentation that lacked critical information necessary for pain management treatment; and
- negligence in providing long term opioid treatment without the proper steps or safeguards to prevent significant risks to the patient's health and safety.

The Board's regulations give it discretion to revoke a license for violation that constitutes a second offense, which this clearly does.[126] It is frankly astonishing that more than ten years later – and more than ten years into the nationwide opioid crisis – Ms. Korn continues to engage in precisely the same kind of conduct, that such practices appears to be the rule rather than the exception in the operation of her practice, and that Ms. Korn appears wholly unconcerned with these patterns.

[126] 12 AAC 720(a)(1).

In terms of Board precedent for disciplinary recommendations, there is little on point. The Board has shown a past willingness to go as far as revoking the license of an ANP whose conduct creates a risk to patient safety.[127] But, likely because the vast majority of the Board's licensees do not have the prescribing authority at issue here, there is a dearth of informative precedent with similar fact patterns, and the parties did not cite any prior decisions addressing pervasive, dangerously substandard prescribing and documentation by an ANP.[128] While not binding on this Board, a review of Medical Board cases is informative in considering how other licensing bodies have approached similar fact patterns around, specifically, opioid and opioid/benzodiazepines prescribing. In *Matter of Ahmad*, that Board summarily suspended and later accepted the surrender of the license of a physician found to be overprescribing opioids and benzodiazepines on a broad scale. While the conduct here is not as egregious as the conduct in that case, there are a troubling number of similarities.[129]

As a final consideration, in addressing what level of discipline should be imposed on the license, there is the question of whether to treat Ms. Korn's RN license differently from her ANP license. Certainly, the prescribing violations most obviously implicate the ANP license. But the charting violations implicate functions under both licenses. And even the prescribing violations implicate nursing judgment and awareness of current issues in patient care (such as the impact of the opioid crisis on prescribing). Ms. Korn's poor judgment and failure to acknowledge the impact of these issues raises concern not just about whether she should be prescribing controlled substances, but also about her professional judgment more broadly.

The Division asks the Board to impose a license suspension of at least one year; 5 years of probation; a fine of $2,500; 30 additional training hours on specific topics; practice monitoring; and a reprimand.[130] In light of the evidence presented, and the Board's disciplinary

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127 *See generally*, *Matter of Small*, OAH No. 09-0396-NUR/10-0057-NUR (Board of Nursing 2010).

128 The Division noted as prior precedent only Ms. Korn's 2009 case for seemingly identical conduct, and a 2013 consent agreement for high dose opioid prescribing with inadequate history or review, in which the Board imposed limitations on prescriptive authority, supervised employment, $5000 fine/4500 stayed, 25 hours CME. Case No. 2013-01243.

129 Apparent factual similarities between this case and that one include a very high number of controlled substances being written during the five month period covered by the PDMP records, opioids being prescribed well in excess of the 90-day limit set out in the model policy set out by the Federation of State Medical Boards, and similar type, volume, and dosage medications being prescribed. Notable differences include that Dr. Ahmad was running weekend clinics in which he saw dozens of patients per day, prescribed controlled substances to all patients, and did not have a longstanding treatment relationship with any of the patients at issue.

130 Amended Accusation, p. 5.

guidelines and other factors discussed above, this decision concludes that a lengthier period of suspension is warranted,[131] and hereby imposes:

- a six-month suspension of Ms. Korn's RN license,
- a three-year period of suspension of Ms. Korn's APRN license,
- a fine of $2,500,
- a requirement to complete at least 40 additional continuing education hours on topics relating to documentation, prescriptive practices, and/or non-opioid pain management – including that at least 20 hours on documentation and prescriptive practices must be completed before the RN license suspension is lifted, and
- a public reprimand.

Further, this decision directs the Division to undertake a review to determine whether the totality of circumstances surrounding Ms. Korn's prescriptive practices but not necessarily raised in the current accusation warrant further discipline by the Board.

IV. Conclusion

The Division met its burden of proving that Ms. Korn more likely than not has violated the standards of professional conduct through multiple unsafe prescription practices and markedly poor documentation, as well as by improperly delegating PDMP access to her unlicensed office staff.

While Ms. Korn may well hold deep compassion and concern for her longtime patients, and may well believe that she has acted in her patients' best interests in providing them with pain and anxiety medication management, she has done so in a manner that exceeds her scope of practice, falls significantly short of professional standards for documentation, and poses unreasonable risks to patient and public safety. In light of the foregoing, this decision imposes:

(1) a six-month suspension of Ms. Korn's RN license,

(2) a three-year license suspension of Ms. Korn's APRN license,

(3) a fine of $2,500,

[131] It could be easily argued that the facts of this case support revocation of at least the APRN license. There is evidence in the record to support a finding of widespread and egregiously dangerous prescribing practices, made more egregious by the fact of the prior consent agreement in which Ms. Korn acknowledged negligence and practicing outside her scope for conduct appearing less severe than the conduct here. But the Division did not bring a revocation case, and did not charge some of the potential violations associated with the question of whether revocation is warranted here. Without an Accusation giving notice that revocation is at issue, and without counts that expressly raise some of the broader patterns suggested in the discussion above, revocation would be an error here. Nothing in this decision, however, should be construed to preclude the Division from pursuing further investigation and analysis of the facts and circumstances surround Ms. Korn's practice and whether further discipline up to and including revocation may be appropriate.

(4) continuing education requirements as set out above, and

(5) the following public reprimand:

Paula Korn: You are hereby reprimanded by the Board for negligently endangering patient health by prescribing medication that was contradicted given your patients' surgical and prescriptive histories, and for failing to take and sufficiently document patient histories before prescribing medication, and for failing to maintain records that accurately reflect nursing problems and interventions, all of which resulted in a significant risk to the health or safety of your patients or the public. Furthermore, you are hereby reprimanded for your negligent failure to utilize the PDMP database prior to prescribing controlled substances, and for negligently delegating PDMP access to an unlicensed individual in contravention of the law. It is your responsibility as an individual licensed under AS 08.68, specifically as an Advanced Nurse Practitioner, to ensure that such an offense does not happen again.

Dated: April 13, 2021

Signed
Cheryl Mandala
Administrative Law Judge

Adoption

The ALASKA STATE BOARD OF NURSING adopts this decision as final under the authority of AS 44.64.060(e)(1). Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of distribution of this decision.

DATED this 6th day of May, 2021.

By: *Signed*
Signature
Danette Schloeder
Name
Chair, Alaska Board of Nursing
Title

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]