AGENDA

CONNECTICUT BOARD OF VETERINARY MEDICINE

Wednesday July 28, 2021 at 8:30 AM
Department of Public Health
410 Capitol Avenue, Hartford, Connecticut

CALL TO ORDER

I. Memorandum of Decision
Amr Wasfi, DVM – Petition Nos. 2019-30; 2019-500; 2019-594; 2019-597; 2020-1173

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STATE OF CONNECTICUT
CONNECTICUT BOARD OF VETERINARY MEDICINE

Amr Wasfi, D.V.M.
License No. 001159

Petition No. 2020-1173
Petition No. 2019-597
Petition No. 2019-500
Petition No. 2019-594
Petition No. 2019-30

MEMORANDUM OF DECISION

Procedural Background

On December 14, 2020, the Department of Public Health ("Department") presented the Connecticut Board of Veterinary Medicine ("Board") with a Statement of Charges ("Charges") and a Motion for Summary Suspension against veterinary license number 001159 of Amr Wasfi, D.V.M. ("Respondent"). Board Exhibit ("Bd. Ex.") 1. The Charges allege that Respondent's license is subject to disciplinary action pursuant to Conn. Gen. Stat. §§ 19a-17 and 20-202. *Id.* The Motion for Summary Suspension was granted, based on the Charges, affidavits, the Department's information, and the Board's belief that Respondent's continued practice of veterinary medicine represented a clear and immediate danger to the public health and safety. *Id.*

On December 21, 2020, the Summary Suspension Order was issued following the Board's review of duly verified affidavits presented by the Department, which alleged violations of § 20-202 of the Connecticut General Statutes. Pursuant to § 4-182(c) and § 19a-17(c) of the Connecticut General Statutes, the Board summarily suspended the Respondent's license to practice veterinary medicine pending a final determination by the Board. *Id.* On December 21, 2020, the Summary Suspension Order, the Statement of Charges, and a Notice of Hearing scheduling a hearing were sent to the Respondent by email. *Id*.

On December 23, 2020, Respondent provided a written Answer to the Charges. *Id.* Respondent also filed a Motion for Extension of Time from December 20, 2020 to the week of January 10, 2021. *Id*. The Department had no objections to Respondent's motion. *Id*.

On December 24, 2020 the Board granted Respondent's request for a continuance and rescheduled the hearing for January 12, 2021 to be held by video conference. *Id*.

On December 28, 2020 Respondent filed a Corrected Answer to the Charges. *Id*.

The hearing convened on January 12 and 15, 2021, before a duly authorized panel of the Board comprised of Chairperson Mary Anne O'Neill, Esq., G. Kenneth Bernhard, Esq., and

Timothy J. Plunkett, D.V.M. Tr. 1/12/21, pp. 2, 232-33. After the second hearing date, it was determined that a third date would be needed to hear evidence; the Board continued the hearing for January 27, 2021. Tr. 1/15/21, pp. 146-48.

On January 22, 2021, the Respondent filed a Motion to Strike evidence contained in Department Exhibits 4 (Monster) and Exhibit 5 (Luna). Board Ex. 4; Tr. 1/27/21, p. 3.

On January 27, 2021, during the hearing, the Board denied Respondent's Motion to Strike. Tr. 1/27/21, p. 9. At the conclusion of the hearing, the Board granted Department's motion to substitute closing statements for briefs, and ordered the statements be filed by February 3, 2021. Tr. 1/27/21, p. 83.

On February 3, 2021, the Department filed Department's Post-Hearing Brief, which is hereby marked as Board Exhibit 6, and Respondent filed Respondent's Brief, which is hereby marked as Board Exhibit 7. Both exhibits were entered into the record.

Each member of the Board involved in this decision attests that he/she was present at the hearing or has reviewed the record, and that this decision is based entirely on the record and the law. The Board does not assert that it relied on its own expertise in rendering this decision.

Allegations

1. In paragraph 1 of the Charges, the Department alleges that Amr Wasfi, D.V.M., of Bridgeport, Connecticut, is and has been at all times referenced in the Charges, the holder of Connecticut veterinary license number 001159.

2. In paragraph 2 of the Charges, the Department alleges that during the course of approximately September 24, 2020 and/or September 25, 2020, Respondent provided treatment to a dog, *Lyric*, that failed to meet the standard of care in one or more of the following ways, in that he:

   a. failed to appropriately assess, manage, and/or treat the dog during and/or post-surgery for ear cropping;
   b. misinformed and/or misrepresented the dog's condition and/or treatment performed; and/or
   c. inappropriately and/or negligently utilized a heating pad, leading to second-degree burns along the dog's thorax, abdomen, and/or rib area and/or eventual cardiac failure.

3. In paragraph 3 of the Charges, the Department alleges that during the course of approximately March 22, 2019 and/or March 23, 2019, Respondent provided treatment to a dog, *Athena*, that failed to meet the standard of care in one or more of the following ways, in that he:

a. failed to appropriately assess, manage, and/or treat the dog's pelvis, hip, and/or leg issues;
b. failed to adequately inform the owner(s) of the dog's condition and/or prognosis; and/or
c. failed to maintain adequate treatment records.

4. In paragraph 4 of the Charges, the Department alleges that during the course of approximately February 14, 2019 through March 25, 2019, Respondent provided treatment to a dog, *Monster*, that failed to meet the standard of care in one or more of the following ways, in that he:

   a. failed to appropriately assess, manage, and/or treat the dog's hip and/or leg issues;
   b. misinformed and/or misrepresented the dog's condition and/or treatment performed;
   c. provided inappropriate and/or inadequate means of sedation and/or pain medications;
   d. performed surgery that was not medically necessary;
   e. failed to provide adequate post-operative care, including but not limited to providing proper healing time, nutrition, hydration, and/or medication;
   f. failed to provide appropriate referral to an emergency and/or twenty-four-hour facility; and/or
   g. failed to maintain adequate treatment records.

5. In paragraph 5 of the Charges, the Department alleges that on or approximately December 13, 2018, Respondent provided treatment to a cat, *Luna*, that failed to meet the standard of care in one or more of the following ways, in that he:

   a. handled the cat in an inappropriately aggressive physical manner;
   b. provided inappropriate and/or inadequate means of sedation;
   c. failed to provide appropriate pain medication; and/or
   d. failed to maintain adequate treatment records.

6. In paragraph 6 of the Charges, the Department alleges that during the course of approximately November 13, 2015 through November 15, 2015, Respondent provided treatment to a dog, *Peanut*, that failed to meet the standard of care in one or more of the following ways, in that he:

   a. failed to appropriately assess, manage, and/or treat the dog's seizure disorder, cardiology issues, and/or sinus issues;
   b. failed to appropriately monitor and/or observe the dog during admission for overnight care;
   c. failed to adequately inform the owner(s) of the dog's condition, treatment, and/or prognosis; and/or
   d. failed to maintain adequate treatment records.

7. In paragraph 7 of the Charges, the Department alleges that Respondent's conduct as described above constitutes grounds for revocation or other disciplinary action pursuant to the General Statutes of Connecticut, §20-202, including but not limited to §20-202(2).

Findings of Fact

1. Respondent of Bridgeport, Connecticut, is, and has been at all times referenced in the Charges, the holder of Connecticut veterinary license No. 001159. Board Exhibit 1, pp. 8, 9.

2. At all relevant times, Respondent worked as a veterinarian at Black Rock Animal Hospital, LLC. Tr. 1/15/21, p. 13.

3. During the course of September 24, 2020, and September 25, 2020, Respondent provided treatment to a dog, Lyric, a ten-week-old Pitbull who was under Respondent's care for ear cropping surgery. Tr. 1/15/21, pp. 15, 27; Department Exhibit ("Dept. Ex.") 2, pp. 61-62, 92.

4. On September 24, 2020, Respondent failed to assess, manage, and/or treat Lyric during and/or post-surgery for ear cropping when he was performing surgery and Lyric became ill with bloody diarrhea. Respondent suspected that Lyric was suffering from Parvovirus ("parvo"), however, he continued with surgery, putting undue stress on the dog. Respondent also failed to maintain continuous intravenous fluid therapy to help counter diarrhea and vomiting. Tr. 1/15/21, pp. 18-21, 56-64.

5. Prior to the surgery, Lyric had received two modified live parvo vaccinations. A second dose of the parvo vaccine was provided on September 18, 2020, when Lyric was six to nine weeks' old, and could have caused positive Polymerase Chain Reaction ("PCR") laboratory test results without the dog suffering from an active parvo infection On September 24, 2020, at the time he was admitted to Black Rock Animal Hospital for surgery, it was unlikely that Lyric suffered from parvo infections because he was not showing symptoms of illness at the time he was admitted to Black Rock Animal Hospital for surgery. Tr. 1/12/21, pp. 198, 218, 224; Dept. Ex. 2, p. 66; Dept. Ex. 8, p. 1; Respondent Exhibit ("Resp. Ex.") G.

6. At all relevant times, Respondent misinformed and/or misrepresented Lyric's condition and/or treatment performed. Respondent failed to inform the owner of Lyric's worsening condition and did not recommend that Lyric be moved to a 24-hour emergency care facility. Tr. 1/15/21, pp. 24, 63-64.

7. At all relevant times, Respondent negligently and inappropriately utilized a heating pad, leading to second-degree burns along Lyric's thorax, abdomen, and rib area. The burn caused by excess use of the heating pad led to the development of a diamond-shaped pattern that penetrated into the subcutaneous tissue. Tr. 1/12/21, pp. 72-73, 76, 197-200.

8. After the surgery on September 24, 2020, and into September 25, 2020, until Lyric's death, Respondent's negligent use of the heating pad likely caused Lyric to overheat. Dept. Ex. 2, pp. 21-29, 92. The result of the excess heat caused Lyric's heart to slow down, leading to cardiac failure. Tr. 1/12/21 p. 79. The heating pad caused multi-organ

congestion and edema, ventral abdomen second degree thermal burns, and subcutaneous congestion and edema. Dept. Ex. 2, p. 93; Tr. 1/12/21, p. 72-75, 77-80.

9. During the course of March 22, 2019, and March 23, 2019, Respondent provided treatment to a dog, Athena. Athena suffered from spastic paralysis and was unable to stand up on her hind legs. Tr. 1/15/21, pp. 94, 96; Dept. Ex. 3, pp. 9-10, 19; Resp. Ex. B, pp. 18-19.

10. On March 22, 2019, when Athena presented to Respondent at Black Rock Animal Hospital, the medical examination revealed that Athena could not stand on her hind legs even with assistance, and she had diarrhea. Respondent admitted Athena into his hospital, and while she was under sedation took radiographs of the spine, pelvis, and hindlimbs. He diagnosed Athena with L11-L12 calcification, as well as narrowed disc spaces and spondylosis between T5-6, T6-7, T7-8, and T8-9. Respondent treated Athena with Depomedrol and Dicyclomine. Blood work revealed hypoproteinemia, hypoalbuminemia and elevated CPK. Athena was discharged on March 23, 2019, with Rimadyl, Prednisolone, Loperamide, and Hill's i/d food. Dept. Ex. 3, pp. 9-10, 19, 36; Resp. Ex. B, pp. 18-19.

11. Respondent failed to assess, manage, and treat Athena's pelvis, hip, and/or leg issues. Respondent used a combination of non-steroidal anti-inflammatory medication ("NSAIDs") and corticosteroids (Depomedrol and Prednisolone), which should not be used together because, when provided together, these drugs may cause gastrointestinal bleeding, especially in Athena's case, where she already had gastrointestinal issues. Tr. 1/12/21, p. 60. When discussing Athena's condition with the owner, Respondent failed to refer Athena to a neurologist, which should have been offered in this case. Tr. 1/12/21, pp. 58-60; Tr. 1/15/21, p. 95; Dept. Ex. 3, p. 37; Resp. Ex. B, pp. 18-19.

12. The evidence is insufficient to establish that Respondent failed to inform the owner of Athena's condition and/or prognosis. Respondent made it clear to the owner that Athena's situation was dire, and that she was likely to perish. Tr. 1/12/21, pp. 59, 95-96; Dept. Ex. 3, p. 19; Resp. Ex. B, pp. 18-19, 20-23.

13. In the course of his treatment of Athena, Respondent failed to maintain adequate treatment records. The records lacked detailed information about Athena's condition, prognosis, and options for care. Tr. 1/12/21, p. 58. The record is devoid of any evidence to show Athena's condition when she arrived at Black Rock Animal Hospital and her condition when she left. Dept. Ex. 3, pp. 18-21. Tr. 1/12/21 pp. 58-59; Resp. Ex. B, pp. 18-19.

14. During the course of February 14, 2019, through March 25, 2019, Respondent provided treatment to a two-year-old Pitbull mix breed dog, Monster. Tr. 1/27/21, pp. 10, 50; Dept. Ex. 4, pp. 3-6, 44, 48-49, 71-72, 75, 142-143, 146. On February 14, 2019, when Monster began under Respondent's care, he weighed 64.3 pounds, suffered from loss of appetite, and was limping on his right hind leg. Dept. Ex. 4, pp.

3, 149. Respondent prescribed Depomedrol and Rimadyl, and discharged the dog from his care. *Id.*

15. On February 27, 2019, Monster was back in Respondent's care, presenting with pain and weight loss. Respondent took another x-ray of the pelvis, and diagnosed Monster with right sacral-Ilium partial or full separation/fracture. Dept. Ex. 4, pp. 149-50. On March 6, 2019, Respondent performed right hip surgery, a surgical repair of the fracture by placing a screw, and provided intravenous antibiotics and Monster was forced fed. Dept. Ex. 4, pp. 149, 153. After the surgery, Monster experienced limb swelling and continued to lose weight. On March 21, 2019, Respondent removed the screw. Dept. Ex. 4, p. 153. On March 25, 2019, when Monster was transferred to Central Hospital for Veterinary Medicine, he had a severely infected surgical site and showed signs of starvation, weighing 46.4 pounds. Dept. Ex. 4, p. 146.

16. At all relevant times, Respondent failed to assess, manage, and/or treat adequately Monster's hip and/or leg issues. Respondent took an x-ray of the pelvis, which was normal. After taking x-rays of Monster's hip, Respondent did not consult with a radiologist to obtain an accurate diagnosis before pursuing major surgery. Respondent admits that he saw no abnormalities of the hip on the x-ray taken prior to surgery. Tr. 1/12/21, pp. 135-36. Tr. 1/27/21, pp. 16-19, 60; Dept. Ex., pp. 70-84.

17. At all relevant times, Respondent misinformed and/or misrepresented Monster's condition and/or treatment performed. Respondent presented the x-ray to Monster's owner when explaining the need for surgery due to sacroiliac subluxation, but later admitted that the x-ray showed no visible deformity. Tr. 1/27/21, pp. 58-61; Dept. Ex., pp. 70-84.

18. At all relevant times, Respondent provided inappropriate and/or inadequate means of sedation and/or pain medications to Monster. Respondent administered Ketamine for sedation for the x-rays. Ketamine is not an acceptable drug to use as a sole agent, as it is known to cause muscle constriction and convulsions. Tr. 1/12/21, pp. 132-34. Additionally, using Ketamine as a sole anesthetic agency is insufficient. Dept. Ex. 4, p. 154.

19. At all relevant times, Respondent performed surgery on Monster which was not medically necessary. The x-rays taken by Respondent did not show any evidence of a fracture or luxation. Instead, they showed a gas lucency line over part of the pelvis where the colon crosses over the bone and where a fracture might have been located. However, when Respondent placed the screw into the dog's pelvis, it was not anywhere near that lucency that might have been assumed to be a fracture. Tr. 1/12/21, pp. 136-37; Dept. Ex. 4, p. 154. Respondent should have confirmed his diagnosis of Monster's pain before proceeding to surgery. Dept. Ex. 4, p. 155.

20. At all relevant times, Respondent failed to provide post-operative care, including but not limited to hydration and medication Monster. Respondent failed to place Monster on IV fluids, despite the fact that Monster was not adequately eating or drinking

during the course of his hospital stay. Dept. Ex. 4, p. 156. Respondent also administered Buprenex to manage Monster's pain level once a day instead of the recommended dosage rate of every six to eight hours. Tr. 1/12/21, pp. 138-39; Tr. 1/27/21, pp. 27-28; Dept. Ex. 4, p. 155.

21. The Department did not sustain its burden in showing that Respondent failed to provide adequate healing time and nutrition following operation in the case of Monster.

22. The Department did not sustain its burden in showing that Respondent failed to provide an appropriate referral to an emergency and/or twenty-four-hour facility to Monster's owner.

23. Respondent failed to maintain adequate treatment records for Monster during the course of February 14, 2019, through March 25, 2019. Respondent's updates on Monster were scarce, often leaving multiple consecutive days with no new information. Tr. 1/12/21, pp. 144, 147; Tr. 1/27/21, p. 51, 53;. Dept. Ex. 4, pp. 70-84, 155.

24. On December 13, 2018, Respondent provided treatment to a cat, Luna, to perform a spay. Tr. 1/15/21, p. 150; Dept. Ex. 5, p. 28.

25. The Department did not sustain its burden of proof in showing that Respondent handled Luna in an inappropriately aggressive physical manner. Tr. 1/12/21, p. 173; Tr. 1/15/21, p. 131.

26. Respondent provided inappropriate and/or inadequate means of sedation to Luna during surgery. According to Respondent's records, Ketamine was administered to Luna as the sole means of sedation. Ketamine as the sole anesthetic agent is inappropriate. Tr. 1/12/21, pp. 172-73; Tr. 1/15/21, pp. 151-52; Dept. Ex. 5, p. 28.

27. Respondent failed to provide Luna with any pain medication post-surgery. Tr. 1/15/21, p. 153; Dept. Ex. 5, p. 28.

28. Respondent failed to maintain adequate treatment records for Luna during the course of treatment on December 13, 2019. Only one entry was made into the medical record on the day of Luna's surgery. Tr. 1/12/21, p. 174; Tr. 1/15/21, pp. 160-61; Dept. Ex. 5, pp. 27-28.

29. From November 13, 2015, through November 15, 2015, Respondent provided treatment to a dog, Peanut, a thirteen-year-old female spayed Jack Russell Terrier. Peanut suffered from sinus arrythmia and periods of sinus arrest, among other conditions, for which she was treated with a diuretic Lasix, which required her to be hydrated with intravenous fluids. Tr. 1/27/21, pp. 69, 75; Dept. Ex. 6, pp. 28-51, 66. Peanut passed away in Respondent's care due to a terminal heart condition. Dept. Ex. 6, p. 68.

30. The Department did not sustain its burden of proof in showing that Respondent failed to appropriately assess, manage, and/or treat Peanut's seizure disorder or cardiology issue of sick sinus syndrome. Tr. 1/27/21, pp. 70, 73.

31. The Department did not sustain its burden of proof in showing that Respondent failed to appropriately monitor and/or observe Peanut during admission for overnight care from November 13, 2015, through November 15, 2015. Tr. 1/27/21, p. 73.

32. The Department did not sustain its burden of proof in showing that Respondent failed to adequately inform the owner of Peanut's condition, treatment, and/or prognosis of Peanut on November 13, 2015. Tr. 1/27/21, pp. 70, 73.

33. Respondent failed to maintain adequate treatment records for Peanut during the course of treatment from November 13, 2015, through November 15, 2015. Respondent did not keep a record of important vital signs and there is no indication that prognosis was discussed with the owner. Tr. 1/12/21, pp. 114, 118; Dept. Ex. 6, pp. 27-31.

34. Dr. Jennifer Loquine's, D.V.M., testimony was credible. Tr. 1/12/21, pp. 55-67.

35. Veterinary Pathologist Dr. Kirklyn Kerr's testimony was credible. Tr. 1/12/21, pp 68-108.

36. The testimony of Dr. Richard Magliula, D.V.M., was credible. Tr. 1/12/21, pp. 188-228.

37. The testimony of Dr. Laurie Brown, D.V.M., was credible. Tr. 1/12/21, pp. 110-27

38. Respondent's testimony was not credible.

Discussion and Conclusions of Law

The Department bears the burden of proof by a preponderance of the evidence in this matter. *Jones v. Connecticut Medical Examining Board*, 309 Conn. 727, 739-40 (2013). The Department sustained its burden of proof with regard to the allegations contained in paragraphs 1, 2a, 2b, 2c, 3a, 3c, 4a, 4b, 4c, 4d, 4g, 5b, 5c, 5d, and 6d of the Charges, and failed to sustain its burden with regard to the allegations contained in paragraphs 3b, 4e, 4f, 5a, 6a, 6b, and 6c of the Charges.

Conn. Gen. Stat. § 20-202(2) provides, in pertinent part, that:

> After notice and opportunity for hearing as provided in the regulations established by the commissioner of public health, said board may take any of the actions set forth in section 19a-17 for any of the following causes: . . . (2) proof that the

> holder of such license or certificate has become unfit or incompetent or has been guilty of cruelty, unskillfulness or negligence towards animals and birds. In determining whether the holder of such license has acted with negligence, the board may consider standards of care and guidelines published by the American Veterinary Medical Association including, but not limited to, guidelines for the use, distribution and prescribing of prescription drugs . . . .

With respect to paragraph 1 of the Charges, Respondent admitted that, at all relevant times referenced in the Charges, he was the holder of Connecticut veterinary license No. 001159. Findings of Fact ("FF") 1.

With respect to paragraph 2a of the Charges, the Department established by a preponderance of the evidence that from September 24, 2020 through September 25, 2020, Respondent failed to assess, manage, and/or treat Lyric during and/or post-surgery for ear cropping. FF 4. The preponderance of the evidence establishes that during the course of September 24, 2020, and September 25, 2020, Respondent provided treatment to a dog, Lyric, a ten-week-old Pitbull who was under Respondent's care for ear cropping surgery. Tr. 1/15/21, pp. 15, 27; Dept. Ex. 2, pp. 61-62, 92. Lyric had received Parvovirus vaccinations a few weeks before surgery, which could result in a positive laboratory test result for parvo without an active infection. FF 5.

In his testimony, Respondent describes how, on the day of the surgery, after he began stitching up the first ear, Lyric began to develop symptoms of severe bloody diarrhea. Tr. 1/15/21, p. 18. Respondent believed the bloody diarrhea was a sign that Lyric was suffering from parvo disease, which is particularly fatal in puppies under six months' old. Tr. 1/15/21, p. 19. Despite his belief that Lyric was suffering from life-threatening symptoms, Respondent administered an IV and continued with the ear cropping surgery. Tr. 1/15/21, p. 19. The surgery concluded at approximately 4:00 p.m., at which time Lyric was moved to a rack in the recovery room where the diarrhea persisted. Tr. 1/15/21, p. 20. At approximately 7:00 p.m., the IV dislodged from Lyric as a result of her moving; Respondent was unable to reattach the IV and attempted instead to administer fluids subcutaneously. Tr. 1/15/21, p. 21. At 2:00 a.m., Respondent noticed Lyric had become recumbent, and Respondent resumed IV treatment at a lower rate of six drops per minute. Tr. 1/15/21, p. 22. Respondent at this point was of the belief that there was nothing left for him to do, and Lyric died at approximately 4:00 a.m. Tr. 1/15/21, p. 23.

It is imperative for a dog suffering from parvo disease, or who showed signs of diarrhea, to be on continuous IV fluid therapy. Tr. 1/15/21, pp. 56-57. With the amount of fluid and blood loss that Lyric was suffering, it would have been impossible for him to recover without proper IV therapy. Tr. 1/15/21, p. 58. Lyric was not receiving IV therapy between the hours of 8:00 p.m. and 2:00 a.m. Tr. 1/15/21, pp. 21-22. Respondent's decision to continue the surgery despite Lyric's worsening condition, and his failure to provide adequate IV fluid therapy, is a breach of the standard of care. Tr. 1/15/21, pp. 19, 21. Dr. Richard Magliula, witness for the Department, testified that if Lyric looked sick, it was egregious to perform elective cosmetic surgery. Tr. 1/12/21, p. 222. Therefore, the Department sustained its burden of proof with respect to the allegations contained in paragraph 2a of the Charges.

With respect to paragraph 2b of the Charges, the Department established by a preponderance of the evidence that Respondent misinformed and/or misrepresented Lyric's condition and/or treatment performed. FF 6. Lyric began to experience symptoms, which Respondent believed were consistent with parvo disease, soon after the surgery began at approximately 3:30 p.m. Tr. 1/15/21, p. 63. Respondent admits that he failed to contact the owner about Lyric's worsening condition. Tr. 1/15/21, p. 64. Respondent did not inform the owner of the situation until 9:00 a.m. on September 25, 2020 – approximately five hours after Lyric had passed away. Tr. 1/15/21, p. 24. Respondent claims that he did not contact the owner about Lyric's death at 4:00 a.m. because he did not want to give him bad news, and that there was nothing that could be done at that point. Tr. 1/15/21, p. 24. Respondent breached the standard of care by not contacting Lyric's owner as soon as he suspected Parvovirus. The owner had no knowledge of his dog's worsening condition until hours after the dog's death. Tr. 1/15/21, p. 24. As a result, the owner was given no opportunity to move Lyric to an emergency care facility equipped to offer twenty-four-hour care and was kept under the impression that the surgery being performed by Respondent was without issue. FF 6. Therefore, the Department sustained its burden of proof with regard to the allegations contained in paragraph 2b of the Charges.

With respect to paragraph 2c of the Charges, the Department established by a preponderance of the evidence that Respondent negligently and inappropriately utilized a heating pad, leading to second-degree burns along Lyric's thorax, abdomen, and rib area. FF 7-8. Dr. Magliula testified that when he first examined Lyric postmortem, the first thing he noticed was

the diamond-shaped pattern on Lyric's skin. Tr. 1/12/21, pp. 197-98. Dr. Magliula deduced that this pattern was a deep subcutaneous burn that was likely caused by excessive use of a heating pad. Tr. 1/12/21, p. 198.

Dr. Kirklyn Kerr, a witness for the Department and pathologist at the University of Connecticut, made the same findings as Dr. Magliula. Tr. 1/12/21, pp. 72-73. He testified that upon examination of the Lyric's body and after reviewing the photographs taken shortly after his death, the dog's body had an unusual, particular diamond pattern on the skin externally, on the ventral abdomen, and off one side, and which continued into the subcutaneous tissue. Tr. 1/12/21, p. 72. While he could not state the exact time the diamond pattern has formed, he could state that it occurred close to or near the time of death, and that the lesions were consistent with a burn. Tr. 1/12/21, pp. 72-73, 76. Therefore, the diamond-shaped pattern must have occurred near the time of death, and the severity of the lesions was most consistent with thermal burns. Tr. 1/12/21, pp. 72-73, 99, 102. Furthermore, the lesions located on Lyric's stomach were inconsistent with the lesions that may develop from parvovirus. Tr. 1/12/21, p. 76.

Respondent argued that the diamond-shaped pattern was not caused by a heating pad, but rather by indentations made by the cage in which Lyric lay for an extended period of time. Tr. 1/15/21, p. 24. Dr. Kerr, in direct contravention to the Respondent's position, testified that a dog would have to lie on the cage for an extended period of time before a noticeable pattern of lesions would form. Tr. 1/12/21, pp. 82, 91. Dr. Kerr testified further that the fact that the lesions were present subcutaneously is further evidence that the damage was not caused by the cage. Tr. 1/12/21, pp. 82, 91. The Board finds that a heating pad more than likely caused the burns located on Lyric. The use of the heating pad also likely led to cardiac failure in Lyric. FF 8. Dr. Kerr testified that based on the burn pattern, Lyric most likely became overheated, which led to heart failure. Tr. 1/12/21, p. 79. The overheating, at the very least, contributed to Lyric's death. Tr. 1/12/21, p. 80. Dr. Kerr credibly testified that the diamond pattern found on Lyric's subcutaneous tissue could not have been caused by the dog lying on a metal frame surface after death. Tr. 1/21/21, pp. 92, 93.

Dr. Kerr also testified that while the laboratory test results were positive for parvo, he could not definitely identify an active infection. Tr. 1/12/21, p. 74. He further testified that the positive parvo test result could be due to the recent administration of the vaccine, or it could have been from an active infection. Tr. 1/12/21, pp. 73-75. Dr. Magliula credibly testified that the

burn marks on Lyric, as well as the bloody diarrhea, are consistent with heat stroke. Tr. 1/12/21, pp. 199-200.

Respondent violated the standard of care by negligently utilizing a heating pad, which led to second-degree burns of Lyric's thorax, abdomen, and rib area. The negligent use of the heating pad likely contributed to Lyric's death by causing cardiac arrest. Therefore, the Department sustained its burden of proof with regard to the allegations contained in paragraph 2c of the Charges.

With respect to paragraph 3a of the Charges, the Department established by a preponderance of the evidence that during the course of March 22, 2019, and March 23, 2019, Respondent failed to appropriately assess, manage, and/or treat the dog Athena's pelvis, hip, and/or leg issues. FF 9-11. The preponderance of the evidence establishes that on March 22, 2019, when Athena presented to Respondent at Black Rock Animal Hospital, the medical examination revealed that Athena could not stand on her hind legs, even with assistance, and she had diarrhea. Respondent admitted Athena into his hospital and took radiographs of the spine, pelvis, and hindlimbs while the dog was under sedation. Respondent diagnosed Athena with L11-L12 calcification, as well as narrowed disc spaces and spondylosis between T5-6, T6-7, T7-8, and T8-9. Respondent treated Athena with Depomedrol and Dicyclomine. Blood work revealed hypoproteinemia, hypoalbuminemia, and elevated CPK. Athena was discharged on March 23, 2019, with Rimadyl, Prednisolone, Loperamide, and Hill's i/d food. Dept. Ex. 3, pp. 9-10, 19, 36; Resp. Ex. B, pp. 18-19.

The x-ray Respondent conducted on Athena also showed that she was suffering from spondylosis and spondylitis. Tr. 1/15/21, p. 95. After taking bloodwork, Respondent deduced that there was very little he could do for Athena. Tr. 1/15/21, p. 96. Respondent administered a combination of NSAIDs and corticosteroids to Athena, which are not used together due to increased risk of gastrointestinal bleeding. Tr. 1/12/21, pp. 58, 60, 65. Athena had already been suffering from a gastrointestinal condition, which further contraindicates the inappropriate combination of medicine. Tr. 1/12/21, pp. 60, 65. Respondent also failed to further assess Athena's condition by making a referral to a neurologist. Dr. Jennifer Loquine, expert witness for the Department, testified that a neurology referral would have been necessary in this case in order to accurately deduce Athena's condition. Tr. 1/12/21, pp. 59-60. Respondent breached the standard of care by failing to properly assess Athena's condition and by administering a

combination of medicine that is harmful to the gastrointestinal tract. Therefore, the Department sustained its burden of proof with regard to the allegations contained in paragraph 3a of the Charges.

With respect to paragraph 3b of the Charges, the Department failed to establish by a preponderance of the evidence that Respondent failed to inform the owner of Athena's condition and/or prognosis. FF 12. Dr. Loquine testified that according to the medical record, Respondent violated the standard of care by failing to discuss prognosis or options for care with the owner. Tr. 1/12/21, p. 59. Respondent testified that after the initial examination on March 22, 2019, he informed the owner that Athena likely had an issue with her disc. Tr. 1/15/21, p. 95. Before discharge on March 23, 2019, Respondent claims that he told the owner that Athena's condition was very dire and she was likely to die if the medication prescribed has no effect. Tr. 1/15/21, p. 96. The Department's evidence is insufficient to rebut the Respondent's claim that he discussed Athena's likely outcome with her owner. Therefore, the Department did not prove by a preponderance of the evidence that Respondent failed to inform the owner of Athena's condition and/or prognosis.

With respect to paragraph 3c of the Charges, the Department established by a preponderance of the evidence that during the course of his treatment of Athena, Respondent failed to maintain adequate treatment records. FF 13. Dr. Loquine testified that it was difficult to obtain information from Respondent's documentation of the Athena's file because the notes were not detailed and were unclear. Tr. p. 1/12/2021, p. 58. Respondent's records fail to indicate Athena's condition when she arrived or left the hospital; instead, the records showed only that Athena was in worse condition on the day of her discharge. Tr. 1/12/21, pp. 58-59. There is nothing in the record that indicates that Respondent discussed Athena's prognosis or care options with the owner. Tr. 1/12/21, p. 59. The records also failed to reflect whether Respondent referred Athena to a neurologist, which would have been appropriate in this case. Tr. 1/12/2021, pp. 58-59. Respondent also did not sufficiently record Athena's vitals into the record; only her temperature from the initial examination was documented. Tr. 1/12/21, p. 61; Dept. Ex. 3, p. 18. Therefore, the Department sustained it burden of proof with regard to its allegations contained in paragraph 3c of the Charges that Respondent violated the standard of care by failing to maintain adequate treatment records.

With respect to paragraph 4a of the Charges, the Department established by a preponderance of the evidence that from February 14, 2019, through March 25, 2019, Respondent failed to assess, manage, and/or treat adequately Monster's hip and/or leg issues. FF 14-16.

The preponderance of the evidence establishes that from February 14, 2019, through March 25, 2019, Respondent provided treatment to a two-year-old Pitbull mix-breed dog, Monster, who suffered from weight loss and loss of appetite, and was limping on his right hind leg. Tr. 1/27/21, pp. 10, 50; Dept. Ex. 4, pp. 3-6, 44, 48-48, 71-72, 75, 142-43, 146. Respondent prescribed Depomedrol and Rimadyl and discharged the dog from his care. Tr. 1/27/21, pp. 10, 50; Dept. Ex. 4, pp. 3-6, 44, 48-48, 71-72, 75, 142-43, 146.

On February 27, 2019, Monster returned to Respondent's care, presenting with pain and weight loss. Respondent took another x-ray of the pelvis and diagnosed Monster with right sacral-Ilium partial or full separation/fracture. Dept. Ex. 4, pp. 149-50. On March 6, 2019, Respondent performed right hip surgery, a surgical repair of the fracture by placing a screw, and provided intravenous antibiotics and force-feeding. Dept. Ex. 4, pp. 149, 153. After the surgery, Monster experienced limb swelling and continued to lose weight. On March 21, 2029, Respondent removed the screw. Dept. Ex. 4, p. 153. On March 25, 2019, when Monster was transferred to Central Hospital for Veterinary Medicine, he had a severely infected surgical site and showed signs of starvation with a weight of 46.4 lbs. Dept. Ex. 4, p. 146.

Prior to performing surgery on Monster's hip, Respondent took x-rays, but failed to have the x-rays examined by a radiologist. Tr. 1/12/21, p. 135. Dr. Ashely Kelley, witness for the Department, testified that when performing a major surgery, it is imperative to get an expert opinion beforehand, particularly when the results of the x-ray are unclear, as they were in this case. Tr. 1/12/21, pp. 135-36. The x-rays themselves show no sign of a fracture or luxation, and are of particularly low quality due to overexposure. Tr. 1/12/21, p. 136. Respondent performed surgery on March 6, 2019, to correct what he believed to be a luxation by placing a screw into Monster's hip. Dept. Ex. 4, p. 70. As Dr. Kelley testified, typically, when correcting a luxation, a screw must be left in for six to eight weeks; Respondent, however, removed the screw after only two weeks due to Monster favoring one side over the other and not walking correctly. Tr. 1/12/21, p. 142. Respondent breached the standard of care by failing to obtain an accurate diagnosis prior to performing major surgery, and then removing the screw meant to correct the

believed luxation too early for proper healing. Therefore, the Department sustained its burden of proof with regard to the allegations contained in paragraph 4a of the Charges.

With respect to paragraph 4b of the Charges, the Department established by a preponderance of the evidence that Respondent misinformed and/or misrepresented Monster's condition and/or treatment performed. FF 17. Respondent testified that he used Monster's x-ray to show the owner why a surgery was needed due to an iliosacral separation. Tr. 1/27/21, p. 58. Respondent later contradicted himself, and claimed that the x-ray did not show any separation, but rather and it was the physical examination that showed the right ileum was separated from the sacrum. Tr. 1/27/21, pp. 60-61. Dr. Kelley testified that she agreed that the x-rays taken of Monster do not show any abnormality. Tr. 1/12/21, p. 136. The fact that Respondent used the x-rays to convince Monster's owner of the need for surgery, but the x-rays show no noticeable abnormality, supports the claim that Respondent misrepresented Monster's condition to the owner, and in so doing breached the standard of care. Therefore, the Department sustained its burden of proof with regard to the allegations contained in paragraph 4b of the Charges.

With respect to paragraph 4c of the Charges, the Department established by a preponderance of the evidence that Respondent provided inappropriate and/or inadequate means of sedation and/or pain medications to Monster. FF 18. When sedating Monster for the x-ray, Respondent's medical records indicate that Respondent used Ketamine as the sole sedation agent. Tr. 1/12/21, p. 132. Ketamine is unsafe to use alone due to increased risk of muscle constriction and convulsions. Tr. 1/12/21, p. 132. To treat pain that Monster was experiencing on February 28, 2019, Respondent administered Buprenex once a day. Tr. 1/12/21, p. 138. The proper dosage for Buprenex is one dose every six to eight hours. Tr. 1/12/21, p. 138. Respondent testified that he only administered the Buprenex once a day because Monster was wagging his tail, which, according to Respondent, indicated that he was happy and pain free. Tr. 1/27/21, pp. 27-28. Dr. Kelley testified that if Monster was indeed experiencing moderate pain, a dosage rate of once per day likely did little to subside the pain. Tr. 1/12/21, p. 138. The Board finds this evidence sufficient to find that Respondent's use of medication was inappropriate and inadequate, and therefore a breach of the standard of care. Therefore, the Department sustained its burden of proof with regard to the allegations contained in paragraph 4c of the Charges.

With respect to paragraph 4d of the Charges, the Department established by a preponderance of the evidence that Respondent performed surgery on Monster which was not

medically necessary. FF 19. The x-rays taken of Monster showed no evidence of fracture, luxation, or cancer. Tr. 1/12/21, p. 136. There was one area in particular on the x-ray that contained a gas lucency line over the part of the pelvis where the colon crossed over, which could have pointed to a possible fracture. Tr. 1/12/21, pp. 136-37. However, where Respondent inserted the screw was not near this location and, had there been a fracture in the area of the lucency, the screw would not have corrected the issue. Tr. 1/12/21, p. 137. When Respondent removed the screw after two weeks, he took another x-ray and measured the legs, which were now equal. Tr. 1/27/21, p. 45. Respondent claimed that Monster healed from the screw; however, Dr. Kelley testified that a screw will usually take six to eight weeks to properly heal a deformity such as Monster's. Tr. 1/12/21, p. 142. Based on the evidence, it is unlikely that the screw placed in Monster by Respondent did anything to correct an alleged luxation of the iliosacral joint. Respondent also admitted in his testimony that the pelvic issue could have healed on its own without surgery if Monster maintained minimal movement for six to eight weeks. Tr. 1/27/21, p. 31. Respondent performed an unnecessary surgery on Monster, and therefore breached the standard of care. Therefore, the Department sustained its burden of proof regarding the allegations contained in paragraph 4d of the Charges.

With respect to paragraph 4e of the Charges, the Department established by a preponderance of the evidence that Respondent failed to provide post-operative care to Monster, including but not limited to hydration and medication, but the Department failed to establish that Respondent failed to provide adequate healing time and nutrition following the operation. FF 20-21. During his stay with Respondent, Monster lost a significant amount of weight: he came into Respondent's care weighing 55 pounds and by March 25, 2019, his weight had dropped to 42.02 pounds. Tr. 1/12/21, pp. 139-40. Dr. Kelley testified that if Monster was not eating or drinking properly, he should have received supportive care in the form of IV fluids or feedings tubes, and been monitored 24 hours a day. Tr. 1/12/21, pp. 139-40. Respondent also failed to provide Monster with adequate pain medication, only administering one dose of Buprenex a day instead of the recommended dose of once every six to eight hours. Tr. 1/12/21, p. 138; Tr. 1/27/21, p. 28. Respondent's failure to keep Monster on a continuous IV fluid therapy in response to the drastic weight loss as well as his failure to adequately manage the dog's pain level, is a breach of the standard of care.

Respondent testified that he was feeding Monster three times a day and providing the dog with plenty of water. Tr. 1/27/21, p. 25. Respondent had no explanation for why Monster was experiencing drastic weight loss; he theorized it could possibly be from the stress of surgery or refeeding syndrome. Tr. 1/27/21, pp. 24, 27., The surgery occurred on March 6, 2019, and Monster was given until the day of discharge on March 25, 2019, to recover at the hospital. Tr. 1/27/21, pp. 22, 37. The Department did not provide sufficient evidence to show that Respondent failed to provide adequate nutrition and time to heal following the operation, especially in light of Respondent's testimony of feeding Monster. Therefore, the Department partially sustained its burden of proof with regard to the allegations contained in paragraph 4e of the Charges.

With respect to paragraph 4f of the Charges, the Department failed to establish by a preponderance of the evidence that Respondent failed to provide appropriate referral to an emergency and/or twenty-four-hour facility to Monster's owner. FF 22. Dr. Kelley testified that the medical records make no mention of a referral to a twenty-four-hour hospital. Tr. 1/12/21, pp. 139-40. There is no evidence, however, that Respondent *should* have referred Monster's owner to a twenty-four-hour facility, only that the records indicate no suggestion. As a result, there is insufficient evidence to support the claim that Respondent failed to provide appropriate referral to an emergency and/or twenty-four-hour facility.

With respect to paragraph 4g of the Charges, the Department established by a preponderance of the evidence that Respondent failed to maintain adequate treatment records for Monster from February 14, 2019, through March 25, 2019. FF 23. There exist large gaps in the records where no updates were recorded for days at a time. Tr. 1/12/21, p. 144. According to the standard of care, if an action is not documented in the medical record, then it did not happen. Tr. 1/12/21, p. 147. Respondent admits that his records are lacking and claims he does not have access to software that would allow him to maintain better records like most veterinarians do. Tr. 1/27/21, p. 53. When asked why he could not handwrite the information required in the record, Respondent answered, "How much I write more than this for one case?" Tr. 1/27/21, p. 53. Over the course of the 26 days that Monster was being treated by Respondent, only seven entries were made into the medical record. Tr. 1/27/21, p. 51. The medical record is not sufficient enough to accurately show how Respondent treated Monster and, therefore, constitutes a violation of the standard of care.

With respect to paragraph 5a of the Charges, the Department failed to establish by a preponderance of the evidence that on December 13, 2018, when Respondent performed a spay to a female cat, Luna, he handled Luna in an inappropriately aggressive physical manner during the spay procedure. FF 25. Jesus Ruiz, witness for Respondent, testified that he had assisted Respondent during the surgery, and while Respondent became verbally frustrated when a portion of Luna's intestine came out, he did not observe Respondent strike Luna. Tr. 1/15/21, pp. 129-31. During her testimony, Dr. Kelley questioned the validity of the claim that Respondent had acted aggressively toward Luna, and also calls into question the validity of this claim. Furthermore, Dr. Kelley testified that Luna was brought to VCA Shoreline the day following the surgery, after the owner was told that Respondent had struck the cat, but VCA Shoreline found no evidence of bruising or injury, and Luna was discharged. Tr. 1/12/21, p. 173. Therefore, the evidence is insufficient to establish that Respondent handled Luna in an inappropriately aggressive physical manner.

With respect to paragraph 5b of the Charges, the Department established by a preponderance of the evidence that Respondent provided inappropriate and/or inadequate means of sedation to Luna during surgery. FF 26. Respondent's records indicate that he used Ketamine as a sole agent to sedate Luna for surgery. Tr. 1/12/21, pp. 172-73. Respondent testified that, he actually used a mixture of Ketamine and Acepromazine to sedate Luna. Tr. 1/15/21, pp. 151-52. The records, however, do not reflect that anything other than Ketamine was used to sedate Luna, and Respondent does not dispute this fact. Tr. 1/15/21, p. 152. The standard of care for medical records is that if something is not documented, it did not occur. 1/12/21, p. 174. For this reason, the Department has provided enough evidence to establish that Respondent violated the standard of care by providing inappropriate and/or inadequate means of sedation to Luna during surgery. Therefore, the Department sustained its burden of proof with regard to the allegations contained in paragraph 5b of the Charges.

With respect to paragraph 5c of the Charges, the Department established by a preponderance of the evidence that Respondent failed to provide Luna with any pain medication post-surgery. FF 27. According to the medical records, Respondent did not provide Luna with any pain medication before or after the surgery, and as Dr. Kelley testified, that he does not provide medication in every case. Tr. 1/12/21, p. 174. In his testimony, Respondent admitted that he did not provide Luna with any medication. Tr. 1/15/21, p. 153. It is the standard of care to

administer pain medication after surgery on any animal. Tr. 1/12/21, p. 174. By failing to provide Luna with the appropriate pain medication, Respondent violated the standard of care. Therefore, the Department sustained its burden of proof with regard to the allegations contained in paragraph 5c of the Charges.

With respect to paragraph 5d of the Charges, the Department established by a preponderance of the evidence that Respondent failed to maintain adequate treatment records for Luna during the course of treatment on December 13, 2019. FF 28. The standard of care for medical records is that if something is not documented, it did not occur. 1/12/21, p. 174. Upon examination, Respondent's records contain only one entry, which was made on the day of the surgery; the rest of the entries concern non-medical-related matters. Dept. Ex. 5, p. 27. Respondent testified that he had offered the owner pain medication for Luna after the surgery, and that the owner had refused; however, nothing of this exchange is included among Respondent's records. Tr. 1/15/21, pp. 160-61. Respondent's failure to maintain adequate treatment records is a breach of the standard of care.

With respect to the allegations contained in paragraph 6 of the Charges, the preponderance of the evidence establishes that from November 13, 2015, through November 15, 2015, Respondent provided treatment to a thirteen-year-old female spayed Jack Russell Terrier dog, Peanut. Peanut suffered from sinus arrythmia and periods of sinus arrest, among other conditions, for which she was treated with a diuretic Lasix, which required her to be hydrated with intravenous fluids. 1/27/21, pp. 69, 75; Dept. Ex. 6, pp. 28-51, 66. Peanut passed away in Respondent's care due to a terminal heart condition. Dept. Ex. 6, p. 68.

With respect to paragraph 6a of the Charges, the Department failed to establish by a preponderance of the evidence that from November 13, 2015, through November 15, 2015, Respondent failed to appropriately assess, manage, and/or treat Peanut's seizure disorder and/or cardiology issue of sick sinus syndrome. FF 30. According to Respondent, Peanut's seizure and cardiac issues had been diagnosed prior to the owner bringing her to Respondent, and the owner already had a clear idea of Peanut's prognosis. Tr. 1/27/21, p. 70. Respondent testified that the owner brought Peanut to him only to provide intravenous fluids to help treat diarrhea; according to Respondent, he was not expected to assess or treat Peanut's underlying conditions. Tr. 1/27/21, p. 73. Therefore, the Department does not meet the burden of proof to establish that Respondent violated the standard of care.

With respect to paragraph 6b of the Charges, the Department failed to establish by a preponderance of the evidence that Respondent failed to appropriately monitor and/or observe Peanut during admission for overnight care from November 13, 2019, through November 15, 2015. FF 31. Respondent explained to the owner that he is not a twenty-four-hour facility. Tr. 1/27/21, p. 73. Respondent testified that he told the owner that he would be able to spend three hours in the morning and three hours at night with Peanut to administer intravenous fluids. Tr. 1/27/21, p. 73. As a result, the owner was made aware that Respondent would not be providing twenty-four-hour care for Peanut, and there is no evidence to show that the owner was misled to believe that Peanut would be receiving twenty-four-hour care. Therefore, the Department has not met the burden of proof to establish that Respondent violated the standard of care.

With respect to paragraph 6c of the Charges, the Department failed to establish by a preponderance of the evidence that Respondent failed to adequately inform the owner of Peanut's condition, treatment, and/or prognosis of Peanut on November 13, 2015. FF 32. The owner was aware of, or should have been aware of, the direness of Peanut's situation prior to bringing him to Respondent. Tr. 1/27/21, p. 70. When Peanut was brought to Respondent, she was dehydrated from weeks-long diarrhea. Tr. 1/27/21, p. 73. Respondent was not expected to inform the owner of Peanut's condition because the owner already was aware of it. Therefore, the Department failed to meet the burden of proof to establish that Respondent violated the standard of care with regard to this allegation.

With respect to paragraph 6d of the Charges, the Department established by a preponderance of the evidence that Respondent failed to maintain adequate treatment records for Peanut during the course of treatment from November 13, 2015, through November 15, 2015. FF 33. Respondent failed to keep records of any discussion he had with Peanut's owner regarding condition or prognosis. Tr. 1/12/21, p. 118. It was also not documented how Peanut deteriorated so quickly while in Respondent's care, only that Peanut had an emergent event and passed away. Tr. 1/12/21, p. 116. The record is missing basic data such as body weight, vital signs, and temperature. Tr. 1/12/21, p. 114. While the Respondent does make mention in the record that Peanut is very sick, he did not record any specifics about her condition at the time of presentation, changes in her medical status that led to her being hospitalized, or an assessment of how she was doing while she was hospitalized up until her death while in Respondent's care. Tr. 1/12/21, p. 114. Respondent's failure to maintain adequate treatment records is a breach of the

standard of care. Therefore, the Department sustained its burden of proof with regard to the allegations contained in paragraph 6d of the Charges.

Conclusions

The Board concludes that the Department has failed to establish by a preponderance of the evidence the allegations in paragraphs 3b, parts of 4e, 4f, 5a, 6a, 6b, and 6c of the Charges. The Board further finds that the Department has proven by a preponderance of the evidence paragraphs 1, 2a, 2b, 2c, 3a, 3c, 4a, 4b, 4c, 4d, 4e in part, 4g, 5b, 5c, 5d, and 6d of the Charges. Accordingly, the Board concludes that Respondent's conduct constitutes grounds for disciplinary action pursuant to Conn. Gen. Stat. §§ 20-202(2) and 19a-17. Respondent's conduct fell below the standard of care for veterinarians in Connecticut, and his conduct presents a significant risk to the health and safety of his patients and the public.

Order

Based upon the record in this case, the above findings of fact and the conclusions of law, and pursuant to the authority vested in it by §§ 19a-17 and 20-220 of the Statutes, the Board finds that the violations listed above warrant the following disciplinary action with respect to Connecticut veterinary license No. 001159 held by Amr Wasfi. The Board further finds that the conduct alleged and proven is severable and each proven allegation warrants the disciplinary action imposed by this Order:

1. Respondent's license number No. 001159 held by Amr Wasfi to practice as a veterinarian, for the conduct alleged and proven in the Charges, shall be permanently restricted in that Respondent is prohibited from performing surgery and prescribing anesthesia. Respondent further is prohibited from working independently: Respondent can only work as a veterinarian as an employee and under the direct supervision of another Connecticut licensed veterinarian.

2. Respondent's license number No. 001159 held by Amr Wasfi to practice as a veterinarian, for the conduct alleged and proven in the Charges, shall be placed on probation for a period of two (2) years under the following terms and conditions:

a. Respondent's practice shall be supervised at all times by a Connecticut licensed veterinarian approved by the Department ("supervisor").

b. Respondent shall provide a copy of this Decision to his supervisor.

c. Respondent's supervisor shall furnish written confirmation to the Department of his or her engagement in the capacity of supervisor, as well as receipt of a copy of this Decision within fifteen (15) days of receipt.

d. The supervisor shall meet with Respondent not less than quarterly for the entire the probationary period.

e. The supervisor shall have the right to monitor Respondent's practice by any other reasonable means which he or she deems appropriate. Respondent shall fully cooperate with such monitoring.

f. Respondent shall be responsible for providing written supervisor reports directly to the Department on a quarterly for the entire probationary period. Such supervisor's reports shall include documentation of dates and durations of meetings with Respondent, number and a general description of the client records and medication orders and prescriptions reviewed, additional monitoring techniques utilized, and a statement regarding whether Respondent is practicing with reasonable skill and safety.

g. Should Respondent's employment as a veterinarian be involuntarily terminated or suspended, Respondent and his employer shall notify the Department within 72 hours of such termination or suspension.

3. Legal notice shall be sufficient if sent to Respondent's last known address of record reported to the Office of Practitioner Licensing and Investigations of the Department.

4. Respondent must inform the Department in writing prior to any change of address.

5. All communications, payments if required, correspondence, and reports are to be addressed to:

Olive Tronchin, HPA
Practitioner Monitoring and Compliance Unit
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P. O. Box 340308
Hartford, CT 06134-0308

6. Any deviation from the terms of probation, without prior written approval by the Board, shall constitute a violation of probation, which will be cause for an immediate hearing on charges of violating this Order. Any finding that Respondent has violated this Order will subject Respondent to sanctions under Conn. Gen. Stat. § 19a-17, including but not limited to, the revocation of his license. Any extension of time or grace period for reporting granted by the Board shall not be a waiver or preclude the Board's right to take subsequent action. The Board shall not be required to grant future extensions of time or grace periods. Notice of revocation or other disciplinary action shall be sent to Respondent's address of record (most current address reported to the Practitioner Licensing and Investigations Section of the Healthcare Quality and Safety Branch of the Department).

7. This Memorandum of Decision has no bearing on any criminal liability without the written consent of the Director of the Medicaid Fraud Control Unit or the Bureau Chief of the Division of Criminal Justice's Statewide Prosecution Bureau.

8. This Decision is effective on the date it is signed by the Board.

Dated at Hartford, Connecticut this _____ day of _____, 2021.

CONNECTICUT BOARD OF VETERINARY MEDICINE

_____ By:_____
Date Mary Anne O'Neill, Chairperson