

BEFORE THE WEST VIRGINIA BOARD OF VETERINARY MEDICINE

**WEST VIRGINIA BOARD OF
VETERINARY MEDICINE,**

COMPLAINANT,

v.

CASE NO. 1021F

**LAURA MEANS, DVM,
VETERINARIAN LICENSE NO. 22-2004,**

RESPONDENT.

CONSENT AGREEMENT AND ORDER

NOW COME the West Virginia Board of Veterinary Medicine (“Board”) and Laura Means, DVM (“Respondent”) for the purpose of agreeing to disciplinary action which shall be taken against Respondent in the above-referenced matter. As a means of compromise, the Board and Respondent hereby agree to resolve this matter by and through a voluntary agreement and consent to disciplinary action, with consideration given to appropriate safeguards for protection of the public.

WHEREAS, Respondent acknowledges that the Board may file a Statement of Charges alleging that she has violated certain provisions of W. Va. Code §§ 30-10-1 *et seq.* and W. Va. Code R. §§ 26-1-1 *et seq.*, and proceed to a hearing and seek disciplinary action in these matters.

WHEREAS, Respondent hereby waives the filing of a formal Statement of Charges and the parties mutually desire to settle this matter without further prosecution and a formal hearing.

WHEREAS, the Board agrees and acknowledges that this agreement is a compromise of claims disputed by Respondent.

THEREFORE, it is hereby STIPULATED and AGREED between the undersigned parties that this matter be settled and resolved, the parties having reached an understanding concerning the proper disposition of the matter in controversy, and the Board, approving such an agreement, does hereby FIND and ORDER as follows:

FINDINGS OF FACT

1. Respondent is a licensee of the Board, holding License No. 22-2004, and at all times relevant, practiced veterinary medicine at the Brook Valley Veterinary Clinic (“Brook Valley”) in Morgantown, West Virginia.

2. On or about October 25, 2021, the Board received a written complaint and supporting documentation from Donald Elliott (“Mr. Elliott”) regarding the veterinary care that his dog “Lexie” received from Respondent at Brook Valley.

3. Mr. Elliott’s complaint states that on June 23, 2021, Respondent made a scheduled house call to his home to perform an annual, routine examination of his dogs, Lexie and Carly. Mr. Elliott maintains that Respondent informed him that Lexie had two infected teeth and Carly had a skin tag that would require removal, and accordingly, Mr. Elliott brought Lexie and Carly to Brook Valley on July 1, 2021 for the procedures.

4. Mr. Elliott states that upon arrival at Brook Valley, he met with an assistant of Respondent’s to sign paperwork, which included permission forms that expressed that if problems should arise during surgery, all necessary steps would be taken to preserve Lexie and Carly’s lives. Mr. Elliot asserts that he and his wife were informed that they could return to pick up Lexie and Carly that afternoon at 4:00 p.m., but when they arrived at Brook Valley, they waited approximately three hours, until 7:00 p.m., until Respondent spoke with them. Mr. Elliott continues in his complaint that Respondent and two assistants struggled to carry Lexie, who was

unconscious, to him after surgery, and that Respondent advised that “it was a difficult extraction” and although Lexie was still under anesthesia, she would wake up soon. Mr. Elliott asserts that he did not receive any post-surgery instructions.

5. Mr. Elliott states that Lexie remained unconscious for approximately forty-five (45) minutes after leaving Brook Valley, and that she was unable to stand on her own, despite her attempts to do so, throughout the evening. Mr. Elliott describes Lexie’s breathing as “labored and extremely moist, with milky, pink drainage from her nose and mouth.” Mr. Elliott states that Lexie finally fell asleep at 5:00 a.m. on the morning on July 2, 2021 on the kitchen floor, where she was found to have passed away at approximately 6:00 a.m. on July 2, 2021. Mr. Elliott asserts that he knew that the administration of anesthesia includes risks to the patient, but that Respondent repeatedly assured that “Lexie would be okay,” and further, that Respondent neglected to provide instructions as how to monitor Lexie as she came out of anesthesia.

6. By letter to Respondent dated November 10, 2021, the Board transmitted a copy of Mr. Elliott’s complaint and requested that Respondent file a written response thereto within 30 days.

7. The Board received Respondent’s written response on or about December 10, 2021, which included Lexie’s medical records. Respondent maintains that the pre-operative examination and bloodwork performed were unremarkable. Respondent explains the dental procedures she performed on Lexie, and notes complications that occurred with the extraction of the teeth due to discovered fractures of the teeth’s roots. Respondent asserts that she did not believe that her staff informed the Elliotts to come to Brook Valley at 4:00 p.m., and that she was unaware that her staff had made any phone calls indicating when Lexie could be discharged. Respondent further asserts that due to Lexie’s prolonged anesthesia recovery, she felt it best for her assistant to communicate

with the Elliotts at the time of discharge so that Respondent could stay with Lexie longer and monitor her. Respondent denies that Lexie was unconscious upon discharge, but notes that she was drowsy and needed assistance. Finally, Respondent states that she discussed the need to monitor Lexie closely that evening for increased respiratory rate and effort, as well as for coughing. Respondent states that although it was very unfortunate that Lexie passed away following her surgical procedure, the only way to determine causes of death without speculation would be to perform a necropsy.

8. The Board's Complaint Committee reviewed Mr. Elliott's complaint, Respondent's response thereto, and the medical records submitted therewith and found probable cause to believe that Respondent failed to maintain complete patient medical records, as the records did not contain vital signs or auscultation of the heart of lungs or anesthesia monitoring, Lexie was sent home with evidence of regurgitant aspiration, and no discharge instructions were provided as to where emergency care should be sought after Lexie was discharged, in violation of W. Va. Code § 30-10-19(g)(3) and W. Va. Code R. §§ 26-1-8.1.5, 26-4-5.2.a., 26-4-5.8.b., 26-4-5.8.c., 26-4-5.8.d., and 26-4-5.6.e.

9. Upon recommendation of the Complaint Committee, and after reviewing the aforementioned complaint, response, and accompanying documents, the Board, by majority vote at its meeting on January 6, 2022, determined there was sufficient evidence to warrant further proceedings and that further action should be taken against Respondent.

CONCLUSIONS OF LAW

1. Respondent is a licensee of the Board, holding License No. 22-2004 and is therefore subject to the license requirements and disciplinary rules of the Board.

2. The Board is a state entity created and governed by W. Va. Code §§ 30-10-1 *et seq.*, and is empowered to regulate the practice of veterinary medicine in the State of West Virginia.

3. In order to carry out its regulatory duties, the Board may suspend, revoke, or otherwise discipline an individual's license to practice veterinary medicine under the authority granted to it by W. Va. Code §§ 30-10-5 and 30-10-19 and W. Va. Code R. §§ 26-1-8 and 26-2-1 to 26-2-6.

4. Respondent does not contest that the Board has probable cause to charge her with one or more violations of the Board's governing statutes and rules based upon its investigation and findings in this matter.

5. The conduct described in the above *Findings of Fact* would, if proven, constitute violations of W. Va. Code § 30-10-19 and W. Va. Code R. §§ 26-1-8, 26-4-5.2.a, 26-4-5.8.b., 26-4-5.8.c., 26-4-5.8.d., and 26-4-5.6.e. Such conduct is therefore grounds for disciplinary action.

CONSENT OF LICENSEE

I, Laura Means, by signing this Consent Agreement and Order, acknowledge the following:

1. After having had the opportunity to consult with an attorney of my choice, I sign this Consent Agreement and Order voluntarily, freely, without compulsion or duress, and understand that my signature has legal consequences.

2. No person or entity has made any promise or given any inducement whatsoever to encourage me to make this settlement other than as set forth in this document.

3. I am aware that I may pursue this matter through appropriate administrative and/or court proceedings. I am aware of my legal rights regarding this matter, but I have chosen to waive those rights intelligently, knowingly, and voluntarily.

4. I waive any defenses including, but not limited to, laches, statute of limitations, and estoppel, that I may have otherwise claimed as a condition of this agreement.

5. I acknowledge that the execution of this document constitutes disciplinary action by the Board and is therefore considered to be public information.

The Respondent, Laura Means, by affixing his signature hereto, agrees to the following Order.

ORDER

Based on the foregoing, the Board does hereby ORDER and DECREE as follows:

1. Respondent is hereby REPRIMANDED for her actions in this matter.
2. Within six (6) months from the date of entry of this Order, Respondent shall complete three (3) hours of Board-approved continuing education on the subject of medical record keeping. These continuing education hours do not count toward the required eighteen (18) hours of continuing education.
3. Within six (6) months from the date of entry of this Order, Respondent shall complete three (3) hours of Board-approved continuing education on the subject of dental surgery/extraction. These continuing education hours do not count toward the required eighteen (18) hours of continuing education.
4. Within six (6) months from the date of entry of this Order, Respondent shall complete three (3) hours of Board-approved continuing education on the subject of anesthesia. These continuing education hours do not count toward the required eighteen (18) hours of continuing education.
5. Within three (3) months after taking the above-mentioned medical record keeping continuing education, Respondent shall submit to the Board for its review five (5) patient medical

records completed and maintained by her.

6. Within three (3) months from the date of the entry of this Order, Respondent shall reimburse the Board the costs of this proceeding, including but not limited to, the administrative and legal expenses incurred by the Board in the investigation and disposition of this case.

7. Any failure to comply with all provisions in the Consent Agreement and Order may result in additional disciplinary action, up to and including the suspension or revocation of Respondent's license to practice veterinary medicine in the State of West Virginia.

8. This document is a public record as defined in W. Va. Code § 29B-1-2. The Board is bound by law and by this Agreement to report the results of all disciplinary actions, including this matter, for posting in the AAVSB Veterinary Practitioners Disciplinary Database and for posting on the Board's website.

9. This Consent Agreement and Order constitutes the entire agreement between the parties.

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In recognition of this Consent Agreement and Order, we hereby affix our signatures.

WEST VIRGINIA BOARD OF VETERINARY MEDICINE

By: John R. Wilson, DVM
Dr. John R. Wilson, Board Chairman

Entered: 4-28-2022
Date

REVIEWED AND AGREED TO BY:

Laura Means, DVM

Laura Means, DVM
Respondent

4/12/22
Date

This day personally appeared before me, Laura Means, whose name is signed to the foregoing document and who is known to me, having acknowledged before me that the statements in the foregoing document are complete, true and correct, to the best of her knowledge, information, and belief, and executed the document voluntarily on the date shown above.

Given under my hand and seal on this the 12 day of April, 2022.

My Commission expires: 4-9-23

Ciara Putila
Notary Public

