BEFORE THE TEXAS BOARD OF NURSING

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In the Matter of
Advanced Practice Registered Nurse License Number AP123323 with Prescription Authorization Number 13799 & Registered Nurse License Number 758246 issued to KEVIN MORGAN

AGREED ORDER

On this day the Texas Board of Nursing, hereinafter referred to as the Board, considered the matter of KEVIN MORGAN, Advanced Practice Registered Nurse License Number AP123323 with Prescription Authorization Number 13799, and Registered Nurse License Number 758246, hereinafter referred to as Respondent.

Information received by the Board produced evidence that Respondent may be subject to discipline pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code. Respondent waived notice and hearing and agreed to the entry of this Agreed Order approved by Katherine A Thomas, MN, RN, FAAN, Executive Director, on December 17, 2018.

FINDINGS OF FACT

1. Prior to the institution of Agency proceedings, notice of the matters specified below in these Findings of Fact was served on Respondent and Respondent was given an opportunity to show compliance with all requirements of the law for retention of the license(s).

2. Respondent waived notice and hearing, and agreed to the entry of this Agreed Order.

3. Respondent's license to practice as a professional nurse in the State of Texas is in suspended status. Respondent's license to practice as an advanced practice registered nurse in the State of Texas with authorization as a Family Nurse Practitioner is in suspended status with Prescription Authorization Number 13799 in suspended status.

5. Respondent's nursing employment history includes:

<table>
<thead>
<tr>
<th>Year</th>
<th>Employment</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-2011</td>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>2012-2015</td>
<td>Occupational Health Specialist</td>
<td>Occucare International Family and Industrial Clinic Port Arthur, Texas</td>
</tr>
<tr>
<td>2015-Present</td>
<td>Family Nurse Practitioner/Owner</td>
<td>Optimum Family Wellness and Hormone therapy Nederland, Texas</td>
</tr>
<tr>
<td>2015-Present</td>
<td>Chairman</td>
<td>Kaliber Industrial Medicine Clinic Nederland, Texas</td>
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<tr>
<td>2016-Present</td>
<td>Chairman</td>
<td>RxFit Nederland, Texas</td>
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6. On or about March 31, 2015 through December 19, 2016, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent’s care for Patient 1 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 1, failed to document the medical rationale for treatment, and prescribed testosterone and thyroid hormone in a manner that put Patient 1 at risk of harm from complications attributable to high amounts of testosterone and thyroid hormone.

Respondent initiated high doses of testosterone and thyroid hormone for Patient 1 despite lab values showing Patient 1's testosterone and thyroid levels were initially within normal limits. Further, Respondent documented "labs within optimal range" and continued to prescribe high doses of testosterone and thyroid hormone to Patient 1 when lab values indicated high amounts of testosterone and thyroid hormone that were above normal limits.
Respondent’s apparent diagnosis of testicular hypofunction and hypothyroidism in Patient 1 were contradicted by laboratory test results ordered by Respondent, and were not supported by documentation in Patient 1’s medical records. Respondent failed to institute and/or failed to document institution of appropriate interventions, such as dose adjustment, phlebotomy, testing of the patient’s thyroid stimulating hormone, and/or referrals, when Patient 1’s abnormal laboratory results indicated high amounts of testosterone and thyroid hormone. Further, Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.

Respondent’s conduct was likely to injure Patient 1 from complications attributable to high doses of testosterone and thyroid hormone, including but not limited to: myocardial infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the potential side effects and complications of testosterone and thyroid hormone therapy with Patient 1. Patient 1 subsequently experienced cardiac arrest and died. The cause of death was hypertensive cardiovascular disease with contributory cause chronic exogenous hormone therapy (not introduced by the body) and obesity. Patient 1’s total testosterone level was noted to be 1,500 ng/dl.

7. On or about January 23, 2017, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent’s care for Patient 2 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 2, failed to document the medical rationale for treatment, and prescribed testosterone and thyroid hormone in a manner that put Patient 2 at risk of harm from complications attributable to high amounts of testosterone and thyroid hormone.

Respondent initiated high doses of testosterone and thyroid hormone for Patient 2 despite initial lab values showing Patient 2’s testosterone and thyroid levels were within normal limits. Respondent failed to document medical rationale for his apparent diagnosis of testicular hypofunction, hashimotos, and hypothyroidism. Respondent initiated the dose for testosterone at 300mg weekly, a very high dose. Respondent failed to document medical rationale for this therapy or dose when Patient 2’s testosterone levels were within normal limits. Respondent failed to document medical rationale for replacing Patient 2’s thyroid therapy, Synthroid, with a high dose of Nature-Throid when Patient 2’s thyroid levels were within normal limits. Further, Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.
Respondent’s conduct was likely to injure Patient 2 from complications attributable to high
doses of testosterone and thyroid hormone, including but not limited to: myocardial
infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and
thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the
potential side effects and complications of testosterone and thyroid hormone therapy with
Patient 2.

8. On or about April 7, 2016 through February 14, 2017, while employed as a Family Nurse
Practitioner and Owner of Optimum Medical Weight Control and Family Wellness,
Nederland, Texas, Respondent’s care for Patient 3 was inadequate and fell below the
minimum standards of nursing practice, in that Respondent failed to perform appropriate
assessments or examinations and/or failed to document appropriate assessments or
examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed
Patient 3, failed to document the medical rationale for treatment, and prescribed
testosterone and thyroid hormone in a manner that put Patient 3 at risk of harm from
complications attributable to high amounts of testosterone and thyroid hormone.

Respondent initiated high doses of testosterone and thyroid hormone for Patient 3 despite
initial lab values showing Patient 3’s testosterone level was high and his thyroid levels
were within normal limits. Respondent failed to document medical rationale for his
apparent diagnosis of testicular hypo-function and hypothyroidism. Respondent failed to
document medical rationale for the utilized treatment. Further, Respondent failed to
document whether the testosterone and thyroid hormone were continued or discontinued.
Laboratory test results subsequent to Patient 3’s initial office visit indicate Patient 3’s
testosterone was high, cortisol was low, hemoglobin was high, and hematocrit was high.
High levels of testosterone can lead to low cortisol, high hemoglobin, and high hematocrit.
Low cortisol may indicate adrenal insufficiency. High hemoglobin and hematocrit can
cause hyper viscosity, which can lead to myocardial infarction or stroke. Respondent failed
to institute and/or failed to document institution of appropriate interventions, such as dose
adjustment, phlebotomy, and/or referrals, when Patient 3’s abnormal laboratory results
indicated high testosterone, low cortisol, high hemoglobin, and high hematocrit. Further,
Respondent failed to collaborate with a delegating physician and/or failed to document
collaboration with a delegating physician.

Respondent’s conduct was likely to injure Patient 3 from complications attributable to high
doses of testosterone and thyroid hormone, including but not limited to: myocardial
infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and
thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the
potential side effects and complications of testosterone and thyroid hormone therapy with
Patient 3. Patient 3 was subsequently admitted to an emergency department for respiratory
failure and unresponsiveness. Patient 3’s hemoglobin was 18.5 and hematocrit was 55.1,
high levels which can result from testosterone supplementation and cause hyper viscosity.
Hyper viscosity can lead to myocardial infarction or stroke. Additionally, Patient 3’s thyroid stimulating hormone was low, indicating hyperthyroid. Patient 3 died three days after admission to the emergency department.

9. On or about November 3, 2015 through September 13, 2016, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent’s care for Patient 4 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 4, failed to document the medical rationale for treatment, and prescribed testosterone and thyroid hormone in a manner that put Patient 4 at risk of harm from complications attributable to high amounts of testosterone and thyroid hormone.

Initial lab values, indicate Patient 4’s testosterone and thyroid hormone levels were within normal limits. A high dose of 200mg of testosterone weekly, Nature-Throid, and anastrazole were initiated. Respondent failed to document medical rationale for his apparent diagnosis of testicular hypofunction and hypothyroidism, when Patient 4’s lab values were within normal limits. Respondent failed to document medical rationale for the utilized treatment. Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.

Respondent’s conduct was likely to injure Patient 4 from complications attributable to high doses of testosterone and thyroid hormone, including, but not limited to: myocardial infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the potential side effects and complications of testosterone and thyroid hormone therapy with Patient 4. Patient 4 subsequently obtained treatment at another facility. It was noted that Patient 4 was hyperthyroid, and Patient 4’s testosterone and free testosterone levels were very high. Patient 4 received a diagnosis for testosterone poisoning. The testosterone was tapered down.

10. On or about June 29, 2016 through September 8, 2016, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent’s care for Patient 5 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 5, failed to document the medical rationale for treatment, and prescribed testosterone and thyroid hormone in a manner that put Patient 5 at risk of harm from complications attributable to high amounts of testosterone and thyroid hormone.
Initial lab values, indicate Patient 5’s thyroid stimulating hormone was within normal limits, and Patient 5’s testosterone and cortisol levels were low. A high dose of 250mg of testosterone weekly was initiated along with thyroid hormone. Respondent failed to document medical rationale for his apparent diagnosis of testicular hypofunction and hypothyroidism. Respondent failed to document medical rationale for the utilized treatment, including hormone therapy. Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.

Respondent’s conduct was likely to injure Patient 5 from complications attributable to high doses of testosterone and thyroid hormone, including but not limited to: myocardial infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the potential side effects and complications of testosterone and thyroid hormone therapy with Patient 5. Patient 5 was subsequently hospitalized for angina, acute coronary syndrome, “excessive” testosterone replacement, and thyrotoxicosis due to inappropriate replacement of thyroid hormone and polycythemia. Patient 5’s thyroid stimulating hormone was low and free T3 was high, indicating hyperthyroid. Patient 5’s testosterone level was noted to be “excessively high.”

On or about April 13, 2016 through June 10, 2016, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent’s care for Patient 6 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 6, failed to document the medical rationale for treatment, and prescribed testosterone and thyroid hormone in a manner that put Patient 6 at risk of harm from complications attributable to high amounts of testosterone and thyroid hormone.

Patient 6’s initial lab values indicated low testosterone, and thyroid hormone levels within normal limits. Respondent initiated high doses of testosterone and thyroid hormone for Patient 6. Respondent failed to document medical rationale for his apparent diagnosis of testicular hypofunction and hypothyroidism. Respondent failed to document medical rationale for the utilized treatment. Subsequent laboratory testing indicated Patient 6’s testosterone level was high, and Patient 6’s thyroid stimulating hormone was low, indicating hyperthyroidism. Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.

Respondent’s conduct was likely to injure Patient 6 from complications attributable to high doses of testosterone and thyroid hormone, including but not limited to: myocardial infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the potential side effects and complications of testosterone and thyroid hormone therapy with Patient 6. Patient 6 was subsequently admitted to an emergency department with atrial
fibrillation. Patient 6's thyroid stimulating hormone at the time of admission was low, indicating hyperthyroidism. Patient 6 underwent a medical procedure to reset the heart's rhythm back to its normal pattern, and was changed to low dose thyroid hormone.

12. On or about October 27, 2015 through November 3, 2015, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent's care for Patient 7 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 7, failed to document the medical rationale for treatment, and prescribed testosterone and thyroid hormone in a manner that put Patient 7 at risk of harm from complications attributable to high amounts of testosterone and thyroid hormone.

Patient 7's initial lab values indicated low testosterone, and thyroid hormone levels within normal limits. Respondent initiated high doses of testosterone and thyroid hormone for Patient 7. Respondent failed to document medical rationale for his apparent diagnosis of testicular hypofunction and hypothyroidism. Respondent failed to document medical rationale for the utilized treatment. Subsequent laboratory testing indicated Patient 7's testosterone level was high, and Patient 7's thyroid stimulating hormone was low, indicating hyperthyroidism. Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.

Respondent's conduct was likely to injure Patient 7 from complications attributable to high doses of testosterone and thyroid hormone, including but not limited to: myocardial infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the potential side effects and complications of testosterone and thyroid hormone therapy with Patient 7. Patient 7 subsequently obtained treatment at another facility. It was noted that Patient 7 was receiving 250mg per week of testosterone and 195mg per day of Nature-Throid, a thyroid hormone, from Optimum Medical Weight Control and Family Wellness. Thyroid hormone and testosterone were both reduced by the treating physician.

13. On or about October 27, 2015 through August 29, 2016, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent's care for Patient 8 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 8, failed to document the medical rationale for treatment, and prescribed testosterone and thyroid hormone in a manner that put Patient 8 at risk of harm from complications attributable to high amounts of testosterone and thyroid hormone.
Patient 8’s initial thyroid stimulating hormone level was low, indicating hyperthyroidism. Patient 8’s thyroid hormone was changed to Nature-Throid and the dose was increased to up to 2 grains per day. Subsequent lab values indicate prescriber induced hyperthyroidism and Patient 8’s testosterone levels are now high. Respondent failed to document medical rationale for his apparent diagnosis of hypothyroidism. Under assessment in the Patient’s medical record, Respondent documented “within normal limits,” when Patient 8’s thyroid stimulating hormone was low and Patient 8’s free T3 was 4.72, nearly double normal. Respondent failed to document medical rationale for the utilized treatment, including hormone therapy. Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.

Respondent’s conduct was likely to injure Patient 8 from complications attributable to high doses of testosterone and thyroid hormone, including but not limited to: myocardial infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the potential side effects and complications of testosterone pellet therapy and thyroid hormone therapy with Patient 8. Patient 8 subsequently obtained treatment at another facility. It was noted that at Optimum Medical Weight Control and Family Wellness, Patient 8 had been changed to 195mg per day of Nature-Throid and was receiving Bio-Te pellets. Patient 8 had anxiety and palpitations. Patient 8’s thyroid stimulating hormone was low, indicating hyperthyroid.

14. On or about February 23, 2016 through August 26, 2016, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent’s care for Patient 9 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 9, failed to document the medical rationale for treatment, and prescribed thyroid hormone and/or testosterone pellet therapy in a manner that put Patient 9 at risk of harm from complications attributable to high amounts of testosterone and thyroid hormone.

Patient 9’s initial laboratory test results indicate thyroid hormone levels within normal limits. High doses of thyroid hormone and testosterone were initiated for Patient 9. Respondent failed to document medical rationale for his apparent diagnosis of hypothyroidism. Respondent failed to document medical rationale for the utilized treatment, including testosterone pellet therapy. Subsequent laboratory testing indicate Patient 9’s testosterone level was high, and Patient 9’s thyroid hormone levels were low. Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.

Respondent’s conduct was likely to injure Patient 9 from complications attributable to high doses of thyroid hormone and testosterone, including but not limited to: myocardial infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the
potential side effects and complications of thyroid hormone therapy and testosterone pellet therapy with Patient 9. Patient 9 subsequently obtained treatment at another facility. It was noted that Patient 9 was experiencing palpitations and Patient 9’s thyroid stimulating hormone was low, indicating hyperthyroid.

15. On or about July 13, 2016 through July 26, 2016, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent’s care for Patient 10 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 10, failed to document the medical rationale for treatment, and prescribed testosterone and thyroid hormone in a manner that put Patient 10 at risk of harm from complications attributable to high amounts of testosterone and thyroid hormone.

Patient 10’s initial lab values indicated low testosterone, and thyroid hormone levels within normal limits. High doses of testosterone and thyroid hormone were initiated for Patient 10. Respondent failed to document medical rationale for his apparent diagnosis of testicular hypofunction and hypothyroidism. Respondent failed to document medical rationale for the utilized treatment. Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.

Respondent’s conduct was likely to injure Patient 10 from complications attributable to high doses of testosterone and thyroid hormone, including but not limited to: myocardial infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the potential side effects and complications of testosterone and thyroid hormone therapy with Patient 10. Patient 10 was subsequently hospitalized for myocardial infarction and coronary artery bypass.

16. On or about March 22, 2016 through June 28, 2016, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent’s care for Patient 11 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 11, failed to document the medical rationale for treatment, and prescribed thyroid hormone in a manner that put Patient 11 at risk of harm from complications attributable to high amounts of thyroid hormone.

Initial lab values ordered by Respondent, indicate Patient 11’s thyroid hormone levels were within normal limits. Respondent failed to document medical rationale for his apparent diagnosis of hypothyroidism. A high dose of thyroid hormone was initiated. Respondent failed to document medical rationale for the utilized treatment. Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.
Respondent’s conduct was likely to injure Patient 11 from complications attributable to high doses of thyroid hormone, including, but not limited to: arrhythmia and thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the potential side effects and complications of testosterone and thyroid hormone therapy with Patient 11. Patient 11 subsequently obtained treatment at another facility. It was noted that Patient 11’s thyroid stimulating hormone was low, indicating hyperthyroid. It was also noted that Patient 11 was taking 2.5 grains of Nature-Throid, a very high dose, and it was reduced.

17. On or about May 5, 2016 through September 23, 2016, while employed as a Family Nurse Practitioner and Owner of Optimum Medical Weight Control and Family Wellness, Nederland, Texas, Respondent’s care for Patient 12 was inadequate and fell below the minimum standards of nursing practice, in that Respondent failed to perform appropriate assessments or examinations and/or failed to document appropriate assessments or examinations, misinterpreted and/or ignored laboratory test results, incorrectly diagnosed Patient 12, failed to document the medical rationale for treatment, and prescribed testosterone and thyroid hormone in a manner that put Patient 12 at risk of harm from complications attributable to high amounts of testosterone and thyroid hormone.

Patient 12’s initial lab values indicated low testosterone, and thyroid hormone levels within normal limits. High doses of testosterone pellet therapy and thyroid hormone were initiated for Patient 12. Respondent failed to document medical rationale for his apparent diagnosis of testicular hypofunction and hypothyroidism. Respondent failed to document medical rationale for the utilized treatment, including testosterone pellet therapy. Subsequent laboratory testing indicated Patient 12’s testosterone level was high, free testosterone level was nearly double normal at 42.8 pg/ml (normal range is 4.8-25.7 pg/ml), and Patient 12’s thyroid stimulating hormone was low, indicating hyperthyroid. Respondent failed to collaborate with a delegating physician and/or failed to document collaboration with a delegating physician.

Respondent’s conduct was likely to injure Patient 12 from complications attributable to high doses of testosterone and thyroid hormone, including but not limited to: myocardial infarction, stroke, atrial fibrillation, tachycardia, testosterone poisoning, and thyrotoxicosis. Respondent failed to discuss and/or failed to document discussion of the potential side effects and complications of testosterone pellet therapy and thyroid hormone therapy with Patient 12. Patient 12 subsequently obtained treatment at another facility. It was noted that Patient 12 was started on Nature-Throid, a thyroid hormone, at Optimum Medical Weight Control and Family Wellness, and Patient 12’s cardiologist wanted to discontinue the testosterone received at Optimum Medical Weight Control and Family Wellness.

18. Formal Charges were filed and Respondent’s licenses were suspended by the Board on December 1, 2017.
19. Respondent by his signature expresses his desire to voluntary surrender the licenses.

20. Mr. Morgan states that "he respectfully disagrees with the Board's findings and allegations and does not admit any wrongdoing. Mr. Morgan believes his care for Patients 1-12 met the standard of care for this patient's comorbidities. Further, Mr. Morgan believes his documentation was appropriate and that he provided medical rationales for his treatment plans, including the medical necessity for Patients' 1-12 prescriptions of testosterone and thyroid hormone. Those prescriptions were the appropriate dosages for Patients' 1-12 and never put Patients' 1-12 at risk for harm. In addition, Mr. Morgan's interpretation of lab values were correct and justified the dosages of testosterone and thyroid hormone. Mr. Morgan also performed the necessary assessments and examination on Patients 1-2. Patients 1-12 were never in any harm from Mr. Morgan's treatment."

21. Respondent states that "his diagnoses of Patients 1-12 testicular hypofunction were correct and supported by the laboratory and medical records. Mr. Morgan did not need to collaborate with a physician for the treatments administered to these patients."

22. Respondent states that "overall, Mr. Morgan's treatment did not injure these patients. Patients 1-12 were very sick individuals before Mr. Morgan began treating them. Any negative outcome, while unfortunate, was caused by preexisting health conditions and/or intervening and superseding causes and was not a proximate or direct cause of the care rendered by Mr. Morgan. There is no evidence that supports Mr. Morgan's treatment harmed these patients or caused any deaths."

CONCLUSIONS OF LAW

1. Pursuant to Texas Occupations Code, Sections 301.451-301.555, the Board has jurisdiction over this matter.

2. Notice was served in accordance with law.


4. The evidence received is sufficient cause pursuant to Section 301.452(b)(10)&(13), Texas Occupations Code, to take disciplinary action against Advanced Practice Registered Nurse License Number AP123323 with Prescription Authorization Number 13799, and Registered Nurse License Number 758246, heretofore issued to KEVIN MORGAN.
5. Pursuant to Section 301.463(d), Texas Occupations Code, this Agreed Order is a settlement agreement under Rule 408, Texas Rules of Evidence, in civil or criminal litigation.

TERMS OF ORDER

NOW, THEREFORE, IT IS AGREED and ORDERED that the VOLUNTARY SURRENDER of Advanced Practice Registered Nurse License Number AP123323 with Prescription Authorization Number 13799, and Registered Nurse License Number 758246 is accepted by the Texas Board of Nursing. In connection with this acceptance, the Board imposes the following conditions:

1. RESPONDENT SHALL NOT practice advanced practice registered nursing, use the title "advanced practice registered nurse" or the abbreviation "APRN" or wear any insignia identifying himself as an advanced practice registered nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is an advanced practice registered nurse during the period in which the license is surrendered.

2. RESPONDENT SHALL NOT practice professional/registered nursing, use the title "registered nurse" or the abbreviation "RN" or wear any insignia identifying himself as a registered nurse or use any designation which, directly or indirectly, would lead any person to believe that RESPONDENT is a registered nurse during the period in which the license is surrendered.

3. RESPONDENT SHALL NOT petition for reinstatement of licensure until at least one (1) year has elapsed from the date of this Order.

4. Upon petitioning for reinstatement, RESPONDENT SHALL satisfy all then existing requirements for relicensure.

IT IS FURTHER AGREED and ORDERED that this Order SHALL be applicable to Respondent's nurse licensure compact privileges, if any, to practice nursing in the State of Texas.
RESPONDENT'S CERTIFICATION

I understand that I have the right to legal counsel prior to signing this Order. I have reviewed this Order. I neither admit nor deny the violation(s) alleged herein. By my signature on this Order, I agree to the entry of this Order, and any conditions of said Order, to avoid further disciplinary action in this matter. I waive judicial review of this Order. I understand that this Order becomes effective upon acceptance by the Executive Director on behalf of the Texas Board of Nursing and a copy will be mailed to me. I understand that if I fail to comply with all terms and conditions of this Order, I will be subject to investigation and disciplinary sanction, including possible revocation of my license(s) and/or privileges to practice nursing in the State of Texas, as a consequence of my noncompliance.

Signed this 1 day of January, 2019.

KEVIN MORGAN, Respondent

Sworn to and subscribed before me this 1 day of January, 2019.

Notary Public in and for the State of Texas

Approved as to form and substance.

Franklin Hopkins, Attorney for Respondent

Signed this 28 day of February, 2019.
WHEREFORE, PREMISES CONSIDERED, the Executive Director, on behalf of the Texas Board of Nursing does hereby ratify and adopt the Agreed Order that was signed on the 7th day of January, 2019, by KEVIN MORGAN, Advanced Practice Registered Nurse License Number AP123323, and Registered Nurse License Number 758246, and said Agreed Order is final.

Effective this 26th day of February, 2019.

Katherine A. Thomas, MN, RN, FAAN
Executive Director on behalf of said Board