BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: VINCENT KEITH JONES, M.D.
License Number: 0101-231063
Case Number: 162454

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), a Special Conference Committee of the Virginia Board of Medicine ("Board") held an informal conference on March 13, 2019, in Henrico County, Virginia, to inquire into evidence that Vincent Keith Jones, M.D., may have violated certain laws and regulations governing the practice of medicine and surgery in the Commonwealth of Virginia.

Vincent Keith Jones, M.D., appeared at this proceeding and was represented by Ward L. Armstrong, Esquire.

Upon consideration of the evidence, the Committee adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Vincent Keith Jones, M.D., was issued License Number 0101-231063 to practice medicine and surgery on July 17, 2001, which is scheduled to expire on April 30, 2020. At all times relevant to the findings contained herein, said license was current and active.

multiple medical maladies, to include chronic back pain, chronic nonmalignant pain, and osteoarthritis. Specifically:

a. Patient A first presented to Dr. Jones on or about November 9, 2003 with complaints of back pain, for which he reported taking Lortab 10 (C-III)\(^1\). Dr. Jones obtained records for Patient A from 1999 and 2000, which included an assessment of low back syndrome and degenerative arthrosis at L5-S1, and a September 2000 recommendation for spinal fusion. Without obtaining updated studies of Patient A’s lumbar spine, or consulting with prior treating practitioners, Dr. Jones began prescribing opioid pain medications to Patient A, and continued to do so, at times intermittently, until in or after April 2015.

b. On or about November 3, 2011, Patient A was admitted to the hospital after an overdose of several medications with the intention of suicide. A consultation note dictated by Dr. Jones on or about November 4, 2011, stated that Patient A overdosed on Xanax (C-IV), methadone (C-II), and possibly hydrocodone, but that Patient A had no intention to harm himself and just wanted to numb himself after an argument with his girlfriend. Dr. Jones also noted that Patient A had issues with “street drugs,” mainly marijuana and cocaine. Despite Patient A’s overdose and use of a drug not prescribed by Dr. Jones (methadone), Patient A’s discharge summary noted that Dr. Jones intended to continue prescribing Lorcet (C-III)\(^2\) and Xanax.

c. Following Patient A’s discharge from the hospital, there is no documentation in Dr. Jones’s record to determine whether Patient A followed recommendations for psychotherapy or medication management provided by community services. Although Patient A’s diagnosis at

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\(^1\) Effective October 6, 2014, the federal Drug Enforcement Administration (“DEA”) rescheduled hydrocodone combination products from schedule III to schedule II of the Controlled Substances Act (“CSA”). 79 Fed. Reg. 163 (August 22, 2014).

discharge included mood disorder not otherwise specified, rule out bipolar disorder, Dr. Jones began listing bipolar disorder as one of Patient A’s presenting problems and prescribing lithium to him, without documenting any further testing or evaluation to confirm the diagnosis.

d. By letter dated November 3, 2011, after Patient A’s hospital admission described in paragraph 2.b., Dr. Jones notified Patient A that he was discontinuing medical care for Patient A due to a broken pain management agreement. Subsequently, Dr. Jones stated he “liked [Patient A]” and wanted to be sure he could receive medical care, so he “took him back as a patient” and continued to treat Patient A with opioids through in or after April 2015.

e. Despite Dr. Jones’s completion of the continuing education required by the 2007 Order, in the subjects of pain management and addiction medicine, between in or about January 2011 and in or about April 2015, Dr. Jones prescribed multiple controlled substances of abuse potential to Patient A, to include hydrocodone, Opana (C-II), oxycodone (C-II), and alprazolam (C-IV). During this time, Dr. Jones failed to utilize consistently and correctly measures, such as contracts for the prescription of controlled substances, reviews of the Prescription Monitoring Program ("PMP"), urine drug screens ("UDS"), and pill counts to ensure Patient A was compliant with Dr. Jones’s treatment regimen. Prior to such prescribing, Dr. Jones failed to perform, or document that he performed, physical examinations or reviewed radiological studies to support such prescribing, or otherwise document the rationale for his medical decision-making. On or about May 15, 2015, during an interview with a Senior Investigator for the Virginia Department of Health Professions ("Investigator"), Dr. Jones stated that he does not have patients complete an activity questionnaire or other form to document their levels of functioning. Rather, Dr. Jones stated he had a routine “mental list of questions” he asked patients about their daily functioning. However, answers to these questions were not contained in Patient A’s medical record.
f. Between in or about May 2010, and in or about February 2015, Dr. Jones requested five UDSs for Patient A (and one was performed after the hospital admission described in paragraph 2.b.); however, Dr. Jones failed to respond appropriately to results that indicated Patient A was not in compliance with Dr. Jones's treatment regimen. Dr. Jones also failed to respond appropriately to Patient A's apparent use of illegal drugs, which were specifically prohibited by a contract for controlled substances signed by Patient A in or about September 2003. Specifically:

<table>
<thead>
<tr>
<th>Date</th>
<th>UDS Result</th>
<th>Drug(s) Prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/07/2010</td>
<td>Positive for marijuana metabolites, Positive for opiates, Positive for methadone, Negative for hydrocodone/metabolites</td>
<td>Lorce, Xanax</td>
</tr>
<tr>
<td>11/03/2011 (hospital)</td>
<td>Presumed positive for benzodiazepines, Presumed positive for opiates, Presumed positive for cocaine, Presumed positive for methadone</td>
<td>Lorce, Xanax, Opana</td>
</tr>
<tr>
<td>01/03/2012</td>
<td>Negative for opiates, Positive for oxycodone/oxyphene</td>
<td>Lorce</td>
</tr>
<tr>
<td>11/01/2013</td>
<td>Negative for opiates, Positive for benzodiazepines</td>
<td>Lorce</td>
</tr>
<tr>
<td>02/22/2015</td>
<td>Presumed positive for benzodiazepines, Presumed positive for opiates, Presumed positive for cocaine, Presumed positive for methadone</td>
<td>Oxycodone</td>
</tr>
<tr>
<td>03/13/2015</td>
<td>Positive for hydrocodone, Positive for norhydrocodone, Positive for hydromorphone, Positive for clonazepam</td>
<td>Oxycodone</td>
</tr>
</tbody>
</table>

g. In an undated summary of Patient A's treatment sent to the Investigator in or about May 2015, Dr. Jones stated that Patient A was a "self-pay" patient who claimed he could not afford the costs of UDSs. Dr. Jones admitted that he was unsure whether Patient A's reluctance to submit to UDS was because "the results were too revealing" or because of true cost issues. To "get around the problem", Dr. Jones stated they "pulled his record on the VA Dept. of Health prescription database" (presumably the PMP); however, records from the PMP indicate that Dr. Jones failed to
request a report for Patient A until on or about April 13, 2015, after he received notice of the instant case.

h. Despite being required to take twelve (12) hours of continuing education in the subjects of medical recordkeeping by an Order of the Board, entered August 24, 2012 ("2012 Order"), Dr. Jones's medical records for Patient A frequently contain inaccurate or contradictory information, so as to render them useless at chronicling Patient A's medical treatment. Dr. Jones informed the Investigator that the notation "drug screen data reviewed" in his electronic medical record ("EMR") notes does not necessarily mean that he required the patient to submit to a UDS at that visit, and that he does not specifically document the goals, treatment plan, or drug rotation schedule for each chronic pain patient. Dr. Jones's handwritten notes for Patient A are similarly deficient of detail, and typically include minimal information, such as vital signs, a problem list, and medications that were prescribed. For example, for February 14, 2008, Dr. Jones's EMR includes a Social History for Patient A with the notation that he "has never smoked tobacco", but also contains a diagnosis of "Nondependent Tobacco Use Disorder" with greater than ten minutes spent on cessation counseling.

i. When asked about reviewing PMP reports, Dr. Jones told the Investigator that he did not know how often he should review a PMP report, so he does not review it on a regular basis. Dr. Jones advised that the notation in his EMR that read, "prescription monitoring (if available): Indicates appropriate behavior" was not meant to imply that he reviewed the PMP at each visit.

j. With respect to Patient A's usage of marijuana and methadone, which was not prescribed by Dr. Jones, Dr. Jones advised the Investigator that Patient A used marijuana on a regular basis, but Dr. Jones did not believe he abused "illicit substances."

3. When asked to review the history and physical documented at Patient A's hospital admission on or about November 3, 2011, which listed a significant history of depression in the patient
and in members of his family, including the suicide of several family members; and asked if it was wise to continue prescribing narcotics to Patient A, Dr. Jones advised the Committee that he did not remember seeing the document, which was contained in his treatment record for Patient A.

4. In a progress note during Patient A’s November 2011 hospital admission, Patient A’s psychiatrist noted that, “Dr. Jones is unwilling to change his pain management[,]” even though “[Patient A] seems to have substance abuse issues.” When asked by the Committee, Dr. Jones was unable to explain his rationale for disregarding the other physician’s recommendation.

5. Dr. Jones explained to the Committee that the results of Patient A’s UDSs did raise red flags for Dr. Jones, and that he did confront Patient A with the findings, but Dr. Jones did not know whether he documented such discussions in Patient A’s treatment record. Further, the Committee noted that Dr. Jones did not alter his prescribing habits in response to such results.

6. On or about January 3, 2013, Dr. Jones documented that Patient A never drank alcohol, smoked tobacco, drank caffeinated beverages, or used any illicit drugs; however, Dr. Jones’s treatment record also contained evidence that Patient A was taking or had abused cocaine, marijuana, and methadone, at various points while he was Dr. Jones’s patient.


a. Patient B first presented to Dr. Jones on or about March 3, 2014, for treatment of hypertension and anxiety. Patient B’s registration form also includes a notation that her previous physician gave her “meds every two months, gave meds for one month ran out took off hydrocodone.”
Three pages of a fifteen page facsimile transmission from Patient B’s prior treating physician are included in her treatment record for Dr. Jones, but Dr. Jones did not consult with her prior physician to explain the notation on her registration form. Further, Dr. Jones failed to perform, or document that he performed, a thorough examination of Patient B prior to prescribing lorazepam (C-IV).

b. Despite the continuing education required by the 2007 Order, in the subjects of pain management and addiction medicine, on or about July 1, 2014, Dr. Jones began prescribing oxycodone to Patient B for her complaints of pain, along with lorazepam until on or about September 30, 2014. On or about October 28, 2014, Dr. Jones prescribed Endocet (C-II) and alprazolam to Patient B. Between on or about December 1, 2014, and on or about March 26, 2015, Dr. Jones only prescribed oxycodone to Patient B. Dr. Jones failed to perform, or document that he performed a comprehensive examination of Patient B to warrant such prescriptions, and despite prescribing multiple medications of abuse potential, Dr. Jones failed to utilize consistently and correctly measures such as medication contracts, UDSs, PMP reports, pill counts, etc., to verify Patient B’s compliance with his treatment regimen. The only radiographic study contained in Dr. Jones’s record for Patient B was of the right hip on or about May 7, 2014, which showed no evidence of acute fracture or injury, and no significant degenerative changes.

c. Despite the continuing education required by the Board in the 2012 Order, in the subject of medical recordkeeping, Dr. Jones’s medical records for Patient B frequently contain inaccurate or contradictory information, so as to render them useless at chronicling Patient B’s medical treatment. For example, on or about September 30, 2014, Dr. Jones documented that Patient B’s pain level the prior week was 10/10, but that 100% of her pain was relieved by medications, and that her overall level of functioning with the pain relievers was better.

8. Dr. Jones informed the Committee that he was no longer treating Patients A or B.
9. Dr. Jones informed the Committee that since the above events, he has restructured his entire practice to ensure that his pain management practices are in compliance with applicable laws and regulations. For example, Dr. Jones hired additional staff to ensure consistent performance of UDSs, contracts for the prescription of controlled substances, and checks of the PMP.

10. Dr. Jones represented to the Committee that his medical recordkeeping was deficient due to his practice being over-extended. After being visited by the Investigator regarding the instant case, Dr. Jones eliminated or reduced his geriatric and hospital practices. Dr. Jones stated to the Committee that he understands that he has to do better in his recordkeeping and the documentation of his prescribing decisions.

11. The Committee noted that Dr. Jones demonstrated lack of insight into the significance of the current allegations, especially in light of action previously taken by this Board.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Medicine hereby ORDERS that the license of Vincent Keith Jones, M.D., is placed on INDEFINITE PROBATION, subject to the following terms and conditions:

1. Effective May 1, 2019, Dr. Jones shall not prescribe, administer, or dispense any Schedule II or III controlled substances. Further, Dr. Jones shall not serve as a supervising or collaborating physician for any physician assistant or nurse practitioner prescribing, administering, or dispensing any Schedule II or III controlled substances.

2. Within six (6) months of entry of this Order, Dr. Jones shall undergo a clinical competency assessment conducted by a nationally recognized program approved by the Board (e.g., PACE or CPEP), in advance of registration. Dr. Jones shall authorize the program to provide the Board with a written report of the assessment. Dr. Jones shall provide proof to the Board that he has
provided the program with a complete copy of this Order, and all previous Orders of the Board. Dr. Jones shall execute all releases necessary for unrestricted communication between the program and the Board, and shall bear all costs associated with the evaluation.

3. Upon receipt of evidence of completion of Term 2, a report shall be prepared regarding Dr. Jones’s compliance with this Order and Dr. Jones shall be noticed to appear before the Board at an administrative proceeding.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD

[Signature]

Jennifer Deschenes, J.D., M.S.
Deputy Executive Director, Discipline
Virginia Board of Medicine

ENTERED: 3/20/19

NOTICE OF RIGHT TO APPEAL

Pursuant to Virginia Code § 54.1-2400(10), Dr. Jones may, not later than 5:00 p.m., on April 25, 2019, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated. This Order shall become final on April 25, 2019, unless a request for a formal administrative hearing is received as described above.