STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING,

Petitioner,

vs. Case Nos. 20-3057PL
20-3062PL
ALEJANDRO PEREZ, A.P.R.N., 20-3066PL

Respondent.
_____/

RECOMMENDED ORDER

On October 28 and 29, 2020, Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings (DOAH), conducted the final hearing by Zoom.

APPEARANCES

For Petitioner: Dirlie Anna McDonald, Esquire
Nicole M. DiBartolomeo, Esquire
Department of Health
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Tallahassee, Florida 32399

For Respondent: Dwight Oneal Slater, Esquire
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STATEMENT OF THE ISSUES

The issues are whether, during 2015, Respondent held himself out as a "doctor of medicine," even though he did not hold a license to practice medicine in Florida, in violation of section 456.072(1)(m), Florida Statutes (2014); whether, during 2015, Respondent exceeded the scope of his advanced

practice registered nursing (APRN)[1] license modifier by removing adipose tissue from a patient's abdomen, performing intravitreous injections of the processed tissue into both eyes of a patient, and failing to have a protocol in place for the removal of abdominal adipose tissue and the intravitreous injection of any material into a living person, in violation of section 456.072(1)(o); and, if so, the penalty that should be imposed.

PRELIMINARY STATEMENT

These three cases involve similar allegations concerning three patients. The Administrative Complaint alleges that, at all material times, Respondent was an APRN, holding license number APRN 9201869, and he was employed by U.S. Stem Cell Clinic (the Clinic), which was an affiliate of Bioheart, Inc.

In DOAH Case 20-3057PL, the Administrative Complaint alleges that E.K., an 88-year-old female with macular degeneration, presented to the Clinic for a "stem cell" injection on May 15, 2015. Allegedly, E.K. had previously been evaluated and approved for the procedure by Shareen Greenbaum, an M.D. specializing in ophthalmology. On May 15, Respondent allegedly represented himself to E.K. and her niece, B.K., as "Dr. Perez" and allegedly held himself out to the public as "Alex Perez, D[octor of] M[edicine], NP-C," on the website of the Clinic, where he was referred to as "Dr. Perez," even though Respondent did not hold a license to practice medicine.

On May 15, Respondent allegedly performed a procedure to remove adipose, or fat, tissue from E.K.'s abdomen and intravitreously inject the tissue, after processing, into both eyes of the patient. On May 15, E.K. allegedly experienced complications, including bilateral retinal detachment and blindness, due to the intravitreal injections of the product created from

[1] Until 2018, an APRN was known as an "advanced registered nurse practitioner." For ease of reference, this recommended order will use only the current title.

the adipose tissue. Due to the injections, E.K. allegedly became legally blind with no light perception in either eye.

In 2015, Respondent allegedly did not have an APRN protocol in place covering the removal of abdominal fat tissue or injection of any material intravitreously into a living person.

Count I of the Administrative Complaint alleges that section 456.072(1)(o) provides that discipline may be imposed if a licensee practices or offers to practice beyond the scope permitted by law or accepts or performs professional responsibilities that the licensee knows, or has reason to know, he is not competent to perform. Count I alleges that Respondent exceeded the scope of his APRN license by removing fat tissue from E.K.'s abdomen, performing intravitreous injections into both of E.K.'s eyes, and failing to have in place an APRN protocol covering the removal of abdominal fat tissue or injection of any material intravitreously into living persons.

Count II of the Administrative Complaint alleges that section 456.072(1)(m) provides that discipline may be imposed if a licensee makes deceptive, untrue, or fraudulent representations in or relation to the practice of a profession or employs a trick or scheme in, or relating or related to, the practice of a profession. Count II alleges that Respondent made deceptive, untrue, or fraudulent representations related to the practice of his profession by representing himself to E.K. and B.C. as "Dr. Perez" and by holding himself out to the public as "Alex Perez, DM, NP-C," on the Clinic's website, which addressed him as "Dr. Perez."

The Administrative Complaint seeks the full range of penalties through revocation.

Counts I and II of the Administrative Complaints in DOAH Case Nos. 20-3062PL and 20-3066PL are identical to Counts I and II of the Administrative Complaint in DOAH Case No. 20-3057PL, except for the facts set forth immediate below.

In DOAH Case No. 20-3062PL, the Administrative Complaint alleges that P.B., a 77-year-old female with macular degeneration, presented to the Clinic for a "stem cell" injection into both eyes on June 16, 2015. Allegedly, P.B. had previously been evaluated and approved for the procedure by William Mestrezat, an M.D. specializing in the retina, and Dr. Greenbaum. On June 16, Respondent allegedly represented himself to P.B. as "Dr. Perez" and held himself out to the public as "Alex Perez, DM, NP-C," on the website of the Clinic, where he was referred to as "Dr. Perez," even though Respondent did not hold a license to practice medicine.

On May 16, Respondent allegedly performed a procedure to remove fat tissue from P.B.'s abdomen and intravitreously inject the tissue, after processing, into both eyes of the patient. On May 15, P.B. allegedly experienced complications, including bleeding from the eyes, due to the intravitreous injections of the product created from the fat tissue. Due to the injections, P.B. allegedly became legally blind with no light perception in either eye.

In DOAH Case No. 20-3066PL, the Administrative Complaint alleges that E.N., a 75-year-old female with macular degeneration, presented to the Clinic for a "stem cell" injection into both eyes on June 16, 2015. Allegedly, E.N. had previously been evaluated and approved for the procedure by Dr. Greenbaum. On June 16, Respondent allegedly represented himself to E.N. as "Dr. Perez" and held himself out to the public as "Alex Perez, DM, NP-C," on the website

of the Clinic, where he was referred to as "Dr. Perez," even though Respondent did not hold a license to practice medicine.

On June 16, Respondent allegedly performed a procedure to remove fat tissue from E.N.'s abdomen and intravitreously inject the tissue, after processing, into both eyes of the patient. On June 16, E.N. allegedly experienced complications, including nausea, vomiting, and loss of consciousness due to the intravitreous injections of the product created from the fat tissue. Due to the injections, E.N. allegedly became legally blind with no light perception in either eye.

For each of the three cases, Respondent requested a hearing involving disputed issues of fact. On July 29, 2020, the administrative law judge issued an Order consolidating the three cases.

At the hearing, Petitioner called 11 witnesses and offered into evidence nine exhibits: Petitioner Exhibits 1 through 4 and 6 through 10. Respondent called one witness and offered two exhibits into evidence: Respondent's Exhibits A and B. All exhibits were admitted except for Respondent's Exhibit A. However, Respondent's exhibits are in Spanish, and Respondent has not provided an interpretation of either of them.

The two-volume Transcript was filed on November 13, 2020. Petitioner timely filed its Proposed Recommended Order on January 11, 2021. On the same date, Respondent's counsel requested additional time within which to file his Proposed Recommended Order due to a recent case of Covid-19. On January 12, 2021, the administrative law judge extended Respondent's deadline to January 14, 2021. Because Respondent would have the advantage of having read Petitioner's Proposed Recommended Order before filing Respondent's Proposed Recommended Order, the Order allowed Petitioner an

opportunity to file a response to Respondent's Proposed Recommended Order by January 19, 2021. Petitioner filed a five-page response on January 19, 2021, which Respondent moved to strike as unauthorized under the law. The administrative law judge denied the motion to strike by Order entered January 20, 2021.

The parties' proposed recommended orders were taken into consideration in the drafting of this Recommended Order. On April 20, 2021, this case was transferred to the undersigned due to the inability of Judge Meale to finalize the Recommended Order. However, prior to the transfer, Judge Meale had drafted a significant portion of this Recommended Order, including his Findings of Fact and credibility determinations. The undersigned reviewed the Transcript and all exhibits prior to editing and finalizing this Recommended Order.

Unless otherwise indicated, all statutory references are to the versions in effect at the time of the alleged violations.

FINDINGS OF FACT

The Parties

1. Petitioner is the state agency charged with regulating the practice of nursing pursuant to section 20.43, and chapters 456 and 464, Florida Statutes.

2. Respondent was born and raised in Cuba, where he obtained a licensed practical nurse degree and, in 1995, Respondent earned a Doctor of Medicine degree and moved to Florida. On two occasions, Respondent failed to pass the examinations in Florida for licensure as a medical doctor.

3. Respondent obtained a Florida license as a registered nurse in 2005 and, in March 2015, a license modifier as an APRN. Respondent's highest

relevant education in the United States is a Master of Science degree in nursing awarded in December 2014 from the south Florida campus of the University of Turabo. A couple of months later, the American Academy of Nurse Practitioners certified Respondent as a Family Nurse Practitioner.

4. The transfer of processed fat tissue into the eye is thought, by some, to treat conditions of the eye, such as dry macular degeneration, to be part of regenerative medicine. This so-called "stem cell injection procedure" ("procedure") comprises three steps: (1) removing the fat tissue, usually from the abdomen; (2) processing the fat tissue to prepare it for injection; and (3) injecting the processed fat tissue into the vitreous cavity at the back of the eye.

5. Following the completion of his medical education in Cuba, Respondent obtained varying degrees of training and experience in the each of the three steps of the procedure. Respondent testified that he trained with a "specialist," possibly an ophthalmologist, in intravitreal injections. This covered such topics as the choice of syringe, the preparation of the patient, maintaining an open eye, the choice of a substance to stabilize the inside and outside eye, and the angle of the needle to the surface of the eye at the point of injection. Respondent also obtained training in intranasal and intraarterial injections, the latter of which is the more complicated. Respondent obtained a certificate in Mexico for completing the training in the removal of tissue from bone marrow. Respondent did not detail his training or experience in processing removed fat tissue.

6. Through much of Latin America, Respondent has injected processed fat tissue, at the rate of about ten patients over one week, and has trained other healthcare providers to perform these procedures. Respondent also testified that he had performed a dozen intravitreal injections of processed fat tissue in Mexico and Chile prior to the three injections at issue in this case, so it seems that most of his experience did not involve intravitreal injections.

7. Respondent's only evidence of purported "stem cell" experience was assisting in bone marrow aspiration, not surgical adipose tissue removal or intravitreal injections.

8. Respondent admitted that he had never performed intravitreal injections under the supervision of an ophthalmologist, a medical doctor of any type, or in a supervised training program prior to performing intravitreal injections on Patients E.K., E.N., and P.B. in May and June of 2015. Respondent failed to provide any evidence that he was educated or supervised by a licensed physician in the performance of these procedures prior to performing them on Patients E.K., E.N., and P.B.

Performance of the Procedure by Respondent at the Clinic

9. Respondent's first intravitreal injection of fat tissue at the Clinic took place in April 2015, about one month after he had completed the educational requirement for this APRN license modifier. Having retained Respondent as an independent contractor, the Clinic called him a few days before an upcoming intravitreal stem cell injection to confirm his availability. The Clinic paid Respondent $500 per procedure, for which it charged each patient $5000. Although the Clinic operated this program as an FDA-registered clinical trial, all procedures were "patient funded treatment," and the Clinic was not affiliated with any educational or research institution investigating stem-cell treatment of eye diseases or disorders.

10. The three patients involved in this case are, or were, E.K., P.B., and E.N. E.K.'s procedure took place on May 15, 2015, and P.B. and E.N.'s procedures took place on June 16, 2015. Each patient suffered from dry macular degeneration. Each patient was sighted at the time of the procedure, at the end of which, each patient was substantially blind. At the time of each patient's procedure, E.K., who died five years after her procedure, was 89 years old and resided in Oklahoma. P.B. was 77 years old and resided in southwest Florida, and E.N. was 72 years old and resided in

Missouri, where she had taught research methods to graduate students at the University of Missouri.

11. At the time of the subject procedures, the Clinic was affiliated with Bioheart, Inc., a publicly traded corporation. Key employees of the Clinic included Kristin Comella, who served as the chief scientist of the Clinic and chief scientific officer of Bioheart and holds bachelor's and master's degrees in chemical engineering, and Dr. Antonio Blanco, who is an internist in Hollywood, Florida, with 26 years of practice and the medical director of the Clinic and holds a medical degree from Georgetown University. The Clinic's website adds that Ms. Comella is in the top 50 of global stem-cell influencers.

12. E.K. and E.N. testified that they learned about or confirmed their interest in the Clinic by an online search of clinical trials of stem-cell treatment for dry macular degeneration. Neither patient differentiated between patient-funded clinical trials, such as these, and clinical trials whose treatment costs were subsidized by research centers, universities, hospitals, and pharmaceutical manufacturers.

13. E.K.'s medical records do not include any representations as to Respondent's status as a healthcare provider. E.K. and her niece, who accompanied her, arrived in Fort Lauderdale in sufficient time for E.K.'s pre-operative appointment with Dr. Greenbaum, an ophthalmologist employed with the Hollywood Eye Clinic. Until she spoke with Dr. Greenbaum, E.K. believed that Dr. Greenbaum would perform the procedure, based on what she had been told by Clinic staff.

14. At the pre-operative exam conducted by Dr. Greenbaum, E.K. and her niece learned that Dr. Greenbaum would not be performing the procedure on the following day. Dr. Greenbaum mentioned Respondent's name, so the niece had her husband research Respondent that night, but his research revealed nothing.

15. The next day, E.K. and her niece were introduced to Respondent by a Clinic employee, likely Ms. Comella. The niece does not recall if the employee referred to Respondent as a physician, but she assumed that he was. She recalled only that the clinic employee introduced him by saying that he was very experienced and had performed lots of stem cell injections of this type. The niece recalled distinctly that Respondent introduced himself as a "medical doctor." Respondent denies doing so. The niece's testimony is credited based on the totality of the evidence.

16. P.B.'s medical records do not include any representations as to Respondent's status as a healthcare provider except for the operative report, which bears Respondent's signature above "Physician Signature." Well prior to the date of the procedure, P.B. called the Clinic, spoke with Dr. Greenbaum and Ms. Comella, who informed her that Dr. Greenbaum would perform the procedure. P.B. later arrived in Fort Lauderdale in time for her pre-operative exam by Dr. Greenbaum, whose office told P.B. that Dr. Greenbaum was no longer performing the procedure. P.B. assumed that another ophthalmologist would perform the procedure.

17. The next day, P.B. and a friend or family member, who had accompanied her on the trip, met Ms. Comella and Respondent, whom Ms. Comella introduced as "Doctor Perez," and he did not correct her. P.B. asked him if he was an ophthalmologist, and Respondent replied, "no, but I'm well-trained in this procedure." He never mentioned that, in terms of Florida licensing, he was only a registered nurse or APRN and was not a physician.

18. E.N.'s medical records include the most references to Respondent's status as a healthcare provider. These records include a page from the Clinic's website that was initialed and dated by E.N., and prominently identifies Respondent as a "DM, NP-C," meaning "doctor of medicine" and "nurse practitioner--certified." The accompanying text discloses that "Dr. Alejandro Perez" graduated from the University of Havana Medical

School in 1993 as a "Doctor in Medicine"; since 2007, he has conducted innovative research on regenerative medicine with a focus on adult stem cells from bone marrow and adipose tissue; "Dr. Perez" has worked on adult stem cells to treat multiple chronic diseases; "Dr. Perez" trains national and foreign "Medical Doctors" on the use of adult stem cells; and that "[h]e currently holds a National Board Certification as a Family Nurse Practitioner." In three out of five references, the document refers to Respondent as a "doctor," never disclosing that he was not a licensed physician in Florida. This website page may have come into existence after Respondent's first patient encounter in this case in May 2015.

19. Ms. Comella introduced Respondent to E.N. and her sister, who had accompanied her on the trip, as "Dr. Alex Perez." Without stating his specialization, Respondent told E.N. that he was a "medical doctor" and was proud of his "profession," which, in context, meant the practice of medicine, not nursing. Respondent wore a white jacket with a printed name tag, "Alex Perez, M.D." At no time did Respondent reveal that his Florida licensure was as a registered nurse or APRN and not a physician.

Lack of a Written Protocol

20. As a licensed APRN, Respondent was required by section 464.012 and Florida Administrative Code Rule 64B9-4.002 to practice under an APRN protocol filed with the Board of Nursing. At all times material, the scope of practice of a certified family nurse practitioner licensed in Florida as an APRN did not include performing any invasive procedures, including surgical removal of adipose tissue or intravitreal injections, without an APRN Protocol on file that ensured physician supervision.

21. By letter dated March 12, 2015, the Board of Nursing notified Respondent that he was required to have an approved APRN protocol on file with the Department "within 30 days of employment." Respondent was employed in March 2015 at the time of receipt of the above-referenced letter.

22. In May and June 2015, Respondent was aware of the protocol requirement and the scope of practice as an APRN. He admitted that he received the March 12, 2015, letter and failed to provide a protocol as instructed.

23. At no time did Respondent ever obtain or file with the Board of Nursing a written protocol between him and a supervising licensed physician authorizing Respondent to perform the subject procedure. Respondent claimed, alternatively, that Drs. Greenbaum and Blanco served as his supervising physicians, but admitted that they served remotely and without a signed written protocol.

Harm to the Patients

24. The impact on the three patients of this unauthorized procedure performed by Respondent was blindness and its incumbent, incalculable damages, including, but not limited to, loss of independence, loss of mobility, and loss of enjoyment of life. Respondent admitted that, if not for the procedure, the three patients would likely not have been blind.[2]

CONCLUSIONS OF LAW

25. DOAH has jurisdiction. §§ 120.569 and 120.57(1), Fla. Stat. (2015).

26. The Administrative Complaints seek to suspend, revoke, or impose other discipline upon a license. This proceeding is penal in nature. *State ex rel. Vining v. Fla. Real Estate Comm'n*, 281 So. 2d 487, 491 (Fla. 1973). Petitioner must prove the material allegations by clear and convincing evidence. § 120.57(1)(j), Fla. Stat.; *Dep't of Banking & Fin. v. Osborne Stern & Co.*, 670 So. 2d 932 (Fla. 1996). Clear and convincing evidence is evidence that is "'precise, explicit, lacking in confusion, and of such weight that it

[2] Respondent contends that it was not the injection which he performed, but rather the separation and preparation of the stem cells from the fat tissue by other Clinic staff prior to the injection that somehow caused the patients' blindness. No credible evidence regarding this argument was presented.

produces a firm belief or conviction, without hesitation, about the matter in issue.'" *Robles-Martinez v. Diaz, Reus & Targ, LLP*, 88 So. 3d 177, 179 n.3 (Fla. 3d DCA 2011)(citing Fla. Std. Jury Instr. (Civ.) 405.4).

Deceptive, Untrue, and Fraudulent Representations by Respondent

27. Section 456.072(1)(m) prohibits "[m]aking deceptive, untrue, or fraudulent representations in or related to the practice of a profession or employing a trick or scheme in or related to the practice of a profession."

28. Respondent's actions at issue in this case involved patient evaluation and treatment in or related to his practice as an APRN, Respondent's representation of himself in a clinical setting as a medical doctor, and whether his performance of procedures that were within the scope of the practice of medicine constituted making deceptive, untrue, or fraudulent representations in or related to the practice of a profession. *See Dep't of Health v. Zamek*, Case No. 11-0546PL (DOAH July 28, 2011; DOH Dec. 14, 2011)(disciplining a physician after finding that the physician made deceptive and untrue representations regarding his identity to patient by failing to advise her that, although he was a Florida-licensed M.D., he was not the physician that the patient believed to be treating her, "due to lack of an introduction and any form of identification on the lab coat--if he was a doctor or a physician's assistant.")

29. Respondent's conduct in introducing himself in a clinical setting as "Dr. Perez," allowing Clinic staff to introduce him to patients in his presence as "Dr. Perez," allowing the Clinic to represent in his biography, which he provided, that he was "Dr. Perez," and allowing the Clinic to fail to include in that biography that he was licensed in Florida as an ARNP, not as a medical doctor, constitutes deceptive, untrue, or fraudulent representations related to the practice of his profession.

30. The fact that Respondent was licensed as a medical doctor in Cuba did not exempt him from the requirements of being licensed as a medical

doctor in Florida prior to performing medical evaluations, designating plans of treatment, and treating patients including Patients E.K., E.N., and P.B. in Florida.

31. Petitioner proved by clear and convincing evidence that Respondent is guilty of three counts of making deceptive, untrue, or fraudulent representations related to the practice of medicine.

Respondent's Practice Beyond the Scope Permitted by Law

32. Section 456.072(1)(o) prohibits "[p]racticing or offering to practice beyond the scope permitted by law." Section 464.012(3) authorizes an APRN to provide certain "advanced-level nursing acts," normally associated with a medical, dental, or osteopathic licensee, if the APRN proceeds under a "written protocol," which, among other things, specifies "the medical acts to be performed and the conditions for their performance." § 464.003(2), Fla. Stat. The protocol must be in writing, signed by both parties, filed with Petitioner, and specify what the APRN may do in providing medical treatment and what the supervising physician must do.

33. Similarly, rule 64B9-4.010, Standards for Protocols, provides that an APRN "shall only perform medical acts of diagnosis, treatment and operation pursuant to a protocol between the APRN and a Florida-licensed medical doctor, osteopathic physician or dentist." It further provides that "the degree and method of supervision, determined by the APRN and the physician … shall be specifically identified in the written protocol and shall be appropriate for prudent healthcare providers under similar circumstances…."

34. Based upon section 464.012(3) and rule 64B9-4.010, Respondent could not practice in May and June of 2015 as an APRN at all, let alone perform the procedures he performed on Patients E.K., E.N., and P.B., without filing an acceptable protocol with the Board of Nursing that demonstrated a collaborative practice agreement with a supervising physician. Respondent

should have had a protocol on file with Petitioner demonstrating collaborative practice with a supervising physician that included performing surgical removal of adipose tissue by any method or injecting any material by intravitreal injection before performing any such procedures.

35. Without meeting the requirements mandated in section 464.012(3) and rule 64B9-4.010, Respondent was bound by the scope of his licensure as a registered nurse.

36. Furthermore, even if Respondent had properly filed an acceptable protocol and practiced within a written collaborative agreement with a physician or dentist when he treated Patients E.K., E.N., and P.B., the procedures Respondent performed on these patients were "under the scope of the practice of medicine" and not advanced nursing practice, according to the materials from Respondent and the Clinic.

37. Even if Respondent was operating under a proper protocol, and these procedures were included in the scope of his licensure, the record does not establish that he possessed the required competency to perform intravitreal injections.

38. Petitioner proved by clear and convincing evidence that Respondent is guilty of three counts of practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities the licensee knows, or has reason to know, the licensee is not competent to perform.

Penalty Assessment

39. Pursuant to section 464.018(5), the Board of Nursing is charged with issuing rules to provide guidelines for the disposition of disciplinary cases involving nursing licensees. Rule 64B9-8.006 sets forth the disciplinary guidelines, range of penalties, and aggravating and mitigating factors to "assure protection of the public from nurses who do not meet minimum requirements for safe practice or who pose a danger to the public."

40. Rule 64B9-8.006(3)(l) provides that a first offense violation of section 456.072(1)(m) merits discipline ranging from a reprimand and a $250 fine to a $10,000 fine and suspension; a second offense merits a range of a $500 fine and suspension to a $10,000 fine and revocation. There is no provision for additional penalties for more than two violations of section 456.072(1)(m). This consolidated case demonstrates three violations of section 456.072(1)(m).

41. Rule 64B9-8.006(3)(k) provides that a first offense violation of section 456.072(1)(o) merits discipline ranging from a reprimand, a $250 fine, and continuing education to revocation. There is no provision for additional penalties for more than one violation of section 456.072(1)(o). This consolidated case demonstrates three violations of section 456.072(1)(o).

Aggravating Factors

42. Rule 64B9-8.006(5) provides that the Board of Nursing is permitted to deviate from its disciplinary guidelines for penalties, if certain factors are present, including, but not limited to:

1. the danger to the public;
2. refusal by the licensee to correct or stop violations;
3. the actual damage (physical or otherwise) caused by the violation;
4. the deterrent effect of the penalty imposed; and
5. cost of treatment.

Danger to the Public

43. An individual who performs services for the public without the required licensure, or practices beyond the scope of his licensure as in this case, is a danger to the public because he is acting without board or departmental oversight and without any kind of verification that the person is trained and able to perform the services of a licensed practitioner safely.

44. The procedures at issue here are beyond the scope of the type of license obtained by Respondent and have been identified as procedures considered within the scope of the practice of medicine. It is clear from the record that Respondent was not qualified to perform these procedures. Respondent has admitted that these procedures were beyond the scope of his license as an APRN and that he should not have performed them at all.

Refusal to Correct or Stop Violations

45. Patients P.B. and E.N. were introduced to Respondent as "Doctor" by one of his colleagues or Respondent himself. For the introductions via one of his colleagues, Respondent did not correct the reasonable assumption that he was a licensed medical doctor in the United States. Further, when the patients and their companions asked Respondent if he was an ophthalmologist or other specialty physician, Respondent did not advise them that he was not a licensed doctor at all.

46. Respondent misstated to all the patients that he was certified to perform the procedure and had received extensive training. Further, Patient E.N. was required to sign a form for the procedure which referred to Respondent as "Dr. Perez."

47. Further, there were numerous instances during Respondent's performance of the procedures where Respondent could have notified physicians to supervise or complete the procedure. Respondent stated that he had an informal verbal agreement with Dr. Blanco and Dr. Greenbaum, in which the physicians agreed to be available to Respondent for questions or emergencies and to supervise the procedures if needed. However, Respondent performed the procedures without the supervision of either physician. There is no evidence that Respondent requested either physician be present for the procedure. There is also no evidence that Respondent sought either physicians' counsel at any time once it became apparent that patients had begun to experience adverse effects from the procedure.

48. At some point after Patient E.K.'s procedure on May 15, 2015, and before Patients E.N. and P.B.'s procedures on June 16, 2015, Respondent learned that Patient E.K. was blind due to the procedure he performed. Yet, he continued to perform at least two more of the same procedure, in the same manner, without supervision and without physician guidance.

Actual Damage Caused by the Violations

49. After Respondent performed the intravitreal injections on these three patients, they rapidly became blind. Evidence confirmed that if not for the procedure being performed, these patients would likely not have been blind today (or in the case of Patient E.K., until the time of her death in April 2020). Respondent admitted that if not for the procedure, the women would likely not have been blind.[3]

50. Patient E.K. experienced emotional damage in addition to blindness. Patient E.K. developed an extreme fear of falling due to her inability to maneuver properly without sight. Towards the end of her life, Patient E.K. experienced such pain due to her blindness that she would often call out to God that she wanted to die.

51. To this day, Patient P.B. still experiences daily eye pain and requires numerous medications and drops to alleviate the pain. Patient P.B. has undergone at least two subsequent surgeries in an attempt to repair her eyes. Because of Respondent's decision to ignore his scope of practice, Patient P.B. stated that "[her] whole life is down the tubes, to be honest with you."

52. Patient E.N. testified that the lack of ability to engage in most of her normal activities has led to a more isolated existence. Many of her former activities involved frequent and relationship-building interactions with other

[3] While it is true, as Respondent argues, that all three patients signed informed consents prior to the procedure acknowledging loss of vison was a potential side effect, none authorized Respondent to practice beyond the scope permitted by law or to perform procedures he knew or had reason to know he was not competent to perform.

individuals. After Respondent performed these procedures, Patient E.N. can no longer participate in such activities. Further, Patient E.N. noted that social services and programs are extremely limited for blind individuals.

53. The patients relied, to their significant detriment, on the assurances made by Respondent that he was properly qualified to perform these procedures. The unfortunate reality is that Respondent admittedly was neither authorized nor qualified to perform these procedures.

The Deterrent Effect of Revocation

54. Respondent testified numerous times that because he was a doctor in Cuba, he believed he was different from other advanced practice nurses in Florida with the same licensure and practitioner credentials. Respondent believed he could perform services beyond the scope of his APRN license because he felt his background made him superior to his professional nurse peers. When Patient E.N. spoke to Respondent about his being a physician, Respondent said "he was a medical doctor, and he was proud of his profession … he spoke very clearly and proudly of his profession."

55. When Respondent found out that Patient E.K. experienced blindness and eye damage after her procedure, he continued to perform the procedure, which led to his blinding of two more patients.

56. Respondent ignored the statutory requirements for supervision of his practice as an APRN and Respondent continually failed to seek and/or follow the guidance of available physicians in his treatment of these patients. The Board of Nursing sent numerous letters during Respondent's first years of licensure as an APRN notifying him of his failure to submit appropriate protocols.

57. Based on Respondent's attitude that he was superior to his peers, his willingness to negligently or intentionally provide misleading information to patients as to his license status in Florida, and his previous disregard for the Board of Nursing's statutory requirements, rules, and procedures,

Respondent will likely continue to disregard the statutory requirements, rules, and procedures if he continues to hold his nursing license.

58. By imposing the most severe punishment allowed under the Board's disciplinary guidelines, Petitioner will send a message to its licensees that performing procedures that exceed the scope and training of their license, especially the complicated and dangerous procedures that were performed here, will not be tolerated

The Costs of Treatment

59. The Department has proven by clear and convincing evidence that the costs of the treatment, both during and after the procedures, for Patients E.K., E.N., and P.B., and their families and caregivers were extensive.

60. Patients E.K., E.N., and P.B. incurred numerous medical and other expenses post-procedures as a result of Respondent's actions. All three patients required emergent ophthalmologic intervention after their procedures.

61. Patient P.B. underwent at least two surgeries on her eyes since the procedure and is required to treat her eyes with multiple medicated drops daily, incurring prescription costs. She had to hire individuals to help her with household cleaning. Patient P.B.'s daughter sustained economic and emotional costs associated with assuming the care of her mother, quitting her job, and relocating her own family to Florida.

62. After the procedure, Patient E.K. moved into an assisted living facility because she needed assistance performing activities of daily living due to her loss of sight.

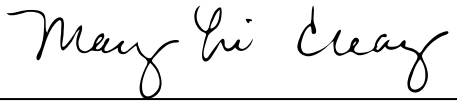
63. Patient E.N. also had to hire someone to assist with routine household tasks, such as laundry and cooking, as she cannot see. Patient E.N. is no longer able to practice her profession as a researcher and professor in an academic setting due to her loss of vision post-procedure.

64. Respondent demonstrated a complete disregard for the laws governing the practice of nursing in Florida and severely injured multiple patients in the process. Based on the aggravating factors discussed above, revocation of Respondent's license is the only penalty that will adequately protect the residents of this state.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Nursing enter a final order finding that Respondent has violated sections 456.072(1)(o) and 456.072(1)(m) and revoking Respondent's license to practice as an advanced practice registered nurse.

DONE AND ENTERED this 3rd day of May, 2021, in Tallahassee, Leon County, Florida.



MARY LI CREASY
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Filed with the Clerk of the
Division of Administrative Hearings
this 3rd day of May, 2021.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.