BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Ranjit Singh Grewal, M.D. Physician's and Surgeon's Certificate No. A 38510 Respondent.	Case No. 800-2020-067497

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 19, 2022.

IT IS SO ORDERED August 12, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka,
Executive Director

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
State Bar No. 173955
300 South Spring Street, Suite 1702
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: RANJIT SINGH GREWAL, M.D. 23000 Crenshaw Boulevard, #205 Torrance, California 90505 Physician's and Surgeon's Certificate A 38510, Respondent.	Case No. 800-2020-067497 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. Ranjit Singh Grewal, M.D. (Respondent) is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On June 14, 1982, the Board issued Physician's and Surgeon's Certificate No. A 38510 to Ranjit Singh Grewal, M.D. (Respondent). That license was in full force and effect at all

times relevant to the charges brought in Accusation No. 800-2020-067497 and will expire on August 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2020-067497 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on February 16, 2022. Respondent timely filed a Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2020-067497 is attached as Exhibit A and is incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read and understands the charges and allegations in Accusation No. 800-2020-067497. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2020-067497, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline.

Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED THAT Physician's and Surgeon's Certificate No. A 38510, issued to Respondent Ranjit Singh Grewal, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2020-067497 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent ever applies for reinstatement, Respondent shall pay the agency its costs of investigation and enforcement in the amount of $3,500.00 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2020-067497 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 08/08/2022

RANJIT SINGH GREWAL, M.D.
Respondent

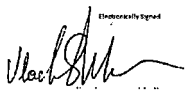
ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: August 8, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General



VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2020-067497

ROB BONTA
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RANJIT SINGH GREWAL, M.D.** **23000 Crenshaw Blvd., #205** **Torrance, California 90505** **Physician's and Surgeon's Certificate A38510,** Respondent.	Case No. 800-2020-067497 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On June 14, 1982, the Board issued Physician's and Surgeon's Certificate Number A 38510 to Ranjit Singh Grewal, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2023, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically

appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

7. On May 11, 2020, the Board received a complaint from the daughter of Respondent's patient, hereafter designated as Patient 1.[1] Patient 1's daughter complained that Respondent was Patient 1's primary care doctor for more than 35 years, during which time he did not treat Patient 1 appropriately, ignored her high cholesterol levels and, shortly before her death, took no action in response to her complaints of fatigue and burning sensation in her chest and lungs. Upon receipt of the complaint, the Board began an investigation, and discovered the following:

Respondent Failed to Timely Diagnose and Treat Cardiac Disease

8. Patient 1, was a 77-year-old woman when she died on April 2, 2020. Respondent had been her primary care provider since July 28, 1993.

[1] The patient is designated by a number for privacy reasons. The patient's name is known to Respondent and/or will be provided in response to a written request for discovery.

9. During the years when Respondent cared for Patient 1, she repeatedly complained to him of burning chest pain and throat pain. She was treated by Respondent repeatedly for infection and for heartburn. Respondent asserted that he did not consider the possibility that Patient 1 suffered from heart disease because the patient's shortness of breath and chest pain were not explicit. Despite numerous symptoms and signs of progressing cardiovascular disease, Respondent failed to diagnose and treat heart disease in Patient 1 in a timely manner, which culminated in her premature and preventable death.

10. Respondent's history and physical examinations of the patient were inadequate. According to her pre-death hospitalization records, the patient was a chronic smoker, but Respondent did not document or acknowledge that in the patient's chart. During the period when he was Patient 1's primary care physician, including the 10 years preceding her death, Respondent failed to elicit and/or document information about the patient's lifestyle, smoking, alcohol use, or family history. Respondent failed to obtain and/or document Patient 1's cardiac disease risk factors. For many years, the patient presented to Respondent with classic signs and symptoms consistent with heart disease, however, Respondent failed to adequately evaluate and treat her, or to refer her to a cardiac specialist.

11. The medical documentation kept by Respondent for Patient 1 was inadequate, for themost part handwritten and illegible, as well as incomplete. Respondent did not document any family and social history and made and/or documented no standard preventive care offerings. He did not counsel Patient 1 to stop smoking, and did not document such counseling. Other than writing "lungs clear" "heart ssr" and "no edema," Respondent did not perform any other physical examination and generally did not document other physical examination findings. Respondent generally did not establish and/or document working diagnoses or treatment plans. When noted, treatment plans, such as prescribing courses of antibiotics and opioid prescription refills, were not consistent with problems raised in a context of absent assessment or diagnosis. Prior documented unresolved problems were lost to follow-up despite regularly-attended subsequent visits. Respondent never signed his notes, even though he submitted claims for care and treatment of Patient 1 to Medicare.

12. During the time when Respondent cared for Patient 1, she consistently suffered from high cholesterol. Patient 1's blood tests on August 10, 2011, August 18, 2012, September 7, 2013, September 18, 2014, October 2, 2015, November 22, 2016, November 21, 2017 and November 2, 2019, all showed elevated cholesterol levels. Respondent never prescribed cholesterol-lowering medication to Patient 1. He dismissed the patient's hyperlipidemia as insignificant in level and did not demonstrate concern despite its duration.

13. During the time when Respondent cared for Patient 1, she consistently suffered from high blood pressure. Respondent prescribed certain blood pressure medications, but when Respondent saw Patient 1, approximately once or twice every month for more than 10 years, despite these prescribed medications, her blood pressure readings remained high or elevated during nearly every visit. Respondent dismissed the patient's hypertension as insignificant in level and did not demonstrate concern despite its duration.

14. On or about November 15, 2017, Patient 1's chest x-ray report stated that the patient's aorta was calcified. Respondent knew, or should have known, that an imaging report of a calcified aorta is a strong predictor of atherosclerosis and cardiovascular morbidity, in addition to the traditional risk factors in this patient that Respondent should have known and recognized. However, during the time when Respondent cared for Patient 1, since at least 2006, he never ordered or performed an electrocardiogram (EKG) on Patient 1, never ordered or performed any stress test, never ordered or performed an echocardiogram, or any other diagnostic studies of the patient's cardiovascular system.

15. In 2019, Patient 1 started complaining to her family that she was feeling fatigued. She also complained of having a burning sensation in her chest and left sided jaw pain. She consistently complained to her family of shortness of breath after walking only a short distance. Respondent saw her on January 24, 2019, February 7, 2019, April 4, 2019, May 20, 2019, May 30, 2019, July 15, 2019, August 8, 2019, October 3, 2019, October 29, 2019, November 11, 2019, and December 10, 2019. Most of the time these complaints were not documented in the patient's chart. When Respondent saw Patient 1 on October 29, 2019, he explained to the Board investigators: "...she was feeling tired so...there were no other complaints so I – she was not

fasting so I said to her we'll do the chem panel and see if everything is good and told her to come back fasting." Patient 1 provided blood samples on November 2, 2019.

16. Patient 1 returned to see Respondent on November 11, 2019, for her test results. Respondent also documented that the patient complained of a "sore throat." Her temperature that day was normal at 98.9 degrees, and her total cholesterol result was 238. Other than writing "chest clear" and "no edema" and something illegible about the patient's throat, Respondent did not document a physical exam and did not obtain the patient's blood pressure. He did not document any impression or plan, though he claimed to Board investigators that he told the patient that she had an iron deficiency. He ordered no further testing of the patient's iron level. Respondent prescribed an antibiotic for the patient's sore throat, and an iron supplement, "because of her tired feeling and elevated RDW." He also ordered a refill of a prescription of Norco. Respondent never considered and/or recorded a diagnosis or consideration of diagnosis of cardiovascular disease in Patient 1.

17. Patient 1 returned on December 10, 2019, and her temperature was normal at 98.2 degrees. Her blood pressure was elevated at 148/80. Respondent stated that the patient was taking iron pills and was feeling better. In his interview with Board investigators, he stated: "...in addition to that she had localized pain and the osteoarthritis pain in her – uh – I don't – I did not put which area.... It has to be one of the extremities. So I prescribe her some Voltaren gel to use along with a refill of her Norco."

18. Patient 1 continued to complain to her family of burning pain in her chest. She returned to see Respondent on January 7, 2020. Her temperature was normal at 98.2 degrees and her blood pressure was elevated at 145/75. Respondent wrote that the patient was "doing better." Her blood pressure medications were refilled. No complaints were documented and no treatment was rendered and/or documented. On February 6, 2020 the patient returned to see Respondent. Her blood pressure was elevated at 138/80. She was noted as "doing well" and no complaints were documented. No treatment was rendered and/or documented.

19. On March 6, 2020, Patient 1 went to see Respondent without an appointment. According to the patient's daughter, the patient continued to suffer from burning pain in her chest,

and she went to see Respondent to complain about this. Respondent took no vital signs and did not obtain the patient's blood pressure that day. He told Board investigators: "she was complaining of some epigastric discomfort." Respondent noted in the patient's chart that she had "stomach upset" and that she "denied any nausea or vomiting." He prescribed Prilosec, an acid reducing medication. The patient's opiate and blood pressure medications were refilled. No other work-up was done and no other treatment was rendered or documented. This was the last time Respondent saw Patient 1. The patient collapsed on March 18, 2020, after suffering a cardiac arrest while shopping at a store. She was rushed to the hospital, but the efforts to save her were not successful. She died at a hospital on April 2, 2020 due to cardiac arrest caused by protracted and untreated coronary artery disease. Respondent found out about the patient's death because Respondent's staff attempted to contact her when she did not show for a scheduled appointment. They reached the patient's daughter who informed them of the patient's death.

Respondent Inappropriately Prescribed Opioids.

20. In his interview with the Board's investigators Respondent summarized Patient 1's health-related complaints: "Her primary problem was high blood pressure and osteoarthritis mainly involving the lumbosacral area and she really never had any serious illness or hospitalization prior to that last one – last episode. And she was primarily managed by metoprolol[2], meloxicam[3], Norco[4], Thiazide[5]. That was mainly the ongoing medication."

21. During the years when Respondent cared for Patient 1, he routinely prescribed controlled opiate medication, ostensibly to treat chronic pain from osteoarthritis.

22. Specifically, Patient 1 was dispensed 120 Norco pills, containing 325 mg of acetaminophen and 5 mg of hydrocodone, on the following dates: March 9, 2020; December 12, 2019; September 11, 2019; July 12, 2019; May 3, 2019; February 8, 2019; September 19, 2018;

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[2] Blood pressure medication.

[3] Meloxicam is an NSAID prescription arthritis pain reliever.

[4] Norco is a combination pain reliever that contains hydrocodone and acetaminophen. Because it contains hydrocodone, Norco presents a high risk of dependence and is a Schedule II controlled substance.

[5] Thiazide is a diuretic, which is used to lower blood pressure.

July 15, 2018; May 11, 2018; February 24, 2018; January 5, 2018; November 22, 2017; September 28, 2017; August 8, 2017; June 16, 2017; April 26, 2017; March 2, 2017; January 10, 2017; December 12, 2016; November 22, 2016; October 27, 2016; September 26, 2016; July 29, 2016; May 31, 2016; April 13, 2016; January 21, 2016. Similar prescribing patterns preceded these dates.

23. The level, location, exacerbating or alleviating factors of the pain Respondent was treating with opiates were never elicited from the patient and were not documented. No treatment goals or pain treatment plans were formulated and were not documented. Respondent never performed and never documented performing periodic evaluation, other than occasionally writing in the patient's record "doing well." Respondent did not obtain or document obtaining Patient 1's informed consent for treatment of chronic pain with opiates. Respondent never documented that he had a dialogue about alternative therapies, never offered or documented offering alternative therapies, never documented discussing weaning and risks, and never performed a functional status assessment for Patient 1. Respondent did not have the patient sign a pain contract, and never performed any testing to confirm that she was taking the controlled substance he was consistently prescribing to her.

Respondent Inappropriately Prescribed Antibiotics

24. During the years when Respondent treated Patient 1, he repeatedly prescribed her courses of antibiotics for recurrent complaints of sore throat and cough. These prescriptions for antibiotics were written without any diagnostic testing, and continued when the patient returned with the same symptoms. There was no diagnosis or differential to entertain the etiology of the patient's complaint, whether infections, irritant, cardiovascular, or other. In addition, when antibiotics were prescribed for cough, there was no assessment to qualify the patient's cough as infections, cardiovascular, or any other etiology. Respondent did not weigh and did not document consideration of the benefits and harms of symptomatic therapy with antibiotics, either to the patient, who appeared to be at high risk of harm from common opportunistic infections due to overuse of antibiotics, or to the larger medical community through antibiotic stewardship.

25. Specifically, Respondent's records show that he prescribed antibiotics to Patient 1 as follows:

a) Amoxicillin on or about November 11, 2019, for a complaint of sore throat;

b) "Z-Pack" (Zithromax) on October 3, 2019, for a complaint of sore throat;

c) Augmentin on January 24, 2019, for a complaint of sore throat and cough and jaw pain that Respondent thought was dental in origin;

d) Augmentin on January 3, 2019, for a complaint of sore throat;

e) Augmentin on October 30, 2018, for a complaint of sore throat;

f) Augmentin on September 18, 2018, for a complaint of sore throat;

g) Levaquin on August 11, 2018, for a complaint of sore throat, cough and sinus pressure;

h) Cipro on March 5, 2018, for a complaint of sore throat;

i) Cipro on August 14, 2017, for a complaint of sore throat and cough;

j) Cipro on June 29, 2017, for a complaint of sore throat;

k) Augmentin on June 15, 2017, for a complaint of sore throat and cough;

l) Augmentin on December 27, 2016, for a complaint of sore throat;

m) Cipro on October 31, 2016, for an undocumented complaint;

n) Cipro on October 24, 2016, for an undocumented/illegible complaint; and

o) Augmentin on December 8, 2015, for sore throat.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

26. Respondent Ranjit Singh Grewal, M.D. is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that he displayed a lack of knowledge or ability, tantamount to incompetence, in his failure to timely diagnose and treat Patient 1's cardiac disease. The circumstances are as follows:

27. The allegations of paragraphs 7 through 24 are incorporated herein by reference.

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SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

28. Respondent Ranjit Singh Grewal, M.D. is subject to disciplinary action under section 2234, subdivision (b) of the Code, in that he was grossly negligent in his care and treatment of Patient 1. The circumstances are as follows:

29. The allegations of paragraphs 7 through 24 are incorporated herein by reference.

30. Respondent's manner of prescribing antibiotics to Patient 1 constituted an extreme departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

31. Respondent Ranjit Singh Grewal, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code, in that he committed repeated negligent acts in his care and treatment of Patient 1. The circumstances are as follows:

32. The allegations of paragraphs 7 through 24 are incorporated herein by reference.

33. Each of the following constitutes a separate departure from the standard of care:

a) Respondent's manner of prescribing antibiotics to Patient 1 constituted a departure from the standard of care.

b) Respondent's failure to timely diagnose and treat Patient 1's cardiac disease was a departure from the standard of care.

c) Respondent's manner of prescribing controlled substances to Patient 1 was a departure from the standard of care

d) Respondent's manner of record-keeping was a departure from the standard of care.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate and Adequate Records)

34. Respondent Ranjit Singh Grewal, M.D. is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate medical records of his care and treatment of Patient 1. The circumstances are as follows:

35. The allegations of paragraphs 7 through 24 are incorporated herein by reference

DISCIPLINARY CONSIDERATIONS

36. To determine the degree of discipline, if any, to be imposed on Respondent Ranjit Singh Grewal, M.D., Complainant alleges that on or about December 19, 2007, in a prior disciplinary action titled In the Matter of the Accusation Against Ranjit Singh Grewal, M.D. before the Medical Board of California, in Case Number 06-2004-156408, Respondent's license was revoked, but the revocation was stayed and the license was placed on probation for a period of thirty-five months, for incompetence, gross negligence, repeated negligent acts and inadequate record keeping in the care and treatment of three patients. That Decision is now final and is incorporated by reference as if fully set forth herein.

37. To determine the degree of discipline, if any, to be imposed on Respondent Ranjit Singh Grewal, M.D., Complainant alleges that on or about June 7, 2010, in a prior disciplinary action titled In the Matter of the Accusation and Petition to Revoke Probation Against Ranjit Singh Grewal, M.D. before the Medical Board of California, in Case Number D1-2004-156408, Respondent's license was revoked, but the revocation was stayed and the previous probation was extended for an additional period of eighteen months, for incompetence occasioned by his failure of the PACE program. That Decision is now final and is incorporated by reference as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 38510, issued to Ranjit Singh Grewal, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. Ordering him to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: FEB 16 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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