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

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| In the Matter of the Fifth Amended Accusation Against:<br><br>Firdos Sameena Sheikh, M.D.<br><br>Physician's and Surgeon's Certificate No. A 50704<br><br>Respondent. | Case No.: 800-2015-018399 |

## DECISION

The attached Stipulated Settlement and Disciplinary 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 June 15, 2023.

IT IS SO ORDERED: May 16, 2023.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

ROB BONTA
Attorney General of California
STEVEN MUNI
Supervising Deputy Attorney General
RYAN J. YATES
Deputy Attorney General
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*Attorneys for Complainant*

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

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| In the Matter of the Fifth Amended Accusation Against:<br><br>**FIRDOS SAMEENA SHEIKH, M.D.**<br>**P.O. Box 30**<br>**Wilton, CA 95693-0030**<br><br>**Physician's and Surgeon's Certificate No. A 50704**<br>Respondent. | Case No. 800-2015-018399<br><br>OAH No. 2022070235<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY 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. Reji Varghese (Complainant) is the Interim 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 Ryan J. Yates, Deputy Attorney General.

2. Firdos Sameena Sheikh, M.D. (Respondent) is represented in this proceeding by attorney Derek F. O'Reilly-Jones, Esq., whose address is: 355 South Grand Ave., Ste. 1750 Los Angeles, CA 90071-1562.

3. On or about April 28, 1992, the Board issued Physician's and Surgeon's Certificate No. A 50704 to Firdos Sameena Sheikh, M.D. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Fifth Amended Accusation No. 800-2015-018399 and will expire on September 30, 2023 unless renewed.

## JURISDICTION

4. Accusation No. 800-2015-018399 was filed before the Board on November 28, 2018. Since then, the pending Accusation 800-2015-018399 was amended several times. On or about October 31, 2022, Fifth Amended Accusation No. 800-2015-018399 was filed before the board and is currently pending against Respondent. The Fifth Amended Accusation and all other statutorily required documents were properly served on Respondent. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Fifth Amended Accusation No. 800-2015-018399 is attached as Exhibit A and incorporated by reference.

## ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Fifth Accusation No. 800-2015-018399. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her 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 and agrees that the charges and allegations in Fifth Amended Accusation No. 800-2015-018399, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

9. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Fifth Amended Accusation No. 800-2015-018399, a true and correct copy of which is attached hereto as Exhibit A.

10. In the interest of resolving this case, including avoiding the expense, stress, and uncertainly of trial, Respondent agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

11. The admissions made by Respondent herein are only for the purposes of this proceeding or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding

## CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her 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 Settlement 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.

13. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the

Board, all of the charges and allegations contained in Accusation No. 800-2015-018399 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

**DISCIPLINARY ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 50704 issued to Respondent Firdos Sameena Sheikh, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for six (6) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours

per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent.

Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If the Respondent did not successfully complete the clinical competence assessment

program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

7. MONITORING - PRACTICE/BILLING. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice and billing monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice and billing shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent

shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and billing, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15

calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

9. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

10. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

11. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of 71,382.57. Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs,.

12. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

14. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

15. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If

Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

16. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

17. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the

Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

19. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

20. FUTURE ADMISSIONS CLAUSE.

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 action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2015-018399 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 license.

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## ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Derek F. O'Reilly-Jones, Esq.. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 03/09/2023

FIRDOS SAMEENA SHEIKH, M.D.
*Respondent*

I have read and fully discussed with Respondent Firdos Sameena Sheikh, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 03/09/2023

DEREK F. O'REILLY-JONES, ESQ.
*Attorney for Respondent*

## ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 3/9/23

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

Ryan Yates

RYAN J. YATES
Deputy Attorney General
*Attorneys for Complainant*

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**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
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| In the Matter of the Fifth Amended Accusation Against:<br><br>**FIRDOS SAMEENA SHEIKH, M.D.**<br>**P.O. Box 30**<br>**Wilton, CA 95693-0030**<br><br>**Physician's and Surgeon's Certificate No. A 50704,**<br><br>Respondent. | Case No. 800-2015-018399<br><br>**FIFTH AMENDED ACCUSATION** |

Complainant alleges:

**PARTIES**

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

2. On or about April 28, 1992, the Board issued Physician's and Surgeon's Certificate Number A 50704 to Firdos Sameena Sheikh, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2023, unless renewed.

## JURISDICTION

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

4. 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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which 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."

5. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

6. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist,

podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

7. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statues or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

8. Section 2264 of the Code states:

"The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct."

9. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

10. Section 4170 of the Code states, in pertinent part:

"(a) No prescriber shall dispense drugs or dangerous devices to patient in his or her office or place of practice unless all of the following conditions are met:

"...

"(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

"...

"(b) The Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Veterinary Medical Board, and the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are specifically charged with the enforcement of this chapter with respect to their respective licensees.

"(c) 'Prescriber,' as used in this section, means a person, who holds a physician's and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, or a certificate to practice podiatry, and who is duly registered by the Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, or the Board of Osteopathic Examiners of this state."

11. California Code of Regulations, title 22, section 87217 provides:

"No licensee or employee may accept any general or special power of attorney for a resident."

12. California Code of Regulations, title 22, section 87468 provides:

"Each resident in an RCFE has personal rights which include the rights to (1) be accorded dignity in personal relationships with staff, and (2) safe, healthful, and comfortable accommodations."

13. California Code of Regulations, title 22, section 87219 provides:

"Residents shall be encouraged to maintain and develop their fullest potential for independent living through participation in planned activities. The activities made available shall include:

"(1) Socialization, achieved through activities such as group discussion and conversation, recreation, arts, crafts, music and care of pets.

"(2) Daily living skills/activities which foster and maintain independent functioning.

"(3) Leisure time activities cultivating personal interests and pursuits, and encouraging leisure time activities with other residents.

"(4) Physical activities such as games, sports and exercise which develop and maintain strength, coordination and range of motion.

"(5) Education, achieved through special classes or activities.

"(6) Provision for free time so residents may engage in activities of their own choosing."

14. California Code of Regulations, title 22, section 87303 provides:

"An RCFE shall be clean, safe, sanitary, and in good repair at all times. Maintenance shall include provisions of maintenance services and procedures for the safety and well-being of residents, employees and visitors. Floor surfaces in bath, laundry, and kitchen areas shall be maintained in a clean, sanitary, and odorless condition."

15. California Code of Regulations, title 22, section 87101, subsection (c)(3) provides:

"'Care and Supervision' means those activities which if provided shall require the facility to be licensed. It involves assistance as needed with activities of daily living and the assumption of varying degrees of responsibility for the safety and well-being of residents. "Care and Supervision" shall include, but not be limited to, any one or more of the following activities provided by a person or facility to meet the needs of the residents:

"(A) Assistance in dressing, grooming, bathing and other personal hygiene;

"(B) Assistance with taking medication, as specified in Section 87465, Incidental Medical and Dental Care Services;

"(C) Central storing and distribution of medications, as specified in Section 87465, Incidental Medical and Dental Care Services;

"(D) Arrangement of and assistance with medical and dental care. This may include transportation, as specified in Section 87465, Incidental Medical and Dental Care Services;

"(E) Maintenance of house rules for the protection of residents;

"(F) Supervision of resident schedules and activities;

"(G) Maintenance and supervision of resident monies or property;

"(H) Monitoring food intake or special diets."

16. California Code of Regulations, title 22, section 87555, subdivision (b) provides, in pertinent part:

"(5) Meals shall consist of an appropriate variety of foods and shall be planned with consideration for cultural and religious background and food habits of residents.

"(6) Facilities licensed for less than sixteen (16) residents shall maintain a sample menu in their file. Menus shall be made available for review by the residents or their designated representatives and the licensing agency upon request."

17. California Code of Regulations, title 22, section 87465, provides, in pertinent part:

"(a) A plan for incidental medical and dental care shall be developed by each facility. The plan shall encourage routine medical and dental care and provide for assistance in obtaining such care, by compliance with the following:

". . .

"(5) The licensee shall assist residents with self-administered medications as needed.

". . .

"(c) If the resident's physician has stated in writing that the resident is unable to determine his/her own need for nonprescription PRN medication but can communicate his/her symptoms clearly, facility staff designated by the licensee shall be permitted to assist the resident with self-administration, provided all of the following requirements are met:

"(1) There is written direction from a physician, on a prescription blank, specifying the name of the resident, the name of the medication, all of the information in Section 87465(e), instructions regarding a time or circumstance (if any) when it should be discontinued, and an indication when the physician should be contacted for a medication reevaluation.

"(2) Once ordered by the physician the medication is given according to the physician's directions.

"(3) A record of each dose is maintained in the resident's record. The record shall include the date and time the PRN medication was taken, the dosage taken, and the resident's response.

"(d) If the resident is unable to determine his/her own need for a prescription or nonprescription PRN medication, and is unable to communicate his/her symptoms clearly, facility staff designated by the licensee, shall be permitted to assist the resident with self-administration provided all of the following requirements are met:

"(1) Facility staff shall contact the resident's physician prior to each dose, describe the resident's symptoms, and receive direction to assist the resident in self-administration of that dose of medication.

"(2) The date and time of each contact with the physician, and the physician's directions, shall be documented and maintained in the resident's facility record.

"(3) The date and time the PRN medication was taken, the dosage taken, and the resident's response shall be documented and maintained in the resident's facility record.

"(e) For every prescription and nonprescription PRN medication for which the licensee provides assistance there shall be a signed, dated written order from a physician, on a prescription blank, maintained in the residents file, and a label on the medication. Both the physician's order and the label shall contain at least all of the following information:

"(1) The specific symptoms which indicate the need for the use of the medication.

"(2) The exact dosage.

"(3) The minimum number of hours between doses.

"(4) The maximum number of doses allowed in each 24-hour period.

". . .

"(h) The following requirements shall apply to medications which are centrally stored:

". . .

"(2) Centrally stored medicines shall be kept in a safe and locked place that is not accessible to persons other than employees responsible for the supervision of the centrally stored medication."

. . .

"(5) Each resident's medication shall be stored in its originally received container. No medications shall be transferred between containers."

18. California Code of Regulations, title 22, section 87705, provides:

"Licensees who accept or retain residents diagnosed by a physician to have dementia shall store the following items in a location that is inaccessible to residents with dementia: Over-the-counter medication, nutritional supplements or vitamins, alcohol, cigarettes, and toxic substances such as certain plants, gardening supplies, cleaning supplies and disinfectants."

19. California Code of Regulations, title 22, section 87506, subdivision (a), provides:

"Separate and complete records must be maintained for each resident of an RCFE in the facility or in a central administrative location readily available to facility staff and to licensing agency staff.

". . .

"(b)(12) The records must contain, among other information, the resident's ambulatory status."

20. California Code of Regulations, title 22, section 87507, subdivision (a), provides: "The licensee shall complete an individual written admission agreement with each resident and that resident's responsible person or conservator, if any."

21. California Code of Regulations, title 22, section 87507, provides:

"Each licensee must maintain personnel records for each employee and the administrator. The record must contain the valid administrator certificate and a record of criminal record clearance or exemption. The staff records must contain records of required training, including ten hours of initial training within the first four weeks of employment, and at least four hours of annual training thereafter. Personnel records must be available to the licensing agency for inspecting on demand."

**COST RECOVERY**

22. 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.

23. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

24. 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.

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

25. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in her care and treatment of patients A and B.[1]

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[1] The patients are referred to by letters in order to preserve their privacy. Their identity will be disclosed in the discovery provided to the respondent.

26. On or around November 28, 2015, the Medical Board of California (MBC) received an anonymous complaint against Respondent. The complaint alleged that Respondent had patients waiting 2-3 hours in chronic pain before being seen and treated. The complaint also alleged that Respondent yelled at her patients in front of other patients and talked negatively about her employees and patients to other employees and other patients. It alleged Respondent used one of her personal homes to house elderly patients. The complaint alleged Respondent made false accounts on the internet to give herself positive reviews in order to raise her ratings. Patients A and B's medical records were obtained from Respondent's office. In Respondent's care and treatment of Patients A and B, departures from the standard of care were identified as follows:

**Allegations Related to Patient A**

27. Patient A was a 37-year-old female when initially evaluated by Respondent. Respondent treated Patient A for the period of August 23, 2016, through February 27, 2018. Multiple diagnoses were given to Patient A, including complex partial seizures, facial tenderness, sacroiliac joint pain, cervical spasm, occipital neuralgia, carpal tunnel syndrome, peripheral neuropathy, vascular migraines without aura, headaches most likely secondary to inadequate sleep secondary to carpal tunnel syndrome as well as neck and back pain, peripheral neuropathy, and superimposed chronic tension headaches. During the follow-up periods, Patient A was prescribed multiple controlled substances, including Xanax[2] and Norco[3]. Patient A was also

[2] Alprazolam (Xanax) is a benzodiazepine. Alprazolam affects chemicals in the brain that may be unbalanced in people with anxiety. Alprazolam is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Norco (acetaminophen and hydrocodone) is used to relieve moderate to severe pain. Norco (hydrocodone) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

prescribed Soma[4], Motrin, Ambien[5], Zonegran[6], and Keppra for epilepsy. Respondent's medical records for Patient A failed to document that an initial history was obtained. In Respondent's medical records for Patient A there is no past medical history, surgical history, orthopedic history, evaluation of primary medications, any mention of allergies, family history, or social history. Additionally, Respondent failed to conduct a review of systems on Patient A.

28. On August 23, 2016, Patient A's medical records show contradicting statements regarding Patient A's seizures. On the same follow-up appointment, Patient A is reported as not having seizure activity since July of 2014 and also having ongoing epileptic activity.

29. Patient A was presumptively diagnosed as suffering from carpal tunnel syndrome and peripheral neuropathy. On October 16, 2016, Patient A's medical records show Respondent recommended an electromyography (EMG)[7] to determine if patient A indeed suffered from these problems. The EMG test was never performed.

30. On November 30, 2016, Patient A's medical records state under diagnosis that patient A had post-concussion syndrome with dizziness, headaches, and short-term memory problems with black-outs. Patient A's history failed to mention any recent history of head injury and provides no information about the patient losing consciousness since, based on her own statements, Patient A has had no further seizures since July 12, 2014. Patient A's neurologic examination showed under mental status that Patient A was "alert and oriented x3", and "High cortical sensation is intact". Based on this information, it is unclear how Respondent arrived at her diagnosis of post-concussion syndrome with short-term memory problems and blackouts.

31. On January 24, 2018, Patient A's medical records state that Patient A was still having little seizures. Patient A's medical records state that the last seizure was on July 12, 2014. It is

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[4] Soma is the brand name for Carisoprodol, a Schedule IV controlled substance pursuant to 21 C.F.R. § 1308, and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Zolpidem, brand name Ambien, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[6] Zonegran (zonisamide) is a sulfa drug with anti-convulsant effects. Zonegran is used together with other anti-convulsant medications to treat partial seizures in adults with epilepsy.

[7] Electromyography (EMG) measures muscle response or electrical activity in response to a nerve's stimulation of the muscle. The test is used to help detect neuromuscular abnormalities.

not clear if Respondent is describing two different type of events (Complex Partial Seizure[8] vs. generalized tonic-clonic seizure[9]).

32. Patient A had a vagas nerve stimulator (VNS) placed in the past; this device was checked every single month for the two years of visits. If Patient A was having ongoing seizure activity, the parameters should have been adjusted as needed (this was done only once); if Patient A was not having ongoing seizure activity, the VNS checks were not necessary. On January 30, 2018, Patient A's medical records state that the VNS settings were changed, but in the following note dated February 13, 2018, the parameters remained unchanged.

33. Patient A's medical records show multiple recurrent inconsistencies throughout Patient A's follow-ups.

34. Patient A's medical records show that Patient A was provided extensive physical therapy at Respondent's facility. However, no referral for an orthopedic evaluation was made after therapy failed to consistently improve Patient A's symptoms.

35. Respondent also considered a diagnosis of peripheral neuropathy. Patient A's medical records show no attempts by Respondent to perform blood and urine panels in an effort to obtain more information regarding the cause of the patient's neuropathy and determine if there are any therapies available.

36. Respondent diagnosed Patient A with cervical radiculopathy at C5-C6 based on clinical grounds, but again no EMG/nerve conduction velocity was ever done and no computed tomography (CT) scan of the neck was ever requested. An MRI could not be performed since Patient A had a VNS implanted. Respondent failed to request orthopedic consultation for Patient A.

37. Respondent provided post-dated prescriptions for controlled substances to Patient A. Patient A was prescribed two anticonvulsants to control her seizures, but there is no indication in

[8] A complex partial seizure is also known as a focal impaired awareness seizure or a focal onset impaired awareness seizure. This type of seizure starts in a single area of the brain. This area is usually, but not always, the temporal lobe of the brain.

[9] A generalized tonic-clonic seizure is a type of generalized seizure that affects the entire brain. During the seizure a person jerks and shakes (convulses) as their muscles relax and tighten rhythmically.

the chart that the patient ever underwent a complete blood count (CBC)[10] test with differential, liver function test, or blood levels to determine any potential complications and appropriateness of dosage.

38. During the period of August 23, 2016, through February 27, 2018, Respondent never performed an electroencephalogram (EEG)[11] on Patient A to rule out the possibility that Patient A was having subclinical seizures not controlled by her medication especially after Respondent recognized that Patient A was still having little seizures.

39. Respondent committed gross negligence in her care and treatment of Patient A, which included, but are not limited to, the following:

(a) Paragraphs 24 through 38, above, which are hereby incorporated by reference as if fully set forth herein;

(b) Respondent departed from the standard of care by chronic prescription of controlled substances and not following the California guidelines for treatment of chronic pain. Respondent also pre-dated prescriptions of controlled substances;

(c) Respondent departed from the standard of care by lacking evaluation of suspected pathologies she presumptively diagnosed. Respondent made no attempt to further evaluate the patient's neuropathy, the patient's carpal tunnel syndrome or the patient's radiculopathy. Despite Respondent commenting on requesting an EMG for the patient, more than two years passed and the test was still not done. In regards to the patient's neuropathy, Respondent failed to order blood or urine testing or neurodiagnostic testing in the attempt to diagnose the cause for the neuropathy;

(d) Respondent departed from the standard of care in her treatment of the patient's seizure disorder;

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[10] A complete blood count (CBC), is an easy and very common test that screens for certain disorders that can affect your health. A CBC determines if there are any increases or decreases in blood cell counts.

[11] The electroencephalogram (EEG) is a medical test used to measure the electrical activity of the brain.

(e) Respondent departed from the standard of care by diagnosing the patient with post-concussion syndrome with memory impairment when the history did not show any evidence for a recent head injury and the physical examination was normal;

(f) Respondent departed from the standard of care in treating the migraines and muscle tension headaches because there were no attempts to provide the patient with any preventive medication for the treatment of her symptoms. Respondent only prescribed narcotics and benzodiazepines; and

(g) Respondent departed from the standard of care by prescribing Savella, a medication only approved for the treatment of fibromyalgia. Nowhere in the patient's chart is it stated that the patient suffered from fibromyalgia or why Savella was prescribed.

**Allegations Related to Patient B**

40. Patient B is a female born in 1959 with headaches, numbness and tingling involving the upper extremities, difficulty gripping objects, hands falling asleep and swelling, and an inability to bend her fingers. Respondent saw Patient B from August 24, 2004 through May 16, 2016, for treatment of her chronic pain issues, as well as her diabetes and hypertension. Patient B was provided with over ten years of physical therapy at Respondent's office. Patient B was prescribed Lortab[12], Soma, and Xanax. Respondent failed to conduct an initial physical examination. Respondent failed to do an initial comprehensive history, including past medical history, surgical history, orthopedic history, medications, allergies, and family and social history. Respondent failed to perform an inquiry regarding the potential overuse of alcohol or drugs, even though the records showed Patient B had several driving under the influence (DUI) convictions for which she was required to do over 100 hours of community service.

41. Patient B underwent multiple EMG/nerve conduction velocity studies of the upper and lower extremities during the period in which she was treated by Respondent. On the one dated August 23, 2006, despite the fact that Patient B showed the presence of mild sensory carpal tunnel syndrome, mild sensory ulnar entrapment, and axonal sensory and motor peripheral

[12] Lortab (acetaminophen and hydrocodone) is used to relieve moderate to severe pain. Lortab is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

neuropathy and abnormal findings on the examination of the cervical and lumbar paraspinal regions, no further interventions were undertaken by Respondent after the study to determine the cause of Patient B's neuropathy. Patient B was diagnosed as suffering from carpal tunnel syndrome. There is no actual data shown to account for the diagnoses provided by Respondent. Patient B's sensory responses of the median nerves were reported as showing normal amplitudes and slowing of nerve conduction velocities; there is no information reported on the median nerve's sensory latencies, the main and first abnormal finding on carpal tunnel syndrome. Patient B was also diagnosed as suffering axonal sensory/motor neuropathy. Electro-diagnostic findings in patients with this condition are characterized by sensory nerve action potential (SNAP) amplitude decrease earlier and to a greater degree than compound muscle action potential (CMAP) amplitude. Distal latencies, F-wave latencies and conduction velocities are mildly affected. In Respondent's report on Patient B, she characterized the findings in the lower extremities as having SNAPs showing slowing of conduction velocities, with normal amplitudes, there is no mention about the distal latencies. The CMAPs were normal in regards to latencies, amplitudes and nerve conduction velocities. Respondent also diagnosed the presence of chronic denervation involving the lumbosacral paraspinal muscles. Respondent's differential diagnosis included muscle spasm.

42. Even though Patient B is diagnosed with lumbosacral radiculopathy in the right and left L5-S1 level, under subjective factors, on November 14, 2006, Patient B's medical records state that Patient B had low back pain with radiation to the lower extremities. Respondent's physical examination shows that Patient B's lumbar spine was not tested. It is unclear how the diagnosis was achieved, especially when the motor strength was normal in the lower extremities and reflexes were normal. During this time, Patient B was being prescribed Lortab, Soma and either Valium or Xanax. Patient B was diagnosed with depression and provided with medication that could lower the threshold for symptomatology. Respondent failed to attempt to either treat Patient B or refer her to a psychiatrist for further assessment of her condition.

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43. On November 10, 2007, Patient B's medical records state Respondent discussed with Patient B the issue of drug rehabilitation and counseling, but it is unclear if the patient ever acted on this information.

44. On November 30, 2007, Patient B's medical records state she was diagnosed with vascular migraines and occipital neuralgia. This is a constant occurrence throughout the follow-ups, but no efforts were made by Respondent to start the patient on preventive medications for her migraines. Also, despite the diagnosis of carpal tunnel syndrome and tendonitis, and the fact that the patient's symptoms were failing to improve with conservative management, Respondent made no efforts to refer the patient for an orthopedic evaluation.

45. On March 7, 2008, Patient B's medical records showed that Respondent was postdating medications. On April 16, 2008, Patient B's medical records show that the patient had to do over 100 hours of community service secondary to several DUIs. Despite that, Respondent continued to prescribe controlled substances to Patient B on a monthly basis.

46. On April 16, 2008, Patient B's medical record states "had a test on ADHD[13] and feels she has it." Respondent started Patient B on Adderall[14] without any notation on the patient's chart regarding what symptomatology she was having consistent with ADHD and no results of testing.

47. On May 1, 2008, Patient B's medical records show Respondent predating prescriptions of controlled substances.

48. Multiple times during the period Respondent treated Patient B, there was discussion about compliance with medication and about going into rehabilitation and counseling centers, which Patient B never acted upon. Despite that, Respondent continued to prescribe Patient B controlled substances.

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[13] Attention-deficit/hyperactivity disorder (ADHD) is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.

[14] Adderall contains a combination of amphetamine and dextroamphetamine. It is a central nervous system stimulant that affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control. Adderall is used to treat ADHD.

49. On August 8, 2008, Patient B's medical records state she completed 360 hours of community service. It also stated and that Patient B obtained Medicaid insurance and therefore Respondent was not going to follow her since Patient B would have to drive a long distance just to get medications refilled.

50. On March 12, 2009, Patient B's medical records state another EMG/nerve conduction was performed. The reason of the exam states that Patient B's symptomatology had continued the same, and this study again shows the same findings as the previous one. By now, Patient B has been symptomatic for at least three years. No efforts were undertaken by Respondent to perform blood and urine panels to determine the cause of the neuropathy. Respondent failed to schedule an orthopedic evaluation to deal with a carpal tunnel syndrome and ulnar neuropathy that was not responding to physical therapy provided by Respondent's facility.

51. On October 13, 2009, Patient B's medical records state she had an episode of loss of consciousness and was taken to Mercy General Hospital. Patient B indicated she did not have any medication with her and believed the episode was not related to her medications. Patient B was examined and an EEG was requested as well as medical records and results from Mercy General Hospital. It is unclear if Patient B's episode of loss of consciousness was reported by Respondent to the California Department of Health, since there is no notation in the chart.

52. On September 22, 2010, Patient B's medical records state Respondent diagnosed her with peripheral neuropathy. Respondent failed to attempt to determine the reason for Patient B's pathology. Respondent stated that another EMG was going to be obtained. Patient B previously had at least two studies showing pathology, but nothing was acted upon. Respondent never investigated the cause of Patient B's pathology and she was never provided with medication to improve her symptoms. Respondent failed to provide Patient B with an orthopedic referral in regards to her carpal tunnel syndrome and ulnar nerve entrapment.

53. On February 9, 2011, Patient B's medical records state Patient B stopped taking Adderall on her own. It is noted that the hospital records requested five months prior to the visit still had not been received. Another EMG on Patient B was going to be obtained. Patient B already had several positive EMGs and additional testing was not necessary at this point.

54. On May 17, 2011, Patient B's medical records state Patient B was evaluated for follow-up and also requesting refills. Although Respondent stated that Patient B stopped taking Adderall on February 9, 2011, Adderall is still listed as a medication being prescribed to patient B. Respondent's assessment states episode of loss of consciousness without specifying when it happened. The only notation in Patient B's records that she passed out was in 2009, when patient B was evaluated at the hospital. Respondent finally requested an EEG.

55. On June 7, 2011, Patient B's medical records state that the previous week she fell on the floor and injured her arm and back of her head with loss of consciousness. Patient B did not seek any medical care at that point. Patient B requested refills. Once again, Adderall is listed as the medication being prescribed along with Xanax. A previous note stated that Patient B's insurance did not cover Xanax and she was given alprazolam instead. This note states that the patient needs an EMG again.

56. On September 14, 2011, Patient B's medical records indicate the EEG that was requested in June of 2011 had not been done and it is not even discussed. Respondent requested another EEG.

57. On December 7, 2011, Patient B's medical records state that the EEG was scheduled for January of 2012. Respondent continued to prescribe Patient B with Soma, Norco, and alprazolam. Respondent stated that the patient fell asleep while driving during October of 2011. Respondent also noted that Patient B was exhausted and sleepy and may have complex partial seizures. The possibility of Patient B overusing the controlled substances provided by Respondent was not discussed despite Patient B having to do 300 hours of community service because of multiple DUIs. Respondent failed to discuss sending Patient B to see a psychiatrist despite the diagnosis of depression. Respondent failed to attempt to treat Patient B's depression.

58. On February 22, 2012, Patient B's medical records state that an electroencephalogram was performed. The result of the study was normal. On February 29, 2012, Patient B's medical records state another EMG/ nerve conduction was done. The findings were similar to all the other studies performed. The same pattern continued throughout Patient B's visits through May 16, 2016. Patient B underwent additional EMG/nerve conductions, continued with the same

neuromuscular treatments by Respondent's office, and she continued to receive injections and controlled substance prescriptions.

59. Patient B reported another injury during 2013. Patient B was evaluated at Methodist Hospital for a finger fracture. A discussion of referring the patient to orthopedics was undertaken with Patient B, but it is unclear if she was ever seen by a specialist. During 2013, there was a discussion regarding the medications being used by Patient B. Patient B refused epidurals or surgical evaluations. Patient B refused a second opinion. Patient B continued to have controlled substances prescribed to her by Respondent. An additional EMG/nerve conduction was done on Patient B in 2015 with similar findings.

60. On March 24, 2016, Patient B's medical records state that she reported the possibility of feeling she may be suicidal. Patient B was given nerve blocks and it was stated that she was going to be sent to the emergency room as her gait was staggering and she was confused. Respondent's notes reflect that Patient B was "alert and oriented x3". Patient B was given the Romberg test that resulted in a negative finding. However, Patient B's medical records state there was no ataxia with tandem walking on the examination. Respondent's comment on the last page of the visit does not match her findings on the physical examination. Also, it was stated that Patient B should hold off on all medications without taking into consideration that Patient B could have seizures secondary to acute withdrawal of benzodiazepines. Emergency Services (911) were contacted, and Patient B was taken to the emergency room immediately.

61. On April 21, 2016, Patient B was evaluated. Patient B's medical records failed to document her evaluation in the emergency room or what interventions were performed or the results of the psychiatric evaluation. Respondent continued to prescribe Patient B Norco, Soma, and Xanax. No treatment for depression was provided to the patient. Patient B's medical record for this date appears to incorporate the same information present on the note dated March 24, 2016. Patient B's medical record states staggering gait and confusion were reported, 911 services were contacted, and Patient B was referred to the emergency department. This note appears to have been cut and pasted from a previous encounter.

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62. Respondent committed gross negligence in her care and treatment of Patient B, which included, but is not limited to, the following:

(a) Paragraphs 37 through 61, above, are hereby incorporated by reference as if fully set forth herein; and,

(b) Respondent departed from the standard of care in her deficiencies present in the patient's history and physical examination, as well as the lack of any intervention aimed to deal with the patient's symptoms.

63. Respondent's conduct, as described above, constitutes gross negligence in the practice of medicine in violation of section 2234(b) of the Code and thereby provides cause to discipline Respondent's license.

## SECOND CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts)**

64. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in her care and treatment of patients A, B, C, D, E, F, G, H, I, J, K, L, and M, and regarding her actions as a RCFE licensee at the Bird of Paradise facility.

**Allegations Related to Patient A**

65. Respondent committed acts of repeated negligence in her care and treatment of Patient A, which included, but are not limited to Paragraphs 27 through 39 as more particularly alleged above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

**Allegations Related to Patient B**

66. Paragraphs 40 through 63 as more particularly alleged above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

67. Respondent committed acts of repeated negligence in her care and treatment of Patient B, which included, but are not limited to, the following:

(a) Respondent departed from the standard of care by not properly managing her prescription of controlled substances to the patient. Respondent prescribed the patient controlled substances for a prolonged period of time. There were multiple red flags regarding Patient B's

potential for abuse, including multiple DUI's, accidents not evaluated by physicians on a timely manner, and refusal to accept other modalities of therapy except for the prescription of controlled substances. Once the patient declined to accept Respondent's recommendations, Patient B should have been slowly tapered off the medications and discharged the patient from the practice;

(b) Respondent departed from the standard of care by failing to establish a medical history and physical examination, including assessment of the pain, physical and psychological functions, substance abuse history, history of prior pain treatment, assessment of underlying or coexisting diseases or conditions, and documentation of the presence of a recognized medical indication for the use of a controlled substance;

(c) Respondent departed from the standard of care by failing to refer Patient B to one or more consulting physicians, including chronic pain management, orthopedics, and neurosurgery;

(d) Respondent departed from the standard of care by failing to establish a treatment plan, such as pain relief or improved physical and psychological function and indicate if any further diagnostic evaluations or other treatments are planned;

(e) Respondent departed from the standard of care by failing to discuss the risks and benefits of the use of controlled substances and other treatment modalities with Patient B and obtain an informed consent regard to their use;

(f) Respondent departed from the standard of care by failing to periodically review the course of pain treatment of Patient B and any new information about the etiology of the pain or the patient's state of health; and

(g) Respondent departed from the standard of care by failing to keep accurate and complete records according to items above, including the medical history, physical examination, other evaluations and consultations, treatment plan objectives, informed consents, treatment, medications, rationale for changes in the treatment plan of medications, agreements with the patient, and periodic review of treatment plans.

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**Allegations Related to Patient C**

68. On or around May 1, 2017, the Medical Board of California (MBC) received a complaint from Patient C's daughter against Respondent. The complaint alleged that Respondent missed appointments with Patient C, canceled appointments without notice, and had him undergo an expensive test for dementia. Patients C's medical records were obtained from Respondent's office. In Respondent's care and treatment of Patient C, a departure from the standard of care was identified as follows:

69. Patient C is a male born in 1934 with a history of memory problems that gradually got worse. Patient C was very forgetful and sleepy, and was unable to recall faces and names as well as events or dates.

70. On July 15, 2016, Patient C was evaluated by Respondent because of dementia and restlessness. Patient C's history was appropriate for his complaints. Respondent's initial consultation with Patient C included a past medical history, past surgical history, list of medications, allergies, past family history, habits and a review of systems. Respondent's physical examination, impression and diagnostic/treatment plans were appropriate for Patient C's case. Patient C's medical record references a positron emission tomography (PET) scan.[15] The PET scan mentioned was an appropriate ancillary test used in the evaluation of patients with suspected dementia.

71. On October 17, 2016, an electromyography (EMG)/ nerve conduction study (NCV) examination was performed on Patient C. Patient C's medical records show significant discrepancies when compared with the interpretation by Respondent in her report. The EMG/NCV study reported on October 17, 2016, involved Patient C's upper and lower extremities. The data shows that the evaluation of the upper extremities was performed on September 22, 2016, and that the evaluation of the lower extremities was performed on October 6, 2016. The reports show multiple undated handwritten corrections in regards to the findings. Respondent's report states that the CMAP of the right median nerve showed prolongation of

[15] A positron emission tomography (PET) scan is an imaging test that uses a special dye with radioactive tracers. The tracers are either swallowed, inhaled, or injected into the arm. They help a doctor measure blood flow, oxygen use, and more.

distal latency with decreased (corrected) amplitude and normal conduction velocity. However, the raw data showed a normal distal latency with decreased amplitude. Respondent's report also states that the right ulnar nerve showed slowing of conduction velocity across the elbow. However, the actual data shows slowing of nerve conduction velocity above and below the elbow with minimal differences between the findings. The same is true for the left ulnar nerve, which was described as having slowing across the elbow when in reality there was slowing both above and below the elbow. Respondent's report also states that bilateral SNAP responses of the superficial peroneal nerves showed slowing of conduction velocities with normal amplitudes. However, review of the raw data shows that amplitudes were also decreased. The same is true in relation to the SNAP responses of the sural nerves, and in the Respondent's report it is stated that the study showed slowing of conduction velocities with normal amplitudes while the raw data showed that the amplitudes were decreased.

72. On October 17, 2016, Patient C's medical records show Respondent diagnosed him as suffering from axonal sensory/motor neuropathy. In Respondent's notes she characterized the findings as both the SNAP and CMAP having normal amplitudes with prolonged distal latencies, which are not consistent with the presence of an axonal process. Respondent also diagnosed Patient C as suffering from a bilateral ulnar neuropathy at the elbow regions, based on the raw data review, both ulnar nerves showed slowing of nerve conduction velocity above and below the elbow not consistent with the presence of the Respondent's stated diagnosis.

73. Respondent committed acts of repeated negligence in her care and treatment of patient C, which included, but are not limited to, the following:

(a) Paragraphs 68 through 72, above, are hereby incorporated by reference as if fully set forth herein; and,

(b) Respondent departed from the standard of care in the significant discrepancies between the findings on the EMG/NCV examination performed on the patient and the reports generated by Respondent.

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**Allegations Related to Patient D**

74. On or around April 4, 2016, the Medical Board of California (MBC) received a complaint from Patient D against Respondent. The complaint alleged that Respondent always over-booked, that the wait times in her office were excessive, and her office does did not provide notice of appointment cancelations. Patient D's medical records were obtained from Respondent's office. In Respondent's care and treatment of Patient D, a departure from the standard of care was identified as follows:

75. Patient D is a female born in 1960 with a history of hypertension, high cholesterol, and diabetes.

76. On October 29, 2014, Patient D was evaluated by Respondent with complaints of vertigo (dizziness), a feeling of fullness in her head, tingling in her feet and hands, back pain, and headaches. A full history was obtained as well as a physical examination. The differential diagnosis was described as well as a treatable plan.

77. On February 4, 2016, an EMG/nerve conduction velocity study was performed on Patient D. Respondent diagnosed Patient D with moderately severe predominantly axonal sensory and motor peripheral neuropathy in the lower extremities. The EMG portion of the examination demonstrated the presence of polyphasic MUPs suggesting chronic denervation as well as musculoskeletal spam with no evidence for denervation. There is no actual data shown to account for the diagnoses Respondent provided. In Respondent's report, she characterized the findings in the lower extremities as having SNAPs showing slowing of conduction velocities, with normal amplitudes, and there is no mention about the distal latencies. The CMAPs were normal in regards to latencies, amplitudes and nerve conduction velocities. Respondent also diagnosed Patient D with chronic denervation involving the lumbosacral paraspinal muscles. Respondent's differential diagnosis included muscle spasm.

78. Respondent committed acts of repeated negligence in her care and treatment of Patient D, which included, but are not limited to, the following:

(a) Paragraphs 74 through 77, above, are hereby incorporated by reference as if fully set forth herein; and,

(b) Respondent departed from the standard of care in the discrepancies between the findings on the EMG/NCV examination performed on the patient and the reports generated by Respondent.

**Allegations Related to Patient E**

79. On or around April 6, 2016, the Medical Board of California (MBC) received a complaint from Patient E's granddaughter against Respondent. The complaint alleged that Respondent showed up to Patient E's home unannounced, provided non-requested medical services that included prescription medications, and claimed she was Patient E's primary physician. In Respondent's care and treatment of Patient E, a departure from the standard of care was identified as follows:

80. On February 2, 2016, Respondent provided Patient E with unrequested medical service, which included prescribing medications claiming that she was Patient E's primary care physician. The only relationship between the Respondent and Patient E is that the Respondent is friends with one of Patient E's daughters. There are no medical records, except for a typed report from December 17, 2012, under the caption of Neurology Consultation (patient seen at home for two and a half hours), there was no history of present illness, there was a past medical history, medication list, and treatment plan. Respondent failed to perform a physical examination. Respondent prescribed Patient E Voltaren Gel[16] and Guaifenesin AC[17], a cough syrup.

81. Respondent committed acts of repeated negligence in her care and treatment of Patient E, which included, but are not limited to, the following:

(a) Paragraphs 79 through 80, above, are hereby incorporated by reference as if fully set forth herein; and,

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[16] Voltaren Gel contains diclofenac, a nonsteroidal anti-inflammatory drug (NSAID). Diclofenac works by reducing substances in the body that cause pain and inflammation. Voltaren Gel is used to treat joint pain caused by osteoarthritis in the hands, wrists, elbows, knees, ankles, or feet.

[17] Guaifenesin AC is a compound of the expectorant guaifenesin and codeine, a Schedule V controlled substance as designated by Health and Safety Code section 11058(c)(1) and a dangerous drug as designated by Business and Professions Code section 4022. It is also known generically as guaifenesin with codeine. These combinations are an expectorant cough syrup, and a narcotic analgesic.

(b) Respondent departed from the standard of care by failing to perform an appropriate history and physical examination on the patient prior to prescribing a controlled substance.

**Allegations Related to Patient F**

82. On or around December 18, 2015, the Medical Board of California (MBC) received a complaint from Patient F's daughter against Respondent. The complaint alleged that Respondent had Patient F waiting five hours in her office before being seen. The complaint alleged Respondent came into the exam room with other patient medical records and ordered unnecessary tests. The complaint also alleged that Patient F went to see Respondent to determine why her speech was difficult and why she was speechless. It stated that Respondent was more concerned with Patient F's arms and hands, suspected the patient had carpal tunnel, and ordered an EMG/nerve conduction, which was unnecessary, and not the reason Patient F was seeing Respondent. It is alleged that Patient F's medical records contained errors and incorrect information about the family history. Respondent diagnosed Patient F with possible dementia or Alzheimer's due to seizures. However, Respondent failed to perform any tests to confirm the diagnosis.

83. The complaint alleges that Patient F was scheduled to be seen at a different office for an ambulatory test and after driving an hour to the office, there was no one there. When Patient F's daughter called the main office to see what was going on, the staff informed her that they decided not to go to the office on that day and forgot to call her to cancel the appointment. Patient F's medical records were obtained from Respondent's office. In Respondent's care and treatment of Patient F, departures from the standard of care were identified as follows:

84. Patient F is a female born in 1937. On June 25, 2015, Patient F was evaluated by Respondent with complaints of difficulty speaking, inability to find words, and memory problems. Patient F's medical records show a heading reading "Neurology Progress Note". Even though there is a brief history of present illness, there is no past medical history, surgical history, or traumatological history recorded, despite the fact that the patient was taking medication for hypertension. Patient F's medical record mentions no information regarding allergies, family or

social history. Respondent performed a physical examination on Patient F. Respondent's diagnostic impression was dementia, most likely Alzheimer's disease, depression, peripheral neuropathy, carpal tunnel syndrome, and primary aphasia. Despite the diagnosis of primary aphasia, there is no data within the neurological examination showing any evidence for a speech impediment consistent with aphasia. Patient F's medical record also has two headings for "High Cortical Sensation", within eleven lines of each other, the first one showing impaired function, the second one showing normal function. It is not clear which one is correct. Respondent correctly included the possibility of complex partial seizures part of the differential diagnosis. Respondent's plan was appropriate for the diagnosis.

85. On July 25, 2015, Patient F had an EEG done and she fell asleep during the recording. A slowing of background activity was found within the recording.

86. On July 28, 2015, Patient F had an EMG/nerve conduction study of the upper and lower extremities performed. Review of the raw data on the report show some contradictions between the data and the Respondent's report. CMAP of the left median nerve were described as showing normal distal latencies with normal amplitudes and normal conduction velocities. However, the data shows decreased nerve conduction velocity below 50 meters/second. Respondent's report states that both tibial and peroneal nerves showed normal distal latencies, normal amplitudes as well as normal conduction velocities. However, the data shows decreased nerve conduction velocity involving the right tibial nerve the left tibial nerve and the right peroneal nerve below 40 meters/second. Also, Respondent's report states that the SNAP responses of the superficial peroneal nerves showed slowing of the conduction velocities and normal amplitudes. However, the data shows that besides decreased nerve conduction velocity the left superficial peroneal nerve also exhibited decreased amplitude below 5 μV. Patient F was also suffering from carpal tunnel syndrome. Patient F's sensory responses of the median nerves were reported as showing normal amplitudes and slowing of nerve conduction velocities; there is no information reported on the median nerve's sensory latencies, the main and first abnormal finding on carpal tunnel syndrome. The median nerve motor responses demonstrated normal distal latencies with normal amplitudes and normal conduction velocities. Since the data gathered

did not show convincing evidence for carpal tunnel syndrome, additional studies should have been performed, and there is no data showing that any additional testing was performed. Patient F was also diagnosed as suffering from a bilateral ulnar neuropathy at the elbow regions, and based on the information available in the patient's chart it appears that this pathology is present. There are significant discrepancies between the raw data obtained during the test and Respondent's evaluation of this study.

87. By September 14, 2015, and despite the fact that Patient F had been under the care of Respondent for almost three months, Patient F was not started on any medications for the treatment of her dementia. Also, despite Respondent's diagnosis of carpal tunnel syndrome and ulnar neuropathy, no therapy was recommended to treat her condition. Further, Patient F's laboratory testing ordered during June 2015 were either not done or if performed, the results were never reviewed by Respondent.

88. Respondent committed acts of repeated negligence in her care and treatment of patient F, which included, but are not limited to, the following:

(a) Paragraphs 82 through 87, above, are hereby incorporated by reference as if fully set forth herein;

(b) Respondent departed from the standard of care in the deficiencies in the patient's history and physical examination, along with a total lack of information regarding corrections made to the chart to deal with incorrect data as stated by family members and lack of any interventions aimed to deal with the patient's medical conditions; and

(c) Respondent departed from the standard of care in regards to the discrepancies between the findings on the patient's EMG/NCV and Respondent's report.

89. Respondent's conduct, as described above, constitutes acts of repeated negligence in the practice of medicine in violation of section 2234(c) of the Code and thereby provides cause to discipline Respondent's license.

**Allegations Related to Patient G**

90. On or around October 1, 2018, the Board received a complaint from Patient G, against Respondent, for allegedly failing to adequately address the patient's medical issues,

performing unnecessary tests, committing possible health insurance fraud, failing to provide medical records, and filing to provide an adequate exam rooms.

91. Specifically, on or about August 3, 2018, Patient G saw Respondent for a neurological consultation concerning a foot drop.[18] During the consultation, Respondent failed to check and/or document Patient G's vital signs. Respondent performed a neurological examination and then recommended electrodiagnostic testing be done, which was scheduled for a later date. Patient G returned on August 31, 2018, where Respondent performed the initial electrodiagnostic solely on Patient G's arms, despite the arms not being a concern. Respondent explained that this was due to not having a bed that would allow lower extremity testing to be done at that time.

**Allegations Related to Patient H**

92. Patient H is a 53-year-old female with a history of chronic back pain, hand numbness, knee pain, and memory issues. Patient H first saw Respondent on March 20, 2018, after she was referred by her general practitioner to determine whether her back pain was caused by nerve damage or arthritis.

93. During the initial examination with Patient H, Respondent did not clearly document a chief complaint and recommended testing that was unrelated to Patient H's primary complaint of back pain. Respondent never performed any type of physical exam on Patient H that day. Respondent then told Patient H she would need a brain test and a nerve test for her arms and legs.

94. Despite Patient H being referred for spinal stenosis, Respondent failed to focus her history and examination on Patient H's back pain. Instead, Respondent recommended electroencephalogram [19] (EEG) testing, as well as electromyography[20] (EMG) testing and a nerve

[18] Foot drop is a muscular weakness or paralysis that makes it difficult for a sufferer to lift the front part of their foot and toes.

[19] An electroencephalogram (EEG) is a test that detects electrical activity in the brain using electrodes attached to the scalp. An EEG is one of the main diagnostic tests for epilepsy and other brain disorders.

[20] Electromyography (EMG) is a form of electrodiagnostic testing that is used to study nerve and muscle function. An EMG nerve test can provide a physician with specific information about the extent of nerve and/or muscle injury and can also determine the exact location of injury and give some indication whether the damage is reversible.

conduction study[21] (NCS) on the arms and legs. Respondent additionally proposed therapy for carpal tunnel syndrome.

95. At the third appointment, Patient H had an EEG performed by someone in Respondent's office.

96. On the last appointment, Respondent conducted testing on Patient H's back, which involved electrical shocks. The test caused a high amount of pain to Patient H, who stated to Respondent that she did not want to continue the test. During the test, Respondent left the door open, which caused people in the halls and waiting area to hear Patient H and Respondent's conversations.

97. Patient H decided to transfer her care to another neurologist. Following her departure, Patient H called the office at least three times. When she finally contacted the front desk, staff stated that Respondent would not send Patient H a copy of her records and would not provide a reason.

**Allegations Related to Patient I**

98. On or around August 8, 2018, Patient I was referred to Respondent for management of his epilepsy. Rather than focusing on the area of Patient I's complaints, Respondent instead recommended electrodiagnostic testing on Patient I's hands, even though Patient I had not had symptoms of carpal tunnel syndrome in several years. After Patient I had a seizure, Respondent recommend increasing his dose of carbamazepine. Patient I additionally complained that Respondent performed unnecessary tests, had conversations about patients that were easily overheard by others, and compromised patient privacy. Patient I further complained that Respondent kept patients waiting for unreasonable amounts of time while she met with pharmaceutical representatives.

**Allegations Related to Patient J**

99. Patient J was referred to Respondent for management of neck pain, which radiated

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[21] A nerve conduction study (NCS) measures how fast an electrical impulse moves through a patient's nerve to identify nerve damage. During the test, the nerve is stimulated, usually with electrode patches attached to a patient's skin.

into the arm, beginning on or about October 1, 2018. During her care and treatment of Patient J, Respondent performed electrodiagnostic testing and later injections. During the injection procedure, Respondent failed to wash her hands and/or use gloves. Additionally, Patient J was diagnosed and treated for carpal tunnel syndrome, despite the fact that carpal tunnel syndrome was not among Patient J's complaints.

**Allegations Related to Patient K**

100. Patient K was referred to Respondent on or about October 5, 2018. The referral followed a coronary valve procedure in May of 2018, which was complicated by pain and numbness in Patient K's right leg, which resulted in Patient K becoming wheelchair bound. During her care and treatment of Patient K, Respondent tested Patient K for carpal tunnel syndrome, and began providing injections into his hand. However, Respondent failed to document the reason why Patient K was referred to her, and failed to focus on Patient K's chief complaint. Instead, Respondent recommend unrelated treatment and testing.

**Allegations Related to Patient L**

101. Patient L was referred to Respondent for multiple issues concerning cognitive dysfunction and other symptoms, following a head injury. During Respondent's care and treatment of Patient L, Respondent failed to document the reason Patient L was referred to her. Instead, Respondent proceeded with carpal tunnel testing, which was unrelated to Patient L's chief complaint.

**Allegations Related to Patient M**

102. Patient M was referred to Respondent by his cardiologist after suffering from periodic fainting spells. During Respondent's initial appointment with Patient M, Respondent failed to document the reason why Patient M was referred to her. Instead, Respondent took a brief health history from Patient M. Shortly afterwards, Respondent stated to Patient M that he had carpal tunnel syndrome, and additional tests needed to be performed. During the appointment, Respondent failed to address Patient M's chief complaint of fainting spells. Instead, Respondent proceeded with EEG testing and electrodiagnostics in Patient M's arms, which were unrelated to Patient M's chief complaint.

103. During the course of Respondent's care and treatment of Patient M, he was seen by Respondent several times at her office. During each of the visits to Respondent's office, Patient M noted that the waiting room would fill to approximately 20 people, with the average wait time being approximately two hours. While located in the waiting room, Patient M spoke with several patients who additionally complained that they were diagnosed with and being treated for carpal tunnel syndrome—while not complaining of symptoms—and that Respondent routinely ignored their chief complaints.

**THIRD CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

104. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in her care and treatment of patients N and O.

**Patient N:**

105. On or around April 19, 2019, Patient N's mother filed a complaint to the Board. Patient N was a 35-year-old male, who was severely injured in a car crash several years prior. As a result of the crash, Patient N suffered from serious brain trauma and other chronic injuries.

106. In July of 2018, Patient N suffered a gran mal seizure and he was referred to a neurologist. Patient N then established treatment with Respondent.

107. On or about January 17, 2019, Patient N and his mother attended an examination with Respondent. During the visit, which lasted a short time, Respondent discussed a previously performed CT scan and ambulatory EEG, which was performed at a different medical provider in October of 2018. Respondent subsequently incorrectly documented in Patient N's chart that the "head CT was negative," or words to that effect. In truth, Patient N had extensive abnormalities in his brain imaging. Respondent additionally incorrectly described performing normal heel-to-shin testing on Patient N's legs. This was despite the fact that Patient N's right leg was amputated above the knee.

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108. On January 25, 2019, Patient N returned to Respondent's office for an EEG study. However, Patient N previously had an EEG study in November of 2018, thus rendering the January 2019 EEG unnecessary.

109. On or about February 14, 2019, Patient N and his mother returned to Respondent's office for an additional EEG. Respondent was not present, so one of the office's employees—who had been working at the front desk—performed the procedure on Patient N. The front desk employee was not a licensed EEG technician, nor did she have formal training in the procedure. Following the visit, Respondent appears to have made duplicate notes from much of the previous January 25, 2019 visit. Additionally, there is no mention that Respondent was not present, or that a separate office employee conducted the EEG.

110. On or about March 14, 2019, Patient N and his mother returned to the office to obtain the EEG test results. Although they were there for a previously scheduled appointment, and during normal hours, no one was present at the office. Patient N's mother attempted to contact the office via telephone, but reached an answering service. The answering service stated to Patient N's mother that Respondent was away at a conference. Patient N's mother requested the EEG results, in order to provide them to Patient N's other doctors. The service replied that she would have to pay $35 to obtain the test results. However, Patient N's insurance had already paid approximately $111 to Respondent for performing the EEG test.

111. Between March 14, 2019, and April 4, 2019, Patient N's mother and Patient N's general practitioner attempted to reach Respondent, in order to obtain Patient N's EEG test results.

112. On or about May 15, 2019, a caller identifying themselves as an employee from Respondent's office, and/or answering service, contacted Patient N's mother and stated that Patient N had an appointment the following day. Patient N's mother responded that no appointment was ever scheduled for May 16, 2019. The caller requested for Patient N to come to Respondent's office to discuss the results of the February 2019 EEG, despite Respondent's office ignoring requests to obtain EEG results over the prior three months. Patient N's mother requested that Respondent call her with the EEG results. The caller provided a number for Respondent's

office in Placerville, and stated that she was located there, or words to that effect. Patient N's mother called the office and no one answered. Patient N's EEG results were never provided by Respondent. Based on Respondent's failure to provide said EEG results, Patient N had to establish care with a new neurologist, who was unavailable to evaluate Patient N, until August of 2019—approximately eleven months after the July 20, 2018 seizure.

**Patient O**:

113. Patient O was a then 38-year-old female who established care with Respondent, after an automobile accident, which occurred on or about May 14, 2018. Following the accident, Patient O experienced chronic severe neck pain, low back pain, and dizziness.

114. Respondent first saw Patient O for treatment on or about September 18, 2018, September 21, 2018, September 25, 2018, and November 9, 2018. During the initial evaluation on September 18, 2018, Respondent documented 4/5 strength in lower extremities, however, Respondent failed to document which muscles were weakened. Respondent additionally noted that Patient O had diminished sensation in the upper and lower extremities, but no specific pattern documented. Respondent noted that she planned to do EMG/NCS and EEG testing and to obtain old records. The planned EEG testing, however was unnecessary, due to Patient O having no symptoms suggestive of seizures.

115. Respondent planned trigger point injections[22] and occipital nerve blocks.[23] Notes from the November 9, 2018, examination describe EMG results as, "right motor and sensory CTS and left sensory CTS" (carpal tunnel syndrome). Respondent noted that Patient O had ulnar neuropathies[24] on both sides and mild cervical radiculopathy[25] at C5-6 and C6-7 (upper vertebrae). However, an MRI performed on July 11, 2018—prior to Respondents involvement with Patient O—indicated central disc protrusion at L5-S1 (lover vertebrae), with no other

[22] The trigger point injection procedure, a health care professional inserts a small needle into the patient's trigger point. The injection contains a local anesthetic or saline, and may include a corticosteroid.

[23] local anesthetic and steroids are injected into back of the head, just above the neck.

[24] Ulnar neuropathy occurs when there is damage to the ulnar nerve. This nerve travels down the arm to the wrist, hand, and ring and little fingers. Commonly called "funny bone."

[25] Cervical radiculopathy occurs when a nerve root in the cervical spine becomes inflamed or damaged, resulting in a change in neurological function, such as numbness, altered reflexes, or weakness, may radiate anywhere from the neck into the shoulder, arm, hand, or fingers.

abnormalities noted. The aforementioned testing, performed by Respondent, in Patient O's arms was unnecessary, since Patient O did not have any symptoms in that body region.

116. When documenting her care and treatment of Patient O, Respondent failed to include raw data or waveforms, and failed to adequately describe muscle groups that she found, that were weakened. She further failed to properly document which parts of Patient O's body had sensory loss.

117. While treating Patient O, Respondent used an unlicensed medical assistant to perform the EEG test and nerve conduction studies on Patient O.

118. Following Patient O's November 9, 2018, examination, Patient O's attorneys attempted to obtain her medical records from Respondent. The attorneys made several attempts to obtain said records, via telephone, mail, and facsimile. On or about April 5, 2019, Respondent's office requested a $35.00 payment for the release of Patient O's records. The attorneys sent a check for $35.00, which was cashed by Respondent's office, on or about April 29. 2019. However, no records were sent to the attorneys. Respondent's failure to provide said records resulted in the substantial delay of receiving compensation for her injury. The records were not provided until May of 2021.

119. During his care and treatment of Patient N and Patient O, Respondent committed the following grossly negligent acts:

A. Failing to provide test results to Patient N; and

B. Failing to provide requested medical records to Patient O.

**FOURTH CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

120. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patients N and O, as more particularly alleged in paragraphs 104 through 120, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

121. During his care and treatment of Patient N and Patient O, Respondent committed the following repeated negligent acts:

A. Ordering an unnecessary EEG test on Patient N;

B. Creating inaccurate medical records pertaining to Patient N;

C. Having unlicensed staff perform EEG studies on Patient N;

D. Being unavailable, locking her office, and failing to notify Patient N of her unavailability;

E. Ordering an unnecessary EEG test on Patient O;

F. Creating inaccurate medical records pertaining to Patient O; and

G. Having unlicensed staff perform EEG studies on Patient O;

**FIFTH CAUSE FOR DISCIPLINE**

**(Repeated Failure to Participate in Board Interview)**

122. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (g) of the Code, in that Respondent repeatedly failed, in the absence of good cause, to attend and participate in an interview with the Board. The circumstances are as follows:

123. On or about April 19, 2019, a complaint was filed against Respondent by the mother of one of Respondent's patients. The aforementioned complaint was separate and unrelated to the misconduct alleged in paragraphs 24 through 86, above. As part of the Department of Consumer Affairs (DCA) consumer protection mandate, the complaint was referred to DCA's Health Quality Investigation Unit (HQIU) for investigation into whether any misconduct occurred.

124. On or about May 30, 2019, the case was assigned to an HQIU investigator (Investigator).

125. On or about November 13, 2019, Investigator contacted Respondent's attorney (Attorney) and requested to set up a date and time for an interview with Respondent. Attorney replied that Respondent would be allowed to attend "something like" an interview with the Board, or words to that effect. Investigator requested that Attorney email her several dates of availability for the interview, then sent Attorney an email which summarized the conversation.

126. On December 6, 2019, Investigator emailed Attorney and stated that she had not heard anything regarding Respondent's participation in a Board interview and still had not received medical records that were previously requested. Attorney responded, stating he had

contacted Respondent the previous night, that the records would be produced soon, and that he understands an interview must be scheduled. Investigator asked him to provide some possible interview dates. Attorney replied that a possible date was January 7, 2020. However, Investigator was unavailable on that date and requested alternative dates. Attorney did not provide additional available dates.

127. On or about January 31, 2020, Investigator emailed Attorney and stated that she had been trying to schedule an interview for over two months and asked again for three to four dates they would both be available over the next 30 days for an interview. Investigator asked Attorney if Respondent was declining to appear for an interview. Attorney replied by email, stating he had been in discussions with Respondent's federal criminal attorneys (representing her in an unrelated federal matter) "who are reluctant to allow her to be interviewed.....still working on it. I will look at dates and advise," or words to that effect. Following that email, Investigator did not hear back from Respondent or Attorney

128. On November 24, 2020, Investigator sent Respondent a letter requesting an interview and provided another copy of her request for medical records.

129. On December 14, 2020, Investigator emailed Attorney to admonish him that she would have to subpoena the medical records and subpoena Respondent to appear for the interview, if no progress could be made. Investigator asked Attorney to reply to the email in writing.

130. On December 17, 2020, Attorney's secretary emailed Investigator an uncertified copy of Respondent's records and stated that Attorney would be available for Respondent's interview the week of February 22, 2021.

131. On or about January 22, 2021, Investigator received emails from both Respondent and Attorney, which stated that Attorney would no longer be representing Respondent. Respondent stated she is looking for new representation. Investigator replied that she would give Respondent time to secure new representation.

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132. On or about February 11, 2021, Investigator emailed Respondent and reminded her that it had been almost two weeks since she had heard from her and requested to set an interview by the next business day, otherwise Investigator would subpoena Respondent.

133. On or about March 18, 2021, Investigator received an email message from Respondent's new attorney (Attorney 2), which informed her that he will now be representing Respondent in this matter. After several emails back and forth, Investigator and Attorney 2 agreed on holding Respondent's interview on May 19, 2021. Investigator sent Respondent and Attorney 2 an interview confirmation letter with all the details regarding the scheduled interview.

134. On or about May 19, 2021, Investigator interviewed Respondent by telephone at the Sacramento HQIU Field Office. Attorney 2 and Respondent's criminal attorney (Criminal Attorney) were also in attendance, as well as other participants on behalf of the Medical Board. At the start of the interview, Investigator verified Respondent's identity, then read some preliminary statements. Criminal Attorney interrupted the interview and stated that he wanted to make statements for the record. Investigator replied that the interview was not yet being recorded, but he would be able make those statements in a few minutes when the interview began recording. Shortly after the recording began, Criminal Attorney interrupted, invoked blanket Fifth Amendment privileges over the interview—prior to any questions being asked, and instructed Respondent not to answer any more questions, and concluded the interview.

## SIXTH CAUSE FOR DISCIPLINE

**(General Unprofessional Conduct)**

135. Respondent is subject to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, regarding Respondent's activities as a Residential Care Facility for the Elderly (RCFE) licensee between April 1, 2014, and December 7, 2017. The circumstances are as follows:

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136. On July 31, 2012, the California Department of Social Services (DSS) issued a license to Respondent to operate and maintain an RCFE, serving up to six (6) non-ambulatory residents. The client groups served were to be elderly and dementia patients.

137. On February 18, 2014, DSS issued Administrator Certificate No. 6037629740 to Respondent, following her successfully completing the Residential-Elderly Administrator Certification Program. The certificate expired on February 17, 2016.

138. On April 1, 2014, a Licensing Program Analyst (LPA) for DSS, conducted an unannounced visit to Respondent's RCFE facility, Bird of Paradise Manor, LLC (Bird of Paradise), located in Wilton, California, in response to a complaint that was lodged against the facility. The complaint alleged Respondent received Power of Attorney for one of her residents, in violation of California Code of Regulations, title 22, section 872172, subdivision (d)(2). Respondent admitted to the LPA that she had received Power of Attorney over the resident. During the visit, the LPA also discovered that two facility employees did not have fingerprint clearances to work at the facility, in violation of California Code of Regulations, title 22, section 87761, subdivision (b). Respondent could not produce complete records for all residents and employees, in violation of California Code of Regulations, title 22, section 87506, subdivision (a), and section 87412, subdivision (a). The LPA additionally found that a resident's medications had been removed from the pharmacy pill bottle and placed in a weekly pill container, in violation of California Code of Regulations, title 22, section 87465, subdivision (h)(5).

139. Respondent was issued plans of correction (POC) (timeframe issued by DSS for a licensee to correct deficiencies), and a $1,000 fine, regarding Respondent's failure to obtain fingerprint clearance for her employees.

140. On October 10, 2014, a different LPA conducted an unannounced site visit at Bird of Paradise, in order to conduct a safety check for a resident. The LPA observed a camera in the resident's room, of which the resident was unaware, in violation of California Code of Regulations, title 22, section 87468, subdivision (a)(l); and furniture blocking an exit to the room, and the bed blocking the resident's access to the closet, both of which violate California Code of Regulations, title 22, section 87307, subdivision (d)(6). The LPA asked the resident whether she

had agreed to the camera in the room, and was informed that the resident did not know a camera was present.

141. Respondent was issued POCs and dates by which the corrections must be made. Respondent was to submit either evidence of written consent, or photographic evidence that the camera was removed. She was also to submit photographic evidence that the furniture was moved from blocking the exit.

142. On October 24, 2014, an LPA and a Licensing Program Manager (LPM) conducted an unannounced facility visit at Bird of Paradise, following a complaint. The complaint alleged that the facility failed to provide a copy of the admission agreement to a resident's responsible party, in violation of California Code of Regulations, title 22, section 87507, and that the facility accepted a resident who had a prohibited health condition (Clostridium difficile colitis[26]), in violation of California Code of Regulations, title 22, section 87615. These two allegations were substantiated by the LPA and LPM, during the visit. While at the facility, the LPA and LPM observed a camera in the resident's bathroom, in violation of California Code of Regulations, title 22, section 87468, subdivision (a)(l). Respondent was issued another POC, and instructed to remove the camera from the resident's room.

143. On March 25, 2015, an LPA conducted an unannounced site visit to the facility. During the visit, the LPA observed Miralax, an over-the-counter medication, in one of the resident's rooms, in violation of California Code of Regulations, title 22, section 87465, subdivision (h)(2). The LPA explained to Respondent that all medications, even over-the-counter medications, must be centrally stored and locked. Respondent was issued POCs, which included providing the LPA with a statement in writing as to how Respondent would ensure that the violation would not recur.

144. On August 7, 2015, an LPA made an unannounced visit to Bird of Paradise to conduct an annual inspection. At the time of the inspection, one resident lived at the facility, who was non-ambulatory with dementia. The LPA observed bleach that was unlocked and accessible

[26] Clostridium difficile colitis is an infection of the colon by the bacterium, Clostridium difficile, which can cause severe damage to the colon and even be fatal.

to the resident, in violation of California Code of Regulations, title 22, section 87705, subdivision (f)(2). The LPA noted a "strong odor of incontinence," in the resident's room, and saw the resident's diaper appeared to be soiled, in violation of California Code of Regulations, title 22, section 80077.4, subdivision (b). The facility's fire extinguisher was expired, in violation of California Code of Regulations, title 22, section 80087, subdivision (a). The resident's file was missing the signature page on the annual medical assessment, in violation of California Code of Regulations, title 22, section 87705, subdivision (c)(5). The LPA additionally noted that the facility's centrally stored medication record (CSMR) was incomplete, in violation of California Code of Regulations, title 22, section 80075, subdivision (k)(7). Respondent maintained several incomplete personnel files, in violation of California Code of Regulations, title 22, section 87412, subdivision (a), and was unable to produce a current administrator's certificate, in violation of California Code of Regulations, title 22, section 87405, subdivision (a). Respondent was issued a POC, which included providing the LPA with a statement in writing as to how Respondent would ensure that the violations would not recur. Respondent was also directed to attend a training on recordkeeping, and to update her certificate.

145. On October 13, 2015, an LPA made an unannounced visit to the facility to conduct a follow-up visit regarding the August 7, 2015, POC. Respondent was not present. Several items that the LPA cited Respondent for on her August 7, 2015, visit had not been corrected, and were re-cited. Specifically, the facility's CSMR was incomplete, personnel records were incomplete, and there was no updated administrator certificate. Additionally, the LPA identified two caregivers in the home who were not fingerprint-cleared, in violation of California Code of Regulations, title 22, section 87355, subdivisions (e)(l) and (f). Respondent was issued a $1,000 fine for having caregivers present who had not been fingerprint-cleared.

146. On January 20, 2016, two (2) LPAs made an unannounced case management visit to the facility. The LPAs found unlocked medications in the facility's refrigerator which were accessible to the residents, in violation of California Code of Regulations, title 22, section 87465, subdivision (h)(2). Respondent was cited and ordered to submit a plan to the DSS regarding how the facility would ensure medications are not available to residents. The LPAs additionally

observed that there was not a menu on which the caregivers based the meals. During a conversation with the facility's caregivers, they told the LPA's that they "cook whatever," or words to that effect, and elaborated that Respondent brought food to the facility, and the caregivers cooked what was available.

147. On January 25, 2016, an LPA and LPM conducted an unannounced site visit to deliver findings regarding a complaint. The LPA substantiated the complaint that the only standing shower in the facility was locked during the day and unavailable to residents. Respondent was cited for violating California Code of Regulations, title 22, section 87307, subdivision (a)(3). Respondent acknowledged the standing shower was locked, and stated that the standing shower would be made available to residents.

148. Later, on January 25, 2016, the LPA and LPM held an informal conference with Respondent at the DSS regional office, in Sacramento, California. The purpose of the meeting was to discuss the number of citations issued to Respondent in the past year. Additionally, the LPA noted that facility staff members were using a resident's shower, in violation of Regulation 87307, subdivision (a)(2)(C), and Respondent could not produce a sample menu for the facility's dining options, in violation of Regulation 87555, subdivision (b)(6). Respondent was directed to submit a Statement of Understanding to DSS regarding staff not using resident showers. Respondent was also directed to submit a sample menu to the DSS, and keep a sample menu on file.

149. On July 12, 2016, two (2) LPAs made an unannounced visit to the facility in response to a complaint. The complaint alleged the facility was infested with insects and bugs, failed to provide a quality and quantity of food to meet the residents' needs, failed to provide toiletries, and failed to order residents' medications in a timely manner. An LPA walked through the facility and inspected the kitchen. He saw cockroaches in the cabinets, drawers, and dishwasher. The caregiver present told the LPA that she was constantly battling the cockroaches, and she felt there was no end to it. The LPA noticed that the kitchen was not clean in that the counters and floor appeared to have food remnants on them, there were dirty dishes in the sink, and spills in cabinet areas.

150. A caregiver at the facility showed the LPA the medication for residents. The CSMR was incomplete, showed that a resident was not getting his medications as ordered, his medications were not recorded, and medications were present that his doctor had not ordered. Each medication must have a written order from the resident's doctor, a manifest from the pharmacy when the medications are filled, and must be logged when the facility receives it, when the medication is started, and when it is administered to the resident. The LPA spoke to Respondent, who stated that when the resident requested hydrocodone for pain, which he was prescribed on an as-needed basis, Respondent instructed staff to give him acetaminophen (Tylenol). Another resident also had centrally stored medication at the facility, with similar recording and control issues.

151. The LPAs observed feces on the floor of a resident bathroom, used continence care wipes and feces in a trash can in the bathroom, dead cockroaches and eggs lining the patio area, and cockroaches in the refrigerator. When interviewing one of the residents in his room, the LPA observed a cockroach on his pillow. The resident additionally complained that cockroaches crawled on him throughout the night and he saw them on his bed. He additionally stated that his food regimen consisted primarily of hot dogs, ramen noodles, and bologna sandwiches.

152. Following the inspection, Respondent was issued a citation, which included civil penalty assessments, a list of deficiencies and corresponding plans of correction, and a narrative of the LPAs' observations and interviews with residents.

153. On December 7, 2017, DSS filed a Second Amended Accusation against Respondent's RCFE license. The Complaint alleged cause to revoke the facility's license to operate a RCFE, revoke or deem forfeited Respondent's certificate, rescind Respondent's criminal record exemption,[27] and prohibit Respondent from being an RCFE licensee for the remainder of her life.

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[27] A criminal record exemption is a document that exempts a RCFE applicant from the requirement of having a criminal record clearance. If an applicant has a criminal history other than minor traffic offenses, a criminal record exemption is needed in order to obtain a RCFE license.

154. On August 20, 2018, through August 28, 2018, and on December 17, 2018, the matter was heard before the Office of Administrative Hearings (OAH).

155. On February 11, 2019, DSS adopted the OAH administrative law judge's January 11, 2019, Proposed Decision, which made factual findings, which included but are not limited to the facts alleged herein in Paragraphs 87 through 104. The DSS additionally adopted the administrative law judge's Order, which stated that the revocation of Respondent's facility license is stayed for a period of three (3) years from the effective date of the Decision, during which time the facility shall be granted a probationary license. Prior to the facility beginning operations, the DSS must be given notice of a new facility administrator, who may not be hired as an administrator without Department approval. The facility license was additionally subjected to several probationary terms and conditions.

**SEVENTH CAUSE FOR DISCIPLINE**

**(Excessive Prescribing)**

156. Respondent is subject to disciplinary action under section 725 of the Code, in that Respondent excessively overprescribed in her care and treatment of Patients A and B, as more particularly alleged in paragraphs 27 through 63 above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

**EIGHTH CAUSE FOR DISCIPLINE**

**(Prescribing Without Prior Examination)**

157. Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed controlled substances without a prior examination, in her care and treatment of Patients A, B, and E, as more particularly alleged in paragraphs 27 through 63, and 79 through 81 above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

**NINTH CAUSE FOR DISCIPLINE**

**(Failure to Label Dangerous Drugs)**

158. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 4170, subdivision (a)(4), of the Code, in the Respondent has failed to fulfill the

labeling requirements imposed on pharmacists by section 4076 of the Code, as more particularly alleged in paragraphs 92 and 103 above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

**TENTH CAUSE FOR DISCIPLINE**

**(Violation of State Statute Regulating Dangerous Drugs)**

159. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2238, of the Code, in that he has violated a state statute regulating dangerous drugs, as more particularly alleged in paragraphs 27 through 63, and 79 through 81 above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

**ELEVENTH CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Records)**

160. Respondent's license is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate medical records relating to his care and treatment of Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, and O, as more particularly alleged in paragraphs 27 through 159, above, which are hereby incorporated by reference and re-alleged 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 50704, issued to Respondent Firdos Sameena Sheikh, M.D.;

2. Revoking, suspending or denying approval of Respondent Firdos Sameena Sheikh, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Firdos Sameena Sheikh, M.D. to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: OCT 31 2022

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

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