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

In the Matter of the First Amended Accusation Against: Niceto Lopez, M.D. Physician's and Surgeon's Certificate No. A 96421 Respondent.	Case No.: 800-2019-060838

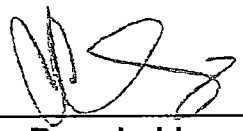
DECISION

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 November 1, 2023.

IT IS SO ORDERED: October 2, 2023.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the First Amended Accusation Against: NICETO LOPEZ, M.D. 2121 Santa Monica Boulevard Santa Monica, California 90404 Physician's and Surgeon's Certificate A 96421, Respondent.	Case No. 800-2019-060838 OAH No. 2022080326 **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 is represented in this matter by Rob Bonta, Attorney General of the State of California, by Trina L. Saunders, Deputy Attorney General.

2. Respondent Niceto Lopez, M.D. (Respondent) is represented in this proceeding by attorney Nicholas Jurkowitz, whose address is The Fenton Law Group, 1990 South Bundy Drive, Suite 777, Los Angeles, California 90025.

3. On July 14, 2006, the Board issued Physician's and Surgeon's Certificate No. A 96421 to Niceto Lopez, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2019-060838, and will expire on May 31, 2024, unless renewed.

JURISDICTION

4. A First Amended Accusation in Case No. 800-2019-060838 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on March 10, 2023. Respondent timely filed a Notice of Defense contesting the First Amended Accusation.

5. A copy of the First Amended Accusation in Case No. 800-2019-060838 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the First Amended Accusation in Case No. 800-2019-060838. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2019-060838, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in First Amended Accusation No. 800-2019-060838, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 96421 to disciplinary action.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

13. 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 his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated 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.

14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2019-060838 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.

15. 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.

16. 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 96421 issued to Respondent Niceto Lopez, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

1. 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.

2. 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.

3. 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.

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

5. 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.

6. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $7,296.25 (seven thousand two hundred ninety-six dollars and

twenty-five cents). 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.

7. 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.

8. 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.

The Respondent may treat hospice patients in their home, if the patient's care has been coordinated through a recognized hospice program and Respondent is required to regularly report

to the program regarding the care he provides to such patients for the program's review.

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.

9. 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.

10. 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..

11. 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.

12. 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.

13. 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.

14. 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.

15. 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. 800-2019-060838 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Nicholas Jurkowitz. 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. 3/21/2023

NICETO LOPEZ, M D
Respondent

I have read and fully discussed with Respondent Niceto Lopez, 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: 3-21-23

NICHOLAS JURKOWITZ
Attorney for Respondent

ENDORSEMENT

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

DATED: 3/21/23

Respectfully submitted,

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

TRINA L. SAUNDERS
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2019-060838

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

In the Matter of the First Amended Accusation Against: **NICETO LOPEZ, M.D.** **2121 Santa Monica Boulevard** **Santa Monica, California 90404** Physician's and Surgeon's Certificate No. A 96421, Respondent.	Case No. 800-2019-060838 **FIRST AMENDED ACCUSATION**

PARTIES

1. Reji Varghese (Complainant) brings this First Amended Accusation solely in his official capacity as the Interim Executive Director of the Medical Board of California (Board).

2. On July 14, 2006, the Board issued Physician's and Surgeon's Certificate Number A 96421 to Niceto Lopez, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2024, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code (Code) unless otherwise indicated.

4. 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.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 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.

COST RECOVERY

7. 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.

Standard of Care

8. Respondent is a hospitalist physician.[1] Hospitalists generally work in shifts. Therefore, maintaining appropriate medical record keeping is important for hospitalists to ensure that information about a patient's care and status is provided to subsequent treaters and other medical care providers. The history of present illnesses and review of systems should be detailed in the chart notes. Accurate recording of the physical findings should be documented at every patient encounter. An appropriate synthesis and/or derivation of a differential diagnoses and treatment plan(s) should be charted. Documenting clear and concise medical records about a patient is also critical to maintaining the continuum of care. A lack of adequate medical records about a patient would make it difficult for subsequent healthcare providers to cover or resume care for a patient after a change in shift. Subsequent providers are dependent on previous charting for details about a patient to compare the current presentation of a patient to the previous presentations for evaluation of efficacy of treatment(s). Conflicting information and/or a lack of differential diagnoses in chart notes, makes it difficult for subsequent providers to efficiently provide medical care to a patient as subsequent provider(s) would have to spend additional time that he or she might not have to evaluate the patient's issues rather than continuing current treatment(s) as is usually expected in situations of shift change care for a patient.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent is subject to disciplinary action under Code section 2234, subdivisions (b) and (d) of the Code, in that Respondent was grossly negligent in connection with the care and

[1] Hospital medicine is a branch of internal or family medicine, dealing with the care of acutely ill hospitalized patients. The primary professional focus of hospitalists is caring for hospitalized patients only while they are in the hospital.

treatment of Patients A, B and C. The circumstances are as follows:

Patient A.[2]

10. On or about October 20, 2016, Patient A, an 84-year-old woman, presented to the Emergency Department (E.D.) at the hospital where Respondent worked with a chief complaint of an altered mental status. Patient A's past medical history included coronary artery disease (CAD), diabetes mellitus (D.M.), paroxysmal atrial fibrillation (PAFIB), gastroesophageal reflux disease (GERD), hypothyroidism, chronic kidney disease (CKD) stage III, hyperkalemia, hyperlipidemia, congestive heart failure (CHF) with ischemic cardiomyopathy (ejection fraction documented as 30-35%), history of urinary retention, cholelithiasis, and peripheral artery disease (PAD). Patient A's past surgical history included cataract removal, left elbow fracture, right femur fracture, right shoulder fracture, left carotid endarterectomy, bilateral lower extremity arterial procedures for PAD, and pacemaker placement. A note by the E.D. physician indicated that the patient was nonverbal. The patient also had a left heel ulcer (a bed sore). She had no leukocytosis. Her urinalysis revealed pyuria, and her ESR[3] and CRP[4] were both elevated. Her head C.T. was negative for acute processes. The E.D. physician noted that Patient A's altered mental status was due to infectious causes: urinary tract infection (UTI), cellulitis of left lower extremity and left heel decubital ulcer. His differential diagnosis included neurological causes and electrolyte abnormalities. Respondent admitted Patient A to the hospital. Of note, the patient had a potassium[5] level of 3.9 (normal range: 3.6-5.2) and Respondent started intravenous fluids (IVF) containing potassium chloride (KCl).

11. On or about October 21, 2016, Respondent saw Patient A and her potassium level

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[2] Letters are used in lieu of names to address privacy concerns.

[3] Erythrocyte Sedimentation Rate, a type of blood test that detects and monitors inflammation in the body.

[4] C-Reactive Protein, also a blood test that measures inflammation.

[5] Potassium is an important electrolyte for nerve and muscle cell functioning, especially for muscle cells in the heart. Kidneys control potassium levels by allowing for excess potassium to leave the body through urine or sweat.

was 4.7. The patient's creatinine was 1.18. Her blood cultures from admission had no growth at 24 hours. A urine culture was in progress. He wrote, "Diagnostic studies: Available data and images were reviewed personally. See reports. Significant results and findings are addressed here or in the Assessment and Plan." Respondent also continued the patient's IVF maintenance with 20 mEq of KCl.

12. From on or about October 22, 2016 through October 23, 2016 another hospitalist saw Patient A. The patient appeared to continue to suffer from confusion and her blood cultures from admission remained negative. The urine culture grew Klebsiella.[6] No lab results were checked during these two days.

13. Patient A suffered a code blue[7] on or about October 24, 2016 and an E.D. physician responded to the code. She had agonal respiration.[8] In addition, her pulse was rapid and thready (that is, weak); pulse oximetry was noted to be 78%. Patient A was unresponsive and initially, in wide complex and irregular tachycardia. She was given an amiodarone trial, intubated, shocked and given bicarbonate and calcium. She was transferred to the ICU. Updated labs showed Patient A's potassium level at 6.5, a critically high level.

14. On or about October 25, 2016, Patient A again coded around 7:00 a.m., while intubated in the ICU on vasopressor drugs[9] at the maximum dose, and evinced pulseless electrical activity (PEA) cardiac arrest. The code was called at 7:09 a.m., and Patient A died.

15. On or about October 20, 2016 and thereafter, Respondent committed gross negligence by failing to maintain adequate and accurate records in connection with this care and treatment of

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[6] A bacterial infection of gram-negative bacilli.

[7] The term "code blue" is used to describe the critical status of a patient. Hospital staff may call a code blue if a patient goes into cardiac arrest, has respiratory issues, or experiences any other medical emergency. Hospitals typically have rapid response teams ready to go when they get notified about a code blue.

[8] Agonal respiration is a distinct abnormal pattern of breathing and brainstem reflex characterized by gasping, labored breathing, accompanied by strange vocalizations and myoclonus. Possible causes include cerebral ischemia, extreme hypoxia, or even anoxia. Agonal breathing is an extremely serious medical sign requiring immediate medical attention, as the condition generally progresses to complete apnea and heralds death.

[9] Medications that contract the blood vessels and raise blood pressure.

Patient A, as follows:

a) Respondent's chart notes for Patient A were long, yet often lacked pertinent positive and negative medical findings about the patient. For example, Respondent admitted Patient A to the hospital with an altered mental status. However, he failed to document Patient A's 's baseline mental status upon examination.

b) Respondent saw Patient A on or about October 24, 2016. He failed to adequately document a full evaluation which would attempt to address Patient A's deterioration, including the reasons for the patient's hypotension which required vasopressor support.

c) Patient A records included conflicting information such as Respondent's admission note which indicated that Patient A had an altered mental status, but the examination portion of his note stated, "oriented x3."[10] Respondent also charted in a note dated October 24, 2016, in the exam section under "Gen" (general) that Patient A was "alert, cooperative, no distress" and under "Neurologic" that the patient was "sedated, nonfocal" and "moving all extremities."

d) Respondent failed to address abnormal findings in his assessments and plans. For example, although on admission, Patient A had elevated creatinine and anemia, his assessment and plan did not include addressing these issues. Similarly, on or about on October 24, 2016, the patient was noted to be hypotensive, but his assessment or plan failed to document how he would address Patient A's hypotension.

16. On or about October 20, 2016 and thereafter, Respondent committed gross negligence by failing to adequately assess and manage Patient A's hypokalemia.[11] Patient A presented with a diagnosis of CKD stage III, a history of hyperkalemia, and a potassium level of 3.9. During his interview with the Board investigator and medical consultant on or about June 1, 2020, Respondent indicated that he added potassium to Patient A's IVF. This was dangerous and

[10] Oriented times three means the patient knows their name, location and date/time.

[11] This is a condition of low potassium levels. Serious side effects include life-threatening complications (arrhythmias, paralysis, rhabdomyolysis, and diaphragmatic weakness).

required vigilant monitoring to avoid hyperkalemia. It would have been safer to provide a one-time dose instead. On or about October 21, 2016, Respondent saw Patient A, and Patient A's potassium level was 4.7. Respondent should have ceased Patient A's potassium replacement in the IVF at that point in time to avoid any further rise in the potassium level or at least, he should have closely monitored Patient A's's potassium level.

17. On or about October 20, 2016 and thereafter, Respondent committed gross negligence by failing to adequately assess and manage Patient A's hyperkalemia.[12] When Patient A initially coded on or about October 24, 2016, she appeared to have had a myocardial infarction, and also hyperkalemia with a potassium level of 6.5. Although Respondent consulted cardiology, he continued to maintain Patient A on IVF with potassium replacement. However, this treatment with potassium replacement should have been discontinued promptly from the IVF. Patient A also suffered an acute kidney injury as well. Despite Patient A's significant renal impairment, Respondent also ordered standing as needed (prn) potassium orders (although the patient apparently did not receive any doses).

Patient B.

18. On or about March 18, 2018, Patient B, a 76-year-old woman, presented to the emergency department at the hospital where Respondent worked for evaluation of her restless leg syndrome, weakness, and low blood pressure. An IVF was started by paramedics during transport, due to hypotension. Her past medical history included CKD, stage III, anxiety disorder, arthritis, lupus anticoagulant, hyperlipidemia, hypertension, nonrheumatic tricuspid valve insufficiency, PAFIB and restless leg syndrome (RLS). Her past surgical history included pacemaker and bioprosthetic aortic valve replacement. Her review of systems was positive for appetite change, fatigue, arthralgia, agitation, confusion, and sleep disturbances. Her presentation heart rate was 124 and her blood pressure was 105/75. Her temperature was 36.5C (97.7 degrees F). She was noted to have bilateral lower extremity pitting edema. She had mild leukocytosis at

[12] This is a condition of high potassium levels. The most serious manifestations of hyperkalemia are muscle weakness or paralysis, cardiac conduction abnormalities and cardiac arrhythmia. Cardiac arrhythmias associated with hyperkalemia include sinus bradycardia, sinus arrest, slow idioventricular rhythms, ventricular tachycardia, ventricular fibrillation, and asystole.

11.9 K. Her platelet count was 70K. Her creatinine was 2.03. The E.D. physician treated her with IVF and IV cardizem. Upon reevaluation in the E.D., the patient's pulse was 119, and her blood pressure was 138/57. Respondent admitted Patient B to the hospital.

19. On or about March 18, 2018, Respondent saw Patient B and noted a history of mitral clip for mitral valve regurgitation. The review of systems was essentially negative. Her white blood cell (WBC) count was 11.9 and her platelet count was 70. No documentation of the electrocardiogram (EKG) interpretation was found under the history and physical, and no DVT prophylaxis was checked. A cardiology consultation was requested. Heart rate control agents were adjusted by the cardiologist. The cardiologist documented that it was permissible to have the systolic blood pressure to go down to the 90's.

20. On or about March 19, 2018, a cardiology consult documented that the patient's heart rate was better controlled at approximately 90-110 beats per minute.

21. On or about March 19, 2018, Respondent saw Patient B and documented that Patient B's heart rate was better controlled at 90-110. Patient B had significant cramping and jerking of lower extremities. Patient B's medications for RLS would be adjusted as per neurology. Patient B's vital signs were notable for a minimum blood pressure of 91/73, a maximum heart rate of 155 and a maximum respiratory rate of 22.

22. On or about March 19, 2018, Respondent saw Patient B and again documented that Patient B's heart rate was better controlled at 90-110. Patient B's medications for restless legs syndrome were adjusted as per discussion with neurology. Patient B's hyponatremia was documented to have resolved after IVF and diuresis. Patient B's vital signs were notable for a minimum blood pressure of 99/73 and a maximum heart rate of 112. No fever or hypothermia was charted. Patient B was noted to be alert and cooperative. The patient was noted to have leukocytosis of 14.8 and thrombocytopenia of 52.

23. On or about March 21, 2018, Respondent saw Patient B and again documented that Patient B's heart rate was better controlled at approximately 90-110. Her medications for restless legs syndrome were adjusted as per discussion with neurology. Hyponatremia was documented as to have resolved after IVF and diuresis. Her vital signs were notable for minimum blood

pressure of 94/47 and maximum heart rate of 96. Patient B was documented as being alert and cooperative on the physical exam. Her Sodium level was 135. She had leukocytosis of 11.8 and thrombocytopenia of 59.

24. On or about March 21, 2018, a nursing note documented that Patient B had anxiety and agitation. Redness and swelling were noted at Patient B's left arm IV site. Nursing also documented Patient B's issues with low blood pressure (systolic in the 90's) and an uncontrolled heart rate up to 130-40.

25. On or about March 22, 2018, cardiology on-call was paged.

26. On or about March 22, 2018, Respondent saw Patient B and again documented that Patient B's heart rate was better controlled at approximately 90-110. He also documented that Patient B was very sleepy after starting Mirapex (a medication for RLS). Hyponatremia was documented as resolved after IVF and diuresis. Her vital signs were notable for a minimum blood pressure of 80/60, a maximum heart rate of 140 and a maximum respiratory rate of 26. His findings upon physical exam of the patient included "AAO x3[13]" under "General," but somnolent under "Psych."

27. On or about March 23, 2018, Respondent saw Patient B and again documented that the Patient B's heart rate was better controlled at approximately 90-110. He also documented that Patient B was very sleepy after starting Mirapex. Hyponatremia was documented as resolved after IVF and diuresis. Her vital signs were documented as a minimum blood pressure 75/59, a maximum heart rate of 141, and a respiratory rate of 22. The patient's sodium level was 129. Patient B's CBC and INR were pending.

28. On or about March 23, 2018, RRT[14] rounds on at 12:07 charted that Patient B's WBC went from 14.8 K on or about March 20, 2018 to 21.8K. Patient B was in rapid atrial fibrillation at 128. Her blood pressure was 102/66. Patient B was moaning a lot and yelling "help", but was unable to say with what she needed help. Respondent was aware of the Patient B's status.

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[13] This abbreviation stands for Awake, alert, and oriented as to person, place and time.

[14] Presumably meaning rapid response team.

29. On or about March 23, 2018, gastroenterology was consulted due to bright red blood per rectum. It was noted that Patient B had leukocytosis (21.8K) and thrombocytopenia (42K).

30. On or about March 23, 2018, the on-call hospitalist for Respondent was called. At approximately 19:27, the on-call hospitalist documented that Patient B met the criteria for severe sepsis.[15] Patient B was started on IVF and broad-spectrum antibiotics. The plan was to transfer Patient B to the ICU. A lumbar puncture was also ordered.

31. On or about March 23, 2018, an RRT documented that Patient B was confused throughout the shift. Patient B remained hypotensive with systolic blood pressure in the 80's. Vasopressor support was started later that night. Patient B was transferred to ICU at 22:16 (10:16 p.m.).

32. On or about March 24, 2018, an infectious disease consult charted impressions of severe sepsis due to suspected acute infectious endocarditis. That same day, a nephrology consultation was obtained due to Patient B's acute kidney injury (AKI) and metabolic acidosis. Her AKI was thought to be due to renal hypo-perfusion. That same day, another hospitalist evaluated Patient B and noted that she was in septic shock on vasopressor support. Endocarditis was suspected as the cause of the sepsis. She was also noted to have AKI, disseminated intravascular coagulation due to sepsis, and demand ischemia with an elevated troponin level. A blood culture from a sample taken on or about March 23, 2018, grew gram positive cocci in clusters. The family was updated on Patient B's condition. Patient B died on or about March 24, 2018.

33. On or about March 18, 2018 and thereafter, Respondent committed gross negligence by failing to maintain adequate and accurate records in connection with his care and treatment of Patient B.

a) Respondent often failed to address abnormal findings with respect to Patient B. For example, he failed to document a plan for thrombocytopenia, leukocytosis, altered

[15] The signs and symptoms of sepsis can include hypotension, tachycardia, fever or hypothermia. In addition, laboratory findings may be nonspecific and could include leukocytosis (or left shift), hyperglycemia, thrombocytopenia, coagulation abnormalities, hyperbilirubinemia, hyperlactatemia, and arterial hypoxemia. Further, many patients may not present with the classic or typical features of fever or hypothermia.

mental status, and hypotension. Respondent documented Patient B's low respiratory rate, but failed to adequately assess and address the condition. Patient B also had a history of atrial fibrillation and lupus anticoagulant, which placed her at risk for thromboembolic events. However, Respondent failed to note DVT prophylaxis on admission or the following day. Respondent failed to document Patient B's baseline creatinine level in the setting of known CKD and elevated creatinine.

b) Respondent's chart notes for Patient B also included conflicting information. For example, Patient B's heart rate was documented to be better controlled in the plan at a rate of 90-110, for days. Yet, Patient B's charted vital signs did not correlate: some days the maximum heart rate was in the 90's and others in the 150's. On or about March 22, 2018, Respondent documented that Patient B's orientation was "AAO x3" under "General," but somnolent under "Psych."

c) Portions of Respondent's notes appeared to have been copied and pasted into the records. For example, a chart note dated March 19, 2018, stated that "Rates during atrial fibrillation are currently better controlled at approximately 90-110 bpm. She is on intravenous diltiazem at present. Metoprolol has been continued and a digoxin [sic] is continued." A note dated March 20, 2018, stated that "Rates during atrial fibrillation are currently better controlled at approximately 90-110 bpm. She is on intravenous diltiazem at present. Metoprolol has been continued and a digoxin [sic] is continued." These same sentences were in chart notes dated March 21, 2018 and March 22, 2018.

d) Respondent also failed to adequately synthesize the underlying differential diagnoses in the notes. He failed to include sepsis as a differential diagnosis for Patient B, despite Patient B's refractory atrial fibrillation, hypotension, altered mental status and leukocytosis.

34. On or about March 18, 2018 and thereafter, Respondent committed gross negligence when he failed to recognize sepsis in Patient B. Patient B's course upon admission deteriorated

continuously in the hospital with refractory atrial fibrillation and rapid ventricular response, hypotension, altered mentation, tachypnea, leukocytosis and thrombocytopenia. Respondent failed to adequately synthesize a differential diagnosis, including sepsis, to unify the patient's symptoms and findings. Despite being notified by nursing staff about Patient B's tachycardia and acute up trending of leukocytosis, Respondent failed to take appropriate action. Ultimately, the on-call hospitalist physician recognized Patient B's severe sepsis.

Patient C.

35. On or about June 25, 2018, Patient C, a 39-year-old man, presented to the emergency department at the hospital where Respondent worked, with complaints of drooling, "hearing a song that no one else is hearing," having had a headache for one week, and intermittent left-hand weakness. Patient C's past medical history included steroid-induced diabetes and ulcerative colitis, and history of a total colectomy. A computed tomography (C.T.) scan of the patient's head identified possible brain edema in Patient C's right frontal lobe. A magnetic resonance imaging (MRI) scan of Patient C's brain subsequently identified possible low grade diffuse astrocytoma in the region. A lumbar puncture was performed as well. Neurosurgery evaluated Patient C and it was noted that a brain biopsy would be considered if infectious and neurological workup was negative or equivocal. Patient C also suffered from an acute kidney injury (AKI), and had hyperglycemia (high blood glucose), but without evidence of diabetic ketoacidosis[16] (DKA). Although Patient C was given IVF, Patient C and his parents refused insulin.

36. On or about June 25, 2018, Respondent admitted Patient C to the hospital to rule out a brain tumor. Patient C had diabetes mellitus with a reported allergy to insulin ("my throat closed off") and only diet control therapy. Review of systems was negative. Patient C's vitals and physical exam were unremarkable. Respondent's assessment and plan included: 1. Brain tumor: medically stable to undergo general anesthesia and surgery as needed; 2. Diabetes mellitus: "NOT on insulin due to history allergic reaction," HgbA1c was to be checked for a baseline, and he would consult endocrinology if hyperglycemia persisted; 3. History of colectomy: Pads and

[16] A serious complication of diabetes that occurs when the body produces high levels of blood acids called ketones.

supportive care were planned. The results of an electrocardiogram (EKG) found normal sinus rhythm with no significant S.T. or T wave abnormalities. Deep Vein Thrombosis (DVT) prophylaxis was not documented.

37. On or about June 26, 2018, Patient C complained of intermittent spasms in his left arm. The exam was notable for confusion at times. Patient C's chemistry was at baseline. The patient's vital signs were unremarkable. Respondent's assessment and plan included a repetition of the diabetes and history of colectomy documentation from the prior day. In addition, Respondent wrote brain tumor vs infective encephalitis vs other, and his plan was for a neurosurgery evaluation with possible need for biopsy. He also documented that he discussed the patient with neurology who recommended an infectious disease workup.

38. On or about June 26, 2018, infectious disease was consulted for antibiotics management and neurology was consulted for brain mass and neurological symptoms.

39. On or about June 27, 2018, Patient C reported fewer episodes of left arm spasms. Patient C also had borderline tachycardia (at 110), but otherwise his vital signs and exam were unremarkable. No chemistry panel was documented. Respondent's plan was for a possible brain biopsy. Patient C was deemed medically stable to undergo general anesthesia and surgery as needed. Infectious disease and neurological workups were in progress. Although Patient C was not on insulin due to his history of an allergic reaction and his refusal, his HgbA1c (commonly referred to as A1c level) was documented at 13.3.[17] His plan was to consult endocrinology if there was persistent hyperglycemia.

40. On or about June 27, 2018, psychiatry was consulted due to "A.H." (presumably auditory hallucinations). Seroquel®[18] was recommended.

41. On or about June 28, 2018, Patient C underwent a right frontal craniotomy procedure and open biopsy of the right frontal lobe. Respondent saw Patient C on that day and noted that

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[17] A1c level is the average of the prior three months' blood sugar levels. Normal A1c is below 5.7%. A level of 6.4% indicates prediabetes. A level greater than 6.5% indicates diabetes.

[18] "Seroquel" is a brand name for quetiapine, which is an atypical antipsychotic drug used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder. It is a dangerous drug pursuant to Business and Professions code section 4022.

Patient C underwent the procedure. No chemistry panel was documented on the progress note. Respondent wrote, "Brain tumor vs infective encephalitis vs othert [sic]." The biopsy and frozen section were consistent with low grade glioma. Neuro oncology evaluation was to follow. Respondent again documented Patient C's refusal for insulin administration due to history of allergic reaction and his plan again was for endocrinology if there was persistent hyperglycemia.

42. On or about June 29, 2018, Respondent again documented that Patient C had a biopsy on the prior day. Hyperglycemia was noted as well. Patient C indulged in food post-surgery and steroids were started per neuro oncology. Patient C's glucose was 596, bicarbonate was 8, his anion gap was 23 and his white blood cell count was 12.2. Respondent again wrote that, "Brain tumor vs infective encephalitis vs othert [sic]," and that the biopsy and frozen section were consistent with low grade glioma. Respondent again documented Patient C's refusal for insulin administration due to history of allergic reaction and his plan again was for endocrinology if there was persistent hyperglycemia. IVF and bicarbonate were planned for the day.

43. On or about June 30, 2018, Respondent again documented that Patient C had a biopsy on the prior day and that he was hyperglycemic and had apparently indulged in food post-surgery and that steroids were started per neuro oncology. Patient C's morning labs showed glucose of 386, serum bicarbonate of 11 with anion gap of 18. (Overnight labs from the day prior, on or about June 30, 2018, revealed glucose of 432, serum bicarbonate of 13 and anion gap of 20.) Respondent again wrote that, "Brain tumor vs infective encephalitis vs othert [sic]," and that "Neurosurgery evaluation and possible need for biopsy by [Dr. B.]" He again noted that the biopsy and frozen section were consistent with low grade glioma. Respondent again documented the patient's refusal for insulin administration due to history of allergic reaction. His plan was to give IVF and bicarbonate and monitor labs and to stop Seroquel®.

44. On or about July 1, 2018, Patient C's serum glucose level was 436 and his potassium was 3.5. His serum bicarbonate was 17, and the anion gap was 16. Respondent again wrote that the patient had brain "tumor vs infective encephalitis vs othert [sic]," and "Neurosurgery evaluation and possible need for biopsy by [Dr. B.,]" and that there was a frozen section consistent with glioma. He also again wrote that Seroquel® was stopped, the patient not on

insulin due to a history of an allergic reaction and his plan was to wean off IVF and bicarbonate.

45. On or about July 2, 2018, Patient C's serum glucose level was 563 and his anion gap was 15. The patient's bicarbonate was 17, his sodium was 128 and his creatinine was 1.48. Respondent again documented that Patient C was not on insulin due to his history of an allergic reaction, and that IVF and bicarbonate would be weaned off. His assessment again included "brain tumor vs infective encephalitis vs othert [sic]," and "Neurosurgery evaluation and possible need for biopsy by [Dr. B.]." The patient's family reported recurrent seizures and an EEG negative for acute seizures was explained to family.

46. On or about July 3, 2018, a nursing note at 09:45, documented "inform [Respondent]" about Patient C's critically high glucose level of 578. The plan was to give NS. Endocrinology saw Patient C and Patient C was transferred to ICU for an insulin drip after discussion with endocrinology. Respondent's progress note for that same day at 10:04 indicated that Patient C's serum glucose was 578, his bicarbonate was 19 and his anion gap was 15. Again, Respondent's assessment included "brain tumor vs infective encephalitis vs othert [sic],"and "Neurosurgery evaluation and possible need for biopsy by [Dr. B.]". He again wrote that the family reported recurrent seizure activity and that he explained to Patient C and family that the EEG was negative for acute seizures. He again documented that Patient C refused insulin. Endocrinology and allergy consults were also documented. Respondent again documented that Seroquel®, IVF and bicarbonate were stopped. He acknowledged that Patient C was to be transferred to ICU. On that same day, an allergist consulted for insulin desensitization in the ICU.

47. On or about July 4, 2018, the intensivist documented that the patient was off the insulin drip.

48. On or about July 5, 2018, Respondent saw Patient C. His potassium was noted to be at 3.4. Respondent's assessment included brain glioma and poorly controlled diabetes/borderline DKA. His plan was to continue anti-epileptic drugs (AED) per neurology. Seroquel® was stopped. Levemir (a long-acting insulin) and goals per endocrinology were charted as well.

49. On or about June 25, 2018 and thereafter, Respondent committed gross negligence by failing to maintain adequate and accurate records in connection with this care and treatment of

Patient C. For example, he documented that Patient C's family reported recurrent seizures to Respondent and he explained that the EEG was negative for seizures, however, he failed to document any explanation about any relevant symptoms of Patient C. He also failed to perform and/or document an adequate informed consent with Patient C regarding any risk, benefit and alternatives relating to Patient C's refusal of insulin treatment. Portions of Respondent's notes appeared to have been copied and pasted on occasions exhibited by typographical errors and abnormal findings in the records that were often not addressed in the assessment and plan, such as hyponatremia and leukocytosis. Conflicting information often co-existed in the same notes. For example, in a chart note dated July 3, 2018, Respondent wrote, "Neurosurgery evaluation and possible need for biopsy by [Dr. B]," and "right frontal craniotomy open brain biopsy with fluorescein guidance and frozen section consistent with low grade glioma." These issues may potentially cause errors in patient care after shift change.

50. On or about June 25, 2018 and thereafter, Respondent committed gross negligence by failing to adequately treat Respondent's diabetic ketoacidosis.

a) Respondent committed gross negligence when he administered bicarbonate therapy to Patient C while Patient C was refusing arterial blood gases. This controversial treatment is potentially harmful. If the pH changes rapidly, electrolyte derangement can occur, such as hypokalemia or hypocalcemia, causing potential risks of cardiac arrhythmia and seizures. Despite the danger, Respondent failed to adequately monitor Patient C while undergoing this controversial treatment. Respondent should have advised Patient C to undergo insulin therapy and fluid replacement, starting with isotonic saline followed by adequate monitoring with laboratory findings and treatment.

b) Respondent committed gross negligence in connection with his care for Patient C and Patient C's refusal of insulin treatment. Respondent failed to adequately discuss and/or document, Patient C's diagnosis and the benefits, risks and alternatives to insulin administration for Patient C's DKA. Respondent failed to adequately engage Patient C in the informed consent process, including by failing to

engage Patient C in an adequate discussion of the diagnosis as well as the risks, benefits and alternative treatment options. In particular, the risks of not using insulin for DKA, including coma or death, should have been adequately discussed and documented. Additionally, Respondent failed to adequately assess and/or document Patient C's capacity to make medical decisions. Further, if the patient had a diminished capacity to make medical decisions, Respondent should have sought a surrogate decision maker for Patient C. Despite documenting on multiple days that endocrinology would be consulted if hyperglycemia was persistent, Respondent never referred Patient C for an endocrinology consult. Instead, the neurosurgeon consulted endocrinology to educate and convince Patient C to start the insulin drip.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

51. Respondent is subject to disciplinary action under Code section 2234, subdivision (c) of the Code, in that Respondent committed repeated negligent acts in connection with his provision of medical services to Patients A, B and C. The circumstances are as follows:

52. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth, and represent repeated negligent acts.

Patient C

53. In addition, on or about June 25, 2018 and thereafter, Respondent was negligent when he failed to adequately perform and/or document, an appropriate preoperative consultation for Patient C. Respondent documented that Patient C was medically stable to undergo a brain biopsy. However, his medical records failed to include an adequate preoperative evaluation, including any assessment of the Patient C's exercise capacity. There was an EKG which appeared to be normal, but Patient C had poorly controlled diabetes (which is associated with increased mortality from coronary artery disease). Patients should be evaluated for preoperative cardiac and pulmonary risk. There are several risk models estimating the cardiac risks based on information from the history, physical examination, electrocardiogram, and type of surgery. All patients

should also be asked about their exercise capacity as part of the preoperative evaluation as exercise capacity is an important determinant of overall perioperative risk.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

54. Respondent is subject to disciplinary action under Code section 2266, of the Code, in that he failed to maintain adequate and accurate records relating to the provision of medical services to Patients A, B and C. The circumstances are as follows:

55. The allegations of the First, Second and Third Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth and represent Respondent's failure to maintain adequate and/or accurate medical records. Respondent's medical records for these patients often lacked the pertinent positives and negatives for the applicable conditions and portions of the chart notes appeared to have been copied and pasted into the record of a patient from other portions of the patient's record. In addition, often a patient's abnormal findings were not adequately addressed in Respondent's chart notes, including his assessments and plans. His chart notes also contained conflicting information within the same note.

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 96421, issued to Niceto Lopez, M.D.;

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

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

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

DATED: MAR 10 2023

REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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