

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

In the Matter of the Accusation Against:

Jeff Jones, M.D.

Physician's and Surgeon's
Certificate No. **G 46282**

Respondent.

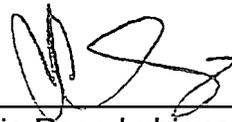
MBC File # **800-2019-055244**

**ORDER CORRECTING NUNC PRO TUNC
CLERICAL ERROR IN DECISION**

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error on page 4 of the Decision in the above-titled matter in the first paragraph under Condition 1 – CONTROLLED SUBSTANCES – PARTIAL RESTRICTION. This paragraph currently states: "Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substance Act, except for those drugs listed in Schedule(s) III and IV of the Act." The Board finds that Schedule V was left off by mistake and that such clerical error should be corrected.

IT IS HEREBY ORDERED that the first paragraph under Condition 1 - CONTROLLED SUBSTANCES – PARTIAL RESTRICTION is corrected to state: "Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substance Act, except for those drugs listed in Schedule(s) III, IV, and V of the Act."

Dated: January 26, 2024



Laurie Rose Lubiano, J.D.
Chair
Panel A

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

In the Matter of the Accusation
Against:

Jeff Jones, M.D.

Physician's and Surgeon's
Certificate No. G 46282

Case No.: 800-2019-055244

Respondent.

DECISION

The attached Stipulated Settlement 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 January 18, 2024.

IT IS SO ORDERED: December 19, 2023.

MEDICAL BOARD OF CALIFORNIA



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

1 ROB BONTA
Attorney General of California
2 STEVE DIEHL
Supervising Deputy Attorney General
3 MARIANNE A. PANSA
Deputy Attorney General
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7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 **JEFF JONES, M.D.**
14 **1524 McHenry Ave, Suite 445**
Modesto, CA 95350-4500
15
16 **Physician's and Surgeon's Certificate No.**
G 46282

17 Respondent.

Case No. 800-2019-055244

OAH No. 2022060004

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

18
19
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of
24 California (Board). He brought this action solely in his official capacity and is represented in this
25 matter by Rob Bonta, Attorney General of the State of California, by Marianne A. Pansa, Deputy
26 Attorney General.¹

27 _____
28 ¹ The Accusation was initially filed by the former Executive Director of the Medical
Board, William Prasifka.

1 CULPABILITY

2 9. Respondent admits that the charges and allegations in Accusation No. 800-2019-
3 055244, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and
4 Surgeon's Certificate No. G 46282.

5 10. For the purpose of resolving the Accusation without the expense and uncertainty of
6 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima
7 facie factual basis for the charges in the Accusation No. 800-2019-055244, a true copy of which
8 is attached hereto as Exhibit A, and that Respondent hereby gives up his right to contest those
9 charges.

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

13 CONTINGENCY

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

24 13. Respondent agrees that if he ever petitions for early termination or modification of
25 probation, or if an accusation and/or petition to revoke probation is filed against him before the
26 Board, all of the charges and allegations contained in Accusation No. 800-2019-055244 shall be
27 deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or
28 any other licensing proceeding involving Respondent in the State of California.

1 complete any other component of the course within one (1) year of enrollment. The prescribing
2 practices course shall be at Respondent's expense and shall be in addition to the Continuing
3 Medical Education (CME) requirements for renewal of licensure.

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

9 Respondent shall submit a certification of successful completion to the Board or its
10 designee not later than 15 calendar days after successfully completing the course, or not later than
11 15 calendar days after the effective date of the Decision, whichever is later.

12 3. EDUCATION COURSE. Within 60 calendar days of the effective date of this
13 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
14 for its prior approval educational program(s) or course(s) which shall not be less than 40 hours
15 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
16 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
17 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
18 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
19 completion of each course, the Board or its designee may administer an examination to test
20 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
21 hours of CME of which 40 hours were in satisfaction of this condition.

22 4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
23 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
24 advance by the Board or its designee. Respondent shall provide the approved course provider
25 with any information and documents that the approved course provider may deem pertinent.
26 Respondent shall participate in and successfully complete the classroom component of the course
27 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
28 complete any other component of the course within one (1) year of enrollment. The medical

1 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
2 Medical Education (CME) requirements for renewal of licensure.

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

8 Respondent shall submit a certification of successful completion to the Board or its
9 designee not later than 15 calendar days after successfully completing the course, or not later than
10 15 calendar days after the effective date of the Decision, whichever is later.

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

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

27 Within 60 calendar days of the effective date of this Decision, and continuing throughout
28 probation, Respondent's practice shall be monitored by the approved monitor. At the Board's

1 discretion, the Practice monitoring condition may be discontinued after twenty-four months of
2 monitoring from the effective date of this Disciplinary Order, provided no deficiencies are
3 discovered during the first twenty-four month period of practice monitoring; otherwise,
4 Respondent's practice will be monitored throughout the entire three year probationary term.
5 Respondent shall make all records available for immediate inspection and copying on the
6 premises by the monitor at all times during business hours and shall retain the records for the
7 entire term of probation.

8 If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective
9 date of this Decision, Respondent shall receive a notification from the Board or its designee to
10 cease the practice of medicine within three (3) calendar days after being so notified. Respondent
11 shall cease the practice of medicine until a monitor is approved to provide monitoring
12 responsibility.

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

19 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
20 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
21 name and qualifications of a replacement monitor who will be assuming that responsibility within
22 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
23 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
24 notification from the Board or its designee to cease the practice of medicine within three (3)
25 calendar days after being so notified. Respondent shall cease the practice of medicine until a
26 replacement monitor is approved and assumes monitoring responsibility.

27 6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
28 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the

1 Chief Executive Officer at every hospital where privileges or membership are extended to
2 Respondent, at any other facility where Respondent engages in the practice of medicine,
3 including all physician and locum tenens registries or other similar agencies, and to the Chief
4 Executive Officer at every insurance carrier which extends malpractice insurance coverage to
5 Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15
6 calendar days.

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

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

11 8. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby
12 ordered to reimburse the Board its costs of investigation and enforcement, including, but not
13 limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena
14 enforcement, as applicable, in the amount of \$27,311.00 (twenty-seven thousand three hundred
15 and eleven dollars and zero cents). Costs shall be payable to the Medical Board of California.
16 Failure to pay such costs shall be considered a violation of probation.

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

21 The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility
22 to repay investigation and enforcement costs.

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

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

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1 10. GENERAL PROBATION REQUIREMENTS.

2 Compliance with Probation Unit

3 Respondent shall comply with the Board's probation unit.

4 Address Changes

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

10 Place of Practice

11 Respondent shall not engage in the practice of medicine in Respondent's or patient's place
12 of residence, unless the patient resides in a skilled nursing facility or other similar licensed
13 facility. Respondent may perform telemedicine from his residence to respond to patient and staff
14 concerns, but Respondent shall not engage in any clinical practice from his residence or engage in
15 any clinical practice at a patient's place of residence.

16 License Renewal

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

19 Travel or Residence Outside California

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

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

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

1 12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
2 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
3 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
4 defined as any period of time Respondent is not practicing medicine as defined in Business and
5 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
6 patient care, clinical activity or teaching, or other activity as approved by the Board. If
7 Respondent resides in California and is considered to be in non-practice, Respondent shall
8 comply with all terms and conditions of probation. All time spent in an intensive training
9 program which has been approved by the Board or its designee shall not be considered non-
10 practice and does not relieve Respondent from complying with all the terms and conditions of
11 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
12 on probation with the medical licensing authority of that state or jurisdiction shall not be
13 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
14 period of non-practice.

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

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

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

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

27 13. COMPLETION OF PROBATION. Respondent shall comply with all financial
28 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the

1 completion of probation. This term does not include cost recovery, which is due within 30
2 calendar days of the effective date of the Order, or by a payment plan approved by the Medical
3 Board and timely satisfied. Upon successful completion of probation, Respondent's certificate
4 shall be fully restored.

5 14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
6 of probation is a violation of probation. If Respondent violates probation in any respect, the
7 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
8 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation,
9 or an Interim Suspension Order is filed against Respondent during probation, the Board shall have
10 continuing jurisdiction until the matter is final, and the period of probation shall be extended until
11 the matter is final.

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

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

27 17. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a
28 new license or certification, or petition for reinstatement of a license, by any other health care

1 licensing action agency in the State of California, all of the charges and allegations contained in
2 Accusation No. 800-2019-055244 shall be deemed to be true, correct, and admitted by
3 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
4 restrict license.

5 **ACCEPTANCE**

6 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
7 discussed it with my attorney, Robert W. Hodges, Esq. I understand the stipulation and the effect
8 it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement
9 and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
10 Decision and Order of the Medical Board of California.

11
12 DATED: 7-22-23 
13 JEFF JONES, M.D.
14 *Respondent*

15 I have read and fully discussed with Respondent Jeff Jones, M.D., the terms and conditions
16 and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve
17 its form and content.

18 DATED: 7-24-2023 
19 ROBERT W. HODGES, ESQ.
20 *Attorney for Respondent*

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ENDORSEMENT

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

DATED: July 24, 2023

Respectfully submitted,

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


MARIANNE A. PANSA
Deputy Attorney General
Attorneys for Complainant

1 ROB BONTA
Attorney General of California
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Supervising Deputy Attorney General
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7 *Attorneys for Complainant*

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10

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

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13

In the Matter of the Accusation Against:

Case No. 800-2019-055244

14

JEFF JONES, M.D.
1524 McHenry Ave., Suite 445
Modesto, CA 95350-4500

A C C U S A T I O N

15

16

Physician's and Surgeon's Certificate
No. G 46282,

17

Respondent.

18

19

20

PARTIES

21

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

24

2. On or about October 5, 1981, the Medical Board issued Physician's and Surgeon's
25 Certificate No. G 46282 to Jeff Jones, M.D. (Respondent). The Physician's and Surgeon's
26 Certificate was in full force and effect at all times relevant to the charges brought herein and will
27 expire on January 31, 2023, unless renewed.

28

///

JURISDICTION

1
2 3. This Accusation is brought before the Board, under the authority of the following
3 laws. All section references are to the Business and Professions Code (Code) unless otherwise
4 indicated.

5 4. Section 2227 of the Code states, in pertinent part:

6 (a) A licensee whose matter has been heard by an administrative law judge of
7 the Medical Quality Hearing Panel as designated in Section 11371 of the Government
8 Code, or whose default has been entered, and who is found guilty, or who has entered
9 into a stipulation for disciplinary action with the board, may, in accordance with the
10 provisions of this chapter:

11 (1) Have his or her license revoked upon order of the board.

12 (2) Have his or her right to practice suspended for a period not to exceed one
13 year upon order of the board.

14 (3) Be placed on probation and be required to pay the costs of probation
15 monitoring upon order of the board.

16 (4) Be publicly reprimanded by the board. The public reprimand may include a
17 requirement that the licensee complete relevant educational courses approved by the
18 board.

19 (5) Have any other action taken in relation to discipline as part of an order of
20 probation, as the board or an administrative law judge may deem proper.

21 ...

22 5. Section 2234 of the Code, states, in pertinent part:

23 The board shall take action against any licensee who is charged with
24 unprofessional conduct. In addition to other provisions of this article, unprofessional
25 conduct includes, but is not limited to, the following:

26 ...

27 (c) Repeated negligent acts. To be repeated, there must be two or more
28 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.

 ...

29 6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain
30 adequate and accurate records relating to the provision of services to their patients constitutes
31 unprofessional conduct.

1 7. Section 741 of the Code¹ states, in pertinent part:

2 (a) Notwithstanding any other law, when prescribing an opioid or
3 benzodiazepine medication to a patient, a prescriber shall do the following:

4 (1) Offer the patient a prescription for naloxone hydrochloride or another drug
5 approved by the United States Food and Drug Administration for the complete or
6 partial reversal of opioid-induced respiratory depression when one or more of the
7 following conditions are present:

8 (A) The prescription dosage for the patient is 90 or more morphine milligram
9 equivalents of an opioid medication per day.

10 (B) An opioid medication is prescribed within a year from the date a
11 prescription for benzodiazepine has been dispensed to the patient. n

12 (C) The patient presents with an increased risk for overdose, including a patient
13 with a history of overdose, a patient with a history of opioid use disorder, or a patient
14 at risk for returning to a high dose of opioid medication to which the patient is no
15 longer tolerant.

16 ...

17 COST RECOVERY

18 8. Section 125.3 of the Code states:

19 (a) Except as otherwise provided by law, in any order issued in resolution of a
20 disciplinary proceeding before any board within the department or before the
21 Osteopathic Medical Board upon request of the entity bringing the proceeding, the
22 administrative law judge may direct a licensee found to have committed a violation or
23 violations of the licensing act to pay a sum not to exceed the reasonable costs of the
24 investigation and enforcement of the case.

25 (b) In the case of a disciplined licentiate that is a corporation or a partnership,
26 the order may be made against the licensed corporate entity or licensed partnership. n

27 (c) A certified copy of the actual costs, or a good faith estimate of costs where
28 actual costs are not available, signed by the entity bringing the proceeding or its
designated representative shall be prima facie evidence of reasonable costs of
investigation and prosecution of the case. The costs shall include the amount of
investigative and enforcement costs up to the date of the hearing, including, but not
limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount
of reasonable costs of investigation and prosecution of the case when requested
pursuant to subdivision (a). The finding of the administrative law judge with regard
to costs shall not be reviewable by the board to increase the cost award. The board
may reduce or eliminate the cost award, or remand to the administrative law judge if
the proposed decision fails to make a finding on costs requested pursuant to
subdivision (a).

¹ This section became effective January 1, 2019.

1 (e) If an order for recovery of costs is made and timely payment is not made as
2 directed in the board's decision, the board may enforce the order for repayment in any
3 appropriate court. This right of enforcement shall be in addition to any other rights
4 the board may have as to any licensee to pay costs.

5 (f) In any action for recovery of costs, proof of the board's decision shall be
6 conclusive proof of the validity of the order of payment and the terms for payment.

7 (g)(1) Except as provided in paragraph (2), the board shall not renew or
8 reinstate the license of any licensee who has failed to pay all of the costs ordered
9 under this section.

10 (2) Notwithstanding paragraph (1), the board may, in its discretion,
11 conditionally renew or reinstate for a maximum of one year the license of any
12 licensee who demonstrates financial hardship and who enters into a formal agreement
13 with the board to reimburse the board within that one-year period for the unpaid
14 costs.

15 (h) All costs recovered under this section shall be considered a reimbursement
16 for costs incurred and shall be deposited in the fund of the board recovering the costs
17 to be available upon appropriation by the Legislature.

18 (i) Nothing in this section shall preclude a board from including the recovery of
19 the costs of investigation and enforcement of a case in any stipulated settlement.

20 (j) This section does not apply to any board if a specific statutory provision in
21 that board's licensing act provides for recovery of costs in an administrative
22 disciplinary proceeding.

23 FIRST CAUSE FOR DISCIPLINE

24 (Repeated Negligent Acts)

25 9. Respondent has subjected his Physician's and Surgeon's Certificate No. G 46282 to
26 disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of
27 the Code, in that he committed repeated negligent acts in his care and treatment of Patients A-F,²
28 as more particularly alleged hereinafter:

29 PATIENT A

30 10. In or around 2006,³ Respondent began providing pain management treatment to
31 Patient A, a then fifty-five-year-old male diagnosed with failed back surgery syndrome, right

32 _____
33 ² To protect the privacy of the patients involved, the patients' names have not been
34 included in this pleading. Respondent is aware of the identity of the patients referred to herein.

35 ³ Conduct occurring more than seven (7) years from the filing date of this Accusation is
36 for informational purposes only and is not alleged as a basis for disciplinary action.

1 lumbar facet pain, and right piriformis syndrome.⁴ When Patient A was initially referred to
2 Respondent, he was already being prescribed a high dose of opioids for pain.

3 11. On or about May 14, 2012, Patient A was seen by Respondent. The chart notes for
4 that visit identify that Patient A was approved to receive Suboxone.⁵

5 12. Between in or around January 2014 and in or around March 2017, Respondent
6 provided treatment to Patient A that included regular prescriptions of diazepam,⁶ carisoprodol,⁷
7 and Suboxone. Patient A's certified complete record contains no records for that time period.⁸

8 13. Between on or about April 6, 2017, and on or about August 9, 2018, Respondent
9 provided treatment to Patient A that included regular prescriptions of Suboxone, diazepam, and
10 Soma.

11 14. On or about September 6, 2018, Patient A was seen by Respondent. At that visit,
12 Patient A informed Respondent that he was scheduled to be evaluated for a hip replacement and a
13 subsequent knee replacement, and wanted to switch his buprenorphine to oxycodone for surgery
14 purposes. Respondent advised Patient A that he needed to stop taking Suboxone prior to surgery,
15

16 ⁴ Piriformis syndrome is a condition in which the piriformis muscle, located in the buttock
17 region, spasms and causes buttock pain. The piriformis muscle can also irritate the nearby sciatic
nerve and cause pain, numbness and tingling along the back of the leg and into the foot.

18 ⁵ Suboxone (brand name for buprenorphine and naloxone), is a Schedule III controlled
19 substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous
20 drug pursuant to Business and Professions Code section 4022. Buprenorphine is in a class of
21 medications called opioid partial agonist-antagonists, and naloxone is in a class of medications
called opioid antagonists. Buprenorphine alone and the combination of buprenorphine and
22 naloxone prevent withdrawal symptoms when someone stops taking opioid drugs by producing
23 similar effects to these drugs.

24 ⁶ Diazepam (brand name Valium), is a Schedule IV controlled substance pursuant to
25 Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to
26 Business and Professions Code section 4022. It is a benzodiazepine medication used to treat
27 anxiety and muscle spasms.

28 ⁷ Carisoprodol (brand name Soma), is a Schedule IV controlled substance as of January
11, 2012, pursuant to Health and Safety Code section 11057, and a dangerous drug pursuant to
Business and Professions Code section 4022. It is a muscle relaxant medication used to treat
pain.

⁸ During his subject interview on or about September 25, 2020, Respondent indicated that
he believed Patient A's paper chart was lost during a transition to an electronic medical record.

1 and he would need to taper off Suboxone if taking opiates. At the conclusion of that visit,
2 Respondent prescribed Patient A oxycodone,⁹ diazepam, and Soma.

3 15. Between on or about September 6, 2018 on or about March 11, 2019, Respondent
4 maintained Patient A on monthly prescriptions of oxycodone, diazepam and Soma. Throughout
5 that time, Respondent did not prescribe Patient A naloxone, and did not discuss and/or document
6 a discussion with the patient regarding prescribing naloxone.

7 16. On or about March 12, 2019, Patient A was seen by Respondent. At that visit,
8 Respondent discontinued Patient A's oxycodone prescription, but prescribed him Soma, and
9 resumed his prescription for Suboxone.

10 17. On or about April 9, 2019, Patient A was seen by a mid-level practitioner under
11 Respondent's supervision pursuant to standardized procedures and protocols. At that visit, the
12 mid-level practitioner discontinued Patient A's diazepam prescription, but maintained his
13 prescription for Suboxone.

14 18. Between on or about June 18, 2019, and on or about January 21, 2020, Patient A was
15 seen by Respondent for approximately five (5) clinical visits. On each of those visits, Patient A's
16 documented history of present illness and physical examination contains the exact same wording.
17 Although the patient's diazepam prescription was discontinued on April 9, 2019, and not
18 renewed, the chart notes throughout that time contains conflicting statements, "no longer taking
19 diazepam," and "reports taking diazepam 5 mg during daytime."

20 19. On or about March 19, 2020, and on or about May 18, 2020, Patient A was seen by
21 Respondent for telephonic visits. On those dates, the patient's chart notes contain a physical
22 examination even though one was not performed. Although the patient's diazepam prescription
23 was discontinued on April 9, 2019, and not renewed, the chart notes for both dates contain
24 conflicting statements, "no longer taking diazepam," and "reports taking diazepam 5 mg during
25 daytime."

26
27 ⁹ Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code
28 section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code
section 4022. It is an opioid medication used to treat pain.

1 20. Respondent committed negligence in his care and treatment of Patient A, which
2 included, but was not limited to, the following:

3 A. Prescribing an opioid and a benzodiazepine without prescribing naloxone and
4 without discussing and/or documenting a discussion with the patient regarding
5 prescribing naloxone; and

6 B. Failing to maintain adequate and accurate records.

7 **PATIENT B**

8 21. On or about October 18, 2011, Respondent began providing pain management
9 treatment to Patient B, a then forty-five-year-old male diagnosed with muscular sclerosis and
10 related symptoms that included pain, neuropathy, weakness, and fatigue. When Patient B was
11 initially referred to Respondent, he was already being prescribed opioid medication.

12 22. Between in or around October 2011, and in or around November 2014, Respondent
13 provided treatment to Patient B that included regular prescriptions of methadone,¹⁰ alprazolam,¹¹
14 and Norco.¹²

15 23. On or about December 6, 2014, Patient B was seen by Respondent. At that visit,
16 Patient B reported concerns with attempting to reduce his medications since he was running short
17 of methadone trying to manage his pain.

18 24. On or about May 28, 2015, Patient B was seen by Respondent. At that visit, Patient
19 B expressed concerns regarding his opioid dependence. Respondent noted that, "at this point it
20 does appear that all we are doing is treating his tolerance rather than his pain." At that time,

21 _____
22 ¹⁰ Methadone is a Schedule II controlled substance pursuant to Health and Safety Code
23 section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code
section 4022. It is in a class of medications called opioid partial agonist, that is used to treat pain
and narcotic addiction.

24 ¹¹ Alprazolam (brand name Xanax), is a Schedule IV controlled substance pursuant to
25 Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to
26 Business and Professions Code section 4022. It is a benzodiazepine medication used to treat
anxiety.

27 ¹² Norco (brand name for hydrocodone-acetaminophen combination), is a Schedule III
28 controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a
dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid
medication used to treat pain.

1 Respondent believed the patient had an opioid use disorder, but did not document that diagnosis
2 in the patient's chart at any time. Respondent identified his plan at that time was to switch the
3 patient from conventional opiates to buprenorphine.

4 25. On or about November 10, 2015, Patient B signed an "Opioid Treatment Contract."
5 This document identified that Patient B was a participant in buprenorphine treatment for opioid
6 misuse and dependence, that he understood that mixing buprenorphine with other medications,
7 especially benzodiazepines, can be dangerous, and that he agreed to abstain from alcohol, opioids,
8 marijuana, cocaine, and other addictive substances.

9 26. Between in or around February 2016, and in or around April 2019, Respondent
10 provided treatment to Patient B that included regular prescriptions of buprenorphine-
11 hydrochloride,¹³ diazepam, and tramadol.¹⁴ Throughout that time, Respondent did not prescribe
12 the patient naloxone, and did not discuss and/or document a discussion with the patient regarding
13 prescribing naloxone. sis

14 27. On or about September 23, 2016, Patient B's chart indicates that his urine drug screen
15 tested positive for cocaine, but that he adamantly denied any use of illegal substances. A copy of
16 the urine screen results was not contained in Patient B's certified medical records.

17 28. On or about April 23, 2019, Patient B met with Respondent. At that visit, Patient B
18 asked to be switched from Valium to Xanax.

19 29. Between in or around May 2019, and in or around May 2020, Respondent provided
20 treatment to Patient B that included regular prescriptions of buprenorphine, alprazolam, and
21 tramadol. Throughout that time, Respondent did not prescribe Patient B naloxone, and did not
22 discuss and/or document a discussion with the patient regarding prescribing naloxone.

23
24 ¹³ Buprenorphine-hydrochloride (brand name Subutex), is a Schedule III controlled
25 substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous
26 drug pursuant to Business and Professions Code section 4022. It is an opioid partial agonist
medication that is used to treat pain and narcotic addiction. sis

27 ¹⁴ Tramadol (brand name Ultram), is a Schedule IV controlled substance pursuant to
28 Health and Safety Code section 11057, subdivision (c), and a dangerous drug pursuant to
Business and Professions Code section 4022. It is a synthetic opioid medication used to treat
pain.

1 30. Between on or about December 14, 2017, and on or about May 26, 2020, Patient B
2 was seen for approximately seventeen (17) clinical visits by either Respondent or a mid-level
3 practitioner under Respondent's supervision pursuant to standardized procedures and protocols.
4 Throughout that time, the patient's physical examinations documented on each visit contain the
5 exact same wording.

6 31. On or about April 29, 2020, and on or about May 26, 2020, Patient B was seen by
7 Respondent for telephonic visits. On those dates, the patient's documented history of present
8 illness contains the exact same wording, and a physical examination is documented for each visit
9 even though a physical examination was not performed. Although the patient had not been
10 prescribed Valium since approximately April 2019, the patient's chart on both of those dates
11 indicated, "He takes Valium for anxiety. He is excessively sleeping with that, and asked us to
12 switch to Xanax..."

13 32. Respondent committed negligence in his care and treatment of Patient B, which
14 included, but was not limited to, the following:

- 15 A. Prescribing an opioid and a benzodiazepine without prescribing naloxone, and
16 without discussing and/or documenting a discussion with the patient regarding
17 prescribing naloxone;
18 B. Prescribing buprenorphine to the patient on November 10, 2015, for substance
19 abuse but failing to document that diagnosis at any time; and
20 C. Failing to maintain adequate and accurate records. isit

21 **PATIENT C**

22 33. In or around 2011, Respondent began providing pain management treatment to
23 Patient C, a then forty-nine-year-old male diagnosed with a work-related injury that had been
24 treated with an intrathecal pump.

25 34. Between in or around October 2012, and in or around July 2020, Respondent
26 provided treatment to Patient C that included regular maintenance of an intrathecal pump
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28

1 containing morphine,¹⁵ and regular oral prescriptions of Norco, oxycodone, carisoprodol, and
2 clonazepam.¹⁶ Throughout that time, Respondent did not prescribe the patient naloxone, and did
3 not discuss and/or document a discussion with the patient regarding prescribing naloxone.

4 35. On or about April 2, 2013, Patient C was seen by Respondent. At that visit,
5 Respondent noted the patient's issues were primarily related to his opiates. Respondent informed
6 the patient that his treatment plan included absolutely no early refills of medications. At that time
7 and thereafter, Respondent recognized Patient C had an opiate use disorder, but did not diagnose
8 him with an opiate abuse disorder or refer him for treatment at any time.

9 36. On or about July 2, 2013, Patient C was seen by Respondent. At that visit, Patient C
10 admitted running out of his medication in only 18 days. At the conclusion of the visit,
11 Respondent provided Patient C with an additional 14 days' worth of oxycodone.

12 37. On or about September 30, 2015, Patient C called Respondent's office after the
13 pharmacist refused to fill his Norco prescription written by another physician. Patient C had
14 recently undergone shoulder surgery and ran out of his medications because he had been "taking"
15 whatever he needs." Staff from Respondent's office contacted the pharmacist and were told the
16 pharmacist was not comfortable releasing more medications, particularly since the patient was
17 receiving Adderall¹⁷ from another physician.

18 38. On or about December 5, 2015, Patient C was seen by Respondent. At that visit,
19 Respondent informed Patient C that he was concerned about his doses of oral opioids particularly
20 since he has an intrathecal pump.

21 _____
22 ¹⁵ Morphine is a Schedule II controlled substance pursuant to Health and Safety Code
23 section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code
section 4022. It is an opioid medication used to treat pain.

24 ¹⁶ Clonazepam (brand name Klonopin) is a Schedule IV controlled substance pursuant to
25 Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to
26 Business and Professions Code section 4022. It is a benzodiazepine medication used to treat
27 anxiety.

28 ¹⁷ Adderall (brand name for dextroamphetamine and amphetamine) is a Schedule II
controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a
dangerous drug pursuant to Business and Professions Code section 4022. It is an amphetamine
salts medication used for attention-deficit hyperactivity disorder and narcolepsy.

1 39. On or about July 27, 2016, Patient C was seen by Respondent. At that visit, the
2 patient informed Respondent that he would be gone for three months. At the conclusion of the
3 visit, Respondent wrote Patient C three months of triplicate prescriptions for his medications.

4 40. Between on or about July 27, 2016, and on or about March 3, 2020, Patient C was
5 seen by Respondent for clinical visits approximately every three months.¹⁸

6 41. On or about July 12, 2017, Patient C's urine drug screen tested negative for
7 carisoprodol. At the patient's following visit with Respondent on or about October 5, 2017,
8 Respondent did not discuss and/or document a discussion with the patient regarding the prior
9 urine screen result.

10 42. Between in or around January 2019, and in or around August 2019, in addition to
11 maintaining Patient C on an intrathecal pump, Respondent prescribed Patient C oral medications
12 that included a combination of benzodiazepines and 90 or more morphine milligram equivalents
13 of opioid medications per day.

14 43. On or about September 5, 2019, Patient C's urine drug screen was negative for all
15 prescribed medications. At the patient's following visit with Respondent on or about December
16 3, 2019, Respondent did not discuss and/or document a discussion with the patient regarding the
17 prior urine screen result.

18 44. On or about December 3, 2019, Patient C's urine drug screen was positive for
19 amphetamine and negative for all prescribed medications. At the patient's following visit with
20 Respondent on or about March 3, 2020, Respondent did not discuss and/or document a discussion
21 with the patient regarding the prior urine screen result.

22 45. On or about March 3, 2020, Patient C's urine drug screen was positive for
23 amphetamine, and negative for hydrocodone, clonazepam, morphine and carisoprodol. At the
24 patient's following clinical visit with Respondent on or about April 14, 2020, Respondent did not
25 discuss and/or document a discussion with the patient regarding the prior urine screen result.

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28 ¹⁸ At his subject interview on or about September 25, 2020 Respondent claimed the
patient's worker's compensation adjuster wanted the patient to be seen every three months. This
fact is not documented anywhere in the patient's chart.

1 46. Between on or about September 20, 2018, and on or about March 3, 2020, Patient C
2 was seen by Respondent and a mid-level practitioner under Respondent's supervision pursuant to
3 standardized procedures and protocols on approximately eight (8) clinical visits. Throughout that
4 time, Patient C's documented history of present illness for each visit contains the exact same
5 wording.

6 47. On or about April 14, 2020, on or about June 23, 2020, and on or about July 1, 2020,
7 Patient C was seen by Respondent for telephonic visits. On those dates, the patient's chart notes
8 contain a physical examination even though one was not performed.

9 48. Respondent committed negligence in his care and treatment of Patient C, which
10 included, but was not limited to, the following:

- 11 A. Prescribing 90 or more morphine milligram equivalents of an opioid per day
12 and/or an opioid and a benzodiazepine without prescribing naloxone, and without
13 discussing and/or documenting a discussion with the patient regarding prescribing
14 naloxone;
15 B. Seeing the patient every three months despite concerns of misuse, abuse, and
16 diversion;
17 C. Failing to diagnose the patient with an opiate abuse disorder, and failing to
18 adequately address behaviors concerning for abuse, misuse, and diversion; and
19 D. Failing to maintain adequate and accurate records.

20 **PATIENT D**

21 49. On or about August 9, 2017, Respondent began providing pain management
22 treatment to Patient D, a then thirty-two-year-old female diagnosed with hip pain from congenital
23 hip dysplasia, Crohn's disease, and depression. At that initial visit, Respondent did not discuss
24 and/or document a discussion with the patient regarding any mental health history or history of
25 illicit drug use. Respondent did not review and/or document review of CURES,¹⁹ and did not

26 _____
27 ¹⁹ CURES is the Controlled Substances Utilization Review and Evaluation System
28 (CURES), a database maintained by the Department of Justice of Schedule II, III and IV
controlled substance prescriptions dispensed in California serving the public health, regulatory
oversight agencies, and law enforcement.

1 document the patient's risk for misuse or abuse of medications. Although Respondent was
2 uncomfortable providing treatment to Patient D because she was a licensed health care
3 professional and the girlfriend of his business partner, at the conclusion of this visit, Respondent
4 prescribed Patient D oxycodone for pain.

5 50. On or about August 25, 2017, Patient D was seen by Respondent. At that visit,
6 Respondent added buprenorphine to the patient's treatment regimen.

7 51. On or about April 17, 2018, Patient D was seen by Respondent. At that visit, Patient
8 D informed Respondent that the buprenorphine was making her tired. At the conclusion of the
9 visit, Respondent discontinued the patient's buprenorphine and prescribed her morphine for pain.

10 52. Between on or about April 17, 2018, and on or about June 16, 2020, Respondent
11 provided treatment to Patient D that included regular prescriptions of morphine and oxycodone.

12 53. On or about October 11, 2018, Patient D was seen by Respondent. At that visit,
13 Patient D informed Respondent that she had recently been in a bicycle accident resulting in
14 broken ribs and a sacral fracture. Due to her increased pain, Respondent increased Patient D's
15 oxycodone prescription from three (3) to eight (8) tablets per day. Despite her significant painful
16 injuries, Patient D's documented physical examination that day revealed normal findings.

17 54. On or about October 23, 2018, Patient D was seen by Respondent. At that visit,
18 Respondent informed Patient D that he was not comfortable prescribing opiates to a health care
19 professional. His plan at that time was to dismiss Patient D but to continue to prescribe her pain^{ful}
20 medications for three months until she could find a health care provider to take over her pain^{ful}
21 medications.

22 55. Between in or around January 2019, and in or around June 2020, Respondent
23 prescribed Patient D medications that included 90 or more morphine milligram equivalents of
24 opioid medications per day. Throughout that time, Respondent did not prescribe Patient D
25 naloxone, and did not discuss and/or document a discussion with the patient regarding prescribing
26 naloxone.

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1 56. Between on or about October 22, 2019, and on or about January 7, 2020, Patient D¹¹
2 was seen by Respondent for approximately four (4) clinical visits. On each of those visits, Patient
3 D's documented history of present illness contains the exact same wording.

4 57. Between on or about March 31, 2020, and on or about June 16, 2020, Patient D was
5 seen by Respondent for four (4) telephonic visits. On those dates, the patient's documented
6 history of present illness contains the exact same wording, and a physical examination is
7 documented for each visit even though a physical examination was not performed.

8 58. Respondent committed negligence in his care and treatment of Patient D, which
9 included, but was not limited to, the following:

- 10 A. Prescribing controlled substances without first completing an appropriate and
- 11 detailed evaluation;
- 12 B. Prescribing 90 or more morphine milligram equivalents of an opioid per day ⁴¹
- 13 without prescribing naloxone, and without discussing and/or documenting a ¹
- 14 discussion with the patient regarding prescribing naloxone; and ^{patient}
- 15 C. Failing to maintain adequate and accurate records.

16 **PATIENT E**

17 59. In or around 2010, Respondent began providing pain management treatment to
18 Patient E, a then eighty-year-old female complaining of neck, sciatica, shoulder, and lower back
19 pain.

20 60. Between on or about April 8, 2010, and on or about December 5, 2013, Respondent
21 provided care and treatment to Patient E that included prescriptions for controlled substances.
22 The patient's chart throughout that time contains handwritten notes that are difficult to read.

23 61. Between in or around January 2014 and in or around April 2017, Respondent
24 provided care and treatment to Patient E that included prescriptions for opioids. Patient E's
25 certified complete record contains no records for that time period.

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1 62. On or about May 17, 2017, Patient E was seen by Respondent with complaints of
2 knee and back pain. At the conclusion of that visit, Respondent prescribed Patient E fentanyl²⁰
3 and oxycodone.

4 63. Between on or about May 17, 2017, and on or about June 10, 2020, Respondent
5 provide care and treatment for Patient E that included regular prescriptions of fentanyl and
6 oxycodone.

7 64. On or about February 6, 2018, Patient E's urine drug screen tested positive for
8 medications that were not being prescribed by Respondent, including morphine, codeine, and
9 benzodiazepines.

10 65. On or about April 4, 2018, Patient E's urine drug screen tested positive for
11 medications that were not being prescribed by Respondent, including morphine, codeine, and
12 benzodiazepines. At the patient's following clinical visit with Respondent on or about May 1,
13 2018, the patient informed Respondent that she takes Valium as needed, but Respondent
14 otherwise did not discuss and/or document a discussion with the patient regarding her two prior
15 inconsistent urine screen results.

16 66. On or about June 12, 2018, Patient E was seen by Respondent. At that visit,
17 Respondent knew he was prescribing Patient E approximately 345 morphine milligram
18 equivalents of an opioid per day, but determined that he would not increase or decrease her
19 medications unless for good reason.

20 67. On or about September 10, 2018, Patient E's urine screen tested positive for alcohol.
21 At the patient's following visit on or about October 8, 2018 with a mid-level practitioner under
22 Respondent's supervision pursuant to standardized procedures and protocols, the practitioner did
23 not discuss and/or a document a discussion with the patient regarding the prior urine screen result.

24 68. On or about November 12, 2018, Patient E's urine screen tested negative for fentanyl.
25 At Patient E's following visit on or about December 10, 2018 with a mid-level practitioner under
26

27 ²⁰ Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code
28 section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code
section 4022. It is an opioid medication used to treat pain.

1 Respondent's supervision pursuant to standardized procedures and protocols, the practitioner did
2 not discuss and/or document a discussion with the patient regarding the prior urine screen result.

3 69. Between on or about July 29, 2019, and on or about March 16, 2020, Patient E was
4 seen by Respondent and multiple mid-level practitioners under Respondent's supervision
5 pursuant to standardized procedures and protocols, on approximately eight (8) clinical visits. On
6 each of those visits, the patient's physical examination contains the exact same wording.

7 70. Between on or about December 18, 2019, and on or about June 10, 2020, Patient E
8 was seen by a mid-level practitioner under Respondent's supervision pursuant to standardized
9 procedures and protocols, on approximately seven (7) clinical visits. Throughout that time, the
10 patient's documented history of present illness contains the exact same wording, including the
11 statements, "Pt had a fall 6 weeks ago on her front porch and was in the ER for 6 hours with 9
12 stitches. Healing up well with some scab remaining on her forehead. Pt had her steroid injections
13 on both knee today on 12/18/19."

14 71. Respondent committed negligence in his care and treatment of Patient E, which
15 included, but was not limited to, the following:

- 16 A. Failing to adequately address inconsistent urine screens; and
17 B. Failing to maintain adequate and accurate records.

18 **PATIENT F**

19 72. On or about August 10, 2010, Respondent began providing treatment to Patient F, a
20 then forty-seven-year-old male diagnosed with testicular pain and left ankle pain related to the
21 rupture of his peroneus brevis tendon. Respondent had concerns with prescribing chronic opioids
22 to a young person, but refilled his prescriptions.

23 73. On or about March 3, 2011, Patient F was seen by Respondent. At that visit, Patient
24 F expressed a desire to stop opiates. At the conclusion of the visit, Respondent prescribed Patient
25 F Subutex for his opiate use disorder and for pain.

26 74. Between in or around March 2011, and in or around July 2020, Respondent provided
27 treatment to Patient F that included regular prescriptions of buprenorphine, oxycodone, and
28 carisoprodol.

1 75. On or about July 2, 2015, Patient F's urine drug screen was positive for
2 buprenorphine, and negative for other prescribed medications. At the patient's following visit
3 with Respondent on or about July 8, 2015, Respondent did not discuss and/or document a
4 discussion with the patient regarding the prior urine screen result.

5 76. Between on or about November 18, 2016, and on or about March 19, 2018,
6 Respondent maintained Patient F on regular prescriptions of buprenorphine, oxycodone, and
7 carisoprodol. Throughout that time, Respondent saw Patient F approximately four (4) times for
8 epidural steroid injections but did not perform and/or document his performance of a physical
9 examination or assessment and evaluation of the patient regarding his controlled medications.

10 77. Between on or about March 20, 2018, through on or about July 14, 2020, Patient F
11 was seen by Respondent on approximately ten (10) clinical visits. On each of those visits, Patient
12 F's physical examination contains the exact same wording.

13 78. On or about March 20, 2018, Patient F's urine drug screen was negative for
14 oxycodone and carisoprodol. At Patient F's following visit with Respondent on or about April
15 24, 2018, Respondent did not discuss and/or document a discussion with the patient regarding the
16 prior urine screen result.

17 79. Between on or about December 17, 2018, and on or about July 14, 2020, Respondent
18 prescribed Patient F approximately 8 mg of buprenorphine per day, and 90 or more morphine
19 milligram equivalents of opioid medications per day. Throughout that time, Respondent did not
20 prescribe Patient F naloxone, and did not discuss and/or document a discussion with the patient
21 regarding prescribing naloxone.

22 80. On or about May 19, 2020, on or about June 16, 2020, and on or about July 14, 2020,
23 Patient F was seen by Respondent for telephonic visits. On those dates, the patient's history of
24 present illness contains the same wording, and the patient's chart notes contain physical
25 examinations even though one was not performed.

26 81. Respondent committed negligence in his care and treatment of Patient F which
27 included, but was not limited to, the following:

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- 1 A. Prescribing 90 or more morphine milligram equivalents of an opioid per day
- 2 without prescribing naloxone and without discussing and/or documenting a
- 3 discussion with the patient regarding prescribing naloxone;
- 4 B. Failing to assess the patient between on or about November 18, 2016, and on or
- 5 about March 19, 2018, while regularly prescribing controlled substances;
- 6 C. Failing to adequately address inconsistent urine screens; and
- 7 D. Failing to maintain adequate and accurate records.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

10 82. Respondent has further subjected his Physician's and Surgeon's Certificate No.

11 G 46282 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the

12 Code, in that Respondent failed to maintain adequate and accurate records regarding his care and

13 treatment of Patients A-F, as more particularly alleged in paragraphs 9 through 81 (D), above,

14 which are hereby incorporated by reference and realleged as if fully set forth herein.

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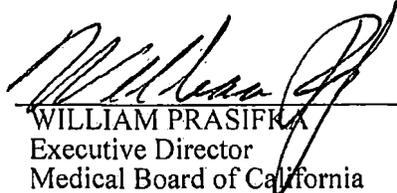
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PRAYER

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 No. G 46282, issued to Respondent, Jeff Jones, M.D.;
2. Revoking, suspending or denying approval of Respondent Jeff Jones, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Respondent Jeff Jones, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and
4. Taking such other and further action as deemed necessary and proper.

DATED: APR 18 2022



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

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