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

In the Matter of the Second Amended Accusation Against: Carlos Orlando Chacon, M.D. Physician's and Surgeon's Certificate No. A 98477 Respondent.	Case No. 800-2018-051342

DECISION

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

This Decision shall become effective at 5:00 p.m. on July 17, 2024.

IT IS SO ORDERED July 10, 2024.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Executive Director

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
KEITH C. SHAW
Deputy Attorney General
State Bar No. 227029
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9515
Facsimile: (619) 645-2012

Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **CARLOS ORLANDO CHACON, M.D.** **180 Otay Lakes Road, Suite 110** **Bonita, CA 91902** **Physician's and Surgeon's Certificate No. A 98477** Respondent.	Case No. 800-2018-051342 OAH No. 2022030078 **STIPULATED LIFETIME SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Keith C. Shaw, Deputy Attorney General.

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2. Carlos Orlando Chacon, M.D. (Respondent) is represented in this proceeding by attorney Marc X. Carlos, Esq., whose address is: 424 F St., Suite 205, San Diego, CA 92101.

3. On or about January 5, 2007, the Board issued Physician's and Surgeon's Certificate No. A 98477 to Carlos Orlando Chacon, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Second Amended Accusation No. 800-2018-051342 and will expire on November 30, 2024, unless renewed.

JURISDICTION

4. Second Amended Accusation No. 800-2018-051342 was filed before the Board, and is currently pending against Respondent. Second Amended Accusation and all other statutorily required documents were properly served on Respondent on October 19, 2023. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Second Amended Accusation No. 800-2018-051342 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Second Amended Accusation No. 800-2018-051342. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Lifetime Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended 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.

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

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8. Respondent, having fully discussed with counsel, voluntarily, knowingly, and intelligently stipulates to a Lifetime Surrender of Physician's and Surgeon's Certificate No. A 98477.

9. Notwithstanding the provisions of Business and Professions Code section 2307, Respondent has fully discussed with counsel and voluntarily, knowingly, and intelligently waives and gives up the right to apply for reinstatement of his Physician's and Surgeon's Certificate throughout the entirety of his lifetime.

CULPABILITY

10. Respondent understands that the charges and allegations in Second Amended Accusation No. 800-2018-051342, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

11. For the purpose of resolving the Second Amended Accusation without the expense and uncertainty of further proceedings, Respondent gives up his right to contest that, at a hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in the Accusation.

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

CONTINGENCY

13. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a . . . stipulation for surrender of a license."

14. This Stipulated Lifetime Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Lifetime Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Lifetime Surrender of License and Disciplinary Order after receiving it. By signing

this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

15. The parties agree that this Stipulated Lifetime Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Lifetime Surrender of License, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Lifetime Surrender of License, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Lifetime Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his review, discussion and/or consideration of this Stipulated Lifetime Surrender of License and Disciplinary Order, or of any matter or matters related hereto.

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

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

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ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 98477, issued to Respondent Carlos Orlando Chacon, M.D., is surrendered for Respondent's lifetime and accepted by the Board.

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

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

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

4. The surrender of Respondent's Physician's and Surgeon's Certificate shall be in effect and binding for the entirety of Respondent's lifetime.

5. Respondent shall be barred from applying for reinstatement of his Physician's and Surgeon's Certificate throughout the entirety of his lifetime.

6. If Respondent should ever apply or reapply for a license or certification by any other health care licensing agency in the State of California, all of the charges and allegations contained in Second Amended Accusation, No. 800-2018-051342 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

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

DATED: 7/1/24

CARLOS ORLANDO CHACON, M.D.
Respondent

I have read and fully discussed with Respondent Carlos Orlando Chacon, M.D., the terms and conditions and other matters contained in this Stipulated Lifetime Surrender of License and Order. I approve its form and content.

DATED: 7/1/24

MARC X. CARLOS, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 7/1/2024

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

KEITH C. SHAW
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Second Amended Accusation No. 800-2018-051342

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
KEITH C. SHAW
Deputy Attorney General
State Bar No. 227029
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9515
Facsimile: (619) 645-2012

Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **CARLOS ORLANDO CHACON, M.D.** **180 Otay Lakes Rd., Ste. 110** **Bonita, CA 91902** **Physician's and Surgeon's Certificate No. A 98477,** Respondent.	Case No. 800-2018-051342 **SECOND AMENDED ACCUSATION**

PARTIES

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

2. On or about January 5, 2007, the Medical Board issued Physician's and Surgeon's Certificate No. A 98477 to Carlos Orlando Chacon, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2024, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Medical Board of California, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

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

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

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

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

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

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

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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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:

". . .

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

"(d) Incompetence.

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

". . . ."

6. Section 2264 of the Code states:

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

7. 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."

8. Section 2069 of the Code states, in pertinent part:

"(a)(1) Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a certified nurse-midwife.

"...."

"(a)(2)(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502, including instructions for specific authorizations, and is approved to do so by the supervising physician and surgeon.

"(b) As used in this section and Sections 2070 and 2071, the following definitions apply:

"(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

"(2) "Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and

surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

"(3) "Supervision" means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

"(A) A licensed physician and surgeon.

"(B) A licensed podiatrist.

"(C) A physician assistant, nurse practitioner, or certified nurse-midwife as provided in subdivision (a).

"(4)(A) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a).

"...."

"(c) Nothing in this section shall be construed as authorizing any of the following:

"(1) The licensure of medical assistants.

"(2) The administration of local anesthetic agents by a medical assistant.

"...."

9. Section 2271 of the Code states: "Any advertising in violation of Section 17500, relating to false or misleading advertising, constitutes unprofessional conduct."

10. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

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COST RECOVERY

11. 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.

PERTINENT DRUGS

12. **Demerol** is drug used to treat moderate to severe pain. It binds to opioid receptors in the central nervous system. Demerol is a type of analgesic agent and a type of opioid. Demerol is a Schedule II controlled substance with effects similar to morphine.

13. **Epinephrine** is an injectable medication used in emergency situations to treat life-threatening allergic reactions. Epinephrine acts quickly to improve breathing, stimulate the heart, raise a dropping blood pressure, reverse hives, and reduce swelling of the face, lips, and throat.

14. **Fentanyl** (Actiq, Fentora, and Duragesic) is a powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent. Like morphine, it is a medication ordinarily used to treat patients with severe pain, especially after surgery. When properly prescribed and indicated, fentanyl is at times used for the management of pain in opioid-tolerant patients, severe enough to require daily, continuous, long term opioid treatment, and for which alternative treatment options are inadequate. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. The Federal Drug Administration (FDA) has issued several black box warnings about fentanyl, including, but not limited to, the risks of addiction, abuse and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS depressants.

15. **Flumazenil** is a benzodiazepine antagonist and used for reversal of benzodiazepine overdose and postoperative sedation from benzodiazepine anesthetics. Flumazenil injection is

indicated for a complete or partial reversal of the sedative effects of benzodiazepines in conscious sedation and general anesthesia.

16. **Ketamine**, or ketamine hydrochloride, is a non-barbiturate, rapid-acting injectable anesthetic. It is a dangerous drug as defined in Business and Professions Code section 4022 and a Schedule III controlled substance as defined by section 11056 of the Health and Safety Code.

17. **Lexapro**, the trade name for Escitalopram, is a Selective Serotonin Reuptake Inhibitor (SSRI) used to treat depression and generalized anxiety disorder.

18. **Narcan**, the trade name for naloxone, is a medicine that rapidly reverses an opioid overdose. It is an opioid antagonist, which attaches to opioid receptors and reverses and blocks the effects of other opioids. Naloxone can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose.

19. **Percocet**, a trade name for Oxycodone, is an opioid analgesic, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of moderate to moderately severe pain. The Drug Enforcement Administration (DEA) has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The FDA has issued a black box warning for Percocet which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

20. **Valium**, the trade name for diazepam, is a medicine of the benzodiazepine class of drugs commonly used to treat anxiety, alcohol withdrawal, and seizures. It is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. The DEA has identified benzodiazepines, such as diazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) Valium can slow or stop breathing, especially if combined with opioid medication, alcohol, or other drugs that can slow breathing.

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21. **Versed**, the trade name for midazolam, belongs to the benzodiazepine class of drugs. Versed is generally used for sedation prior to surgery. When combined with alcohol or other depressants, or when taken in large dosages, Versed can cause a loss of consciousness and respiratory failure, so it's imperative to know how long it remains in the system to avoid dangerous drug interactions and potential overdoses. Benzodiazepines, such as diazepam, are identified as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

22. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A,[1] as more particularly alleged hereinafter:

23. Respondent, a plastic surgeon, owns and operates Divino Plastic Surgery, which includes Divino Outpatient Surgery Center (Divino). Procedures at Divino are performed under conscious sedation[2] or general anesthesia by either a board certified anesthesiologist or a registered nurse (RN).

24. On or about December 19, 2018, Respondent performed a sub-muscular, bilateral breast augmentation procedure on Patient A, a healthy 36-year-old female, who weighed 104 pounds. Patient A's intake form included that she was taking prescriptions of Lexapro and Lunesta (a sedative used as a sleep aid), as well as Kava tea (an herb used to relieve anxiety). She had a history of exercise-induced asthma and palpitations due to anxiety, as well as prior sensitivity to epinephrine. Patient A had located Divino through online marketing.

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[1] The patients listed in this document are unnamed to protect their privacy. Respondent knows the name of the patients and can confirm their identity through discovery.

[2] Conscious sedation is an induced state of sedation by a large combination of sedatives, opioids, and other agents, and characterized by a minimally depressed consciousness such that the patient is able to continuously and independently breathe, retain protective reflexes, and respond to verbal commands and physical stimulation.

25. Respondent predetermined that the procedure would be performed under conscious sedation by an RN, rather than an anesthesiologist.[3] Respondent provided the RN with a preprinted chart of medications to administer to patients, which included Fentanyl, Versed, and Demerol. The chart did not have specific orders for individual patients. Respondent later admitted there was no discussion with Patient A regarding the absence of an anesthesiologist. Preoperative vitals of Patient A on the day of surgery indicated normal vitals and oxygen saturation[4] of 100%. Percocet (5/325 mg) and Valium (5 mg) were taken orally prior to the start of surgery.

26. Conscious sedation of Patient A began at approximately 12:35 p.m., and was administered by an RN under the supervision of Respondent. During the course of surgery, the RN administered divided doses of Fentanyl (425 mcg), Ketamine (200 mg), Versed (4 mg), and Demerol (50 mg). There was no prior discussion between the RN and Respondent regarding the selection, dose, timing, and frequency of medications to be administered during conscious sedation, as Respondent left full discretion to the RN. Additionally, a medical assistant (MA) injected the local anesthesia, lidocaine, without Respondent being present, and without knowing the differences in lidocaine concentrations or appropriate quantities to administer.[5] Another MA administered IV medications, as well as an unknown medication intravenously, but did not know if the medication was compatible with normal saline or how fast to push. Video of the procedure showed numerous staff members taking selfies with their cameras.

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[3] Sub-muscular breast augmentation procedures often require muscle relaxation for proper placement of implants and are generally performed under general anesthesia in a certified facility by a qualified anesthesiologist for patient safety. Pneumothorax (collapsed lung) can occur during these procedures.

[4] Oxygen saturation indicates that amount of oxygen traveling through the body with red blood cells. Oxygen saturation is normally between 95% and 100% for most healthy adults.

[5] MA's are not permitted to inject local anesthesia or intravenous medications in California. Respondent falsely stated that he had administered the local anesthesia even though video clearly shows that it was performed by a MA when Respondent was not even in the room. The MA indicated that she had administered local anesthesia on at least 20 occasions with and without Respondent present.

27. At approximately 2:22 p.m., and shortly after administering the last dose of Fentanyl, Patient A's oxygen saturation dropped significantly to 48%, her heart rate increased, and she became hypotensive (low blood pressure). Patient A then became pulseless and suffered sudden cardiac arrest. An oral airway was placed and bag valve ventilation[6] began. Respondent initiated an automated external defibrillator (AED) and started cardiopulmonary resuscitation (CPR) by performing 10 chest compressions. The AED then showed a return of heart rate, but Patient A was still not breathing on her own.[7] Bag and mask ventilation continued. Epinephrine was administered a total of three times. Patient A's oxygen saturation rose to 95% at approximately 2:45 p.m. Nine separate doses of Narcan (0.4 mg)[8] were subsequently administered between approximately 2:45 p.m. and 4:10 p.m., in addition to one dose of Flumazenil at approximately 3:20 p.m.

28. Despite the numerous attempts to reverse sedation, Patient A remained unconscious, responding only to painful stimuli while making spontaneous respirations. However, Patient's A's spontaneous respirations were inadequate and she required continuous intermittent bag and mask ventilation with oxygen saturation fluctuating between 50-94%.

29. As Patient A's condition remained unstable, Respondent called two anesthesiologists he worked with for advice, rather than call 911. Respondent concealed from each anesthesiologist critical facts, including that Patient A was comatose and suffered cardiac arrest, had become pulseless and apneic, was administered CPR and an AED, had extremely low oxygen saturation, was unable to breathe on her own, or needed epinephrine. Rather, Respondent inaccurately relayed that Patient A was stable but slow to awaken.

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[6] Bag valve ventilation is a hand-held device typically used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.

[7] Multiple Divino staff clearly recounted that Respondent also shocked Patient A with the AED, but Respondent denied that she was shocked.

[8] Following a total dosage of 2 mg of Narcan, it is unlikely that narcotics are the cause of respiratory depression and the diagnosis of narcotic induced toxicity should be questioned.

30. One of the anesthesiologists, Dr. L, volunteered to come into Divino and assist Patient A at approximately 4:42 p.m., but Respondent declined.[9] The other anesthesiologist, Dr. D, advised Respondent shortly after 4:49 p.m. to immediately call 911, and that she needed to be intubated[10] by paramedics. Respondent and Dr. D had a second conversation at approximately 5:03 p.m., where Dr. D asked Respondent whether he had called 911 yet, and Respondent replied, "I'm working on it." Dr. D again alerted Respondent to immediately call the paramedics. Still, Respondent did not call 911, even as Patient A started to make gurgling noises and exhibit seizure-like activity. Instead, Respondent abandoned Patient A in the surgical room and saw his last scheduled patient of the day for a post-operative check-up. In fact, Respondent saw three patients (two post-operative and one pre-operative consultation) while Patient A lay helpless in the surgical room following cardiac arrest with no ambulance en route.

31. Paramedics were finally called by Respondent at approximately 5:24 p.m., *more than three hours after CPR*. Respondent falsely told the 911 dispatcher that the patient was conscious, even though she had been unconscious for three hours, not breathing and unresponsive. Respondent omitted that CPR was performed. Respondent falsely reported that Patient A "was waking up from anesthesia, her eyes were open, and she was making movements and moaning," when in fact her movements were twitching and seizure-like.

32. Paramedics arrived on scene within minutes after 911 was called and found Patient A unresponsive, with low blood pressure and poor oxygen saturation between 60-70%, labored and agonal breathing, poor coloring, and on bag and mask ventilation. She was assessed a Glasgow Coma Scale[11] of three (3) by paramedics. A firefighter captain and EMT on scene indicated that

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[9] Dr. L later stated that had he been given the actual facts, he would have called 911 himself since it presented a medical emergency.

[10] Endotracheal intubation is the placement of a tube into the trachea (windpipe) in order to maintain an open airway in patients who are unconscious or unable to breathe on their own.

[11] The Glasgow Coma Scale (GSC) is the most common scoring system used to describe the level of consciousness in a person following a traumatic brain injury and based on ability to perform eye and body movements, and speak. A GCS score of 3 is the lowest possible score and is associated with an extremely high mortality rate.

paramedics were in "disbelief" that three hours had passed after Patient A suffered a cardiac arrest before 911 was called. Paramedics also verified that Divino had been using a bag valve mask on an unconscious patient with agonal respirations for three hours before calling 911. Patient A was transferred to the Emergency Room (ER) of Scripps Mercy Hospital.

33. Upon arrival to the ER at approximately 6:01 p.m., Patient A was hypoxic (low levels of oxygen in the blood), not breathing independently, and had seizure-like activity. She was intubated and a chest x-ray revealed acute pulmonary edema (excess fluid in the lungs) and tension pneumothorax. Patient A was transferred to the intensive care unit, where she remained comatose with refractory seizures. Testing suggested that Patient A sustained post anoxic ischemic encephalopathy.[12] Patient A was transferred to UCSD Medical Center several days later without neurological improvement. Patient A never woke up or regained the ability to breathe on her own. She later died on or about January 28, 2019, of hypoxic brain injury.

34. At no time prior to cardiac arrest had Respondent discussed vital signs, level of consciousness, or medications being administered with the RN. Appropriate patient monitoring was not performed during conscious sedation, including an available cardiac rhythm strip, documented level of consciousness (response to verbal and physical stimuli), or documented end-tidal carbon dioxide (Co2).[13] Further, auscultation of the patient's chest was never performed to verify bilateral breath sounds, even though the surgery placed her at risk for pneumothorax.

35. Both Respondent and Divino staff lacked the necessary training, expertise and intensive care to manage critically ill patients.[14] Respondent was unable to provide medical assistant certifications or qualifications for Divino staff, including evaluation and verification that

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[12] Anoxic encephalopathy, or hypoxic-ischemic brain injury, is a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning (for example, carbon monoxide or drug overdose), vascular injury, or cardiac arrest.

[13] Continuous monitoring of end-tidal Co2 during conscious sedation detects respiration and provides an early indicator of inadequate respiration.

[14] Out of hospital cardiac arrest has a poor chance of survival and requires immediate transfer to a hospital with expertise and intensive care to manage these patients.

the RN possessed the necessary knowledge, training, and skills to administer conscious sedation. Respondent had never performed a code blue[15] drill at Divino. Patient A remained hypoxic on intermittent bag and mask ventilation for three hours following cardiac arrest, even though endotracheal intubation and ventilation should have been performed immediately to ensure appropriate expansion of the lungs and effective ventilation. In fact, the RN admitted she had never performed intubation outside of training and did not feel comfortable performing it. Both the RN and Respondent were unaware of potential chest complications from fentanyl, and the RN was unaware of the side effects of Ketamine. Additionally, Respondent should have been alerted to other causes of continued hypoxia, such as the presence of pneumothorax or pulmonary edema, after Patient A did not respond to numerous doses of Narcan, as well as Flumazenil. An incident report was also not completed as required.

36. Video of the procedure revealed Respondent using Advanced Cardiovascular Life Support (ACLS) cheat sheets while attempting to rescue Patient A. Still, neither ACLS protocols, nor basic cardiac arrest chain of survival protocols of the American Heart Association (AHA), were properly followed and Respondent failed to institute an appropriate emergency response order. The very first step of AHA's chain of survival protocol for an out of hospital cardiac arrest is to call 911, even prior to initiating CPR. Respondent, who was ACLS certified, not only failed to follow the first step of out-of-hospital cardiac arrest ACLS protocol by calling 911, he failed to follow his own code blue protocol by calling 911 following cardiac or respiratory arrest. Staff used phone lights for visualization along with the panicked exchange of dysfunctional monitors. Respondent failed to properly assess Patient A prior to or after sudden cardiac arrest. He abandoned the patient on multiple occasions following cardiac arrest, including being absent from the operating room on numerous occasions while his staff worked on rescuing the patient.

37. The RN later indicated she knew that 911 needed to be called 30 minutes following cardiac arrest, but was relying on Respondent's "professional medical opinion" to make that call. Other Divino staff repeatedly asked when 911 was going to be called. In fact, every member of

[15] Code blue is an emergency code used to describe the critical status of a patient, such as cardiac arrest, respiratory issues, or any other medical emergency.

Devino staff in the surgical room recognized the need to call 911, but did not because "doctor said to wait." When Respondent was later asked when he was going to call 911, he stated, "it was going to boil down to the importance of the etiology of the circumstances that had taken place, the ease with which I am able to resuscitate the patient, and the safety of the patient on transport."

38. Respondent admitted to never caring for an out of hospital cardiac arrest patient outside of a single occasion in medical school which was handed off to paramedics. Further, Respondent falsely inferred on Divino's website and online marketing that he was board certified with the American Society for Aesthetic Plastic Surgery, as well as the American Society for Plastic Surgeons, when in fact he was not board certified. He also falsely implied that he was a member of several societies, including the California Society of Plastic Surgeons, when he was not a member.

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

(a) Respondent failed to adequately supervise the RN during the performance of conscious sedation;

(b) Respondent failed to provide adequate ventilation following sudden cardiac arrest;

(c) Respondent failed to consider differential diagnosis and treatment of continued hypoxia;

(d) Respondent failed to transfer the patient to the hospital following sudden cardiac arrest to improve the likelihood of survival and neurological recovery;

(e) Respondent performed a sub-muscular breast augmentation under conscious sedation without the proper knowledge of ability to rescue the patient in extremis or control her airway;

(f) Respondent performed breast augmentation surgery under conscious sedation without appropriate patient monitoring and close

observations, competence, certifications of staff, and emergency preparations;

(g) Respondent failed to timely implement and activate a basic emergency response system;

(h) Respondent intentionally and recklessly failed to call 911 for three hours following cardiac arrest despite an unresponsive patient with agonal respirations;

(i) Respondent intentionally permitted medical assistants to engage in the unauthorized practice of medicine by injecting local anesthesia and intravenous medications, and without proper training or knowledge of the risks involved;

(j) Respondent abandoned the patient on numerous occasions while in extremis;

(k) Respondent failed to assess and acknowledge that the patient was unconscious or comatose, either due to intentional concealment or incompetence;

(l) Respondent falsely advertised and misrepresented his credentials, including inferring that he was board certified, on Divino's website and online marketing;

(m) Respondent failed to follow established protocols set forth by the American Heart Association when cardiac arrest occurs in an out of hospital setting; and

(n) Respondent failed to evaluate and verify that the RN possessed the necessary knowledge, training, and skills to administer conscious sedation.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

40. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged herein.

(a) Paragraphs 23 through 39, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent administered nine separate doses of Narcan (0.4 mg) for reversal of respiratory depression during conscious sedation in the absence of the patient responding to previous doses of Narcan;

(c) Respondent failed to document monitoring of end-tidal Co2 during conscious sedation;

(d) Respondent failed to document the patient's level of consciousness during conscious sedation; and

(e) Respondent failed to prescribe medication order prior to conscious sedation.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

41. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient A, as more particularly alleged in paragraphs 23 through 40, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

42. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he was incompetent and/or lacked knowledge in his care and treatment of Patient A, as more particularly alleged herein.

(a) Paragraphs 23 through 41, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent administered nine separate doses of Narcan (0.4 mg) for reversal of respiratory depression during conscious sedation in the absence of a response to previous doses of Narcan; and

(c) Respondent stated multiple times that the patient was conscious when she was unconscious.

FIFTH CAUSE FOR DISCIPLINE

(Aiding and Abetting the Unlicensed Practice of Medicine)

43. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2264, of the Code, in that Respondent aided and abetted an unlicensed person to engage in the practice of medicine in the care and treatment of Patient A, as more particularly alleged in paragraphs 23 through 42, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: False Advertising)

44. Respondent is subject to disciplinary action under section 2271 of the Code in that Respondent engaged in unprofessional conduct and engaged in false advertising, as more particularly alleged in paragraphs 23 through 42, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Dishonest/Corrupt Acts)

45. Respondent is subject to disciplinary action under section 2234, subdivision (e), of the Code in that Respondent engaged in unprofessional conduct and engaged in dishonest and/or corrupt acts as more particularly alleged in paragraphs 23 through 44, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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EIGHTH CAUSE FOR DISCIPLINE

(Gross Negligence)

46. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient B, as more particularly alleged hereinafter:

47. On or about November 4, 2021, Respondent performed a breast augmentation procedure, abdominoplasty (tummy tuck), liposuction of various areas, and a buttocks lift on Patient B, a then 41-year-old female, at Devino. An unlicensed medical assistant (S.C.), who was under the supervision of Respondent, sutured Patient B's surgical sites during the procedure, including the stomach area.[16]

48. Patient B signed an informed consent form on or about October 22, 2021, but at no time was informed that a medical assistant would be suturing her body. It was Patient B's understanding that only Respondent would be performing each part of the surgery. Patient B indicated that she was still experiencing numbing in the area of the surgical scar of her tummy tuck area nearly one year following surgery.

49. In an interview on or about October 5, 2022, S.C. confirmed that Respondent trained her how to suture, that she routinely sutured patients, and that she was aware that suturing patients was outside the scope of her practice as a medical assistant and illegal. In fact, while working at Respondent's office, S.C. trained a registered nurse, Y.G., how to suture. Respondent explained to Y.G. that it takes too much time if he performs all the suturing himself even though he is the surgeon.

50. Respondent subsequently attested that he believed medical assistants could administer local anesthesia under his supervision.[17] Additionally, Respondent was unable to provide certification of the requisite training for any medical assistant at his office.

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[16] Medical assistants are not lawfully permitted to suture patients pursuant to Code section 2053.5(a)(1).

[17] Medical assistants are precluded from administering anesthesia to patients pursuant to Code section 2053.5(a)(4), and California Code of Regulations, Title 16, section 1366(b)(1).

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

(a) Respondent directed and/or permitted an unlicensed medical assistant under his supervision to suture Patient B.

NINTH CAUSE FOR DISCIPLINE

(Gross Negligence)

52. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient C, as more particularly alleged hereinafter:

53. Paragraphs 47 through 51, above, are hereby incorporated by reference and realleged as if fully set forth herein.

54. On or about October 28, 2021, Respondent performed abdominoplasty and liposuction of various areas on Patient C, a then 26-year-old female, at Devino. S.C., an unlicensed medical assistant, who was under the supervision of Respondent, sutured Patient C's surgical sites during the procedure.

55. Patient C signed an informed consent form on or about October 7, 2021, but at no time was informed that a medical assistant would be suturing her body. Patient C indicated that she never would have given anyone other than Respondent permission to perform sutures on her body. Patient C reported that multiple sutures came undone following surgery and the wounds did not heal as expected, resulting in scarring.

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

(a) Respondent directed and/or permitted an unlicensed medical assistant under his supervision to suture Patient C.

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TENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

57. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient D, as more particularly alleged hereinafter:

58. Paragraphs 47 through 56, above, are hereby incorporated by reference and realleged as if fully set forth herein.

59. On or about November 2, 2021, Respondent performed extended abdominoplasty and liposuction of various areas on Patient D, a then 40-year-old female, at Devino. S.C., an unlicensed medical assistant, who was under the supervision of Respondent, sutured Patient D's surgical sites during the procedure.

60. Patient D signed an informed consent form on or about October 18, 2021, but at no time was informed that a medical assistant would be suturing her body. Patient D indicated that she never would have given anyone other than Respondent permission to perform sutures on her body.

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

(a) Respondent directed and/or permitted an unlicensed medical assistant under his supervision to suture Patient D.

ELEVENTH CAUSE FOR DISCIPLINE

(Incompetence)

62. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he was incompetent and/or lacked knowledge in his care and treatment of Patients B, C, and D, as more particularly alleged herein.

(a) Paragraphs 47 through 61, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent directed and/or permitted an unlicensed medical assistant under his supervision to suture Patients B, C, and D; and

(c) Respondent erroneously believed that medical assistants could administer local anesthesia under his supervision.

TWELFTH CAUSE FOR DISCIPLINE

(Aiding and Abetting the Unlicensed Practice of Medicine)

63. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2264, of the Code, in that Respondent aided and abetted an unlicensed person to engage in the practice of medicine in the care and treatment of Patients B, C, and D, as more particularly alleged in paragraphs 47 through 62, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

64. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients B, C, and D, as more particularly alleged herein.

(a) Paragraphs 47 through 63, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

65. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient E, as more particularly alleged hereinafter:

66. On or about August 13, 2019, Respondent performed a bilateral breast augmentation and lift, extended abdominoplasty, and liposuction of various areas on Patient E, a then 48-year-old female, at Devino. Patient E had a history of hypertension, obesity, hypercholesterolemia, and a gastric bypass surgery less than two years prior with a subsequent 100 pound weight loss.

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The total operating time was nearly nine hours, and Patient E was under anesthesia for over nine hours.[18] Respondent noted the procedure went well without complications. Patient E was discharged home in stable condition that evening. Respondent instructed Patient E to call him if there were any complications.

67. At approximately 1:00 a.m. the following morning, Patient E awoke to a loss of sensation in her left leg, and experienced difficulty moving it and walking. Soon after, Patient E began to experience numbness in her left arm. Patient E was being cared for by her friend, and the two discussed calling 911. Per Respondent's instructions should any complications arise, Patient E attempted to call Respondent first. However, Respondent did not answer, and Patient E tried calling him numerous more times and left multiple messages. Respondent did not return any of the calls. Next, at approximately 6:00 a.m., Patient E called the anesthesiologist from the surgery and explained her medical condition. Finally, Respondent called Patient E back approximately five hours after the onset of her symptoms, and recommended that she come into the office that morning. Patient E reported that Respondent advised her condition was likely caused by a pinched nerve, and she did not need to go to the hospital as it was not severe.

68. On or about the morning of August 14, 2019, Patient E came into Respondent's office as directed by Respondent.[19] By the time of her appointment, Patient E was having difficulty speaking and moving her left arm, in additional to the loss of feeling in her left leg. Respondent documented an examination of Patient E's lower extremities. Patient E recalled that Respondent only examined her incision points and did not conduct a neurological examination. Respondent again told Patient E that her condition could be a pinched nerve.

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[18] Despite such a long and invasive surgery, Respondent did not perform pre-operative baseline blood work to evaluate Patient E's medical status to ensure that she was a candidate for surgery, nor did he conduct stratification of her deep vein thrombosis/pulmonary embolism risk and consideration of post-operative anti-coagulation.

[19] Patient E had experienced great difficulty getting downstairs from her residence and into the car, and needed the assistance of both her husband and her friend.

69. At the appointment, Patient E's husband expressed concern regarding her slurred speech, and he stated that they should go to the hospital immediately. Respondent agreed but asked that they let him finish his notes first.[20] Respondent noted that Patient E was "doing well" but needed to rule out "compressive etiology vs retroperitoneal bleeding vs lumbar plexopathy." Respondent recommended "imaging CT pelvis and MRI if warranted for lumbar spine."[21]

70. Patient E went to the Sharp Memorial Hospital emergency department directly from Respondent's office. After undergoing testing, hospital emergency staff identified that Patient E had experienced an acute ischemic stroke.[22] Patient E was immediately treated to minimize the effects of stroke, but she was not treated with a tissue plasminogen activator (tPA)[23] as she was outside the treatment window. Patient E was later transferred to the rehabilitation unit at Sharp Memorial Hospital, whereby she stayed for nearly one month. She progressed well, and at the time of her discharge, she was using a walker and could climb steps with close supervision. She was left with residual leg and lip lag.

71. Respondent was later interviewed and admitted that even though his overall concern for Patient E was "high" following her evaluation, he did not notify the emergency department regarding his concerns, nor include in the record his "high" concern. Respondent affirmed that retroperitoneal bleeding could be a significant medical issue, yet it was "very low on his suspicion," even though he never documented this opinion. Despite Patient E's progression of symptoms indicative of a potential stroke, a neurological assessment of the left arm and face were

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[20] Patient E indicated that Respondent stated if she felt more comfortable, she could go to the hospital, and he suggested that she go to Sharp Memorial Hospital rather than Sharp Chula Vista, which was in much closer proximity to Respondent's office.

[21] There was an anomaly in Respondent's note for this encounter, as it was missing standard date and time stamping, even though it is present for other notes involving Patient E. Additionally, on more than one occasion, Respondent's encounter date was inconsistent with the date of service listed on the notes for Patient E.

[22] An ischemic stroke occurs when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes. A stroke is a medical emergency, and prompt treatment is crucial.

[23] A tPA is a drug used to break up a blood clot and restore blood flow to the brain. A tPA can only be administered within a few hours after stroke symptoms appear.

not conducted by Respondent, but rather only a specific examination of the left lower leg.[24] Respondent did not document any concern regarding a potential stroke.

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

(a) Respondent failed to appropriately screen Patient E before undergoing major elective cosmetic surgery.

FIFTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

73. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient E, as more particularly alleged herein.

(a) Paragraphs 66 through 72, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to respond to Patient E's acute, post-operative medical concerns in a timely manner;

(c) Respondent failed to communicate his finding and concerns to the emergency department, as well as expedite timely care for a patient with differential diagnoses requiring emergent evaluation; and

(d) Respondent failed to generate accurate medical records with correct date/time stamping.

SIXTEENTH CAUSE FOR DISCIPLINE

(Incompetence)

74. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he was incompetent and/or lacked knowledge in his care and treatment of Patient E, as more particularly alleged herein.

[24] Respondent erroneously documented that Patient E had reduced motor strength of her right leg when in fact it was her left leg.

(a) Paragraphs 66 through 73, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to recognize and consider the possibility of an acute stroke following the evaluation of Patient E.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

75. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient E, as more particularly alleged in paragraphs 66 through 74, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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. A 98477, issued to Respondent Carlos Orlando Chacon, M.D.;

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

3. Ordering Respondent Carlos Orlando Chacon, 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: OCT 19 2023

Jenna Jones FOR
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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