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

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| **In the Matter of the Accusation Against:**<br><br>**Tsilya Bass, M.D.**<br><br>**Physician's & Surgeon's Certificate No. A 63630**<br><br>**Respondent.** | **Case No. 800-2022-088973** |

## DECISION

**The attached Decision 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 11, 2025.**

**IT IS SO ORDERED: June 13, 2025.**

**MEDICAL BOARD OF CALIFORNIA**

Michelle A. Bholat, MD

**Michelle Anne Bholat, M.D., Chair**
**Panel A**

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General
TRINA L. SAUNDERS
Deputy Attorney General
State Bar No. 207764
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6516
Facsimile: (916) 731-2117
E-mail: Trina.Saunders@doj.ca.gov
*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**TSILYA BASS, M.D.**<br>**7250 Franklin Avenue, Apt. 907**<br>**Los Angeles, CA 90046**<br><br>**Physician's and Surgeon's Certificate No. A 63630,**<br><br>Respondent. | Case No. 800-2022-088973<br><br>OAH No. 2024100233<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** |

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

## PARTIES

1. Reji Varghese (Complainant) is the 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 Trina L. Saunders, Deputy Attorney General.

2. Respondent Tsilya Bass, M.D. (Respondent) is represented in this proceeding by attorney Gillian E. Friedman, whose address is 2121 Avenue of the Stars, Suite 800 Los Angeles, California 90067-5080.

3. On or about October 10, 1997, the Board issued Physician's and Surgeon's Certificate No. A 63630 to Tsilya Bass, 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 Accusation No. 800-2022-088973, and will expire on May 31, 2027, unless renewed.

## JURISDICTION

4. Accusation No. 800-2022-088973 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on August 8, 2024. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2022-088973 is attached as exhibit A and incorporated herein by reference.

## ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2022-088973. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

## CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2022-088973, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

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

11. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2022-088973, a true and correct copy of which is attached hereto as Exhibit A, and that she has thereby subjected her Physician's and Surgeon's Certificate, No. A 63630 to disciplinary action.

12. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

## CONTINGENCY

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

14. Respondent agrees that if an accusation is filed against her before the Board, all of the charges and allegations contained in Accusation No. 800-2022-088973 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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15. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreement of the parties in this above entitled matter.

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

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

## DISCIPLINARY ORDER

A. PUBLIC REPRIMAND.

**IT IS HEREBY ORDERED THAT** Physician's and Surgeon's Certificate No. A 63630 issued to Respondent Tsilya Bass, M.D., shall be and is hereby Publicly Reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand is issued in connection with the care and treatment of six patients, as set forth in Accusation No. 800-2022-088973, and is as follows:

> "Between 2016 and 2019, you departed from the standard of care by inappropriately monitoring patients to whom you prescribed controlled medications and failing to maintain adequate records in connection with the treatment and care of these patients, as more fully described in Accusation No. 800-2022-088973."

B. EDUCATION COURSE. In addition, within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational programs) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in

satisfaction of this condition.

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

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

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

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

A medical record keeping course taken after the acts that gave rise to the charges in the

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

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

E. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, legal reviews, and investigation(s), as applicable, in the amount of $46,282.80 (forty-six thousand two hundred eighty-two dollars and eighty cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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

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

F. ENFORCEMENT. Failure to fully comply with any term of this Disciplinary Order shall constitute unprofessional conduct and will subject Respondent's physician's and surgeon's certificate to further disciplinary action.

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## ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Gillian E. Friedman. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order Board of California.

DATED: 03.10.2025 Tsilya Bass, MD

TSILYA BASS, M.D.
*Respondent*

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

DATED: 3-12-2025

GILLIAN E. FRIEDMAN
*Attorney for Respondent*

## ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General

TRINA L. SAUNDERS
Deputy Attorney General
*Attorneys for Complainant*

## ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Gillian E. Friedman. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order Board of California.

DATED: _____

TSILYA BASS, M.D.
*Respondent*

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

DATED: _____

GILLIAN E. FRIEDMAN
*Attorney for Respondent*

## ENDORSEMENT

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

DATED: March 13, 2025

Respectfully submitted,

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General

Trina L. Saunders

TRINA L. SAUNDERS
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**Accusation No. 800-2022-088973**

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
BRIAN D. BILL
Deputy Attorney General
State Bar No. 239146
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 269-6461
Facsimile: (916) 731-2117
*Attorneys for Complainant*

**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
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|---|---|
| In the Matter of the Accusation Against:<br><br>TSILYA BASS, M.D.<br><br>7250 Franklin Avenue, Apt. 907<br>Los Angeles, California 90046<br><br>Physician's and Surgeon's Certificate No. A 63630,<br><br>Respondent. | Case No. 800-2022-088973<br><br>**ACCUSATION** |

## PARTIES

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

2. On or about October 10, 1997, the Medical Board issued Physician's and Surgeon's Certificate Number A 63630 to Tsilya Bass, 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 May 31, 2025, unless renewed.

## JURISDICTION

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

indicated.

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

5. Section 2228 of the Code states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

## STATUTORY PROVISIONS

6. 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.
>
> ...

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.

## COST RECOVERY

8. 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.

## DEFINITIONS

9. Controlled Substances – A controlled substance is a drug that has been declared by federal or state law to be illegal for sale or use but may be dispensed under a physician's

prescription. The basis for control and regulation is the danger of addiction, abuse, physical or mental harm, and death. Controlled substances include:

a. Benzodiazepines are a Schedule IV controlled substance. Benzodiazepines are depressants that produce sedation and hypnosis, relieve anxiety and muscle spasms, and reduce seizures. They are habit-forming and have significant addiction potential when improperly prescribed and/or used over prolonged periods. Adverse side effects include drowsiness, dizziness, increased saliva, mood changes, hallucinations, thoughts of suicide, slurred speech, loss of coordination, difficulty walking, coma, and combining with other substances can slow breathing and possibly lead to death.

b. Clonazepam (Klonopin). A benzodiazepine prescribed as a short-term treatment of anxiety.

c. Triazolam (Halcion) is a benzodiazepine prescribed to treat insomnia. This medicine is for short-term (usually 7 to 10 days) use only.

d. Opioids are a Schedule II controlled substance generally prescribed for moderate to severe pain that have a high potential for abuse, dependence, and addiction. The dangers of using such drugs include, but are not limited to, drug abuse, psychic dependence, immunosuppression, hormonal changes, central nervous system depression, and death.

e. Acetaminophen and codeine (Tylenol with Codeine Phosphate) is a combination medicine made up of codeine (an opioid medication) and acetaminophen (a non-opioid medication) and is used to relieve pain.

10. Non-Controlled Substances are pharmaceutical preparations that can only be obtained through a practitioner's prescription dispensed by a pharmacist and are not considered controlled substances under the Controlled Substances Act.

a. Aricept (Donepezil) is a medication that treats symptoms of Alzheimer's Disease like memory loss and confusion. This medication works by improving the patient's attention, memory, and ability to engage in daily activities.

b. Buspirone is an anxiolytic drug prescribed to treat anxiety.

c. Cymbalta is a selective serotonin and norepinephrine reuptake inhibitor

antidepressant (SSRI). It is used to treat major depressive disorder and general anxiety disorder.

d. Namenda XR (memantine hydrochloride) is an NMDA receptor antagonist used to treat moderate to severe dementia of the Alzheimer's type. Side effects include dizziness, headaches, and confusion.

e. Propranolol a prescription medication used to treat tremors, angina, hypertension, heart rhythm disorders, and other heart or circulatory conditions. It is also used to treat or prevent heart attacks and to reduce the severity and frequency of migraine headaches.

f. Rozerem is a sedative, also called a hypnotic. It works by affecting certain substances in the body that help regulate a person's "sleep-wake cycle."

g. Silenor is used to treat insomnia. It is in a class of medications called tricyclic antidepressants.

h. Viibryd. An SSRI medication used to treat depression.

11. CURES (Controlled Substance Utilization Review and Evaluation System) is a database of Schedule II, III, IV, and V controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement. CURES is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

## FACTUAL ALLEGATIONS

**Board Complaint**

12. On June 3, 2022, the Medical Board received a complaint from the Legal Coordinator at the Citizens Commission on Human Rights International (CCHR) regarding possible Medicare fraud related to Respondent's prescribing practices. According to a CCHR investigation, Respondent was the fourth-highest prescriber of medications nationally, billing over $7,500,000 to Medicare.

13. Upon receipt of the complaint, Health Quality Investigation Unit (HQIU) Investigators obtained CURES reports for Respondent and elected to focus on six patients. During the investigation, HQIU Investigators obtained prescription records for the patients from

multiple pharmacies. HQIU Investigators found that several of the pharmacies that filled prescriptions for the six patients had closed, and their licenses were cancelled.

**Patient 1**

14. Patient 1[1] treated with Respondent between approximately 2006 and 2023. The relevant treatment period in this case is March 31, 2016, through September 3, 2019 (Treatment Period). Patient 1 had a history of depression that was exacerbated by complications from a hip replacement in 2006, hypertension, cerebrovascular disease, hyperlipidemia, hypothyroidism, coronary artery disease, congestive heart failure, degenerative joint and spine disease, rheumatoid arthritis, and chronic pain syndrome.

15. In the summary of care dated January 10, 2023, Respondent noted that Patient 1's co-morbidities led to severe anxiety attacks and insomnia. However, clonazepam "controlled her anxiety state, improve and stabilize mood, blood pressure, pulse, general condition;" and "Triazolam controlled the patient insomnia, improved sleep pattern." The summary of care also noted that both the patient and caregiver were instructed that the medications should be used only as needed and not within three hours of each other.

**Treatment Record**

16. The record for the treatment period included:

a. Initial Consent Form.[2] A generalized initial consent for treatment signed on May 6, 2006.

b. General treatment notes[3] for Patient 1 are dated at approximately three to four-month intervals. Respondent documented in a treatment note dated July 25, 2016, Patient 1

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[1] Patients are identified by number to protect their privacy.

[2] The Initial Consent Form contained a general discussion of treatment with various forms of services, including medication treatment. However, it did not list any medications prescribed or information about each medication, particularly the risks and benefits of each. During the subject interview, Respondent stated that she completes a treatment and medication consent with every patient at the first visit but made no mention of ongoing or updated informed consent for medications.

[3] Respondent's progress notes were templates that included Respondent's hand-written annotations. Each note is one page with a history section at the top, and medications and (continued...)

reported chronic pain and the impact on her mood and anxiety. At the bottom of the note, the words "ortho eval" are circled, and it states, "cont all previous meds, sleep hygiene family, psychotherapy." That note is followed by a sleep evaluation form, which endorses many issues related to insomnia. Overall, the treatment notes were difficult to read and/or interpret, and were not sequentially numbered. Additionally, the notes lacked documentation of coordination with other treating specialists; and documentation that Respondent reviewed Patient 1's CURES reports. Finally, the individual treatment notes did not contain Patient 1's identifying information

c. A progress note dated November 7, 2019, written by Patient 1's orthopedist that documents more than 30 medications that were prescribed to Patient 1.

d. A medication list from Shiloh Pharmacy dated April 25, 2018, documented more than 40 medications regularly prescribed to Patient 1.

**HQIU Investigation.**

17. CURES Report. During the investigation, HQIU Investigators obtained a CURES report for January 1, 2016, through December 31, 2019, that contained all controlled substances prescribed to Patient 1 by all providers. The CURES report documented that Respondent prescribed triazolam 0.25 mg #30 and clonazepam 0.5 mg #30 approximately every month during the period. Additionally, Patient 1's orthopedist concurrently prescribed Tylenol with codeine and tramadol approximately monthly between January 20, 2016, through December 6, 2017, and tramadol in September and November of 2018.

18. Subject Interview.[4] During the subject interview, Respondent stated:

a. Patient 1 suffered from anxiety, insomnia, and chronic pain.

b. Patient 1 was unable to sleep without triazolam and had failed a trial of a

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diagnoses sections at the bottom. The template portion of the note contains multiple aspects of a mental status exam, including grooming/hygiene, eye contact, motor activity, speech, interaction style, orientation, thought processes and content, an extended cognitive functioning section, behavioral disturbance, and suicidal/homicidal ideation. Symptoms are circled from the checklist or annotated. The annotated portions are not easily readable, but appeared to contain interval history and symptoms. Each individual treatment note lacked patient identifying information and page numbers.

[4] Concerning her general practices, Respondent told investigators she had completed treatment and medication consent forms with every patient at the first visit. She did not use controlled substance agreements or use toxicology screenings as a medication monitoring tool.

different medication.

c. She prescribed Patient 1 clonazepam on an as-needed basis.

d. She instructed Patient 1 not to take the medications together.

e. She could not remember the name of Patient 1's primary care physician, but she was aware that Patient 1's orthopedic physician prescribed Tylenol with codeine and tramadol.

**Medical Issue: Documentation and Recordkeeping**

19. Standard of Care. A medical record should include adequate documentation of the presenting issue, the current or interval history, medication compliance, effectiveness and side effects, relevant past history, the mental status examination, risk assessment, diagnoses, and a treatment plan. The medical record should be easily read and understood by others. The record should document the physician's periodic medication evaluation that includes an assessment of the current medications for compliance, side effects, and efficacy. Additionally, the medication assessment should include consideration of decreasing or simplifying medications, particularly if the patient is stabilized and the medication regimen is complicated, or the dosages are outside the normal range. Psychiatric records should document the patient's psychological issues, a psychiatric examination[5], a mental status exam[6], the psychiatric medications, reference to any medical issues that may affect the patient, and documentation of coordination with primary care or other specialists as needed. Although each individual progress note need not contain each of the above elements, each should be represented and documented over time, particularly when there are changes in the clinical situation or changes in the patient's medications.

20. Analysis. The record of Patient 1's care and treatment was generally illegible due to handwriting issues and limited space. Respondent acknowledged that she did not have space to write everything and had some trouble reading the records during the Medical Board interview. The treatment notes were difficult to read and/or interpret, and were not sequentially numbered.

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[5] A standard psychiatric examination involves obtaining a patient's history and performing a mental status examination.

[6] The mental status examination usually includes an assessment of general appearance and behavior, speech, mood, affect, perceptions, thought content, thought processes, attention, concentration, orientation, cognition, memory, judgment and insight.

Additionally, the notes lacked documentation of coordination with other treating specialists and documentation that Respondent reviewed Patient 1's CURES reports. Finally, the individual treatment notes did not contain Patient 1's identifying information.

21. Conclusion: Respondent's failure to properly document her care and treatment of Patient 1 constituted a simple departure from the standard of care.

**Medical Issue: Consent for Medications and Treatment**

22. Standard of Care: Consent for treatment and consent for medications is a necessary element of care for the patient in that it provides the patient, caregiver, and family with information to make informed decisions about the risks and benefits of various treatment options. Informed consent involves regular updates whenever medications or the treatment plan is changed. Medication consents often contain information such as the name of the medication, the reason it is being used, the dose range to be used, common side effects, the length of expected treatment, and treatment alternatives. If a form is not used, these elements need to be documented in the chart. These conversations are needed for all psychiatric medications, but are especially important to document when treatment involves use of controlled substances or other medications with known risks, or the use of medications in cases where it may fall outside their standard recommendation for use.

23. Analysis: The record contains an appropriate initial consent to treatment form, which includes a discussion of treatment with various forms of services, including medication treatment. The initial consent form, however, is not a medication consent form. The initial consent form does not list any medications prescribed or provide information about each medication, particularly the risks and benefits of each. Respondent prescribed controlled substances to Patient 1 that had known risks and warnings against general use in elderly patients, where documentation of informed consent is particularly important. The record contains no medication consent forms, or detailed documentation regarding consent for specific medications that is updated with changes over time.

24. Conclusion: Respondent's failure to properly obtain and/or document Patient 1's consent to prescribe controlled substances constituted a simple departure from standard of care.

**Prescribing and Treatment with Controlled Substances**

25. Standard of Care: Prescribing controlled substances requires extra care and monitoring, as these are high-risk medications; concurrent use of controlled substances can also increase the risks. Coordination between physicians providing these medications is important, and monitoring for side effects and signs of abuse is crucial. This may include lab work including liver functioning tests or toxicology screens, and treatment for patients who are on controlled substances often entails attempts to decrease their burden of medication by use of other non-pharmacological interventions.

26. Analysis: Respondent concurrently prescribed triazolam and clonazepam to Patient 1 throughout most of the treatment period. During the same time, Patient 1 was also prescribed an opioid pain medication by a separate physician. Patient 1 was elderly, had multiple physical ailments, and was prescribed multiple medications that increased her risk for an adverse outcome. The symptoms Patient 1 described, such as anxiety, dysphoria, and apathy, could be partially caused by the use or withdrawal from the "as needed" controlled substances. The record does document that Respondent instructed Patient 1 and/or her caregivers that the triazolam and clonazepam should be used "only as necessary" and with three-hour intervals between them. However, the CURES database shows the medications were filled regularly, suggesting that Patient 1 regularly used triazolam and clonazepam. Further, the half-lives of triazolam, clonazepam, and opioids, particularly in elderly patients, may be substantially longer than the recommended three-hour window.

27. Respondent's medication monitoring appears to be extremely limited from charting, which does not document any CURES information and only documents one medication list from the pharmacy. Although Respondent stated that she reviewed CURES and pharmacy reports more frequently, there is no evidence of such in the record. Additionally, Respondent did not perform toxicology screenings or other screening laboratory work as a medication-monitoring tool. Additionally, the chart contained no information of Respondent's coordination of care with other providers, save for a single note from Patient 1's orthopedist that has no additional context. Given the complexity of Patient 1's medical baseline, her comorbidities, the ongoing severity of

her pain and regular use of controlled substances, additional coordination and monitoring would have been advised to ensure Patient 1's safety.

28. Conclusion: Respondent's prescribing controlled substances to treat Patient 1 constituted a simple departure from the standard of care.

**Patient 2**

29. Patient 2 began treatment with Respondent in June 2005. Patient 2 was diagnosed with Alzheimer's disease in 2012 and subsequently developed anxiety, psychosis, and extreme behavioral symptoms. The relevant treatment period in this case is January 8, 2016, through September 3, 2019 (Treatment Period).

30. In the summary of care dated January 20, 2023, Respondent documented that Patient 2 "was absolutely unable to get and to maintain sleep without pills," and that temazepam was prescribed after other medications failed. Respondent prescribed clonazepam to control Patient 2's "frequent agitation, aggression, anger, hostility, [and] oppositional behavior" and to improve Patient 2's "mood, behavior, socialization, quality of life, prevent hospitalization and placement in a long-term treatment facility." Patient 2's caregiver and family members were instructed that the temazepam and clozapine should be used on an as necessary basis and not within three hours of each other. Patient 2 died at age 99.

**Treatment Record**

31. The treatment record included:

a. An initial consent form, signed on June 3, 2005.

b. General treatment notes for the period of January 8, 2016, through September 2, 2019, dated in four-to-five-month intervals. On January 8, 2016, the note reflects Patient 2's deteriorating mental and physical condition. Throughout the Treatment Period, Respondent documented the patient's deteriorating condition. On May 23, 2016, the note reflects that Patient 2 exhibited behavioral disturbances, including wandering and screaming. On January 13, 2017, the record documents Patient 2's progressive mental and physical deterioration, including decreased mobility. Respondent advised Patient 2 and/or her caregivers to take clonazepam separately from temazepam. Finally, Respondent increased the dose of quetiapine to 25 mg twice

daily. On September 2, 2019, the note documented Patient 2's decreased mobility, dizziness, and a history of three falls in the 14 months prior to the treatment date. The treatment notes were difficult to read and/or interpret, and were not sequentially numbered. Additionally, the notes lacked documentation of coordination with other treating specialists, and documentation that Respondent reviewed Patient 2's CURES reports. Finally, the individual treatment notes did not contain Patient 2's identifying information.

c. Multiple pages of prescription refill requests, and copies of prescriptions for the medications that include the clonazepam 0.5 mg and temazepam 15 mg.

d. A patient drug profile dated September 20, 2019, that documents more than 20 medications prescribed to Patient 2 during the treatment period.

**HQIU Investigation**

32. CURES Report. During the investigation, HQIU Investigators obtained a CURES Report for the period January 1, 2016, through December 31, 2019, for all controlled substances prescribed to Patient 2 by all providers. According to the CURES report, Respondent regularly prescribed 30 tablets of temazepam, 15 mg, and 30 tablets of clonazepam, 0.5 mg for most of the report period. The report also documents early refills of clonazepam on January 23, 2019, February 4, 2019, and February 26, 2019. Respondent prescribed Belsomra 10 mg monthly between July 3, 2018, and January 4, 2019. A separate provider prescribed 60 tablets of Tylenol with codeine on April 28, 2017, and 45 tablets on July 8, 2017. During the same time, Respondent prescribed clonazepam on April 28, 2017, and July 12, 2017, and temazepam on May 8, 2017. Concurrent prescribing of temazepam, clonazepam, and Tylenol with codeine also occurred intermittently throughout 2016.

33. Subject Interview. During the subject interview, Respondent stated:

a. Patient 2 had a psychiatric disorder with delusions, depression, advanced dementia, anxiety, and insomnia. She had support from family and caregivers who provided 24-hour supervision.

b. She was not aware that Patient 2 was prescribed Tylenol with codeine by another physician.

c. She prescribed quetiapine to treat Patient 2's insomnia and to decrease Patient 2's agitation.

**Medical Issue: Documentation and Recordkeeping**

34. Analysis. The treatment notes were difficult to read and/or interpret, and were not sequentially numbered. Additionally, the notes lacked documentation of coordination with other treating specialists, and documentation that Respondent reviewed Patient 2's CURES reports. Finally, the individual treatment notes did not contain Patient 2's identifying information.

35. Conclusion: Respondent's failure to properly document her care and treatment of Patient 2 constitutes a simple departure from the standard of care.

**Medical Issue: Consent for Medications and Treatment**

36. Analysis. The record contains an appropriate initial consent to treatment form that includes a discussion of treatment with various forms of services, including medication treatment. The initial consent form, however, is not a medication consent form. The initial consent form does not list any medications prescribed or information about each medication, particularly the risks and benefits of each. Respondent prescribed controlled substances to Patient 2 that have known risks and warnings against general use in elderly patients, where documentation of informed consent is particularly important. The record contains no medication consent forms or detailed documentation regarding consent for specific medications, which has been updated with changes over time.

37. Conclusion: Respondent's failure to properly obtain and/or document Patient 2's consent to prescribe controlled substances constitutes a simple departure from the standard of care.

**Prescribing and Treatment with Controlled Substances**

38. Analysis: Respondent concurrently prescribed triazolam and clonazepam to Patient 2 throughout most of the treatment period. During the same period, Patient 2 was also prescribed an opioid pain medication by a separate physician. Patient 2 was elderly, had multiple physical ailments, and was prescribed multiple medications that increased her risk for an adverse outcome. The symptoms Patient 2 described, such as episodic confusion, apathy, depression, agitation,

dizziness and falls could be partially caused by use or withdrawal from the "as needed" controlled substances. The record documents the benefits Patient 2 received from triazolam and clonazepam, as well as some attempts at trials of alternative medication. The record also documents that Respondent advised Patient 2 and/or her caregivers that triazolam and clonazepam should be used "only as necessary" and with three-hour intervals between the two drugs. However, the CURES report shows the medications were regularly filled, which indicates Patient 2 regularly used triazolam and clonazepam. Further, the half-lives of triazolam, clonazepam, and Tylenol with codeine, particularly in elderly patients, may be substantially longer than the recommended three-hour window.

39. Monitoring was extremely limited, according to the treatment record. Respondent did not document any CURES information and the treatment record contained only one medication list generated by a pharmacy. The CURES report documented early refills of clonazepam. Respondent should have identified and documented the early refill as required. Respondent did not perform toxicology screenings or other testing using medication-monitoring tools. Additionally, the chart contained no information concerning Respondent's coordination of care with other providers, even though Patient 2 suffered three falls within 14 months. The treatment record shows significant gaps in Respondent's coordination of care and medication monitoring during the Treatment Period.

40. Conclusion: Respondent's prescribing controlled substances to treat Patient 2 constituted an extreme departure from the standard of care.

**Medical Issue: The Use of the Antipsychotic Medication Quetiapine**

41. Standard of Care: The use of antipsychotics in elderly patients with dementia-related psychosis is subject to a black box warning that states, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine is not approved for the treatment of patients with dementia-related psychosis." However, quetiapine is still used by the psychiatric community as the behavioral consequences of dementia-related psychosis can be extreme and treatment options are limited. Quetiapine is also listed in the Beers Criteria as potentially inappropriate for use in patients 65 years and older. Due to adverse

metabolic effects, regular monitoring is suggested in patients of all ages when taking antipsychotics, which includes annual blood chemistries, monitoring of extrapyramidal symptoms annually, monitoring fall risk and mental alertness at every visit, checking fasting glucose and a lipid panel annually, and using a formalized rating scale at least annually to assess for tardive dyskinesia. Vital signs should be checked four weeks after dose changes, and weight/height/BMI should be checked quarterly (with a consideration of monitoring waist circumference annually). Providers must be cautions when prescribing quetiapine to elderly patients diagnosed with dementia-related psychosis. The provider must carefully weigh the risks and benefits of prescribing quetiapine. Finally, providers should only prescribe quetiapine if alternative therapies have failed. Dosing in the elderly begins at 25 mg at bedtime and can increase up to 75 mg twice daily.

42. Analysis: Respondent initially prescribed quetiapine to Patient 2 at a low dose, but later increased the dose after other treatment options proved ineffective. During the Board interview, Respondent stated she felt the quetiapine was effective in decreasing Patient 2's agitation. The record does not document that Respondent ordered lab work, screenings, or other monitoring of side effects. Additionally, there is no documentation that Respondent discussed the black box risks associated with Patient 2, or her caregivers.

43. Conclusion: Respondent's failure to obtain consent to prescribe, and her failure to monitor quetiapine use properly was a simple departure from the standard of care.

**Patient 3.**

44. Patient 3 began treatment with Respondent on or about December 22, 2011. The relevant treatment period in this case is January 11, 2016, through September 17, 2019 (Treatment Period). Patient 3 had a history of major depressive disorder, anxiety disorder, pain disorder, primary insomnia, dementia, and essential tremor. According to the medical record, Patient 3 was "attached to multispecialty care for years secondary to hypertension, cerebrovascular disease, coronary artery disease, congestive heart failure, degenerative spine and joint disease, bronchial asthma, allergy, bladder/uterus prolapse, urinary incontinence."

45. In the summary of care, dated January 10, 2023, Respondent documented that Patient

3 developed anxiety and panic attacks secondary to her medical conditions. Additionally, Patient 3's chronic pain interfered with her functioning, and she was unable to sleep without medication. Regarding treatment, Respondent documented that clonazepam "alleviated the patient's anxiety symptoms, stabilize her mood, improve emotional state, level of functioning and activities daily living." Silenor "improved [Patient 3's] sleep pattern, next day emotional state, energy, motivation." It was noted that the patient and caregiver had been advised not to take clonazepam and other sleeping medications concomitantly, "but with interval at least 3 hours," and recommended to use on "as necessary basis only." The summary concludes that the patient, as of January 2023, was 93 years old and continued to treat with Respondent.

**Treatment Record**

46. The treatment record included:

a. An initial consent form, signed on June 3, 2005.

b. General treatment notes for the period from January 8, 2016, through September 2, 2019, dated in four-to-five-month intervals. On January 8, 2016, Respondent documented that Patient 3 felt worse after knee replacement and rehab, and experienced continued pain, depression, and severe insomnia. The plan was to stop Requip[7]; increase Viibryd, Mizopex, and Lunesta 2 mg; and continue all other medications. On August 11, 2016, Patient 3 reported feeling worse, with poor mood, and sleep limited to three or four hours a night with medication. Respondent stopped the Lunesta prescription and prescribed Silenor. On February 19, 2019, Respondent documented that Patient 3's symptoms persisted, triazolam was stopped, and Ambien 10 mg was added to the list of medications. Throughout the Treatment Period, Patient 3 complained of anxiety, depression, fear, and insomnia. Overall, the treatment notes were difficult to read and/or interpret and were not sequentially numbered. Additionally, the notes lacked documentation of coordination with other treating specialists, and documentation that Respondent reviewed Patient 3's CURES reports. Finally, the individual treatment notes did not contain Patient 3's identifying information.

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[7] Requip is used to treat symptoms of Parkinson's disease (stiffness, tremors, muscle spasms, and poor muscle control) and used to treat restless legs syndrome.

c. Cardiology and pulmonary test result documents ordered by a different physician.

d. Pharmacy records documenting that Patient 3 was prescribed multiple other medications from eight other physicians.

47. The treatment notes were difficult to read and/or interpret, and were not sequentially numbered. Additionally, the notes lacked documentation of coordination with other treating specialists, and documentation that Respondent reviewed Patient 3's CURES reports. Finally, the individual treatment notes did not contain Patient 3's identifying information.

**HQIU Investigation**

48. CURES report for January 1, 2016, through December 31, 2019. According to the CURES report, a separate physician prescribed tramadol from January 7, 2016, through March 4, 2016. Respondent prescribed the remaining medications. Respondent prescribed 30 tablets of clonazepam .5 mg approximately monthly from February 1, 2016, through December 31, 2016. However, the patient obtained refills of 30 tablets of clonazepam .5 mg on May 3, 2019, May 9, 2019, and two refills on June 7, 2019, August 5, 2019, and August 22, 2019. Respondent also prescribed Lunesta approximately monthly between January 11, 2016, and August 26, 2016, and zolpidem 10 mg monthly between February 20, 2019, and December 31, 2019.

**Medical Issue: Documentation and Recordkeeping**

49. Analysis. The treatment notes were difficult to read and/or interpret, and were not sequentially numbered. Additionally, the notes lacked documentation of coordination with other treating specialists and documentation that Respondent reviewed Patient 3's CURES reports. Finally, the individual treatment notes did not contain Patient 3's identifying information.

50. Conclusion: Respondent's failure to properly document her care and treatment of Patient 3 constituted a simple departure from the standard of care.

**Medical Issue: Consent for Medications and Treatment**

51. Analysis. The record contains an appropriate initial consent to treatment form that includes a discussion of treatment with various forms of services, including medication treatment. The initial consent form, however, is not a medication consent form. The initial consent form

does not list any medications prescribed or provide information about each medication, particularly the risks and benefits of each. Respondent prescribed controlled substances to Patient 3 that have known risks and warnings against general use in elderly patients, where documentation of informed consent is particularly important. The record contains no medication consent forms or detailed documentation regarding consent for specific medications, which has been updated with changes over time.

52. Conclusion: Respondent's failure to properly obtain and/or document Patient 3's consent to prescribe controlled substances constituted a simple departure from the standard of care.

**Prescribing and Treatment with Controlled Substances**

53. Analysis: Respondent concurrently prescribed clonazepam and a sleeping pill (Lunesta or zolpidem) throughout the interval reviewed. During the same period, Patient 3 was also prescribed controlled substance pain medication by a separate physician. Patient 3 was elderly, had multiple physical ailments, and was prescribed multiple medications that increased her risk for an adverse outcome. The symptoms Patient 3 described, such as anxiety, depression, fear, and insomnia, could be partially caused by the use or withdrawal from the "as needed" controlled substances. The record documents the benefits Patient 3 received from triazolam and clonazepam, as well as some attempts at trials of alternative medication. The record also documents that Respondent advised Patient 3 and/or her caregivers that triazolam and clonazepam should be used "only as necessary" and with a three-hour interval between dosing. However, the CURES report shows the medications were regularly filled, suggesting that Patient 3 regularly used triazolam and clonazepam. Further, the half-lives of the triazolam, clonazepam, and opioids, particularly in elderly patients, may be substantially longer than the recommended three-hour window. Monitoring appears to be extremely limited from charting, which does not document any CURES information and only shows one medication list from the pharmacy. The CURES report documented frequent refills of clonazepam at several points in 2019 that should have been noticed and documented given the monitoring requirements that existed at that time. Additionally, Respondent did not perform toxicology screenings or other tests as a medication-

monitoring tool. Additionally, the chart contained little information regarding Respondent's coordination of care with other providers, with the exception of various cardiology and pulmonary tests documents. During the Board interview, Respondent stated she and Patient 3's primary care physician discussed the patient's condition, but this was not well documented in the chart. The treatment record shows significant gaps in Respondent's coordination of care and medication monitoring during the Treatment Period.

54. Conclusion: Respondent's prescribing controlled substances to treat Patient 3 constituted a simple departure from the standard of care.

**Patient 4**

55. Patient 4 was treated by Respondent from approximately June 20, 2008, through November 22, 2019. In a summary of care dated January 10, 2023, Respondent documented that Patient 4 had a history of trauma both in childhood and in her marriage, a history of recurrent head injuries, and past psychiatric care from 2004-2007. Patient 4's diagnoses included posttraumatic stress disorder, anxiety disorder, depressive disorder, pain disorder, and cerebral atherosclerosis. Lorazepam was prescribed to stabilize the patient's mood and behavior and to improve her daily functioning level and socialization. Zaleplon was prescribed to manage Patient 4's symptoms of "insomnia, distressing nightmares, illusions, and hallucination, and to improve sleep pattern, next day mood, functioning level, and activities." Both medications were recommended "to be taken separately with 3 hour intervals and as necessary basis only." The summary concludes that the treatment prevented hospitalization and placement in a long-term care facility.

**Treatment Record**

56. The treatment record consisted of:

a. Initial consent form, signed on June 20, 2008.

b. General treatment notes for April 22, 2016, through November 22, 2019, dated in three-to-four-month intervals. On April 22, 2016, Respondent documented that Patient 4 felt worse and described anxiety, depression, and the relationship to her medical conditions. Respondent noted that Patient 4 was unable to sleep. Medications listed include Trintellix 20 mg,

gabapentin 300 mg twice a day, zaleplon 10 mg, lorazepam 0.5 mg twice daily as needed, and sleep hygiene. On July 8, 2016, Respondent noted that Patient 4 was severely depressed with a recent hospitalization for cardiac concerns, and the lorazepam was increased to 0.5 mg every six hours. On February 24, 2017, Respondent documented that Patient 4 had a recent fall. Respondent again noted that Patient 4 could not sleep without medication. Respondent continued all medications and recommended "Stress management, fall precaution, family psychotherapy." On March 16, 2018, Respondent documented that Patient 4 was "absolutely unable to sleep without meds." Medications, including zaleplon and lorazepam were continued. On July 12, 2019, Respondent again documented that Patient 4 was unable to sleep without medication. Amitriptyline[8] was increased to 50 mg, meclizine[9] was started, and all previous medications were continued. On November 22, 2019, Respondent documented that Patient 4 continued to experience depression, anxiety, and chronic pain. Respondent continued to prescribe all medications, particularly zaleplon and lorazepam.

c. A patient drug history report from September 1, 2017, to October 27, 2017, that documents more than 30 prescribed medications.

**HQIU Investigation.**

57. CURES report for January 1, 2016, through December 31, 2019. According to the CURES report, Respondent prescribed all controlled substances, save for one prescription for hydrocodone bitartrate acetaminophen written by a separate physician on January 8, 2018. Respondent also prescribed lorazepam 0.5 mg twice daily as needed, approximately monthly.

58. Subject Interview. Respondent stated:

a. She would communicate with Patient 4's primary care physician and would request a list of medications from the pharmacy to consider drug interactions and would request bloodwork as needed. However, when further questioned about coordination of care (to avoid

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[8] Amitriptyline is a tricyclic antidepressant used to treat symptoms of depression (FDA approved), and amitriptyline is used off-label for insomnia, migraine prevention, ADHD, eating disorders, bipolar disorder, anxiety, psychotic disorders, and some types of pain.

[9] Meclizine is an antihistamine used to treat vertigo and to prevent and control nausea, vomiting, and dizziness caused by motion sickness.

duplication of treatment), Respondent stated she communicated with another physician if the patient presented with a severe physical condition such as dehydration.

b. The treatment notes contained the names of a patient's primary care physician and other specialists. However, Respondent was unable to locate the name of Patient 4's primary care physician documented on the progress note dated April 22, 2016.

c. She believed that Patient 4 only used the prescribed sleep aids once or twice a week. When questioned about the regular prescribing pattern documented in CURES, Respondent stated she could not calculate the number of tablets the patient used per month.

d. She did not use any controlled substance contracts or do any drug screening tests, as Patient 4 was not a drug abuser.

e. She did not have the capability to do a urine drug screen and felt that would be part of the role of a primary care doctor.

**Medical Issue: Documentation and Recordkeeping**

59. Analysis. The treatment notes were difficult to read and/or interpret, and were not sequentially numbered. Additionally, the notes lacked documentation of coordination with other treating specialists, and documentation that Respondent reviewed Patient 4's CURES reports. Finally, the individual treatment notes did not contain Patient 4's identifying information.

60. Conclusion: Respondent's failure to properly document her care and treatment of Patient 4 constituted a simple departure from the standard of care.

**Medical Issue: Consent for Medications and Treatment**

61. Analysis. The record contains an appropriate initial consent to treatment form that includes a discussion of treatment with various forms of services, including medication treatment. The initial consent form, however, is not a medication consent form. The initial consent form does not list any medications prescribed or provide information about each medication, particularly the risks and benefits of each. Respondent prescribed controlled substances to Patient 4 that have known risks and warnings against general use in elderly patients, where documentation of informed consent is particularly important. The record contains no medication consent forms, or detailed documentation regarding consent for specific medications that is

updated with changes over time.

62. Conclusion: Respondent's failure to properly obtain and/or document Patient 4's consent to prescribe controlled substances constituted a simple departure from the standard of care.

**Prescribing and Treatment with Controlled Substances**

63. Analysis: Respondent prescribed lorazepam and zaleplon to Patient 4 throughout much of the treatment period. Patient 4 was elderly, had multiple physical ailments, and was on multiple medications that also increased her risk for an adverse outcome. The symptoms she described, such as anxiety, depression, insomnia, nightmares, and a fall, could be partially caused by use or withdrawal from the "as needed" use of these medications. The treatment record does document the benefits the patient received from these medications, as well as some attempts at trials of alternative medication. It also documents that Respondent advised Patient 4 and/or her caregivers that lorazepam and Zaleplon should be used "only as necessary," and with a three-hour interval between doses. However, the half-lives of these medications, especially in elderly patients, may have been substantially longer than the recommended three-hour window. Respondent reported she believed Patient 4 only took the sleeping pill once or twice a week, whereas the CURES report documents regular prescribing at monthly intervals, which is more consistent with nightly use. During the subject interview, Respondent described logistical difficulties in prescribing fewer pills and stated she could not calculate the number of tablets the patient used per month. Respondent said she did not use any controlled substance contracts or do any drug toxicology screenings, as her patient was not a drug abuser. She stated she did not have the capability to do a urine drug screen and felt that would be part of the role of a primary care doctor.

64. Overall monitoring appears to have been extremely limited from charting, which does not document any CURES information and only shows one medication list from the pharmacy. The chart shows little documentation of coordination with other providers, and the pharmacy report shows overlapping prescriptions of tricyclic medications among multiple providers. Respondent stated during her interview that she used the medication list from the pharmacy to

monitor medications, and would only call the primary care physician if the patient presented with a severe physical condition such as dehydration. She stated she had a practice that primarily consisted of elderly patients in pain and that she could not call each pain doctor, orthopedic doctor, or pain clinic. She felt her patient population would only use one pharmacy, so she was not worried about a duplicative prescription for a controlled substance. She also stated that she checked the CURES database when the law started requiring it. In summary, there were gaps in coordination of care and medication monitoring that is customarily done.

65. Conclusion: Respondent's prescribing to and treatment of Patient 4 with controlled substances constituted an extreme departure from the standard of care.

**Patient 5**

66. According to the summary of treatment dated January 10, 2023, Respondent began treating Patient 5 in 2001. Patient 5 was diagnosed with Alzheimer's disease in 2014, and "personality, mood, behavioral disturbance, episodic hostility, agitation, opposition, aggression, anger, poor impulse control required intervention with psychotropic medications to control her mental state symptoms." According to the summary of care, Respondent prescribed clonazepam to treat Patient 5's aggression and agitation and to improve her compliance with care and socialization. Additionally, Respondent prescribed flurazepam to treat Patient 5's insomnia that improved her nighttime behavior and decreased caregiver stress. Finally, Respondent informed Patient 5's caregiver to administer the medications separately, with at least a three-hour interval between dosing the medications. The treatment improved her daily life, functioning, mood, behavior, and quality of life and prevented hospitalization and long-term care placement.

**Treatment Record.**

67. The record did not contain a general consent form.

68. The record only contained one progress note, dated May 6, 2016. The narrative was not easily readable, but did contain interval history and symptoms. The note did not contain the name of the patient. The note documented Patient 5's increasing reliance on others for the tasks of daily living and depression. Respondent wrote the following at the bottom of the treatment note: "Interval between clonazepam & flurazepam of 3 hours. Unable to get & to maintain sleep

without meds." Respondent documented the prescribed medications as Viibryd, Nuedexta, clonazepam 0.5 mg twice daily as needed, and Flurazepam 15 mg. The progress note was followed by an anxiety screening that documented severe anxiety and did contain the patient's name or date on the document. The other pages in the chart were pharmacy refill requests, copies of prescriptions, and insurance-related forms.

69. The CURES report covered the period from January 1, 2016, through December 31, 2019. Respondent prescribed clonazepam and flurazepam multiple times between January 7, 2016, and December 15, 2016.

**Medical Issue: Documentation and Recordkeeping**

70. Analysis: The chart contains only one progress note, dated May 6, 2016, for the Treatment Period. The CURES report documents that Respondent stopped prescribing controlled substances on August 26, 2016. The treatment note was not easily read due to handwriting issues and limited space. The single note does not contain Patient 5's name or a page number.

71. Conclusion: Respondent's failure to properly document her care and treatment of Patient 5 constituted a simple departure from the standard of care.

**Medical Issue: Consent for Medications and Treatment**

72. Analysis: Respondent prescribed controlled substances to Patient 5 that have known risks and warnings against general use in elderly patients, where documentation of informed consent is particularly important. The record contains no medication consent forms, or detailed documentation regarding consent for specific medications that is updated with changes over time.

73. Conclusion: Respondent's failure to properly obtain and/or document Patient 5's consent to prescribe controlled substances constitutes a simple departure from the standard of care.

**Patient 6**

74. Respondent began treating Patient 6 on April 1, 2015. The relevant treatment period in this case is from March 3, 2016, through October 15, 2016. In the summary of care dated January 10, 2023, Patient 6 was diagnosed with obsessive-compulsive disorder, Alzheimer's disease, anxiety due to the general medical condition, and primary insomnia. Respondent

prescribed clonazepam to treat obsessive-compulsive disorder and anxiety, and zolpidem to treat insomnia. Respondent advised that the medications should be taken only as necessary and should be dosed at least three hours apart.

**Treatment Record**

75. The treatment record consisted of:

a. An initial consent form, dated April 1, 2015.

b. General treatment notes covering the period March 3, 2016, through October 15, 2016, dated in two-to-three-month intervals. On March 3, 2016, Respondent documented Patient 6's deteriorating mental condition, irrational fears, anxiety, and insomnia. Respondent prescribed Namenda and zolpidem. All other medications were continued. On June 23, 2016, Respondent documented that Patient 6 experienced excessive anxiety and exhibited behavioral issues. Respondent stopped the Namenda prescription. On August 22, 2016, Respondent noted Patient 6 experienced continued anxiety and depression; the prescription for Luvox was increased to 50 mg twice daily. On October 13, 2016, Respondent documented progressive functional decline. Luvox was increased to 100 mg a day. Overall, the treatment notes were difficult to read and/or interpret, and were not sequentially numbered. Additionally, the notes lacked documentation of coordination with other treating specialists, and documentation that Respondent reviewed Patient 6's CURES reports. Finally, the individual treatment notes did not contain Patient 6's identifying information.

c. A chest x-ray report, dated March 8, 2016, that was annotated "SN assessed that patient demonstrated congested lungs and coarse lung sounds."

d. Several incomplete records signed by Respondent that address non-psychiatric conditions, including degenerative joint disease and fungal infection.

e. A June 25, 2016, order written by Respondent terminating Patient 6's home care services.

f. A medication list that documents Luvox 50 mg, clonazepam 0.5 mg, and zolpidem 10 mg.

g. Urinalysis and blood laboratory results, dated October 26, 2016, previously

ordered by Respondent. The urinalysis was normal. However, the blood panel showed elevated triglycerides and TSH and slightly decreased potassium levels. The record also contained Respondent's written note to evaluate the laboratory results.

**HQIU Investigation**

76. CURES report for January 1, 2016, through December 31, 2019. Respondent prescribed clonazepam 0.5 mg and zolpidem 5 mg beginning on January 25, 2016, and filled approximately monthly through December 2016.

77. Subject interview – During the subject interview, Respondent stated she did not obtain a patient drug history, did not use a controlled substance contract with Patient 6, and did not order toxicology screenings.

**Medical Issue: Documentation and Recordkeeping**

78. Analysis. The treatment notes were difficult to read and/or interpret, and were not sequentially numbered. Additionally, the notes lacked documentation of coordination with other treating specialists, and documentation that Respondent reviewed Patient 6's CURES reports. The record also documents that Respondent prescribed medication for non-psychiatric issues, but the rationale is not well documented. During the subject interview, Respondent clarified that non-psychiatric medications were prescribed in order to help place the patient in a long-term care facility and did not constitute ongoing medical care. Finally, the individual treatment notes did not contain Patient 6's identifying information.

79. Conclusion: Respondent's failure to properly document her care and treatment of Patient 6 constitutes a simple departure from the standard of care.

**Medical Issue: Consent for Medications and Treatment**

80. Analysis: Respondent prescribed controlled substances to Patient 6 that have known risks and warnings against general use in elderly patients, where documentation of informed consent is particularly important. The record contained no medication consent forms, or detailed documentation regarding consent for specific medications that is updated with changes over time.

81. Conclusion: Respondent's failure to properly obtain and/or document Patient 6's consent to prescribe controlled substances constituted a simple departure from the standard of

care.

**Prescribing and Treatment with Controlled Substances**

82. Analysis: Respondent concurrently prescribed zolpidem and clonazepam to Patient 6 throughout most of the treatment period. Patient 6 was elderly, had multiple physical ailments, and was prescribed multiple medications that increased her risk for an adverse outcome. The symptoms Patient 6 described, such as anxiety, fears, and progressive functional decline, could be partially caused by use or withdrawal from the "as needed" use of the prescribed zolpidem and clonazepam. The record documents the benefits Patient 6 received from zolpidem and clonazepam, as well as some attempts at trials of alternative medication. The record also documents that Respondent advised Patient 6 and/or her caregivers that zolpidem and clonazepam should be used "only as necessary" and with three-hour intervals between doses. However, the CURES report shows the medications were regularly filled, suggesting that Patient 6 regularly used zolpidem and clonazepam. Further, the half-lives of zolpidem and clonazepam, particularly in elderly patients, may be substantially longer than the recommended three-hour window. Monitoring appears to be extremely limited from charting, and Respondent confirmed she did not obtain a drug history or perform any toxicology screening or other testing. The record also has very little documentation of care coordination with other providers. Additionally, Respondent prescribed non-psychiatric medications when attempting to facilitate the patient's transfer to a long-term care facility. Given Patient 6's medical status, the ongoing severity of her pain, and numerous physical symptoms, additional coordination and monitoring would have been advised to ensure patient safety.

83. Conclusion: Respondent's prescribing controlled substances to treat Patient 6 constituted a simple departure from the standard of care.

**FIRST CAUSE FOR DISCIPLINE**

**(Gross Negligence)**

84. Respondent Tsilya Bass, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the code, in that Respondent acted with gross negligence by prescribing controlled substances to Patients 2 and 4 without proper medication monitoring. The facts and

allegations set forth in paragraphs 29 through 43, and 54 through 65, above, are incorporated by reference as if set forth in full herein.

**SECOND CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate Treatment Records)**

85. Respondent Tsilya Bass, M.D. is subject to disciplinary action under section 2262, of the code, in that Respondent failed to create and maintain proper medical records of her care and treatment of Patients 1 through 6. The facts and allegations set forth in paragraphs 14 through 83, above, are incorporated by reference as if set forth in full herein.

**THIRD CAUSE FOR DISCIPLINE**

**(Repeated Negligent Acts)**

86. Respondent Tsilya Bass, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the code, in that Respondent:

a. Prescribed medications and controlled substances to Patients 1-6 without obtaining prior informed consent;

b. Failed to properly monitor Patients 1-6 after prescribing multiple controlled substances; and

c. Failed to maintain adequate treatment records during the care and treatment of Patients 1-6.

87. The facts and allegations set forth in paragraphs 14 through 85, above, are incorporated by reference as if set forth in full 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 Number A 63630, issued to Respondent Tsilya Bass, M.D.;

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

3. Ordering Respondent to pay the Board the costs of the investigation and enforcement

of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent Tsilya Bass, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

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

DATED: 8/8/24

JENNA JONES FOR
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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