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

In the Matter of the Accusation Against, **BRENDA ANN LEWIS, M.D.** P.O. Box 55005 Hayward, CA 94545 **Physician's and Surgeon's Certificate No. G52614** One.	Case No. 12-2013-231939 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about November 20, 2014, Complainant Kimberly Kirchmeyer, in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed Accusation No. 12-2013-231939 against Brenda Ann Lewis, M.D. (Respondent) before the Medical Board of California.

2. On or about June 25, 1984, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G52614 to 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 April 30, 2016, unless renewed. (Exhibit Package, Exhibit 1, Certificate of Licensure.)[1]

[1] The evidence in support of this Default Decision and Order is attached and submitted as the "Exhibit Package" and is incorporated by reference as if fully set forth.

3. On or about November 20, 2014, an employee of the Board, served by Certified Mail a copy of the Accusation No. 12-2013-231939, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is: P.O. Box 55005, Hayward, CA 94545. On or about January 20, 2015, the aforementioned documents were returned by the U.S. Postal Service marked "Unclaimed.". (Exhibit Package, Exhibit 2, Accusation Packet, Declaration of Service, return receipt card, copy of the "Unclaimed" returned Accusation Packet, and a copy of the U.S. Postal Service Track and Confirm search results.)

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

5. On or about February 3, 2015, an employee of the Attorney General's Office sent by certified mail to Respondent Courtesy Notices of Default, advising Respondent of the service of the Accusation, and providing her with the opportunity to request relief from default. The Courtesy Notices were addressed to Respondent's address of record, as set forth above, as well as two additional addresses identified as alternatives by the Board. All three Courtesy Notice Packages were returned to the Attorney General's Office as either "unclaimed" or "undeliverable." (Exhibit Package, Exhibit 3, Courtesy Notice of Default, Declaration of Service, copies of the returned envelopes, and copies of the U.S. Postal Service Track and Confirm search results.)

6. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 12-2013-231939.

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7. California Government Code section 11520 states, in pertinent part:

"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

8. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in the Exhibit Package, finds that the allegations in Accusation No. 12-2013-231939 are true.

9. The Board makes the following factual findings related to the care and treatment of Patient GR:

a. Respondent provided psychiatric services to Patient GR at Tia Maria's Board and Care Home since 1985. GR committed suicide on July 23, 2010. Respondent admitted during her interview with an investigator for the Health Quality Investigation Unit (HQIU) that she mostly provided medication management rather than psychotherapy. (Scarlett Declaration Supporting Default Decision and Order (Scarlett Decl.) ¶ 2a; Lavid Declaration Supporting Default Decision and Order (Lavid Decl.) ¶ 4a.)

b. Respondent admitted during the interview with HQIU that she ordered blood work; however, she did not produce any lab results at the interview or in the medical record. (Scarlett Decl. ¶ 2b; Lavid Decl. ¶ 4d.)

c. Respondent acknowledged that GR had a history of suicide attempts and should not be permitted access to sharp object. (Scarlett Decl. ¶ 2c; Lavid Decl. ¶ 4a.)

d. GR's certified medical records from Respondent dated from January 12, 2009 through July 25, 2010 are not the same as the records she produced to the Alameda County Behavioral Health Care Services (ACBHCS). For example, the records to the Board did not include a June 18, 2010 progress note on the same page as a July 22, 2010 record like the records submitted to ACBHCS. Additionally, the records Respondent produced to ACBHCS included a progress note for a patient visit with GR on August 26, 2010—almost

one month after he committed suicide. This record was not in the records Respondent produced to the Board. (Scarlett Decl. ¶ 2d; Lavid Decl. ¶ 4a.)

e. Respondent acknowledged during the interview that she met with GR on July 22, 2010, and the visit was "unremarkable" and she did not observe any suicidal ideations. She only learned after the fact from another party that GR killed himself on July 23, 2010. (Scarlett Decl. ¶ 2e; Lavid Decl. ¶ 4b.)

f. Respondent could not explain the different sets of medical records for GR provided to the Board and ACBHCS, or why there was a progress note for a patient visit with GR on August 26, 2010. (Scarlett Decl. ¶ 2f.)

g. The standard of care requires psychiatrists to maintain accurate and complete medical records. Psychiatric records should document an assessment, the basis for the assessment, the treatment options offered, and the response to treatment. If the documents are handwritten, they should be legible or typed, particularly to make the records understandable by other physicians. Respondent produced two different sets of medical records: one to the ACBHCS and one that she claimed she maintained herself. The records produced from Respondent's practice include a progress note for a visit with GR almost one month after GR committed suicide. Respondent could not explain why she maintained two different sets of medical records for Patient GR. This was an extreme departure in the standard of care. (Lavid Decl. ¶ 5a.)

h. The standard of care requires psychiatrists to provide an appropriate good faith evaluation with a face-to-face evaluation that includes a Mental Status Examination. The examination may also be augmented by testing, including serology testing. Respondent's failure to document and conduct any psychiatric evaluation of GR and/or her practice of conducting a one minute psychiatric diagnosis represents an extreme departure in the standard of care. (Lavid Decl. ¶ 5b.)

i. The standard of care requires regular serum testing for patients on Tegretol.[2] Additionally, psychiatrists should review and document the patient's response to treatment, as well as the risks and benefits of the treatment. Respondent's failure to monitor GR's Tegretol use, including regular blood testing and noting the effectiveness/response of the medication represents an extreme departure in the standard of care. (Lavid Decl. ¶5c.)

j. The standard of care requires an assessment of the dangerousness and suicide risk in psychiatric evaluations. This should include a thorough evaluation that enables the psychiatrist to identify factors and features that may increase or decrease the risk of suicide, address the patient's immediate safety, and determine the most appropriate setting for treatment. Despite GR's denial of suicidal thoughts, Dr. Lewis indicated she wanted to start prescribing Clozaril to GR in an attempt to reduce his suicidal behaviors. Dr. Lewis's evaluation, or lack thereof, of GR's dangerousness and risk assessment related to the risk of suicide represents a lack of knowledge. (Lavid Decl. ¶ 5d.)

10. The Board makes the following factual findings related to the care and treatment of Patient LS:

a. Respondent provided psychiatric services to Patient LS since 1994 at Maria Silva's Board and Care Home (MSBCH). LS fell which resulted in her death on April 15, 2012. (Scarlett Decl. ¶ 3a; Lavid Decl. ¶ 6a.)

b. The certified copies of LS's medical records from MSBCH only contained Medication Administration Records. There were no progress notes from Respondent in the records from MSBCH. Respondent admitted that she maintained all of her patient medical records herself and did not keep any patient records at MSBCH or provide any copies of those records to MSBCH staff. (Scarlett Decl. ¶ 3b.)

c. Respondent produced 16 pages of progress notes for her care of LS at MSBCH between January 1, 2011 through March 27, 2012. (Scarlett Decl. ¶ 3c; Lavid Decl. ¶ 6c.)

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[2] Tegretol is typically prescribed for patients who suffer from mood symptoms as a mood stabilizer.

d. During Respondent's interview with HQIU, she admitted that she prescribed Clozaril to LS but that she did not follow-up with MSBCH staff to ensure that the patient received monthly blood testing. Respondent thought the pharmacy would simply deny the prescription for Clozaril if there was no proof of monthly blood testing. She also admitted that she did not order the necessary blood testing between January 2011 to April 2012. (Scarlett Decl. ¶ 3d; Lavid Decl. ¶ 6c.)

e. The standard of care requires psychiatrists to maintain accurate and complete medical records. Psychiatric records should document an assessment, the basis for the assessment, the treatment options offered, and the response to treatment. If the documents are handwritten, they should be legible or typed, particularly to make the records understandable by other physicians. Dr. Lewis's records for Patient LS do not contain comprehensive examinations and suicide risk assessments. This was a simple departure in the standard of care. (Lavid Decl. ¶ 7a.)

f. The standard of care requires very specific monitoring requirements for patients taking Clozaril. Initially blood must be tested once per week for the first six months, every two weeks for the following six months, and then monthly thereafter. This monitoring is ordered by not only the treating physician but also by the dispensing pharmacy. Dr. Lewis's failure to adequately monitor LS, including ordering monthly blood testing and prescribing Risperdal (both sedating medications) concurrently with prescribing Clozaril was an extreme departure from the standard of practice. (Lavid Decl. ¶ 7b.)

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Brenda Ann Lewis, M.D. has subjected her Physician's and Surgeon's Certificate No. G52614 to discipline.

2. A copy of the Accusation and the related documents and Declaration of Service are attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Medical Board of California is authorized to revoke Respondent's Physician's and Surgeon's Certificate based upon the following violations alleged in the Accusation: sections

2234 [unprofessional conduct], and/or 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [incompetence/lack of knowledge]; and/or 2262 [alteration of medical records] and/or 2266 [inadequate medical records] based on the care she provided to Patients GR and LS.

ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. G52614, heretofore issued to Respondent Brenda Ann Lewis, M.D., is REVOKED.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on May 29, 2015.

It is so ORDERED May 1, 2015

FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO November 20, 2014
BY: [illegible] ANALYST

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

In the Matter of the Accusation Against: **BRENDA ANN LEWIS, M.D.** P.O. Box 55005 Hayward, CA 94545 **Physician's and Surgeon's Certificate No. G52614** Respondent.	Case No. 12-2013-231939 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about June 25, 1984, the Medical Board of California issued Physician's and Surgeon's Certificate Number G52614 to Brenda Ann Lewis, M.D. (Respondent). At all times relevant to this Accusation, Respondent's Physician's and Surgeon's Certificate was renewed and current and expires on April 30, 2016.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board),[1] Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

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

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

"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.

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[1] The term "Board" means the Medical Board of California. "Division of Medical Quality" or "Division" shall also be deemed to refer to the Board (Bus. & Prof. Code section 2002).

6. Section 2262 of the Code states in relevant part:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, 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."

American Psychiatric Association (APA), Principles of Medical Ethics

8. Section 1 of the APA, Principles of Medical Ethics states:

"A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights."

9. Section 2 of the APA, Principles of Medical Ethics states:

"A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities."

10. Section 3 of the APA, Principles of Medical Ethics states:

"A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient."

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence, and/or Repeated Negligent Acts and/or Incompetence/Lack of Knowledge in the Care of Patient GR)

11. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [incompetence/lack of knowledge] based on the care she provided to Patient GR.[2] The circumstances are as follows:

12. Patient GR was a 50-year-old male with a 30-year diagnosed history of Schizophrenia, Paranoid Type. GR was a client of the Alameda County Behavioral Health Care Services (ACBHCS) since 1985. He was a resident of Tia Maria's Board and Care Home (Tia

[2] Patient initials will be used to protect their privacy. Respondent may learn the patient identities during the discovery process.

Maria's) from 1999 to July 23, 2010, when GR committed suicide. He had two prior suicide attempts. Respondent provided psychiatric services to GR at Tia Maria's approximately once per month.

13. On or about July 22, 2010, Respondent saw GR at Tia Maria's. That same evening, GR had an overnight visit with his family. GR had not had an overnight visit with his family for a long time. The two prior suicide attempts occurred while he visited his family or shortly after returning from a family visit.

14. On or about July 23, 2010, GR committed suicide at Tia Maria's. He entered the kitchen, got a knife, and then stabbed himself several times in the stomach. GR died in the operating room at Eden Medical Center.[3]

15. ACBHCS investigated the circumstances surrounding GR's suicide, including requesting Respondent's treatment records for him. Respondent produced three pages of detailed handwritten progress notes for June 18, 2010 (a partial record), July 22, 2010, and August 26, 2010 (almost a month after GR died).[4]

16. Respondent's progress note provided to ACBHCS for July 22, 2010 specifically stated that GR denied having any "homicidal/suicidal ideation," but that he was "convinced that another resident at B & C is trying to infect him." Respondent also listed all of GR's medications, including that he was taking Tegretol.[5]

17. The progress note Respondent provided to ACBHCS for August 26, 2010 (over a month after GR's death) stated that GR was still concerned that residents at the Tia Maria's were

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[3] GR's prior suicide attempts also involved stabbing himself in the abdomen. Respondent told the Board investigators that she advised Tia Maria's to keep all sharp objects away from GR.

[4] The first page of progress notes included the partial June 18, 2010 record and a portion of the July 22, 2010 record. The second page included the remaining portion of the July 22, 2010 record and part of the August 26, 2010 record. The final page included the remaining note for the August 26, 2010 visit.

[5] Tegretol, the trade name for carbamazepine, is an anticonvulsant used to treat seizures and nerve pain such as trigeminal neuralgia and diabetic neuropathy. It may also be used to treat bipolar disorder, or for patients who suffer from mood symptoms (to act as a mood stabilizer). Regular blood testing is required with prescribing Tegretol to ensure therapeutic levels are constant in the patient. Tegretol can cause aplastic anemia, which also requires regular blood testing. It is a dangerous drug as defined by Business and Professions Code section 4022.

trying to "contaminate him." Respondent also wrote that she discussed Clozaril[6] with GR but he did not want to do the required blood testing. Respondent also listed all of GR's medications, including that he was taking Tegretol.

18. Tia Maria's paid Respondent $250 each month to have her come to the facility to treat all of the residents, including GR. The facility would write Respondent a check on the day of her monthly visit. Tia Maria's provided a copy of a cancelled check written to Respondent for her services on July 22, 2010.[7] Tia Maria's also had a calendar of house activities for July 2010, with a note that "Dr. Lewis came" on July 22, 2010 and that GR "was taken to Eden Hospital" on July 23, 2010.

19. Respondent provided GR's medical records to the Board dating from January 12, 2009 through July 25, 2010; however, these records are different from the records she produced to ACBHCS. For example, there was not a partial June 18, 2010 progress note on the same page as a July 22, 2010 record like the records submitted to ACBHCS. Nor was there the entry for August 26, 2010. The record Respondent provided to the Board included a progress note from June 12, 2010, July 2, 1010, and a note from July 25, 2010. The July 25, 2010 note stated, "call from Anita [sic] Greg died couple of days ago [sic] taken to Eden MC" and was signed by Respondent. The last page of the medical records for GR that Respondent provided to the Board indicated that she saw GR "without charge" because she was already seeing other patients at the home.

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[6] Clozaril, the trade name for clozapine, is an anti-psychotic used to treat severe schizophrenia. It is only available through specific pharmacies after the patient registers for the program and Complete Blood Count (CBC) testing is done regularly. Clozaril can result in agranulocytosis, which is an acute and severe condition known as leukopenia (low white blood count). Patients with agranulocytosis are at a serious risk of infection due to their low white blood count, which requires regular CBC testing. Initially, blood work must be conducted weekly for the first six months of using on Clozaril, every other week for the next six months, and monthly thereafter. It is a dangerous drug as defined by Business and Professions Code section 4022.

[7] Tia Maria's no longer had any treatment records for GR.

20. Respondent's July 2, 2010 medical record provided to the Board indicates that GR was taking several medications including Tegretol.[8] There are no records supporting any blood tests for GR to ensure the effective levels of Tegretol or if he was suffering from aplastic anemia.

21. During Respondent's Medical Board interview on May 15, 2014 at the Pleasant Hill District Office, Respondent could not explain why she had two different sets of medical records for GR.

22. In the medical records Respondent provided to the Medical Board, there is no psychiatric evaluation of GR nor is there a definitive diagnosis and treatment plan. The record only consists of prescribed medications to GR. Respondent admitted during her Board interview that she was not providing any therapy to GR, but rather only monitored his medications. Respondent also stated that she prescribed the Tegretol to address GR's delusions.

23. During Respondent's Board interview she indicated she does not conduct a "standard" psychiatric evaluation, but rather diagnoses Schizophrenia after speaking with the patient for approximately one minute. She also indicated that she does not find it useful to rely on the diagnosis and impressions of other providers.[9]

24. Respondent's use of two different sets of medical records for GR represents an extreme departure in the standard of care.

25. Respondent's failure to document and conduct any psychiatric evaluation of GR and/or her practice of conducting a one minute psychiatric diagnosis represents an extreme departure in the standard of care.

26. Respondent's failure to monitor GR's Tegretol use, including regular blood testing and noting the effectiveness/response of the medication represents an extreme departure in the standard of care.

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[8] Based on Respondent's records to the Board, she first prescribed Tegretol to GR on July 16, 2009. Between July 19, 2009 and July 23, 2010 (the date of Gr's death), Respondent never ordered any blood testing or other lab work.

[9] Respondent stated in her Board interview that she also does not rely on the records and/or diagnosis from other medical providers.

27. Respondent's evaluation of GR's dangerousness and risk assessment related to the risk of suicide represents a lack of knowledge.

28. Respondent's failure to comply with the standard of practice coupled with her lack of knowledge related to the care she provided to GR amounts to repeated negligent acts.

SECOND CAUSE FOR DISCIPLINE

(Inadequate/Inaccurate Medical Record Keeping and/or Altered or Modified Medical Records related to Patient GR)

29. Respondent is subject to disciplinary action under sections 2262 and/or 2266 in that she failed to keep adequate and accurate medical records and/or altered or modified the medical records of GR as alleged in paragraphs 11 through 28, which are herein incorporated by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence, and/or Repeated Negligent Acts in the Care of Patient LS)

30. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b) [gross negligence] and/or 2234(c) [repeated negligent acts] based on the care she provided to Patient LS. The circumstances are as follows:

31. Patient LS was a 58-year old female with a chronic history of schizophrenia. LS was a resident at the Maria Silva's Board and Care Home (Maria Silva's) since 1994.[10] Respondent began treating LS approximately 15 years before her death at Maria Silva's. LS had been a client of the ACBHCS for many years and was classified as a Level I client—the most severe and chronically ill client level.

32. Respondent visited Maria Silva's approximately once per month to treat all of the residents, including LS. Respondent admitted during her Board interview that she did not provide therapy services to LS, but only medication management. Respondent was paid $250 per monthly visit by Maria Silva's to see all of the residents. Respondent also admitted during her

[10] Maria Silva's is next door to Tia Maria's and appear to be owned by the same family.

Board interview that she personally maintained all the medical records for her patients and she did not keep any medical records or maintain/send copies to the Board and Care facility. There were no progress notes from Respondent in the medical records provided by Maria Silva's.[11]

33. Respondent began prescribing Clozaril to LS many years before for delusions and auditory hallucinations, gradually increasing the dosage. The last dose increase noted in the patient's medical records was on September 27, 2011. On that date, Respondent increased LS's Clozaril to 700 mg per day.[12]

34. Respondent provided medical records for LS from January 6, 2011 through March 27, 2012 to the Board. These records indicate that blood work was only done for LS on January 19, 2011. Respondent admitted during her Board interview that she did not follow up with the required monthly blood work for LS. She stated she assumed that the pharmacy would deny the Clozaril prescription if the monthly blood testing was missing.

35. On or about March 27, 2012, Respondent's last progress note for a patient encounter with LS, indicates that the patient was laughing, still suffered from delusions ("I'm married to the president"), her sleep was variable, she had dry mouth, and she did not have any Parkinsonian tremors. Respondent noted the plan as: Clozaril (100 mg, three in the morning and four in the evening, for a daily total of 700 milligrams (mg); Risperdal;[13] Cogentin;[14] and Trazadone.[15]

36. On or about April 15, 2012, LS fell at Maria Silva's (unobserved fall). LS told the employees of the home that she did not want to be moved and staff was unable to move her. At

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[11] The majority of the 61 pages of medical records from Maria Silva's included the Medication Administration Record for the medications LS was receiving. There were no progress notes from any medical providers in Maria Silva's records for LS.

[12] The maximum approved daily dosage by the Federal Drug Administration is 700 mg to 900 mg daily.

[13] Risperdal, the trade name for risperidone, is an antipsychotic medicine and is used to treat schizophrenia and symptoms of bipolar disorder (manic depression). One of the side effects is somnolence and extra caution should be made when prescribing it with other medications that also produce somnolence, such as Clozaril. It is a dangerous drug as defined by Business and Professions Code section 4022.

[14] Cogentin, the trade name for benztropine, is used to treat the symptoms of Parkinson's disease, such as muscle spasms, stiffness, tremors, sweating, drooling, and poor muscle control. It is a dangerous drug as defined by Business and Professions Code section 4022.

[15] Trazadone hydrochloride is a triazolopyridine derivative antidepressant, sometimes marketed under the trade name Desyrel. It is a dangerous drug as defined by Business and Professions Code section 4022.

some point, 911 was called. LS lost consciousness and within minutes of the ambulance's arrival to the home she died. The Alameda County Sheriff's Office Coroner's report listed the cause of death as "spinal cord compression with dysfunction due to atlanto-occipital joint laxity with hypermobility" and "blunt forced head trauma."

37. Respondent's failure to adequately monitor LS, including ordering monthly blood testing and prescribing Risperdal concurrently with prescribing Clozaril was an extreme departure from the standard of practice.

38. Respondent's failure to maintain adequate and accurate medical records, including noting necessary blood work, and not maintaining medical records at Maria Silva's represent departures from the standard of practice, and constitutes repeated negligent acts.

FOURTH CAUSE FOR DISCIPLINE

(Inadequate/Inaccurate Medical Record Keeping in the care of Patient LS)

39. Respondent is subject to disciplinary action under section 2266 in that she failed to keep adequate and accurate medical records of the care she provided to LS as alleged in paragraphs 30 through 38 which are herein incorporated by reference as if fully set forth.

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 G52614, issued to Brenda Ann Lewis, M.D.

2. Revoking, suspending or denying approval of Brenda Ann Lewis, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering Brenda Ann Lewis, M.D. to pay the Medical Board of California the costs of probation monitoring, if placed on probation; and

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

DATED: November 20, 2014

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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