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

In the Matter of the Accusation Against: Kulendu Ghanshyam Vasavda , M.D. Physician's and Surgeon's Certificate No. A 49048 Respondent.	Case No.: 800-2017-031800

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 4, 2021.

IT IS SO ORDERED: October 5, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D. , Chair
Panel B

MATTHEW RODRIQUEZ
Acting Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KULENDU GHANSHYAM VASAVDA, M.D.** **221 Tuxedo Court Ste. C** **Stockton, CA 95204** **Physician's and Surgeon's Certificate No. A 49048** Respondent.	Case No. 800-2017-031800 OAH No. 2020060563 **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. William Prasifka (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 Matthew Rodriquez, Acting Attorney General of the State of California, by Megan R. O'Carroll, Deputy Attorney General.

2. Respondent Kulendu Ghanshyam Vasavda, M.D. (Respondent) is represented in this proceeding by attorney Joseph S. Picchi, Esq., whose address is: 2300 Contra Costa Blvd, Suite 350 Pleasant Hill, CA 94523-2398.

3. On or about August 31, 2000, the Board issued Physician's and Surgeon's Certificate No. A 49048 to Kulendu Ghanshyam Vasavda, 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. 800-2017-031800, and will expire on June 30, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-031800 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 April 13, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-031800 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. 800-2017-031800. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-031800, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2017-031800, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 49048 to disciplinary action.

12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2017-031800 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.

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

RESERVATION

14. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

15. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and

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

16. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2017-031800 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.

17. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 49048 issued to Respondent Kulendu Ghanshyam Vasavda, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

1. 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.

2. PROHIBITED PRACTICE. During probation, Respondent is prohibited from ordering, prescribing, dispensing, administering, or furnishing any Schedule II controlled substances as defined by the California Uniform Controlled Substances Act, except to patients who have been admitted to hospice care. After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from ordering, prescribing, dispensing, administering, or furnishing any Schedule II controlled substances to non-hospice patients. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

3. 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.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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

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

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective

date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

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

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief

Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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

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

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

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

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

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

Travel or Residence Outside California

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

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

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

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

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

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

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

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

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate

and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

17. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-031800 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

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

DATED: 4/24/2021

KULENDU GHANSHYAM VASAVDA, M.D.
Respondent

I have read and fully discussed with Respondent Kulendu Ghanshyam Vasavda, 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: April 26, 2021

JOSEPH S. PICCHI, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 4/28/2021

Respectfully submitted,

MATTHEW RODRIQUEZ
Acting Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

MEGAN R. O'CARROLL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-031800

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

In the Matter of the Accusation Against: **Kulendu Ghanshyam Vasavda, M.D.** **221 Tuxedo Court Ste. C** **Stockton, CA 95204** **Physician's and Surgeon's Certificate No. A 49048,** Respondent.	Case No. 800-2017-031800 **ACCUSATION**

PARTIES

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

2. On or about August 31, 2000, the Medical Board issued Physician's and Surgeon's Certificate No. A 49048 to Kulendu Ghanshyam Vasavda, 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 June 30, 2022, 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

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

6. Section 3502 of the Code, as it was in effect between January 1, 2016 and December 31, 2019 stated:

(a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

(b) (1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient specific orders from the supervising physician and surgeon.

(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when such assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c) (1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow up care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2) (A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.

(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other provision of law, the Medical Board of California or board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

(d) No medical services may be performed under this chapter in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

(f) Compliance by a physician assistant and supervising physician and surgeon with this section shall be deemed compliance with Section 1399.546 of Title 16 of the California Code of Regulations.[1]

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[1] The current version of this statute is as follows:

(a) Notwithstanding any other law, a PA may perform medical services as authorized by this chapter if the following requirements are met:

(1) The PA renders the services under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California or by the Osteopathic Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant.

(2) The PA renders the services pursuant to a practice agreement that meets the

7. California Code of Regulations, Title 16, Section 1399.540 states:

(a) A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.

(b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

(c) The board or Medical Board of California or their representative may require proof or demonstration of competence from any physician assistant for any

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requirements of Section 3502.3.

(3) The PA is competent to perform the services.

(4) The PA's education, training, and experience have prepared the PA to render the services.

(b)(1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from a supervising physician and surgeon.

(2) A supervising physician and surgeon shall be available to the physician assistant for consultation when assistance is rendered pursuant to this subdivision. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c) Nothing in regulations shall require that a physician and surgeon review or countersign a medical record of a patient treated by a physician assistant, unless required by the practice agreement. The board may, as a condition of probation or reinstatement of a licensee, require the review or countersignature of records of patients treated by a physician assistant for a specified duration.

(d) This chapter does not authorize the performance of medical services in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

(f) Notwithstanding any other law, a PA rendering services in a general acute care hospital as defined in Section 1250 of the Health and Safety Code shall be supervised by a physician and surgeon with privileges to practice in that hospital. Within a general acute care hospital, the practice agreement shall establish policies and procedures to identify a physician and surgeon who is supervising the PA.

tasks, procedures or management he or she is performing.

(d) A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem which the physician assistant determines exceeds his or her level of competence or shall refer such cases to a physician.

8. Title 22 of the California Code of Regulations, section 72303, states:

(a) All persons admitted or accepted for care by the skilled nursing facility shall be under the care of a physician selected by the patient or patient's authorized representative.

(b) Physician services shall mean those services provided by physicians responsible for the care of individual patients in the facility. Physician services shall include but are not limited to:

(1) Patient evaluation including a written report of a physical examination within 5 days prior to admission or within 72 hours following admission.

(2) An evaluation of the patient and review of orders for care and treatment on change of attending physicians.

(3) Patient diagnoses.

(4) Advice, treatment and determination of appropriate level of care needed for each patient.

(5) Written and signed orders for diet, care, diagnostic tests and treatment of patients by others. Orders for restraints shall meet the requirements of Section 72319(b).

(6) Health record progress notes and other appropriate entries in the patient's health records.

(7) Provision for alternate physician coverage in the event the attending physician is not available.

(c) Subsection (b) shall not prevent or limit other licensed healthcare practitioners acting within the scope of their professional licensure from providing services to and being responsible for the care of individual patients in the facility, including providing those services listed in subsection (b) above that are within the scope of their licensure.

9. Title 22 of the California Code of Regulations, section 72307, states:

(a) Each patient admitted to the skilled nursing facility shall be under the continuing supervision of a physician who evaluates the patient as needed and at least every 30 days unless there is an alternate schedule, and who documents the visits in the patient health record.

(b) Alternate schedules of visits shall be documented in the patient health record with a medical justification by the attending physician. The alternate schedule shall conform with facility policy.

10. 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.

FACTUAL ALLEGATIONS

11. Respondent is a Family Medicine Practitioner in Stockton, California. He has a medical office where he sees patients, as a solo practitioner, one day per week. The rest of his practice consists of treating patients at various skilled nursing, assisted living, and hospice facilities in and around the Stockton area.

Patient 1

12. Patient 1 was a 31-year-old man when he began seeing Respondent at his office-based practice on or about February 16, 2017. Before seeing Respondent, Patient 1 had been under the care of a physician, Dr. M.C. The last prescription Patient 1 filled from Dr. M.C. was on December 1, 2016 for fentanyl patches, 25 mcg, every three days. Patient 1 had also filled a prescription for oxycodone from Dr. M.C. on September 7, 2016, of 120 30 mg tablets, intended to last for 30 days. Patient 1 had not filled any opioid prescriptions since December 1, 2016 before coming to Respondent on or about February 16, 2017.

13. At the February 2017 appointment, Patient 1 reported to Respondent a history of lower back and neck pain from previous motor vehicle accidents. He provided Respondent with two MRI reports from 2009 and 2012 of lumbar and cervical spine. Respondent did not check CURES reports at his initial visit with Patient 1. Respondent later told Board investigators that he did not register with CURES until the Fall of 2018.
Respondent did not obtain any medical records from previous providers or attempt to verify Patient 1's reported history any further. Respondent stated that Patient 1 brought empty pill bottles with him from previous providers.

14. At his initial appointment with Patient 1, Respondent did not document a comprehensive assessment of Patient 1's pain or his previous pain treatment history. There is no complete history and physical examination. Apart from listing Patient 1's pain as a 7 out of 10, Respondent did not make any objective characterizations of the pain such as whether it was

intractable, or any functional impairments it caused. In addition, Respondent's notations of the visit contradict objective pain findings that would warrant the doses of medications he prescribed. For example, Respondent noted that Patient 1 was smiling, with "some low back distress on sitting and walking." Further Respondent documented Patient 1 had "range of motion tenderness," with "neck similar discomfort on range of motion," but "no neuro localized findings," and Patient 1's gait was normal.

15. At this initial visit, Respondent prescribed Patient 1: fentanyl 100 mcg every 48 hours (three boxes of five patches) and oxycodone IR 30 mg, 2 tabs to be taken four times per day (240 tabs). Respondent did not indicate the medical necessity for this particular regime of medications, or provide any kind of comprehensive plan of care for Patient 1. Respondent did not indicate any rationale for departing from the recommended maximum dose of fentanyl patches which is 100 mcg every three days instead of every two. Respondent did not document Patient 1's psychological assessment, alternative therapies, or contraindications to the medication regimen Respondent prescribed. Respondent did not establish an opioid agreement or document that he explained the risks and benefits of the medication to Patient 1. There was no documentation that Patient 1 gave his informed consent for the medications Respondent prescribed to him. Respondent did not document any discussion of alternative therapies considered or proposed.

16. At Respondent's second visit with Patient 1, on or about April 27, 2017, Respondent noted that Patient 1 had hair transplant surgery four weeks ago. Respondent ordered additional MRI studies, and referred Patient 1 to a neurosurgeon for evaluation. Patient 1 did not obtain the MRI or follow up on the referral. Respondent still did not document a comprehensive pain assessment or care plan. Respondent did not document any discussion of the risks and benefits of the treatment. Respondent had not obtained any medical records from previous providers. Respondent obtained a release from Patient 1 to obtain previous medical records, but there is no documentation that Respondent or his office ever followed up to obtain a history of Patient 1's previous pain treatment history. There is no documentation to show that Respondent attempted to coordinate Patient 1's care with other providers or specialists.

17. On or about May 25, 2017, Respondent sent a letter to Patient 1 discharging him from the practice. Respondent stated that since Patient 1 had failed to follow up on the neurology consultation Respondent issued to him, and had failed to obtain the MRI of his lumbar spine, that Respondent was no longer able to continue as his physician.

18. On or about June 9, 2017, Patient 1 had another appointment with Respondent. Respondent documented that Patient 1 indicated he had not received the letter discharging him from the practice because he had been traveling in the Midwest. Respondent further documented that Patient 1 indicated he would cooperate now, and documented a new referral to neurology. Respondent still failed to document a history and physical examination, review of systems, plan, or informed consent. Under the heading "A/P," Respondent simply wrote, "as before."

19. Respondent continued to refill Patient 1's fentanyl and oxycodone prescriptions medications at the same rate that he prescribed on the initial visit, approximately every 30 days, through July of 2017, even though Patient 1 only appeared for two additional appointments with Respondent. Moreover, Patient 1 did not fill the final prescription Respondent wrote (dated July 12, 2017) until August 29, 2017, at which point Respondent had not seen Patient 1 for nearly three months. Patient 1 was receiving controlled substance prescriptions from other providers by August of 2017.

Patient 2

20. Patient 2 was a 74-year-old man with congestive heart failure, coronary artery disease with history of coronary artery bypass surgery, and myocardial infarction. He also suffered from hypertension, chronic kidney disease, atrial fibrillation, pacemaker implantation, carotid endarterectomies, prior cerebral vascular accident, Parkinson's disease, anxiety, osteoarthritis, and chronic pain. Patient 2 lived in an assisted living facility in Manteca, California. He was hospitalized, briefly, in January of 2016, and again in March of 2016.

21. On or about March 27, 2016, Patient 2 experienced chest pain and was admitted to Doctors Hospital of Manteca to rule out acute coronary syndrome. He was discharged on or about March 28, 2016 in stable condition. His pain medication dosage at discharge was 12 mcg fentanyl patch every 72 hours, and 2 mg tablets of hydromorphone, every four hours as needed.

This discharge pain medication regimen represented a reduction from his regimen three months earlier, when he had been receiving 25 mcg patches and 4 mg hydromorphone tablets every four hours.

22. Patient 2's primary care physician referred to him Infinity Care Hospice Services (Infinity), on or about May 26, 2016. Infinity is a corporation out of Stockton, California, that provides various medical services and home health visits. Respondent is the Medical Director for Infinity. In his role as the Medical Director for the hospice group providing care to Patient 2, Respondent assumed responsibility for prescribing Patient 2's pain medications between May 27, 2016, and November 16, 2016. Respondent stopped prescribing medications to Patient 2 after November of 2016, and reported that Patient 2 was no longer under his care after that time.[2]

23. When Respondent took over prescribing Patient 2's medications, Patient 2 was taking 25 mcg fentanyl patches and 4 mg hydromorphone tablets every four hours. Respondent immediately increased the frequency of the 4 mg hydromorphone to every three hours. On or about June 1, 2016, Respondent added methadone 5 mg, twice per day, and increased the hydromorphone to every two hours, around the clock, while continuing the fentanyl patches. Patient 2 also had alprazolam, .5 mg three times per day and lorazepam available for breakthrough anxiety. On or about November 11, 2016, Respondent increased the methadone dose to two tablets twice a day.

24. Respondent increased Patient 2's medications without having done a physical assessment of him and with no medical necessity documented in the record. The nursing notes did not indicate that Patient 2's pain was uncontrolled, and the written narrative in the hospice Interdisciplinary Team meeting had no mention of pain. Nursing notes indicate that Patient 2 was being awakened to take medication every two hours. Respondent never assessed Patient 2's pain level, never noted a response to current medication, and never established a care plan with

[2] There is a discharge note in Patient 2's records showing that he was discharged from Infinity on September 21, 2016, and was scheduled to move out of the assisted living facility where he was living due to financial concerns. There is also a typed recertification narrative in the Infinity records, dated November 22, 2016, with Respondent's signature on it. Patient 2 would have been eligible for recertification of hospice services on September 2, 2016. It is not clear whether Patient 2 continued receiving hospice insurance benefits with another hospice service after September 22, 2016, or where he lived. Patient 2 died on April 19, 2017.

specific goals for ongoing pain management. During his interview with Board investigators he was unable to state what painful condition Patient 2 had that required the pain medications he was prescribing. Respondent reported that he had one patient visit with Patient 2, on or about November 4, 2016, however, there is no documentation recording such a visit.

25. When asked by Board investigators why Patient 2 was on multiple long acting opioids, and multiple benzodiazepines at the same time, Respondent could not explain a medical purpose for that medication regimen. Respondent did not document any rationale in the medical record for the high doses of opioid medications or the rationale of dosing Patient 2 with short acting opioids every two hours. While it may be possible for there to be a medical rationale for such a complex pain medication treatment regimen, it is highly onerous on caregivers, and carries a sufficiently high risk of discomfort and adverse consequences to the patient that it would require documentation in the record to explain a variation from normal prescribing protocols. Respondent did not provide any such documentation in the record.

26. On or about September 2, 2016, Patient 2 was admitted to Brookdale Board and Care Facility. This is a Community Care Facility licensed by the Department of Social Services to provide living care. To ensure a resident is appropriate for living in such a facility, there must be a completed Form 602A, which is a Report for Community Care Facilities for the Elderly, (RCFE). This form is intended to reflect a physician's findings of the patient's medical condition and what treatments the patient requires for the condition. Respondent signed Patient 2's RCFE, on or about September 2, 2016. The date for physical examination on Patient 2's RCFE is blank. Respondent had never seen or evaluated Patient 2 before signing this form.

Patient 3:

27. Patient 3 was a 68-year-old man with Parkinson's Disease and many other health conditions, including hypothyroidism, diabetes, anxiety, pituitary adenoma, and headaches. Although Respondent stated that he assumed Patient 3's care on or about October 17, 2015, and documented that in the medical record, Respondent did participate in Patient 3's care before October 17, 2015. Beginning on or about March 19, 2015, Patient 3 was admitted to Arbor Nursing Center (Arbor), in Lodi, California. While at Arbor, Patient 3 was being treated

by a medical group owned and operated by a Physician Assistant, Mr. S.R. Respondent reported that he was a consulting physician to Mr. S.R.'s medical group. Respondent's name and D.E.A. number appeared on shared prescriptions, with Mr. S.R. The CURES system reflects that Respondent prescribed controlled medications to Patient 3 before October 17, 2015. Respondent reported that he rounded on Patient 3 before October 17, 2015, and Respondent co-signed Mr. S.R.'s medical records for Patient 3.

28. On or about March 21, 2015, the nursing facility sent a reminder to Respondent that he needed to complete a history and physical examination of Patient 3. Respondent never documented a history and physical examination of Patient 3 at any time. Arbor's records further show that other professionals at the facility, like physical therapists and nurse practitioners, contacted Respondent many times between March and October of 2015 to inquire about aspects of Patient 3's care. On or about October 17, 2015, Respondent documented in Arbor's records that he was taking over Patient 3's care. He still did not document a traditional history and physical examination, or record clinical data concerning Patient 3.

29. When Patient 3 was admitted to Arbor in March of 2015, Respondent began prescribing methadone to him, and added Oxycontin. Several weeks later, Respondent added M.S. Contin. There was no documentation in the record for why Patient 3 required three long acting opioid medications. Patient 3 was also taking clonazepam, 1 mg, as needed at bedtime, in addition to lorazepam, .25 mg daily. During June, July and August, Patient 3 had several falls, requiring Emergency Room visits to rule out head trauma. Respondent did not enter any documentation indicating that he was aware of these events. In May of 2015, a nutritionist recommended the physician review Patient 3's pain and psychiatric medications to determine whether they could be reduced. Respondent did not issue any new or changed orders for the medications. A psychiatry specialist recommended switching Patient 3's clonazepam to lorazepam, but Respondent did not acknowledge or act on this recommendation either.

30. Respondent's records show that he billed Patient 3 for visits on October 17, 2015, November 23, 2015, and December 11, 2015. Respondent did not document a history, examination, assessment, or plan for any of these visits. Patient 3 was hospitalized at Lodi

Memorial Hospital on or about November 25, December 4, and December 11, 2015. A hospital note on or about November 26, 2015, states that Patient 3 was admitted for a suspected opioid overdose. Patient 3's medications at that time were: methadone, 10 mg every four hours, M.S. Contin, 30 mg every 12 hours, clonazepam, 1 mg at bedtime as needed and lorazepam, .25 mg daily. Patient 3's admission of December 4, 2015 states his principal diagnoses were aspiration pneumonia, major depression, hypoxia, and opiate toxicity. His medications at the time of the second admission were unchanged showing that Respondent failed to reduce Patient 3's opioid doses despite his previous admission for opioid toxicity less than a week earlier. Upon the second discharge, the hospital physician discontinued both the methadone and the M.S.Contin. Nonetheless, Patient 3's opioid medications were refilled through the month of December, 2015, as were the benzodiazepines. On or about December 8, 2015, Patient 3 was admitted to Lodi Memorial with the chief complaint of respiratory distress. He required intubation and mechanical ventilation.

31. Respondent did not make any documentation of the indication for prescribing opioids to Patient 3, either before or after October 17, 2015. He made no clinical assessments of Patient 3, either in his personal office records, or in the nursing facility notes at Arbor. When Board investigators asked the diagnoses for which Patient 3 received opioid medications, Respondent could not recall. Respondent did not document any indication for the pain medications he prescribed, he documented no periodic assessments of Patient 3's condition, or any treatment goals for Patient 3. Respondent failed to document Patient 3's hospitalizations or reassess Patient 3's treatment following the hospitalizations. Respondent did not conduct a medication reconciliation when he assumed care of Patient 3, or following the hospitalizations. Respondent did not complete required documentation for care to a patient in a skilled nursing facility by documenting a patient evaluation with a diagnosis and orders for diet, care, and treatment within 72 hours of Patient 3's admission to Arbor, or every 30 days thereafter.

32. Although Respondent stated he was a "consultant" for Mr. S.R.'s medical group, Respondent had shared prescription pads with Mr. S.R. and other providers. He cosigned Mr. S.R.'s records for Patient 3. Despite acknowledging that he collaborated with Mr. S.R. on Patient

3's care, Respondent does not have a delegation of services agreement with Mr. S.R. setting forth a scope of practice. Respondent took on a supervisory role but failed to establish protocols for prescribing authorizations and care procedures.

Patient 4:

33. Patient 4 was a 68-year-old woman who had suffered a stroke several years before she started care with Respondent. The stroke caused Patient 4 to have left hemiparesis and dysphasia. She also had a history of hypertension, seizure disorder, and arthritis pain. She had been prescribed oxycodone and hydrocodone before she began seeing Respondent. Her initial encounter with Respondent was on or about August 17, 2015, when she was admitted to a residential care facility called Stacey's Chalet, although Respondent did not complete a full initial encounter note with a documented history, examination, assessment or plan for the initial encounter or the admission.

34. When Respondent took over prescribing to Patient 4 in August of 2015, he escalated her oxycodone dose, without documenting any reason for the change. In September of 2015, Respondent stopped the oxycodone, and instead prescribed Patient 4 M.S. Contin, 60 mg, twice a day. This resulted in Patient 4 receiving almost twice the daily morphine equivalent dose that she had received before Respondent took over her medications. Respondent did not document any reason for this change in the record. When asked by Board investigators, Respondent claimed that he made the change to reduce Patient 4's amount of opioid medication. Then, in July of 2016, Respondent reduced Patient 4's M.S. Contin by 50%, to 30 mg twice per day. Again, he provided no documentation of the reason for this change, and documented no pain assessments before or after the change.

35. On or about November 20, 2017, Patient 4 visited the emergency room with shortness of breath. She was diagnosed with bronchitis, and returned to Stacey's Chalet the same day. Staff at Stacey's Chalet contacted Respondent to inform him of the visit, and he responded that the staff should continue the discharge medications. On or about December 4, 2017, Stacey's Chalet staff reported that Patient 4 requested and needed additional pain medication. Patient 4 was hospitalized from December 7 to December 29, 2017, during which time the orthopedic

specialist noted that Patient 4 was on M.S. Contin 30 mg, three times per day. It is not clear whether Respondent responded to Patient 4's request and increased Patient 4's M.S. Contin before she was admitted to the hospital, or whether hospital staff increased the morphine from twice a day to three times per day. During her hospital stay, Patient 4 was diagnosed with metabolic encephalopathy, a urinary tract infection, acute respiratory failure with hypoxia, pneumonia, and acute left acetabular fracture. She was prescribed tramadol for five days post discharge. Staff at Stacey's Chalet informed Respondent that Patient 4 had been returned to the facility and his response was to continue the discharge medications. As a result of Respondent's orders, it appears that Patient 4 inadvertently continued to receive tramadol in addition to the morphine three times per day.

36. On or about January 6, and January 8, 2018, Patient 4 suffered falls. She was sent to the hospital for evaluation and was found to have an exacerbation of bronchitis. On or about January 11, 2018, Patient 4 had an emergency room visit for stomach pain. On or about January 30, 2018, Respondent prescribed Patient 4 long acting morphine 30, mg twice per day. As of February of 2018, Patient 4 appeared to have remained on this reduced opioid regimen.

37. Although Respondent told Board investigators that he was Patient 4's primary care physician since August of 2015, and he began prescribing to her in August of 2015, he did not maintain an independent medical chart of his care to her. Respondent only maintained chart notes for Patient 4 for the following dates: March 16, 2016, April 27, 2016, June 8, 2016, August 3, 2016, October 11, 2016, November 23, 2016, February 4, 2017, July 12, 2017, Aug 17, 2017, and October 30, 2017. Although he stated that his last visit with Patient 4 was on October 30, 2017, he continued to write orders for her through February of 2018. Many of his own chart notes for Patient 4 are photocopied, handwritten pages with limited, new information written on the bottom. Respondent did not document a reassessment or altered care plan after Patient 4's multiple falls, or even after her 21-day extended hospital stay in December of 2017. He failed to complete medication reconciliations after Patient 4's hospital visits and discharges in December of 2017 and January of 2018.

38. Respondent did not complete an RCFE when Patient 4 entered Stacey's Chalet in August of 2015. The facility records contain an incomplete RCFE for Patient 4, dated October 11, 2016. There are no examination findings or vital signs. She is listed as non-ambulatory, but there is no medical reason listed for the lack of ambulation. Her physical condition is listed as fair. The form does not provide care instructions for the facility. The form appeared to have been updated at some point, and contained multiple additional dates. Respondent signed the form twice. None of the versions of the form contained an examination and none provided any direction to staff as to Patient 4's functional status or care needs.

Patient 5:

39. Patient 5 was a 68-year-old man with terminal, state IV, colon cancer, that had metastasized to his liver, spine, lungs, and abdominal cavity. His primary care physician referred him to Kindred Hospice, a medical service provider, on or about March 9, 2016. Respondent was the Medical Director of Kindred Hospice. Patient 5's primary care physician had been prescribing a regimen of Norco, M.S. Contin, and a low dose of Xanax before the hospice referral. Patient 5 was admitted to Kindred Hospice service on or about March 11, 2016, and Respondent took over prescribing on that date. The nurse who prepared Patient 5's intake forms reported his pain level at 8 out of 9. Patient 5 was receiving hydrocodone with acetaminophen three to four times a day and 30 mg extended release morphine three times per day. Respondent never saw Patient 5 in person during the entire time he cared for him. When asked by Board investigators, Respondent stated that there was no need for him see Patient 5 in person.

40. Respondent started Patient 5 on lorazepam, in addition to the Xanax. On or about March 15, 2016, Respondent added morphine immediate release tablets. None of the previous medications were discontinued. Patient 5 had controlled substance prescriptions filled on March 15, 23, and 31, 2016, and April 7, 2016. On or about April 5, 2016, the Interdisciplinary Team met and noted that Patient 5's pain was now 5 out of 10. On or about April 15, 2016, the nursing notes stated that Patient 5's pain was not adequately controlled. The notes indicate that the nurses called Respondent who stated he would see Patient 5 and assess him the following week. There is no record of such a visit ever occurring.

41. On or about May 23, 2016, Respondent added fentanyl patches, at 12 mcg every three days and 8 mg hyrodmorphone tablets. Patient 5's pain was recorded to be controlled in all other notes, except for a note on June 19, 2016, when a nurse reported pain that was controlled with the use of hydrocodone and acetaminophen. On or about June 29, 2016, Patient 5's morphine solution and hydromorphone doses were increased. He continued simultaneously on the hydrocodone and fentanyl. Prescriptions for hydromorphone and hydrocodone were filled on July 18, 2016 and July 25, 2016. On or about July 19, 2016, nurses noted that Patient 5 was having jerking movements in his body and hands. Nursing staff called Respondent who directed staff to use lorazepam if the jerks persisted. On that day, he prescribed alprazolam, .5 mg three times per day. Patient 5 died on July 29, 2016.

42. Respondent did not document any narrative notes or assessments for Patient 5 at any time. He did not document any examination assessment, or indication for the medication. While the objective of hospice treatment is understood to be pain management and comfort care, Respondent did not indicate any individualized care plan for Patient 5 to achieve that. He did not document any consideration of opioid toxicity or possible seizure activity in response to nursing reports of jerking movements. There are no documented explanations for the frequency of the prescriptions or the combination of multiple long and short acting opioids and multiple concurrent use of benzodiazepines. The only documentation by Respondent was the initial hospice services certification signed March 22, 2016, and the recertification, signed June 28, 2016.

Patient 6:

43. Patient 6 was a 76-year-old woman who was under Respondent's care between 2011 and her death on April 21, 2017. Her medical history included a pulmonary embolism in 2011, Alzheimer's type dementia, cardiac arrhythmia, hypertension and osteoarthritis. She was not able to speak. Patient 6 was a resident of Creekside Care Center, (Creekside), in Stockton, which is a skilled nursing facility, from 2011 until her death. Respondent prescribed Patient 6 methadone, 5 mg, twice a day. This dose remained constant, at least between December 2014 and her death.

44. When asked by Board investigators what the source of Patient 6's pain was that required the methadone prescriptions, Respondent was unable to identify the source of the pain he

was treating. Nursing notes always reported Patient 6's pain as zero out of 10. Respondent's office chart notes contain no history or examination, no pain assessment, no diagnosis and no plan or goals of treatment. Patient 6 lost approximately 10 pounds over the last year of her life, but Respondent did not comment on this or address it in his chart notes. Respondent's notes in Creekside's records also lack any narrative of a physical examination, symptoms, assessment, or plan of care. There is no documentation to show the reason Patient 6 required methadone, or her response to treatment.

45. Patient 6 was admitted to Creekside on three separate occasions, on June 3, 2015, December 6, 2015, and June 20, 2016. Although Respondent completed forms indicating that he conducted a history and physical for each of these admissions, the forms he signed contained no meaningful clinical information about Patient 6 as required for admission to a kkilled nursing facility. Respondent did not provide the facility with the information necessary to establish orders for diet, care, and treatment. Respondent did not update this information every 30 days as required to support evidence of regular visitation to Patient 6. His documentation and orders in the Creekside's chart for Patient 6 are repetitive, sporadic, and devoid of content. For example, Respondent frequently wrote "no changes," or "patient continues to receive excellent TLC." On April 16, 2017, Patient 6 was transferred to the hospital where she was noted to have sever hypoxia and was diagnosed with aspiration. She died on April 21, 2017 from acute hypoxia and respiratory filature secondary to aspiration pneumonia.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

46. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that he was grossly negligent. The circumstances are set forth in Paragraphs 11 through 45 above, which are incorporated by reference as if fully set forth.

47. Respondent was grossly negligent his care and treatment of Patients 1, 2, 3, 4, 5, and 6 for his acts and omissions, including but not limited to, the following:

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(a) Prescribing opioid medications to Patient 1 without properly assessing the risk of abuse, confirming prior diagnoses or treatment, and without establishing a comprehensive plan of care;

(b) Failing to coordinate care and prescribing with Patient 1's previous providers or specialists before prescribing opioid medications to him;

(c) Failing to access or even register with the CURES database before prescribing opioids to Patient 1;

(d) Failing to document a history and physical examination, review of systems, goals, or a care plan in Patient 1's medical records;

(e) Increasing Patient 2's opioid medications before any physical assessment and without evidence of medical necessity;

(f) Prescribing a complicated, burdensome medication regimen to Patient 2 without any comprehensive assessment, plan of care or goals;

(g) Altering the medications and dosages to Patient 2 without medical reasoning or documentation;

(h) Prescribing multiple opioid medications to Patient 3, concurrently with benzodiazepines, without a documented medical indication, without ever performing an assessment, establishing goals, or establishing a care plan in a high-risk patient;

(i) Failing to reconcile Patient 3's medications and care after discharge and readmission to the skilled nursing facility, including failing to alter Patient 3's opioid medications after he was discharged from the hospital for opioid toxicity;

(j) Failing to comply with state laws for care and treatment of a patient in a skilled nursing facility by failing to document and update evaluations and orders for Patient 3;

(k) Failing to supervise Mr. S.R.'s care and prescribing to Patient 3;

(l) Prescribing multiple opioid medications to Patient 4 without a thorough pain assessment, plan of care, goals or indications for treatment;

(m) Failing to document a reassessment of Patient 4's condition and orders after multiple falls and presentations to the hospital;

(n) Failing to reconcile Patient 4's medications after discharge from hospital presentations and instead merely continuing discharge orders leading to errors and complications;

(o) Failing to document and update an accurate RCFE for Patient 4 on multiple occasions;

(p) Prescribing and altering multiple opioids and benzodiazepines to Patient 5 without a physical examination, pain assessment, individualized care plan, or dose adjustment planning;

(q) Prescribing opioid medications to Patient 6 without a pain assessment, or plan of care, and without even identifying the source of her pain, or the need for ongoing opioid prescriptions;

(r) Failing to document a history or physical examination, symptoms, assessments or goals of care to justify prescribing and altering Patient 6's opioid medications; and

(s) Failing to comply with state laws for care and treatment of a patient in a skilled nursing facility by failing to document and update evaluations and orders for Patient 6.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

48. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he was repeatedly negligent. The circumstances are set forth in Paragraphs 11 through 46 above, which are incorporated by reference as if fully set forth.

49. Respondent was repeatedly negligent his care and treatment of Patients 1, 2, 3, 4, 5, and 6 for his acts and omissions, including but not limited to, the following:

(a) Prescribing opioid medications to Patient 1 without properly assessing the risk of abuse, confirming prior diagnoses or treatment, and without establishing a comprehensive plan of care;

(b) Failing to coordinate care and prescribing with Patient 1's previous providers or specialists before prescribing opioid medications to him;

(c) Failing to access or even register with the CURES database before prescribing opioids to Patient 1;

(d) Failing to document a history and physical examination, review of systems, goals, or a care plan in Patient 1's medical records;

(e) Increasing Patient 2's opioid medications before any physical assessment and without evidence of medical necessity;

(f) Prescribing a complicated, burdensome medication regimen to Patient 2 without any comprehensive assessment, plan of care or goals;

(g) Altering the medications and dosages to Patient 2 without medical reasoning or documentation;

(h) Failing to document and update an accurate RCFE for Patient 2;

(i) Prescribing multiple opioid medications to Patient 3, concurrently with benzodiazepines, without a documented medical indication, without ever performing an assessment, establishing goals, or establishing a care plan in a high-risk patient;

(j) Failing to reconcile Patient 3's medications and care after discharge and readmission to the skilled nursing facility, including failing to alter Patient 3's opioid medications after he was discharged from the hospital for opioid toxicity;

(k) Failing to comply with state laws for care and treatment of a patient in a skilled nursing facility by failing to document and update evaluations and orders for Patient 3;

(l) Failing to supervise Mr. S.R.'s care and prescribing to Patient 3;

(m) Prescribing multiple opioid medications to Patient 4 without a thorough pain assessment, plan of care, goals or indications for treatment;

(n) Failing to document a reassessment of Patient 4's condition and orders after multiple falls and presentations to the hospital;

(o) Failing to reconcile Patient 4's medications after discharge from hospital presentations and instead merely continuing discharge orders leading to errors and complications;

(p) Failing to document and update an accurate RCFE for Patient 4 on multiple occasions;

(q) Prescribing and altering multiple opioids and benzodiazepines to Patient 5 without a physical examination, pain assessment, individualized care plan, or dose adjustment planning;

(r) Prescribing opioid medications to Patient 6 without a pain assessment, or plan of care, and without even identifying the source of her pain, or the need for ongoing opioid prescriptions;

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(s) Failing to document a history or physical examination, symptoms, assessments or goals of care to justify prescribing and altering Patient 6's opioid medications; and

(t) Failing to comply with state laws for care and treatment of a patient in a skilled nursing facility by failing to document and update evaluations and orders for Patient 6.

THIRD CAUSE FOR DISCIPLINE

(Failure to Supervise Physician Assistant)

50. Respondent is subject to disciplinary action under section 2234, subdivision (a), and 3502, for unprofessional conduct in that he failed to properly supervise a physician assistant. The circumstances are set forth in Paragraphs 11, and 27 through 32, which are incorporated by reference as if fully set forth.

51. As set forth in Paragraphs 11, and 27 through 32, above, Respondent took on a supervisory role with a Physician Assistant, Mr. S.R., while caring for Patient 3, and cosigned Mr. S.R.'s records without having any clear relationship with Mr. S.R. for following patients or providing care.

52. Respondent's conduct as described above constitutes unprofessional conduct in violation of sections 2234, subdivision (a), and 3502, thereby providing cause for discipline against Respondent's license.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Have a Delegation of Services Agreement)

53. Respondent is subject to disciplinary action under California Code of Regulations, title 16, section 1399.540, subdivision (b), for failing to have a delegation of services agreement between the physician assistant and supervising physician. The circumstances are set forth in Paragraphs 11, and 28 through 33, above, which are incorporated by reference as if fully set forth.

54. As set forth in Paragraphs 11, and 27 through 32, above, Respondent collaborated on care with a Physician Assistant while not having a delegation of services agreement between himself and Mr. S.R.

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55. Respondent's conduct as described above constitutes unprofessional conduct in violation of California Code of Regulations, title 16, section 1399.540, subdivision (b) and thereby provides cause for discipline against Respondent's license.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Comply with Requirements for Visitation to a Skilled Nursing Facility)

56. Respondent is subject to disciplinary action under California Code of Regulations, title 22, sections 72303 and 72307 in that he failed to comply with requirements for visitation to a skilled nursing facility. The circumstances are set forth in Paragraphs 11 and 27 through 32, and 44 through 46, above, which are incorporated by reference as if fully set forth.

57. As set forth in Paragraphs 11 and 27 through 32, and 43 through 45, above, Respondent failed to complete accurate and timely visits and documents for Patients 3 and 6.

58. Respondents conduct, in failing to complete accurate and timely visits and documents for Patients 3 and 6 constitutes a violation of California Code of Regulations, title 22, sections 72303 and 72307, thus subjecting Respondent's license to discipline.

SIXTH CAUSE FOR DISCIPLINE

(Medical Recordkeeping)

59. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate medical records for Patients 1, 2, 3, 4, 5, and 6. The circumstances are set forth in Paragraphs 11 through 45, above which are incorporated by reference as if fully set forth. Respondent's conduct is in violation of section 2266, thus subjecting his license to discipline.

SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

60. Respondent is subject to disciplinary action under section 2234 in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrated an unfitness to practice medicine. The circumstances are set forth in Paragraphs 11 through 45, above, which are incorporated here 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 No. A 49048, issued to Kulendu Ghanshyam Vasavda, M.D.;

2. Revoking, suspending or denying approval of Kulendu Ghanshyam Vasavda, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Kulendu Ghanshyam Vasavda, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: APR 13 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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