

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

In the Matter of the First Amended  
Accusation Against:

Navin Saran, M.D.

Physician's & Surgeon's  
Certificate No A 37985

Respondent

Case No. 800-2018-044642

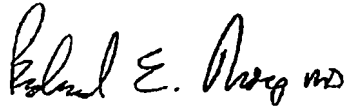
DECISION

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

This Decision shall become effective at 5:00 p.m. on February 11, 2022.

IT IS SO ORDERED January 12, 2022.

MEDICAL BOARD OF CALIFORNIA



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

1 ROB BONTA  
Attorney General of California  
2 ALEXANDRA M. ALVAREZ  
Supervising Deputy Attorney General  
3 ROSEMARY F. LUZON  
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6 San Diego, CA 92186-5266.  
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8 *Attorneys for Complainant*

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

13 In the Matter of the First Amended Accusation  
14 Against:

15 **NAVIN SARAN, M.D.**  
16 **1661 W. Broadway, #14**  
**Anaheim, CA 92802**

17 **Physician's and Surgeon's Certificate**  
18 **No. A 37985,**

19 Respondent.

Case No. 800-2018-044642

OAH No. 2021020340

**STIPULATED SETTLEMENT AND**  
**DISCIPLINARY ORDER**

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

23 **PARTIES**

24 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of  
25 California (Board). He brought this action solely in his official capacity and is represented in this  
26 matter by Rob Bonta, Attorney General of the State of California, by Rosemary F. Luzon, Deputy  
27 Attorney General.

28 ///







1 course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be  
2 Category I certified. Specific areas include: medical record keeping, clinical documentation, and  
3 patient chart and progress note legibility. The educational program(s) or course(s) shall be at  
4 Respondent's expense and shall be in addition to the Continuing Medical Education (CME)  
5 requirements for renewal of licensure. Following the completion of each course, the Board or its  
6 designee may administer an examination to test Respondent's knowledge of the course.  
7 Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in  
8 satisfaction of this condition.

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

18 Respondent shall submit a certification of successful completion to the Board or its  
19 designee not later than 15 calendar days after successfully completing the course, or not later than  
20 15 calendar days after the effective date of the Decision, whichever is later.

21 4. FAILURE TO COMPLY. Any failure by Respondent to comply with the terms and  
22 conditions of the Disciplinary Order set forth above shall constitute unprofessional conduct and  
23 grounds for further disciplinary action.

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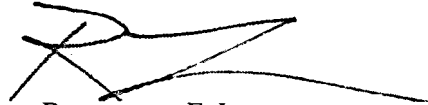
**ENDORSEMENT**

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

DATED: 10/28/21

Respectfully submitted,

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



ROSEMARY F. LUZON  
Deputy Attorney General  
*Attorneys for Complainant*

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**Exhibit A**

**First Amended Accusation No. 800-2018-044642**

1 ROB BONTA  
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2 ALEXANDRA M. ALVAREZ  
Supervising Deputy Attorney General  
3 ROSEMARY F. LUZON  
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10 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
11 **DEPARTMENT OF CONSUMER AFFAIRS**  
12 **STATE OF CALIFORNIA**

13 In the Matter of the First Amended Accusation  
Against:

Case No. 800-2018-044642

14 **NAVIN SARAN, M.D.**  
15 **1661 W. Broadway, #14**  
**Anaheim, CA 92802**

**FIRST AMENDED ACCUSATION**

16 **Physician's and Surgeon's Certificate**  
17 **No. A 37985,**

Respondent.

18  
19  
20 Complainant alleges:

21 **PARTIES**

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

25 2. On or about February 1, 1982, the Board issued Physician's and Surgeon's  
26 Certificate No. A 37985 to Navin Saran, M.D. (Respondent). The Physician's and Surgeon's  
27 Certificate was in full force and effect at all times relevant to the charges brought herein and will  
28 expire on October 31, 2021, unless renewed.

**JURISDICTION**

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

5       4.     Section 2220 of the Code states:

6             Except as otherwise provided by law, the board may take action against all  
7 persons guilty of violating this chapter. . .

8       5.     Section 2227 of the Code states:

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

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

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

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

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

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

24             . . .

25       6.     Section 2234 of the Code states:

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

           . . .

           (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.

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1 (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  
3 (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  
4 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  
5 constitutes a separate and distinct breach of the standard of care.

6 ...  
7 7. Section 2266 of the Code states:

8 The failure of a physician and surgeon to maintain adequate and accurate  
9 records relating to the provision of services to their patients constitutes unprofessional  
conduct.

10 8. Unprofessional conduct under section 2234 of the Code is conduct which breaches  
11 the rules or ethical code of the medical profession, or conduct which is unbecoming a member in  
12 good standing of the medical profession, and which demonstrates an unfitness to practice  
13 medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

14 **FIRST CAUSE FOR DISCIPLINE**

15 **(Repeated Negligent Acts)**

16 9. Respondent has subjected his Physician's and Surgeon's Certificate No. A 37985 to  
17 disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of  
18 the Code, in that he committed repeated negligent acts in his care and treatment of Patient A and  
19 Patient B, as more particularly alleged hereinafter:<sup>1</sup>

20 **Patient A**

21 10. Between on or about January 14, 2014, and May 8, 2020, Respondent treated Patient  
22 A for his primary care needs while Patient A resided at two assisted living facilities.<sup>2</sup> Patient A's  
23 medical problems included type 2 diabetes, recurrent urinary tract infection, peptic ulcer disease,  
24 anxiety, major depression, psychosis, scalp laceration repair, urinary incontinence, gait  
25 abnormality, and stroke, in addition to multiple other medical issues.

26 \_\_\_\_\_  
<sup>1</sup> References to "Patient A" and "Patient B" herein are used to protect patient privacy.

27 <sup>2</sup> Any medical care or treatment rendered by Respondent to Patient A and Patient B more  
28 than seven years prior to the filing of the Accusation is described for informational purposes only  
and not pleaded as a basis for disciplinary action.

11. During this timeframe, Respondent saw Patient A on a near-monthly basis. For each of these visits, Respondent's handwritten progress notes were illegible.

12. On or about March 4, 2014, Respondent saw Patient A after he fell at the assisted living facility and sustained a laceration to his scalp that required hospitalization and repair. Respondent's medical chart for Patient A did not include any information or details relating to the repair of the scalp laceration, including any hospitalization records.

13. On or about April 7, 2017, Respondent saw Patient A. According to Respondent, Patient A was "very stable" at this time and "not sick." However, on or about April 10, 2017, Patient A filled a prescription for Phenergan-Codeine syrup.<sup>3</sup> According to Respondent, he prescribed this medication to Patient A for a cough. On or about May 4, 2017, Respondent saw Patient A again. Respondent did not document Patient A's cough or the prescription for Phenergan-Codeine syrup in his progress notes.

14. On or about November 27, 2017, Patient A filled a prescription for alprazolam<sup>4</sup> 0.5 mg, which Respondent prescribed. According to Respondent, Patient A had been on alprazolam 0.25 mg for a long time, but he increased the dosage to 0.5 mg due to Patient A's increased anxiety. On or about December 7, 2017, Respondent saw Patient A. Respondent did not document Patient A's increased anxiety or the change to the alprazolam dosage in his progress notes.

15. On or about December 25, 2017, Patient A suffered a fall at the assisted living facility. On or about January 4, 2018, Respondent saw Patient A. Respondent did not document Respondent's fall in his progress notes, including Patient A's status post-fall or any assessment of potential causes such as the higher alprazolam dosage.

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<sup>3</sup> Phenergan-Codeine syrup (promethazine HCL-codeine phosphate) is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

<sup>4</sup> Alprazolam (Xanax) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

1           16. On or about August 2, 2018, Respondent saw Patient A. According to Respondent,  
2 he did a history and physical exam of Patient A, however, the progress note for this visit did not  
3 include any notes or markings by Respondent, except for a single illegible notation regarding a  
4 plan of care change.

5           17. On or about June 6, 2019, Respondent saw Patient A. On or about June 14, 2019,  
6 Patient A filled a prescription for Phenergan-Codeine syrup, which Respondent prescribed to  
7 Patient A for a cough. According to Respondent, he prescribed this medication after Patient A  
8 tried Robitussin DM first, but Patient A told him it was not working. On or about July 5, 2019,  
9 Respondent saw Patient A. Respondent did not document Patient A's cough or the prescription  
10 for Phenergan-Codeine syrup in his progress notes.

11           18. On or about January 2, 2020, Respondent saw Patient A. According to Respondent,  
12 he conducted a physical exam of Patient A and administered a vaccine, however, the progress  
13 note for this visit did not include any notes or markings by Respondent regarding the exam.

14           19. On or about February 6, 2020, Respondent saw Patient A for complaints of urinary  
15 incontinence. Respondent recommended and ordered a consultation with urology. According to  
16 Respondent, Patient A did not go to the consultation. Respondent did not document Patient A's  
17 reason for refusing the urology consultation in his progress notes.

18           20. On or about March 5, 2020, Respondent saw Patient A. According to Respondent, he  
19 filled all of Patient A's medications during this visit, however, the corresponding progress note  
20 did not include any notes or markings by Respondent, except for Patient A's temperature and a  
21 single illegible notation regarding a plan of care change.

22           21. Between on or about January 14, 2014, and May 8, 2020, several of Respondent's  
23 progress notes were lacking in that they omitted Patient A's problems list, did not address main  
24 problems for Patient A such as his status and progress relating to his diabetes, and did not address  
25 significant medical issues and treatments that took place in between visits. In addition,  
26 Respondent's medical chart for Patient A included a consultation report for an entirely different  
27 patient.

28       ///

1           22. Respondent committed repeated negligent acts in his care and treatment of Patient A,  
2 which included, but were not limited to, the following:

3           A. Respondent's progress notes for Patient A were illegible.

4           B. Respondent failed to maintain adequate and accurate medical records for  
5 Patient A in that several of Respondent's progress notes omitted Patient A's problems  
6 list, did not address main problems for Patient A such as his status and progress  
7 relating to his diabetes, did not address significant medical issues and treatments that  
8 took place in between visits, and included a consultation report for a different patient.

9           **Patient B**

10          23. Between on or about February 7, 2013, and May 16, 2019, Respondent treated Patient  
11 B for her primary care needs while Patient B resided at an assisted living facility. Patient B's  
12 medical problems included multiple sclerosis, hypertension, GERD, major depression, seizure  
13 disorder, and history of bilateral rib fracture, in addition to multiple other medical issues.

14          24. During this timeframe, Respondent's handwritten progress notes for his visits with  
15 Patient B were illegible and not kept in chronological order.

16          25. Between on or about July 24, 2017, and February 23, 2018, Respondent regularly  
17 prescribed alprazolam and temazepam<sup>5</sup> to Patient B. On or about December 12, 2017, and  
18 January 29, 2018, respectively, Patient B filled a prescription for hydrocodone bitartrate-  
19 acetaminophen,<sup>6</sup> which Respondent prescribed to Patient B. On or about February 26, 2018,  
20 Patient B filled a prescription for hydrocodone bitartrate-acetaminophen, which a pain specialist  
21 prescribed to Patient B.

22          26. In or about March 2018, Patient B fractured a rib on her left side following another  
23 fall. On or about March 15, 2018, and April 26, 2018, Respondent saw Patient B. Respondent  
24 did not document Patient B's fall or rib fracture in his progress notes. Respondent also did not

25 \_\_\_\_\_  
26           <sup>5</sup> Temazepam (Restoril) is a Schedule IV controlled substance pursuant to Health and  
27 Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and  
28 Professions Code section 4022.

<sup>6</sup> Hydrocodone bitartrate-acetaminophen is a Schedule II controlled substance pursuant to  
Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to  
Business and Professions Code section 4022.

1 document Patient B's concurrent use of opioids and benzodiazepines, including any concerns  
2 relating to such usage.

3 27. In or about July 2018, Patient B developed left knee pain after tripping over a chair,  
4 which caused her to twist her knee and collapse on the ground. On or about July 19, 2018,  
5 Respondent saw Patient B. Respondent did not document Patient B's fall or left knee pain in his  
6 progress notes.

7 28. On or about July 26, 2018, Patient B underwent a meniscus repair of the left knee.  
8 On or about August 16, 2018, Respondent saw Patient B. Respondent did not document Patient  
9 B's meniscus repair or her status post-repair in his progress notes.

10 29. On or about December 13, 2018, Respondent saw Patient B. Respondent noted that  
11 Patient B had left arm pain and that x-rays showed a wrist fracture. According to Respondent, he  
12 considered Patient B to be a fall risk, however, he did not document this concern in his progress  
13 notes.

14 30. In or about February 2019, Patient B developed right knee pain after falling on her  
15 right knee when she attempted to pick up her shoes off the ground. On or about February 21,  
16 2019, an MRI of Patient B's right knee showed a meniscus tear. On or about February 21, 2019,  
17 Respondent saw Patient B. Respondent did not document Patient B's fall or any problems with  
18 her extremities in his progress notes, including her right knee pain or injury.

19 31. Between on or about February 7, 2013, and May 16, 2019, several of Respondent's  
20 progress notes were lacking in that they omitted Patient B's problems list and did not address  
21 significant medical issues and events that took place in between visits.

22 32. Respondent committed repeated negligent acts in his care and treatment of Patient B,  
23 which included, but were not limited to, the following:

24 A. Respondent's progress notes for Patient B were illegible.

25 B. Respondent failed to maintain adequate and accurate medical records for  
26 Patient B in that several of Respondent's progress notes omitted Patient B's problems  
27 list and did not address significant medical issues and events that took place in  
28 between visits.



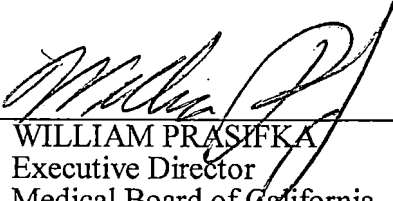


1           2.    Revoking, suspending or denying approval of Respondent Navin Saran, M.D.'s  
2 authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced  
3 practice nurses;

4           3.    Ordering Respondent Navin Saran, M.D., if placed on probation, to pay the Board the  
5 costs of probation monitoring; and

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

7  
8           **OCT 22 2021**  
9           DATED: \_\_\_\_\_

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

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