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

In the Matter of the Accusation Against: **Natasha Kelly Creighton, M.D.** **Physician's and Surgeon's Certificate No. A 111863** **Respondent.**	**Case No.: 800-2018-041120**

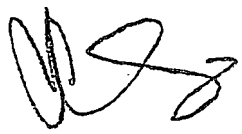
DECISION

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 September 30, 2022.

IT IS SO ORDERED: September 2, 2022.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

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

In the Matter of the Accusation Against:	Case No. 800-2018-041120
NATASHA KELLY CREIGHTON, M.D. **39000 Bob Hope Drive, Suite 1100** **Rancho Mirage, CA 92270**	OAH No. 2021040078
Physician's and Surgeon's Certificate No. A 111863,	**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**
Respondent.	

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 Rob Bonta, Attorney General of the State of California, by Tan N. Tran, Deputy Attorney General.

2. Respondent Natasha Kelly Creighton, M.D. (Respondent) is represented in this proceeding by attorneys Deborah deBoer and Tamara L. Glaser of Kramer, deBoer & Keane, LLP, 74770 Highway 111, Suite 201, Indian Wells, California 92210.

3. On or about April 7, 2010, the Board issued Physician's and Surgeon's Certificate No. A 111863 to Natasha Kelly Creighton, 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. 800-2018-041120, and will expire on November 30, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-041120 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 February 11, 2021. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-041120 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. 800-2018-041120. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands that the charges and allegations in Accusation No. 800-2018-041120, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent admits that at a hearing, Complainant could set forth a prima facie case for the charges and allegations in Accusation No. 800-2018-041120, and Respondent declines to defend same.

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

CONTINGENCY

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

13. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in Accusation No. 800-2018-041120 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.

14. 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.

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15. 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 111863 issued to Respondent Natasha Kelly Creighton, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Until Respondent successfully completes the Prescribing Practices Course, as described in term #4 below, Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

If Respondent forms the medical opinion, after an appropriate prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use

of marijuana.

2. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

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

4. 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.

5. 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.

6. 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.

7. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting 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. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the

Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, 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. The Respondent shall not resume practice until an appropriate practice setting is established.

8. 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.

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

10. 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.

11. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, joint investigations, and subpoena enforcement, as applicable, in the amount of $6,355.00 (six thousand three hundred fifty-five dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Any and all requests for a payment plan shall be submitted in writing by Respondent to the Board.

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs, including expert review costs (if applicable).

12. 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.

13. 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.

14. 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.

15. 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..

16. 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.

17. 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.

18. 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.

19. 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.

20. 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. 800-2018-041120 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Deborah deBoer and Tamara L. Glaser. 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: 4/5/2022

NATASHA KELLY CREIGHTON, M.D.
Respondent

I have read and fully discussed with Respondent Natasha Kelly Creighton, 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: 4/6/2022

DEBORAH DEBOER, ESQ.
TAMARA L. GLASER, ESQ.
Attorneys for Respondent

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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: 4/7/22

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

TAN N. TRAN
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2018-041120

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

In the Matter of the Accusation Against: **NATASHA KELLY CREIGHTON, M.D.** **Bannan Building** **39000 Bob Hope Drive, Suite 1100** **Rancho Mirage, CA 92270-3221** **Physician's and Surgeon's** **Certificate No. A 111863,** Respondent.	Case No. 800-2018-041120 **A C C U S A T I O N**

PARTIES

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

2. On or about April 7, 2010, the Medical Board issued Physician's and Surgeon's Certificate Number A 111863 to Natasha Kelly Creighton, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2021, 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.

STATUTORY PROVISIONS

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 that 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 2242 of the Code, states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or

furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and. if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

7. Subdivision (a) of section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any

of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

8. 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.

9. Health and Safety Code section 11165.4, subdivision (a) states, in pertinent part:

(a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

DEFINITIONS

"Acetaminophen" is a widely used over-the-counter analgesic (pain reliever) and antipyretic (fever reducer). It is also known as paracetamol, or APAP. It is typically used for mild to moderate pain relief, such as relief of headaches. It is a major ingredient in numerous cold and flu remedies. In combination with opioid analgesics, paracetamol can also be used in the management of more severe pain such as post surgical pain and providing palliative care in advanced cancer patients. Acute overdoses of paracetamol can cause potentially fatal liver damage and, in rare individuals, a normal dose can do the same; the risk is heightened by alcohol consumption. It is sold in varying forms, including under the brand name Tylenol®.

"Alaway®" is a brand name for ketotifen an antihistamine mediation used to treat itchy eyes and discomfort caused by allergies.

"Albuterol" (also known as salbutamol) is used to prevent and treat wheezing and shortness of breath caused by breathing problems (such as asthma, chronic obstructive pulmonary disease). It is a bronchodilator that can treat or prevent bronchospasm. It is sold under the brand names ProAir®, Ventolin®, RespiClick® and Proventil®. It is a dangerous drug as defined in Business and Professions code section 4022.

"Alprazolam" is a benzodiazepine drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other central nervous system depressant drugs during treatment with it. Addiction prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence. The usual starting dose of alprazolam is 0.25 mg to 0.5 mg, three times per day (for a maximum 1.5 mg per day). It is also sold under various brand names including, Intensol®, Xanax®, and Xanax XR®. It is a schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(1), and a dangerous drug as defined in Business and Professions code section 4022. It is also a Schedule IV controlled substance as defined by the Code of Federal Regulations Title 21, section 1308.14 (c).

"Amoxicillin" is a penicillin antibiotic medication used to treat infections and stomach ulcers. It is sold under the brand name Moxatag®. It is a dangerous drug as defined in Business and Professions code section 4022.

"Azithromycin" is an antibiotic medication used to treat various types of infections, including pink eye (bacterial conjunctivitis). It is sold under the brand names Zithromax®, Z-Pak®, Zmax®, AzaSite®, and Zithromax TRI-PAK®. It is a dangerous drug as defined in Business and Professions code section 4022.

"Bactrim®" is a brand name for "trimethoprim / sulfamethoxazole," which is an antibiotic medication used to treat infections.

"Benzodiazepines" are a class of drugs that produce central nervous system (CNS) depression. They are used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. They are most commonly used to treat insomnia and anxiety. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses, and are used for a limited time period. There is the potential for dependence on and abuse of benzodiazepines particularly by individuals with a history of multi-substance abuse. Benzodiazepines can cause dangerous deep unconsciousness. When combined with other CNS depressants such as alcoholic drinks and opioids, the potential for toxicity and fatal overdose increases. Benzodiazepines are commonly misused and taken in combination with other drugs of abuse. Commonly prescribed benzodiazepines include alprazolam (Xanax®), lorazepam (Ativan®), clonazepam (Klonopin®), diazepam (Valium®), and temazepam (Restoril®), Risks associated with use of benzodiazepines include 1) tolerance and dependence, 2) potential interactions with alcohol and pain medications, and 3) possible impairment of driving. Before initiating a course of treatment, patients should be explicitly advised of the goal and duration of benzodiazepine use. Risks and side effects, including risk of dependence and respiratory depression, should be discussed with patients. Alternative treatment options should be discussed. Treatment providers should coordinate care to avoid multiple prescriptions for this class of drugs. Low doses and short durations should be utilized.

"Bimatoprost" is glaucoma medication used help reduce pressure inside the eye when used as bimatoprost ophthalmic (eye drops). As an eyelash solution, it can help eyelashes grow. It is sold under the brand names Latisse® and Lumigan®. It is a dangerous drug as defined in Business and Professions code section 4022.

"Buprenorphine" is an opioid medication used to treat opioid addiction. It is a semi-synthetic opioid derived from thebain. It is sold in its various forms under several brand name, including, Butrans® and Suboxone. Suboxone, Zubslov, and Bunavail contain both buprenorphine and the opiate antagonist naloxone. It is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

"Celebrex" is a brand name for celecoxib, which is a nonsteroidal anti-inflammatory drug (NSAID) used for the relief of pain, fever, swelling, and tenderness caused by arthritis. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Ciprofloxacin" is an antibiotic medication used to treat infections. It is sold under the brand names Cetraxal®, Ciloxan®, Cipro® and Otiprio®. It is a dangerous drug as defined in Business and Professions code section 4022.

"Clarithromycin" is an antibiotic medication used to treat infections. It is sold under the brand names Biaxin®. It is a dangerous drug as defined in Business and Professions code section 4022.

"Clonazepam" is a benzodiazepine-based sedative. It is generally used to control seizures and panic disorder. It is also sold under the brand name Klonopin®. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined in Business and Professions Code section 4022.

"Clotrimazole/betamethasone" is a topical cream that contains a steroid and is used to treat fungal skin infections such as athlete's foot, jock itch, and ringworm. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Cymbalta®" is a brand name for duloxetine, an antidepressant and nerve pain medication used to treat depression, anxiety, diabetic peripheral neuropathy, fibromyalgia, and chronic muscle or bone pain. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Fluocinonide" is a steroid medication used to treat many skin disorders and can also relieve pain, itching, and swelling of the skin. It is sold under the brand names Vanos® and Fluocinonide-E®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Fluticasone" is a steroid medication used to treat pain, itching, and swelling caused by many skin diseases when applied topically. It can also prevent asthma attacks when inhaled. It is sold under the brand names Flovent®, Diskus®, Aller-Flo® and Ticanase®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Diflucan®" is a brand name for "fluconazole," which is an antifungal medication used to treat and prevent fungal infections. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Hydrocodone" is a semisynthetic opioid analgesic similar to but more active than codeine. It is used as the bitartrate salt or polistirex complex, and as an oral analgesic and antitussive. It is marketed, in its varying forms, under a number of brand names, including Vicodin®, Hycodan® (or generically Hydromet®), Lorcet®, Lortab®, Norco®, and Hydrokon®, among others). Hydrocodone also has a high potential for abuse. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Business and Professions Code section 4022.

"Hydrocortisone" is a steroid medication containing the hormone cortisol, and used to treat conditions such as adrenocortical insufficiency, adrenogenital syndrome, high blood calcium, thyroiditis, rheumatoid arthritis, dermatitis, asthma, and COPD.

"Including" or "included" means, "including, without limitation."

"Keflex®" is a brand name for "cephalexin," which is an antibiotic medication used to treat infections. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Levaquin®" is a brand name for levofloxacin.

"LMX®" is a brand name for "lidocaine" is an anesthetic that works to

decrease pain by temporarily numbing the area. It causes loss of feeling in the skin and surrounding tissues. It is used to prevent and to treat pain from some procedures. This medicine is also used to treat minor burns, scrapes and insect bites. It is sold as a topical cream under many brand names LMX 5®, LidaMantle®, RectiCare®, AneCream®, LMX 4 with Tegaderm®, Aspercreme with Lidocaine®, and RectaSmoothe®.

"Levofloxacin" is an antibiotic medication used to treat infections. It is sold under the brand name Levaquin®. It is a dangerous drug pursuant to Business and Professions code section 4022.

"Macrobid®" is a brand name for "nitrofurantoin," which is an antibiotic medication used to treat and prevent urinary tract infections. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Medrol®" is a brand name for "methylprednisolone," which is a steroid medication used to treat inflammation, severe allergies, flares of chronic illnesses, and many other medical problems. It can also decrease some symptoms of cancer. It is sold under the brand names Depo-Medrol®, Medrol®, Solu-Medrol®, P-Care D40®, ReadySharp Methylprednisolone®, and P-Care D80® among others. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Metronidazole" is an antibiotic mediation used to treat various infections, including certain types of vaginal infections. It can also treat skin redness and pimples caused by rosacea. It is sold under the brand names MetroCream®, Nuvessa®, Metrogel®, Noritate®, MetroLotion®, Metro I.V. ®, and Flagyl®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

Norco®" is a brand name for acetaminophen and hydrocodone. This combination of hydrocodone and acetaminophen is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerate. Other brand names for this combination of drugs include Hycet®, Lorcet®, Lortab®, Maxidone®, Vicodin®, Zamicet® and Zydone®.

"Nystatin" is an antifungal medication used to treat fungal infections. It is sold under the brand names Nyamyc®, Nystop®, and Nyata®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Ondansetron" is an antiemetic medication used to prevent nausea and vomiting. It is sold under the brand names Zuplenz® and Zofran®. It is a dangerous drug as defined in Business and Professions code section 4022.

"Percocet®" is a form of "oxycodone," which is an opioid analgesic medication synthesized from thebaine. It is a semi-synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is generally used as an analgesic, but it also has a high potential for abuse. Repeated administration of oxycodone may result in psychic and physical dependence. Oxycodone is commonly prescribed for moderate to severe chronic pain. It is sold in its various forms under several brand name, including OxyContin® (a time-release formula) and Roxicodone®. Oxycodone is also available in combination with other drugs and sold under brand names including, acetaminophen (Endocet®, Percocet®, Roxicet®, and Tylox® among others); aspirin (Endodan®, Percodan® and Roxiprin® among others); and ibuprofen (Combunox®). It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug as defined in Business and Professions Code section 4022.

"Phentermine" is a stimulant similar to an amphetamine. It acts as an appetite suppressant by affecting the central nervous system. It is used medically as an appetite suppressant for short term use, as an adjunct to exercise and reducing calorie intake. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (b)(f)(4), and a dangerous drug pursuant to Business and Professions Code section 4022.

"Phendimetrazine" is a stimulant drug used for weight loss. Phendimetrazine is similar to an amphetamine. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (b)(6), and a dangerous drug pursuant to Business and Professions Code section 4022.

"ProAir®" is a brand name for albuterol.

"Promethazine with codeine" or codeine phosphate/promethazine hydrochloride is an antihistamine and opioid antitussive combination drug. The combination of an opiate agonist with antitussive activity (codeine) and a phenothiazine-structure antihistamine (promethazine) when used together can be prescribed to relieve cough and upper respiratory symptoms due to conditions such as the common cold. Promethazine is sold in its various forms under the brand names Phenadoz®, Promethegan®, and Phenergan®. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Suboxone®" is a brand name for a formulation of buprenorphine that contains naloxone and a drug used to treat opiate addiction. Buprenorphine is an opioid medication that is similar to other opioids such as morphine, codeine, and heroin, however, it produces less euphoric effects and therefore may be easier to stop taking. Naloxone blocks the effects of opioids such as morphine, codeine, and heroin.

"Temazepam" is a benzodiazepine medication. It is generally indicated for the short-term treatment of insomnia. It is sold under the brand names Restoril® among others. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(29), and a dangerous drug as defined in Business and Professions Code section 4022.

"Tramadol" is a synthetic pain medication used to treat moderate to moderately severe pain. The extended-release or long-acting tablets are used for chronic ongoing pain. Tramadol is sold under various brand names, including Ultram® and ConZip®. It is a Schedule IV controlled substance pursuant to federal Controlled Substances Act, and a dangerous drug pursuant to Business and Professions Code section 4022.

"Triamcinolone" is a glucocorticoid used to treat certain skin diseases, allergies, and rheumatic disorders among others. It is also used to prevent worsening of asthma and COPD. It can be taken in various ways including by mouth, injection into a muscle, and inhalation. It is sold under the brand names Kenalog®, Nasacort® and Adcortyl®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Soma®" is a brand name for carisoprodol. It is a muscle-relaxant and sedative. It is a Schedule IV controlled substance pursuant to federal Controlled Substances Act, and a dangerous drug pursuant to Business and Professions Code section 4022.

"Tretinoin" is a Vitamin A derivative medication used to treat acne and other skin conditions when applied topically. Its oral form can treat a specific type of leukemia. It is sold under the brand names Retin-A Micro®, Refissa®, Retin-A

Micro Pump®, Tretin-X, Retin-A®, Atralin®, TRETIN-X Cream Kit®, Renova®, and Avita®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Valacyclovir" is an antiviral mediation used to treat herpes virus infections, including shingles, cold sores, and genital herpes. It can also treat chickenpox. It is sold under the brand name Valtrex®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Venlafaxine" is an antidepressant belonging to a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SSNRIs). Venlafaxine affects chemicals in the brain that may be unbalanced in people with depression. Venlafaxine is used to treat major depressive disorder, anxiety and panic disorder. It is sold under various brand names, including, Effexor XR®. It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Zofran®" is a brand name for ondansetron.

"Zoloft®" is the trade name for sertraline, which a drug used to treat depression, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), premenstrual dysphoric disorder (PMDD), social anxiety disorder, and panic disorder. It is a Selective Serotonin Reuptake Inhibitor (SSRI). It is a dangerous drug pursuant to Business and Professions Code section 4022.

"Zolpidem" is a sedative drug primarily used for the treatment of trouble sleeping. It has a short half-life. Its hypnotic effects are similar to those of the benzodiazepine class of drugs. It is sold under the brand name Ambien®. It is a schedule IV controlled substance and narcotic as defined by Health and Safety Code section 11057, subdivision (d)(32) and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

10. On or about November 20, 2020, an investigator and medical consultant interviewed Respondent ("Interview") on behalf of the Board. At her Interview, Respondent explained that her specialty is internal medicine. Respondent stated that she issued prescriptions only electronically, and that her office did not dispense any medications. She also stated that she was not aware that any prescription pad had been stolen from her office, or that any other practitioner was using her name to write a prescription for a patient. Furthermore, she stated that narcotic prescriptions required a second electronic verification by her to be issued to a patient. However, four other doctors in her office still used paper scripts.

Patient A.[1]

11. At her Interview, Respondent stated that she remembered Patient A who became her patient through her old practice and carried over to her current practice group. She also stated

[1] Letters are used in lieu of names to address privacy concerns.

that she had treated Patient A for hypertension, hyperlipidemia, diet-controlled diabetes, and more recently, in connection with the patient's diagnosis of papillary thyroid cancer and dyspnea.

12. On or about September 24, 2014, Respondent saw Patient A, a 74-year-old man, who was returning to the care of Respondent. The patient had history of a colonoscopy in 2011 and follow up visits with specialists for benign prostatic hyperplasia (BPH), bladder stones, prostate stones and left knee torn ligament. The patient's medications included alprazolam, atorvastatin, benazepril, finasteride, gemfibrozil, ketodan, metformin, multivitamins, nabumetone and zolpidem. Respondent's assessment included BPH, diabetes, essential hypertension, hyperlipidemia, and screening for prostate cancer. Respondent's plan for the patient was to continue current therapy and follow up with specialists. Respondent ordered labs and refilled the patient's medications.

13. On or about October 8, 2014, Respondent saw the patient for a follow up visit. The patient had seen specialists for BPH, bladder stones, prostate stones and left knee torn ligament. The patient's medications included, among others, alprazolam, atorvastatin, benazepril, finasteride, gemfibrozil, ketodan combo pack, metformin, multivitamins, nabumetone and zolpidem. The patient had back stiffness and back pain. The patient's laboratory results revealed elevated triglycerides and cholesterol. Respondent's assessment included diabetes, BPH, essential hypertension and hyperlipidemia. Respondent's plan was to continue the patient's current therapy.

14. On or about January 7, 2015, Respondent saw the patient for a follow up visit. His blood pressure was controlled and he had seen specialists for BPH, bladder and prostate stones, and a torn left knee ligament. He stopped his gemfibrozil and atorvastatin, and lipid panel was elevated. The patient's medications included allpurinol, alprazolam, atorvastatin, benazepril, finasteride, gemfibrozil, ketoconazole shampoo, metformin, multivitamins, nabumetone, and zolpidem. Respondent's assessment included diabetes, BPH, essential hypertension, and hyperlipidemia. Her plan was to continue the patient's current therapy and follow up with specialists as scheduled.

15. On or about May 6, 2015, Respondent saw the patient for follow up. The patient

reported weird dreams from taking Ambien®. The patient's medications included allopurinol, alprazolam, atorvastatin, benazepril, celebrex, finasteride, gemfibrozil, ketoconazole shampoo, metformin, multivitamins, nabumetone, and zolpidem. The patient had joint pain and exhibited abnormal gait, knee joint tenderness and abnormal knee range of motion upon examination. Respondent's assessment included diabetes, BPH, essential hypertension, insomnia and localized osteoarthritis. Respondent's plan included continuing her current management of the patient except for the prescription for temazepam for insomnia.

16. On or about September 21, 2015, Respondent saw the patient (75-years-old at the time) for a pre-surgical clearance evaluation (a total knee replacement surgery). She documented that the patient was not on warfarin or aspirin. The patient's EKG results were normal. The patient's hypertension, diabetes and hyperlipidemia were also noted to be well-controlled. The patient was also sedentary due to knee pain. His medications included allopurinol, alprazolam, atorvastatin, benazepril, celebrex, finasteride, gemfibrozil, ketoconazole shampoo, multivitamins, and zolpidem. The patient was positive for left knee pain, and his vitals and examination results were unremarkable except for left knee pain with movement. Respondent deemed that the patient was low risk for the procedure and celebrex was advised to be held one week prior to surgery. She also prescribed Cymbalta® to the patient for dysthymia.

17. On or about January 19, 2016, Respondent saw the patient for a follow up visit. He was reported to be doing well after his left knee replacement surgery in November, but his right knee was still painful (he had his right knee replaced in 2001). The patient's medications included alprazolam, atorvastatin, celebrex, Cymbalta®, finasteride, multivitamins, oxycodone with acetaminophen (10-325) as needed, pepto-bismol as needed and temazepam at bedtime. The patient reported joint pain and a skin rash, right knee erythema and left knee pain with movement. Respondent's assessment included allergy, essential hypertension, hyperlipidemia, and diabetes.

18. On or about August 22, 2016, Respondent saw the patient with complaints of constant bilateral knee pain. His blood pressure was slightly elevated, but he did not take his medications that day. He also discontinued the atorvastatin. Respondent reported that the patient's diabetes was controlled through diet and that he needed CPAP supplies. The patient's medications

included probiotic, benazepril, finasteride, ibuprofen, meloxicam, multivitamins, Norco (10-325) two times daily as needed, temazepam 15 mg nightly as needed, and voltaren topical gel. The patient had joint pain and difficulty sleeping as well. Respondent's assessment included diabetes, BPH, essential hypertension, hyperlipidemia, osteoarthritis, and depression, and her plan was to start or restart Cymbalta® at a low dose.

19. On or about October 11, 2016, Respondent saw the patient in connection with a post-hospitalization follow up. The patient went to the Emergency Room ("ER") for dyspnea on exertion and chest pain. The patient's cardiac and pulmonary embolism testing yielded negative results. He had epigastric pain and stopped his nonsteroidals. He also reported extreme fatigue. The patient's medications were probiotics, alprazolam, atorvastatin, benazepril, coreg, EPA-DHA, finasteride, gemfibrozil, ibuprofen, meloxicam, multivitamins, esomeprazole, sucralfate, vitamin D, voltaren gel, zofran as needed, and zolpidem. The patient reported a loss of appetite and abdominal pain, but denied joint pain or swelling. His vitals and exam were unremarkable. Respondent's assessment included generalized abdominal pain, essential hypertension, hyperlipidemia, osteoarthritis, diabetes and an incidental thyroid nodule. Respondent's plan was to order imaging of the abdomen and thyroid.

20. On or about October 19, 2016, Respondent saw the patient for a follow up visit. The patient's abdominal pain was worked up with mostly negative results. The patient responded well to esomeprazole (Nexium®)[2]. Thyroid function tests were normal per documentation. The patient was referred to gastroenterology and advised to restart Cymbalta® with a low dose.

21. On or about November 16, 2016, Respondent saw the patient for a follow up visit. He had been diagnosed with papillary thyroid carcinoma. He was referred to Dr. S. at Loma Linda Medical Center. The patient underwent an esophagogastroduodenoscopy (EGD), to examine the lining of his esophagus, stomach, and duodenum, with normal results. The patient's medications included probiotic, alprazolam, atorvastatin, benazepril, coreg, Cymbalta®, EPA-DHA, finasteride, ibuprofen, meloxicam, esomeprazole, sucralfate, tramadol, vitamin D, voltaren

[2] An over the counter medication which is a proton-pump inhibitor that can treat gastroesophageal reflux disease.

gel, zofran, and zolpidem. He also had fatigue, joint pain and difficulty sleeping. Respondent's assessment included papillary thyroid carcinoma, chronic fatigue, and gastroesophageal reflux disease (GERD) without esophagitis. Respondent's plan was to continue the patient's current therapy, follow up with the surgeon and use CPAP at night.

22. On or about November 29, 2016, Respondent saw the patient in connection with preoperative clearance. The patient screened positive for depression. An EKG was interpreted as unchanged. The patient's reported medications included probiotics, alprazolam, atorvastatin, benazepril, coreg, Cymbalta®, EPA-DHA, finasteride, gemfibrozil, ibuprofen, meloxicam, multivitamins, esomeprazole, sucralfate, tramadol, triamcinolone cream, vitamin D, voltaren gel, zofran and zolpidem. The patient had fatigue, weight loss, and difficulty sleeping. He denied joint pain. Respondent's assessment included preoperative evaluation, chronic fatigue, BPH, and papillary thyroid cancer. Respondent wrote that patient would also have pre-op with anesthesia. The patient's Cymbalta dose was increased and was to continue with other current management. Lifestyle modifications were discussed with the patient as well.

23. On or about August 18, 2017, Respondent saw the patient for a follow up visit. He had a slightly elevated blood pressure (although he had not taken his medications). The patient was going to see a cardiothoracic surgeon for his thyroid cancer issue, and his diabetes was reported to have been controlled with diet. The patient had been taking Xanax® three to four times a day for dysthymia. He had also tried Cymbalta® but it was not tolerated. The patient reported to have fatigue, ear discharge, constipation and back pain. Right ear cerumen impaction was noted in the chart. Respondent's examination revealed that the patient's ear exam was normal, and his physical exam was unremarkable. Respondent's assessment included diabetes, BPH, essential hypertension, GERD, hyperlipidemia, papillary thyroid carcinoma with post operative hypothyroidism, and depression. Respondent's plan was to start the patient with a low dose of sertraline (Zoloft®) and to minimize Xanax®.

24. On or about September 22, 2017, Respondent saw the patient for a follow up visit He had a slightly elevated blood pressure (although he had not taken his medications). The patient was going to see a cardiothoracic surgeon for his thyroid and mediastinal lymphadenopathy, and

his diabetes was reported to have been controlled with diet. The patient's dysthymia was much improved on one month of sertraline, and he only required one Xanax® per day. He also reported fatigue. His medications included amoxicillin, atorvastatin, benazepril, calcium carbonate-vitamin D3, vitamin D3, diclofenac, esomeprazole, finasteride, ibuprofen, probiotic, liothyronine, multivitamins, ondansetron, sertraline, synthroid, tramadol, valacyclovir, diclofenac gel and alprazolam. Respondent's assessment included essential hypertension, mediastinal lymphadenopathy/papillary thyroid carcinoma post total thyroidectomy with postoperative hypothyroidism, GERD, BPH, type 2 diabetes mellitus, hyperlipidemia and depression. Respondent's plan of care was to continue the patient's current therapy. Lifestyle modifications were discussed as well.

25. On or about December 18, 2017, Respondent saw the patient for a follow up visit. He had a slightly elevated blood pressure (although he had not taken his medications). He also planned to follow up with Dr. S. for his thyroid cancer. His diabetes was reported to have been controlled with diet and he used his CPAP machine to address his obstructive sleep apnea (OSA). His dysthymia was much improved on sertraline after approximately one month, and he only used Xanax® once a day. Respondent's medications included alprazolam, atorvastatin, benazepril, calcium carbonate-vitamin D3, vitamin D3, diclofenac, finasteride, probiotic, multivitamin, liothyronine, ondansetron, esomeprazole, synthroid, tramadol and valacyclovir. The patient's laboratory results indicated anemia. Respondent's assessment included essential hypertension, mediastinal lymphadenopathy/papillary thyroid carcinoma s/p total thyroidectomy with postoperative hypothyroidism, GERD, BPH, type 2 diabetes mellitus, hyperlipidemia and depression. Respondent's plan was to continue with the patient's current therapy. Lifestyle modifications were documented.

26. On or about January 4, 2018, Respondent saw the patient for a right groin mass which he reported as benign in October, but started causing him pain recently. Respondent had fatigue, abdominal pain, and dysphoric mood. Respondent's medications included amoxicillin, atorvastatin, benazepril, calcium carbonate/vitamin D3, vitamin D3, diclofenac, esomeprazole, finasteride, probiotic, liothyronine, multivitamins, ondansetron, sertraline, synthroid, tramadol

and valacyclovir. Respondent's exam revealed a right inguinal mass that was hard to reduce. Respondent's assessment included inguinal hernia. Her plan included ultrasound evaluation and possible referral for surgery.

27. On or about May 15, 2018, Respondent saw the patient for a follow up visit. He had a slightly elevated blood pressure (although he had not taken his medications). He also planned to follow up with Dr. S. for his thyroid cancer. His diabetes was reported to have been controlled with diet. His dysthymia was much improved on sertraline after approximately one month, and he only used Xanax® once a day. The patient had a hoarse voice that had been evaluated by ENT who recommended a voice specialist. The patient reported voice change. Respondent's medications included alprazolam, amoxicillin, atorvastatin, benazepril, calcium carbonate/vitamin D3, vitamin D3, diclofenac, finasteride, hydrocodone-acetaminophen 5-325, probiotic, liothyronine, metformin, multivitamins, synthroid, tramadol, valcyclovir, esomeprazole, and ondansetron. Laboratory results revealed anemia. Respondent's assessment included essential hypertension, papillary thyroid carcinoma post total thyroidectomy with postoperative hypothyroidism, GERD, BPH, type 2 diabetes mellitus, hyperlipidemia and depression. Respondent's plan included pursing an esophagram. She ordered right ear cerumen removal for the patient and temazepam.

28. On or about September 11, 2018, Respondent saw the patient for a follow up visit. He had a slightly elevated blood pressure (although he had not taken his medications). The patient was going to see a cardiothoracic surgeon for his thyroid cancer, and his diabetes was reported to have been controlled with diet. The patient had a hoarse voice that had been evaluated by ENT who recommended a voice specialist. The patient's medications included atorvastatin, benazepril, calcium carbonate, vitamin D3, finasteride, probiotics, liothyronine, metformin, multivitamins, ondansetron, synthroid, tramadol, triamcinolone cream, diclofenac cream and esomeprazole. The patient had fatigue, unexpected weight change, dysphoric mood and sleep disturbance. The physical exam results were normal and the laboratory results revealed anemia. Respondent's assessment was essential hypertension, mediastinal lymphadenopathy/papillary thyroid carcinoma s/p total thyroidectomy with postoperative

hypothyroidism, GERD, BPH, type 2 diabetes mellitus, hyperlipidemia and depression. Lifestyle modifications were discussed. Respondent's plan was to continue the same treatment.

29. On or about January 8, 2019, Respondent saw the patient for a follow up visit. He had a slightly elevated blood pressure (although he had not taken his medications). He also planned to follow up with Dr. S. for his thyroid cancer. His diabetes was reported to have been controlled with diet. His dysthymia was much improved on sertraline after approximately one month, and he only used Xanax® once a day. Respondent also documented that the patient had a colonoscopy within the past 10 years. The patient had a hoarse voice that had been evaluated by ENT who recommended a voice specialist. Respondent's medications included alprazolam, atorvastatin, benazepril, diclofenac gel, esomeprazole, ferrous sulfate, finasteride, probiotic, liothyronine, metformin, multivitamins, ondansetron, sertraline, synthroid, tramadol and triamcinolone cream. The patient had fatigue. The patient's physical exam results were normal and the laboratory results revealed anemia. Respondent's assessment included essential hypertension, papillary thyroid carcinoma post total thyroidectomy with postoperative hypothyroidism, GERD, BPH, type 2 diabetes mellitus, hyperlipidemia and depression. Respondent's plan was to continue with the current treatment regimen.

30. On or about April 9, 2019, Respondent saw the patient for a follow up visit. He had a slightly elevated blood pressure (although he had not taken his medications). He also planned to follow up with Dr. S. and Dr. W. for his papillary thyroid cancer. His diabetes was reported to have been controlled with diet. His dysthymia was much improved on sertraline after approximately one month, and he only used Xanax® once a day. The patient had a hoarse voice that had been evaluated by ENT who recommended a voice specialist. The patient's medications included alprazolam, atorvastatin, benazepril, diclofenac tablet, diclofenac gel, esomeprazole, ferrous sulfate, finasteride, probiotic, liothyronine, metformin, multivitamin, ondansetron, synthroid, tramadol and sertraline. The patient had fatigue and voice change. The patient's physical exam results were normal and the laboratory results revealed anemia. Respondent's assessment included OSA, essential hypertension, papillary thyroid carcinoma post total thyroidectomy with postoperative hypothyroidism, GERD, BPH, type 2 diabetes mellitus,

hyperlipidemia, depression and iron deficiency anemia. Iron studies and fecal occult blood testing were ordered. Respondent discontinued the patient's omeprazole and multivitamins and advised lifestyle modifications.

31. On or about July 16, 2019, Respondent followed up with the patient who had slightly elevated blood pressure (although he had not taken his medications). He also planned to follow up with Dr. S. and Dr. W. for his papillary thyroid cancer. His diabetes was reported to have been controlled with diet. His dysthymia was much improved on sertraline after approximately one month, and he only used Xanax® once a day. The patient had a hoarse voice that had been evaluated by ENT who recommended a voice specialist. The patient's medications prior to this visit included atorvastatin, benazepril, calcium carbonate, vitamin D3, diclofenac, ferrous sulfate, finasteride, probiotic, liothyronine, metformin, sertraline, synthroid, tramadol, alprazolam and ondansetron. Review of systems was positive for fatigue, dry mouth and voice change. The patient's physical exam was normal and his laboratory results revealed anemia. Respondent's assessment included OSA, essential hypertension, mediastinal lymphadenopathy/papillary thyroid carcinoma post total thyroidectomy with postoperative hypothyroidism, GERD, BPH, type 2 diabetes mellitus, hyperlipidemia and insomnia. Respondent's plan was to continue his current treatment. The patient was educated and zolpidem was planned for his insomnia. He was also due for a colonoscopy.

32. On or about October 22, 2019, Respondent followed up with the patient who had slightly elevated blood pressure (although he had not taken his medications). The patient had been using his CPAP machine. The patient's diabetes was controlled with diet and his dysthymia was better controlled on sertraline for about one month. The patient also only needed to take Xanax® about once a day. The patient's medications included alprazolam, atorvastatin, benazepril, calcium carbonate, vitamin D3, diclofenac, ferrous sulfate, finasteride, levothyroxine, liothyronine, metformin, ondansetron, sertraline, tramadol, zolpidem, and probiotic. The patient had fatigue, voice change and finger pain. The patient's physical exam was normal and his laboratory results revealed anemia. Respondent's assessment included OSA, essential hypertension, mediastinal lymphadenopathy/papillary thyroid carcinoma post total thyroidectomy

with postoperative hypothyroidism, GERD, BPH, type 2 diabetes mellitus, hyperlipidemia and depression. Respondent's plan was to continue the same medication regimen. Education was provided for the patient. The patient's left finger pain was addressed with an order for an x-ray.

33. On or about February 18, 2020, Respondent saw the patient for a follow up exam with slightly elevated blood pressure. He had been taking benazepril and coreg. His PET scan revealed an increased uptake in the right cervical lymph nodes and base of tongue. The patient also had follow up with Dr. S. and Dr. W. The patient had been using his CPAP machine for his OSA, and his dysthymia was better controlled on sertraline for about one month. He also had been taking Xanax® only once a day. The patient's medications prior to his visit included atorvastatin, benazepril, calcium carbonate, vitamin D3, diclofenac, ferrous sulfate, finasteride, liothyronine, metformin, ondansetron, sertraline, synthroid, multivitamin with folic acid, zolpidem, alprazolam and tramadol. Review of systems was positive for fatigue and arthralgias. The patient's physical exam was normal and his laboratory results revealed anemia. Respondent's assessment included OSA, hypertension, mediastinal lymphadenopathy/papillary thyroid carcinoma post total thyroidectomy with postoperative hypothyroidism, GERD, BPH with urinary retention, type 2 diabetes mellitus, hyperlipidemia, vitamin D deficiency, anxiety and osteoarthritis. Respondent's plan was to continue the current therapy, and lifestyle modifications were discussed.

34. A CURES report for the period from June 5, 2015 through March 27, 2020 revealed that Respondent wrote prescriptions for alprazolam, zolpidem, oxycodone with acetaminophen (5-325), and temazepam to the patient.

Patient B.

35. At her Interview, Respondent stated that she remembered Patient B, that she became her patient around 2014 and that she was a nurse who worked with Respondent. She stated that the patient had proteinuria; Respondent ordered lab work.

36. On or about March 3, 2014, Respondent prescribed tramadol and Soma® to Patient B, a 28-year-old woman. The note was initialed and electronically signed. There is no corresponding office visit note.

37. Thereafter, Respondent continued to prescribe drugs to Patient B through November 27, 2019, including on or about the following dates, but failed to adequately document an assessment or rationale for the prescriptions: March 19, 2014 (ProAir®); April 1, 2014 (amoxicillin); April 7, 2014 (azithromycin and Zofran®), April 14, 2014 (levaquin and promethazine-codeine); May 6, 2014 (Soma®), May 7, 2014 (hydrocodone/acetaminophen 10/325); June 3, 2014 (phendimetrazine tartrate 35 mg); July 10, 2014 (ciprofloxacin eye drops); July 16, 2014 (Alaway®); July 17, 2014 (Levaquin); August 5, 2014 (Ventolin® / albuterol); August 19, 2014 (hydrocortisone suppository, Diflucan® and Keflex); September 3, 2014 (Bactrim®); September 23, 2014 (nystatin); October 3, 2014 (azithromycin and promethazine-codeine); October 17, 2014 (clotrimazole-betamethasone topical cream); November 19, 2014 (triamcinolone topical ointment); December 16, 2014 (hydrocodone 10/325); February 13, 2015 (Macrobid®); March 10, 2015 (venlafaxine); April 1, 2015 (azithromycin); April 22, 2015 (clarithromycin) and an override for the combination of clarithromycin and hydrocodone/acetaminophen was entered by the patient and initialed and electronically signed); April 28, 2015 (azithromycin and Ventolin®); May 14, 2015 (valacyclovir); June 2, 2015 (tretinoin); June 9, 2015 (azithromycin, LMX® topical cream and Medrol®); July 8, 2015 (fluocinonide topical solution); October 2, 2015 (Proventil® /albuterol); December 4, 2015 (ciprofloxacin); January 21, 2016 (amoxicillin and fluconazole); March 14, 2016 (amoxicillin); March 15, 2016 (valacyclovir); April 19, 2016 (ciprofloxacin and fluconazole, and the patient overrode the warnings for drug interactions); June 29, 2016 (metronidazole); July 11, 2016 (bimatoprost eye drops); August 5, 2016 (ciprofloxacin); (azithromycin and promethazine-codeine); December 22, 2016 (Macrobid®); January 25, 2017 (phentermine); January 26, 2017 (Percocet 10-325); February 3, 2017 (azithromycin, fluticasone nasal spray and promethazine with codeine); March 20, 2017 (phentermine); April 4, 2017 (azithromycin and promethazine with codeine and Respondent overrode the warning for combination of opioid (cough and cold) and benzodiazepine (temazepam on March 21, 2017) with the reason that the patient had tolerated the same combination in the past without apparent problems).

38. On or about August 18, 2014, Respondent documented a communication to the

patient that her labs looked "ok," but she did have low platelets. The platelet count did fluctuate so the plan was to monitor this.

39. On or about October 10, 2014, Respondent documented a message that the labs looked good.

40. On or about October 14, 2014, Respondent further commented on October 14, 2014 that the cholesterol was amazing and asked if patient was taking a statin. The patient replied that she was not taking a statin.

41. On or about February 18, 2015, Respondent documented a message to the patient that she did have bacteria in the urine after 3 days of Macrobid®. The patient was instructed to continue with Bactrim®.

42. On or about March 9, 2015, Respondent had a telephone interaction with the patient regarding her father who passed away after suffering from a massive stroke. She was very upset and would be taking leave.

43. On or about February 27, 2018, Respondent saw patient B (33 years of age at the time) in her office for a post-pregnancy follow up visit, with complaints of hemorrhoids and a request for hydrocortisone suppository. Patient B also had concerns about her 40 pound weight gain during pregnancy and desired to try weight loss medications. She had success with phentermine (using half a tablet a day). The patient had reported an appetite change and weight change, however no BMI or weight was documented. Respondent's assessment included hemorrhoids during pregnancy and overweight. Respondent advised the patient to maintain a high fiber diet, adequate hydration, hydrocortisone suppository as needed, low carb diet and exercises daily. Respondent also prescribed phentermine (37.5 mg half a tablet daily) to the patient. The risks of the medication were discussed. The patient's medications at the end of the visit included phentermine and hydrocortisone (suppository).

44. On or about June 14, 2018, Respondent saw Patient B who had lost about thirty pounds of weight. She had been working out but was stressed about work: anxious, having palpitations and not sleeping at night. The patient reported that she was not taking any hydrocortisone suppository. The patient reported fatigue, palpitations, dizziness, nervousness and

anxiety. Her vitals included a pulse at 100 and BMI of 27.67. Respondent's assessment included palpitations, overweight and anxiety. Patient B desired to see a psychologist and was reluctant to start medications. Respondent advised the patient to undergo deep breathing exercises, diet modification/weight loss, psychology referral, and the patient was given a take-off work for one week note. Active medications at the end of the visit were hydrocortisone (suppository), valacyclovir, amoxicillin, ibuprofen, phentermine and phendimetrazine tartrate.

45. Several medication lists in the medical records for this patient had a generic note which stated that the report was for documentation purposes only and that the patient should not follow instruction and instead consult their physician or after visit summary.

46. A CURES report for the period from June 5, 2015 through March 27, 2020 revealed that Respondent wrote multiple prescriptions for phentermine, phendimetrazine, oxycodone or hydrocodone with acetaminophen (10-325 mg), alprazolam, and temazepam to the patient.

Patient C.

47. At her Interview, Respondent stated that she remembered Patient C because she was a long time patient of Respondent. Respondent also stated that she had been treating Patient C for approximately eight years and that her medical conditions included hypertension, hyperlipidemia, dyspnea, and osteoarthritis. When confronted about prescribing Patient C, three different benzodiazepines within a five day period (namely on or about, January 26, 2017 (clonazepam); January 30, 2017 (alprazolam); and January 31, 2017 (temazepam), Respondent initially admitted that this conduct did not fall within the standard of care, but after a short break, she changed her statement.

48. The patient's medical records begin in or around November 2012. Based upon these records, Patient C had a history of arthritis, degenerative disc disease of the spine, chronic neck pain, depression, hypothyroidism, GERD, hypertension, hyperlipidemia, inguinal hernia, history of melanoma on her back, occipital neuralgia, restless leg syndrome (RLS), a pulmonary embolism and inferior vena cava (IVC) filter placement. She had ongoing complaints of pain. From in or around November 2012 through in or around February 2014, Patient C's medications included controlled substances such as opioid drugs (e.g., Suboxone® on or about February 13,

2013 and February 28, 2013, April 15, 2013, May 15, 2013) and diazepam.

49. On or about February 26, 2014, Respondent saw Patient C for follow up for depression. Her mediations included trazodone. Her assessment and plan were similar to the patient's previous visit. The patient continued to see Respondent on an approximate bi-monthly basis throughout 2014 with complaints of pain and continued to list trazodone among the patient's medications.

50. On or about March 12, 2015, Respondent saw the patient for hip pain and pain with intercourse. Her medications included Norco®. She saw the patient three more times in 2015 and medications for hydrocodone with acetaminophen were regularly listed along with trazodone. Respondent prescribed Xanax® to the patient on or about December 22, 2015.

51. On or about February 4, 2016, Respondent saw the patient for post-discharge follow up. Her medications included hydrocodone with acetaminophen, temazepam and trazodone. Respondent's plan included maintaining the patient on her medications.

52. On or about February 17, 2016, Respondent saw the patient for follow up. Her medications included hydrocodone with acetaminophen, temazepam and trazodone.

53. On or about March 3, 2016, Respondent saw the patient for follow up. Her medications included hydrocodone with acetaminophen, temazepam and trazodone. Respondent's plan included maintaining the patient on her current management.

54. On or about April 11, 2016, Respondent saw the patient for hypertension after an ER visit for high blood pressure with a headache and loss of appetite. Her medications included alprazolam.

55. On or about April 15, 2016, Respondent saw the patient for follow up on her high blood pressure. Her medications included alprazolam.

56. On or about April 22, 2016, Respondent saw the patient for follow up about her hypertension. Her medications included oxycodone, temazepam and alprazolam. Respondent's plan included continuing the patient's treatment.

57. On or about June 1, 2016, Respondent saw the patient for a routine checkup. Her medications included Norco®, temazepam and alprazolam. Her assessment included chronic

pain and unspecified pain.

58. On or about June 29, 2016, Respondent saw the patient. Her medications included Norco®, temazepam and alprazolam.

59. On or about August 1, 2016, Respondent saw the patient with a complaints of "not feeling well." She had fallen off the bed because "it wasn't there" and had left buttock pain. She was also taking Suboxone® to get off her pain meds. Her medications included alprazolam, oxycodone and Suboxone®. Respondent's assessment included an unsteady gait and elderly fall.

60. On or about August 5, 2016, Respondent saw the patient with vesicular lesions on her right buttock area and associated nerve pain. Her medications included alprazolam, oxycodone and Suboxone®.

61. On or about September 7, 2016, Respondent saw the patient with a complaint of stomach pain. She had a fall on or about August 29, 2016. Her medications included alprazolam, temazepam and Suboxone®. Respondent's assessment included an elderly fall and chronic pain.

62. On or about September 15, 2016, Respondent saw the patient for follow up after her mechanical fall on or about September 12, 2016. She was unable to sit down. An x-ray was negative for fractures. Her medications included alprazolam, temazepam and Suboxone®. Her assessment included sacrococcygeal disorder, depressive disorder, elderly fall, episodic opioid dependence, injury of the pelvis and unsteady gait. Her plan included follow up with balance clinic, obtaining an MRI and for the patient to ice the affected area.

63. On or about October 4, 2016, Respondent saw the patient for follow up of the MRI results. She was reportedly not taking pain medications. Her medications included alprazolam, temazepam and Suboxone®. Respondent's assessment included unsteady gait, elderly fall, spasm of back muscles and sequela of pelvic injury. Respondent advised the patient to be careful with ambulation and to continue current management.

64. On or about November 9, 2016, Respondent saw the patient who presented with frequent falls, dizziness, headache, and lightheadedness. Her medications included alprazolam, Suboxone® and temazepam. The patient had low back pain and anxiety. Respondent's assessment included continued opioid dependence, degeneration of her intervertebral disc,

depressive disorder, hypertension and unspecified pelvic injury/sequela. Her plan included discussing reducing the patient's Suboxone® with Dr. T. due to her frequent falls and continue with other current treatment plans.

65. On or about January 31, 2017, Respondent saw the patient for a follow up for joint pain and stiffness in the morning. She had another fall. Her medications included alprazolam, Suboxone®, clonazepam, and temazepam. Respondent's assessment included opioid dependence, degeneration of intervertebral disc, elderly fall, hypertension, hypothyroidism and restless legs. Respondent's plan was to continue the patient's current therapy.

66. On or about June 30, 2017, Respondent saw the patient for follow up for depression. Her medications included alprazolam, clonazepam, Suboxone® and temazepam.

67. On or about July 25, 2017, Respondent saw the patient for an inguinal lump and some pain in the area. She complained of abdominal and back pain. Her medications included hydrocodone with acetaminophen (5-325) every 4 hours as needed. Respondent's assessment included chronic pain.

68. On or about January 4, 2018, Respondent saw the patient for high blood pressure. Respondent had blurry vision for two weeks and right hip pain. The patient's medications included Suboxone®, temazepam, alprazolam and clonazepam.

69. On or about January 18, 2018, Respondent saw the patient for blood pressure control. The patient's depression was worsening; she had been taking care of her husband with dementia. Her medications included alprazolam, Suboxone®, clonazepam and temazepam. Respondent's assessment included chronic pain, continuous opioid dependence, hypertension, hypothyroidism, hyperlipidemia, depressive disorder, and vitamin D deficiency. Respondent documented that there was to be "No benzodiazepines on suboxone" and that the patient needed to stop the benzodiazepines.

70. On or about January 22, 2018, Respondent saw the patient for follow up after an ER visit for hyperkalemia and acute renal failure. She also discontinued taking Suboxone®. She was followed with pain management.

71. On or about February 7, 2018, Respondent saw the patient for follow up after an ER

visit for hyperkalemia and acute renal failure. The patient discontinued her Suboxone® and she was followed with pain management. Her medications included alprazolam, clonazepam, hydrocodone with acetaminophen 10-325 every 4 to 6 hours as needed and temazepam.

72. On or about February 20, 2018, Respondent saw the patient for follow up after an ER visit for hyperkalemia and acute renal failure. The patient's medications included clonazepam, temazepam, alprazolam, and hydrocodone with acetaminophen (10-325) every 4 to 6 hours as needed.

73. On or about March 6, 2018, Respondent saw the patient for hyperkalemia and acute renal failure. The patient's medications included alprazolam, clonazepam, hydrocodone with acetaminophen 10-325 every 4-6 hours as needed and temazepam. Respondent's plan was to continue current management.

74. On or about March 20, 2018, Respondent saw the patient for follow up. The patient's medications included alprazolam, clonazepam, hydrocodone with acetaminophen 10-325 every 4-6 hours as needed and temazepam.

75. On or about April 5, 2018, Respondent saw the patient for hypertension. The patient had a recent fall and went to the ER. Her head CT was documented as negative. The patient had confusion. The patient's medications included alprazolam, clonazepam, hydrocodone with acetaminophen 10-325 mg every 4 to 6 hours as needed and temazepam.

76. On or about April 19, 2018, Respondent saw the patient for blood pressure control. The patient also had a recent fall and went to the ER. Her head CT was documented as negative. The patient's medications were alprazolam, clonazepam, hydrocodone with acetaminophen 10-325 every 4 to 6 hours as needed and temazepam.

77. On or about May 3, 2018, Respondent saw the patient for blood pressure control. Her medications included alprazolam, clonazepam, hydrocodone-acetaminophen 10-325 every 4 to 6 hours as needed and temazepam. Respondent's plan was to continue the same regimen and follow lifestyle modifications.

78. On or about June 11, 2018, Respondent saw the patient for a follow up visit. Respondent's medications included clonazepam, hydrocodone-acetaminophen (10-325 mg) every

4 to 6 hours as needed and diazepam. Respondent's plan was to continue the same therapy.

79. On or about June 21, 2018, Respondent saw the patient about osteoarthritis of her hands, wrists and knees. She had been putting CBD oil on the affected joints to alleviate her pain.

80. On or about August 29, 2018, Respondent saw the patient about her blood pressure. The patient's medications included alprazolam. Her assessment stated the patient had well-controlled hypertension. Her plan was to continue current therapy and follow lifestyle recommendations.

81. On or about September 24, 2018, Respondent saw the patient in connection with follow up for hypertension. Her medications included alprazolam and temazepam.

82. On or about January 18, 2019, Respondent saw the patient for follow up. Her medications included alprazolam and temazepam. Respondent's plan was to continue with the patient's current therapy. Lifestyle modifications were discussed.

83. On or about March 14, 2019, Respondent saw the patient for follow up. An MRI of the lumbar spine and pelvis was reviewed and demonstrated degenerative changes in lumbar spine and bursitis. She complained of hand pain and swelling. Her medications included alprazolam, hydrocodone with acetaminophen (10-325 mg) every 6 to 8 hours as needed and temazepam. She also had back pain. Respondent's assessment included benign hypertension, chronic osteoarthritis, swelling of both hands, hyperlipidemia, and depressive disorder. Respondent's plan was to continue the same treatment. Lifestyle modifications were discussed. X-rays of both hands were ordered.

84. On or about May 1, 2019, Respondent saw the patient for follow up. An MRI of the lumbar spine and pelvis was reviewed and demonstrated degenerative changes in the lumbar spine and bursitis. Her medications prior to the visit included alprazolam, hydrocodone with acetaminophen (10-325 mg) every 6 to 8 hours as needed, and temazepam. She had back pain. Respondent's assessment included chronic pain, lumbar radiculopathy, chronic osteoarthritis, disorder of thyroid gland, hyperlipidemia, depressive disorder, health screening, and age-related osteoporosis. Respondent's plan included following up with pain management, behavioral health and continue with current therapy. Lifestyle modifications were discussed.

85. On or about July 3, 2019, Respondent saw the patient for follow up. She had been hospitalized for intractable pain. She was referred to pain management. The patient reported that her pain was improved on oral medications. Her medications included alprazolam and diazepam. The patient had fatigue, neck pain and neck stiffness. The patient's assessment included chronic pain, chronic neck pain/cervical radiculopathy and chronic osteoarthritis. Respondent's plan was to continue with Norco® and gabapentin.

86. On or about July 18, 2019, Respondent saw the patient for follow up. Her medications included alprazolam and diazepam. The patient had back pain, neck pain and neck stiffness. Her assessment included chronic neck pain, and depressive disorder. The chart included documentation that the patient was aware of the risks and benefits of using three pills of Norco® per day for pain, but it was not listed as an active medication. Lifestyle modifications were discussed. Dr. J.L., who was prescribing lithium, also prescribed alprazolam.

87. On or about October 9, 2019, Respondent saw the patient with complaints of left knee pain. She was tearful during the visit. Her medications prior to the visit were alprazolam, temazepam and diazepam. Her assessment included left knee pain, well-controlled hypertension, osteoarthritis, restless leg syndrome, hyperlipidemia and depression. Respondent's plan was to continue current therapy. Lifestyle modifications were discussed. The patient had a follow up appointment with pain management. Her active medications after the visit included diazepam, alprazolam, and temazepam. Respondent noted that Dr. J.L., who was prescribing lithium, also prescribed alprazolam. Respondent prescribed both diazepam and temazepam to the patient.

88. A CURES report for the period from January 1, 2017 through March 1, 2020, indicated that Respondent wrote prescriptions for multiple benzodiazepines on a recurring basis, and that other providers prescribed opioid prescriptions concurrently.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

89. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that she committed gross negligence in her care and treatment of three patients. The circumstances are as follows:

90. Respondent committed the following acts of gross negligence:

Patient A.

91. On or about September 24, 2014 and thereafter, Respondent committed the following acts, individually and/or collectively, of gross negligence, in connection with her treatment and care of Patient A, as follows:

92. Respondent inappropriately prescribed drugs to Patient A, including when she concurrently prescribed to the patient benzodiazepines and nonbenzodiazepine benzodiazepine receptor agonists.[3] Respondent prescribed alprazolam concurrently with zolpidem for the patient. Given the alprazolam dosing (three times per day), the patient could have been under the effect of both alprazolam and zolpidem at the same time. The patient also had a history of obstructive sleep apnea, putting him into a higher risk category for respiratory compromise from these medications. Respondent failed to adequately address treatment goals and the proposed duration of treatment with the patient. Respondent's chart notes failed to adequately evaluate any adverse side effects from these prescriptions. Respondent failed to adequately monitor the patient for any possible aberrant behavior. She also failed to adequately consider and/or utilize a psychiatry consultation for this patient.

Patient B.

93. On or about March 3, 2014, and thereafter, Respondent committed the following acts, individually and/or collectively, of gross negligence, in connection with her treatment and care of Patient B as follows:

(A) Respondent failed to adequately assess, monitor and/or reassess her continuous prescribing of controlled substances to Patient B, including when she failed to appropriately titrate the drugs she was prescribing to the patient;

(B) Respondent failed to adequately obtain and or document an informed consent and/or pain management agreement with Patient B;

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[3] Common adverse effects associated with these two classes of medications include residual daytime sedation, drowsiness, dizziness, lightheadedness, cognitive impairment, motor incoordination, and dependence. In addition, they are both respiratory suppressants that can make obstructive sleep apnea or hypoventilation worse.

(C) Respondent inappropriately prescribed controlled substance to Patient B, including when concurrently prescribing opioids, benzodiazepines and/or muscle relaxants to Patient B. She failed to adequately document her rationale for these prescriptions as well. Respondent prescribed benzodiazepines and opioid medications, including alprazolam and Percocet® to Patient B simultaneously, including as follows:

- alprazolam (filled on July 3, 2014 , August 10, 2014 , September 9, 2014, October 3, 2014, November 6, 2014 , December 3, 2014 , December 28, 2014 , January 29, 2015, February 26, 2015, April 6, 2015, May 4, 2015, June 1, 2015, July 2, 2015, August 3, 2015); September 9, 2015, October 14, 2015, November 9, 2015, December 14, 2015, January 6, 2016, February 7, 2016, March 8, 2016, April 12, 2016, May 12, 2016, September 15, 2016, October 19, 2016, November 16, 2016,.
- hydrocodone (oxycodone)/APAP (filled on May 7, 2014, June 3, 2014, July 3, 2014, August 10, 2014, September 5, 2014, October 3, 2014, October 29, 2014, November 26, 2014, December 30, 2014, January 29, 2015, February 28, 2015, July 2, 2015, August 3, 2015, September 1, 2015, October 14, 2015, November 10, 2015, December 18, 2015, January 12, 2016, February 4, 2016, March 3, 2016, March 23, 2016, April 14, 2016, May 13, 2016, June 3, 2016, July 1, 2016, July 23, 2016 August 22, 2016, September 22, 2016, October 21, 2016, November 22, 2016, December 16, 2016, December 21, 2016);, January 23, 2017, and February 27, 2017.
- temazepam (filled on March 21, 2017).
- tramadol (prescribed on March 3, 2014).
- Soma® (prescribed on March 3, 2014 and May 6, 2014).

(D) Respondent inappropriately prescribed phentermine and phendimetrazine to Patient B.[4] Respondent failed to adequately perform and/or document an assessment of the patient as an appropriate candidate for using these prescribed drugs, including any initial pre-prescription cardiac evaluation. She also failed to adequately monitor the patient's use of these drugs, including for efficacy and/or side effects. Respondent prescribed these drugs to Patient B

[4] Combining these medications can increase the risk of serious heart problems.

simultaneously, including as follows:

- May 10, 2016 (phentermine) and May 26, 2016 (phendimetrazine).
- November 16, 2016 (phentermine) and November 13, 2016 (phendimetrazine).
- December 17, 2016 (phendimetrazine).
- January 4, 2017 (phentermine) and January 16, 2017 (phendimetrazine).
- June 14, 2018 (phentermine) and June 26, 2018 (phendimetrazine).

Patient C.

94. On or about February 26, 2014, and thereafter, Respondent was grossly negligent in her treatment and care of Patient C, by prescribing multiple benzodiazepines to Patient C, who was also receiving opioid mediations from other providers. Patient C suffered from multiple falls, which is concerning because benzodiazepines can cause confusion, altered mentation, disturbance in attention and equilibrium in addition to respiratory depression.[5] Respondent also failed to coordinate care with Patient C's other providers, including her other healthcare providers (who prescribes benzodiazepines and opioids to the patient), in order to jointly evaluate whether any drugs should be adjusted and/or tapered. Respondent prescribed the following drugs to the patient:

- alprazolam (filled on June 9, 2019, April 4, 2019, March 6, 2019, February 1, 2019, January 4, 2019, December 6, 2018, November 7, 2018, October 11, 2018, September 10, 2018, August 13, 2018, July 16, 2018, June 11, 2018, January 22, 2018, October 6, 2017, June 27, 2017, May 18, 2017, March 22, 2017, and January 30, 2017.
- diazepam (filled on June 26, 2019).
- clonazepam (filled on August 16, 2017, June 27, 2017, March 23, 2017, and January 26, 2017).
- temazepam (filled on September 16, 2019, March 13, 2019, February 15, 2019, January 14, 2019, December 16, 2018, November 18, 2018, October 22, 2018, September 3, 2018, July 29, 2018, June 9, 2018, April 2, 2018, February 28,

[5] These side effects may be further potentiated by the usage of opioid medications.

2018, January 18, 2018, December 17, 2017, October 26, 2017, August 31, 2017, June 2, 2017, ; April 28, 2017, and January 31, 2017).

- oxycodone/ (hydrocodone)/APAP (filled on June 24, 2019).

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

95. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that Respondent committed repeated negligent acts in the care and treatment of three patients. The circumstances are as follows:

96. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

97. Each of the alleged acts of gross negligence set forth above in the First Cause for Discipline is also a negligent act.

98. Respondent committed the following acts of negligence:

Patient A.

99. On or about September 24, 2014, and thereafter, Respondent negligently failed to adequately perform assessments (including obtaining histories and performing examinations), formulate plans and/or maintain adequate and/or accurate medical records in connection with her care and treatment of Patient A. Respondent's medical records for this patient inaccurately contained notes that had been copied and pasted from prior notes of medical visits and/or did not accurately reflect the patient's current condition. Further, information in her chart notes for patient encounters also contained conflicting information and abnormal findings and/or complaints were not consistently addressed in the assessment and plans.

100. On or about September 24, 2014 and thereafter, Respondent committed the following acts of negligence, in connection with her treatment and care of Patient A with controlled substances:

(A) Respondent failed to adequately assess, monitor and/or reassess her continuous prescribing of controlled substances to Patient A, including when she failed to appropriately titrate the drugs she was prescribing to the patient. During her interview, Respondent explained

that she prescribed tramadol to the patient for the patient's osteoarthritis. However, Respondent failed to adequately discuss with the patient and/or document, functional goals. She also failed to monitor the patient for compliance with urine drug testing or pill counting.

(B) Respondent failed to adequately perform the process for, enter into and/or document an informed consent and/or a pain management agreement with the patient, including any appropriate discussion of the risks of long term opiate therapy.

(C) Respondent inappropriately prescribed controlled substance to Patient A, including when concurrently prescribing opioids and benzodiazepines to Patient A. The patient was prescribed benzodiazepines and opioid medications simultaneously, including alprazolam, temazepam and tramadol. Although Respondent attempted to wean the patient off alprazolam with Cymbalta and Zoloft, she failed to consult with a specialist, including a psychiatrist, to assist in managing the patient's symptoms. In addition, the CURES report reflects prescriptions that do not match the medical records.

(D) Respondent failed to adequately perform and/or document her preoperative assessment of the patient, which lacked adequate detail and failed to include any documentation of the cardiac and/or pulmonary risks from surgery. In an appropriate preoperative assessment, patients should be evaluated for preoperative cardiac and pulmonary risk, which include utilization of risk models estimating the cardiac risks based on information from the history, physical examination, electrocardiogram, and type of surgery. Patients should be assessed for their exercise capacity and a complete medication history should be obtained.

Patient B.

101. On or about March 3, 2014, and thereafter, Respondent negligently failed to adequately perform assessments (including obtaining histories and performing examinations), formulate plans and/or maintain adequate and/or accurate medical records in connection with her care and treatment of Patient B. Respondent failed to adequately document the reasoning behind her multiple prescriptions for antibiotics and controlled substances to Patient B. Despite warnings entered and overridden by the patient herself at times, Respondent still approved these prescriptions in her medical records. Respondent's medical records for Patient B inaccurately

contained notes that had been copied and pasted from prior notes of medical visits and/or did not accurately reflect the patient's current condition. Further, information in her chart notes for patient encounters also contained internal conflicts within the same note. Her record keeping for this patient was sparse relative to the number of prescriptions she was writing to this patient.

Patient C.

102. On or about February 26, 2014, and thereafter, Respondent negligently failed to adequately perform assessments (including obtaining histories and performing examinations), formulate plans and/or maintain adequate and/or accurate medical records in connection with her care and treatment of Patient C. Respondent's medical records for Patient C inaccurately contained notes that had been copied and pasted from prior notes of medical visits and/or did not accurately reflect the patient's current condition. Further, information in her chart notes for patient encounters also contained internal conflicts within the same note.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

103. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records related to the provision of medical services to a patient. The circumstances are as follows:

104. The allegations of the First and Second Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination)

105. Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed drugs to the three patients above, without appropriate prior examinations and/or medical indications. The circumstances are as follows:

106. The allegations of the First, Second and Third Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

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FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

107. Respondent is subject to disciplinary action under Code sections 2234 and 2228.1, in that her action and/or actions represent unprofessional conduct, generally and patient harm occurred as a result. The circumstances are as follows:

108. The allegations of the First, Second, Third and Fourth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

109. In addition, patient harm occurred from Respondent's unprofessional conduct, including, when she inappropriate prescribed medications to patients, including Patient C.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

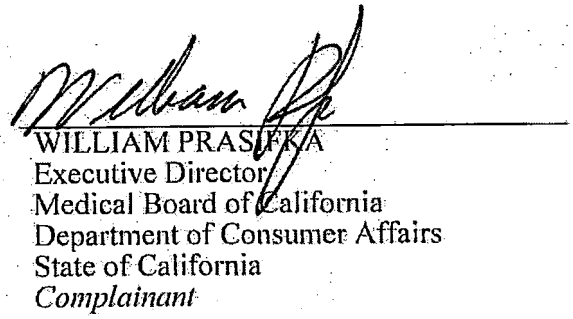
1. Revoking or suspending Physician's and Surgeon's Certificate Number A 111863, issued to Natasha Kelly Creighton, M.D.;

2. Revoking, suspending or denying approval of Natasha Kelly Creighton, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Natasha Kelly Creighton, 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: FEB 11 2021



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

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