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

In the Matter of the First Amended Accusation Against: **Richard Joseph Kempert, M.D.** **Physician's and Surgeon's Certificate No. C 37249** **Respondent.**	**Case No.: 800-2019-058719**

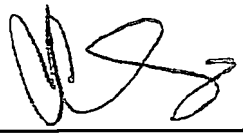
DECISION

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 October 6, 2022.

IT IS SO ORDERED: September 6, 2022.

MEDICAL BOARD OF CALIFORNIA



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

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **RICHARD JOSEPH KEMPERT, M.D.** 34052 La Plaza, Suite 101 Dana Point, CA 92629 **Physician's and Surgeon's Certificate No. C 37249.** Respondent.	Case No. 800-2019-058719 OAH No. 2021110587 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by LeAnna E. Shields, Deputy Attorney General.

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2. Respondent Richard Joseph Kempert, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Esq., with Doyle Schafer McMahon, LLP, whose address is: 5440 Trabuco Road, Irvine, CA 92620.

3. On or about January 31, 1977, the Board issued Physician's and Surgeon's Certificate No. C 37249 to 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. 800-2019-058719, and will expire on August 31, 2023, unless renewed.

JURISDICTION

4. On or about February 2, 2022, the First Amended Accusation No. 800-2019-058719 was filed before the Board, and is currently pending against Respondent. On or about February 2, 2022, the First Amended Accusation and all other statutorily required documents were properly served on Respondent. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of the First Amended Accusation No. 800-2019-058719 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2019-058719. Respondent has also carefully read, fully discussed with his counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

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

7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to each and every charge and allegation contained in the First Amended Accusation No. 800-2019-058719 and agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. C 37249 to disciplinary action.

9. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Medical Board of California, all of the charges and allegations contained in the First Amended Accusation No. 800-2019-058719 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.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. C 37249 is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

11. This Stipulated Settlement and Disciplinary Order shall be subject to approval of the Board. The parties agree that this Stipulated Settlement and Disciplinary Order shall be submitted to the Board for its consideration in the above-entitled matter and, further, that the Board shall have a reasonable period of time in which to consider and act on this Stipulated Settlement and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Board considers and acts upon it.

12. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify

the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order be rejected for any reason by the Board, Respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

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

14. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 37249 issued to Respondent RICHARD JOSEPH KEMPERT, M.D., is hereby 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. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule V of the Act, until Respondent submits proof of completion of the Prescribing Practices Course.

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 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 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. 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.

3. 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.

4. 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.

5. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, 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 medical 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.

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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. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

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

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

including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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

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

9. 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, and legal reviews, as applicable, in the amount of $12,027.50 (twelve thousand twenty-seven dollars and fifty cents). 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.

10. 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.

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11. 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.

12. 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.

13. 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 Board'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; and Quarterly Declarations.

14. 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.

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15. 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.

16. 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.

17. 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.

18. 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 the First Amended Accusation No. 800-2019-058719 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 attorney, Raymond J. McMahon, Esq. I fully understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. C 37249. 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: 05-04-2022

RICHARD JOSEPH KEMPERT, M.D.
Respondent

I have read and fully discussed with Respondent Richard Joseph Kempert, 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: May 4, 2022

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: May 4, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

LEANNA E. SHIELDS
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2019-058719

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **RICHARD JOSEPH KEMPERT, M.D.** 34052 La Plaza, Suite 101 Dana Point, CA 92629 **Physician's and Surgeon's Certificate No. C 37249,** Respondent.	Case No. 800-2019-058719 OAH No. 2021110587 **FIRST AMENDED ACCUSATION** [Cal. Gov. Code, § 11507.]

Complainant alleges:

PARTIES

1. William Prasifka (Complainant) brings this First Amended 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 January 31, 1977, the Board issued Physician's and Surgeon's Certificate No. C 37249 to Richard Joseph Kempert, M.D. (Respondent). The Physician's and Surgeon's Certificate No. C 37249 was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2023, unless renewed.

JURISDICTION

3. This First Amended Accusation, which supersedes Accusation No. 800-2019-058719 filed on September 28, 2021, in the above-entitled matter, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

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

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

...

6. Section 2242 of the Code states, in pertinent part:

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

...

7. Section 2052 of the Code states, in pertinent part:

(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter [Chapter 5, the Medical Practice Act], or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.

(b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.

...

8. Section 2264 of the Code states:

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

9. 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.

10. Section 2228.1 of the Code states, in pertinent part:

(a) On or after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that include the licensee's probation status, the length of 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 or 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:

...

(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 contendere 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.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

...

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

...

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

COST RECOVERY

12. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FACTUAL ALLEGATIONS[1]

13. In or around 1987, Respondent formed a medical group, Pacific Crest Medical Group (PCMG). At PCMG, Respondent supervises a medical assistant, S.M., who is not a licensed physician. As recently as 2020, Respondent's custom and practice was to allow S.M. to approve and deny prescription refills to Respondent's patients without physician involvement.

14. On or about May 26, 2020, during an interview with investigators with the Health Quality Investigation Unit (HQIU), Department of Consumer Affairs (DCA), S.M. indicated, when a request for a prescription refill was received, S.M. would review the patient's record to determine when the patient was last seen by Respondent, then, depending on the length of time, S.M. would authorize the prescription refill without consulting Respondent. If S.M. determined the patient was due for an office visit, S.M. would deny the refill request or authorize a partial refill in order to prompt the patients to schedule an office visit with Respondent. S.M. indicated she only consulted Respondent if she had a question or concern about the combination of medications.

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[1] Conduct occurring more than seven (7) years from the filing date of the original Accusation filed on September 28, 2021, is for informational purposes only and is not alleged as a basis for disciplinary action.

15. On or about August 25, 2020, during an interview with HQIU investigators, Respondent also described S.M.'s duties to include the refilling of routine prescription medications for Respondent's patients. According to Respondent, S.M. authorized refills for routine medications without his involvement. Respondent indicated S.M. was not authorized to issue refills for controlled substances, that requests to refill controlled substances were reviewed and authorized by Respondent.

Patient A[2]

16. On or about October 28, 2016, Patient A, a then 32-year-old female, an established patient with Respondent since Patient A was approximately 15 years old, presented for an office visit with Respondent. Patient A's medical history was significant for, among other things, over twenty (20) surgical procedures, and numerous diagnoses including, but not limited to, complex regional pain syndrome (CRPS),[3] phlebitis,[4] paresthesia,[5] dysesthesia,[6] allodynia,[7] Stevens-Johnson syndrome (SJS),[8] osteoporosis, and neuropathy. Patient A also had a Hickman catheter[9] in place through which she received intravenous medications, including, but not limited to, Benadryl and antibiotics. According to records for this visit, Patient A presented for a review of

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[2] For patient privacy purposes, patients' true names are not used in the instant Accusation to maintain patient confidentiality. The patients' identities are known to Respondent or will be disclosed to Respondent upon receipt of a duly issued request for discovery and in accordance with Government Code section 11507.6.

[3] Complex regional pain syndrome is a form of chronic pain that usually affects the extremities, such as an arm or leg, but can affect any part of the body, typically developing after an injury or surgery.

[4] Phlebitis involves the inflammation of the veins.

[5] Paresthesia involves a burning or prickling sensation.

[6] Dysesthesia involves a cutaneous symptom such as burning, tingling, without a cutaneous condition in a well-defined location that is often caused by nerve trauma, impingement or irritation.

[7] Allodynia involves the experience of pain from stimuli that is not normally painful.

[8] Stevens-Johnson syndrome (SJS) is a serious skin condition that causes the skin to develop rashes and blisters. It also causes extensive damage to the mucous membranes resulting in sores and blisters in the mouth, nose, eyes and genitals.

[9] Hickman catheter is a central line catheter placed on the right side of the chest wall, to allow long term access to veins typically to provide intravenous medications and to draw labs.

laboratory results and was diagnosed with central vein thrombosis as a complication from her Hickman catheter. According to records for this visit, Respondent was prescribing several medications to Patient A, including, but not limited to, fentanyl citrate,[10] MS Contin,[11] warfarin sodium,[12] atenolol,[13] and Zofran.[14] According to records for this visit, Respondent continued Patient A's diagnoses for CRPS and phlebitis.

17. On or about November 4, 2016, Patient A presented for an office visit with Respondent. According to records, Patient A suffered from an infection at or near the insertion site of her Hickman catheter and required suture removal.

18. On or about December 16, 2016, Patient A presented for an office visit with Respondent to refill her prescriptions and discuss a timeline for tapering down her intravenous Benadryl and fentanyl citrate. According to records, Respondent indicated the benefits of Patient A's opiate prescriptions outweighed the risks, and a plan to continue Patient A's current medication regimen with a possible tapering down in the near future. In his review of systems, Respondent noted Patient A was positive for nausea, vomiting, fatigue, insomnia and chronic paresthesia. Respondent notes a recommendation for Patient A to begin an exercise program for weight loss and to cease smoking.

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[10] Fentanyl citrate lozenges, brand name Actiq, are a transmucosal immediate release fentanyl. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Fentanyl is classified as a potent synthetic opioid. When properly prescribed and indicated, it is used for the treatment of pain relief. It is approximately 100 times more potent than morphine and considered a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 edition), at p. 40.)

[11] MS Contin is a brand name for morphine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[12] Warfarin is an anticoagulant, or blood thinner, commonly prescribed to prevent blood clot formations. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[13] Atenolol is commonly prescribed to treat high blood pressure and chest pain. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[14] Zofran is an anti-nausea medication commonly prescribed to prevent nausea and vomiting caused by cancer medication. It is a dangerous drug pursuant to Business and Professions Code section 4022.

19. On or about March 24, 2017, Patient A presented for an office visit with Respondent to refill her prescriptions. According to records, Respondent noted Patient A still needed to maintain her prescriptions for MS Contin and fentanyl citrate for pain, and intravenous Benadryl for hives and swelling. According to records, Respondent documented a plan to remove Patient A's Hickman catheter in the near future.

20. On or about October 9, 2017, Patient A presented for an office visit with Respondent. According to records, Patient A had moved to northern California where culture testing revealed the presence of E. coli and staph in her sinuses. According to records, Respondent was still prescribing intravenous Benadryl and oral narcotics to Patient A, with a plan to taper over the next three (3) months. In his review of systems, Respondent noted Patient A was negative for anxiety and positive for nausea, vomiting, fatigue, insomnia and chronic paresthesia. According to records, Patient A's current medication list for this date identified alprazolam[15] in addition to the other previous medications, including, but not limited to, fentanyl citrate and MS Contin.[16] Records do not reflect the performance of an evaluation by Respondent to support Patient A's prescription for alprazolam.

21. On or about December 8, 2017, Patient A presented for an office visit with Respondent. According to records, Patient A was concerned about her Hickman catheter being infected. According to records, Patient A's medications at this time included, but was not limited

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[15] Alprazolam, brand name Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Alprazolam is classified as a short-acting benzodiazepine. When properly prescribed and indicated, it is commonly used to relieve anxiety.

[16] All opioids carry a Black Box Warning that states, in part, "assess opioid abuse or addiction risk prior to prescribing; monitor all patients for misuse, abuse, and addiction." The combination of opioids with benzodiazepines is among the most common causes of death due to prescription drug overdose. The Black Box Warning for opioids states, "Concomitant opioid use with benzodiazepines... may result in profound sedation, respiratory depression, coma, and death; reserve concomitant use for patients with inadequate alternative treatment options; limit to minimum required dosage and duration."

to, fentanyl citrate (0.6 mg, #120) and MS Contin (100 mg, #120), equating to a morphine equivalent dose (MED)[17] over 700 mg per day, in addition to alprazolam (2 mg, #120).

22. On or about December 27, 2017, Patient A presented for an office visit with Respondent to follow up about her Hickman catheter infection site. According to records, Patient A's medications at this time included, but was not limited to, fentanyl citrate (0.6 mg, #120) and MS Contin (100 mg, #120), equating to an MED over 700 mg per day, and alprazolam (2 mg, #120). According to records, Respondent and Patient A discussed a plan to taper Patient A off her intravenous Benadryl over the next thirty (30) days.

23. On or about March 12, 2018, Patient A presented for an office visit with Respondent after being diagnosed with pneumonia in northern California where Patient A was living at the time. According to records, Respondent noted Patient A appeared to be in distress, with an oxygen saturation of approximately 84%. Respondent confirmed the diagnosis of pneumonia and referred Patient A to a local emergency department for treatment.

24. On or about April 5, 2018, Patient A presented for an office visit with Respondent for follow up after her recent hospitalization. According to records, Patient A's current medication list for this date identified the continuation of Patient A's prescription for MS Contin (100 mg, #90), and the addition of Oxycodone[18] (20 mg, #120), equating to an MED of 420 mg per day. Records for this date do not identify alprazolam under Patient A's current medications, despite

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[17] Morphine Equivalent Dose (MED), also commonly referred to as Morphine Milligram Equivalent (MME or MEQ), is a calculation used to equate different opioids into one standard value, based on morphine and its potency, referred to as MED. MED calculations permit all opioids to be converted to an equivalent of one medication, for ease of comparison and risk evaluations. In general, the standard of practice is to limit a patient's daily opioid dose to less than 50 MED in most patients receiving opioid treatment for chronic pain, and to exceed 90 MED in only the most unusual circumstances.

[18] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. Oxycodone is classified as a synthetic opioid. The Drug Enforcement Administrative (DEA) has identified opioids, such as Oxycodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), p. 47.)

being continuously prescribed by Respondent to Patient A per the Controlled Substance Utilization Review and Evaluation System[19] (CURES).

25. On or about May 15, 2018, Patient A presented for an office visit with Respondent. According to records, Patient A's current medication list for this date indicated MS Contin (100 mg, #90), Oxycodone (20 mg, #120), equating to an MED of 420 mg per day, and alprazolam (2 mg, #120). According to records, Patient A had discontinued her intravenous Benadryl and informed Respondent that she rarely took alprazolam and only took MS Contin twice a day, relying mostly on Oxycodone for pain control. According to records, Patient A indicated her self-reduction in medications was due to Patient A's fear of increasing tolerance. According to records, despite Patient A's lowered intake, Respondent continued Patient A's prescriptions, including, but not limited to, MS Contin (100 mg, #90), Oxycodone (20 mg, #120), and alprazolam (2 mg, #90).

26. On or about August 16, 2018, Patient A presented for an office visit with Respondent. According to records, Patient A had reduced her use of alprazolam and exhibited significant weight loss. According to records, Respondent's plan for Patient A was to reduce and eventually stop her prescription for Oxycodone and increase her prescription for MS Contin. According to records, Respondent issued prescriptions to Patient A for MS Contin (100 mg, #90), Oxycodone (20 mg, #120), equating to an MED of 420 mg per day, and alprazolam (2 mg, #90).

27. On or about January 28, 2019, Patient A presented for an office visit with Respondent to discuss her medications. According to records, Respondent discontinued Patient A's prescription for Oxycodone and increased her prescription for MS Contin from three (3) per day to four (4) per day (100 mg, #120), equating to an MED of 400 mg per day. According to

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[19] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

records, Respondent also issued a prescription for Narcan[20] to Patient A, but Respondent's records do not reflect or document any discussion with Patient A regarding this prescription for Narcan. According to records, Respondent continued Patient A's prescription for alprazolam (2 mg, #120) without any documentation of an assessment of her anxiety levels or explanation for the increase in quantity.

28. On or about July 18, 2019, Patient A presented for an office visit with Respondent. According to records, since the last visit, Patient A had been placed in a coma due to sepsis in her intravenous line, fractured her right ankle, and gained significant weight. Records also note Patient A now suffered from a chronic bladder infections, yeast infections and frequent diarrhea. According to records, Respondent and Patient A discussed alternative medications and decided to add liquid morphine concentrate (20 mg/5 mL) for breakthrough episodes. According to records, Respondent issued prescriptions to Patient A for MS Contin (100 mg, #120) and morphine sulfate (20 mg/5 mL, #200), equating to an MED of 520 mg per day, and alprazolam (2 mg, #100).

29. On or about January 24, 2020, Patient A presented for an office visit with Respondent. According to records, Patient A complained of persistent pain in the pelvic and vaginal area. According to records, Respondent continued Patient A's prescriptions but noted a plan to switch alprazolam for lorazepam[21] at the next visit. Records for this visit do not document the reason for this change or any assessment of Patient A's anxiety. According to records, Patient A's current medication list as prescribed by Respondent included MS Contin (100 mg, #120) and morphine sulfate (20 mg/5 mL, #200), equating to an MED of 520 mg per day, and alprazolam (2 mg, #60).

30. On or about May 19, 2020, Patient A presented for an office visit with Respondent. According to records, Patient A was still living in northern California and had recently sustained

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[20] Narcan, brand name for naloxone, is a medication used to counteract and treat suspected opioid overdose. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[21] Lorazepam, brand name Ativan, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It belongs to a group of drugs called benzodiazepines. When properly prescribed and indicated, it is commonly used to relieve anxiety.

another ankle fracture. According to records, Respondent had a discussion with Patient A about her "high dose opiate medication regimen." According to records, Respondent diagnosed Patient A with anxiety disorder but still did not document an appropriate assessment of Patient A's anxiety levels. According to records, Respondent continued Patient A's prescriptions, including, but not limited to, MS Contin (100 mg, #120) and morphine sulfate (20 mg/5 mL, #200), equating to an MED of 520 mg per day, and alprazolam (2 mg, #60).

31. At no time throughout Respondent's care and treatment of Patient A did Respondent perform and/or document the performance of an in depth discussion with Patient A regarding the risks associated with taking high dose opioids and the risks of combining opioids with benzodiazepines.

32. At no time throughout Respondent's care and treatment of Patient A did Respondent obtain and/or document the obtaining of a pain agreement between Patient A and Respondent regarding her use of controlled substances and multiple pharmacies.

33. At no time throughout Respondent's care and treatment of Patient A did Respondent review and/or document any review of CURES, any requests for urine drug screens, or any other careful review for aberrant behaviors as indications of possible diversion, abuse or tolerance.

34. At no time throughout Respondent's care and treatment of Patient A did Respondent refer and/or document a referral for Patient A to a pain management specialist, psychiatrist, or any other physician in northern California where Patient A was living.

35. On or about August 25, 2020, Respondent attended a subject interview with HQIU investigators. During the interview, Respondent admitted he rarely reviewed CURES, and when he was inclined to review CURES, this review was not documented. Respondent also indicated he did not have a written pain agreement with Patient A, but a verbal understanding to the same effect. Respondent admitted he failed to document Patient A's opioid dependence or tolerance, or any referrals to psychiatry or a pain management. Respondent also indicated he often communicated with Patient A by phone and text after her move to northern California, but these communications were not documented in Patient A's record. Respondent also admitted not

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having a signed release by Patient A to authorize his communications with Patient A's mother about Patient A's health.

36. From as early as May 2014, through in or around December 2015, according to CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances, including, but not limited to, MS Contin, fentanyl citrate, and alprazolam.

37. From in or around January 2016, through in or around December 2016, according to CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances, including, but not limited to, twelve (12) prescriptions for MS Contin (100 mg, #120), thirteen (13) prescriptions for fentanyl citrate (0.6 mg, #120), and five (5) prescriptions for alprazolam (2 mg, #120).

38. From in or around January 2017, through in or around December 2017, according to CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances, including, but not limited to, eleven (11) prescriptions for MS Contin (100 mg, #120), fourteen (14) prescriptions for fentanyl citrate (0.6 mg, #120), and nine (9) prescriptions for alprazolam (2 mg, #120). From in or around January 2017, through in or around December 2017, according to records, Patient A had office visits with Respondent on four (4) separate occasions, March 24, 2017; October 9, 2017; December 8, 2017; and December 27, 2017.

39. From in or around January 2018, through in or around December 2018, according to CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances, including, but not limited to, twelve (12) prescriptions for MS Contin (100 mg, #90-120), two (2) prescriptions for fentanyl citrate (0.6 mg, #120), twelve (12) prescriptions for alprazolam (2 mg, #90-120), and ten (10) prescriptions for oxycodone (20 mg, #120). From in or around January 2018, through in or around December 2018, according to records, Patient A had office visits with Respondent on four (4) separate occasions, March 12, 2018; April 5, 2018; May 15, 2018; and August 16, 2018.

40. From in or around January 2019, through in or around December 2019, according to CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances, including, but not limited to, thirteen (13) prescriptions for MS Contin (100 mg, #90-120), five

(5) prescriptions for morphine sulfate (20 mg/5 mL, #200), one (1) prescription for oxycodone (20 mg, #120), and thirteen (13) prescriptions for alprazolam (2 mg, #60-120). From in or around January 2019, through in or around December 2019, according to records, Patient A had office visits with Respondent on two (2) separate occasions, January 28, 2019 and July 18, 2019.

41. From in or around January 2020, through in or around December 2020, according to CURES, Respondent issued repeated prescriptions to Patient A for several controlled substances, including, but not limited to, thirteen (13) prescriptions for MS Contin (100 mg, #80-120), ten (10) prescriptions for morphine sulfate (20 mg/5 mL, #200), and twelve (12) prescriptions for alprazolam (2 mg, #60). From in or around January 2020, through in or around December 2020, according to records, Patient A had office visits with Respondent on two (2) separate occasions, January 24, 2020 and May 19, 2020.

Patient B

42. On or about June 9, 2016, Patient B, a then 67-year-old female, an established patient with Respondent since in or around 2012, presented for an office visit with Respondent. Patient B's medical history was significant for, among other things, chronic pain syndrome, lumbar disc degeneration, hypertension, diabetes, diabetic neuropathy, chronic arthritis, anxiety, depression and ankle fracture. In or around 2014, Respondent took over the care of Patient B's pain management, in addition to continuing as her primary care physician. According to records for this visit with Respondent, Patient B presented for a review of laboratory results and complaints of perineal itching. According to records, Respondent was prescribing several medications to Patient B, including, but not limited to, hydrocodone-acetaminophen (10/325),[22] fentanyl

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[22] Hydrocodone-acetaminophen (10/325), brand name Norco, is a drug combination of hydrocodone (10 mg) and acetaminophen (325 mg). Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to moderately severe pain. The DEA has identified opioids, such as hydrocodone, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2015 Edition), at p. 43.)

transdermal patch (50 mcg/hour),[23] lisinopril hydrochlorothiazide,[24] citalopram.[25] According to CURES, Respondent was also issuing regular prescriptions to Patient B for alprazolam beginning in or around 2014. According to records for this visit, Respondent's assessment of Patient B determined Patient B was negative for anxiety, depression and sleep disturbances. According to records, Respondent continued Patient B's diagnoses for chronic pain syndrome and diabetes. Respondent also assessed Patient B with pruritus[26] and prescribed Diflucan.[27]

43. On or about December 27, 2016, Patient B presented for an office visit with Respondent. According to records, Patient B presented with complaints of experiencing difficulty swallowing. According to records for this visit, Respondent noted Patient B was positive for anxiety, continued Patient B's diagnosis of chronic pain and added a new diagnosis for dysphagia.[28] According to records, Patient B's current medication list for this date remained unchanged and still did not reflect Respondent's regular prescriptions of alprazolam to Patient B.

44. On or about May 2, 2017, Patient B presented for an office visit with Respondent. According to records, Patient B presented with complaints of a rash. According to records, Respondent noted Patient B was negative for anxiety, depression and sleep disturbances. According to records, Patient B's current medication list for this date remained unchanged and still did not reflect Respondent's regular prescriptions of alprazolam to Patient B.

45. On or about May 9, 2017, Patient B presented for an office visit with Respondent for a follow up on her recent past conditions. According to records, Respondent noted Patient B was

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[23] Fentanyl transdermal patch, brand name Duragesic, is a transdermal patch commonly used to treat chronic and severe pain in opioid tolerant patients. The maximum dose for fentanyl patches is 100 mcg per hour for a maximum dose of 2,400 mcg per day. See Footnote 10.

[24] Lisinopril hydrochlorothiazide is commonly prescribed to treat high blood pressure. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[25] Citalopram is commonly prescribed to treat depression. It a dangerous drug pursuant to Business and Professions Code section 4022.

[26] Pruritus is a condition involving itchy skin often caused by dry skin.

[27] Diflucan, brand name for fluconazole, is an antifungal medication commonly prescribed to treat fungal infections. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[28] Dysphagia is the medical term for swallowing difficulties.

negative for anxiety, depression and sleep disturbances. According to records, Patient B's current medication list for this date remained unchanged and still did not reflect Respondent's regular prescriptions of alprazolam to Patient B.

46. On or about November 21, 2017, Patient B presented for an office visit with Respondent. According to records, Patient B presented for her annual exam. According to records for this visit, Respondent noted Patient B had an onset of depression since in or around 2013, but in his history of present illness and evaluation of Patient B, Respondent noted Patient B showed no signs or symptoms of depression, no history of depression, and normal mood and affect. Respondent further noted Patient B had no history of fractures or prior musculoskeletal injuries. According to records, Respondent's list of diagnoses for Patient B, included, but was not limited to, chronic pain, anxiety, and mixed anxiety and depressive disorder. According to records, Respondent issued prescriptions to Patient B for, among other things, alprazolam and hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks associated with combining opioids and benzodiazepines.

47. On or about February 2, 2018, Patient B presented for an office visit with Respondent. According to records, Patient B presented with complaints of an infection on her foot. According to records, Respondent continued Patient B's medications, but no longer listed diagnoses for anxiety or depression.

48. On or about April 6, 2018, Patient B presented for an office visit with Respondent. According to records, Respondent noted Patient B did not show signs of depression or anxiety. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl transdermal patches and hydrocodone-acetaminophen.

49. On or about April 13, 2018, Patient B presented for an office visit with Respondent for a follow up on her recent past conditions. According to records, Patient B's diagnosis for mixed anxiety and depressive disorder is listed under assessment and plan without any further details regarding Respondent's assessment.

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50. On or about June 5, 2018, Patient B presented for an office visit with Respondent for a follow up on her recent past conditions. According to records, Patient B's diagnosis for mixed anxiety and depressive disorder is removed and Respondent now indicated a diagnosis for anxiety, without any further details regarding Respondent's assessment. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl transdermal patches and hydrocodone-acetaminophen.

51. On or about July 5, 2018, Patient B presented for an office visit with Respondent. According to records, Patient B presented with complaints of foot issues. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl transdermal patches and hydrocodone-acetaminophen.

52. On or about July 26, 2018, Patient B presented for an office visit with Respondent to follow up on her foot issues. According to records, Respondent's plan and assessment for Patient B included directions to continue taking citalopram for her diagnosis of major depressive disorder, with no further documentation or details regarding Respondent's assessment of Patient B's mental condition. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl transdermal patches and hydrocodone-acetaminophen.

53. On or about October 1, 2018, Patient B presented for an office visit with Respondent to follow up on her foot issues. According to records, Respondent's plan and assessment for Patient B included directions to continue taking alprazolam for her diagnosis of anxiety, with no further documentation or details regarding Respondent's assessment of Patient B's mental condition.

54. On or about October 30, 2018, according to CURES, this was the last prescription by Respondent filled to Patient B for fentanyl transdermal patches.

55. On or about November 5, 2018, Patient B presented for an office visit with Respondent. According to records, Respondent's plan and assessment for Patient B included

directions to continue taking alprazolam for her diagnosis of anxiety, with no further documentation or details regarding Respondent's assessment of Patient B's mental condition. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl transdermal patches and hydrocodone-acetaminophen.

56. On or about December 11, 2018, Patient B presented for an office visit with Respondent. According to records, Respondent's plan and assessment for Patient B included directions to continue taking alprazolam for her diagnosis of anxiety, with no further documentation or details regarding Respondent's assessment of Patient B's mental condition, and to continue taking hydrocodone-acetaminophen for her chronic low back pain, with no further documentation or details regarding Respondent's assessment of Patient B's pain levels. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl transdermal patches and hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks associated with combining opioids and benzodiazepines.

57. On or about February 12, 2019, Patient B presented for an office visit with Respondent. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl transdermal patches and hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks associated with combining opioids and benzodiazepines.

58. On or about March 5, 2019, Patient B presented for an office visit with Respondent. According to records, Patient B requested a refill of her fentanyl transdermal patches for her chronic pain. According to records for this visit, Respondent issued a prescription to Patient B for fentanyl transdermal patches. However, according to CURES, Patient B's last prescription filled for fentanyl transdermal patches was on October 30, 2018.

59. On or about March 15, 2019, Patient B presented for an office visit with Respondent. According to records for this visit, Respondent issued a prescription to Patient B for fentanyl

transdermal patches. However, according to CURES, Patient B's last prescription filled for fentanyl transdermal patches was on October 30, 2018. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, fentanyl transdermal patches and hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks associated with combining opioids and benzodiazepines.

60. On or about May 7, 2019, Patient B presented for an office visit with Respondent. According to records, Respondent issued a prescription to Patient B for alprazolam without any documented discussion or assessment of Patient B's anxiety. Records for this visit no longer reflect fentanyl transdermal patches among Patient B's current medications and show no documentation regarding the termination of this prescription.

61. On or about June 24, 2019, Patient B presented for an office visit with Respondent. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, and hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks associated with combining opioids and benzodiazepines. Records for this visit do not reflect a discussion or assessment of Patient B's anxiety.

62. On or about July 12, 2019, Patient B presented for an office visit with Respondent. According to records, Respondent issued a prescription to Patient B for alprazolam without any documented discussion or assessment of Patient B's anxiety.

63. On or about October 3, 2019, Patient B presented for an office visit with Respondent. According to records, Patient B reported experiencing severe nausea for several weeks. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, and hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks associated with combining opioids and benzodiazepines.

64. On or about October 10, 2019, Patient B presented for an office visit with Respondent. According to records, Patient B's current medication list for this date remained

unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, and hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks associated with combining opioids and benzodiazepines.

65. On or about December 31, 2019, Patient B presented for an office visit with Respondent. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, and hydrocodone-acetaminophen. Records for this visit do not reflect a discussion regarding the risks associated with combining opioids and benzodiazepines.

66. On or about May 15, 2020, Patient B presented for an office visit with Respondent. According to records, Patient B's current medication list for this date remained unchanged and continued to show current prescriptions for, among other things, alprazolam, citalopram, and hydrocodone-acetaminophen. According to records, Respondent's plan and assessment for Patient B's lumbar spine degeneration was to continue with her current opiate regimen, and to continue with citalopram and alprazolam for Patient B's depressive disorder. Records for this visit do not reflect a discussion or assessment of Patient B's depression or anxiety. Records for this visit do not document a discussion regarding the risks associated with combining opioids and benzodiazepines.

67. At no time throughout Respondent's care and treatment of Patient B did Respondent perform and/or document the performance of an in depth discussion with Patient B regarding the risks associated with combining opioids with benzodiazepines.

68. At no time throughout Respondent's care and treatment of Patient B did Respondent obtain and/or document the obtaining of a pain agreement between Patient B and Respondent regarding Patient B's use of controlled substances and multiple pharmacies.

69. At no time throughout Respondent's care and treatment of Patient B did Respondent review and/or document any review of CURES, any requests for urine drug screens, or any other careful review for aberrant behaviors as indications of possible diversion, abuse or tolerance.

70. On or about November 4, 2020, Respondent attended a subject interview with HQIU investigators. During the interview, Respondent admitted he rarely reviewed CURES, and when

he was inclined to review CURES, this review was not documented. Respondent also indicated he did not have a written pain agreement with Patient B. Respondent also indicated he often communicated with Patient B by phone and text, but these communications were not documented in Patient B's record. When asked about the termination of Patient B's prescription for fentanyl transdermal patches, Respondent indicated Patient B weaned herself off of fentanyl on her own, and that there was no coordination with pain management physicians.

71. From as early as May 2014, through in or around December 2015, according to CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances, including, but not limited to, fentanyl transdermal patches, hydrocodone-acetaminophen, and alprazolam.

72. From in or around January 2016, through in or around December 2016, according to CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances, including, but not limited to, eight (8) prescriptions for hydrocodone-acetaminophen (10/325 mg, #120), four (4) prescriptions for fentanyl transdermal patches (50 mcg/hr, #15), and two (2) prescriptions for alprazolam (0.5 mg, #60).

73. From in or around January 2017, through in or around December 2017, according to CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances, including, but not limited to, ten (10) prescriptions for hydrocodone- acetaminophen (10/325 mg, #120), four (4) prescriptions for fentanyl transdermal patches (50 mcg/hr, #15), and nine (9) prescriptions for alprazolam (0.5 mg, #60-120).

74. From in or around January 2018, through in or around December 2018, according to CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances, including, but not limited to, twelve (12) prescriptions for hydrocodone-acetaminophen (10/325 mg, #120), four (4) prescriptions for fentanyl transdermal patches (50 mcg/hr, #15), and five (5) prescriptions for alprazolam (0.5 mg, #60).

75. From in or around January 2019, through in or around December 2019, according to CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances,

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including, but not limited to, twelve (12) prescriptions for hydrocodone-acetaminophen (10/325 mg, #120), and six (6) prescriptions for alprazolam (0.5 mg, #60).

76. From in or around January 2020, through in or around December 2020, according to CURES, Respondent issued repeated prescriptions to Patient B for several controlled substances, including, but not limited to, twelve (12) prescriptions for hydrocodone-acetaminophen (10/325 mg, #120), and eight (8) prescriptions for alprazolam (0.5 mg, #60).

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

77. Respondent has subjected his Physician's and Surgeon's Certificate No. C 37249 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient A, which included, but was not limited to, the following:

A. Paragraphs 16 through 41, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent prescribed opioids in excessive amounts to Patient A over several years without corresponding office appointments, ongoing monitoring, appropriate risk mitigation, or risk stratification;

C. Respondent prescribed benzodiazepines in extremely high levels to Patient A over several years without an appropriate evaluation to support a diagnosis to justify high dose benzodiazepines, an evaluation by a mental health expert or psychiatrist, corresponding office appointments, ongoing monitoring, appropriate risk mitigation, or risk stratification;

D. Respondent prescribed a combination of high dose opioids in combination with high levels of benzodiazepines to Patient A over several years without corresponding office appointments, ongoing monitoring, appropriate risk mitigation, or risk stratification; and

E. Respondent failed to perform appropriate ongoing monitoring of Patient A while prescribing controlled substances, including, but not limited to, CURES

database review, urine drug screens, pain evaluations, and regular monthly office visits.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

78. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 37249 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts as more particularly alleged hereinafter.

79. Respondent committed repeated negligent acts in his supervision of his medical assistant, S.M., in that he permitted his medical assistant, S.M., an unlicensed person, to engage in the practice of medicine, including, but not limited to, permitting S.M. to approve, deny, and/or issue prescription refills for patients without Respondent's involvement, as more particularly alleged in paragraphs 13 through 15, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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

A. Paragraphs 16 through 41, and 77, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to discuss and/or document a discussion with Patient A regarding the risks of taking controlled substances, risks associated with the high doses prescribed, and risks presented when combining opioids with benzodiazepines; and

C. Respondent failed to accurately and thoroughly document his care and treatment with Patient A, including, but not limited to, failure to document an adequate and appropriate history and physical examination prior to refilling controlled substances on a monthly basis, failure to document the performance of musculoskeletal examinations during office visits, failure to accurately document all medications prescribed to Patient A during office visits, failure to document his basis

for prescribing alprazolam and Narcan, failure to document informed consent, and failure to document telephone conversations and text messages with Patient A.

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

A. Paragraphs 42 through 76, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent prescribed a combination of opioids and benzodiazepines to Patient B without appropriate ongoing monitoring, risk mitigation, and accurate documentation;

C. Respondent failed to discuss and/or document a discussion with Patient B regarding the risks of taking controlled substances, and risks presented when combining opioids with benzodiazepines;

D. Respondent failed to accurately and thoroughly document his care and treatment with Patient B, including, but not limited to, failure to document an adequate and appropriate history and physical examination prior to refilling controlled substances on a monthly basis, failure to accurately document all medications prescribed to Patient B during office visits (identifying fentanyl on Patient B's medication list long after it has been discontinued, and not identifying alprazolam for months after first prescribing alprazolam to Patient B), failure to document his basis for prescribing alprazolam, failure to document informed consent, and failure to document telephone conversations and text messages with Patient B; and

E. Respondent failed to perform appropriate ongoing monitoring of Patient B while prescribing controlled substances, including, but not limited to, CURES database review, urine drug screens, pain evaluations, attempts at risk mitigation, and regular monthly office visits.

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THIRD CAUSE FOR DISCIPLINE

(Aiding and Abetting the Unlicensed Practice of Medicine)

82. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 37249 to disciplinary action under sections 2227, 2264, and 2234, as defined by section 2052, subdivision (b), of the Code, in that he aided and abetted the unlicensed practice of medicine as more particularly alleged in paragraphs 13 through 15, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs without Appropriate Examination and/or Indication)

83. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 37249 to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that he prescribed, dispensed, and/or furnished dangerous drugs without an appropriate prior examination and/or medical indication in his care and treatment of Patients A and B and his supervision of S.M., as more particularly alleged in paragraphs 13 through 82, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and/or Accurate Records)

84. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 37249 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and/or accurate medical records in his care and treatment of Patients A and B, as more particularly alleged in paragraphs 16 through 81, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

85. Respondent has further subjected his Physician's and Surgeon's Certificate No. C 37249 to disciplinary action under sections 2227 and 2234, of the Code, in that Respondent engaged in conduct which breaches the rules or ethical code of the medical profession or which was unbecoming a member in good standing of the medical profession, and which demonstrates

an unfitness to practice medicine, as more particularly alleged in paragraphs 13 through 84, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. C 37249, issued to Respondent Richard Joseph Kempert, M.D.;

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

3. Ordering Respondent Richard Joseph Kempert, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Respondent Richard Joseph Kempert, M.D., if placed on probation, to disclose the disciplinary order to patients pursuant to section 2228.1 of the Code; and

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

DATED: FEB 0 2 2022

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

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