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

In the Matter of the First Amended Accusation Against: Dana Suzanne Ware, M.D. Physician's and Surgeon's Certificate No. G 55407 Respondent.	Case No.: 800-2019-053690

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 14, 2022.

IT IS SO ORDERED: September 14, 2022.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

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: **DANA SUZANNE WARE, M.D.** **199 Reynolds Road** **Chester, CA 96020** Physician's and Surgeon's Certificate No. G 55407 Respondent.	Case No. 800-2019-053690 OAH No. 2021100168 **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 John S. Gatschet, Deputy Attorney General.

///

2. Respondent Dana Suzanne Ware, M.D. ("Respondent") is represented in this proceeding by attorney Michael A. Firestone, JD, MBA, whose address is:

Law Firm of Marvin Firestone, MD, JD, & Associates, LLP
1700 South El Camino Real, Suite 408
San Mateo, CA 94402

3. On or about July 16, 1985, the Board issued Physician's and Surgeon's Certificate No. G 55407 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in the First Amended Accusation No. 800-2019-053690, and will expire on September 30, 2022, unless renewed.

JURISDICTION

4. The First Amended Accusation No. 800-2019-053690 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on January 26, 2022. Respondent timely filed her Notice of Defense contesting both the Accusation and First Amended Accusation.

5. A copy of the First Amended Accusation No. 800-2019-053690 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 First Amended Accusation No. 800-2019-053690. 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 First Amended 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 and agrees that the charges and allegations in the First Amended Accusation No. 800-2019-053690, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

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

11. Respondent agrees 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 the First Amended Accusation No. 800-2019-053690 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.

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. G 55407 issued to Respondent Dana Suzanne Ware, M.D. is revoked. However, the revocations are stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. 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.

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

A professionalism program taken after the acts that gave rise to the charges in the First Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

///

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

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 the First Amended Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), the First Amended Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and the First Amended 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 practice 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. PROHIBITED PRACTICE. During probation, Respondent is prohibited from prescribing Schedule II controlled substances as defined in Health and Safety section 11055, subdivisions (b) and (c), to patients in order to provide chronic pain management therapy. Chronic pain is defined as pain that lasts for over three months and is not related to acute pain. Chronic pain management therapy is a medical approach, that can include the prescription of Schedule II medications as defined in Health and Safety section 11055, subdivisions (b) and (c), to treat chronic pain.

///

As an exception to this practice prohibition, Respondent shall be allowed to prescribe Controlled II substances as defined in Health and Safety section 11055, subdivisions (b) and (c) to treat acute pain. In treating acute pain, Respondent may issue Schedule II prescriptions as defined in Health and Safety section 11055, subdivisions (b) and (c), in a quantity that is medically consistent with a prescription of up to five days. The reasonableness of a prescription to treat acute pain and whether a quantity of up to five days is medically consistent with the standard of care shall be subject to the review of the Respondent's practice monitor. If a Schedule II prescription is found by the practice monitor to be inconsistent with a five-day quantity as defined in this practice prohibition, it may serve as a basis for a violation of probation under this term.

After the effective date of this Decision, all patients being treated for chronic pain management therapy by the Respondent shall be notified that the Respondent is prohibited from prescribing Schedule II controlled substances as defined in Health and Safety section 11055, subdivisions (b) and (c), to patients in order to provide chronic pain management therapy. Any new patients must be provided this notification at the time of their initial appointment.

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

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and the First Amended 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, in the amount of $550.00. 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.

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; and, Quarterly Declarations.

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 a First Amended 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 the First Amended Accusation No. 800-2019-053690 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, Michael A. Firestone, JD, MBA. 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: 5/2/22

DANA SUZANNE WARE, M.D.
Respondent

I have read and fully discussed with Respondent Dana Suzanne Ware, 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: 5/2/2022

MICHAEL A. FIRESTONE, JD, MBA
Attorney for Respondent

ENDORSEMENT

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

DATED: 5/2/2022

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

SA2021302165
36133747.docx

Exhibit A

First Amended Accusation No. 800-2019-053690

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

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: **DANA SUZANNE WARE, M.D.** **199 Reynolds Road** **Chester, CA 96020** Physician's and Surgeon's Certificate No. G 55407, Respondent.	Case No. 800-2019-053690 **FIRST AMENDED ACCUSATION**

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 July 16, 1985, the Medical Board issued Physician's and Surgeon's Certificate Number G 55407 to Dana Suzanne Ware, 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 September 30, 2022, unless renewed.

JURISDICTION

3. On July 27, 2021, the Board properly filed an Accusation in Case No. 800-2019-053690 and served that Accusation on Respondent's address of record with the Board. The First Amended Accusation contains the same allegations and causes for discipline that were alleged in the Accusation filed on July 27, 2021.

4. This First Amended 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.

5. Section 2227 of the Code provides, in pertinent part, 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.

STATUTORY PROVISIONS

6. Section 2234 of the Code, provides 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.
>
> ...

///

7. Section 2266 of the Code provides, in pertinent part:

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.

8. Section 741 of the Code provides, in pertinent part:

(a) Notwithstanding any other law, when prescribing opioid or benzodiazepine medication to a patient, a prescriber shall do the following:

(1) Offer the patient a prescription for naloxone hydrochloride or other drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression when one or more of the following conditions are present:

(A) The prescription dosage for the patient is 90 or more morphine milligram equivalents for an opioid medication per day.

(B) An opioid medication is prescribed within one year from the date of a prescription for benzodiazepine has been dispensed to the patient.

(C) The patient presents with an increased risk for overdose, including a patient with a history of overdose, a patient with a history of substance use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

(2) Consistent with the existing standard of care, provide education to patients receiving a prescription under paragraph (1) on overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression.

...

9. Section 742 of the Code provides, in pertinent part:

A prescriber who fails to offer a prescription, as required by paragraph (1) of subdivision (a) of Section 741, or fails to provide the education and use information required by paragraphs (2) and (3) of subdivision (a) of Section 741 shall be referred to the appropriate licensing board solely for the imposition of administrative sanctions deemed appropriate by that board. This section does not create a private right of action against a prescriber, and does not limit a prescriber's liability for the negligent failure to diagnose or treat a patient.

///

///

///

COST RECOVERY

10. Section 125.3[1] of the Code, states in pertinent part:

(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 licensee 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.

---

[1] Effective January 1, 2022. As amended by 2021 Cal.Legs.Serv.Ch. 649 (S.B. 806)(WEST), the Board will be seeking costs of investigation and enforcement incurred after January 1, 2022, to comply with the legislature's intent that investigative and enforcement costs be imposed in Medical Board disciplinary matters. The Board's amendment of the Accusation to add Bus. & Prof. Code section 125.3 does not involve the statute of limitations pursuant to Bus. & Prof. Code section 2230.5. The underlying allegations upon which the Board will make findings related to whether the Respondent committed unprofessional conduct were filed before the expiration of the statute of limitations. The collection of costs for the investigation and prosecution of the disciplinary matter is instead related to the imposition of discipline. The amendment to add Bus. & Prof. Code 125.3 is in line with the express legislative intent of the California legislature in Senate Bill 806.

(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.

DEFINITIONS

11. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12.[2] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

12. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet is a short, acting semi-synthetic opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055 subdivision (b).

13. Oxycodone – Generic name for Roxicodone and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and even death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting formulation known as Oxycontin-ER. This formulation allows for extended release of the medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

[2] Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).

14. Tramadol – Generic name for the drug Ultram. Tramadol is an opioid pain medication used to treat moderate to moderately severe pain. Effective August 18, 2014, tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and Professions Code section 4022, and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (c).

15. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Morphine sulfate – Generic name for the drug MS Contin. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

17. Buprenorphine – Generic name for Butrans. Buprenorphine is an opioid used to treat opioid addiction, moderate acute pain, and moderate chronic pain. When used in combination with naloxone for treating opioid addiction, it is known by the trade name Suboxone. As a transdermal patch, Butrans is used for chronic pain. Buprenorphine is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 Section 1308.13(e). Buprenorphine is a dangerous drug pursuant to Business and Professions Code section 4022.

18. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for the treatment of long-term chronic pain. It has an extremely high

danger of abuse and can lead to addiction, as the medication is estimated to be 80 times more potent than morphine and hundreds of more times more potent than heroin.[3] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (c).

19. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

20. Flurazepam – Generic name for Dalmane and Dalmadorm. Flurazepam is a long-acting member of the benzodiazepine family used for the treatment of mild to moderate insomnia. Flurazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. Mixed amphetamine salts – Generic name for Adderall and Mydayis. Mixed amphetamine salts are used in the treatment of attention deficit hyperactivity disorder (ADHD) and narcolepsy. The can be used recreationally as an aphrodisiac and euphoriant. Mixed amphetamine salts are a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Mixed amphetamine salts are a dangerous drug pursuant to Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (d).

22. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal muscle relaxant. Carisoprodol is indicated for the short-term treatment of muscle pain. On January 11, 2012, carisoprodol was classified as a Schedule IV controlled substance pursuant to

[3] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

Code of Federal Regulations Title 21 section 1308.14 subdivision (c). It is a dangerous drug pursuant to Business and Professions Code section 4022.

23. Methylphenidate – Generic name for Ritalin. Methylphenidate is a stimulant drug used to treat attention-deficit/hyperactivity disorder (ADHD) and narcolepsy. Methylphenidate is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Methylphenidate is a dangerous drug pursuant to Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (d).

24. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

25. Clonazepam – Generic name for Klonopin. Clonazepam is an anti-anxiety medication in the benzodiazepine family used to prevent seizures, panic disorder and akathisia. Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It 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.

26. Zolpidem tartrate – Generic name for Ambien. Zolpidem tartrate is a sedative and hypnotic used for short-term treatment of insomnia. Zolpidem tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c). It 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.

27. Butalbital-acetaminophen-caffeine – Generic name for Fiorcet. Fiorcet is a combination medication containing acetaminophen, a less potent analgesic; butalbital, a

barbiturate; and caffeine, a stimulant, used for the treatment of moderate to severe headaches. Fiorcet is a dangerous drug pursuant to Business and Professions Code section 4022.

28. Alprazolam – Generic name for Xanax. Alprazolam is a member of the benzodiazepine family and is an anti-anxiety medication used for the short-term management of severe anxiety and panic attacks. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

Patient 1[4]

29. On September 1, 2013[5], Patient 1 was seen by Respondent at Seneca District Hospital ("Seneca") for nausea/vomiting and generalized weakness. Respondent previously provided general care to Patient 1, but had not seen her in over a year. Respondent noted that Patient 1 had low back pain and, in desperation, had consumed an out-of-date MS Contin pill that was eight years old. Respondent documented that the patient became lightheaded, sweaty, was staggering, slurring her words, and that her pupils were constricted. At an interview with the Board on September 24, 2020, Respondent stated that Patient 1 had taken two out-of-date 60 mg MS Contin pills prior to receiving treatment on September 1, 2013. Respondent documented that Patient 1 suffered from near syncope secondary to medication use due to taking the MS Contin pills. Respondent discharged Patient 1 with a prescription for 50 tablets of 50 mg tramadol to be taken 1-2 tablets, four times a day for pain. Respondent also documented that Patient 1 was on a prescription of Vicodin for pain. At the September 24, 2020, interview with the Board, Respondent stated she did not actually think that Patient 1 had taken the MS Contin pills for pain

[4] All witnesses have been identified by numerical characters in order to protect confidentiality. All witnesses will be fully identified in discovery.

[5] Conduct occurring before August 1, 2014, is for historical context and does not serve as an independent basis for discipline. However, conduct occurring before August 1, 2014, may be relied upon by the fact finder in determining whether Respondent's actions after August 1, 2014, are subject to appropriate discipline.

but that she had consumed them due to depression and/or unhappiness and was seeking attention for her misery.

30. Respondent saw Patient 1 on September 17, 2013, and on December 17, 2013, and noted that Patient 1 was suffering from back pain that was not well managed by her current opioid treatment. Patient 1 was noted to have renal insufficiency and was advised to not take NSAIDs[6]. Respondent started her on Percocet. Respondent also ordered an MRI[7]. On February 12, 2014, an MRI of Patient 1's lower back noted minimal disc bulge at L1, L2, L3[8] with signs consistent with degenerative joint disease (osteoarthritis). On or about February 14, 2014, a different physician saw Patient 1 at Seneca District Hospital for a complaint of dizziness and frequent falls, which had been ongoing for the previous two months. According to the other physician's note, the patient was falling an average of 1-2 times per day and was concerned that Patient 1 was at risk for serious injury. The physician advised Patient 1 to follow up with Respondent. On February 26, 2014, Patient 1 was seen by Respondent in the clinic for concerns of dizziness, light-headedness and insomnia. Respondent refilled tramadol and prescribed lorazepam, apparently for insomnia. On March 20, 2014, Respondent assessed Patient 1 as having an adult failure to thrive, possible early dementia, and advised her to increase her fluid intake. On March 20, 2014, Respondent saw Patient 1, following a March 7, 2014, hospitalization, and noted that Patient 1 was experiencing dizziness, cognitive decline, and possible dementia. Between March 25, 2014, and September 24, 2014, Respondent noted that Patient 1 was still taking Percocet, tramadol, and lorazepam on a regular basis.

31. According to a review of Patient 1's medical records and the CURES[9] reports, Respondent prescribed controlled substances to Patient 1 on a regular basis between June 18,

---

[6] Non-steroidal anti-inflammatory drugs (NSAIDs) are medicines that widely used to relieve pain such as naproxen (Aleve) and ibuprofen (Advil).

[7] Magnetic Resonance Imaging (MRI) scans produce detailed images of the organs and tissues in the body.

[8] L1, L2, and L3, refers to the lower end of the spinal column and refers to three of the five lumbar vertebra.

[9] Controlled Substance Utilization Review and Evaluation System (CURES) is a database maintained by the California Department of Justice, which tracks all controlled drug prescriptions that are dispensed in the State of California.

2014, and March 4, 2019. Between June 18, 2014, and March 29, 2016, Respondent prescribed controlled substances to Patient 1 that averaged between 10 MME[10] and 20 MME per day in any given month. Between August 22, 2016, and March 4, 2019, Respondent prescribed controlled substances to Patient 1 that averaged between 8 MME and 20 MME per day in any given month. However, on March 4, 2019, Respondent prescribed a prescription to Patient 1 that would have been 60 MME per day if taken as directed. Between June 8, 2015, and January 1, 2019, Respondent prescribed 13 prescriptions of 120 tablets of 5/325 mg hydrocodone with acetaminophen to Patient 1 for pain. However, on or about March 4, 2019, Respondent prescribed 120 tablets of 5 mg oxycodone HCL and 60 tablets of 10 mg Oxycontin to Patient 1 as a thirty-day supply. This represented a significant escalation in MME dosages per day from the January 24, 2019, prescription of 120 tablets of 5/325 hydrocodone with acetaminophen.

32. Between January 30, 2015, and March 4, 2019, Respondent saw Patient 1 in the clinic for follow-up and management of her pain. In addition to the information documented above, a review of the records revealed the following additional details related to the care and treatment of Patient 1. On or about February 9, 2015, Respondent documented that Patient 1 presented with delirium and that Patient 1's husband was going to have to keep an eye on medication disbursement in the future. On or about March 30, 2015, Respondent saw Patient 1 in the hospital for transient global amnesia. Respondent documented that Patient 1 may suffer from mild dementia and that Patient 1 was uncertain about the safety of taking her medication. On or about March 29, 2016, Respondent documented that Patient 1 rarely used alcohol and had no illicit drug use. However, on March 21, 2017, Respondent documented that Patient 1 was now occasionally using alcohol. On or about July 31, 2017, Respondent documented that Patient 1 cried during the entire appointment, which was consistent with Respondent documenting in other visits that she had concerns with Patient 1 being depressed. At the same visit, Respondent also

[10] Morphine Milligram Equivalents ("MME") and Morphine Equivalent Dose ("MED"), is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency. The California Medical Board Guidelines issued in November 2014 stated that any physicians should proceed cautiously (yellow flag warning) once an MED reaches 80 mg per day.
https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf at page 17.

documented that Patient 1 had issues with taking her medication appropriately at times. On or about July 13, 2018, Respondent documented that Patient 1 was depressed about her pain. On October 4, 2018, Respondent documented that Patient 1 presented in clinic for "reasons that she is confused about." On that visit, Respondent noted that Patient 1 had on-going problems with mentation (thinking clearly) since consuming two 60 mg. MS Contin pills from an out of date prescription five years ago, that both her long-term and short-term memory were poor.

33. On March 4, 2019, Patient 1 presented before Respondent with a complaint of redness and pain in her shoulder. Patient 1 was scheduled to have a shoulder replacement performed but an infection had delayed the surgery. Respondent noted that the patient had either a possible infection or possible rotator cuff injury. Respondent, having prescribed 120 tablets of 5/325 mg hydrocodone with acetaminophen on January 24, 2019, as noted above, dramatically increased Patient 1's controlled substance prescription to 120 tablets of 5 mg oxycodone and 60 tablets of 10 mg Oxycontin. On March 8, 2019, Patient 1 presented at Seneca Hospital's emergency room. A different physician learned that Patient 1's husband had found Patient 1 non-responsive, with pinpoint pupils and facial droop on the left. Patient 1's husband contacted 911. Upon arrival, Emergency Medical Services (EMS) administered Narcan[11] fearing a possible overdose and Patient 1 aroused but was still unable to mover her left side, upper, and lower extremities and had difficulty speaking. EMS determined that Patient 1's oxygenation was 83% when they made contact with her, which is consistent with respiratory depression consistent with drug overdose. According to Patient 1's husband, Patient 1 was confused all day on March 7, 2019. The physician on duty documented that Patient 1 had a possible CVA (cerebral vascular accident or stroke) versus possible overdose of controlled substances. Patient 1 was later transferred to Enloe Medical Center for a higher level of care and was diagnosed with opioid dependence with intoxication delirium, acute respiratory failure with hypoxemia, and acute encephalopathy.

///

[11] Narcan (naloxone) is a reversal medication used for the treatment of known or suspected opioid overdose emergency with signs of respiratory loss.

34. A review of Patient 1's medical records from August 2014 to March 2019 reveals that Respondent failed to undertake any risk assessment for prescribing long-term use of opioids through various screening tools such as the PHQ-2, PHQ-9, CAGE-AID, Opioid Risk Tool, or SOAPP-R. A review of Patient 1's medical records from August 2014 to March 2019 revealed that Respondent failed to specify measurable goals and objectives to evaluate long-term opioid treatment progress. Respondent failed to document that Patient 1 had discernible improvement in pain, failed to document an exit strategy for the termination of controlled substance therapies, and failed to clearly describe a pain management treatment plan. A review of Patient 1's medical records from August 2014 to March 2019 revealed that Respondent failed to document that she discussed the potential risks of long-term opioid use with Patient 1, including respiratory depression, motor impairment, cognitive impairment, death, and the possible risk of dependence and misuse that comes from opioid use. There is no evidence that Respondent had Patient 1 complete a pain management agreement or had Patient 1 undergo drug screening.

35. A review of Patient 1's medical records from August 2014 to March 2019 revealed that Respondent failed to perform and/or document performing any investigation into whether Patient 1 was complying with her prescriptions, including the use of biological fluid screening, a review of CURES reports, and/or conducting pill counts. A review of Patient 1's medical records from August 2014 to March 2019 revealed that Respondent performed no ongoing assessment and/or documented performing an on-going assessment of how Patient 1 was progressing towards appropriate treatment objectives with controlled substances. Respondent failed adequately evaluate patient's activity level (functional goals), adverse effects (side effects), aberrant behaviors (alcohol use), and patient's affect (changes to mood, depression, or anxiety) on a continuous basis.

Patient 2

36. Respondent has been providing general medical care to Patient 2 for approximately 20 years. At her interview with the Board on September 24, 2020, Respondent stated that Patient 2 is retired. According to Respondent, despite being in her late 70s, Patient 2 is very active and helps with home improvement projects like roofing and painting her house. In addition,

Respondent stated that Patient 2 spends a significant part of her time living in Mexico as well as living in northern California. Respondent stated she has prescribed a high dose of pain medication to Patient 2 to treat fibromyalgia and lumbago with sciatica. At the Board interview, Respondent stated that Patient 2 had been treated with back injections in the past but that they were not very helpful. Respondent stated that she asked Patient 2 about tapering her medications but Patient 2 refused because her medications allowed her to be active. Finally, during the interview with the Board, Respondent stated that in her experience, pain medicine is not the best treatment for fibromyalgia but that other medications designed for fibromyalgia such as pregabalin and duloxetine had caused significant side effects and Patient 2 had stopped taking them.

37. On or about June 12, 2013, Respondent documented that Patient 2 was seen for short-term memory loss, and balance issues. Respondent noted that Patient 2 complained of tremors, memory loss and forgetfulness. Respondent documented that Patient 2's ataxia, tremor, and confusion could be related to some of her prescriptions but failed to document that it could also be related to her opioid pain medication. Respondent documented that Patient 2's blood pressure was 84/58 despite not being on blood pressure medication. Respondent noted that Patient 2 had standing and walking ataxia. On June 23, 2013, Respondent saw Patient 2 for follow-up and noted that Patient 2 may have suffered from delirium and falling episodes. Respondent also documented that Patient 2 had stubborn depression, that Patient 2 had difficulty staying awake and altered levels of consciousness with falling attacks. At the time, Respondent prescribed a 90-day prescription of 360 tablets of 10/325 mg hydrocodone with acetaminophen on June 11, 2013, and then Patient 2 prematurely refilled a prescription for 90 tablets of 10/325 mg hydrocodone with acetaminophen on August 12, 2013, after just sixty days.

38. According to CURES, between July 2013 and February 2014, Patient 2 used two separate addresses and filled prescriptions at different pharmacies for hydrocodone with acetaminophen. Between March 2014 and August 2014, Patient 2 was seen in the clinic by Respondent and Respondent refilled her Norco prescriptions. In addition, during that time Respondent began Patient 2 on a Butrans patch with the idea of lowering Patient 2's dependence

on Norco. During that time, Patient 2 continued to use different addresses to refill prescriptions at different pharmacies.

39. A review of CURES and Patient 2's medical records revealed that between June 11, 2013, and October 5, 2013, Patient 2 was on an average of over 90 MME per day. Between June 11, 2013, and October 7, 2013, she received 1,170 tablets of 10/325 mg hydrocodone with acetaminophen. From October 7, 2013, to March 9, 2015, Patient 2 was on an average of 57 MME per day as she received hydrocodone with acetaminophen and Butrans. During that time, on or about October 31, 2014, Respondent issued Patient 2 a prescription for a 90-day supply of 720 tablets of 10/325 mg hydrocodone with acetaminophen because Patient 2 was going to Mexico. Between March 26, 2015, and July 31, 2016, Patient 2's MME increased to approximately 75 MME per day with the MME being significantly higher between September 11, 2015, and October 10, 2015 (120 MME per day) and between October 10, 2015, and October 28, 2015 (200 MME per day). The increase in Patient 2's MME between March 26, 2015, and July 31, 2016, coincides with Respondent changing Patient 2's prescriptions. On or about June 11, 2015, Respondent prescribed 10 patches of 50 mcg/hr fentanyl to Patient 2. Also, on or about August 6, 2015, Respondent began prescribing 60 tablets of 30 mg MS Contin to Patient 2. Respondent continued to prescribe 120 to 180 tablets of 10/325 mg hydrocodone with acetaminophen to Patient 2.

40. A review of CURES and Patient 2's medical records revealed that between August 4, 2016, and April 9, 2018, Patient 2 was prescribed an average of 120 MME per day. However, at times the MME per day was higher. On or about November 6, 2017 and November 7, 2017, Respondent prescribed a three month supply of 270 tablets of 30 mg MS Contin, and 720 tablets of 10/325 Norco to Patient 2 for a prescribed MME of 180 per day. This was a mere 16 days after Respondent had also prescribed 115 tablets of 15 mg oxycodone to Patient 2 that was supposed to be a twenty-day supply. Finally, a review of CURES and Patient 2's medical records revealed that between April 9, 2018, and November 1, 2019, Patient 2 was prescribed an average of 108 MME per day. Respondent continued Patient 2 on morphine sulfate and hydrocodone with acetaminophen, albeit on lower dosages, during that time. On or about April 4, 2019,

Respondent prescribed 10 tablets of 5 mg diazepam while Patient 2 was receiving her opioid medications.

41. Between August 6, 2014, and May 15, 2020, Respondent saw Patient 2 in clinic for various ailments and to continue her pain management therapy. On June 11, 2015, Respondent documented that Patient 2 experienced a fall onto her left ribs. She noted that the Butrans patch had stopped working and Respondent prescribed fentanyl. On August 6, 2015, Patient 2 was seen in the clinic and expressed frustration with the fentanyl patch because it required changing and wanted time released pills. Respondent diagnosed Patient 2 with osteoarthritis and fibromyalgia and prescribed Norco and MS Contin. On September 2, 2015, Respondent saw Patient 2 for follow-up and a pain management agreement was documented which stated that Patient 2 would obtain medication at Walgreens and set forth terms and conditions for the continued prescribing of medication by Respondent. On October 10, 2015, Patient 2 received 60 tablets of 30 mg MS Contin and 180 tablets of 10/325 mg Norco. A mere eighteen days later, Patient 2 received 200 tablets of 10/325 mg Norco and 270 tablets of 30 mg MS Contin. On October 21, 2015, Respondent documented that Patient 2 would be in Mexico until February 2016 but there was no subsequent documentation regarding the early refill.

42. On March 28, 2016, Patient 2 filled Respondent's prescription for MS Contin at Rite Aid pharmacy in violation of her pain management agreement. On August 30, 2016, Patient 2 was seen by a mid-level medical provider and it was documented that Patient 2 had tripped and had fallen, injuring her right knee. On September 6, 2016, Respondent saw Patient 2 regarding the knee pain and advised Patient 2 to take Aleve. On October 25, 2016, Respondent saw Patient 2 in the clinic and continued her medications. A drug screen taken that day was consistent with Respondent's prescriptions to Patient 2. On April 13, 2017, Respondent documented that Patient 2 was seen for follow-up regarding her treatment for fibromyalgia. Respondent documented that Patient 2 had widespread pain, sleep disturbance, cognitive impairment, depression, and noted pain levels ranging from 4 out of 10 to 9 out of 10 on a pain scale level with 1 being the lowest form of pain and 10 being the highest level. Respondent documented that Patient 2 reported that her pain was constant and that she experienced functional limitation to general activities.

Respondent documented that she would refer Patient 2 to pain management to consider Suboxone and refilled her medications.

43. On October 12, 2017, Respondent documented that she saw Patient 2 for follow-up regarding her MS Contin prescription. Respondent documented that Patient 2 was experiencing depression. Respondent noted that Patient 2 was taking MS Contin every 4 hours and that Respondent told Patient 2, "that was a good way to overdose." Respondent documented that Patient 2 didn't want to stop taking her MS Contin in this way because she didn't want to stop doing the activities that she wanted to do. Respondent informed Patient 2 that if she continued to take the medication every four hours rather than every eight hours as prescribed, she would stop prescribing to her. Despite this new issue with Patient 2's intake of her medications, Respondent prescribed Patient 2 a three-month supply of 270 tablets of 30 mg. MS Contin and refilled her hydrocodone prescription. The October 12, 2017 and October 20, 2017, chart notes do not mention that Respondent was also now prescribing oxycodone and on October 20, 2017, Patient 2 filled a prescription for 115 tablets of 15 mg oxycodone at Lassen Drug in violation of her pain management agreement.

44. On November 2, 2017, Patient 2's gastroenterologist documented that Patient 2 was dealing with constipation. On November 3, 2017, Respondent saw Patient 2 in the clinic and Patient 2 made a complaint regarding depression. Respondent documented that Patient 2 had a "rough lot in life with chronic pain and pain medications." Respondent documented that Patient 2 was advised to limit her activities but found no way to do that. Respondent continued Patient 2's pain management treatment and increased her anti-depression medication. As noted above, Patient 2's MME per day increased in November 2017. On April 9, 2018, Respondent lowered Patient 2's hydrocodone prescription to 540 tablets from 720 tablets in another three-month prescription. On October 24, 2018, Respondent documented that Patient 2 presented for a medication refill and she was depressed. Respondent documented that she was going to continue Patient 2's anti-depressant medications and other medications and that Patient 2 was heading to Mexico for five months. Respondent failed to document any information related to Patient 2's controlled substances but on October 24, 2018, Patient 2 filled prescriptions for 270 tablets of 30

mg MS Contin and 540 tablets of 10/325 mg Norco at Lassen Drug in violation of the pain management agreement.

45. On April 4, 2019, Patient 2 requested refills of her medications and complained of arthritis pain to her hands, back, and shoulders. Respondent documented that Patient 2 was very active. Respondent prescribed a 90-day supply of 270 tablets 30 mg MS Contin, 540 tablets of 10/325 mg Norco and 10 tablets of 5 mg diazepam to Patient 2. Respondent failed to document any discussion with Patient 2 regarding any of the possible interactions diazepam may have with Patient 2's high dose opioids. On August 27, 2019, Patient 2 was seen for a medication refill. Respondent documented that Patient 2 complained of fatigue, sleepiness, and, while she hasn't fallen asleep while driving, tends to nap if sitting down during the daytime. Respondent ordered labs to evaluate Patient 2's fatigue and documented that she would consider prescribing stimulants. On October 31, 2019, Respondent saw Patient 2 for refills of her pain medications and noted that Patient 2 was once again going to Mexico for four months. Respondent noted that Patient 2's medication quantities were a problem and that she had not changed her dosages in eight years. Respondent documented that she would prescribe 360 tablets of 30 mg morphine sulfate and 960 tablets of 10/325 mg Norco for Patient 2 to receive over the next four months. Patient 2 filled four separate prescriptions at Lassen Drug for a total of 360 tablets of 30 mg MS Contin and 720 tablets of Norco on October 31, 2019 and November 1, 2019, in violation of her pain management agreement.

46. A review of Patient 2's medical records between June 11, 2013, and November 1, 2019, revealed that she used six different pharmacies to obtain prescriptions including the following: CVS Caremark (a mail order pharmacy), Lassen Drug, Walmart Pharmacy #10-1616, Walmart Pharmacy #10-2002, Walgreens # 10421, and Rite Aid # 6105. In addition, Patient 2 used two separate home addresses at various times when receiving prescriptions. Even after signing a pain management agreement that stated she would only receive prescriptions from Walgreens in September 2015, Patient 2 filled prescriptions at Lassen Drug and Rite Aid. In addition to those violations of her pain management agreement, Patient 2 also received a prescription for 180 tablets of 10/325 mg Norco on November 28, 2016, and 10 tablets of 15 mg

flurazepam HCL on July 26, 2018, from other medical providers. A review of the records between June 11, 2013, and November 1, 2019, revealed that Patient 2 refilled medications early, as noted above on October 28, 2015. As noted above, Respondent and other practitioners documented that Patient 2 fell or had trouble walking on June 11, 2015, August 6, 2015, and August 30, 2016.

47. A review of Patient 2's medical records between June 1, 2019, and November 1, 2019, revealed that Respondent failed to offer and/or document offering a prescription of naloxone to Patient 2 despite the fact that Patient 2 was on greater than 90 MME per day. A review of the records from August 1, 2014, and November 1, 2019, revealed that Respondent failed to specify and/or document measurable goals and objectives of treatment. Respondent failed to show discernible improvements in Patient 2's pain and associated symptoms during the treatment period. Respondent also failed to document an exit strategy for discontinuing controlled substances in the event that tapering or termination of controlled substance therapy became necessary. A review of the records from August 1, 2014, and November 1, 2019, failed to document that Respondent discussed the long-term risks and benefits of controlled substances as Respondent as Respondent modified and changed Patient 2's controlled substances prescriptions aside from one pain management agreement signed in September 2015. While a review of the records from August 1, 2014, and November 1, 2019, revealed that Respondent used biological fluid testing, there was no evidence that Respondent reviewed CURES, performed pill counting, or periodically contacted Patient 2's pharmacy to ensure compliance with her prescriptions.

48. A review of the records from August 1, 2014, and November 1, 2019, failed to reveal if Respondent engaged in on-going assessment and/or documented an on-going assessment of Patient 2's progress toward specific goals or whether Patient 2's controlled substances were causing side effects or negatively impacting Patient 2's changes to mood, depression, and anxiety. While Respondent frequently discussed Patient 2's functional goals and frequently discussed side effects, Respondent consistently blamed the side effects on Patient 2's non-narcotic medication rather than Patient 2's narcotic prescriptions. Finally, a review of the records from August 1,

2014, and November 1, 2019, showed that Respondent failed to establish and/or document establishing that Patient 2's chronic pain management therapy with opioids was medically appropriate to treat fibromyalgia and muscle-skeletal pain. Respondent failed to take into account the high risk of harm that Patient 2 was exposed to while being prescribed a MME per day of greater than 90 when compared to the lack of evidence that chronic opioid therapy can treat fibromyalgia and musculoskeletal pain.

Patient 3

49. Respondent provided general medical care to Patient 3 for over 20 years. Patient 3 suffers from neck and lower back problems with multiple surgeries. According to Respondent, Patient 3 had a history of narcolepsy. Respondent documented that Patient 3 had at one point fallen asleep in her bed with a lit candle which caused a fire. On March 3, 2020, Patient 3 was seen at a sleep center and reported a past substance abuse history of methamphetamine and marijuana. Patient 3 reported to the sleep center that it had been 5 to 10 years since she last used those substances. The sleep center documented that she had previously been assessed with narcolepsy and also documented a suspicion that Patient 3 may have central sleep apnea.

50. Between June 14, 2013, and April 1, 2020, Respondent saw Patient 3 in the clinic for a total of 33 visits. Of these visits, approximately 22 were for medication refills. Between August 1, 2014, and April 1, 2020, Respondent prescribed 450 tablets of 15 mg oxycodone HCL to Patient 3 every three months. Prior to October 9, 2018, Patient 3 was receiving 30 tablets of 20 mg mixed amphetamine salts on a monthly basis from other medical providers. On or about October 9, 2018, Respondent began prescribing 30 tablets of 20 mg mixed amphetamine salts. On or about September 5, 2019, Respondent converted Patient 3's monthly prescription to 90 tablets of 20 mg mixed amphetamine salts every three months. A review of the records between August 1, 2014, and April 1, 2020, revealed little variation in Patient 3's pain complaints and treatment plan. Patient 3's lower back pain was documented as moderate to severe, it was also noted that the patient presented with pain. Respondent documented that Patient 3 was also on NSAIDs, gabapentin, and tizanidine. Respondent furthermore documented that Patient 3 had lumbar degenerative disc disease and was being treated with antidepressants.

51. On or about July 9, 2014, Respondent entered into an opioid pain management agreement with Patient 3. Patient 3 provided urine drug screens that were consistent for oxycodone on or about July 9, 2014, September 27, 2017, and October 9, 2018. It was noted in the medical records that Patient 3's drug screen was inconsistent for amphetamines on or about July 9, 2014, despite receiving the prescription from another provider. On or about November 5, 2019, Respondent documented that Patient 3 needed her Adderall medication refilled for narcolepsy because her previous provider was no longer in practice. The Respondent documented that she was "not really sure what the patient's pain relief is and whether it's adequate or not though she noted she did not have side effects from oxycodone," regarding Patient 3's progress on chronic pain therapy. Between August 1, 2014, and April 1, 2020, Patient 3 was on an MME of approximately 110 per day based on receiving 450 tablets of 15 mg oxycodone every ninety days.

52. A review of the records between August 1, 2014, and April 2, 2020, revealed that Patient 3 had a number of risk factors for abuse or misuse of opioid medications, which could lead to motor impairment, cognitive impairment, respiratory depression, overdose, and even death. On or about December 28, 2016, Respondent documented that Patient 3 was "in recovery" next to the entry space for alcohol use. On or about March 3, 2020, another provider documented in Patient 3's medical records that Patient 3 had a history of illicit drug use, noting the prior use of methamphetamine and marijuana. Throughout the records, it was noted that Patient 3 was on an antidepressant. On or about April 24, 2019, Respondent documented that Patient 3 had fallen hard at home two weeks earlier.

53. A review of Patient 3's medical records from January 1, 2019, to April 2, 2020, did not reveal whether Respondent prescribed and/or documented prescribing naloxone to Patient 3. A review of Patient 3's medical records from August 1, 2014 to April 2, 2020, showed that Respondent failed to specify measurable goals and objectives to evaluate treatment progress. Respondent failed to document whether Patient 3 was receiving discernible improvement from pain management and failed to document an exit strategy for the discontinuing of therapy in the event that tapering or termination of controlled substances became necessary. A review of Patient

3's medical records from August 1, 2014 to April 2, 2020, showed that Respondent failed to provide and/or document adequate informed consent related to the potential risks of long-term opioid therapy, aside from having her sign a pain management agreement on July 9, 2014. The risks that should have been documented include a discussion of the risk of dependence, motor impairment, cognitive impairment, overdose, and even death. A review of Patient 3's medical records from August 1, 2014 to April 2, 2020, showed that Respondent failed to use pill counts or review Patient 3's CURES report as part of a plan of compliance monitoring

54. A review of Patient 3's medical records from August 1, 2014 to April 2, 2020, showed that Respondent failed to perform and/or document performing a complete on-going assessment of Patient 3's progress on pain management therapy including functional goals, adverse effects, aberrant behaviors, and patient's affect. A review of Patient 3's medical records from August 1, 2014 to April 2, 2020, showed that Respondent failed to consider and/or document considering whether Patient 3's pain medication was appropriate to treat degenerative joint disease of the neck and low back pain. While there was some evidence of the use of opioids for failed back surgery, Respondent failed to document whether the greater risk of harm posed by high dose opioid therapy was outweighed by the benefits gained in treating Patient 3's conditions.

Patient 4

55. Approximately fifteen years ago, Patient 4 suffered a back injury while helping unload a snowmobile from the back of a truck. Patient 4 had a L4 disc herniation with moderate to severe chronic pain, but the medical records lack a great deal of work-up regarding her chronic pain due to Patient 4's financial issues. Respondent provided general medical care to Patient 4.

56. Between April 29, 2013, and August 18, 2014, Respondent prescribed oxycodone HCL, carisoprodol and Ritalin to Patient 4. Patient 4 at that time had an MME over 250 per day while receiving a stimulant and muscle relaxer. On November 5, 2013, Patient 4 received 120 tablets of 10 mg Ritalin from Walmart pharmacy. On November 6, 2013, Patient 4 received 30 tablets of 350 mg carisoprodol from Lassen Drug. On November 26, 2013, Patient 4 received 275 tablets of 15 mg oxycodone HCL. Patient 4 next received 275 pills of 15 mg oxycodone HCL on or about December 18, 2013. Assuming that the November 26, 2013, prescription was

taken over approximately 22 days, Patient 4's MME per day was approximately 280 while on a stimulant and muscle relaxer. On April 11, 2014, Patient 4 refilled her Ritalin prescription 6 days early at a Walmart pharmacy despite previously receiving her Ritalin at Walgreens. On May 21, 2014, Patient 4 refilled her Ritalin prescription 21 days early at a Walmart pharmacy despite previously receiving her Ritalin prescription at RiteAid. On August 18, 2014, Patient 4 refilled her Ritalin prescription 5 days early at Lassen Drug. Respondent failed to document any information related to Patient 4's early refills or use of multiple pharmacies. On or about June 4, 2014, Respondent had Patient 4 enter a pain management agreement. The pain management agreement was incompletely filled out as it failed to list the Respondent's name, did not list a pharmacy where Patient 4 would fill future prescriptions, and did not list any of the medications Respondent was going to be prescribing to Patient 4. Between August 1, 2014, and May 25, 2020, Respondent failed to complete and/or modify the pain management agreement for completeness.

57. Between September 8, 2014, and March 9, 2015, Patient 4 received oxycodone HCL with an average MME per day of 200, carisoprodol, and Ritalin as a result of Respondent's prescriptions. On September 8, 2014, Patient 4 received 120 tablets of 10 mg Ritalin. On September 9, 2014, Patient 4 received 30 tablets of 350 mg carisoprodol. On September 10, 2014, Patient 4 received 280 tablets of 15 mg oxycodone HCL. Patient 4 furthermore received 280 tablets of 15 mg oxycodone HCL on October 8, 2014, and 280 tablets of 15 mg oxycodone HCL on October 31, 2014. If the oxycodone received on September 10, 2014, and October 8, 2014, were taken over 51 days, Patient 4's MME per day would be approximately 250. Patient 4 received early refills of Ritalin on September 15, 2014 (21 days early) and February 3, 2014 (5 days early).

58. Between March 19, 2015, and September 1, 2015, Patient 4 received oxycodone HCL with an average MME per day of approximately 250, carisoprodol, and Ritalin as a result of Respondent's prescriptions. On June 3, 2015, Patient 4 received 280 tablets of 15 mg oxycodone HCL and 90 tablets of 10 mg Ritalin. On June 22, 2015, Patient 4 received 30 tablets of 350 mg carisoprodol. Patient 4 next received oxycodone HCL on June 29, 2015. Patient 4 received early

refills of Ritalin on April 16, 2015 (14 days early), May 6, 2015 (10 days early), and June 29, 2015 (4 days early). On June 29, 2015, Patient 4 received a prescription for 100 tablets of 5/325 mg hydrocodone with acetaminophen from Respondent. Respondent failed to document the hydrocodone prescription and/or whether this prescription increased Patient 4's MME per day. Between September 10, 2015 and October 7, 2016, Patient 4 continued to receive oxycodone HCL with an average of approximately 250 MME per day, a total of 330 tablets of carisoprodol, and a total of 1,230 tablets of 10 mg Ritalin. During that period, Patient 4 received 4,200 tablets of 15 mg oxycodone HCL. On December 7, 2015, Patient 4 received an early refill (28 days early) of her 90 tablet Ritalin at Lassen Drug after obtaining her 90 tablet Ritalin prescription at Costco on December 5, 2015. Patient 4 also received early refills of Ritalin on February 15, 2016 (7 days early), April 1, 2016 (9 days early), June 22, 2016 (9 days early), and September 14, 2016 (4 days early). Patient 4 received an early refill of carisoprodol on June 13, 2016 (5 days early).

59. Between October 10, 2016, and April 15, 2020, Respondent continued to prescribe oxycodone HCL, Ritalin, and carisoprodol to Patient 4. During that period of time, Patient 4's MME per day began to slightly decrease. On or about April 19, 2017, Respondent lowered Patient 4's oxycodone prescription from 280 tablets of 15 mg oxycodone HCL to 260 tablets of 15 mg oxycodone HCL. Respondent continued the 260 tablets of 15 mg oxycodone HCL on a monthly basis until January 4, 2019. On or about February 5, 2019, Respondent lowered Patient 4's oxycodone prescription to 230 tablets of 15 mg oxycodone HCL and continued that as a monthly prescription through July 19, 2019. On or about August 14, 2019, Respondent lowered Patient 4's prescription to 225 tablets of 15 mg oxycodone HCL on a monthly basis. Finally, on or about February 21, 2020, Respondent lowered Patient 4's oxycodone prescription to 200 tablets of 15 mg oxycodone HCL per month. Accordingly, Patient 4's MME per day went from approximately 200 to approximately 150 withh these reductions. On January 1, 2019, Patient 4's MME per day was still approximately 200. At the same time that Respondent was tapering down Patient 4's oxycodone HCL, Respondent continued to prescribe carisoprodol and Ritalin to Patient 4, however, both prescriptions began to taper down with carisioprodol being prescribed every other month and the Ritalin prescription being reduced to 60 pills per month.

60. Between October 10, 2016, and April 15, 2020, there were continued early refills of prescriptions. On March 6, 2017, Patient 4 filled her Ritalin prescription early (10 days). Patient 4 filled her Ritalin prescription early on July 10, 2017 (6 days) and July 29, 2017 (11 days). Patient 4 also filled her prescription early on October 19, 2017 (16 days), and November 3, 2017 (14 days). On December 19, 2017, Patient 4 filled Respondent's prescription for 90 pills of 10 mg Ritalin twice, receiving tablets at two separate pharmacies, Lassen Drug and Costco. Patient 4 filled her Ritalin prescription early on July 16, 2018 (4 days early), August 5, 2019 (28 days early), and March 16, 2020 (5 days early).

61. A review of Patient 4's medical records between April 29, 2013, and April 15, 2020, revealed a number of pertinent details related to Respondent's care and treatment of Patient 4. On June 12, 2013, Respondent documented that Patient 4 experienced a recent fall. On July 17, 2017, Respondent documented that Patient 4 was experiencing sleep disturbance. During Respondent's September 24, 2020 interview with the Board, Respondent noted that Patient 4 preferred short acting narcotic medications despite Respondent being frustrated in providing the prescriptions. Respondent also acknowledged in the interview with the Board that there was a lack of objective medical work-up for Patient 4's back ailments because she had financial issues. The same financial issues had prevented Patient 4 from receiving back surgery, which would potentially get her off narcotic medication. On October 5, 2017, Respondent documented that Patient 4 took Ritalin when driving to maintain alertness. On or about June 4, 2017, Patient 4 provided an inconsistent urine drug screen result that showed the presence of a metabolite for hydrocodone. Respondent failed to document whether she looked into this inconsistent result with Patient 4. On or about August 17, 2018, Respondent had Patient 4 undergo a drug test for oxycodone only, and failed to test Patient 4 for Ritalin or Soma.

62. As noted above, between April 29, 2013, and April 15, 2020, Patient 4 repeatedly filled prescriptions early at different pharmacies and on December 19, 2017, and filled the same prescription for 90 tablets of 10 mg Ritalin at two separate pharmacies. Between April 29, 2013, and April 15, 2020, Patient 4 used six different pharmacies to receive controlled substances: Lassen Drug; Costco #125; Walmart # 102044; RiteAid # 6093; Walgreens #1041; and Costco

#1011. As noted above, Respondent's pain management agreement with Patient 4 failed to specify a pharmacy at which Patient 4 was to receive all controlled substances.

63. A review of Patient 4's medical records between August 1, 2014, and April 15, 2020, showed that Respondent failed to provide adequate informed consent to Patient 4, including the potential risks of long-term opioid use including respiratory depression, motor impairment, and cognitive impairment. In addition, Respondent failed to provide and/or document providing any informed consent regarding the risks of overdose and death related to oxycodone HCL, Ritalin, or Soma, aside from having Patient 4 enter a pain management agreement. Respondent failed to document counseling Patient 4 regarding the possible side effects caused by Soma while Patient 4 was on opioid therapy. A review of Patient 4's medical records between August 1, 2014, and April 15, 2020, revealed that Respondent failed to properly ensure that Patient 4 was complying with her controlled substance medications and her pain management agreement. Despite having Patient 4 provide urine drug testing, Respondent failed to follow up on an inconsistent result and failed to test for all of the medications that she was prescribing. Respondent also failed to undertake a review of CURES, failed to conduct pill counts, and failed to consult the various pharmacies where Patient 4 was receiving controlled substances, which as noted above, led to early refills.

64. Between August 1, 2014, and April 15, 2020, Respondent repeatedly prescribed oxycodone HCL, Ritalin and Soma to Patient 4. There was no evidence that Respondent evaluated whether the high risks of these medications supported the prescription of these medications for musculoskeletal pain. Between August 1, 2014, and April 15, 2020, Respondent failed to create and/or document a treatment plan with objectives and goals of treatment for Patient 4. Respondent failed to specify the goals of Patient 4's controlled substance therapy and failed to show discernible improvement in pain and associated symptoms during the treatment period. Respondent also failed to document an exit strategy in the event that tapering or termination of controlled substances became necessary. Respondent failed to perform and/or document an on-going assessment of whether Patient 4 was progressing on controlled substances

and failed to evaluate adverse effects and aberrant behaviors by Patient 4 such as early refills of medications and the use of multiple pharmacies to fill prescriptions.

Patient 5

65. According to Respondent, Patient 5 was retired and was seen by Respondent as a general family practice patient. Patient 5's past medical history involved a series of surgeries on his back and neck. Unfortunately, Patient 5's back surgeries failed and he began taking high-dose opioids for chronic pain. Respondent stated that Patient 5 preferred short-acting pain medicine, and had chronic severe migraines, and suffered from neck pain. Patient 5 was seen by a pain management specialist in person and/or by telemedicine on or about April 20, 2018, May 11, 2018, June 12, 2018, February 14, 2019, and March 31, 2019. Prior to the pain management specialist introducing methadone into Patient 5's pain management regimen, Respondent treated Patient 5's pain with short acting narcotics. The pain management specialist documented on February 14, 2019, that Patient 5 received a DCS,[12] and Patient 5's pain had improved, and it was necessary to start tapering off methadone, as methadone and valium were a dangerous combination. On or about March 21, 2019, Patient 5 reported to tapering himself from methadone.

66. Between April 24, 2013, to August 31, 2020, Respondent prescribed at different times, oxycodone HCL, methadone HCL, diazepam, clonazepam, testosterone, Androderm, Axiron[13], zolpidem tartrate, and butalbital-acetaminophen-caffeine to Patient 5 to treat a number of health concerns related to chronic pain, anxiety, migraine headaches, sleeplessness, and low testosterone. From July 1, 2014, to April 3, 2015, Patient 5 was on an MME per day of approximately 275 and he received 1080 tablets of 10 mg diazepam tablets and 90 10 mg zolpidem tartrate tablets. From April 15, 2015, to March 2, 2016, Patient 5 was on an MME per day of approximately 375 and received 1800 tablets of 10 mg diazepam and 540 tablets of Fioricet. From March 4, 2016, to April 4, 2017, Patient 5 was on an MME per day of

[12] DCS, dorsal column stimulation, a neuromodulation therapy.

[13] Tesosterone, Androderm, and Axiron are Schedule III controlled substances pursuant to Code of Federal Regulations Title 21 section 1308.13, used to treat low testosterone levels in males as they are classified as anabolic steroids.

approximately 400 and received 1440 tablets of 10 mg diazepam. From April 10, 2017, to March 8, 2018, Patient 5 was an MME per day of approximately 400 and received 720 tablets of 10 mg diazepam. From March 30, 2018, to November 6, 2018, Patient 5 was an MME per day of approximately 450 and received 270 tablets of diazepam. On May 17, 2018, Patient 5 received 270 tablets of 10 mg diazepam from Optum RX. On May 22, 2018, Patient 5 received 360 tablets of 10 mg methadone and 360 tablets of 15 mg oxycodone HCL from Optum RX. On May 23, 2018, Patient 5 received 20 tablets of 10 mg methadone from Lassen Drug. Patient 5 next refilled medications on August 20, 2018. If those prescriptions were taken as expected over an approximately 90 day period, Patient 5 would have consumed an average of 42 mg of methadone, 60 mg of oxycodone HCL for an MME of approximately 500 in combination with 30 mg of diazepam each day.

67. From November 16, 2018, to May 31, 2019, Patient 5 was on an MME per day of approximately 200 and received 810 tablets of 10 mg diazepam and 270 tablets of 1 mg clonazepam. On or about February 7, 2019, Patient 5 received 270 tablets of 10 mg diazepam from OptumRX. On or about February 14, 2019, Patient 5 received 270 tablets of 1 mg clonazepam from Lassen Drug. On or about February 15, 2019, Patient 5 received 120 tablets of 15 mg oxycodone HCL and 120 tablets of 10 mg methadone from Lassen Drug. This was the last prescription of methadone received by Patient 5 from Respondent. Patient 5 next filled 120 tablets of 15 mg oxycodone HCL on April 24, 2019. On or about February 8, 2019, Respondent saw Patient 5 in clinic and documented that Patient 5 was trying to decrease his methadone intake and that clonazepam and clonidine[14] could help him taper off. Respondent documented that she prescribed the medications and informed him he could not take diazepam concurrent to taking clonazepam. She did not, however, do a pill count of Patient 5's diazepam or ask that Patient 5 destroy his remaining diazepam medication while he was receiving clonazepam. Respondent documented Patient 5 was still seeing a pain management specialist by telemedicine and that Patient 5 would follow-up in Redding. Patient 5 saw the pain management specialist on March

[14] Clonidine, sold under the brand Catapres, is a sedative and antihypertensive drug.

21, 2019. Finally, between July 16, 2019, and August 31, 2020, Patient 5 was on an MME per day of approximately 90 and received 1080 tablets of 10 mg diazepam and 30 tablets of Fioricet.

68. On or about March 5, 2014, Respondent documented that Patient 5 suffered from relentless migraines in addition to chronic low back pain and neck pain. On June 4, 2014, Patient 5 entered into a pain management agreement with Respondent. The agreement specified that Patient 5 would receive all medications at Lassen Drugs. A review of Patient 5's medical records between June 4, 2014, and August 2020, revealed that Patient 5 received controlled substances from Lassen Drug while also receiving controlled substances from CVS Caremark (mail order), CVS Pharmacy #7506, Wal-Mart Pharmacy # 10-1616, OptumRX (mail order), Walgreens #10421, and Thrifty Payless/Rite Aid # 6105, in violation of the pain management agreement. Respondent had Patient 5 provide a urine drug test on June 6, 2014, October 14, 2016, and September 25, 2017, with results that were consistent with the prescriptions he was receiving. Patient 5 also provided a urine drug test as ordered by the pain management specialist on February 15, 2019, that was consistent with his prescriptions. However, on or about March 21, 2019, Patient 5 provided a urine drug test as ordered by the pain management specialist, that was inconsistent as it showed the presence of both the clonazepam metabolite and the presence of Ethyl Glucuronide, a metabolite of alcohol. Despite being instructed by Respondent to not take diazepam concurrently with clonazepam, the urine result raised questions that Patient 5 was taking both benzodiazepine prescriptions at the same time.

69. On August 22, 2014, Patient 5 filled a 90-day prescription for 360 tablets of 10 mg diazepam 17 days early. On December 17, 2014, Respondent documented that Patient 5 tried to taper his medications and documented that Patient 5 reported his life to be unbearable. Respondent documented that Patient 5 had pain from several different sources and that his migraines were debilitating. On March 13, 2015, Patient 5 was seen for a medication refill for severe chronic back pain. At the time, Patient 5 was receiving 360 tablets of 15 mg oxycodone HCL each month for an MME per day of 270. At the March 13, 2015, visit, Respondent documented that Patient 5 tried to stop his medication and that his quality of life had plummeted, as he would spend 20 hours a day in bed. On March 27, 2015, Respondent documented that

Patient 5 was seen for his annual check-up. Respondent documented that Patient 5 was taking 10 mg Zolpidem as needed, 30 mg oxycodone HCL every three hours, a tablet of Fioricet three times a day, and a 10 mg tablet of diazepam twice daily, in addition to various depression and anti-anxiety medications. Respondent documented that Patient 5 reported drinking alcohol under "habits" in a medical questionnaire and that he had difficulty sleeping. Respondent documented that Patient 5 often experienced falls, was depressed, was hopeless and had little interest or pleasure in doing things. Respondent did not document whether she informed Patient 5 of the risks of consuming alcohol while on high dose opioids, benzodiazepines, and hypnotics.

70. On or about August 28, 2015, and October 1, 2015, Patient 5 received two ninety-day prescriptions of 720 tablets of 30 mg oxycodone HCL despite Respondent documenting in the medical lists that she was prescribing 15 mg tablets of oxycodone HCL on or about June 10, 2015, and August 30, 2015[15]. Respondent documented in the treatment plan on June 10, 2015, that Patient 5 was insisting on an MRI and a refill of his 720 tablets of 30 mg oxycodone prescription, but there was no explanation provided in why Respondent was changing the prescription from 15 mg oxycodone tablets as she had prescribed previously on or about March 16, 2015. On or about January 29, 2016, the Respondent documented in the treatment plan that Patient 5 was now receiving 30 mg tablets of oxycodone. On November 20, 2015, Respondent documented that Patient 5 suffered from back pain, stiffness, depressed mood, and sleeping problems with an average pain scale of 5/10, ranging from 3/10 to 9/10. Respondent documented that his pain was worsening, that he was functionally limited, and had good adherence to treatment. On March 29, 2016, Respondent documented that Patient 5 rarely used alcohol but did not document whether she informed him of the risks of consuming any amount of alcohol while on high dose opioid treatment, benzodiazepines, and zolpidem tartrate. On April 5, 2017, Respondent documented that Patient 5 was having balance problems. On January 11, 2018, Respondent documented that Patient 5 was taking 40 mg of diazepam per day and would start

[15] In Patient 5's medical record for August 30, 2015, two of the treatment plans mention that Respondent was prescribing 15 mg tablets of oxycodone and one of the treatment plans mentions Respondent was prescribing 30 mg tablets of oxycodone. There was no explanation in the medical record provided for the discrepancy between the three treatment plans.

tapering down Patient 5's diazepam prescription. Despite documenting that treatment plan to reduce his diazepam prescription to 10 mg, Patient 5 received 270 tablets of 10 mg diazepam on May 17, 2018, August 29, 2018, and November 17, 2018, from OptumRX (mail order suppliers) in violation of the pain management agreement. Patient 5 continued to take at least 30 mg diazepam per day between May 17, 2018, and November 16, 2018. As noted above, Patient 5 remained on a high MED of opioid pain medications while on high dose diazepam.

71. On January 11, 2018, Respondent also documented that Patient 5 suffered from severe depression and was currently on paroxetine (SSRI) and Abilify (aripiprazole, an adjunct medication to assist SSRIs in treating depression). On May 21, 2018, Respondent documented that Patient 5 was suffering from opioid-induced constipation. On June 15, 2018, a different medical provider who saw Patient 5 documented in Patient 5's medical records that Patient 5 suffered a fall three to four weeks earlier. On October 17, 2018, Respondent documented that Patient 5's additional medications to his controlled substances were depressants and that Respondent believed that they might be impacting his functioning and activities of daily living. On March 21, 2019, the pain management specialist documented that Patient 5's pain was partially controlled by oxycodone but that Patient 5 often ran out early because he must take three tablets at a time. On September 5, 2019, Patient 5 reported on a pre-anesthesia evaluation that he occasionally consumed alcohol.

72. On September 24, 2020, in an interview with the Board, Respondent denied knowing that Patient 5's pain management physician had documented that in March 2018, Patient 5 self-reported taking 3 tablets of oxycodone and that Patient 5 often ran out of medication, despite the documentation in Respondent's medical chart for Patient 5. Respondent stated that Patient 5's use of diazepam and Ambien in combination with opioids was a point of contention while she treated Patient 5. During the interview, Respondent agreed that Patient 5 might have been experiencing opioid-induced hyperalgesia while on the medications he was receiving, but failed to document those concerns. A review of Patient 5's medical records between August 1, 2014, and August 31, 2020, revealed that Respondent failed to create and/or document creating a treatment plan with objectives and goals for Patient 5. Respondent failed to specify the goals of

Patient 5's controlled substance therapy and failed to show discernible improvement in pain and associated symptoms during the treatment period. Respondent also failed to document an exit strategy in the event that tapering or termination of controlled substances became necessary. Respondent failed to perform and/or document performing an on-going assessment of whether Patient 5 was progressing on controlled substances.

73. Between August 1, 2014, and August 31, 2020, there was no documentation that Respondent provided informed consent to Patient 5 regarding the potential risks of long-term opioid use, including risk of respiratory depression, motor impairment, cognitive impairment, and even death aside from having him enter a pain management agreement. Between August 1, 2014, and August 31, 2020, despite multiple changes in dosages and opioid medications, while in combination with both hypnotics and benzodiazepines, Respondent failed to document that Patient 5 was at risk of dependence, misuse, addiction, overdose, and even death. Finally, despite documenting that Patient 5 occasionally consumed alcohol, Respondent failed to document that she ever discussed the dangers of alcohol consumption in any amount while Patient 5 was on controlled substances. Between August 1, 2014, and August 31, 2020, Respondent failed to use CURES, pharmacy records, and pill counts to determine if Patient 5 was compliant with his controlled substance therapy.

74. Between August 1, 2014, and August 31, 2020, Respondent failed to evaluate and/or document evaluating whether Patient 5 was an appropriate candidate for long-term controlled substance therapy, long-term benzodiazepine therapy, and long-term Fioricet therapy. While Respondent did consult with a pain management specialist, Respondent treated Patient 5's musculoskeletal pain and chronic migraines with benzodiazepines despite a lack of efficacy. The concurrent use of benzodiazepines with opioids substantially increased the risk that Patient 5 would be harmed while on those medications, especially while he received Ambien. Between August 1, 2014, and August 31, 2020, Respondent prescribed daily use of Fioricet to treat Patient 5's migraines despite the fact that daily use of Fioricet can lead to rebound headaches. A review of Patient 5's medical records from January 1, 2019, to August 31, 2020, failed to reveal whether Respondent prescribed and/or documented prescribing naloxone to Patient 5.

Patient 6

75. Patient 6 is approximately 43-years-old and began seeing Respondent for general medicine care and treatment approximately 25 years ago. According to Respondent, Patient 6 has chronic myofascial pain and other treatment modalities like physical therapy and acupuncture have failed to make any difference. Respondent stated that Patient 6 was bi-polar. Respondent began Patient 6 on opiates and has kept her on both long and short-term opiates to deal with the myofascial pain. Respondent acknowledged that the diagnosis of myofascial pain was based on a physical examination finding and not based on any radiological information.

76. Between May 10, 2013, and November 29, 2019, Patient 6 was on a daily MME of approximately 100, in combination with carisoprodol as a result of Respondent's prescriptions. Patient 6 was also receiving alprazolam from different medical providers on a monthly basis. On or about January 23, 2015, Patient 6 received 60 tablets of 350 mg carisoprodol. On or about January 28, 2015, Patient 6 received 30 tablets of 1 mg alprazolam. On or about February 4, 2015, Patient 6 received 60 tablets of 30 mg morphine sulfate and 180 tablets of 5/325 mg oxycodone with acetaminophen. If taken over a one-month period as prescribed, Patient 6's MME per day was 105 in combination with a daily intake of 700 mg of carisoprodol and 1 mg alprazolam. On or about October 19, 2016, Patient 6 received 60 tablets of 1 mg alprazolam. On or about October 21, 2016, Patient 6 received 60 tablets of 30 mg morphine sulfate and 180 tablets of 5/325 mg oxycodone with acetaminophen. On October 24, 2016, Patient 6 received 90 tablets of 350 mg carisoprodol. If taken over a one-month period as prescribed, Patient 6's MME per day was 105 in combination with a daily intake of 1050 mg carisoprodol and 2 mg of alprazolam. On or about December 13, 2018, Patient 6 received 15 tablets of .25 mg alprazolam. On or about December 16, 2018, Patient 6 received 180 tablets of 5/325 mg oxycodone with acetaminophen. On or about December 23, 2018, Patient 6 received 60 tablets of 30 mg morphine sulfate and 90 tablets of 350 mg carisoprodol. If taken over a one-month period as prescribed, Patient 6's MME per day was 105 in combination with 1050 mg carisoprodol and .25 mg alprazolam every other day. Respondent did not start lowering Patient 6's carisoprodol and daily MME intake until December 2019.

77. On October 16, 2013, Respondent entered a pain management agreement with Patient 6. The pain agreement template was not completely filled out and failed to include the name of the prescribing physician, the phone number of the pharmacy where prescriptions would be filled, or the controlled substances that were under the contract. The contract made no mention of the inherent risks of opioid therapy in combination with benzodiazepines and carisoprodol.[16] The contract listed Quincy Drug as the pharmacy where Patient 6 would receive controlled substances. The contract was signed by Respondent and Patient 6. Between August 1, 2014, and March 21, 2020, Patient 6 received controlled substances at both Quincy Drug and Rite Aid Pharmacy # 6093, in violation of the pain management agreement. Patient 6 provided drug-screening samples on or about July 11, 2014, March 2, 2015, October 12, 2016, September 13, 2017, and December 17, 2018. On December 17, 2018, Patient 6's sample was positive for a metabolite of marijuana.

78. Between May 10, 2013, and November 29, 2019, Respondent repeatedly documented that Patient 6 likely used carisoprodol to calm the effects of her bi-polar mania and that Respondent disliked prescribing carisoprodol to Patient 6. On or about December 13, 2019, Respondent documented that Patient 6's psychiatrist had tried to taper her off alprazolam and Respondent would not prescribe it any further. On or about December 16, 2019, and January 8, 2020, Patient 6 received 60 tablets of .25 alprazolam because of prescriptions issued by Respondent.

79. A review of Patient 6's medical records from January 1, 2019, to November 29, 2019, did not reveal whether Respondent prescribed and/or documented prescribing naloxone to Patient 6. Between August 1, 2014, and November 29, 2019, revealed that Respondent failed to create and/or document a treatment plan with objectives and goals of treatment for Patient 6. Respondent failed to specify the goals of Patient 6's controlled substance therapy, and failed to

[16] Referred to as "The Holy Trinity," in *The Perfect Storm: Opioid Risks and "The Holy Trinity"* by Fudin, Jeffrey, and Wolf, Autumn Edition, Pharmacy Times. 9/24/2014. When combined, opiates, benzodiazepines, and Soma, have a synergistic effect that greatly increases the risks of respiratory depression, motor impairment, cognitive impairment, and death. In addition, the primary metabolite of carisoprodol, is a barbiturate called Meprobamate, which can be associated with cardiac arrhythmias. The maximum recommended duration of Soma use is 2 to 3 weeks according to the FDA in October 2009.

document whether Patient 6 showed discernible improvement in pain and associated symptoms during the treatment period. Respondent also failed to document an exit strategy in the event that tapering or termination of controlled substances became necessary. Respondent failed to perform and/or document an on-going assessment of whether Patient 6 was progressing on controlled substances.

80. Between August 1, 2014, and November 29, 2019, there was no documentation that Respondent provided informed consent to Patient 6 regarding the potential risks of long-term opioid use, including risk of respiratory depression, motor impairment, cognitive impairment, and even death, aside from having Patient 6 enter an incomplete pain management agreement. Between August 1, 2014, and November 29, 2019, Respondent failed to provide and/or document the extremely high risks of overdose and death while Patient 6 received a combination of opiates, benzodiazepines, and carisoprodol. Between August 1, 2014, and November 29, 2019, Respondent failed to use CURES, pharmacy records, and pill counts to determine if Patient 6 was compliant with his controlled substance therapy.

81. Between August 1, 2014, and November 29, 2019, Respondent failed to evaluate and/or document whether Patient 6 was an appropriate candidate for long-term controlled substance therapy, long-term benzodiazepine therapy, and long-term carisoprodol therapy despite the risks of the combined medications. Despite carisoprodol being only recommended for the short-term treatment of muscle related pain, Respondent failed to document why she believed it was appropriate to prescribe the medication to Patient 6 over six years. Finally, Respondent failed to evaluate and/or document why long-term opioid therapy was appropriate to treat myofascial pain despite the lack of clinical evidence that long-term opioid therapy can treat myofascial pain.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

82. Respondent's license is subject to disciplinary action under section 2234, subdivision (b) of the Code in that she committed gross negligence during the care and treatment of Patients 1, 2, 3, 4, 5, and 6. The circumstances are as follows:

83. Complainant realleges paragraphs 29 through 81, and those paragraphs are incorporated by reference as if fully set forth herein.

84. Respondent's license is subject to disciplinary action because she committed gross negligence between August 1, 2014, and January 1, 2021, during the care and treatment of Patients 1, 2, 3, 4, 5, and 6, in the following distinct and separate ways:

a. By failing to document a rationale on March 4, 2019, in Patient 1's medical chart for a three-fold escalation in Patient 1's opioid dosage, and by failing to reevaluate Patient 1's opioid needs. In increasing the dosage, Respondent failed to offer Patient 1 naloxone and failed to document that she educated the patient on the known risks of overdose and misuse despite repeatedly documenting that Patient 1 was at risk for inappropriate medication dosing and had cognitive decline which required the assistance of her husband to dispense medications;

b. By repeatedly prescribing a single prescription for 90 day supplies of controlled substances rather than providing multiple separate 30 day prescriptions to Patient 2, Respondent increased the risk of misuse, overdose and death without proper oversight to prevent diversion;

c. By failing to offer and/or document offering a prescription for naxolone to Patient 2 after January 1, 2019, despite Patient 2 receiving an MME per day higher than 90, in violation of section 741 of the Code;

d. By failing to develop and/or document treatment goals for the long-term use of opioids for Patient 2's chronic non-cancer pain;

e. By failing to provide and/or document informed consent to Patient 2 regarding the long-term risks and benefits of long-term opioid therapy as Respondent modified and changed Patient 2's prescriptions;

f. By failing to evaluate and/or document whether an MME of greater than 90 per day was appropriate in the treatment of Patient 2's fibromyalgia and musculoskeletal pain despite the risks posed by such an MME per day;

g. By repeatedly prescribing a single prescription for 90 day supplies of controlled substances rather than providing multiple separate 30 day prescriptions to Patient 3, Respondent increased the risk of misuse, overdose and death without proper oversight to prevent diversion;

h. By failing to offer and/or document a prescription for naxolone to Patient 3 after January 1, 2019, despite Patient 3 receiving an MME per day higher than 90, in violation of section 741 of the Code;

i. By failing to develop and/or document treatment goals for the long-term use of opioids for Patient 3's chronic non-cancer pain;

j. By failing to provide and/or document informed consent to Patient 3 regarding the long-term risks and benefits of long-term opioid therapy as Respondent continued her chronic pain management;

k. By failing to provide and/or document informed consent to Patient 4 regarding the long-term risks and benefits of long term opioid therapy with Ritalin and carisoprodol as Respondent continued her chronic pain management;

l. By failing to properly undertake and/or document appropriate compliance monitoring of Patient 4's controlled substance usage including following up on inconsistent biological fluid testing, reviewing CURES reports, and conducting pill counts;

m. By failing to evaluate and/or document whether an MME of greater than 90 per day with Ritalin and carisoprodol over the long-term was appropriate in the treatment of Patient 4's musculoskeletal pain;

n. By repeatedly prescribing a single prescription for 90 day supplies of controlled substances rather than providing multiple separate 30 day prescriptions to Patient 5, Respondent increased the risk of misuse, overdose and death without proper oversight to prevent diversion;

o. By failing to offer and/or document a prescription for naxolone to Patient 5 after January 1, 2019, despite Patient 5 receiving an MME per day higher than 90, in violation of section 741 of the Code;

p. By failing to adequately develop and/or document a treatment plan with goals and objectives for the prescription of controlled substances to Patient 5;

q. By failing to provide and/or document informed consent to Patient 5 regarding the long-term risks and benefits of long-term opioid therapy with benzodiazepines, Ambien, and alcohol as Respondent continued his chronic pain management;

r. By failing to evaluate and/or document whether an MME of greater than 90 per day was appropriate in the treatment of Patient 5's musculoskeletal pain, and whether benzodiazepines and Fioricet were appropriate to treat Patient 5's chronic pain issues and chronic headaches, despite the risks posed by such a combination of medications;

s. By prescribing a dangerous combination of medications in the form of opioids, carisoprodol, and benzodiazepines (either by other health practitioners with Respondent's knowledge or by Respondent) to Patient 6 despite the fact that the medications can have a synergistic effect which can lead to respiratory depression and death;

t. By failing to offer and/or document a prescription for naxolone to Patient 5 after January 1, 2019, despite Patient 6 receiving an MME per day higher than 90, in violation of section 741 of the Code;

u. By failing to adequately develop and/or document a treatment plan with goals and objectives for the prescription of controlled substances to Patient 6;

v. By failing to provide and/or document informed consent to Patient 6 regarding the long-term risks and benefits of long-term opioid therapy in combination with benzodiazepines and carisoprodol as Respondent continued her chronic pain management; and,

w. By failing to evaluate and/or document whether an MME of greater than 90 per day was appropriate in the treatment of Patient 6's complaint of pain caused by myofasciitis.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

85. Respondent's license is subject to disciplinary action under section 2234, subdivision (c) of the Code in that she engaged in repeated negligent acts during her care and treatment of Patients 1, 2, 3, 4, 5, and 6. The circumstances are as follows:

86. Complainant realleges paragraphs 29 through 84, and those paragraphs are incorporated by reference as if fully set forth herein.

87. The gross departures from the standard of care as set forth in paragraph 82, are incorporated by reference as if fully set forth herein and serve as repeated negligent acts.

88. In addition to the repeated negligent acts involving Patients 1, 2, 3, 4, 5, and 6, detailed above as gross negligence, between August 1, 2014, and January 1, 2021, Respondent also engaged in repeated negligent acts with Patients 1, 2, 3, 4, 5, and 6, including the following:

a. By failing to perform and/or document a risk assessment, including the use of know assessment tools, for Patient 1 prior to prescribing the long-term use of opioids despite being aware that Patient 1 was capable of misusing narcotics and had mental decline;

b. By failing to adequately develop and/or document a treatment plan with goals and objectives for the prescription of controlled substances to Patient 1;

c. By failing to properly inform and/or document Patient 1 of the risks and benefits of long-term opioid use through a discussion of potential risks including respiratory depression, motor impairment, cognitive impairment and death;

d. By failing to properly undertake and/or document appropriate compliance monitoring of Patient 1's controlled substance usage including biological fluid testing, reviewing CURES reports and conducting pill counts;

e. By failing to properly perform and/or document an on-going assessment of Patient 1's progress on controlled substance therapy and whether she was meeting appropriate treatment objectives.

f. By failing to provide and/or document compliance monitoring during Patient 2's long term pain management treatment including the use of CURES, pharmacy records, and pill counts;

g. By failing to properly assess and/or document Patient 2's progress on long term pain management therapy and whether that therapy was helping Patient 2 reach appropriate treatment objectives;

h. By failing to provide and/or document compliance monitoring during Patient 3's long-term pain management treatment including the use of CURES, pharmacy records, and pill counts;

///

///

i. By failing to properly assess and/or document Patient 3's progress on long-term pain management therapy and whether that therapy was helping Patient 3 reach appropriate treatment objectives;

j. By failing to evaluate and/or document whether an MME of greater than 90 per day over the long-term was appropriate in the treatment of Patient 3's musculoskeletal pain and failed back surgery syndrome.

k. By failing to adequately develop and/or document a treatment plan with goals and objectives for the prescription of controlled substances to Patient 4;

l. By failing to properly assess and/or document Patient 4's progress on long-term pain management therapy with Ritalin and carisoprodol and whether that therapy was helping Patient 4 reach appropriate treatment objectives;

m. By failing to provide and/or document compliance monitoring during Patient 5's long-term pain management treatment including the use of CURES, pharmacy records, and pill counts;

n. By failing to provide and/or document compliance monitoring during Patient 6's long-term pain management treatment including the use of CURES, pharmacy records, and pill counts; and,

o. By failing to evaluate and/or document Patient 6's progress toward appropriate goals such as activity level, adverse effects, or aberrant behaviors.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

89. Respondent's license is subject to disciplinary action under section 2266 of the Code in that she kept inadequate and inaccurate medical records during her care and treatment of Patients 1, 2, 3, 4, 5, and 6. The circumstances are as follows:

90. Complainant realleges paragraphs 29 through 88, and those paragraphs are incorporated by reference as if fully set forth herein.

///

///

DISCIPLINARY CONSIDERATIONS

91. To determine the degree of discipline, if any, to be imposed on Respondent, Dana Suzanne Ware, M.D., Complainant alleges that on or about November 30, 2009, in a prior disciplinary action titled *In the Matter of the Accusation Against Dana Suzanne Ware, M.D. before the Medical Board of California*, in Case Number 02-2008-194744, Respondent's license was revoked, with the revocation stayed and placed on five years' probation with terms and conditions for fraudulently issuing prescriptions for controlled substances, including Norco and Vicodin, in the names of her family members that she then consumed for personal use. That Decision and Order is now final and is incorporated by reference 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 Number G 55407, issued to Dana Suzanne Ware, M.D.;

2. Revoking, suspending or denying approval of Dana Suzanne Ware, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Dana Suzanne Ware, M.D., to pay the Medical Board of California the reasonable costs of the investigation and enforcement of this case pursuant to Bus. & Prof. Code 125.3[17], and, 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: JAN 26 2022

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

SA2021302165/35845619.docx

[17] Costs of the investigation and enforcement of this case after January 1, 2022.