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

In the Matter of the First Amended Accusation Against: **Jeannie Kim, M.D.** **Physician's and Surgeon's Certificate No. A 72965** **Respondent.**	**Case No.: 800-2017-034649**

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

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

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
ROSEMARY F. LUZON
Deputy Attorney General
State Bar No. 221544
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9074
Facsimile: (619) 645-2061

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: **JEANNIE KIM, M.D.** **7922 Palm Street** **Lemon Grove, CA 91945-2956** **Physician's and Surgeon's Certificate No. A 72965,** Respondent.	Case No. 800-2017-034649 OAH No. 2020090997 **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 Rosemary F. Luzon, Deputy Attorney General.

///

///

2. Respondent Jeannie Kim, M.D. (Respondent) is represented in this proceeding by attorney Derek F. O'Reilly-Jones, Esq., whose address is: BONNE, BRIDGES, MUELLER, O'KEEFE & NICHOLS, 355 South Grand Ave., Suite 1750, Los Angeles, CA 90071-1562.

3. On or about August 31, 2000, the Board issued Physician's and Surgeon's Certificate No. A 72965 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2017-034649, and will expire on April 30, 2024, unless renewed.

JURISDICTION

4. On or about February 3, 2022, First Amended Accusation No. 800-2017-034649 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 or about February 3, 2022, at her address of record. Respondent timely filed her Notice of Defense contesting the First Amended Accusation.

5. A true and correct copy of First Amended Accusation No. 800-2017-034649 is attached as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2017-034649. 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, having been fully advised of same by her attorney, Derek F. O'Reilly-Jones, Esq.

///

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

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations in First Amended Accusation No. 800-2017-034649, and Respondent hereby gives up her rights to contest those charges. Respondent further agrees that she has thereby subjected her Physician's and Surgeon's Certificate No. A 72965 to disciplinary action.

10. 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 First Amended Accusation No. 800-2017-034649 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.

11. Respondent agrees that her Physician's and Surgeon's Certificate No. A 72965 is subject to discipline and she agrees to be bound by the Board's imposition of discipline 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. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

14. The parties 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. A 72965 issued to Respondent Jeannie Kim, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years from the effective date of the Decision on the following terms and conditions:

1. CONTROLLED SUBSTANCES - TOTAL RESTRICTION. Until Respondent has successfully completed the clinical competence assessment program required by this Decision, Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act, except that Respondent may possess medications lawfully prescribed to her by another practitioner for a bona fide illness or condition.

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

If Respondent forms the medical opinion, after an appropriate prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana

for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

2. CONTROLLED SUBSTANCES - SURRENDER OF DEA PERMIT. If Respondent fails the clinical competence assessment program required by this Decision, Respondent shall be prohibited from practicing medicine until Respondent provides documentary proof to the Board or its designee that Respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, Respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

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

///

4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the 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. 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 nine (9) 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.

6. 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 nine (9) 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.

///

///

///

///

7. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision, First Amended Accusation, and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine

until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

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

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

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to

cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. 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.

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

///

nursing facility setting, assisted living facility setting, and independent living facility setting and may treat patients who are discharged home from these facilities to ensure continuity of care.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

10. PROHIBITED PRACTICE. During probation, Respondent is prohibited from providing treatment to Respondent's family members or employees, including medical assistants, except that Respondent may provide treatment to her elderly father in emergency situations only, however, Respondent may not prescribe controlled substances to him under any circumstances. After the effective date of this Decision, all patients being treated by the Respondent shall be notified of the foregoing prohibition. 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.

11. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and 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.

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

13. 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.

14. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement in the amount of $8,000.00 (eight thousand dollars and zero cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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

The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs.

15. 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.

16. 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 or the patient has been discharged home from these facilities under Respondent's continuing care.

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.

///

///

17. 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.

18. 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' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

///

///

///

///

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

19. 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.

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

21. 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 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.

22. 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.

23. 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 First Amended Accusation No. 800-2017-034649 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, Derek F. O'Reilly-Jones, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 72965. 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: 6/7/22

JEANNIE KIM, M.D.
Respondent

I have read and fully discussed with Respondent Jeannie Kim, 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: 6/7/2022

DEREK F. O'REILLY-JONES, ESQ.
Attorney for Respondent

///

///

///

///

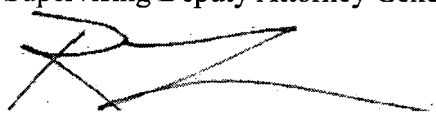
ENDORSEMENT

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

DATED: June 8, 2022

Respectfully submitted,

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



ROSEMARY F. LUZON
Deputy Attorney General
Attorneys for Complainant

SD2020800074
83438927.docx

Exhibit A

First Amended Accusation No. 800-2017-034649

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
ROSEMARY F. LUZON
Deputy Attorney General
State Bar No. 221544
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9074
Facsimile: (619) 645-2061

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: **JEANNIE KIM, M.D.** **7922 Palm Street** **Lemon Grove, CA 91945-2956** **Physician's and Surgeon's Certificate No. A 72965,** Respondent.	Case No. 800-2017-034649 **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 August 31, 2000, the Board issued Physician's and Surgeon's Certificate No. A 72965 to Jeannie Kim, 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 April 30, 2022, unless renewed.

///

JURISDICTION

3. 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.

4. Section 2220 of the Code states:

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

5. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> . . .

6. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

. . .

7. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon . . .

. . .

8. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

9. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

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

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

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

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

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

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

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

10. Health and Safety Code section 11152 states:

No person shall write, issue, fill, compound, or dispense a prescription that does not conform to this division.

11. Health and Safety Code section 11153 states:

(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

. . .

12. Health and Safety Code section 11154 states:

(a) Except in the regular practice of his or her profession, no person shall knowingly prescribe, administer, dispense, or furnish a controlled substance to or for any person or animal which is not under his or her treatment for a pathology or condition other than addiction to a controlled substance, except as provided in this division.

. . .

///

///

///

13. Section 2266 of the Code states:

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

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

COST RECOVERY

15. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to 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, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

16. Section 125.3 of the Code states:

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

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

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent has subjected her Physician's and Surgeon's Certificate No. A 72965 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that she committed gross negligence in her care and treatment of Patients A, B, C, and D, and Individual 1, a non-patient, as more particularly alleged hereinafter:[1]

Patient A

18. Between on or about November 5, 2015, and March 28, 2018, Respondent treated Patient A for his primary care needs at multiple independent living and skilled nursing facilities.

19. On or about November 5, 2015, Respondent saw Patient A for the first time. According to the progress note for this visit, Patient A had multiple medical issues, including

[1] References to "Patient A," "Patient B," "Patient C," and "Patient D" herein are used to protect patient privacy. References to "Individual 1" are used to protect the privacy of the non-patient.

coronary artery disease, chronic obstructive pulmonary disease, acute pain, lower extremity edema, chronic heart failure, hypothyroidism, tobacco dependence, malnutrition, degenerative joint disease, osteoarthritis, and a history of gastrointestinal bleeding. Clonazepam[2] and fentanyl[3] were among the medications listed on the progress note. Patient A's history of pain and fentanyl use, including his prior dosage of fentanyl, were not documented. During this visit, Respondent referred Patient A to a pain specialist.

20. On or about November 20, 2015, Respondent saw Patient A. No history of present illness was documented. During this visit, Respondent prescribed alprazolam[4] and Tylenol-Codeine #4[5] to Patient A. Respondent did not document the alprazolam prescription in the progress note for this visit or her rationale for prescribing alprazolam and Tylenol-Codeine #4. Respondent also prescribed carisoprodol[6] to Patient A for "muscle spasms," but she did not include any details about this condition, including the location of the spasms. Respondent noted that Patient A had anxiety, but no details about this condition were documented.

21. On or about November 30, 2015, Patient A received a prescription for Tylenol-Codeine #4, which Respondent prescribed. There was no corresponding progress note for this prescription.

22. On or about December 9, 2015, Respondent saw Patient A again. Respondent prescribed Tylenol-Codeine #4 to Patient A, but did not document the amount prescribed, the

---

[2] Clonazepam 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.

[3] Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

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

[5] Tylenol-Codeine #4 (acetaminophen and codeine) is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[6] Carisoprodol (Soma) is a Schedule IV controlled substance pursuant to 21 Code of Federal Regulations, part 1308.14, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

rationale for the frequent prescriptions, or any consideration of equianalgesia calculations. Testosterone[7] was included on the medication list, however, the history and rationale for prescribing this medication were not documented. Clonazepam was also included on the medication list, but alprazolam was not.

23. On or about January 11, 2016, Respondent saw Patient A. Respondent prescribed oxycodone[8] and fentanyl to Patient A, however, no rationale for prescribing either medication was provided in the progress note for this visit. Respondent did not document the amount or dosage of fentanyl prescribed or any consideration of equianalgesia calculations for both medications. Prescriptions for zolpidem,[9] clonazepam, and testosterone were not documented. The rationale for prescribing these medications was also not documented. During this visit, Respondent referred Patient A to a pain specialist once again, but did not document the status of the prior referral, including the outcome.

24. On or about February 1, 2016, February 18, 2016, and February 29, 2016, respectively, Respondent saw Patient A. During this timeframe, Respondent prescribed clonazepam, oxycodone, zolpidem, and testosterone to Patient A, however, the rationale for prescribing these medications was not evident. Moreover, efforts to wean Patient A from clonazepam and oxycodone were not undertaken or documented. Respondent referred Patient A to a pain specialist on each of these visits, but did not document the status of the prior referrals, including the outcome.

25. On or about July 27, 2016, Respondent saw Patient A. According to the progress note for this visit, the medication list included clonazepam (Klonopin), oxycodone, and zolpidem.

///

---

[7] Testosterone is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022.

[8] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Zolpidem tartrate (Ambien) 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. According to the Controlled Substance Utilization Review and Evaluation System (CURES) report for Patient A, between in or about November 2015, and July 2016, Patient A received the following prescriptions, which Respondent prescribed:

Date Filled	Drug Name	Form	Strength	Quantity	Days Supplied
11-20-2015	Carisoprodol	TAB	350 mg	60	30
11-20-2015	Acetaminaphen-Codeine Phosphate	TAB	300 mg-60 mg	60	5
11-20-2015	Alprazolam	TAB	1 mg	60	20
11-30-2015	Acetaminaphen-Codeine Phosphate	TAB	300 mg-60 mg	60	10
12-9-2015	Acetaminaphen-Codeine Phosphate	TAB	300 mg-60 mg	60	5
1-12-2016	Oxycodone HCL	TAB	30 mg	90	30
1-15-2016	Fentanyl	TDM	100 mcg/ 1 hr	24	72
1-18-2016	Zolpidem Tartrate	TAB	10 mg	30	30
1-18-2016	Clonazepam	TAB	1 mg	90	30
1-26-2016	Testosterone Cypionate	Oil	200 mg/ 1 ml	1	28
2-1-2016	Clonazepam	TAB	2 mg	60	30
2-3-2016	Oxycodone HCL	TAB	30 mg	74	25
2-19-2016	Clonazepam	TAB	2 mg	60	30
2-19-2016	Testosterone Cypionate	Oil	200 mg/ 1 ml	1	28
2-19-2016	Oxycodone HCL	TAB	30 mg	100	34
2-19-2016	Zolpidem Tartrate	TAB	10 mg	30	30
3-1-2016	Oxycodone HCL	TAB	30 mg	90	30
3-12-2016	Testosterone Cypionate	Oil	200 mg/ 1 ml	1	28
3-14-2016	Clonazepam	TAB	2 mg	60	30
3-14-2016	Zolpidem Tartrate	TAB	10 mg	30	30
4-3-2016	Testosterone Cypionate	Oil	200 mg/ 1 ml	1	28
5-20-2016	Zolpidem Tartrate	TAB	5 mg	30	30
5-20-2016	Clonazepam	TAB	1 mg	90	30
5-29-2016	Oxycodone HCL	TAB	30 mg	74	25
7-27-2016	Zolpidem Tartrate	TAB	5 mg	10	10

Date Filled	Drug Name	Form	Strength	Quantity	Days Supplied
7-27-2016	Alprazolam	TAB	2 mg	28	14
7-27-2016	Oxycodone HCL	TAB	30 mg	12	3
7-27-2016	Fentanyl	TDM	100 mcg/ 1 hr	1	3
7-27-2016	Clonazepam	TAB	1 mg	50	30

27. Prior to November 2015, Patient A received prescriptions for oxycodone, fentanyl, clonazepam, and testosterone from multiple prescribers. During the November 2015, and July 2016, timeframe, Patient A also received prescriptions for oxycodone, fentanyl, clonazepam, zolpidem, and testosterone from prescribers other than Respondent.

28. Between in or about August 2016, and May 2017, Patient A received prescriptions for oxycodone, fentanyl, alprazolam, and lorazepam,[10] which Respondent prescribed. During this timeframe, Patient A filled prescriptions for oxycodone, fentanyl, alprazolam, and hydrocodone[11] from prescribers other than Respondent.

29. Between on or about May 26, 2017, and June 21, 2017, Respondent saw Patient A while he was at a skilled nursing facility. According Patient A's chart from the skilled nursing facility, Patient A had a history of alcohol dependence and abuse of cocaine and heroin.

30. Between on or about May 23, 2017, and July 3, 2017, Patient A received prescriptions for oxycodone, lorazepam, temazepam,[12] and testosterone, which Respondent prescribed.

///

///

///

---

[10] Lorazepam 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.

[11] Hydrocodone (Norco) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[12] Temazepam 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.

31. In or about August 2017, and September 2017, Respondent saw Patient A while he was at a post-acute skilled nursing facility. Respondent continued to see Patient A in 2018, including on or about February 28, 2018, March 7, 2018, March 14, 2018, March 21, 2018, and March 28, 2018, respectively.

32. Between in or about September 2017, and March 2018, Patient A received prescriptions for oxycodone and lorazepam, which Respondent prescribed.

33. Respondent's last visit with Patient A took place in or about March or April 2018.

34. Between on or about November 5, 2015, and March 28, 2018, Respondent did not have any safeguards in place, such as a pain contract, drug screenings, and CURES checks, to ensure therapeutic prescribing of opioid medications to Patient A.

35. Between on or about November 5, 2015, and March 28, 2018, Respondent did not document the rationale or justification for prescribing large amounts of opioids to Patient A or prescribing multiple opioids concurrently to Patient A, nor did Respondent document that she considered and calculated morphine equivalence when prescribing these medications to Patient A.

36. Between on or about November 5, 2015, and March 28, 2018, Respondent simultaneously prescribed opioids, benzodiazepines, and sleep medications to Patient A. In doing so, Respondent did not document that she considered and calculated morphine equivalence or that she warned Patient A of the sedating nature and risks of these medications when used in combination.

37. Between on or about November 5, 2015, and March 28, 2018, Respondent prescribed multiple benzodiazepines to Patient A in a haphazard pattern and concurrently.

38. Between on or about November 5, 2015, and March 28, 2018, Respondent's handwritten progress notes were nearly illegible. Moreover, the progress notes lacked documentation regarding important aspects of Patient A's medical care and treatment, including Patient A's past treatment responses and referral outcomes; Patient A's history of present illness; and the medical rationale for diagnoses listed, frequency of visits, and medications prescribed and any changes thereto. In addition, for certain medications that Respondent prescribed to Patient A, the progress notes either lacked documentation of the medications altogether or lacked

documentation of the amounts of the medications prescribed. Respondent's progress notes also did not document that Respondent searched CURES or consulted any other sources to determine Patient A's controlled substances use and history.

39. Respondent committed gross negligence in her care and treatment of Patient A, which included, but was not limited to, the following:

A. Respondent improperly prescribed opioids to Patient A by failing to have safeguards in place to ensure therapeutic prescribing of opioid medications to Patient A; failing to document the rationale or justification for prescribing large amounts of opioids to Patient A; failing to document the rationale or justification for prescribing multiple opioids concurrently to Patient A; and failing to consider and document morphine equivalence when prescribing these medications to Patient A.

B. Respondent improperly prescribed sedating medications to Patient A by prescribing opioids, benzodiazepines, and sleep medications to Patient A simultaneously; failing to consider and document morphine equivalence when prescribing these medications to Patient A; and failing to warn and document that she warned Patient A of the sedating nature and risks of these medications when used in combination.

C. Respondent improperly prescribed benzodiazepines to Patient A by prescribing multiple benzodiazepines to Patient A in a haphazard pattern and concurrently.

D. Respondent failed to maintain adequate and accurate records regarding her care and treatment of Patient A.

Patient B

40. Between on or about June 10, 2015, and January 24, 2018, Respondent treated Patient B for his primary care needs at multiple independent living and skilled nursing facilities.

41. On or about June 10, 2015, Respondent saw Patient B. She previously saw Patient B on April 28, 2015, May 2, 2015, and June 4, 2015, respectively, while he was at a skilled nursing facility.

42. Beginning on or about April 28, 2015, Patient B received prescriptions of oxycodone, morphine sulfate,[13] and zaleplon,[14] which Respondent prescribed.

43. For the June 10, 2015, visit, oxycodone and morphine sulfate were among the medications listed on the progress note. According to Respondent, Patient B was seeing a pain doctor for his oxycodone and morphine sulfate at that time, however, no details regarding Patient B's pain care and treatment were documented. Respondent noted that Patient B's medical conditions included arm contusion fracture, facial bump, extreme agitation and labile state, high blood pressure, nephropathy, chronic obstructive pulmonary disease with exacerbation, weakness, ataxia, malnutrition, right arm fracture, non-compliance history, fatigue, chronic right arm tendonitis, open reduction internal fixation surgery of the right shoulder, psychiatric issues, folliculitis and rash of the hip, insomnia, acute chronic pain, and a history of past alcohol use. Respondent started Patient B on tramadol[15] for pain, which he received on or about July 1, 2015.

44. Between on or about June 10, 2015, and September 11, 2015, Patient B received prescriptions for Tylenol-Codeine #3,[16] Tylenol-Codeine #4, zaleplon, alprazolam, and tramadol, which Respondent prescribed. The rationale for prescribing these medications was not documented in the progress notes. The prescriptions for Tylenol-Codeine #3, Tylenol-Codeine #4, and tramadol were also not documented.

45. On or about September 21, 2015, September 25, 2015, December 28, 2015, and January 20, 2016, respectively, Respondent saw Patient B. Tylenol-Codeine #4, alprazolam, and tramadol were among the medications listed on the progress notes for these visits. Patient B

---

[13] Morphine sulfate is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[14] Zaleplon (Sonata) is a Schedule IV controlled substances pursuant to Health and Safety Code section 11057, subdivision (d), and dangerous drugs pursuant to Business and Professions Code section 4022.

[15] Tramadol 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.

[16] Tylenol-Codeine #3 (acetaminophen and codeine) is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

received prescriptions for these medications between on or about September 24, 2015, and January 30, 2016, which Respondent prescribed. Neither the rationale for prescribing these medications nor their dosages were documented in Respondent's progress notes.

46. On or about February 3, 2016, February 9, 2016, and February 15, 2016, respectively, Respondent saw Patient B at a skilled nursing facility following his hospitalization for exacerbation of bilateral knee, ankle, and back pain on or about January 27, 2016. According to the facility's hospitalization records, Patient B was noted to be a chronic alcoholic and that he quit drinking alcohol a week before being hospitalized. According to the facility's psychiatric intake records, Patient B was also noted to be a current alcoholic. Neither Patient B's hospitalization nor his alcoholism were addressed in Respondent's progress notes.

47. On or about February 1, 2016, February 7, 2016, February 10, 2016, and February 18, 2016, respectively, Patient B received prescriptions for oxycodone, which Respondent prescribed. These prescriptions were not documented in Respondent's progress notes. The rationale for prescribing oxycodone, including the adjustment from Tylenol-Codeine #4 to oxycodone, were also not documented. During this timeframe, Patient B also received prescriptions for alprazolam, which Respondent prescribed.

48. On or about March 15, 2016, Respondent saw Patient B. Respondent discontinued oxycodone and started Patient B on Norco at 5 mg, which he received on or about March 16, 2016.

49. On or about March 22, 2016, Respondent saw Patient B again. According to the progress note for this visit, alprazolam was included on the medication list, but Norco was not. On or about March 22, 2016, Patient B received prescriptions for Norco at 10 mg, which Respondent prescribed. The rationale for increasing the dosage of Norco was not documented, and the master medication list contained in Patient B's chart did not reflect the correct date for the dosage adjustment to 10 mg.

50. On or about June 3, 2016, Respondent saw Patient B. According to the progress note for this visit, Respondent increased Patient B's dosage of alprazolam from 1 mg to 2mg. The rationale for increasing the dosage of alprazolam was unclear and not documented. Prior to this

increase, the dosage of alprazolam prescribed by Respondent to Patient B varied from 0.25 mg to 1 mg.

51. In or about September 2016, Respondent saw Patient B on four separate visits, including on or about September 8, 2016, September 15, 2016, September 22, 2016, and September 29, 2016. During the September 15, 2016 visit, Respondent referred Patient B to a pain specialist for gradual dose reduction of his pain medications.

52. On or about October 31, 2016, Respondent saw Patient B at a skilled nursing facility following his hospitalization for left facial numbness on or about October 19, 2016. According to the facility's hospitalization records, Patient B was noted to be opiate dependent with chronic pain syndrome. Neither Patient B's hospitalization nor his opiate dependency were addressed in Respondent's progress notes.

53. In or about December 2016, Respondent also saw Patient B on four separate visits, including on or about December 1, 2016, December 8, 2016, December 15, 2016, and December 23, 2016. During the December 23, 2016 visit, Respondent again referred Patient B to a pain specialist, however, the status and outcome of the prior referral were not documented.

54. Between in or about September 2016, and December 2016, Patient B continued to receive prescriptions for Norco, alprazolam, and Lyrica,[17] which Respondent prescribed. Neither the rationale for the frequency of visits nor the amounts and strengths of the prescriptions were documented in the corresponding progress notes during this timeframe.

55. In or about 2017, Respondent saw Patient B on approximately 24 separate visits. For the visits that took place on or about February 9, 2017, February 16, 2017, February 22, 2017, March 2, 2017, March 9, 2017, March 16, 2017, March 23, 2017, and September 1, 2017, respectively, there were two progress notes for each visit, which were located at different places in Patient B's chart. The medical need for the frequency of visits was not documented.

///

///

[17] Lyrica (pregabalin) is a Schedule V controlled substance pursuant to 21 Code of Federal Regulations, part 1308.15, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

56. On or about February 4, 2017, Patient B was hospitalized for acute benzodiazepine and alcohol poisoning. Neither Patient B's hospitalization nor his conditions were addressed in Respondent's progress notes.

57. Between in or about January 2017 and March 2017, Patient B received prescriptions for hydrocodone at varying dosages of 5 mg and 10 mg, which Respondent prescribed. During visits that took place on or about February 9, 2017, and March 3, 2017, Respondent noted the need for gradual dose reduction of Patient B's pain medications. However, on or about February 22, 2017, and March 10, 2017, Patient B received prescriptions for hydrocodone at 10 mg, which Respondent prescribed. The rationale for the adjusted dosages of hydrocodone were not documented in Respondent's progress notes.

58. On or about March 23, 2017, Respondent saw Patient B. Respondent noted that Patient B was seeing Dr. D.S., a pain specialist. On or about March 24, 2017, however, Patient B received a prescription for oxycodone at 10 mg, which Respondent prescribed. According to Respondent, she wrote the prescription because Patient B told her that Dr. D.S. gave his approval for her to write it, but she never discussed the prescription with Dr. D. S. or his care and management of Patient B. Respondent's progress note for this visit did not document that she wrote the oxycodone prescription, why she wrote it, or the rationale for switching Patient B from hydrocodone to oxycodone.

59. According to the CURES report for Patient B, between in or about April 2017, and December, 2017, Patient B received the following prescriptions, which Respondent prescribed:

///

///

///

///

///

///

///

///

Date Filled	Drug Name	Form	Strength	Quantity	Days Supplied
4-4-2017	Alprazolam	TAB	2 mg	90	30
4-4-2017	Lyrica	CAP	100 mg	60	30
4-6-2017	Hydrocodone Bitartrate-Acetaminophen	TAB	325 mg-10 mg	120	15
4-20-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	120	15
4-24-2017	Diazepam[18]	TAB	10 mg	30	10
4-24-2017	Alprazolam	TAB	0.25 mg	8	1
4-24-2017	Temazepam	CAP	15 mg	30	30
4-24-2017	Alprazolam	TAB	2 mg	30	10
4-24-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	120	20
4-25-2017	Acetaminophen- Hydrocodone Bitartrate	TAB	325 mg-10 mg	60	11
5-8-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	8	1
5-10-2017	Acetaminophen-Hydrocodone Bitartrate	TAB	325mg-10mg	4	1
5-11-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	26	1
5-12-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	90	5
5-14-2017	Alprazolam	TAB	2 mg	6	2
5-16-2017	Alprazolam	TAB	2 mg	9	3
5-16-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	32	2
5-19-2017	Alprazolam	TAB	2 mg	30	10
5-21-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	28	1
5-25-2017	Acetaminophen-Hydrocodone Bitartrate	TAB	325 mg-10 mg	8	2
5-26-2017	Acetaminophen-Hydrocodone Bitartrate	TAB	325 mg-10 mg	20	1
5-27-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	95	6

[18] Diazepam 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.

Date Filled	Drug Name	Form	Strength	Quantity	Days Supplied
5-28-2017	Acetaminophen-Hydrocodone Bitartrate	TAB	325 mg-10 mg	60	15
5-28-2017	Temazepam	CAP	15mg	30	30
6-2-2017	Oxycodone HCL-Acetaminophen	TAB	325mg-10mg	95	6
6-2-2017	Alprazolam	TAB	2 mg	30	10
6-11-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	95	6
6-11-2017	Acetaminophen-Hydrocodone Bitartrate	TAB	325 mg-10 mg	60	15
6-12-2017	Alprazolam	TAB	2 mg	30	10
6-13-2017	Alprazolam	TAB	2 mg	30	10
6-20-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	95	6
6-23-2017	Acetaminophen-Hydrocodone Bitartrate	TAB	325 mg-10 mg	60	15
6-28-2017	Temazepam	CAP	15 mg	30	30
6-29-2017	Oxycodone HCL-Acetaminophen	TAB	325 mg-10 mg	95	6
7-7-2017	Temazepam	CAP	15 mg	30	30
7-7-2017	Lyrica	CAP	100 mg	60	30
7-7-2017	Alprazolam	TAB	2 mg	120	30
8-2-2017	Alprazolam	TAB	2 mg	120	30
8-2-2017	Temazepam	CAP	15 mg	30	30
8-2-2017	Lyrica	CAP	100 mg	60	30
8-30-2017	Temazepam	CAP	15 mg	30	30
8-30-2017	Alprazolam	TAB	2 mg	120	30
8-30-2017	Lyrica	CAP	100 mg	60	30
9-27-2017	Temazepam	CAP	15 mg	30	30
9-27-2017	Lyrica	CAP	100 mg	60	30
10-24-2017	Lyrica	CAP	100 mg	60	30
10-24-2017	Alprazolam	TAB	2 mg	30	30
10-24-2017	Temazepam	CAP	15 mg	30	30
11-21-2017	Alprazolam	TAB	2 mg	30	30
11-21-2017	Lyrica	CAP	100 mg	60	30
11-21-2017	Temazepam	CAP	15 mg	30	30
12-19-2017	Alprazolam	TAB	2 mg	30	30

Date Filled	Drug Name	Form	Strength	Quantity	Days Supplied
12-19-2017	Lyrica	CAP	100 mg	60	30
12-19-2017	Temazepam	CAP	15 mg	30	30

60. During the April 2017, and December 2017, timeframe, Respondent saw Patient B on approximately 14 separate visits, including on or about April 6, 2017, April 13, 2017, April 20, 2017, July 21, 2017, July 28, 2017, August 4, 2017, August 11, 2017, August 18, 2017, August 28, 2017, September 1, 2017, September 8, 2017, September 15, 2017, December 16, 2017, and December 23, 2017. In addition, on or about May 26, 2018, June 1, 2017, and June 9, 2017, Respondent saw Patient B at a skilled nursing facility following his hospitalization for groin pain on or about April 21, 2017. According to the facility's hospitalization records, Patient B was noted to be dependent on oral pain narcotics. Neither Patient B's hospitalization nor his pain medication dependency were addressed in Respondent's progress notes.

61. On or about July 7, 2017, Patient B's daily dosage of alprazolam increased to 8 mg. The rationale for the increase in dosage was not documented in Respondent's progress notes.

62. On or about October 3, 2017, Patient B was hospitalized again for acute alcoholic encephalopathy and poisoning and acute benzodiazepine poisoning. Neither Patient B's hospitalization nor his conditions were addressed in Respondent's progress notes.

63. In or about October 2017, November 2017, and December 2017, Patient B received prescriptions for hydrocodone and alprazolam from a prescriber other than Respondent.

64. On or about January 24, 2018, Respondent had her last visit with Patient B. In or about January 2018, and February 2018, Patient B continued to receive prescriptions for oxycodone, alprazolam, temazepam, and Lyrica, which Respondent prescribed. During this timeframe, Patient B also continued to receive prescriptions for hydrocodone from a prescriber other than Respondent.

65. Between on or about June 10, 2015, and January 24, 2018, Respondent did not have any safeguards in place, such as a pain contract, drug screenings, and CURES checks, to ensure therapeutic prescribing of opioid medications to Patient B.

///

66. Between on or about June 10, 2015, and January 24, 2018, Respondent did not document the rationale or justification for prescribing large amounts of opioids to Patient B or prescribing multiple opioids concurrently to Patient B, nor did Respondent document that she considered and calculated morphine equivalence when prescribing these medications to Patient B.

67. Between on or about June 10, 2015, and January 24, 2018, Respondent simultaneously prescribed opioids, benzodiazepines, and Lyrica to Patient B. In doing so, Respondent did not document that she considered and calculated morphine equivalence or that she warned Patient B of the sedating nature and risks of these medications when used in combination.

68. Between on or about June 10, 2015, and January 24, 2018, Respondent did not ascertain, verify, or document Patient B's substance abuse history and his multiple relapses while under her care.

69. Between on or about June 10, 2015, and January 24, 2018, Respondent did not document the steps she took to verify Patient B was using his controlled medications therapeutically.

70. Between on or about June 10, 2015, and January 24, 2018, Respondent prescribed multiple benzodiazepines to Patient B concurrently.

71. Between on or about June 10, 2015, and January 24, 2018, Respondent's handwritten progress notes were nearly illegible. Moreover, the progress notes lacked documentation regarding important aspects of Patient B's medical care and treatment, including Patient B's past treatment responses, medical events, and referral outcomes; Patient B's history of present illness; and the medical rationale for diagnoses listed, frequency of visits, and medications prescribed and any changes thereto. In addition, for certain medications that Respondent prescribed to Patient B, the progress notes either lacked documentation of the medications altogether or lacked documentation of the amounts of the medications prescribed. Respondent's progress notes also did not document that Respondent searched CURES or consulted any other sources to determine Patient B's controlled substances use and history.

///

72. Respondent committed gross negligence in her care and treatment of Patient B, which included, but was not limited to, the following:

A. Respondent improperly prescribed opioids to Patient B by failing to have safeguards in place to ensure therapeutic prescribing of opioid medications to Patient B; failing to document the rationale or justification for prescribing large amounts of opioids to Patient B; failing to document the rationale or justification for prescribing multiple opioids concurrently to Patient B; and failing to consider and document morphine equivalence when prescribing these medications to Patient B.

B. Respondent improperly prescribed sedating medications to Patient B by prescribing opioids, benzodiazepines, and Lyrica to Patient B simultaneously; failing to consider and document morphine equivalence when prescribing these medications to Patient B; and failing to warn and document that she warned Patient B of the sedating nature and risks of these medications when used in combination.

C. Respondent prescribed controlled substances to Patient B despite Patient B's significant prior and ongoing substance abuse issues.

D. Respondent improperly prescribed benzodiazepines to Patient B by prescribing multiple benzodiazepines to Patient B concurrently.

E. Respondent failed to maintain adequate and accurate records regarding her care and treatment of Patient B.

Patient C

73. Between on or about March 6, 2015, and August 2016, Respondent treated Patient C for his primary care needs at multiple independent living and skilled nursing facilities.

74. On or about March 6, 2015, Respondent saw Patient C for the first time to establish care. Patient C's medical conditions included acute anxiety, chronic pain, severe osteoarthritis, questionable obstructive sleep apnea, muscle spasm, bipolar disorder, insomnia, depression, neuropathy, and back pain. Soma was among the medications listed on the progress note for this visit, but oxycodone and morphine were not.

///

75. On or about March 5, 2015, Patient C received prescriptions for oxycodone and morphine, which another provider prescribed. Patient C's prior use of these medications was not documented in Respondent's progress note for the March 6, 2015, visit.

76. On or about March 20, 2015, Respondent saw Patient C. Between on or about March 9, 2015, and March 18, 2015, Patient C continued to receive prescriptions for oxycodone, morphine, Soma, and zolpidem, which other providers prescribed. These prescriptions were not documented in Respondent's progress note for this visit.

77. On or about April 15, 2015, Patient C received a prescription for zolpidem and Soma, which Respondent prescribed. The rationale for prescribing these medications was not documented in Respondent's progress notes.

78. In or about late April 2015, Respondent saw Patient C while he was at a skilled nursing facility. According to the facility's records of Patient C's prior admission from in or about June 2014, Patient C had a history of polysubstance abuse.

79. Between in or about April 2015, and December 2015, timeframe, Patient C received multiple, recurring prescriptions for morphine, oxycodone, hydrocodone, Soma, and zolpidem, which Respondent prescribed:

Date Filled	Drug Name	Form	Strength	Quantity	Days Supplied
4-25-2015	Carisoprodol	TAB	350 mg	30	10
4-25-2015	Morphine Sulfate	TER	15 mg	14	7
4-25-2015	Zolpidem Tartrate	TAB	10 mg	30	30
4-25-2015	Oxycodone HCL	TAB	20 mg	30	7
4-26-2015	Morphine Sulfate	TAB	30 mg	14	7
4-26-2015	Oxycodone HCL	TAB	20 mg	30	5
5-1-2015	Morphine Sulfate	TAB	15 mg	60	10
5-3-2015	Oxycodone HCL	TAB	20 mg	30	5
5-5-2015	Morphine Sulfate	TAB	30 mg	60	30
5-9-2015	Carisoprodol	TAB	350 mg	6	2
5-14-2015	Carisoprodol	TAB	350 mg	6	2
5-14-2015	Oxycodone HCL	TAB	20 mg	30	5
5-15-2015	Carisoprodol	TAB	350 mg	60	20

Date Filled	Drug Name	Form	Strength	Quantity	Days Supplied
5-22-2015	Oxycodone HCL	TAB	20 mg	30	5
5-28-2015	Oxycodone HCL	TAB	20 mg	30	5
6-1-2015	Morphine Sulfate	TAB	15 mg	60	10
6-5-2015	Oxycodone HCL	TAB	20 mg	60	10
6-10-2015	Morphine Sulfate	TAB	15 mg	60	10
6-16-2015	Oxycodone HCL	TAB	20 mg	60	10
6-18-2015	Morphine Sulfate	TAB	15 mg	60	10
6-26-2015	Zolpidem Tartrate	TAB	10 mg	30	30
7-1-2015	Morphine Sulfate	TAB	15 mg	60	10
7-4-2015	Oxycodone HCL	TAB	20 mg	60	10
7-11-2015	Morphine Sulfate	TAB	15 mg	60	10
7-17-2015	Oxycodone HCL	TAB	20 mg	15	2
7-19-2015	Morphine Sulfate	TAB	15 mg	60	10
7-20-2015	Oxycodone HCL	TAB	20 mg	60	7
7-21-2015	Zolpidem Tartrate	TAB	10 mg	30	30
7-29-2015	Morphine Sulfate	TAB	15 mg	60	10
7-30-2015	Oxycodone HCL	TAB	20 mg	60	7
8-10-2015	Morphine Sulfate	TAB	15 mg	60	10
8-10-2015	Oxycodone HCL	TAB	20 mg	60	7
8-22-2015	Zolpidem Tartrate	TAB	10 mg	30	30
8-26-2015	Oxycodone HCL	TAB	20 mg	60	7
8-31-2015	Morphine Sulfate	TAB	15 mg	60	10
9-8-2015	Morphine Sulfate	TAB	15 mg	60	10
9-11-2015	Oxycodone HCL	TAB	20 mg	60	7
9-16-2015	Morphine Sulfate	TAB	15 mg	36	6
9-16-2015	Zolpidem Tartrate	TAB	10 mg	30	30
9-21-2015	Oxycodone HCL	TAB	20 mg	60	7
9-22-2015	Morphine Sulfate	TAB	15 mg	60	10
10-2-2015	Morphine Sulfate	TAB	15 mg	60	10
10-12-2015	Oxycodone HCL	TAB	5 mg	2	1
10-12-2015	Hydrocodone Bitartrate-Acetaminophen	TAB	325 mg-5 mg	30	7
10-12-2015	Morphine Sulfate	TER	15 mg	14	7
10-12-2015	Zolpidem Tartrate	TAB	10 mg	30	30
10-12-2015	Morphine Sulfate	TER	15 mg	14	7

Date Filled	Drug Name	Form	Strength	Quantity	Days Supplied
10-12-2015	Oxycodone HCL	TAB	20 mg	42	7
10-14-2015	Carisoprodol	TAB	350 mg	90	30
10-19-2015	Morphine Sulfate	TER	15 mg	4	2
10-19-2015	Morphine Sulfate	TER	30 mg	4	2
10-21-2015	Oxycodone HCL	TAB	20 mg	42	7
10-21-2015	Morphine Sulfate	TER	30 mg	60	30
10-22-2015	Morphine Sulfate	TER	15 mg	3	2
10-23-2015	Morphine Sulfate	TER	15 mg	1	1
10-24-2015	Morphine Sulfate	TER	15 mg	1	1
10-26-2015	Oxycodone HCL	TAB	20 mg	42	7
10-26-2015	Morphine Sulfate	TER	15 mg	30	15
10-28-2015	Hydrocodone Bitartrate-Acetaminophen	TAB	325 mg-5 mg	31	8
10-30-2015	Morphine Sulfate	TER	15 mg	30	15
11-3-2015	Hydrocodone Bitartrate-Acetaminophen	TAB	325 mg-5 mg	30	8
11-7-2015	Zolpidem Tartrate	TAB	10 mg	30	30
11-9-2015	Oxycodone HCL	TAB	20 mg	42	7
11-9-2015	Hydrocodone Bitartrate-Acetaminophen	TAB	325 mg-5 mg	30	8
11-11-2015	Carisoprodol	TAB	350 mg	90	30
11-15-2015	Morphine Sulfate	TER	30 mg	30	15
11-16-2015	Oxycodone HCL	TAB	20 mg	42	7
11-16-2015	Morphine Sulfate	TER	15 mg	30	15
11-21-2015	Hydrocodone Bitartrate-Acetaminophen	TAB	325 mg-5 mg	30	8
11-24-2015	Oxycodone HCL	TAB	20 mg	42	7
11-26-2015	Zolpidem Tartrate	TAB	5 mg	2	1
12-1-2015	Zolpidem Tartrate	TAB	10 mg	30	30
12-2-2015	Zolpidem Tartrate	TAB	5 mg	2	1
12-4-2015	Morphine Sulfate	TER	30 mg	4	2
12-4-2015	Oxycodone HCL	TAB	20 mg	42	7
12-5-2015	Morphine Sulfate	TER	30 mg	14	7
12-5-2015	Morphine Sulfate	TER	15 mg	30	15
12-10-2015	Oxycodone HCL	TAB	20 mg	42	7

Date Filled	Drug Name	Form	Strength	Quantity	Days Supplied
12-10-2015	Hydrocodone Bitartrate-Acetaminophen	TAB	325 mg-5 mg	60	8

80. During this timeframe, Patient C received Soma from another provider on or about May 22, 2015, June 18, 2015, July 12, 2015, August 4, 2015, August 23, 2015, and September 12, 2015. Patient C also received clonazepam from another provider on or about November 25, 2015, November 26, 2015, and December 1, 2015, and December 2, 2015.

81. On or about December 11, 2015, Respondent saw Patient C. Anxiety was noted on the progress note for this visit. Respondent started Patient C on clonazepam, which Patient C received on or about the same day. The rationale for prescribing this medication was not documented. Safer alternatives for treating Patient C's anxiety were not considered or documented. On or about December 11, 2015, Patient C also received a prescription for zolpidem, which Respondent prescribed.

82. On or about January 5, 2016, February 18, 2016, February 22, 2016, March 2, 2016, March 10, 2016, March 21, 2016, April 5, 2016, and April 15, 2016, Respondent saw Patient C. The progress note for the February 18, 2016, visit, included the following notation: "Pain management control gradually [d]ecrease[.]" During the January 2016, and April 2016, timeframe, Patient C continued to receive multiple, recurring prescriptions for oxycodone, morphine, and hydrocodone, which Respondent prescribed. On or about January 6, 2016, February 1, 2016, March 2, 2016, and April 19, 2016, Patient C also received prescriptions for clonazepam, which Respondent prescribed. On or about January 6, 2016, and February 6, 2016, Patient C received prescriptions for zolpidem, which Respondent prescribed. The rationale for prescribing these medications was not documented in Respondent's progress notes. With the exception of the January 5, 2016 progress note, the amounts and strengths of these medications were not documented in Respondent's progress notes. On or about April 15, 2016, Respondent referred Patient C to a pain specialist.

///

///

83. From in or about May 2016, to August 2016, Patient C continued to receive multiple prescriptions for oxycodone, morphine, clonazepam, lorazepam, and zaleplon, which Respondent prescribed.

84. Between on or about March 6, 2015, and August 2016, Respondent did not have any safeguards in place, such as a pain contract, drug screenings, and CURES checks, to ensure therapeutic prescribing of opioid medications to Patient C.

85. Between on or about March 6, 2015, and August 2016, Respondent did not document the rationale or justification for prescribing large amounts of opioids to Patient C or prescribing multiple opioids concurrently to Patient C, nor did Respondent document that she considered and calculated morphine equivalence when prescribing these medications to Patient C.

86. Between on or about March 6, 2015, and August 2016, Respondent simultaneously prescribed opioids, benzodiazepines, sleep medications, and muscle relaxants to Patient C. In doing so, Respondent did not document that she considered and calculated morphine equivalence or that she warned Patient C of the sedating nature and risks of these medications when used in combination.

87. Between on or about March 6, 2015, and August 2016, Respondent prescribed benzodiazepines and sleep medications to Patient C concurrently.

88. Between on or about March 6, 2015, and August 2016, Respondent's handwritten progress notes were nearly illegible. Moreover, the progress notes lacked documentation regarding important aspects of Patient C's medical care and treatment, including Patient C's past treatment responses, referral outcomes, and medical events; Patient C's history of present illness; and the medical rationale for diagnoses listed, frequency of visits, and medications prescribed and any changes thereto. In addition, for certain medications that Respondent prescribed to Patient C, the progress notes either lacked documentation of the medications altogether or lacked documentation of the amounts of the medications prescribed. Respondent's progress notes also did not document that Respondent searched CURES or consulted any other sources to determine Patient C's controlled substances use and history.

///

89. Respondent committed gross negligence in her care and treatment of Patient C, which included, but was not limited to, the following:

A. Respondent improperly prescribed opioids to Patient C by failing to have safeguards in place to ensure therapeutic prescribing of opioid medications to Patient C; failing to document the rationale or justification for prescribing large amounts of opioids to Patient C; failing to document the rationale or justification for prescribing multiple opioids concurrently to Patient C; and failing to consider and document morphine equivalence when prescribing these medications to Patient C.

B. Respondent improperly prescribed sedating medications to Patient C by prescribing opioids, benzodiazepines, sleep medications, and muscle relaxants to Patient C simultaneously; failing to consider and document morphine equivalence when prescribing these medications to Patient C; and failing to warn and document that she warned Patient C of the sedating nature and risks of these medications when used in combination.

C. Respondent improperly prescribed benzodiazepines to Patient C by prescribing benzodiazepines and sleep medications to Patient C concurrently.

D. Respondent failed to maintain adequate and accurate records regarding her care and treatment of Patient C.

Patient D

90. In or about 2016, Respondent had five visits with Patient D, Respondent's relative. According to Respondent, these visits took place at Respondent's home on or about March 1, 2016, March 15, 2016, April 14, 2016, May 20, 2016, and December 1, 2016, respectively.

91. Prior to these visits, Patient D received prescriptions for clonazepam, alprazolam, and zolpidem, which Respondent prescribed:

///

///

///

///

Date Filled	Drug Name	Form	Strength	Quantity	Days Supplied
5-23-2015	Zolpidem Tartrate	TAB	10 mg	60	60
6-23-2015	Clonazepam	TAB	0.5 mg	30	60
10-19-2015	Clonazepam	TAB	1 mg	60	60
11-28-2015	Clonazepam	TAB	1 mg	60	30
12-9-2015	Alprazolam	TAB	1 mg	90	30
1-14-2016	Alprazolam	TAB	1 mg	60	30

92. On or about April 24, 2015, and June 23, 2015, Patient D also received prescriptions for clonazepam, which another provider prescribed.

93. The prior prescriptions for clonazepam, alprazolam, and zolpidem, which Respondent prescribed to Patient D between in or about May 2015, and January 2016, lacked any corresponding clinical notes. In addition, none of the prior prescriptions were noted or discussed in any of Respondent's progress notes for the visits that took place with Patient D in or about 2016.

94. On or about March 1, 2016, Respondent saw Patient D. Respondent noted that she "started" Patient D on alprazolam at "0.25 mg" for anxiety. However, on or about March 5, 2016, Patient D received a prescription for alprazolam at 2 mg, which Respondent prescribed. No details regarding Patient D's anxiety were documented in the progress note for this visit.

95. On or about March 15, 2016, Respondent saw Patient D for complaints of a syncopal episode. Respondent did not document Patient D's response to alprazolam, including any assessment of whether the medication may have contributed to his syncope. The progress note for this visit continued to note Patient D's dosage of alprazolam as "0.25 mg."

96. On or about June 28, 2016, Patient D received another prescription for alprazolam at 2 mg, which Respondent prescribed. The progress notes for the April 14, 2016, and May 20, 2016, visits, however, continued to note Patient D's dosage of alprazolam as "0.25 mg."

97. On or about November 25, 2016, Patient D received a prescription for Tylenol-Codeine #3, which Respondent prescribed. The rationale for prescribing this medication was not documented in Respondent's progress notes. During her interview with the Board, Respondent stated that she did not recall the reason for this prescription.

98. On or about December 1, 2016, Respondent saw Patient D. Tylenol-Codeine #3 was not among the medications listed on the progress note for this visit.

99. Respondent committed gross negligence in her care and treatment of Patient D, which included, but was not limited to, the following:

A. Respondent improperly prescribed medications to Patient D, a family member, by prescribing large quantities of benzodiazepines and sleep medications to Patient D without formal encounters, medical indication, or corresponding clinical notes for the prescriptions; prescribing benzodiazepines to Patient D without properly documenting Patient D's prior treatment history, anxiety diagnosis, response to treatment, and the dosages prescribed; and prescribing Tylenol-Codeine #3 to Patient D without a formal encounter, medical indication, or documentation of the prescription.

Individual 1

100. Between in or about October 2016, and July 2017, Individual 1, Respondent's medical assistant, received prescriptions for tramadol, hydrocodone, codeine-guaifenesin, Tylenol-Codeine #3, Tylenol-Codeine #4, and alprazolam, which Respondent prescribed.

101. During her interview with the Board, Respondent stated that she only prescribed Tylenol-Codeine #3 to Individual 1 "maybe a couple of times" following surgery. Respondent did not mention any of the other controlled substances that she prescribed to Individual 1. Respondent did not prepare clinical notes corresponding to any of the prescriptions that she wrote for Individual 1.

102. Respondent committed gross negligence in her care and treatment of Individual 1, which included, but was not limited to, the following:

A. Respondent improperly prescribed medications to Individual 1, her medical assistant, by prescribing multiple controlled substances to Individual 1 without formal encounters, medical indication, or corresponding clinical notes for the prescriptions.

///

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

103. Respondent has subjected her Physician's and Surgeon's Certificate No. A 72965 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in her care and treatment of Patients A, B, C, and D, and Individual 1, a non-patient, as more particularly alleged hereinafter:

Patient A

104. Paragraphs 18 through 39, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

105. Between on or about November 5, 2015, and March 28, 2018, Respondent did not ascertain, verify, or document Patient A's substance abuse history.

106. Between on or about November 5, 2015, and March 28, 2018, Respondent did not document the steps she took to verify Patient A was using his controlled medications therapeutically.

107. Respondent committed further repeated negligent acts in her care and treatment of Patient A, which included, but were not limited to, the following:

A. Respondent prescribed controlled substances to Patient A despite Patient A's substance abuse history.

Patient B

108. Paragraphs 40 through 72, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

109. On or about February 16, 2018, Patient B received a prescription for alprazolam at 2 mg #30, which Respondent prescribed. Two days later, on or about February 18, 2018, Patient B received a second prescription for alprazolam at 1 mg #15, which Respondent also prescribed.

110. Respondent committed further repeated negligent acts in her care and treatment of Patient B, which included, but were not limited to, the following:

///

///

A. Respondent improperly prescribed benzodiazepines to Patient B by weaning Patient B abruptly from alprazolam and by failing to explain and document the rationale or justification for the adjustment.

Patient C

111. Paragraphs 73 through 89, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

112. Between on or about March 6, 2015, and August 2016, Respondent did not ascertain, verify, or document Patient C's substance abuse history.

113. Between on or about March 6, 2015, and August 2016, Respondent did not document the steps she took to verify Patient C was using his controlled medications therapeutically.

114. Respondent committed further repeated negligent acts in her care and treatment of Patient C, which included, but were not limited to, the following:

A. Respondent prescribed controlled substances to Patient C despite Patient C's substance abuse history.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing of Controlled Substances)

115. Respondent has subjected her Physician's and Surgeon's Certificate No. A 72965 to disciplinary action under sections 2227 and 2234, as defined by section 725, subdivision (a), of the Code, in that she committed repeated acts of clearly excessive prescribing of controlled substances to Patients A, B, C, and D, and Individual 1, as more particularly alleged in paragraphs 18 through 102, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

///

///

///

///

///

///

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without Prior Examination and Medical Indication)

116. Respondent has subjected her Physician's and Surgeon's Certificate No. A 72965 to disciplinary action under sections 2227 and 2234, as defined by section 2242, subdivision (a), of the Code, in that she prescribed, dispensed, or furnished dangerous drugs, as defined in section 4022, to Patient D and Individual 1 without an appropriate prior examination and a medical indication, as more particularly alleged in paragraphs 90 through 102, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Violation of State Laws Regulating Dangerous Drugs and/or Controlled Substances)

117. Respondent has subjected her Physician's and Surgeon's Certificate No. A 72965 to disciplinary action under sections 2227 and 2234, as defined by section 2238, of the Code, in that she has violated a state law or laws regulating dangerous drugs and/or controlled substances, as more particularly alleged hereinafter:

A. Paragraphs 90 through 102, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

B. Respondent issued prescriptions to Patient D and Individual 1 for controlled substances outside the usual course of her professional practice, in violation of Health and Safety Code sections 11152 and 11153.

C. Respondent issued prescriptions to Patient D and Individual 1 for controlled substances, even though Patient D and Individual 1 were not under her treatment for a pathology or condition, in violation of Health and Safety Code sections 11152 and 11154.

D. Respondent issued prescriptions to Patient D and Individual 1 for dangerous drugs without an appropriate prior examination and a medical indication, in violation of section 2242, subdivision (a), of the Code.

///

///

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

118. Respondent has subjected her Physician's and Surgeon's Certificate No. A 72965 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that she failed to maintain adequate and accurate records regarding her care and treatment of Patients A, B, C, and D, and Individual 1, as more particularly alleged in paragraphs 18 through 114, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Violating or Attempting to Violate Any Provision of the Medical Practice Act)

119. Respondent has subjected her Physician's and Surgeon's Certificate No. A 72965 to disciplinary action under sections 2227 and 2234, subdivision (a), of the Code, in that she has violated or attempted to violate, directly or indirectly, provisions or terms of the Medical Practice Act, as more particularly alleged in paragraphs 18 through 118, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

EIGHTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

120. Respondent has subjected her Physician's and Surgeon's Certificate No. A 72965 to disciplinary action under sections 2227 and 2234 of the Code, in that she has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 18 through 119, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

///

///

///

///

///

///

DISCIPLINARY CONSIDERATIONS

121. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that, on or about November 25, 2009, in a prior disciplinary action before the Medical Board of California, titled *In the Matter of the Accusation Against Jeannie Kim, M.D.*, Case No. 10-2005-170754, Respondent's license was subjected to an order requiring Respondent to complete an ethics course arising from Respondent's January 5, 2004, petty theft conviction. That decision 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 No. A 72965, issued to Respondent Jeannie Kim, M.D.;

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

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

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

DATED: FEB 0 3 2022

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

SD2020800074
83221043.docx