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

In the Matter of the Accusation Against: Jennifer Dela Rosa Reyes-Ng, M.D. Physician's and Surgeon's Certificate No. A 93486 Respondent.	Case No.: 800-2019-056361

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 March 16, 2023.

IT IS SO ORDERED: February 14, 2023.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JENNIFER DELA ROSA REYES-NG, M.D.** **1894 Meritt Drive** **Tracy, CA 95304** **Physician's and Surgeon's Certificate No. A 93486** Respondent.	Case No. 800-2019-056361 OAH No. 2022010312 **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 Megan R. O'Carroll, Deputy Attorney General.

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2. Respondent Jennifer Dela Rosa Reyes-Ng, M.D. (Respondent) is represented in this proceeding by attorney Michael F. Ball, whose address is: 7647 North Fresno Street Fresno, CA 93720-89122.1. On or about December 7, 2005, the Board issued Physician's and Surgeon's Certificate No. A 93486 to Jennifer Dela Rosa Reyes-Ng, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-056361, and will expire on December 31, 2023, unless renewed.

JURISDICTION

3. Accusation No. 800-2019-056361 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on September 22, 2021. Respondent timely filed her Notice of Defense contesting the Accusation.

4. A copy of Accusation No. 800-2019-056361 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-056361. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2019-056361, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

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

10. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2019-056361, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected her Physician's and Surgeon's Certificate, No. A 93486 to disciplinary action.

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

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

13. 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.

14. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in Accusation No. 800-2019-056361 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.

15. 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.

16. 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 93486 issued to Respondent Jennifer Dela Rosa Reyes-Ng, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

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

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

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

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

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

3. 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(s), Accusation(s), 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.

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

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the

Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

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

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

5. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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

7. 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.

8. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, from the applicable statutory date forward, in the amount of 7,658.75. 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.

9. 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.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. 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.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

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

Controlled Substances; and Biological Fluid Testing..

13. 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.

14. 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.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. 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.

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17. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2019-056361 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Michael F. Ball. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 7/20/22

JENNIFER DELA ROSA REYES-NG, M.D.
Respondent

I have read and fully discussed with Respondent Jennifer Dela Rosa Reyes-Ng, 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: 7/20/2022

MICHAEL F. BALL
Attorney for Respondent

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ENDORSEMENT

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

DATED: 7/20/22

Respectfully submitted,

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

Megan R. O'Carroll

MEGAN R. O'CARROLL
Deputy Attorney General
Attorneys for Complainant

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

In the Matter of the Accusation Against: **JENNIFER DELA ROSA REYES-NG, M.D.** **1894 Meritt Drive** **Tracy, CA 95304-5920** **Physician's and Surgeon's Certificate** **No. A 93486,** Respondent.	Case No. 800-2019-056361 **A C C U S A T I O N**

PARTIES

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

2. On or about December 7, 2005, the Medical Board issued Physician's and Surgeon's Certificate Number A 93486 to Jennifer Dela Rosa Reyes-Ng, 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 December 31, 2021, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
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> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 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.

7. 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.

8. Health and Safety Code section 11839.6, in pertinent part, provides:

> (a) The department shall establish a program for the operation and regulation of office-based narcotic treatment programs. An office-based narcotic treatment program established pursuant to this section shall meet either of the following conditions:
>
> (1) Hold a primary narcotic treatment program license.
>
> (2) Be affiliated and associated with a primary licensed narcotic treatment program. An office-based narcotic treatment program meeting the requirement of this paragraph shall not be required to have a license separate from the primary licensed narcotic treatment program with which it is affiliated and associated.
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> (b) For purposes of this section, "office-based narcotic treatment program" means a program in which interested and knowledgeable physicians and surgeons provide addiction treatment services, and in which community pharmacies or medication units supply necessary medication both to these physicians and surgeons for distribution to patients and through direct administration and specified dispensing services.
>
> (c) Notwithstanding any other law or regulation, including Section 10020 of Title 9 of the California Code of Regulations, an office-based narcotic treatment program in a remote site that is affiliated and associated with a licensed narcotic treatment program may be approved by the department, if all of the following conditions are met:
>
> (1) A physician may provide office-based addiction services only if each office-based patient is registered as a patient in the licensed narcotic treatment program and both the licensed narcotic treatment program and the office-based narcotic treatment program ensure that all services required under Chapter 4 (commencing with Section 10000) of Division 4 of Title 9 of the California Code of Regulations for the management of narcotic addiction are provided to all patients treated in the remote site.
>
> (2) A physician in an office-based narcotic treatment program may provide treatment for an appropriate number of patients under the appropriate United States Drug Enforcement Administration registration.
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> The primary licensed narcotic treatment program shall be limited to its total licensed capacity as established by the department, including the patients of physicians in the office-based narcotic treatment program.

(3) The physicians in the office-based narcotic treatment program shall dispense or administer pharmacologic treatments for narcotic addiction or a substance use disorder that have been approved by the federal Food and Drug Administration for the purpose of narcotic replacement therapy or medication-assisted treatment of substance use disorders.

(4) Office-based narcotic treatment programs, in conjunction with primary licensed narcotic treatment programs, shall develop protocols to prevent the diversion of medication. The department may develop regulations to prevent the diversion of medication.

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FACTUAL ALLEGATIONS

9. Respondent is Board-certified in family medicine. She is employed as a primary care physician by Kaiser Permanente. The four patients alleged below are long-term patients of Respondent who received controlled medications over the course of several years during their care with her.

Patient 1

10. Patient 1[1] was a 24-year-old man when he first began seeing Respondent for care in approximately 2011. In April of 2011, before Respondent became his primary care physician, Patient 1 presented to the Emergency Room (ER), seeking a refill of his Xanax prescription. He claimed that his Xanax bottle had been inadvertently put the washing machine and the medication was destroyed. The ER staff documented that Patient 1 appeared under the influence of drugs or alcohol during the visit, and that discussion with the pharmacy revealed that Patient 1 frequently sought early refills of his controlled medication and had been disruptive in the pharmacy. The ER physician prescribed Patient 1 a four-day course of Xanax and advised him to follow up with his primary care provider.

11. After the ER visit, Patient 1 sought an increase in pain medication from his primary care physician. In June of 2011, Patient 1's primary care physician noted that Patient 1 had not followed up with his orthopedic appointment for his injury, and was not compliant with his pain medications. He refused to increase Patient 1's opioid medication, and referred Patient 1 to psychiatry for his anxiety treatment.

[1] In this Accusation the patients are referred to by number to protect their privacy. The full names of the patients will be provided to Respondent and/or her attorney in discovery.

12. In July of 2011, after his previous primary care physician refused to escalate his opioid dose, Patient 1 switched to Respondent as his primary care physician. Respondent increased Patient 1's Opana dose, despite noting that he had failed to follow up with his orthopedic appointment for his chronic pain. Respondent advised Patient 1 to follow up with the orthopedic appointment. In August of 2011, Patient 1 emailed Respondent to request she refill his Xanax prescription. He claimed there was a death in the family and that his psychiatrist was out of town. Respondent agreed to refill his Xanax, but advised him he would need to follow up with psychiatry for future refills. Despite this statement, Respondent continued to prescribe Xanax to Patient 1 well into 2012.

13. Patient 1 was seen again in the ER on November 12, 2011, following a motor vehicle accident several hours earlier. He reported that he was driving his truck when it flipped over three or four times, causing him to lose consciousness. He was examined and released. His medical record for this encounter included a diagnosis of opioid dependence.

14. On November 19, 2011, Patient 1 was arrested for driving under the influence of drugs or alcohol. On or about December 26, 2011, Patient 1 presented to the ER again reporting nausea and vomiting. He stated that he had lost his controlled medications and requested refills of oxycodone, Opana, and Xanax. He was diagnosed with opioid dependence and advised to follow up with pain management.

15. On May 12, 2012, Patient 1 was seen in the Kaiser ER suffering from injuries from another vehicle crash. He was diagnosed with an injury to his head and knee. Physicians removed glass from his scalp. On July 3, 2012, Patient 1 underwent surgical debridement of his knee.

16. On multiple occasions during 2012, Patient 1's mother contacted Respondent by phone and in person to inform her that Patient 1 was abusing his medications and it was causing him to endanger himself and others. Respondent failed to document any of these contacts and continued to prescribe medications to Patient 1 until approximately August of 2012.
On July 30, 2012, Patient 1 was arrested for driving under the influence of drugs or alcohol. Hydrocodone and Xanax were seized by police. Respondent discharged Patient 1 from her

patient list in August of 2012. Although Respondent did not document the discharge or the reasons at the time of the events, she later noted that Patient 1 had forged her name on a prescription.[2]

17. In December of 2012, Patient 1 required surgery on his foot. During surgery the podiatrist noted that Patient 1 abuses his pain medications, but indicated that the medication was necessary for treatment and he would try to limit it as much as possible. Following surgery, Patient 1 followed up with various Kaiser physicians on an outpatient basis in both primary care and podiatry. The physicians all noted that Patient 1 suffered from opioid dependence and required a referral to the chemical dependency program and services to assist him in tapering down opioid medications.

18. After having been discharged from Respondent's patient list, Patient 1's new primary care physician refused to continue escalating his opioid and benzodiazepine doses. In February of 2013, his primary care physician noted that he had broken his pain contract with her and that she would not continue to prescribe medications. His new physician switched him to methadone and referred him to chronic pain management and the chemical dependency program. Patient 1 did not follow through with the chemical dependency program or pain management. Patient 1 attempted to see various other primary care physicians who agreed to prescribe short courses of opioids until he could obtain chemical dependency treatment, but Patient 1 was noncompliant and eventually left the Kaiser Permanente system in the middle of 2013. For the remainder of 2013 and 2014 Patient 1 received care outside of the Kaiser Permanente system.

19. In 2015 Patient 1 returned to Kaiser Permanente. On April 10, 2015, Respondent accepted Respondent back onto her panel of patients and became his primary care physician

[2] The information about Patient 1 is contained in an email exchange between Patient 1 and Respondent on May 24, 2013. In May of 2013 Patient 1 wrote an email to Respondent explaining that he did not "get along" with his new primary care physicians and he needed her to prescribe him Roxicodone and Xanax. Respondent replied that she was no longer willing to prescribe controlled medications to him because she lost trust in him due to the "last incident" when he forged her prescription. She explained that the pharmacy had reported the incident to her and that she was going to talk to "Member Services" to ensure that he could not be assigned to her patient list again.

again. She signed a pain contract with Patient 1. Respondent did not document any concerns about Patient's previous aberrant drug behaviors or the concerns she had with him in the past. Respondent regularly prescribed opioid pain medications and benzodiazepines to Patient 1 again from April 2015 through February of 2019. During these years, Respondent regularly prescribed the following medications to Patient 1, with only minor deviations from the medication regimen: oxycodone 30 mg, 1 tablet every 4 hours, (168 tablets every 28 days); Norco 10/325mg 1 tablet every 6 hours, (112 tablets every 28 days, ending January 10, 2018);, and Xanax, 2mg, twice per day, decreasing to 1 twice per day in 2018, (60 tablets every thirty days).

20. Respondent documented history and physical examinations of Patient 1's pain diagnoses during her prescribing to him, including chronic knee pain, ankle pain, and later a leg fracture. Respondent failed, however, to document an indication for the anxiety diagnosis, or any information about her prescribing of benzodiazepines to Patient 1. It was not until October 5, 2018 that Respondent first prescribed a selective serotonin reuptake inhibitor (SSRI), to Patient 1. Respondent failed to document why she was prescribing Patient 1 two short-acting opioid pain medications with a total pill count of approximately 10 pills per day instead of establishing him on a long-acting pain medication. On or about March 1, 2016, Respondent filled out a Department of Motor Vehicles Authorization form for Patient 1, indicating that he was medically cleared to receive a driver's license. She indicated that he was stable on oxycodone and hydrocodone. She did not indicate his medication misuse or any concerns with his judgement and attention. She did not disclose that he was also taking Xanax, or that he had sustained multiple previous motor vehicle accidents while under her care and treatment.

21. Respondent failed to perform adequate periodic reviews of Patient 1 and respond to the numerous red flags of medication misuse. Respondent's evaluation of Patient 1 was based largely on the Patient's own reports of his function status or statements, for example, that he denied side effects, or illicit drug use. Respondent performed urine toxicology screenings periodically. On January 1, 2018, Patient 1's urine toxicology report was negative for opioids. When questioned via email, Patient 1 claimed that he had been having flu symptoms and was

unable to keep down oral medications. Respondent accepted this statement at face value, and allowed him to fill a prescription for more hydrocodone that very day.

22. From 2015 through 2019, Respondent failed to act on red flags that presented in Patient 1's behavior or concerns that were raised by other Kaiser medical providers and in-patient records. Patient 1 frequently contacted Respondent asking for early refills of medication or escalating doses of medications. Respondent often accepted Patient 1's excuses or claims of being out of town or attending multiple funerals, and ignored other providers' comments of Patient 1's medication misuse. In April of 2017, Patient 1's podiatrist noted that he was untrustworthy and unreliable, and that he could not authorize any further surgeries for Patient 1 due to his lack of follow through and medication abuse issues. Respondent repeatedly warned Patient 1 that he needed to follow up with orthopedics and podiatry before she would continue prescribing opioids, but she did not hold to her word, and would prescribe the medications and provide early refills despite Patient 1's lack of compliance.

23. On November 18, 2017, Patient 1 was arrested for possession of heroin, being under the influence of a drug, and driving a vehicle without an ignition interlock device as required due to previous DUI convictions.

24. On April 6, 2018, Patient 1 was taken to Eden Hospital after driving his car into a tree at a high rate of speed. Patient 1 was driving erratically, split the car in two, and was thrown from it. He sustained a broken tibia. Patient 1 had just filled a prescription for Xanax from Respondent the day of the accident. Respondent's conduct and prescribing contributed to the harm Patient 1 sustained in the accident. During the accident, police seized Patient 1's Xanax and opioid prescriptions as evidence. Respondent was aware of the circumstances of this vehicle accident. Patient 1's Kaiser records made it clear that Patient 1 struck a tree at a high rate of speed while under the influence of prescription medications.

25. On April 10, 2018, Patient 1 saw Respondent for follow up of his injuries after being released from the hospital. He told Respondent that his Xanax and opioid medications had been lost in the accident. Respondent issued an early refill of Patient 1's Xanax and Oxycodone,

which he filled that same day. Respondent continued prescribing opioids and benzodiazepines to Respondent throughout 2018, even after the accident.

26. On or about January 10, 2018, Patient 1 was arrested for possession of cocaine and Xanax and being under the influence of a drug in public.

27. On or about January 22, 2019, Patient 1's mother filed a complaint with the Board complaining that physicians at Kaiser had been prescribing large amounts of controlled medications to her son, leading to his arrest and incarceration on drug charges.

On or about February 1, 2019, Respondent entered a note in Patient 1's medical record saying that she had been informed Patient 1 was in jail and she would not be able to prescribe any further controlled medications to him. She went on to indicate that he was no longer in jail, but was staying with a friend, that she still would not prescribe him any more controlled medications, and was referring him to a chemical dependency program. It is not clear whether Respondent issued any tapering advice or instructions or a period of medication to transition to another provider or another course of treatment.

Patient 2

28. Patient 2 saw Respondent as a primary care physician between at least 2012 through 2020. Patient 2 was a man in his sixties when he began treating with Respondent. Patient 2 had a history of heroin abuse and reported receiving addiction treatment from the Veteran's Administration Hospital (VA), in addition to receiving primary medical care from Respondent. Respondent was aware of Patient 2's heroin addiction history since at least 2013. Respondent's notes from February of 2013 indicate that Patient 2 had a diagnosis of "opioid dependence in remission," however, further on in the record Respondent documented that Patient 2 suffered from chronic pain and received methadone prescribed by the VA.

29. Beginning in at least Fall of 2012, Respondent prescribed Patient 2 with Norco and Xanax. On March 24, 2017, Patient 2 sent the following email to Respondent:

> Dr. Reyes I need some help. I am at dale rd pharm. they told me I could pick up my xanax and norco today. I just drove out here from denair for the second time today. The call center said they were ready and the clerk earlier today said I could pick up today. If you can release them today I will not ask for any more Norco, And we can start detox on the xanax again. The methadone clinic wants to inventory my

pills next week and if I am short they wont dose me, and cut my dose in half. I need to bring my pills in for them to count. I really am tired of all this and I wont ask for any more Norco. I also want to get off xanax. please help me..." [sic]

30. In May of 2017, Patient 2 told Respondent that he was receiving methadone treatment at a facility outside Kaiser. At an appointment on or about May 16, 2017, Patient 2 asked Respondent to take over his methadone treatment. Patient 2 reported that it was too difficult for him to attend the methadone clinic daily, and that it would be more convenient for him if Respondent took over his methadone treatment. There is a discrepancy in the record as to whether Patient 2 was receiving methadone as a treatment for heroin addiction or whether he was receiving it as pain management. Respondent did not clarify this discrepancy.

31. Respondent began prescribing methadone to Patient 2 on or about May 16, 2017, based on his request. Respondent is not a certified methadone clinic provider. Patient 2 reported to Respondent that he was receiving 97 mg of methadone per day. Beginning on May 16, 2017, Respondent ordered 90 mg of methadone per day for Patient 2. Respondent never called the methadone clinic to confirm that Patient 2 was a patient or what his dose was. Respondent began prescribing the methadone to Patient 2 before obtaining any urine toxicology screening to confirm he was on methadone. Patient 2's CURES[3] report did not show that he was being prescribed methadone prior to Respondent's prescription beginning in May of 2017.

32. Also at the May 16, 2017 appointment, Respondent documented that she directed Patient 2 to taper off his Xanax and stop taking the medication at the end of two weeks, and Patient 2 understood and agreed with this plan. Despite this statement, Respondent continued to prescribe Xanax to Patient 2 regularly over the next several years before eventually tapering his Xanax use.

33. Patient 2 signed documents indicating that he had been informed about the risks and benefits of his controlled medication and had been prescribe Narcan in case of accidental overdose. Despite this, the record indicates that Patient 2 was not informed of and did not

[3] CURES stands for "Controlled Substance Utilization Review and Evaluation System." It is an electronic databased containing records of controlled medication prescriptions. Physicians and pharmacists can access a patient's CURES records to determine what medications the patient has been receiving from different providers and pharmacies.

understand the distinction between use of methadone for chronic pain as opposed to treatment with methadone for addiction.

34. Despite Patient 2's history of opioid dependence, Respondent prescribed Norco to Patient 2 throughout her treatment of him. The reason for the Norco regimen was based primarily on Patient 2's subjective complaints of pain. Respondent regularly provided early refills of controlled medications despite having a pain contract in place that forbade this. Respondent stated in her interview with Board investigators that she referred Patient 2 to specialists in pain management and chemical dependency, but the record does not show that she initiated and followed through with these programs in a timely manner for Patient 2. Her failure to initiate and follow through with these specialists in a timely manner delayed Patient 2's path to sobriety and caused him harm. At her interview with Board investigators, Respondent reported that Patient 2 has since been referred to the chemical dependency program and is no longer taking methadone, Norco, or Xanax.

Patient 3

35. Patient 3 was a man in his early fifties when Respondent assumed primary care of him toward the end of 2010 and beginning of 2011. She continued to treat him through at least 2020. Patient 3 had a history of colon disease and lower back pain due to previous physical injuries.

36. During most of the time Respondent was Patient 3's primary care physician, she prescribed him oxycodone 20 mg tablets. Respondent's directions to Patient 3 were usually to take two tablets by mouth every six hours as needed for pain. Patient 3's CURES report shows that Respondent prescribed the medication approximately every month between October of 2012 and October of 2019, with an average daily pill count of 8 tablets per day. (Respondent generally ordered either 240 tablets for 30 days or 200 tablets for 25 days.)

37. In her history and physical examination, Respondent documented the pain condition requiring controlled medications, however, her observations were generally limited to Patient 3's subjective reports that his pain was controlled and that he was not experiencing side effects or taking illicit drugs. Although Respondent prescribed the medication to Patient 3 "as

needed," the refill pattern shows that Patient 3 refilled the medication as if he was taking the maximum dose of medication around the clock. Despite taking 8 tablets of oxycodone 20 mg tablets every day for at least seven years, Respondent never documented any discussion of switching Patient 3 to a long-acting opioid. During her interview with Board investigators, Respondent stated that Patient 3 had experienced a rash when taking one particular long-acting opioid, but this was not documented in the record, and would not explain why no other long-acting opioids were considered.

38. Respondent documented addressing the risks and benefits of opioid treatment with Patient 3, however, there is only one pain contract in his file dated May of 2012. There is no prescription for Narcan to Patient 3, and Respondent failed to document ever having offered Narcan to Patient 3 or instructed him on its use.

39. Respondent used urine toxicology screenings in her treatment of Patient 3. The first three urine toxicology screenings Respondent ordered for Patient 3, dated August 2012, August 2013, and May of 2014, all returned negative for opioids. Respondent did not address the first two aberrant toxicology results and continued to prescribe large doses of opioids to Patient 3. After the third aberrant result in 2014, Respondent addressed the results with Patient 3. Patient 3 said that he had misplaced his medication. Respondent advised Patient 3 that if his urine toxicology came back negative for opioids, she would taper him off the medication or reduce his dose. After this discussion, Patient 3 provided compliant urine toxicology results. This is concerning because it is likely that Patient 3 simply used the information Respondent provided of how she uses the toxicology results to provide compliant urine samples in order to continue receiving the medication. This did not address the concern that Patient 3 may be diverting the medication or using the medication early and being off his dose for long enough to produce a negative result. Moreover, Respondent's discussion with Patient 3 failed to address whether Patient 3 needed the medication on an occasional or around the clock basis.

40. Patient 3 had regular appointments with a Physical Medicine and Rehabilitation (PMR) specialist who provided him with interventions such as steroid injections for pain relief. Starting in 2018, the PMR physician frequently recommended that Patient 3 limit his use of

oxycodone. Between 2018 and 2019, Respondent did not address this recommendation or incorporate it into her treatment plan for Patient 3.

41. Despite maintaining Patient 3 on a regular regimen of 360 morphine milligram equivalent (MME)[4] per day of a short-acting opioid, Respondent did not refer Patient 3 to pain management specialists over the course of her lengthy treatment of him. During her interview with Board investigators in August of 2020, Respondent reported that she had just referred Patient 3 to pain management in the past week. Respondent's records of Patient 3's visits through February of 2020 contain no reference to any referral to pain management.

Patient 4

42. Respondent became Patient 4's primary care physician in approximately February of 2014. Patient 4 was a 59-year old woman with a history of arthritis in her left hip. Patient 4 had been receiving oxycodone and Norco for arthritis from her previous provider. From 2014 through 2019 Respondent regularly prescribed oxycodone 30mg (112 tablets every 28 days) and Norco 10/325 mg (up to 180 tablets every 30 days). Patient 4 signed a pain contract with Respondent dated February 9, 2015.

43. When Respondent took over Patient 4's care in February of 2014, she increased Patient 4's oxycodone dose. In February of 2015, Patient 4 reported that she was taking more oxycodone than prescribed. In March of 2015, Patient 4 again reported that she was taking more oxycodone than prescribed and was borrowing oxycodone medication from her husband's supply of medication. Respondent did not document any counselling of Patient 4 on this matter or address it in the records.

44. Respondent performed a history and physical for Patient 4, indicating that Patient 4 required opioid pain medication for left hip pain and arthritis. However, after Patient 4 had a successful hip replacement surgery of her left hip in February of 2017, Respondent continued prescribing high doses of opioids. During her interview with Board investigators, Respondent

[4] The medical community uses the MME to compare non-morphine opioids to morphine opioids to provide a standardized dose comparisons. Medical guidelines consider an MME above 80 to warrant additional caution.

indicated that Patient 4 began experiencing right hip pain after her left hip was surgically repaired.

45. Respondent did not document why she was maintaining Patient 4 on a regimen of two short-acting opioids with a 200-240 MME per day and approximately 10 tablets per day for so many years. Although Respondent referred Patient 4 to orthopedics and pain management, Respondent failed to coordinate care with these specialists. For example, on March 25, 2016, the pain management providers specifically directed that Patient 4's opioid dose should not be escalated. However, on or about August 23, 2016, Respondent did escalate Patient 4's opioids from 120 to 180 tablets per month. Although this escalation was reportedly due to a fall Patient 4 experienced, Respondent maintained this escalated dose until 2018. Notably, when Patient 4 reported having experienced a fall at an appointment in August of 2016, she stated she was out of Norco, despite having refilled a prescription approximately two weeks earlier. This would mean that Patient 4 was taking approximately 10 tablets of Norco per day during the previous two weeks. Respondent failed to address this.

46. When Patient 4 received surgery in February of 2017, Patient 4 was prescribed an additional 120 tablets of Norco and 20 tablets of hydromorphone. Respondent continued to prescribe the same monthly doses of Norco and oxycodone without addressing the additional opioids prescribed to Patient 4.

47. In February of 2019, Respondent abruptly documented the need to taper Patient 4 off of Norco due to the risk of respiratory depression from the combined oxycodone and Norco prescriptions. There was no discussion of why Respondent had suddenly come to the conclusion that Patient 4's medication regimen was a danger to her, after having prescribed this medication regimen for the last several years without any documented concern.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

48. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that she was grossly negligent in her care and treatment of Patients 1, 2, and 3.

49. Paragraphs 9 through 41 above, are incorporated herein as if fully set forth.

50. Respondent was grossly negligent in her care and treatment of Patients 1, 2, and 3, for her acts and omissions including, but not limited to, the following:

(a) Failing to comply with the Board Guidelines for prescribing controlled substances for pain for Patients 1, 2, and 3;

(b) Prescribing two short-acting opioids to Patient 1 over a long period of time without documenting a reason for this medication regimen;

(c) Failing to document a basis for the prescription of Xanax to Patient 1;

(d) Continuing to prescribe controlled medications to Patient 1 despite the presence of multiple, unaddressed red flags of medication misuse;

(e) Failing to provide complete information of Patient 1's medical status to the DMV;

(f) Failing to follow through with referrals of Patient 1 to psychiatry, addiction medicine, and pain management;

(g) Taking over Patient 2's methadone treatment despite not being a certified narcotic treatment provider, and without confirming his treatment and dose of methadone or obtaining a urine test before prescribing methadone;

(h) Continuing to prescribe Norco and Xanax to Patient 2 despite his known history of addiction;

(i) Increasing Patient 2's Norco prescription despite his known history of addiction and inconsistent urine toxicology results;

(j) Failing to clarify with Patient 2 the difference between narcotic-assisted addiction treatment and pain treatment;

(k) Failing to timely refer Patient 2 to chemical dependency services;

(l) Maintaining Patient 3 on high doses of opioids for over seven years before referring him to pain management services;

(m) Prescribing two short-acting opioids to Patient 3 for several years without valid justification or documentation for this medication regimen;

(n) Failing to implement urine toxicology screenings properly or to follow up appropriately on aberrant test results; and

(o) Failing to timely coordinate Patient 3's care with specialists and to implement the recommendations of specialist consultations.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

51. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that she was repeatedly negligent in her care and treatment of Patients 1, 2, 3, and 4.

52. Paragraphs 9 through 47, above, are incorporated herein as if fully set forth.

53. Respondent was repeatedly negligent in her care and treatment of Patients 1, 2, 3, and 4, for her acts and omissions including, but not limited to, the following:

(a) Failing to comply with the Board Guidelines for prescribing controlled substances for pain for Patients 1, 2, 3, and 4;

(b) Prescribing two short-acting opioids to Patient 1 over a long period of time without documenting a reason for this medication regimen;

(c) Failing to document a basis for the prescription of Xanax to Patient 1;

(d) Continuing to prescribe controlled medications to Patient 1 despite the presence of multiple, unaddressed red flags of medication misuse;

(e) Failing to provide complete information of Patient 1's medical status to the DMV;

(f) Failing to follow through with referrals of Patient 1 to psychiatry, addiction medicine and pain management;

(g) Taking over Patient 2's methadone treatment despite not being a certified narcotic treatment provider, and without confirming his treatment and dose of methadone or obtaining a urine test before prescribing methadone;

(h) Continuing to prescribe Norco and Xanax to Patient 2 despite his known history of addiction;

(i) Increasing Patient 2's Norco prescription despite his known history of addiction and inconsistent urine toxicology results;

(j) Failing to clarify with Patient 2 the difference between narcotic-assisted addiction, treatment and pain treatment;

(k) Failing to timely refer Patient 2 to chemical dependency services;

(l) Maintaining Patient 3 on high doses of opioids for over seven years before referring him to pain management services;

(m) Prescribing two short-acting opioids to Patient 3 for several years without valid justification or documentation for this medication regimen;

(n) Failing to implement urine toxicology screenings properly or to follow up appropriately on aberrant test results;

(o) Failing to timely coordinate Patient 3's care with specialists and to implement the recommendations of specialist consultations.

(p) Prescribing two short-acting opioids to Patient 4 for several years without valid justification or documentation for this medication regimen;

(q) Failing to document Patient 4's need for continued pain medication treatment after her hip surgery;

(r) Failing to coordinate Patient 4's care with specialists, leading to double dosing of pain medications after surgery and failure to implement medication reduction recommendations; and

(s) Failing to address instances of Patient 4 self-escalating her medications.

THIRD CAUSE FOR DISCIPLINE

(Violation of Drug Statutes)

54. Respondent is subject to disciplinary action under section 2238 of the Code making it an act of unprofessional conduct to violate state laws regulating dangerous drugs or controlled substances, in that she violated Health and Safety Code section 11839.6 by administering narcotic-based addiction treatment to Patient 2, without a valid license and certification to do so.

55. Paragraphs 28 through 34, above, are realleged and incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Records)

56. Respondent is subject to disciplinary action under section 2266 of the Code in that she failed to adequately and accurately maintain medical records for Patients 1, 2, 3, and 4. The

circumstances are set forth in paragraphs 9 through 47, above, which are incorporated here by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 93486, issued to Respondent Jennifer Dela Rosa Reyes-Ng, M.D.;

2. Revoking, suspending or denying approval of Respondent Jennifer Dela Rosa Reyes-Ng, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Jennifer Dela Rosa Reyes-Ng, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: SEP 22 2021

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

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