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

In the Matter of the Accusation Against: Vlad Nusinovich, M.D. Physician's and Surgeon's Certificate No. A 92996 Respondent.	Case No.: 800-2017-034952

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 28, 2021.

IT IS SO ORDERED: September 28, 2021.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
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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: **VLAD NUSINOVICH, M.D.** **7855 Santa Monica Blvd.** **West Hollywood, CA 90046** **Physician's and Surgeon's Certificate No. A 92996,** Respondent.	Case No. 800-2017-034952 OAH No. 2021020527 **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 Christine R. Friar, Deputy Attorney General.

2. Respondent Vlad Nusinovich, M.D. (Respondent) is represented in this proceeding by

attorney Edward Shkolnikov, Esq. of The Law Offices of Edward Shkolnikov, located at 13245 Riverside Drive, Suite 501, Sherman Oaks, California 91423.

3. On or about October 5, 2005, the Board issued Physician's and Surgeon's Certificate No. A 92996 to Vlad Nusinovich, 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. 800-2017-034952, and will expire on May 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-034952 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 July 23, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-034952 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-034952. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent admits the truth of each and every charge and allegation in Accusation

No. 800-2017-034952.

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

CONTINGENCY

11. This 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 his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his 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.

12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2017-034952 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.

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 92996 issued to Respondent VLAD NUSINOVICH, 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. 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.

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

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

this Decision.

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

3. 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.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the

time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the 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.

5. 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.

Respondent shall not practice medicine until Respondent has successfully completed the program and has been so notified by the Board or its designee in writing.

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

7. 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.

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

9. 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 place of residence.

License Renewal

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

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.

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. 800-2017-034952 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, Edward Shkolnikov, Esq. 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: June 23, 2021

VLAD NUSINOVICH, M.D.

I have read and fully discussed with Respondent Vlad Nusinovich, 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: 06/23/2021

EDWARD SHKOLNIKOV, 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 24, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

Christine R. Friar

CHRISTINE R. FRIAR
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-034952

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

In the Matter of the Accusation Against: **VLAD NUSINOVICH, M.D.** **7855 Santa Monica Blvd.** **West Hollywood, CA 90046** **Physician's and Surgeon's Certificate No. A 92996,** Respondent.	Case No. 800-2017-034952 **ACCUSATION**

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 October 5, 2005, the Medical Board issued Physician's and Surgeon's Certificate Number A 92996 to Vlad Nusinovich, 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 May 31, 2021, unless renewed.

///

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code 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, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> ....

6. Section 2242, subdivision (a), of the Code states:

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

7. Section 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, dentist, podiatrist, psychologist,

physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

8. Section 2266 of the Code states, the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 3501 of the Code states in pertinent part:

As used in this chapter:

...

(d) "Physician assistant" or "PA" means a person who meets the requirements of this chapter and is licensed by the board.

(e) "Supervising physician" or "supervising physician and surgeon" means a physician and surgeon licensed by the Medical Board of California or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation prohibiting the employment or supervision of a physician assistant.

(f) (1) "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant...

....

10. California Code of Regulations, Title 16, section 1399.541 states as follows:

Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician. In any setting, including for example, any licensed health facility, out-patient settings, patients' residences, and hospices, as applicable, a physician assistant may, pursuant to a delegation and protocols where present:

(a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician.

(b) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services.

(c) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.

(d) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

(e) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.

(f) Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.

(g) Initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community.

(h) Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive, of Section 3502.1 of the Code.

....

11. California Code of Regulations section 1399.545 states, in pertinent part, as follows:

...

(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision.

12. California Code of Regulations section 1399.546 states as follows:

Each time a physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When a physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

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13. Section 2285 of the Code states, in pertinent part:

> The use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit obtained pursuant to Section 2415 constitutes unprofessional conduct...

THE RELEVANT STANDARD OF CARE

14. The standard of care in the medical community requires that physicians keep timely, legible and accurate medical records. This includes documentation of the history of present illnesses and review of systems in a patient's record. Additionally, accurate recordings of the physical findings should be documented at each visit. Medication reconciliation, including identifying the most accurate list of all the medication that a patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider is also expected to ensure patient safety and quality of care. The author of a patient note should be clearly indicated in the note and there should be clear documentation of the physician's impressions and plans.

15. The standard of care in the medical community requires that when primary care physicians evaluate a patient prior to surgery that an appropriate preoperative consultation is performed. Identification of increased risk for the surgery provides patients and surgeons with a better understanding of the benefit-to-risk ratio of a procedure and also interventions that can decrease the risk of the procedure. In general, patients should be evaluated for preoperative cardiac and pulmonary risk. There are several risk models estimating the cardiac risks based on information from the history, physical examination, electrocardiogram, and type of surgery. All patients should be asked about their exercise capacity as part of the preoperative evaluation as exercise capacity is an important determinant of overall preoperative risk. A complete medication history should also be obtained. Medication reconciliation must be addressed to ensure accuracy of drugs and doses. This should include over-the-counter and herbal medications in addition to prescription medications. Substance use, including alcohol, nicotine and illicit drugs, should also be elicited.

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16. The standard of care in the medical community requires that a physician conduct proper evaluation and treatment when presented with a patient with dyspepsia (indigestion). Dyspepsia is a common presenting symptom with extensive differential diagnosis and a heterogeneous pathophysiology. A detailed history, physical examination, and laboratory studies are necessary to determine the underlying etiology. Certain medications, such as non-steroidal anti-inflammatory drugs (NSAIDs), can cause dyspepsia even in the absence of peptic ulcer disease. In general, patients over 60 years should undergo an upper endoscopy. Patients who are younger than 60 should be tested for *H. pylori*. Any patients with alarm features, such as unexplained iron deficiency anemia, family history, or progressive weight loss should undergo workup to rule out underlying malignancy.

17. The standard of care in the medical community requires physicians provide adequate evaluation and treatment for potential infectious complaints. More specifically, prior to formulating a treatment plan for a potential infection, adequate evaluation should be carried out including assessment of the patient's symptoms, physical examination of the potential infectious site, and comorbidities, which could alter the course of management. Excessive antibiotic prescription could lead to resistance and development of superinfections.

18. The standard of care in the medical community requires that a physician manage a patient's blood pressure according to the patient's cardiovascular risk profile and other comorbid conditions. In general, a patient with an average office blood pressure of greater than 140/90 should be initiated on treatment. Depending on a patient's risk factors, this number could be lower. Once a patient's blood pressure goal is determined, it should be documented and communicated to the patient. An evaluation should be performed to determine the extent of target organ damage, if any, as well as the presence of other cardiovascular risk factors. Lifestyle factors that could potentially contribute to hypertension should be addressed with the patient. Medications, such as sympathomimetics and NSAIDs, which can potentially elevate blood pressure readings, should be identified and used with caution.

19. The standard of care in the medical community requires proper evaluation and treatment for pharyngitis (sore throat). Acute pharyngitis is one of the most common conditions

encountered in outpatient clinical practice. A stepwise approach should be taken with the patient to help identify those cases that can be clinically diagnosed with a respiratory viral syndrome, those requiring testing for Group A Streptococcus (GAS) or other treatable pathogens, and those which have severe or life-threatening conditions. Patients with a strong suspicion for viral upper respiratory infection based on clinical features such as cough, coryza, conjunctivitis, rhinorrhea, hoarseness, viral exanthema, or oral ulcers should be offered supportive care. Suspicion for GAS pharyngitis should be raised with the patient if the patient has fever, tonsillar exudates and cervical lymphadenopathy and lacks features of a viral respiratory tract infection. Patients with lower respiratory tract symptoms should be stabilized and/or referred to the emergency room for care.

20. The standard of care in the medical community requires adequate evaluation for vertigo. Vertigo is the predominant symptom of vestibular dysfunction. It encompasses a large range of diagnoses from benign to life threatening. A thorough history should be taken to distinguish vertigo from other types of dizziness and also to make a hypothesis about the site and type of lesion. Attention should be paid to time course, aggravating and provoking factors, associated symptoms, and prior medical history. Physical examination should confirm vestibular dysfunction and distinguish the types of vertigo. The type of nystagmus can localize lesion to central versus peripheral. Balance and gait should be tested and sensitivity may be increased by closing the eyes and performing head movements. A detailed neurological exam should be performed as abnormalities may suggest central lesion. Numerous other tests are available and useful in the evaluation of vertigo, including Weber and Rinne tests, Dix-Hallpike maneuver test and the head impulse test.

21. The standard of care in the medical community requires that a physician provide adequate evaluation of polyarticular pain. The causes of multiple joint pain are various and range from benign to disabling and life threatening. A patient history and physical evaluation should be conducted and musculoskeletal emergencies should be ruled out first. Inflammatory (rheumatoid) arthritis should be distinguished from noninflammatory. The physical examination should also seek to establish the presence or absence of synovitis. Joints should be physically evaluated and

tested for range of motion restrictions. Evaluation for bony enlargement or crepitus should also be conducted.

22. The standard of care in the medical community requires proper evaluation and treatment for iron deficiency anemia. Major causes of iron deficiency include blood loss and reduced absorption. Iron deficiency in males warrants an endoscopic evaluation to rule out occult bleed.

23. The standard of care in the medical community requires adequate analysis and treatment of urinary tract infection (UTI). As part of that analysis and treatment, it is important to differentiate between UTI and asymptomatic pyuria (pus in the urine). Accordingly, physicians should be familiar with the different types of microbes that generate or cause UTI. Additionally, Staphylococcus aureus, if found in urine culture, should raise concerns for systemic infection and should be addressed.

24. The standard of care in the medical community requires proper evaluation and treatment of stage IV decubitus ulcer. The management of pressure-induced skin and soft tissue injuries should begin with a comprehensive assessment of the patient's general medical condition to identify possible reversible risk factors and clinical assessment of the wound. The most common factors in the pathogenesis of decubitus ulcers include immobility and compromised nutritional status. General principles of management would include reduction/elimination of underlying contributing factors such as proper reposition and optimization of nutritional status, provision of appropriate wound care, consideration of adjunctive therapies, monitoring and documentation of the patient's progress. As all open ulcers are colonized with bacteria, patients with deep wounds should be evaluated for the presence of osteomyelitis. Only clinically evident infections should be addressed with cultures and antibiotics. Prolonged wound healing may be a sign of infection in the appropriate context. Stage III and IV pressure ulcers require debridement of necrotic tissue.

25. The standard of care in the medical community requires discussion of the goals of care when treating advanced dementia. Advanced dementia is a terminal illness with well-characterized clinical course. Physicians should assist the patient and family in advance care

planning by carrying out goals of care discussions early. Understanding a patient's care goals in the context of advanced dementia allows physicians to align the care provided with what is most important to the patient and family. There are many possible treatments that impact both quantity and quality of life. Decisions by patients are often influenced by their values and preferences. Provision of palliative care should be guided by a preference for comfort-focused care, not estimated prognosis. Such discussions can avoid excessive interventions, such as feeding tubes, misuse of antimicrobials, hospitalizations and chronic daily medications, without meaningful recovery to the patient.

26. Benzodiazepines are gamma-aminobutyric acid (GABA) receptor agonists that have hypnotic, anxiolytic, muscle relaxant, and anticonvulsant properties. Benzodiazepines have been found to be efficacious in the treatment of anxiety, insomnia and other symptoms of depression when used in conjunction with an antidepressant in patients with unipolar major depression and for generalized anxiety disorder when used alone. Benzodiazepines, however, carry risks of dependence and tolerance. Benzodiazepines should be avoided in patients with a history of alcohol or substance abuse disorder. Nonbenzodiazaphone benzodiazepine receptor agonists, such as Zolpidem (generic for Ambien) and Zaleplon (generic for Sonata), have a structure that is different from benzodiazepines and include more targeted action at one GABA type A receptor. A consequence of their specificity is less anxiolytic and anticonvulsant activity. As such, they are commonly used for insomnia. Common side effects of both types of medications include residual daytime sedation, drowsiness, dizziness, lightheadedness, cognitive impairment, motor incoordination, and dependence. Both are also respiratory suppressants.

27. The standard of care in the medical community requires that before initiating a course of benzodiazepine treatment that a patient be explicitly advised of the goal and duration of treatment. Risks and side effects, including risk of dependence and respiratory depression, should be reviewed with the patient and the patient should be evaluated for suitability for benzodiazepine therapy. Exit strategies, such as tapering and switching to alternative therapies, and alternative treatment options should be discussed with the patient. The provider and patient should agree on one provider to be the benzodiazepine prescriber for the patient. Patients should be titrated to the

lowest dose for the shortest duration possible for treatment due to side effect profile and abuse potential. Psychiatry consultations can assist with the management of these patients. Concurrent use of the same classes of medications can potentiate adverse effects and should be avoided.

28. The standard of care in the medical community requires that when prescribing opiates, an appropriate initiation/continuation, titration and monitoring of chronic opiate pain management be performed. Opiates can play a vital role in chronic pain management, if their benefits outweigh the risks. Opiates with the lowest potency and addiction potential should be tried first for a defined period and the patient's progress monitored for both benefit and harm, including pain level, quality of life, functional status and adverse effects. To continue opiate therapy, there should be fulfillment of functional goals. The patient's risk of drug addiction and aberrancy should also be assessed prior to initiation of long-term opiate therapy. Risk stratification is important to help mitigate potentially adverse consequences of opiate prescribing. Patients with above average risk of addiction can benefit from referral to a psychiatrist and can also benefit from close monitoring with regular urine drug screenings. If a patient transfers care for pain management, the standard of care calls for the physician to obtain the medical records from the previous physician and re-evaluate the patient for continuous and titration of therapy. The adverse side effects of opiate therapy must be addressed with the patient.

29. The standard of care in the medical community requires informed consent and a pain management agreement when treating a patient with long-term use of opiates. Specifically, the physician should discuss the risks and benefits of the treatment plan with the patient. The patient consent typically addresses the risks and side effects associated with opiates, including constipation, sexual dysfunction, addiction/dependency, osteoporosis, cognitive impairment, over-sedation, drug interactions, respiratory depression, and impaired driving. Medical evidence on the efficacy of long-term opiate therapy should also be addressed. A pain management agreement typically outlines the joint responsibilities of the physician and patient, including replacement and early refills of lost medication. The patient should agree to only obtain the opiate prescribed from one physician or practice. A patient should also agree to submit to periodic drug screening and Controlled Substances Utilization Review and Evaluation System

(CURES) monitoring should be included. At a minimum, such discussions with the patient should be documented in the record, even if they are not in a formal agreement.

30. The standard of care in the medical community discourages the concurrent use of benzodiazepines and opiates. Both classes of medications, as well as nonbenzodiazepine receptor agonists, cause central nervous system depression and can decrease respiratory drive. Concurrent use of benzodiazepines and opiates has been associated with the risks of overdose death almost four folds compared with opiate prescription alone. Physicians should avoid prescribing both narcotics and benzodiazepines whenever possible. When confronted with a patient on both medications already, physicians should attempt to taper the patient off one of the medications first. Psychiatry consults for cognitive behavioral therapy and alternative therapy should be utilized when necessary. Patients and caregivers should also be educated and prescribed naloxone antidote therapy. A patient receiving high doses without side effects or with negative urine toxicology should raise concerns for diversion.

31. The standard of care in the medical community requires that when prescribing Adderall (brand name for Dextroamphetamine-Amphetamine, a Schedule II stimulant), a clear discussion and monitoring of the adverse side effects of this controlled substance should be carried out. Adderall is a form of amphetamine like substance with both potential for abuse and serious side effects, such as worsening of anxiety disorders, transient elevations in blood pressure, and other cardiac side effects. Adderall is used to treat attention deficit hyperactivity disorder ("ADHD"). When prescribing Adderall, a patient should be started at a low dose and incrementally increased at weekly intervals until optimal response is obtained. The maximum dose used in clinical trials was 60 milligrams a day.

32. The standard of care in the medical community requires adequate evaluation for adverse drug events. Adverse drug events (ADEs) are injuries that occur from the use of a drug. They can include hospitalizations, prescribing cascades, drug-drug interactions and dose-related adverse drug events. Physicians should continually reappraise a patient's medication regimen in light of the current clinical status, goals of care, and the potential risks/benefits of each medication. Medication reviews should be done in a systemic manner to prevent adverse drug

events.

FACTUAL ALLEGATIONS

33. At all relevant times, Respondent owned, operated and was engaged in the practice of medicine at Prestige Medical Center located in West Hollywood, California.

34. Respondent practices internal medicine and is a primary care physician. He treats patients at his office, in skilled nursing facilities and in their homes.

Patient 1[1]

35. Patient 1 first presented to Respondent on September 14, 2012. At the time, Patient 1 was 68 years old.

36. At the initial visit, Patient 1 complained of labile hypertension, right eye melanoma (treated by an ophthalmologist), rectal bleeding and pain in multiple joints. Patient 1's blood pressure was recorded at 124/78. Respondent diagnosed Patient 1 with hypertension, hemorrhoids, osteoarthritis at multiple sites and right eye melanoma.

37. Between Patient 1's initial visit and December 7, 2017, Patient 1 consistently presented to Respondent for care and treatment as his primary care physician. Throughout that time period, Patient 1 saw Respondent several times each year, sometimes as frequently as weekly or monthly.

38. Throughout Patient 1's care and treatment with Respondent, he consistently complained of labile hypertension and back pain, among numerous other ailments, including neck pain, joint pain, indigestion, vertigo, fatigue, insomnia and depression. Patient 1 regularly requested medication from Respondent for a variety of ailments and symptoms, which Respondent often provided. The medications provided by Respondent include repeated and, at times, concurrent prescriptions for Clonazepam (generic for Klonopin, a Schedule IV benzodiazepine), Alprazolam (generic for Xanax, a Schedule IV benzodiazepine) and Zolpidem (generic for Ambien, a Schedule IV nonbenzodiazapine benzodiazepine receptor agonist).

[1] The patients whose care and treatment are at-issue in this charging document are designated by number (e.g., "Patient 1") to address privacy concerns. The patients' identities are known to Respondent and will be further disclosed during discovery.

Respondent's care and treatment of Patient 1 included, but was not limited to, the following instances of care:

A. On or about September 12, 2013, Patient 1 presented for a health check up and preoperative clearance for ptosis correction (eye) surgery. Respondent performed a preoperative and routine medical examination that included a heart exam and palpitations. Respondent deemed Patient 1 to be low risk for the procedure. As part of the examination, an EKG was performed on Patient 1, which came back abnormal and with a read of "left-precordial ST elevation, consider acute ischemia."

B. In October 7, 2013, Patient 1 complained of vertigo, dizziness and unsteady balance. Respondent performed a hearing exam that was documented as normal. Respondent diagnosed Patient 1 with vertigo or dizziness and labyrinthine disorder. Respondent's treatment plan included obtaining an electronystagmography (ENG) and Vestibular Autorotation Test (VAT). A medication list was not documented at this visit.

C. Patient 1 returned to Respondent on October 15, 2013, to retrieve his test results. Patient 1 was provided with a copy of ENG plus testing with unclear interpretation and lack of test data in multiple rows. Likewise the VAT results provided to Patient 1 also contained unclear interpretation and insufficient data documented in multiple panels. No date and time was recorded for either test.

D. On or about January 14, 2015, Patient 1 presented for preoperative clearance for cataract surgery. Respondent's review of systems was positive for fatigue, pain at multiple sites, nocturia, hesitancy of urine stream, headache, vertigo, dizziness, anxiety, depression, and insomnia. The type of anesthesia to be used and Patient 1's exercise tolerance were not documented. Respondent deemed Patient 1 to be low risk for the procedure. As part of the examination, an EKG was performed on Patient 1, which came back abnormal and with a read of "left-precordial ST elevation, consider acute ischemia."

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E. On or about October 15, 2015, Patient 1 presented to Respondent complaining of neck pain, back pain and hypertension. Patient 1 had suffered from all conditions for years. Patient 1 also complained of muscle pain, arthralgias, pain with movement, pain with walking and pain limiting active motion. These complaints had been ongoing as well. Patient 1's blood pressure was documented at 154/80. Respondent's diagnoses included back pain with radiculopathy, cervicalgia and hypertension. Respondent's treatment plan included lifestyle modification, analgesics, and consideration of physical therapy or joint injections. Patient 1's medication list contained over a dozen medications, including Clonazepam and Ambien.

F. On or about December 9, 2015, Patient 1 presented to Respondent complaining of dyspepsia, hemorrhoids, and pain in multiple joints. A proton pump inhibitor was tried for Patient 1's dyspepsia with unclear efficacy. No rectal bleeding was reported, no rectal exam was documented and Patient 1 denied weakness and paresthesia. Respondent attributed Patient 1's rectal bleeding to hemorrhoids. Lifestyle modification was discussed and Proctosol was prescribed. Respondent documented that referral to a colorectal surgeon would be considered if symptoms did not improve.

G. On or about January 25, 2016, Patient 1 presented to Respondent for elevated blood pressure. His in-office reading was 139/76. Patient 1 also reported worsening depression, insomnia, stress and behavior problem. Patient 1's medication list contained over a dozen medications, including Ambien, Clonazepam and Latuda, a second generation antipsychotic (SGA).

H. On or about March 7, 2016, Respondent recorded a progress note stating that Patient 1 was requesting medication for an "infected wound." Respondent prescribed Rocephin, an antibiotic, and, a topical cream. Follow up was for regular appointment.

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I. On or about April 15, 2016, Respondent recorded a progress note stating that Patient 1 was requesting medication for urinary tract infection symptoms. Respondent prescribed Levaquin, an antibiotic. No description of symptoms, physical exam or labs were documented in the record.

J. On or about April 18, 2016, Respondent recorded a progress note stating that Patient 1 was again requesting medications and that his symptoms were worsening, as antibiotics were not working: "suspect sepsis." No other symptoms, physical exam or labs were documented in the record. Respondent prescribed Vancomycin Hydrochloride, an antibiotic.

K. On or about August 15, 2016, Patient 1 presented to Respondent for a follow up visit and reported poorly controlled, labile hypertension and that the condition is worsening based on at home measurements. His in-office blood pressure was 132/56. A discussion regarding elevation of blood pressure was documented and dietary and lifestyle modifications were charted. Patient 1's medication list was comprised of over a dozen medications, including: Ambien, Clonazepam, and Alprazolam.

L. Patient 1's records indicate that between November 29, 2016, and January 27, 2017, Patient 1 was under homebound status and the care of Heaven Home Health Care Services. It was noted that Patient 1 required assistance getting up and moving safely, was unable to leave his home unassisted, exhibited considerable and taxing effort to leave home, suffered from severe dyspnea (difficulty breathing) and is unsafe to leave his home due to cognitive/psychiatric impairments.

M. On or about December 9, 2016, Patient 1 presented to Respondent for all over body pain the day after being in a car accident. Patient 1 reported anxiety, headache and nausea as well. Respondent diagnosed Patient 1 with muscle strains and ordered x-rays of the C-spine and L-spine. Naprosyn (a nonsteroidal anti-inflammatory drug (NSAID)) and Skelaxin (a muscle relaxant) were ordered. Over the course of the next several months, Patient 1's pain from the accident continued, Naprosyn and

Skelaxin were continued and he engaged in physical therapy sessions at Respondent's office.

N. On or about February 2, 2017, Patient 1 presented to Respondent for an "emergency visit." Patient 1 reported cough, sore throat, nasal congestion, postnasal drip and fatigue, but denied fevers or chills. Patient 1 also complained of poorly controlled hypertension with poor at-home readings. His in-office blood pressure was 132/80. Respondent diagnosed Patient 1 with acute bronchitis and a Z-pack (Zithromax, an antibiotic) was prescribed. Alcohol cessation was also advised and dietary and lifestyle modification was documented for hypertension.

O. On or about March 8, 2017, Patient 1 saw Respondent for another follow up visit relating to the car accident. Among other problems, Patient 1 complained of insomnia. Patient 1 had tried Ambien and Respondent documented that his insomnia is "improved by nothing." At that visit, Respondent prescribed Patient 1 Ambien, Skelaxin and Naprosyn.

P. On or about June 6, 2017, Patient 1 saw Respondent for follow up regarding dyspepsia and nausea. Patient 1 reported years of severe "symptoms of hemorrhoids," but denied rectal bleeding or melena. The review of systems was positive for fatigue, weakness, pain, nasal congestion, constipation, heartburn, nocturia, slow urination, hesitancy of urination, headache, vertigo, and dizziness. A rectal exam was not documented. A breath test for *H. pylori* was documented, but the outcome was unclear. No other diagnostics or treatment plans were documented. The cause of Patient 1's rectal bleeding was thought to be hemorrhoids. Patient 1 was counseled on dietary and lifestyle modifications. Respondent documented that referral to a colorectal surgeon would be considered if the problem persists.

39. Respondent committed an extreme departure from the standard of care when he failed to keep accurate medical records for Patient 1. For example, Respondent's records often lack the pertinent positives and negatives of the conditions discussed. While general counseling is

documented, actual treatment plans are often not apparent in Respondent's notes. Further, conflicting information pertaining to symptoms and complaints, for example, often appear in the same note. Additionally, relevant medical history and medication reconciliation are often lacking. Electronic medical records appear to have been copied and pasted on several occasions, making it difficult to access the current condition of the patient. Finally, relevant physical findings were often not addressed and abnormal findings are not consistently addressed.

40. Respondent committed an extreme departure from the standard of care when he failed to provide Patient 1 with an appropriate preoperative consultation. Specifically, Respondent failed to conduct any assessment of Patient 1's exercise capacity as part of his preoperative evaluations. Additionally, Patient 1's EKGs were abnormal and revealed ST segment elevation, concerning for acute ischemia. Respondent failed to address these findings in Patient 1's record.

41. Respondent committed an extreme departure from the standard of care when he prescribed multiple benzodiazepines and nonbenzodiazaphone benzodiazepine receptor agonists concurrently to Patient 1 and failed to adequately monitor adverse side effects and aberrant behavior.

42. Respondent committed an extreme departure from the standard of care when he failed to properly evaluate and treat Patient 1's dyspepsia. Patient 1 had persistent dyspepsia despite being on a proton pump inhibitor. It is not clear from the record, however, if he was also taking Naprosyn, as the medication reconciliation was often not clear. Naprosyn also should have been avoided in Patient 1. Respondent checked Patient 1 for *H. pylori* at least twice during the course of his care and treatment, but there is no record of an endoscopy referral.

43. Respondent committed an extreme departure from the standard of care when he failed to provide Patient 1 adequate evaluation and treatment for his infectious complaints. Patient 1 requested medications for an "infected wound" on or about March 7, 2016. No further details of the symptoms or evaluation of the wound were documented. Respondent prescribed Rocephin, an antibiotic. A few weeks later, Respondent documented that Patient 1 requested medication for a urinary tract infection. Respondent prescribed another antibiotic, Levaquin, without documentation of symptoms, physical exams or labs. Three days later, Patient 1 reported that

antibiotics were not working. Respondent prescribed yet another antibiotic, Vancomycin, for suspected "sepsis." The sepsis site, however, is unclear from the record. Further, no exam or laboratory findings were documented in the record, nor there is documentation of Vancomycin dosing monitoring.

44. Respondent committed a departure from the standard of care when he failed to provide Patient 1 with comprehensive evaluation and treatment for his hypertension. Specifically, Respondent repeatedly documented that Patient 1 complained of poorly controlled hypertension when his in-office reading was normal or borderline elevated. While Respondent instructed Patient 1 to monitor his blood pressure at home, Respondent never documented reviewing any home blood pressure logs. Patient 1's compliance was not assessed in detail, which was important given the labile nature of his blood pressure readings. Finally, Respondent prescribed Patient 1 both Valsartan and Azilsartan, both angiotensin receptor blockers (ARBs), at the same time and a funduscopic examination to evaluate for hypertensive retinopathy was never carried out.

45. Respondent's care and treatment of Patient 1 departed from the standard of care on February 2, 2017, when he failed to provide proper evaluation and treatment for pharyngitis. According to Respondent's documentation, Patient 1 presented with classic viral upper respiratory symptoms and Respondent diagnosed him with acute bronchitis. It is unclear how Respondent arrived at this diagnosis from the record.

46. Respondent's care and treatment of Patient 1 departed from the standard of care when he failed to adequately document a workup confirming a diagnosis causing Patient 1's vertigo.

47. Respondent's care and treatment departed from the standard of care when he failed to adequately evaluate Patient 1's polyarticular pain. Respondent's history and physical for the patient's polyarticular pain did not provide sufficient positive and negatives to assist in diagnosing the etiology of patient's polyarticular pain. Patient 1 was often diagnosed with radiculopathy despite a lack of documentation of neuropathic pain.

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Patient 2

48. Patient 2 first presented to Respondent on May 10, 2012, when he was 66 years old. He complained of chronic and worsening lower back pain, dermatitis, and burning pain in the bilateral extremities, which had been present for years. Patient 2's medication list consisted of Lyrica (a Schedule V nerve pain medication that can also be used to treat seizures), Vitamin B12 and Vitamin D.

49. Between Patient 2's initial visit and November 17, 2017, Patient 2 consistently presented to Respondent for care and treatment as his primary care physician. Throughout that time period, Patient 2 saw Respondent several times each year, sometimes as frequently as monthly or weekly.

50. Throughout his care and treatment with Respondent, Patient 2 consistently complained of back pain, insomnia, and poorly controlled, labile hypertension, among numerous other ailments, including, knee pain, hip pain, vertigo and fatigue. As part of his care and treatment, Respondent prescribed numerous medications to Patient 2. Those prescriptions included, repeated and, at times, concurrent orders for Lorazepam (generic for Ativan, a Schedule IV benzodiazepine), Zolpidem and Ultram (brand name for Tramadol, a Schedule IV synthetic opiate pain reliever).

51. Respondent's care and treatment of Patient 2 included, but was not limited to, the following instances of care:

A. On or about August 23, 2013, Patient 2 presented to Respondent with a cough and sore throat. He denied fevers or chills and had tried over the counter medication. Patient 2's temperature in the clinic was recorded at 100.3 and his oxygen saturation at 96%. Exams of the eyes, ear, nose, throat/oropharynx and lungs were unremarkable. Respondent diagnosed Patient 2 with acute bronchitis and prescribed a Z-pak, Flonase, and Robitussin with Codeine, a Schedule V opiate cough suppressant.

B. On or about September 26, 2013, Patient 2 presented complaining of pain in multiple joints. His symptoms were described as chronic and worsening without

preceding trauma or focal paresthesia. Respondent's examination revealed decreased range of motion in affected joints. Respondent diagnosed Patient 2 with osteoarthritis of the knees, back pain with radiculopathy and neck pain. Patient 2 was referred to physical therapy. Patient 2's medication list included Ativan, Ambien, and Ultram, among numerous other medications.

C. On or about May 30, 2014, Patient 2 presented for hip pain and fatigue. His symptoms were chronic and worsening and the examination revealed decreased motion in affected joints. Respondent diagnosed Patient 2 with hip pain due to arthritis and fatigue. The treatment plan included continuing current medications, ordering laboratory testing, and consideration of physical therapy. Ultram was ordered.

D. On or about June 20, 2014, Patient 2 presented for generalized weakness, fatigue and headache related to high blood pressure. Patient 2 complained of years of poorly controlled, labile hypertension, which was worsening. He also complained of dizziness, unsteady gait and pain in multiple joints. His in-office blood pressure was 145/80. Respondent diagnosed Patient 2 with fatigue/malaise, hypertension and osteoarthritis. Patient 2's medication list included Ativan, Ultram, Ambien and Neurontin, (brand name for Gabapentin, a Schedule V controlled substance), among numerous other medications.

E. Patient 2 engaged in regular physical therapy throughout October 2014, but continued to complain of joint pain, as well as generalized weakness. At a November 6, 2014, visit, he described these conditions as worsening. His medication list again included Ativan, Ultram, Ambien and Neurontin, among numerous other medications.

F. On or about November 20, 2014, Patient 2 presented to Respondent complaining of headache, high blood pressure, back pain, insomnia and chronic fatigue. Patient 2 reported that his chronic pain was worsening and that his hypertension was poorly controlled. His in-office blood pressure reading was 150/90. Respondent

documented discussing the differential diagnoses and lifestyle modifications with Patient 2. A DNA analysis was to be ordered.

G. On or about December 15, 2014, Respondent conducted urine drug testing on Patient 2. The result was positive for Phenobarbital, a Schedule IV barbiturate, and aminoclonazepam. Respondent had not prescribed Phenobarbital to Patient 2, nor did he at any point during Patient 2's course of care and treatment.

H. On or about January 6, 2015, Patient 2 presented to Respondent for a post hospitalization follow up for severe shingles. Patient 2 was diagnosed with shingles and postherpetic neuralgia. Respondent prescribed Norco 10/325 (brand name for Hydrocodone-Acetaminophen, a Schedule II opiate) and Lyrica. Patient 2 was unable to obtain the Lyrica under his coverage and Neurontin was prescribed instead.

I. Patient 2's pain continued to be poorly controlled and on or about February 27, 2015, Respondent increased the frequency of his doses of Neurontin.

J. Patient 2 returned the following month on or about March 18, 2015, complaining of postherpetic neuropathy in his back and chest that started months ago. Patient 2 had tried Neurontin and Norco with undocumented efficacy. Patient 2's review of systems was positive for fatigue, arthalgias, headaches, vertigo and depression. Patient 2 was referred to a pain management specialist. His medication list included Ativan, Ultram, Ambien and Neurontin, among numerous other medications.

K. On or about April 3, 2015, Patient 2 presented to Respondent with a cough and sore throat. The review of systems was negative for fever or dyspnea and Patient 2 had tried over the counter medication. Patient 2's temperature in the clinic was recorded at 100.3 and his oxygen saturation at 96%. Exams of the eyes, ear, nose, throat/oropharynx and lungs were unremarkable. Respondent diagnosed Patient 2 with acute viral upper respiratory infection and prescribed Nasonex and Robitussin with Codeine.

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L. Patient 2 continued to present to Respondent with complaints of joint pain, weakness, headaches, insomnia and vertigo. Patient 2 was continued on his medication regime. Patient 2's medication list contained well over a dozen medications, including Ativan, Amitriptyline (generic for Elavil, an antidepressant and nerve pain medication), Cymbalta (brand name for Duloxetine, an antidepressant and nerve pain medication), Ultram, Ambien and Neurontin.

M. On or about September 21, 2015, Patient 2 presented to Respondent complaining of joint pain. Respondent documented that he discussed compliance issues with Patient 2 and instructed him to take medications as prescribed. Respondent documented that Patient 2 needed to notify him if he stops taking any medications, including the details of any side effects, if that is his reason for stopping. No specific medications of concern were mentioned.

N. On or about November 18, 2015, Patient 2 presented with dyspepsia and low back pain. Respondent documented that Patient 2 had tried a proton pump inhibitor and H2 blockers with unclear efficacy. Patient 2 was diagnosed with osteoarthritis, dyspepsia and headache. His treatment plan included a breath test for *H. pylori*, and acid suppressive regimen. Respondent prescribed Vimovo (brand name for Naproxen, an NSAID) and Esomeprazole, a proton pump inhibitor.

O. On or about December 18, 2015, Patient 2 presented to Respondent still complaining of dyspepsia, headache, back pain and pain in multiple joints. Patient 2's breath test for *H. pylori* returned negative.

P. On or about December 29, 2015, Respondent conducted a urine drug screen on Patient 2. It was negative for opiates, antidepressants and sedatives. Respondent had prescribed Patient 2 Ambien and Ativan in December 2015.

Q. On or about April 5, 2016, Patient 2 presented for headache, multiple joint pain and cough. He also reported poorly controlled and labile hypertension. His in-office blood pressure was 110/60. The examination was unremarkable and Patient 2 was diagnosed with tobacco use disorder, hypertension, acute viral upper respiratory

infection and headache. The treatment plan included over the counter medications, rest and fluids. A viral respiratory swab was to be obtained. Respondent documented discussing lifestyle and dietary modification for blood pressure and lifestyle modification, over the counter analgesics and a headache diary were also discussed. Smoking and alcohol cessation were advised. Patient 2's medication list contained well over a dozen medications, including Ativan, Amitriptyline, Cymbalta, Ultram, Ambien, Neurontin and Vimovo.

R. On April 11, 2016, Patient 2 presented for a urine drug screen. He tested positive for Gabapentin (Neurontin), Tramadol, Zolpidem, Aminoclonazepam (all prescribed by Respondent) and negative for Duloxetine and Lorazepam.

S. On June 21, 2016, Patient 2 presented for dyspepsia, weight loss, depression and fatigue. He also reported vertigo and dizziness. He had seen a gastroenterologist and was seeing a psychiatrist. The review of systems was positive for cough, sore throat and rhinorrhea. Patient 2 was diagnosed with vertigo or dizziness, fatigue, vitamin B12 deficiency, weight loss and acute respiratory tract infection. Patient 2's respiratory viral panel returned negative on the same day. Patient 2's medication list contained well over a dozen medications, including Ativan, Amitriptyline, Cymbalta, Ultram, Ambien, Neurontin and Vimovo.

T. Patient 2 underwent a urine drug screen on June 21, 2016, that was positive for Gabapentin, Tramadol, Zolpidem, Phenobarbital, Clonazepam, Aminoclonazepam and negative for Duloxetine and Lorazepam.

U. On or about November 28, 2016, Patient 2 presented to Respondent with a cough, sore throat, fever and fatigue for days. Patient 2 had tried over the counter medication. Patient 2's temperature in the clinic was recorded at 100.3 and his oxygen saturation at 96%. Exams of the eyes, ear, nose, throat/oropharynx and lungs were unremarkable. Respondent diagnosed Patient 2 with acute bronchitis and prescribed Levaquin, an antibiotic, and Robitussin with Codeine.

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V. On or about January 10, 2017, Patient underwent urine drug screening. The test was positive for Tramadol, Zolpidem, Phenobarbital, Aminoclonazepam and negative for Amitriptyline, Duloxetine, Gabapentin, and Lorazepam.

W. At the January 10, 2017 visit, Patient 2 presented with multiple joint pain, anxiety, depression, panic attacks with hand tremor, chronic fatigue, and dyspepsia. Patient 2's wife reported that he drank alcohol and smoked daily, although Patient 2 denied. Patient 2 was diagnosed with dyspepsia, osteoarthritis, tobacco use disorder, weight loss, alcohol abuse disorder and anxiety disorder. Respondent advised Patient 2 to continue on his current medications without change and was advised on smoking cessation and lifestyle modification. Consideration of analgesics was documented for osteoarthritis. A *H. pylori* test was conducted with unclear results.

X. On or about January 19, 2019, Patient 2 requested medication and Respondent prescribed Bactrim, an antibiotic. No symptoms or examination were documented.

Y. On March 2, 2017, Patient presented to Respondent for an emergency visit due to days of sore throat, cough, fevers and chills. Patient 2 had tried over the counter medication. Patient 2's temperature in the clinic was recorded at 100.3 and his oxygen saturation at 96%. Exams of the eyes, ear, nose, throat/oropharynx and lungs were unremarkable. Respondent diagnosed Patient 2 with acute bronchitis and prescribed Levaquin, an antibiotic, and Robitussin with Codeine and Nasonex.

Z. On or about May 11, 2017, Patient 2 presented to Respondent for dyspepsia, dizziness and fatigue. Respondent documented that Patient 2 had a recent EGD/colonoscopy, which were negative. Those tests, however, had revealed grade I internal hemorrhoids, diverticular disease of the describing and sigmoid colon, evidence of previous subtotal gastrectomy and friability of the gastric remnant. Patient 2's blood pressure was recorded at 129/65. His treatment plan included over the counter analgesics, smoking cessation, lifestyle modification and medication. Patient 2's medication list contained well over a dozen medications, including Ativan, Amitriptyline, Cymbalta, Ultram, Ambien and Neurontin.

AA. On or about June 12, 2017, Patient 2 submitted to a urine drug screen that was positive for Tramadol, Zolpidem, Cotinine (found in tobacco), Phenobarbital and Aminoclonazepam and negative for Lorazepam, Duloxetine and Gabapentin.

BB. On or about July 6, 2017, Patient 2 presented to Respondent with weakness, headache, heartburn and multiple joint pain. He reported years of symptoms of fatigue and dyspepsia. Respondent diagnosed him with headache, gastroesophageal reflux disease (GERD), fatigue, hyperuricemia and tobacco use disorder. His treatment plan included over the counter analgesics for headaches and nonsteroidals.

CC. On or about November 6, 2017, Patient 2 presented for urine drug screening that was positive for Tramadol, Cotinine, and Aminoclonazepam and negative for Lorazepam and Zolpidem. Other opiates were negative.

52. Respondent committed an extreme departure from the standard of care when he failed to keep accurate medical records for Patient 2. For example, Respondent's records often lack the pertinent positives and negatives of the conditions discussed. While general counseling is documented, actual treatment plans are often not apparent in Respondent's notes. Further, conflicting information pertaining to symptoms and complaints, for example, often appear in the same note. Additionally, relevant medical history and medication reconciliation are often lacking. Electronic medical records appear to have been copied and pasted on several occasions, making it difficult to access the current condition of the patient. Finally, relevant physical findings were often not addressed and abnormal findings are not consistently addressed.

53. Respondent committed an extreme departure from the standard of care when he repeatedly and continuously prescribed Patient 2 Ultram, a synthetic opiate, without appropriate initiation/continuation, titration and monitoring of chronic opiate pain management. Specifically, Respondent failed to document how Patient 2 was risk stratified for opioid misuse. Further, no titration of doses was found in the records and functional goals and adverse events were not clearly delineated. Patient 2 had aberrant behavior as shown by inconsistent positives and negatives in his urine drug screens. For example, he repeatedly tested positive for Phenobarbital, which was not on his medication list. These inconsistencies were never addressed in Patient 2's

record.

54. Respondent committed an extreme departure from the standard of care when he failed to document informed consent or a pain management agreement during the course of his care and treatment of Patient 2. Specifically, Respondent did not document any formal discussion between Respondent and Patient 2 regarding the benefit, risk and alternatives of long term opiate therapy. There was also no documentation of any discussion regarding aberrant behavior, and monitoring, despite Patient 2's inconsistent and concerning urine drug screening results, which were repeatedly positive for Phenobarbital.

55. Respondent committed an extreme departure from the standard of care when he concurrently prescribed Patient 2 narcotics, nonbenzodiazepine receptor agonists and benzodiazepines without consideration for tapering or antidote therapy, thereby, exposing Patient 2 to risk of respiratory depression.

56. Respondent committed a departure from the standard of care when he failed to provide Patient 2 with comprehensive evaluation and treatment for his hypertension. Specifically, Respondent repeatedly documented that Patient 2 complained of poorly controlled hypertension when his in-office readings were within normal range. Additionally, a funduscopic examination to evaluate for hypertensive retinopathy was never carried out. Respondent also did not document reviewing any home blood pressure logs. Finally, it was often not clear from the medical record what medications Patient 2 was taking.

57. Respondent committed a departure from the standard of care when he failed to provide proper evaluation and treatment for pharyngitis. Patient 2 presented with a sore throat and cough multiple times. Respondent would arrive at different diagnoses, however, even when presented with the same symptoms and in-office vital signs.

58. Respondent committed a departure from the standard of care when he failed to provide adequate evaluation and treatment for a potential infectious complaint. On or about January 19, 2019, Patient 2 requested medication and Respondent prescribed Bactrim, an antibiotic. No justification was documented for the prescription.

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59. Respondent committed a departure from the standard of care when he failed to adequately evaluate Patient 2's vertigo. Patient 2 repeatedly and consistently complained of vertigo. Respondent failed to document an adequate workup confirming a diagnosis causing the vertigo.

60. Respondent committed a departure from the standard of care when he failed to adequately evaluate Patient 2's polyarticular pain. Respondent's history and physical for the patient's recurrent polyarticular pain did not provide sufficient positive and negatives to assist in diagnosing the etiology of the patient's polyarticular pain. Patient 2 was often diagnosed with radiculopathy despite a lack of documentation of neuropathic pain.

61. Respondent committed a departure from the standard of care when he failed to provide adequate evaluation for adverse drug events during his care and treatment of Patient 2. Patient 2 was prescribed both Cymbalta and Amitriptyline for depression. Cymbalta may enhance the serotonergic effect of tricyclic antidepressants, resulting in serotonin syndrome. There is no documentation on this potential interaction in Patient 2's record or on the reasons why Patient 2 was placed on this combination of medications.

Patient 3

62. Between January 20, 2014, and February 13, 2018, Patient 3 consistently presented to Respondent for primary care and treatment. Throughout that time period, Patient 3 generally saw Respondent at least once a month and often multiple times per month. Over the course of his care and treatment, Patient 3 complained of, and received treatment for, numerous ailments and symptoms, including but not limited to: joint pain, back pain, hypertension, urinary problems, insomnia, vertigo, iron deficiency, abdominal pain, fatigue, dyspepsia and pharyngitis.

63. As part of his care and treatment of Patient 3, Respondent regularly prescribed numerous medications. Those medications included, but are not limited to, Vicodin (brand name for Hydrocodone/Acetaminophen, a Schedule II opiate), Norco (brand name for Hydrocodone/Acetaminophen, a Schedule II opiate), Robitussin or Phenergan with Codeine, Ambien, and Ativan.

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64. Respondent's care and treatment of Patient 3 included, but was not limited to, the following instances of care:

A. On or about January 24, 2014, Patient 3, already an established primary care patient of Respondent's, presented to Respondent for care and treatment. Patient 3 was 69 years old. He presented with uncontrolled blood pressure, reporting poor compliance with therapy. His in-clinic blood pressure reading was 132/59. Patient 3's recent laboratory results revealed elevated cholesterol and low iron and vitamin D. Patient 3 also complained of urination problems and a history of such problems. A urinalysis revealed 2-5 white blood cell count and negative nitrite/blood. The culture showed coagulase negative for staphylococcus. Respondent diagnosed Patient 3 with urinary tract infection (UTI), hypertension, noncompliance and cerumen (earwax) impaction. Respondent prescribed antibiotics for the UTI and referred Patient 3 to a urologist. Review of systems was positive for fatigue, multiple joint pain and stiffness, depression, apathy, stressing and insomnia. No referral to gastroenterology is documented. Patient 3's medication list was comprised of over twenty different medications, including but not limited to: Cymbalta, Geodon (an antipsychotic), Zoloft (a Selective Serotonin Reuptake Inhibitor (SSRI)), Ativan, Ambien, Soma (brand name for Carisoprodol, a Schedule IV muscle relaxant), Vicodin, Exelon (used to treat dementia), Dexilant (proton pump inhibitor), and Cialis (for erectile dysfunction).

B. On or about May 30, 2014, Respondent prescribed Patient 3 Vicodin for pain with 3 refills.

C. On or about June 10, 2014, laboratory results were positive for rheumatoid factor.

D. On or about June 13, 2014, Patient 3 presented to Respondent still complaining of urination problems. Patient 3 also reported worsening pain in multiple joints. There was no report of preceding trauma, paresthesia or joint swelling. Respondent documented that Patient 3 continues to smoke. Respondent diagnosed Patient 3 with a UTI, osteoarthritis at multiple sites and tobacco abuse. Respondent's plan

included a discussion of the diagnosis of osteoarthritis. Rheumatoid arthritis was not documented as being discussed. Patient 3's medication list was comprised of over twenty different medications, including but not limited to: Cymbalta, Geodon, Zoloft, Ativan, Ambien, Soma, Vicodin, Exelon, Dexilant, and Cialis.

E. In the following months, Patient 3 continued to complain of osteoarthritic pain at multiple sites, while participating in physical therapy with Respondent and maintaining his medication regimen.

F. On or about September 10, 2014, Patient 3 presented to Respondent complaining of poorly controlled labile hypertension and joint pain. Patient 3's in-clinic blood pressure was 117/52. At his previous visit, it was 130/70.

G. On or about October 23, 2014, Patient 3 presented to Respondent complaining of cough and sore throat, among other symptoms. Patient 3 denied fever and had an in clinic temperature of 98.9. Respondent diagnosed Patient 3 with viral upper respiratory tract infection and prescribed Promethazine (generic for Robitussin) with Codeine, as needed for cough.

H. On or about October 27, 2014, lab results for Patient 3 showed low iron, a positive rheumatoid factor and a urinalysis positive for 1+ blood, 2+ leukocytes and 2-5 WBC. The culture grew Staphylococcus aureus.

I. On or about October 30, 2014, Patient 3 presented to Respondent complaining of uncontrolled hypertension, dyspepsia, multiple joint pain and urination problems. His in-clinic blood pressure was 141/60. The plan includes discussion of a "fungal rash" without further detail, but for which Ketoconazole was prescribed. Respondent diagnosed Patient 3 with a UTI, dyspepsia, tinea corporis, tobacco abuse and osteoarthritis. Included in the treatment plan was an *H. pylori* test, which came back negative. Respondent prescribed antibiotics for the UTI.

J. Patient 3 continued to complain of low back and knee pain and on or about December 2, 2014, Respondent prescribed Vicodin 5/325. Vicodin had not been listed on Patient 3's most recent medication list dated November 17, 2014, although

Ativan, Ambien and Soma were included.

K. On or about January 5, 2015, Patient 3 presented complaining of sciatica. Patient 3 reported the pain was worsening and radiating down his leg. Respondent documented that Patient 3 had "tried Vicodin, was not helping much." Respondent changed Patient 3's pain medication from Vicodin to Naprosyn (a nonsteroidal anti-inflammatory drug (NSAID)) and Norco 325/10. Patient 3 was to take the Norco four times daily.

L. On or about January 28, 2015, lab results for Patient 3 showed hyponatremia (low sodium), low iron, and a urinalysis positive for nitrite, 1+ leukocytes and 2-5 WBC. The culture was coagulase negative Staphylococcus.

M. On or about February 3, 2015, Patient 3 presented to Respondent complaining of weakness, loss of appetite and weight loss. He also complained of pain in multiple joints and edema in the bilateral lower extremities. Respondent diagnosed him with peripheral vascular disease, fatigue, edema and tobacco abuse. The plan included increasing the frequency of Patient 3's Norco doses from four times daily to four to five times daily for pain control.

N. On or about April 13, 2015, lab results for Patient 3 showed low iron, hemoglobin and ferritin with an elevated sedation rate. The urinalysis positive for nitrite, 2+ leukocytes and 2-5 WBC. The culture grew Staphylococcus aureus.

O. On or about April 15, 2015, Patient 3 requested prescriptions for Nasonex, Robitussin with Codeine and a Z-pak, which Respondent filled. Respondent had filled a prescription for Patient 3 for Norco, four times daily, on or about April 6, 2015.

P. On or about April 17, 2015, Patient 3 presented to Respondent complaining of abdominal pain. Patient 3 associated the pain with taking iron pills. He denied heartburn symptoms and the abdominal exam was normal. Patient 3 was diagnosed with iron deficiency anemia, constipation, tobacco use and fatigue. The plan included continuing the iron supplements, dietary and lifestyle modification,

laxatives and "if conservative measures fail and the patient is clearly compliant with the advice, a more detailed evaluation will be performed and patient will be referred to gastroenterologist." An abdominal ultrasound was also ordered. The ultrasound revealed fatty infiltration of liver and possible small calcifications in the left kidney.

Q. On May 6, 2015, Respondent refilled prescriptions for ferrous sulfate (iron supplement) and Norco.

R. On or about May 26, 2015, lab results for Patient 3 showed low iron again. The urinalysis was positive for nitrite, 1+ leukocytes and 10-20 WBC. The culture grew coagulase negative Staphylococcus. A urine drug screen was positive for Hydrocodone/Norhydrocodone and Ambien, but otherwise negative for other sedatives and antidepressants.

S. Patient 3 continued to present to Respondent complaining of joint pain, insomnia, headache, back pain, and knee pain, in addition to a variety of other ailments throughout the summer of 2015. Respondent continued to prescribe Norco, among other medications.

T. On or about August 7, 2015, Respondent instructed Patient 3, among other things, to "follow up with psych for continuation of treatment with Geodon."

U. On or about September 9, 2015, Patient 3 presented to Respondent for neck pain. Respondent's plan included continuing Patient 3's medications without change. Patient 3's medication list consisted of over twenty medications including, but not limited to: Naprosyn, Ambien, Norco, Ativan, Exelon, Advair Diskus (a bronchodilator), Cymbalta, blood pressure medication, cholesterol medication, laxatives and iron supplements.

V. A September 21, 2015, urine drug screen of Patient 3 was positive for Hydrocodone/Norhydrocodone and Ambien, but otherwise negative for other sedatives and antidepressants.

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W. On or about October 1, 2015, Patient 3 presented to Respondent complaining of weakness, weight loss and heartburn. Patient 3 also reported multiple joint pain. His blood pressure was recorded at 96/47. Respondent documented that Patient 3 denied weight loss. A *H. pylori* test was conducted and returned negative.

X. A January 7, 2016, urine drug screen of Patient 3 was positive for Hydrocodone/Norhydrocodone, Ambien, and Aminoclonazepam, but otherwise negative for other sedatives and antidepressants.

Y. On or about February 1, 2016, Patient 3 requested medication and Respondent filled prescriptions for a Z-pak and Robitussin with Codeine. No symptoms or examination were documented.

Z. On or about March 15, 2016, Patient 3 presented to Respondent complaining of poorly controlled hypertension, back pain, cough and sore throat, without fever. Respondent prescribed Norco (120 count according to the electronic record and 90 count according to the handwritten prescription) and Robitussin with Codeine.

AA. A March 15, 2016, urine drug screen of Patient 3 was positive for Hydrocodone/Norhydrocodone, but negative for Lorazepam, a reported prescription, and other sedatives and antidepressants.

BB. An April 25, 2016, urine drug screen of Patient 3 was positive for Hydrocodone/Norhydrocodone and Ambien, and negative for other sedatives and antidepressants.

CC. On or about June 8, 2016, Patient 3 presented to Respondent with back pain and poor compliance with the treatment plan. Respondent documented discussing compliance issues with Patient 3 and refilled his Norco prescription.

DD. On or about July 15, 2016, Patient 3 presented to Respondent complaining of back pain and insomnia. Patient 3 reported taking more than on Ambien at a time. Respondent again documented discussing compliance issues with Patient 3.

EE. On or about July 16, 2016, laboratory results for Patient 3 of the same date, showed low hemoglobin, elevated sedation rate, elevated BUN/creatinine, elevated uric

acid, elevated lipid panel and elevated magnesium. The urinalysis revealed trace blood, 1+ protein, positive nitrite, 3+ leukocytes. The urine culture grew coagulase negative Staphylococcus and there was a handwritten note, "no symptoms," next to the urine studies.

FF. On or about August 5, 2016, Patient 3 requested a Z-pak, which Respondent prescribed. No other symptoms or exams were documented.

GG. On or about August 10, 2016, Patient 3 requested Robitussin with Codeine, which Respondent prescribed. No other symptoms or exams were documented.

HH. A September 6, 2016, urine drug screen of Patient 3 was positive for Norhydrocodone, Codeine, Aminoclonazepam and Ambien, and negative for other sedatives and antidepressants.

II. A November 8, 2016, a urine drug screen of Patient 3 was positive for Norhydrocodone, Temazepam, and Ambien, and negative for metabolites.

JJ. On or about November 11, 2016, Patient 3 presented to Respondent complaining of hypertension and joint pain. Patient 3's in-clinic blood pressure was 152/87. At his last visit, it had been 173/89. Respondent diagnosed him with osteoarthritis, fatigue, hypertension and iron deficiency anemia. Patient 3's medication list consisted of over twenty medications including, but not limited to: Naprosyn, Ambien, Norco, Ativan, Exelon, Advair Diskus, Cialis, Cymbalta, blood pressure medication, cholesterol medication, laxatives and iron supplements. Lab results for Patient 3 of the same date showed iron and vitamin D deficiency.

KK. On or about December 22, 2016, Patient 3 presented for erectile dysfunction which he had had for years. A genitourinary exam was not documented. Respondent diagnosed Patient 3 with male erectile disorder. Respondent prescribed Cialis.

LL. Lab results dated January 3, 2017, showed low hemoglobin, elevated BUN/creatinine, low iron and low vitamin D.

MM. Between January and May 2017, Patient 3 repeatedly presented to Respondent complaining of joint pain, hypertension, urinary problems and cough. He also

repeatedly requested medication. For example, on April 26, 2017, he requested prescriptions for bacitracin-polymyxin ophthalmic ointment and ciloxan eye drop, which Respondent filled. Likewise, on or about May 2, 2017, Patient 3 requested a prescription for tobramycin ophthalmic solution and a Z-pak, which Respondent filled. In both instances, no other symptoms or examinations were documented.

NN. On or about May 15, 2017, Patient 3 presented to Respondent complaining of cough, sore throat, fever and back pain. Patient 3's in-office temperature was 99.6. Exams of the eyes, ears, nose, throat/oropharynx and lungs were unremarkable. Respondent diagnosed him with back pain with radiculopathy and acute bronchitis. Respondent prescribed Levaquin, an antibiotic, and Robitussin with Codeine, while continuing Patient 3's other medications.

OO. On or about June 6, 2017, Patient 3 presented complaining of fatigue, joint pain and insomnia. Respondent's plan included maintaining Patient 3 on the same medications for insomnia. A new prescription for Ibuprofen (NSAID) was added to his medication list. A urine drug screen of Patient 3 of the same date was positive for Hydrocodone/Norhydrocodone, Cotinine, Codeine, Aminoclonazepam and Ambien, and negative for other metabolites. There is a handwritten note that the Cotinine is "most likely error." A urinalysis of the same date came back positive for UTI.

PP. On or about June 8, 2017, Respondent prescribed Patient 3 a Z-pak in response to a request from the patient.

QQ. On June 13, 2017, Respondent prescribed Levaquin for UTI. No other symptoms or exams were documented.

RR. On or about June 27, 2017, Patient 3 presented again with cough, sore throat and fever. Patient 3 had the symptoms for weeks, had tried over the counter medication and two different antibiotics. His in-office temperature was 97.9. His lungs were documented as clear. Respondent diagnosed him with acute bronchitis and prescribed Amoxicillin, an antibiotic, and Robitussin with Codeine, in addition to

ear drops.

SS. On or about September 15, 2017, Patient 3 presented for runny nose and back pain. The plan included continuing Patient 3 on his medications without change. Patient 3's medication list consisted of over thirty medications including, but not limited to: Naprosyn, Ibuprofen, Ambien, Norco, Ativan, Exelon, Advair Diskus, Cymbalta, blood pressure medication, cholesterol medication, laxatives and iron supplements.

TT. On or about October 9, 2017, Patient 3 presented complaining of weakness and joint pain. Respondent noted that Patient 3 "takes Norco, but more than 3 times a day, runs out." Respondent's plan included increasing Patient 3's Norco dose frequency from three times daily to four times daily. Lab results from the same day continued to show low iron and vitamin D and the urinalysis showed persistent pyuria and culture coagulase negative Staphylococcus. A urine drug screen of Patient 3 of the same date was positive for Hydrocodone/Norhydrocodone, Cotinine, Aminoclonazepam and Ambien, and negative for other metabolites.

UU. On or about November 15, 2017, Patient 3 presented to Respondent for back pain, unsteady gait and insomnia. His in-clinic blood pressure was 168/72. Respondent's plan included maintaining Patient 3's medications unchanged. Patient 3's medication list consisted of over thirty medications including, but not limited to: Naprosyn, Ibuprofen, Ambien, Norco, Ativan, Exelon, Advair Diskus, Cialis, Cymbalta, blood pressure medication, cholesterol medication, laxatives and iron supplements.

VV. On or about December 12, 2017, and January 5, 2018, Patient 3 requested a Z-pak, which Respondent prescribed on both dates. No other details about symptoms were documented. On or about January 5, 2018, Respondent also prescribed Phenergan with Codeine.

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WW. On or about January 9, 2018, Patient 3 presented to Respondent for erectile problems and joint pain. Respondent did not document whether Cialis helped, but did prescribe it again along with Norco.

XX. On or about February 12, 2018, a urine drug screen of Patient 3 was positive for Phenobarbital (not prescribed by Respondent), Hydrocodone/Norhydrocodone, Hydromorphone, and Ambien, and negative for other metabolites.

65. Respondent committed an extreme departure from the standard of care when he failed to keep accurate medical records for Patient 3. For example, Respondent's records often lack the pertinent positives and negatives of the conditions discussed. While general counseling is documented, actual treatment plans are often not apparent in Respondent's notes. Further, conflicting information pertaining to symptoms and complaints, for example, often appear in the same note. Additionally, relevant medical history and medication reconciliation are often lacking. Electronic medical records appear to have been copied and pasted on several occasions, making it difficult to access the current condition of the patient. Finally, relevant physical findings were often not addressed and abnormal findings are not consistently addressed.

66. Respondent committed an extreme departure from the standard of care when he repeatedly and continuously prescribed Patient 3 Vicodin, then Norco, both opiates, without appropriate initiation/continuation, titration and monitoring of chronic opiate pain management. Specifically, Respondent failed to document how Patient 3 was risk stratified for opioid misuse. Functional goals and adverse events were not clearly delineated for titration of the opiate dose. Patient 3 had aberrant behavior as shown by inconsistent positives and negatives in his urine drug screens. These inconsistencies, such as testing positive for medications not prescribed, were never addressed in Patient 3's record.

67. Respondent committed an extreme departure from the standard of care when he concurrently prescribed Patient 3 narcotics, nonbenzodiazepine receptor agonists and benzodiazepines without consideration for tapering or antidote therapy, thereby, exposing Patient 3 to risk of respiratory depression. Specifically, Respondent concurrently prescribed Ambien, Ativan, Soma and Vicodin, then Norco. Throughout Patient 3's care and treatment, no consistent

effort for tapering was documented. Patient 3 was also a smoker and using Advair Diskus, thereby, increasing his respiratory risk.

68. Respondent committed an extreme departure from the standard of care when he failed to provide Patient 3 proper evaluation and treatment for iron deficiency anemia. Patient 3 was noted to have low iron deficiency anemia on repeated lab results throughout his care and treatment. However, there was no documented endoscopic evaluation as part of Patient 3's preventative care as an adult male over 50. The patient also should have been referred to gastroentology as soon as possible. While fecal occult blood can be tested, even if negative, it does not rule out an occult malignancy. It was also documented that Patient 3 was losing weight, which is additional cause for concern.

69. Respondent committed an extreme departure from the standard of care when he failed to adequately evaluate Patient 3's polyarticular pain. Respondent's history and physical for the patient's recurrent polyarticular pain did not provide sufficient positive and negatives to assist in diagnosing the etiology of Patient 3's polyarticular pain. It was noted, however, on multiple blood draws that Patient 3's rheumatoid factor was positive. There is no indication in the record that the anti-cyclic citrullinated peptide test, which has a higher specificity for rheumatoid arthritis, was checked. If inflammatory or rheumatoid arthritis were confirmed as the diagnosis, it would call for completely different treatment than that prescribed for Patient 3 by Respondent. Respondent also concurrently prescribed Patient 3 Ibuprofen and Meloxicam, both NSAIDs.

70. Respondent committed a departure from the standard of care when he failed to provide Patient 3 with comprehensive evaluation and treatment for his hypertension. Specifically, Respondent repeatedly documented that Patient 3 complained of poorly controlled hypertension when his in-office readings were within range. Additionally, Respondent never documented reviewing any home blood pressure logs. Likewise, a funduscopic examination to evaluate for hypertensive retinopathy was never carried out. Finally, it was also often not clear what medications Patient 3 was taking.

71. Respondent committed a departure from the standard of care when he failed to provide proper evaluation and treatment for pharyngitis. Patient 3 presented with a sore throat

and cough multiple times. Respondent would arrive at different diagnoses, however, for the same documented presentation for unknown reasons.

72. Respondent committed a departure from the standard of care when he failed to provide adequate evaluation and treatment for potential infectious complaints. During the course of Patient 3's care and treatment, Patient 3 requested medications from Respondent, which Respondent then prescribed without documenting any justification for the prescription. For example, Respondent prescribed Patient 3 Z-paks and tobramycin ophthalmic solution without any documentation of symptoms or exam or other justification for these antibiotic prescriptions.

Patient 4

73. Between January 24, 2014, and January 29, 2018, Patient 4 consistently presented to Respondent for primary care and treatment. Throughout that time period, Patient 4 saw Respondent numerous times each year, sometimes multiple times per month. Over the course of her care and treatment, Patient 4 complained of, and was treated by Respondent for numerous ailments and symptoms, including but not limited to: joint pain, hypertension, urinary problems, insomnia, vertigo, fatigue and pharyngitis.

74. As part of his care and treatment of Patient 4, Respondent prescribed numerous medications. Those medications include, but are not limited to, Clonazepam and Temazepam, both Schedule IV benzodiazepines.

75. Respondent's care and treatment of Patient 4 includes, but is not limited to, the following instances of care:

A. On or about January 28, 2014, Patient 4, already an established patient of Respondent's, presented to Respondent for care and treatment. She was 65 years old. Patient 4 complained of severe worsening back pain. Respondent diagnosed her with back syndrome with radiculopathy and muscle spasms. Over a dozen medications appear on Patient 4's medication list including, but not limited to: Sonata (brand name for Zaleplon, a Schedule IV narcotic), Ambien, Clonazepam, antidepressants (Savella, Trazadone, Zoloft), dementia medication (Aricept), urinary incontinence medication and blood pressure medication.

B. On or about March 6, 2014, Patient 4 presented to Respondent complaining of high blood pressure, excessive weight gain, urinary frequency and incontinence. Her in-clinic blood pressure was 145/90.

C. On or about April 10, 2014, Patient 4 presented to Respondent for a preoperative evaluation for hammer toe deformities. She reported symptoms of palpitations and dizziness. Her in-clinic blood pressure was 145/68. The plan included a general discussion of palpitations, laboratory evaluation, chest x-ray, EKG, and a Holter echocardiogram.

D. On or about August 11, 2014, Patient 4 presented with ear pain, tinnitus and hearing problems for the past several weeks. Patient 4 endorsed symptoms of vertigo and room spinning. An otoscopic exam revealed cerumen impaction. Respondent diagnosed Patient 4 with likely benign paroxysmal positional vertigo. Over a dozen medications appear on Patient 4's medication list including, but not limited to: Sonata, Ambien, Clonazepam, Aricept, and Lyrica.

E. On or about August 26, 2014, Patient 4 presented for a preoperative examination. Patient 4 was scheduled for a right foot bunionectomy/osteotomy. Her in-clinic blood pressure was recorded at 95/48. Medication reconciliation was carried out and Lyrica, Clonazepam, Ambien and Sonata were all discontinued, but Temazepam, a Schedule IV benzodiazepine, was added. Respondent determined that Patient 4 was low risk and cleared her for the surgery. An EKG conducted that day revealed T wave inversions to V1 and V3, but no prior EKG was available for comparison.

F. On or about October 3, 2014, Patient 4 presented for an influenza vaccination. Respondent administered the vaccination. He did not document the vaccination lot number or expiration date. Patient 4 also continued to complain of poorly controlled labile blood pressure, weight gain, and fatigue. A review of her systems was positive for dyspepsia, pain in multiple joints, depression and insomnia. Her in-clinic blood pressure was 143/69.

G. On or about November 17, 2014, Patient 4 presented for care complaining of back and joint pain, which was chronic and worsening. Patient 4 also complained of constipation. Respondent diagnosed her with osteoarthritis. Over twenty medications appear on Patient 4's medication list including, but not limited to: Sonata, Ambien, Clonazepam, Temazepam, Trazadone, and Aricept.

H. On or about January 16, 2015, Patient 4 presented to Respondent with chief complaints of "fever, cough and sore throat." Respondent later noted that she denied fevers. Her in-office temperature was 103.8 and her blood pressure was 150/68. Her lung exam was normal. Respondent diagnosed her with pneumonia and prescribed Robitussin with Codeine, Flonase and Levaquin.

I. On or about January 18, 2015, Patient 4 submitted to a urine drug screen. The test was positive for Levorphanol, a Schedule II synthetic opioid, and negative for other metabolites, including benzodiazepines and antidepressants. Respondent had not prescribed Patient 4 Levorphanol.

J. On or about January 23, 2015, Patient 4 returned to Respondent reporting cough, fevers and fatigue. She reported being hospitalized with the influenza, although the dates of hospitalization are unclear. Her oxygenation was documented at 74%. Respondent diagnosed her with influenza and fatigue and prescribed Tamiflu, an antiviral.

K. On or about June 12, 2015, Patient 4 presented complaining of bilateral calf pain, vertigo, muscle spasms and numbness/tingling of bilateral upper extremities. Respondent assessed that she "most likely" suffered from benign paroxysmal positional vertigo. An ENG/VAT was ordered. Her medication list included both Clonazepam and Temazepam, in addition to numerous other medications. Ambien and Trazadone were not listed.

L. On or about July 21, 2015, Patient 4 returned to Respondent for joint pain, headache, ataxia and constipation. Her medication list included Clonazepam, Temazepam, Ambien, Sonata and Trazodone, in addition to numerous other medications. The

following day, Respondent wrote a pharmacy note to discontinue Trazadone and several other medications.

M. On or about July 27, 2015, Patient 4 presented for ENG/VAT testing. Data was missing from the test fields and the interpretation was unclear.

N. On or about August 14, 2015, Patient 4 presented to Respondent for vertigo, high blood pressure and heartburn. She reported that her at-home blood pressure readings were poor and labile. Her in-clinic blood pressure was 150/90.

O. On or about August 27, 2015, Respondent prescribed Patient 4 Motrin (an NSAID), 600 milligrams.

P. On or about November 16, 2015, Patient 4 requested Linzess (used to treat Irritable Bowel Syndrome), which Respondent prescribed. Respondent did not document any symptoms or exam.

Q. On or about December 11, 2015, Patient 4 submitted to a urine drug screen that was negative for benzodiazepines.

R. On or about February 17, 2016, Patient 4 presented for preoperative clearance. Patient 4 was scheduled for a hernia repair surgery. Her review of systems was positive for dyspnea (difficulty breathing). Respondent determined that Patient 4 was low risk and cleared her for the surgery.

S. Over the course of the next several months, Patient 4 sought treatment from Respondent for a variety of ailments, including abdominal pain and poorly controlled hypertension.

T. On or about July 26, 2016, a urine drug screen of Patient 4 was positive for Phenobarbital and negative for all other metabolites tested. On May 4, 2016, and July 28, 2016, Patient 4 filled prescriptions for Clonazepam and Temazepam.

U. On or about August 25, 2016, Patient 4 presented to Respondent for follow up complaining of back pain and hypertension. She also reported episodes of hypotension. Her in-office blood pressure was 146/66. Patient 4 was given a prescription for lumbar orthosis and instructed to continue with NSAIDs, among

other care. Her medication list was comprised of over a dozen medications and included Clonazepam, Temazepam and Motrin.

V. On or about January 9, 2017, Patient 4 submitted to a urine drug screen that was negative for all metabolites tested, including benzodiazepines. On or about October 24, 2016, and January 18, 2017, Patient 4 filled prescriptions from Respondent for Clonazepam and Temazepam.

W. On or about March 7, 2017, Patient 4 presented to Respondent for constipation, hypertension and dyspepsia. An *H. pylori* test was negative. Her in-clinic blood pressure was 147/62. Her medication list was comprised of over a dozen medications and included Clonazepam, Temazepam and Motrin.

X. Over the course of the next several months, Patient 4 repeatedly presented to Respondent complaining of hypertension, leg pain, weakness and constipation, among other ailments.

Y. On October 18, 2017, Patient 4 presented to Respondent for palpitations and weakness following a hospital visit. The reason for the hospital visit is unclear. The review of her systems was negative for palpitations. Her in-clinic blood pressure was 146/74. Her cardiac auscultation was described as normal. Respondent diagnosed her with cardiac arrhythmia (unspecified), fatigue and anxiety. Namzaric (used to treat Alzheimer's disease) was prescribed.

Z. On or about November 28, 2017, Patient 4 presented to Respondent complaining of weakness, hypertension, bradycardia (slow heart rate) and dizziness. Her in-clinic blood pressure was 152/75 and her pulse was 57. Cardiae auscultation revealed regular rhythm. Respondent diagnosed Patient 4 with bradycardia, fatigue and malaise, hypertension and vertigo. Her medication list included Clonazepam, Ultram, (50 milligram tablets with 3 refill) and Motrin. Temazepam is not listed.

AA. On or about January 29, 2018, Patient 4 presented with cough, sore throat and fever. She denied dyspnea and was stable on exam. Respondent diagnosed her with acute bronchitis and prescribed a Z-pak, Flonase and Robitussin.

76. Respondent committed an extreme departure from the standard of care when he failed to keep accurate medical records for Patient 4. For example, Respondent's records often lack the pertinent positives and negatives of the conditions discussed. While general counseling is documented, actual treatment plans are often not apparent in Respondent's notes. Further, conflicting information pertaining to symptoms and complaints, for example, often appear in the same note. Additionally, relevant medical history and medication reconciliation are often lacking. Electronic medical records appear to have been copied and pasted on several occasions, making it difficult to access the current condition of the patient. Finally, relevant physical findings were often not addressed and abnormal findings are not consistently addressed.

77. Respondent committed an extreme departure from the standard of care when he failed to provide Patient 4 with an appropriate preoperative consultation. Specifically, Respondent failed to conduct any assessment of Patient 4's exercise capacity as part of his preoperative evaluations. In fact, at one time Patient 4 complained of shortness of breath and he still cleared her for surgery. An EKG revealed T wave inversions to V1 and V3, but no prior EKG was available for comparison. Additionally, Patient 4 complained of palpitations and it was unclear if the issue was resolved prior to surgery.

78. Respondent committed an extreme departure from the standard of care when he prescribed multiple benzodiazepines and nonbenzodiazaphone benzodiazepine receptor agonists concurrently to Patient 4 and failed to address aberrant behavior. Throughout the course of her care and treatment, Respondent repeatedly and consistently prescribed Patient 4, Clonazepam and Temazepam. Ambien and Sonata were also frequently included on her medication list. At one point, Respondent attempted to discontinue Ambien, but from his documentation appears to have been unsuccessful. This combination of medication carries an increased risk of adverse effects. Respondent also did not document if, when and how he ever addressed Patient 4's urine drug screens which repeatedly showed positive for narcotics he did not prescribe (Phenobarbital) and negative for ones that he did (Clonazepam and Temazepam).

79. Respondent committed an extreme departure from the standard of care when he failed to provide proper evaluation and treatment for pharyngitis. According to Respondent's

documentation, Patient 4 presented with a sore throat and cough numerous times. Despite the same documented presentation, Respondent would arrive at different diagnoses for reasons that cannot be determined from the records. At one time, Patient 4 was documented to have an oxygen saturation of 74% and Respondent did not direct her to the emergency room. At another visit, Respondent diagnosed her with pneumonia despite a clear lung exam.

80. Respondent committed an extreme departure from the standard of care when he failed to adequately evaluate Patient 4's polyarticular pain. Respondent's history and physical for the patient's polyarticular pain did not provide sufficient positive and negatives to assist in diagnosing the etiology of her polyarticular pain. Patient 4 was often diagnosed with radiculopathy despite a lack of documentation of neuropathic pain. Patient 4 repeatedly presented with pain and it is unclear from the record, if she was correctly diagnosed or treated.

81. Respondent committed a departure from the standard of care when he failed to provide Patient 4 with a comprehensive evaluation and treatment for her hypertension. Specifically, Respondent repeatedly documented that Patient 4 complained of poorly controlled hypertension when her in-office reading was within range. Additionally, while Respondent instructed Patient 4 to monitor her blood pressure at home, he never documented reviewing any home blood pressure logs. Likewise, a funduscopic examination to evaluate for hypertensive retinopathy was never carried out. It was also often not clear what medications Patient 4 was taking and Respondent continued to prescribe Motrin even when Patient 4's blood pressure reading was high.

82. Respondent's care and treatment of Patient 4 departed from the standard of care when he failed to adequately document a workup confirming a diagnosis causing Patient 4's vertigo.

Patient 5

83. Patient 5 first presented to Respondent and established care on April 7, 2015. At the time, Patient 5 was 23 years old.

84. At the initial visit, Patient 5 complained of problems concentrating and "feeling all over the place." She was diagnosed with Attention Deficit Disorder (ADD). Patient 5 reported that her symptoms were improved with Adderall, which Respondent then prescribed twice daily

in 30 milligram doses. Respondent discussed the treatment options with Patient 5 and requested her prior medical records.

85. Between Patient 5's initial visit and January 1, 2018, Patient 5 consistently presented to Respondent for care and treatment. Respondent was not aware that she was under the care of any other primary care physician. Throughout that time period, Patient 5 saw Respondent numerous times each year, generally monthly or every other month.

86. Throughout his care and treatment with Respondent, Patient 5 consistently complained of attention problems and later on in her care, back pain. As part of his care and treatment of Patient 5, Respondent prescribed numerous medications. Those medications include, but are not limited to, Adderall and Oxycodone, a Schedule II opiate.

87. Respondent's care and treatment of Patient 5 includes, but is not limited to, the following instances of care:

A. After Patient 5's initial visit, on April 7, 2015, during which Respondent prescribed Adderall, and through February 3, 2016, Patient 5 saw Respondent six (6) times. Each time she complained of attention and concentration problems. At the February 3, 2016 visit, she also complained of generalized fatigue. Throughout this time period, Respondent prescribed her Adderall.

B. On or about April 7, 2016, Patient 5 presented to Respondent for problems concentrating. She also reported low back pain, but denied paresthesia. Respondent's examination revealed decreased range of motion in affected joints as well as tenderness to palpitation along the paravertebral muscles and spinous process. Respondent diagnosed Patient 5 with back pain with radiculopathy, vitamin D deficiency and attention deficit/hyperactivity disorder (ADHD). Respondent prescribed Naprosyn, vitamin D and home exercise.

C. On or about July 5, 2016, Patient 5 presented to Respondent for difficulties concentrating and back pain. She reported that Naprosyn, pain creams and physical therapy did not alleviate the pain. She denied preceding trauma or paresthesia and was diagnosed with back pain with radiculopathy. The documented plan was to

continue with a nonsteroidal, but also to start Oxycodone three times a day as needed. Respondent prescribed Patient 5 90 tablets of 30 mg Oxycodone, in addition to Adderall.

D. On or about August 5, 2016, Patient 5 presented to Respondent and reported that the Adderall and Oxycodone were helping her symptoms. No changes were made to her treatment plan and her medications were refilled.

E. On or about September 2, 2016, October 5, 2016, and November 4, 2016, Patient 5 presented to Respondent and reported worsening back pain. At the November 4, 2016 visit, Respondent increased her Oxycodone dose to four times daily as needed.

F. On or about January 6, 2017, Patient 5 presented to Respondent complaining of worsening back pain. She also reported that her concentration was improved by Adderall, but was still not good in the afternoon. Respondent increased her Adderall dosage from twice daily to three times daily. He also continued her Oxycodone prescription.

G. On or about February 3, 2017, Patient 5 presented complaining of worsening back pain. Respondent increased her Oxycodone dose from four times daily to four-five times daily.

H. On or about May 5, 2017, Patient 5 presented to Respondent complaining of numbness and tingling of the right upper extremity for a few weeks. Respondent diagnosed her with peripheral neuropathy, back pain and ADHD. She was continued on the same medications and the treatment plan included obtaining an MRI of L-spine and refer to neurology. The MRI of L-spine without contrast revealed very mild degenerative disc disease at L4-5, L5-SI without spinal stenosis, neuroforaminal narrowing or evidence of nerve root compression.

I. On or about June 6, 2017, Patient 5 came in for a follow-up visit. The results of the MRI were discussed and Patient 5's Oxycodone was tapered to three times daily.

J. On or about August 4, 2017, Patient 5 presented to Respondent complaining of back pain and difficulties concentrating, in addition to headache and neck pain.

Respondent's plan was to taper her from Adderall three times daily to twice daily. Respondent ordered an MRI of the brain and C-spine. The MRI of the brain and C-spine with and without contrast revealed an incidental 1 to 2 millimeter focus hyperintensity within the right frontal lobe matter, 1 millimeter right paracentral protrusion with partial annular fissure without cord compression, canal or foraminal stenosis at C6-7, and minimal 1 millimeter right sided asymmetric disc bulge without canal or foraminal stenosis at C3-4.

K. On or about September 5, 2017, Patient 5 presented to Respondent for difficulties concentrating and worsening back pain. Respondent increased her Oxycodone dose back to three a day.

L. On or about October 6, 2017, Patient 5 presented to Respondent for difficulties concentrating. She reported that the Adderall was wearing off toward the end of the day. Respondent increased her Adderall dose frequency from two to three times daily.

M. On or about January 26, 2018, Patient 5 presented to Respondent for difficulties concentrating and back pain. Respondent instructed her to find a pain specialist to continue her Oxycodone prescription. He would continue to prescribe to provide her time to establish care with a pain specialist.

N. On or about July 3, 2017, August 4, 2017, and October 8, 2017, Patient 5's records reflect that a prescription refill requests were made for Promethazine/Codeine but were denied.

88. Respondent committed an extreme departure from the standard of care when he prescribed, and continued to prescribe, Patient 5 Adderall without clear indication for high dosage Adderall use. Specifically, Respondent started Patient 5 at 60 milligrams of Adderall a day, which is higher than the manufacturer recommended dose, and then titrated her up at an increment that exceeded the manufacturer's dose. Though Patient 5 was prescribed Adderall for presumed ADHD, Respondent's records are lacking a clear description or basis for the diagnosis of ADHD. For example, there was no documentation of the DSM-5 diagnostic criteria for ADHD

in the patient record. Features such as combined presentations, predominantly inattentive presentation or predominantly hyperactive/impulsive presentation are not specified. Further, Respondent failed to document the severity and remission status. Respondent also failed to distinguish ADHD from other mood disorders, substance use disorders or other psychotic disorders that may have features similar to those noted in ADHD. As such, there was no clear indication from Patient 5's records that Adderall was appropriate. If Adderall is used, a clear discussion and monitoring of the adverse side effects of this controlled substance should be carried out, which Respondent failed to do.

89. Respondent committed an extreme departure from the standard of care when he repeatedly and continuously prescribed Patient 5 Oxycodone, an opiate, without appropriate initiation/continuation, titration and monitoring of chronic opiate pain management. Specifically, Respondent started Patient 5 on Oxycodone after she reported that Naprosyn and conservative therapy did not alleviate her back pain. Respondent failed to document how Patient 5 was risk stratified for opioid misuse. Further, functional goals and adverse events were not clearly delineated and there was no clear indication from the record that Oxycodone was indicated for the patient's pain. Finally, Respondent failed to regularly monitor Patient 5 with urine drug screens and consultation of her CURES prescription records.

Patient 6

90. Patient 6 first presented to Respondent and established care on July 21, 2014. At the time, Patient 6 was 27 years old.

91. At the initial visit, Patient 6 complained of problems concentrating and "feeling all over the place." He had been diagnosed with Attention Deficit Disorder (ADD), although Respondent did not obtain his prior medical records. Patient 6 reported that his symptoms were improved with Adderall, which Respondent then prescribed twice daily in 30 milligram doses. Respondent did not refer him for a psychiatric consultation.

92. Between Patient 6's initial visit and January 1, 2018, Patient 5 consistently presented to Respondent for care and treatment as his primary care physician. Throughout that time period, Patient 6 saw Respondent numerous times each year, generally monthly.

93. Throughout his care and treatment with Respondent, Patient 6 consistently complained of attention problems and back pain. As part of his care and treatment of Patient 6, Respondent prescribed numerous medications. Those medications include, but are not limited to, Adderall and Norco.

94. Respondent's care and treatment of Patient 6 includes, but is not limited to, the following instances of care:

A. After Patient 6's initial visit, on July 21, 2014, during which Respondent prescribed Adderall, and through December 1, 2014, Patient 6 had two office visits with Respondent. At both visits, he complained of attention and concentration problems and was continued on Adderall.

B. On or about January 28, 2015, Patient 6 presented to Respondent for problems concentrating. He also reported lower back pain that had been worsening for the past few months, but denied trauma or paresthesia. Respondent's examination revealed tenderness to palpitation along the spine with spasm, but otherwise the muscular, skeletal and joint exams were unremarkable. Respondent diagnosed Patient 6 with back pain with radiculopathy. Respondent prescribed Naprosyn and Norco 325/10, for severe pain.

C. Patient 6 continued to treat with Respondent and complain of concentration problems and back pain. Respondent continued Patient 6's medication regimen of Adderall, Naprosyn and Norco until May 13, 2015, when Patient 6 presented to Respondent for follow up. Respondent documented that Patient 6's pain was improved with opiate analgesics, but that Naprosyn and Norco were "not helping." Respondent's plan included continuing with a nonsteroidal, but also starting Oxycodone every six hours as needed for pain. Respondent prescribed Patient 6 90 tablets of 30 mg Oxycodone, in addition to Adderall.

D. Respondent continued Patient 6 on this medication regimen until January 5, 2016, when Patient 6 presented to Respondent for follow up for difficulties concentrating and low back pain. Respondent documented that Patient 6 "feels that [the Adderall]

wears of [sic] in the afternoon." Respondent's plan included Oxycodone "twice daily as needed for pain" and to increase Patient 6's Adderall dose from 30 milligrams twice daily to three times daily. Patient 6 was also referred for an X-ray of the L-spine and referred to a pain management specialist.

E. Patient 6 continued to treat with Respondent and complain of concentration problems and back pain. Respondent continued Patient 6's dosages of Adderall and Oxycodone until July 15, 2015, when Patient 6 presented to Respondent for follow up. Respondent documented that Patient 6's pain is "improved by opiate analgesics, but takes more than 2 times a day, running out earlier. Has tried NSAIDs." Respondent's plan included increasing Patient 6's Oxycodone dose frequency from twice daily to three times daily.

F. On or about August 15, 2016, Patient 6 presented to Respondent complaining of cough, sore throat, nasal congestion and back pain. He denied fevers or chills. His in-office temperature was 97.8 and his oxygenation was 97%. Exams of the eyes, ear, nose, throat and lungs were unremarkable. Respondent diagnosed Patient 6 with viral cough, low back pain and ADD. Respondent prescribed Patient 6 Promethazine with Codeine, in addition to refilling his Oxycodone prescription.

G. On October 14, 2016, Patient 6 presented to Respondent for follow up related to difficulties concentrating and back pain. Respondent documented that Patient 6 reported that he "takes Oxycodone, but runs out, takes more than 3 times a day... was referred to pain management, but didn't go yet." Respondent increased Patient 6's Oxycodone dose frequency from three times daily to four times daily.

H. On or about November 18, 2016, Respondent prescribed Patient 6, Ambien 10mg, once a day with one refill, and Ventolin HFA (Proventil/Abuterol), among other medications. These prescriptions are not documented in Patient 6's medical record.

I. On or about December 14, 2016, Patient 6 presented to Respondent. In addition to complaining of difficulties concentrating and back pain, he also complained about anxiety. Respondent documented that Patient 6 reported his anxiety symptoms as

continuous, severe and present for years. He reported that Xanax (brand name for Alprazolam, a Schedule IV benzodiazepine) had helped in the past. At that visit, in addition to Oxycodone and Adderall, Respondent prescribed Patient 6 Xanax, 90 2 milligram bars with three refills, to be taken three times daily.

J. On or about January 13, 2017, Patient 6 presented to Respondent complaining of cough, sore throat, and nasal congestion for days. He denied fevers or chills. His in-office vitals were unremarkable. Respondent diagnosed Patient 6 with a viral respiratory infection. Respondent prescribed Patient 6 Promethazine with Codeine, in addition to refilling his Oxycodone and Adderall prescriptions.

K. On or about February 10, 2017, Patient 6 presented to Respondent complaining of recurrent cough, sore throat and nasal congestion, among other symptoms. Respondent again prescribed Patient 6 Promethazine with Codeine.

L. On or about March 8, 2017, Patient 6 presented to Respondent still complaining of a cough, now with shortness of breath. Respondent documented that Patient 6 had the conditions for months and that he had tried bronchodilators and cough syrup. Respondent diagnosed him with asthma, cough, low back pain and ADD. In addition to asthma medication, Respondent prescribed Patient 6 Oxycodone, Adderall and Promethazine with Codeine.

M. On or about April 12, 2017, Respondent reduced Patient 6's Oxycodone dose frequency from four times daily to three times daily after Patient 6 reported not taking as much pain medication.

N. On or about July 12, 2017, Respondent increased Patient 6's Oxycodone dose back to four times daily.

O. On or about August 11, 2017, Patient 6 presented to Respondent and is documented as reporting that he "feels that the current dose [of Oxycodone] is not enough." Respondent also documented that Patient 6 was referred to both an orthopedist and a pain management specialist, but did not go. Respondent increased Patient 6's Oxycodone dose frequency from four times daily to five or six times daily. Patient

6 was again referred to pain management.

P. Through at least February 9, 2019, Respondent continued to prescribe Patient 6 Adderall and Oxycodone.

95. Respondent committed an extreme departure from the standard of care when he prescribed, and continued to prescribe, Patient 6 Adderall without clear indication for high dosage Adderall use. Specifically, Respondent started Patient 6 at 60 milligrams of Adderall a day, which is higher than the manufacturer recommended dose, and then titrated him up at an increment that exceeded the manufacturer's dose. Though Patient 6 was prescribed Adderall for presumed ADHD, Respondent's records are absent a formal diagnosis or clear description or basis for the diagnosis of ADHD. For example, there was no documentation of the DSM-5 diagnostic criteria for ADHD in the patient record. Features such as combined presentations, predominantly inattentive presentation or predominantly hyperactive/impulsive presentation are not specified. Further, Respondent failed to document the severity and remission status. Respondent also failed to distinguish ADHD from other mood disorders, substance use disorders or other psychotic disorders that may have features similar to those noted in ADHD. As such, there was no clear indication from Patient 6's records that Adderall was appropriate. If Adderall is used, a clear discussion and monitoring of the adverse side effects of this controlled substance should be carried out, which Respondent failed to do.

96. Respondent committed an extreme departure from the standard of care when he repeatedly and continuously prescribed Patient 6 opiates, including Oxycodone, without appropriate initiation/continuation, titration and monitoring of chronic opiate pain management. Specifically, while under Respondent's care, Patient 6's pain regimen was quickly escalated to include opiate modalities for back pain. Respondent did so without documenting how Patient 6 was risk stratified for opioid misuse. Further, functional goals and adverse events were not clearly delineated and there was no clear indication from the record that Oxycodone was indicated for the patient's pain. Finally, Respondent failed to regularly monitor Patient 6 with urine drug screening.

97. Respondent committed an extreme departure from the standard of care when he concurrently prescribed Patient 6 opiates, nonbenzodiazepine receptor agonists and benzodiazepines without consideration for tapering or antidote therapy, thereby, exposing Patient 6 to risk of respiratory depression. Specifically, during the course of his care and treatment, Respondent concurrently prescribed Patient 6, Ambien, Xanax and Oxycodone. Respondent prescribed this regimen even though he was also treating Patient 6 for asthma with medications such as Albuterol, tapering attempts for Oxycodone had proved unsuccessful and Patient 6 had repeatedly failed to follow up on Respondent's referral to pain management.

Patient 7

98. Patient 7 first presented to Respondent in order to establish care on July 31, 2015. At the time, Patient 7 was 54 years old. His past medical history included hypertension, anxiety disorder, back pain with radiculopathy and neck pain. Patient 7 had a history of neck surgery following a gunshot wound.

99. At the initial visit, Patient 7 complained of multiple joint pain, poorly controlled labile hypertension, anxiety and panic attacks. Patient 7's medication list included Soma, Norco, Xanax and blood pressure medication. Patient 7 was documented as a smoker. His in-office blood pressure was recorded at 146/76. Respondent diagnosed Patient 7 with hypertension, anxiety disorder, back syndrome with radiculopathy and neck pain. The plan included at-home blood pressure monitoring, dietary and lifestyle modifications, obtain previous records and continue the same medications.

100. Respondent's care and treatment of Patient 7 includes the following instances of care:

A. On or about September 1, 2015, Patient 7 presented to Respondent for a follow up visit complaining of low back pain and muscle pain. Respondent documented that Patient 7's pain was "[i]mproved by opiate analgesics, but 60 pills not enough, running out. Has tried NSAIDs, Tylenol, rubbing creams, pain patches." Respondent also documented that Xanax was "helping" with Patient 7's anxiety symptoms. Respondent also documented that Patient 7 reported symptoms of palpitations and irregular heartbeat, weakness or tiredness and fatigue. Respondent

diagnosed him with palpitations, back syndrome with radiculopathy, anxiety disorder and fatigue and malaise. Respondent continued Patient 7's Soma, Xanax and Norco prescriptions, but increased his Norco dose from twice daily to three times daily.

B. On or about February 2, 2016, Patient 7 presented to Respondent for a follow up visit with his chief complaints being low back pain and muscle pain. Respondent documented that Patient 7 reported that his pain was "[i]mproved by opiate analgesics, still says he is running out, takes up to 4 times a day, also takes Soma. Has tried NSAIDs, Tylenol, rubbing creams, pain patches." Respondent's plan included increasing Patient 7's Norco dose frequency from three times to four times daily or from 90 to 120 tablets in 30 days. Patient 7 was referred for an MRI of the lumbar spine.

C. On or about March 2, 2016, Patient 7 presented to Respondent for a follow up visit with his chief complaints being neck, shoulder and back pain. Respondent also documented symptoms of hypertension that was poorly controlled and labile. Patient 7's in-office blood pressure was 123/83. Respondent's plan included continuing Patient 7's medication regimen without change and referral to a pain management specialist.

D. On or about April 1, 2016, Patient 7 presented to Respondent for a follow up visit with his chief complaints being joint pain and muscle pain. Respondent also documented symptoms of hypertension that was labile. Patient 7's in-office blood pressure was 130/76. Respondent's plan included continuing Patient 7's medication regimen without change. Though Respondent's medical record for that visit indicates a reduction in the frequency of Norco doses from four times a day to three times a day that change is not reflected in the prescription record, which is for 120 pills.

E. On or about April 29, 2016, Patient 7 presented to Respondent for a follow up visit with his chief complaint being back pain. Respondent's plan included a discussion

with Patient 7 that his office could not provide the large number of controlled substances (opiates and benzodiazepines) that Patient 7 was taking on a continuous basis. Respondent referred Patient 7 to a pain management specialist and provided him with a 30-day prescription for Norco.

101. Respondent committed an extreme departure from the standard of care when he repeatedly and continuously prescribed Patient 7 Norco, an opiate, without appropriate initiation/continuation, titration and monitoring of chronic opiate pain management. For example, Respondent prescribed Patient 7 Norco, in increasing doses, without ever documenting how Patient 7 was risk stratified for opioid misuse. Additionally, no clarification of previous treatment modality was carried out, and functional goals and adverse events were not clearly delineated. Finally, Respondent failed to regularly monitor Patient 7 with urine drug screening or consultation of CURES.

102. Respondent committed an extreme departure from the standard of care when he concurrently prescribed Patient 7 narcotics and benzodiazepines without consideration for tapering or antidote therapy, thereby, exposing Patient 7 to risk of respiratory depression. Specifically, Respondent prescribed Patient 7 Norco and Xanax. It was unclear, however, from the record whether first line and safer therapy for anxiety disorder, such as serotonergic antidepressants or cognitive behavioral therapy, had been tried for the patient prior to initiating or resuming Xanax. There is also no record that Patient 7 was ever evaluated by a psychiatrist to see if he could be tapered off Xanax and an alternative used. Likewise, there is no record that Respondent ever counseled Patient 7 on naloxone antidote therapy in case of accidental overdose.

Patient 8

103. Patient 8 first presented to Respondent on May 16, 2016. At the time, Patient 8 was 31 years old.

104. At the initial visit, Patient 8 complained of insomnia, circadian rhythm sleep disorder (shift work type) and Attention Deficit Disorder (ADD). At the time he presented to Respondent, Patient 8 was taking Adderall and reported taking Provigil (brand name for Modafinil, a Schedule IV stimulant) in the past. Respondent did not document who had prescribed these medications to

Patient 8, nor did he document any attempts to contact or request records from any of Patient 8's prior medical treaters at any time. Respondent diagnosed Patient 8 with ADD based upon his symptoms of problems concentrating, "feeling all over the place," and complaining of sleep problems. Respondent did not perform any diagnostic tests on Patient 8. Patient 8's blood pressure was recorded at 144/98. Respondent prescribed Patient 8 extended release Adderall to take in the mornings (20 mg) and regular Adderall (30 mg) to take in the afternoons.

105. After Patient 8's initial visit, Respondent saw Patient 8 again on June 13, 2016, October 13, 2016, December 14, 2016 and March 8, 2017. At each of these visits, Patient 8 continued to complain of problems concentrating and reported symptoms of anxiety. At each of these visit, Respondent continued to prescribe Patient 8 Adderall. Patient 8's blood pressure was documented as follows at these visits, respectively: 159/93, 137/81, 140/94 and 155/80.

106. Patient 8's next and final visit with Respondent was on January 9, 2018. Patient 8 reported problems concentrating. Respondent documented that Patient 8 reported that his symptoms were improved by Adderall, but that the 20 mg he was taking in the morning was not helping. Patient 8 continued to report symptoms of anxiety. Respondent increased Patient 8's morning dosage of Adderall from 20 mg to 30 mg, while maintaining Patient 8's 30 mg afternoon dose. Patient 8's blood pressure was documented at 154/76.

107. Respondent committed an extreme departure from the standard of care when he failed to keep accurate medical records for Patient 8. Specifically, Respondent's records do not document an adequate treatment plan for Patient 8, nor are abnormal findings and symptoms addressed consistently in Patient 8's progress notes. Further, Respondent's records for Patient 8 refer to historical medical records not found in Patient 8's chart and do not contain a clearly documented medication reconciliation.

108. Respondent committed an extreme departure from the standard of care when he failed to address Patient 8's abnormal blood pressure findings. Specifically, Patient 8 had elevated blood pressure readings at numerous visits and was taking medications, which can contribute to hypertension. Respondent did not document that he addressed these abnormal readings or Patient 8's cardiovascular risk factors, discussed home blood pressure monitoring or lifestyle

modifications with Patient 8 or carried out a funduscopic examination to evaluate for hypertensive retinopathy.

109. Respondent committed an extreme departure from the standard of care when he prescribed, and continued to prescribe, Patient 8 Adderall without clear indication and in increasing dosage. As an initial matter, Patient 8's records are absent a clear description or basis for the diagnosis of ADD. For example, it is unclear from Patient 8's records if Respondent's diagnosis of "ADD" referred to the generalized term for ADHD or the inattention subtype of ADHD. Additionally, there was no documentation of the DSM-5 diagnostic criteria for ADHD in the patient record. Features such as combined presentations, predominantly inattentive presentation or predominantly hyperactive/impulsive presentation are not specified. Further, Respondent failed to document the severity and remission status. Respondent also failed to document any request for Patient 8's previous medical records, even though Respondent documented that Patient 8 presented with an established diagnosis of ADHD.

Patient 9

110. Patient 9 first presented to Respondent on November 6, 2017. At the time, Patient 9 was 82 years old. Respondent saw him at his home on account of Patient 9's "advance age and/or medical conditions and /or mobility problems that make an office visit impossible, impractical or unsafe." Respondent documented that the visit was a "follow up," however, this was Patient 9's first visit with Respondent and the one during which he established care with Respondent.

111. At the initial visit, Respondent diagnosed Patient 9 with hypertension and dementia. As part of the treatment plan, Patient 9 was instructed to be compliant with his prescribed medications. No medication list or reconciliation, however, was documented at the visit, so it is unclear what medications Patient 9 was taking, or supposed to be taking, at the time.

112. Over the course of the next eight months, until July 2, 2018, Patient 9 remained under Respondent's care and was seen at least monthly. With the exception of the first home visit, which Respondent performed himself, all other home visits with Patient 9 were carried out by a physician assistant under Respondent's supervision. It is not documented in Patient 9's records, however, that he was ever treated by a physician assistant. Respondent signed all of the records

himself.

113. Throughout the course of his care and treatment, Patient 9 suffered from weakness, fatigue, decubitus ulcers (bedsores), dementia and hypertension.

114. On or about December 11, 2017, after another home visit, it was documented that Patient 9's anti-hypertensive medications were reviewed and compliance with medications was discussed. The progress note, however, does not contain a medication list or reconciliation. Accordingly, it cannot be determined from the record which specific medications Patient 9 was being prescribed or counseled on.

115. On or about March 5, 2018, after another home visit, it was documented that Patient 9's treatment responses to medications was discussed with his family and that Patient 9 would continue on his current medications. Again, there is no medical list or reconciliation and it cannot be determined, from the record, what medications are being referenced.

116. On or about May 3, 2018, after another home visit, it was documented that Patient 9 had complained of cough, decubitus ulcers and fatigue with the cough worsening. Respondent documented that the patient will continue with medications without change. The progress note, however, does not contain a medication list or reconciliation. Similarly, Respondent documented that Patient 9's current conditions, treatment response and treatment goals were discussed with Patient 9's family. No specific conditions or treatment were described, however.

117. Throughout the remainder of his visits and treatment with Respondent, no medication reconciliation is contained in the record.

118. Respondent committed an extreme departure from the standard of care when he failed to keep accurate medical records for Patient 9. Specifically, Respondent's records often only addressed general counseling and actual plans were often not apparent in the notes. Abnormal physical findings, such as poor skin turgor, were often not addressed in the assessment and plan. It was also not documented in Patient 9's chart that Patient 9 was often seen by Respondent's physician assistant and not Respondent. Relevant medication reconciliation was also lacking throughout Patient 9's medical record. Electronic medical records appear to have been copied and pasted on several occasions, making it difficult to assess the current condition of the patient.

Finally, discrepant information on Patient 9's condition, such as whether or not he was bedbound, was also not addressed.

119. Respondent committed an extreme departure from the standard of care when he failed to properly evaluate and treat Patient 9's stage IV decubitus ulcer. Respondent provided general counseling on treatment for decubitus ulcers, but no concrete instructions regarding the frequent turning required for a bedbound patient are documented throughout most of his care. Instead, "exercise regularly" is documented in one of the general counseling sessions, even though Respondent documented Patient 9 as bedbound. While it was documented that Respondent educated Patient 9 and/or his family on strict aspiration precautions, there was no discussion documented as to whether Patient 9 was getting adequate oral intake. Wound healing also appeared to be prolonged based on documentation because of slough and necrotic tissue. There was no documentation of discussion of a surgical consult or more intensive wound care at a skilled nursing facility. Respondent did not document instructing Patient 9's family to call 911 or a take him to a hospital if his condition worsened until toward the end of Patient 9's course of care with Respondent.

120. Respondent's care and treatment of Patient 9 departed from the standard of care when he failed to adequately discuss the goals of care for advanced dementia. Specifically, the goals for this bedbound patient were unclear from Respondent's medical records. Respondent maintains and documented that he advised the family to send the patient to the emergency room. Respondent also stated, but did not document, that the family was seeking more of a palliative care approach to Patient 9's illness. There is no documentation of any discussions regarding the overall functional status and wishes from Patient 9 or his family and the wishes of the family appeared contradictory over time.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

121. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he committed gross negligence in the care and treatment of Patients 1-9. The circumstances are as follows:

122. The Factual Allegations alleged herein pertaining to Patients 1-9 are incorporated by reference and re-alleged as if fully set forth herein.

123. Respondent's acts and/or omissions as set forth in the Factual Allegations pertaining to Patients 1-9, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. As such, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

124. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he committed repeated negligent acts in the care and treatment of Patients 1-9. The circumstances are as follows:

125. The Factual Allegations alleged herein pertaining to Patients 1-9 are incorporated by reference and re-alleged as if fully set forth herein.

126. Respondent's acts and/or omissions as set forth in the Factual Allegations pertaining to Patients 1-9, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts, pursuant to section 2234, subdivision (c), of the Code. As such, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Prescribing, Dispensing, or Furnishing Dangerous Drugs without an Examination or Medical Indication)

127. Respondent is subject to disciplinary action under section 2242, subdivision (a), of the Code, in that Respondent prescribed dangerous drugs to Patients 1-8, without appropriate prior examinations and/or medical indications. The circumstances are as follows:

128. The Factual Allegations alleged herein pertaining to Patients 1-8 are incorporated by reference and re-alleged as if fully set forth herein.

129. Respondent's acts and/or omissions as set forth in the Factual Allegations pertaining to Patients 1-8, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute prescribing dangerous drugs, without appropriate prior examinations and/or

medical indication in violation of section 2242, subdivision (a), of the Code. As such, cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

130. Respondent is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed narcotic medications to Patients 1-8. The circumstances are as follows:

131. The Factual Allegations alleged herein pertaining to Patients 1-8 are incorporated by reference and re-alleged as if fully set forth herein.

132. Respondent's acts and/or omissions as set forth in the Factual Allegations pertaining to Patients 1-8, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute excessive prescribing, pursuant to section 725, of the Code. As such, cause for discipline exists.

FIFTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

133. Respondent is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate records concerning his care and treatment of Patients 1-9. The circumstances are as follows:

134. The Factual Allegations alleged herein pertaining to Patients 1-9 are incorporated by reference and re-alleged as if fully set forth herein.

135. Respondent's acts and/or omissions as set forth in the Factual Allegations pertaining to Patients 1-9, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute inadequate record keeping in violation of section 2266 of the Code. As such, cause for discipline exists.

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SIXTH CAUSE FOR DISCIPLINE

(Practicing without a Fictitious Name Permit)

136. Respondent is subject to disciplinary action under section 2285 of the Code in that he practiced medicine without a Fictitious Name Permit. The circumstances are as follows:

137. During the relevant time period, Respondent owned, operated and practiced medicine at Prestige Medical Center located in Beverly Hills, California.

138. The Fictitious Name Permit for Prestige Medical Center expired on May 31, 2017, and, as of May 3, 2019, had not been renewed.

139. Respondent's acts and/or omissions as set forth paragraphs 137 and 138, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute practicing without a Fictitious Name Permit in violation of section 2285 of the Code. As such, cause for discipline exists.

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 92996, issued to Vlad Nusinovich, M.D.;

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

3. Ordering Vlad Nusinovich, 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: JUL 23 2020

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

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