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9  
10 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
**DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**  
12

13 In the Matter of the Accusation Against,

Case No. 800-2019-057808

14 **EILEEN SHELLY SHAPIRO, M.D.**  
15 **P.O. BOX 3715**  
**Olympic Valley, CA 96146**

**DEFAULT DECISION**  
**AND ORDER**

16 **Physician's and Surgeon's**  
17 **Certificate No. C 43259**

[Gov. Code, §11520]

18 Respondent.  
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**FINDINGS OF FACT**

22 1. On or about April 26, 2022, Complainant William Prasifka, in his official capacity as  
23 the Executive Director of the Medical Board of California, Department of Consumer Affairs, filed  
24 Accusation No. 800-2019-057808 against Eileen Shelly Shapiro, M.D. (Respondent) before the  
25 Medical Board of California.

26 2. On or about February 22, 1995, the Medical Board of California (Board) issued  
27 Physician's and Surgeon's Certificate No. C 43259 to Respondent. The Physician's and  
28

1 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought  
2 herein and will expire on November 30, 2022, unless renewed.

3 3. On or about May 12, 2022, Sharee Woods, an employee of the California Medical  
4 Board, served by Certified Mail a copy of the Accusation No. 800-2019-057808, Statement to  
5 Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5,  
6 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is P.O.  
7 Box 3715 Olympic Valley, CA, 96146. A copy of the Accusation, the related documents, and  
8 Declaration of Service are attached as Exhibit A, and are incorporated herein by reference.

9 4. Section 1399.511 of Title 16 of the California Code of Regulations provides that the  
10 licensee shall notify the Board at its office of any and all changes of mailing address within 30  
11 days after each change, providing both old and new addresses.

12 5. Service of the Accusation was effective as a matter of law under the provisions of  
13 Government Code section 11505, subdivision (c). Service by registered mail shall be effective if  
14 a statute or agency rule requires the respondent to file the respondent's address with the agency  
15 and to notify the agency of any change, and if a registered letter containing the accusation or  
16 District Statement of Reduction in Force and accompanying material is mailed, addressed to the  
17 respondent at the latest address on file with the agency.

18 6. Government Code section 11506 states, in pertinent part:

19 (c) The respondent shall be entitled to a hearing on the merits if the respondent  
20 files a notice of defense, and the notice shall be deemed a specific denial of all parts  
21 of the accusation not expressly admitted. Failure to file a notice of defense shall  
22 constitute a waiver of respondent's right to a hearing, but the agency in its discretion  
23 may nevertheless grant a hearing.

24 Respondent failed to file a Notice of Defense within 15 days after service upon her of the  
25 Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 800-  
26 2019-057808. (Exhibit B: Declaration of Deputy Attorney General Kalev Kaseoru)

27 7. California Government Code section 11520 states, in pertinent part:

28 (a) If the respondent either fails to file a notice of defense or to appear at the  
hearing, the agency may take action based upon the respondent's express admissions  
or upon other evidence and affidavits may be used as evidence without any notice to  
respondent.

1           8. Pursuant to its authority under Government Code section 11520, the Board finds  
2 Respondent is in default. The Board will take action without further hearing and, based on  
3 Respondent's express admissions by way of default and the evidence before it, contained in  
4 Exhibits A, B, C, D, and E, finds that each of the allegations in Accusation No. 800-2019-057808,  
5 separately, and severally, are true and correct.

6           9. On May 28, 2019, Patient 1, a mental health worker and co-worker of Respondent at  
7 the Marie Green Psychiatric Center (MGPC), informed Respondent during a casual conversation  
8 about an upcoming trip that he had anxiety regarding flying. Later that same day, Respondent  
9 gave Patient 1 two 2mg tablets of Lorazepam and four .5mg tablets of Xanax packaged in three  
10 envelopes and told Patient 1, "don't worry it will be O.K." Handwritten on the exterior of one of  
11 the envelopes was "Ativan 2mg (round), Ativan 0.5mg (oval) 1-2 tabs for panflight anxiety"  
12 followed by Respondent's signature and dated May 28, 2019. The envelope actually contained  
13 both Xanax and Lorazepam. After handing the envelope to Patient 1, Respondent departed  
14 MGPC, and when she was asked to return later that day she failed to do so. Patient 1 then gave  
15 these prescription medications to MGPC Licensed Vocational Nurse T.L. (See Exhibit C:  
16 Declaration of Gina Leyva)

17           10. Respondent failed to conduct any type of examination on Patient 1 prior to  
18 prescribing these controlled substances to Patient 1. During Respondent's course of treatment of  
19 Patient 1 Respondent failed to maintain adequate and accurate medical records, in that no records  
20 of her treatment and prescribing for Patient 1 were created. At no time in May of 2019 was  
21 Patient 1 a registered patient in the MGPC. (Id., Exhibit D: Declaration of Andre Loftis, and  
22 Exhibit E: Declaration of Leslie McDaniel, M.D.)

23           11. On or about May 28, 2019, at approximately 7:00 a.m., Licensed Vocational Nurse  
24 T.L. was on duty at MGPC and conducted a narcotic count with Licensed Vocational Nurse O.E.  
25 without any narcotics discrepancies at MGPC. Later that same day, T.L. observed Respondent at  
26 work at MGPC and overheard a conversation between Respondent and Patient 1 regarding Patient  
27 1's travel plans and fear of flying. T.L. then observed Respondent access the MGPC medication  
28 cabinets without documenting the withdrawal of any medications. This prompted T.L. and O.E. to

1 perform an additional medication reconciliation. Upon completion of the reconciliation there was  
2 no indication that Respondent documented and/or created a medication order or notified staff of  
3 any medications she dispensed to Patient 1. The reconciliation revealed a discrepancy for nine  
4 Schedule IV medication tablets: two tablets of Ativan (Lorazepam) at 2mg each; four tablets of  
5 Xanax (Alprazolam) at 0.5mg each; three tablets of Soma (Carisoprodol) at 350mg each; in  
6 addition to two non-controlled substances: Vistaril and Benadryl, which were also unaccounted  
7 for. According to T.L. and O.E., the envelopes Respondent gave to Patient 1 that Patient 1  
8 provided to T.L. on May 28, 2019, accounted for all of the medication discrepancies except for the  
9 missing Soma. (Exhibit C)

10 12. On or about May 29, 2019, MGPC received a hand-written resignation letter, dated  
11 May 29, 2019, from Respondent addressed to MGPC Medical Director Dr. I.M. reading, "I resign  
12 my position effective immediately" bearing Respondent's signature. (Exhibit C, Attachment 2,  
13 page 25)

14 13. The Board finds pursuant to Business and Professions Code section 125.3, the costs  
15 of investigation and enforcement of the case prayed for in the Accusation total \$17,080.00 based  
16 on the Certification of Costs (Exhibit F: Declarations of Costs.)

### 17 **DETERMINATION OF ISSUES**

18 1. Based on the foregoing findings of fact, Respondent Eileen Shelly Shapiro, M.D. has  
19 subjected her Physician's and Surgeon's Certificate No. C 43259 to discipline.

20 2. A copy of the Accusation and the related documents and Declaration of Service are  
21 attached.

22 3. The agency has jurisdiction to adjudicate this case by default.

23 4. The Medical Board of California is authorized to revoke Respondent's Physician's and  
24 Surgeon's Certificate based upon the following violations alleged in the Accusation:

25 a. Gross Negligence: Respondent committed gross negligence by failing to create a  
26 medical record and perform a standard psychiatric evaluation including documentation the  
27 indication for the medication given, prior to prescribing psychotropic controlled substances and  
28 non-controlled substances to Patient 1. Respondent took controlled and non-controlled

1 psychoactive medications from the MGPC stock without writing a medication order and  
2 notification to MGPC staff so it could be properly logged. Respondent dispensed multiple  
3 controlled and non-controlled medications to Patient 1 who was not a registered patient of  
4 MGPC. Respondent dispensed controlled and non-controlled medications in envelopes that were  
5 mislabeled, in unauthorized envelopes, with confusing handwritten directions. Respondent's acts  
6 constitute gross negligence and are in violation of section 2234, subdivision (b) of the Code.

7           b. Repeated Negligent Acts: Respondent committed repeated negligent acts in her  
8 care and treatment of Patient 1 in her prescribing of psychotropic controlled substances to Patient  
9 1 without examination and without a medication order in unauthorized, mislabeled envelopes as  
10 detailed *supra*. Respondent's acts constitute repeated acts of negligence and are in violation of  
11 section 2234, subdivision (c), of the Code.

12           c. Prescribing Controlled Substances Without Appropriate Examination or Medical  
13 Indication: Respondent prescribed controlled substances and dangerous drugs to Patient 1  
14 without any medical or physical examination, and without any psychiatric examination.  
15 Respondent's acts are in violation of section 2242 of the Code.

16           d. Failure to Maintain Adequate and Accurate Records: Respondent failed to  
17 maintain adequate and accurate records of Patient 1 as she did not conduct any examination or  
18 evaluation of Patient 1 nor did she document her prescriptions to Patient 1 thus creating no  
19 records at all for her treatment. Respondent's acts are in violation of section 2266 of the Code.

20           e. Failure to Attend & Participate in Interview by the Board: Respondent failed to  
21 attend and participate in an interview by the Board and failed to follow up and respond to  
22 multiple messages and phone calls from the Board. Respondent's acts are in violation of section  
23 2234, subdivision (g) of the Code.

24           f. Failure to Notify Board of Change of Address: Respondent failed to inform the  
25 Board of her change of address, including email address, within 30 days after a change occurred.  
26 Respondent's acts are in violation of section 2021, subdivision (b) of the code.

27           g. General Unprofessional Conduct: Respondent engaged in unprofessional conduct  
28 which breached the rules or ethical code of the medical profession, or conduct which is

1 unbecoming of a member in good standing of the medical profession, and which demonstrates an  
2 unfitness to practice medicine in her care and treatment of Patient 1. Respondent's acts are in  
3 violation of section 2234 of the Code.

4 5. Respondent is liable to the Board the cost of investigation and enforcement in Case  
5 No. 800-2019-057808 in the amount of \$17,080.00.

6 **ORDER**

7 IT IS SO ORDERED that Physician's and Surgeon's Certificate No. C 43259, heretofore  
8 issued to Respondent Eileen Shelly Shapiro, M.D., is revoked.

9 **Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a**  
10 **written motion requesting that the Decision be vacated and stating the grounds relied on**  
11 **within seven (7) days after service of the Decision on Respondent.** The agency in its  
12 discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in  
13 the statute.

14 This Decision shall become effective on **DEC 02 2022**

15 It is so ORDERED **NOV 02 2022**

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19 William Prasifka, Executive Director  
20 FOR THE MEDICAL BOARD OF CALIFORNIA  
21 DEPARTMENT OF CONSUMER AFFAIRS

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