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

In the Matter of the Accusation Against: Anantjit Singh, M.D. Physician's and Surgeon's Certificate No. A 53927 Respondent	Case No. 800-2017-032626

DECISION

The attached Proposed Decision 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 July 23, 2021.

IT IS SO ORDERED June 24, 2021.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against:

ANANTJIT SINGH, M.D., Respondent

Agency Case No. 800-2017-032626

OAH No. 2020070603

PROPOSED DECISION

Mary Agnes Matyszewski, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter by video conference and telephone on April 19, 20, 21, 22, and 23, 2021, due to the ongoing pandemic.

Rosemary Luzon, Deputy Attorney General, represented complainant, William Prasifka, Executive Director of the Medical Board of California (medical board).

Raymond McMahon, Attorney at Law, Doyle, Schafer, McMahon, represented respondent, Anantjit Singh, M.D., respondent, who was present.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on April 23, 2021. Identifying information was redacted from the exhibits after submission and, for ease of reference, parenthetical information in the decision is the ALJ's explanation of various medical terms used.

SUMMARY

This matter arose from Dr. Singh's care and treatment of one patient at Downey Care Center (Downey), a skilled nursing facility (SNF). (Although individuals in SNF's are referred to as "residents," the individual in this case will be referred to as a patient for clarity.) The patient was admitted to Downey in October 2016 under the care of another physician. She was extremely ill, on multiple medications, was non-compliant, and was hospitalized several times, eventually passing away in January 2017. At issue was Dr. Singh's care and treatment of her during December 2016 and January 2017, when she was under his care. The primary issue was whether he prescribed Metformin (brand name Glucophage), a drug used to treat diabetes, that was contraindicated given the patient's renal condition, and whether he lied about it when interviewed by the Health Quality Investigation Unit (HQUI). The other issue was Dr. Singh's prescribing opioids[1] for chronic pain and hypnotics for insomnia.

The county public health investigator who filed the complaint with the medical board had not considered all the facts, her notes inaccurately reflected her discussion with Dr. Singh, and the online complaint she filed with the medical board contained her inaccurate conclusions that were not supported by the evidence. The testimony of the nurse who claimed Dr. Singh gave her the Metformin order was not credible and when the important information regarding Dr. Singh's care of the patient on January 13, 2017, was pointed out to her, she could not offer any explanation for her actions.

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[1] The accusation used the word "opiates," but the drugs Dr. Singh prescribed were opioids. Opioids are either natural or synthetic substances used to control pain; opiates are natural substances. All opiates are opioids, but not all opioids are opiates.

Her recording of Dr. Singh's purported order on January 19, 2017, was also suspect. Complainant's expert selectively chose records that cast Dr. Singh in a poor light, was unaware of those that did not, misread the records, did not consider all the records, including important information after the patient's January 13, 2017, lab results were reviewed by Dr. Singh, and based her opinions on facts that were not established at hearing.

In contrast, Dr. Singh's explanation for what occurred and for why he first discussed Metformin during his medical board interview on January 6, 2020, was credible and supported by the evidence. Dr. Singh did not order Metformin for this patient and he was not dishonest at the HQIU interview. His prescription of opioids and hypnotics for this patient was reasonable and did not violate the standard of care. Dr. Singh's expert, a former district medical consultant for the medical board and currently an expert reviewer for the medical board, considered all the records and facts when formulating his opinions. His opinions were more reliable than complainant's expert's opinions, made more sense than the opinions to the contrary, and were supported by the evidence.

Complainant failed to prove by clear and convincing evidence any of the causes for discipline that were pled and the accusation is dismissed.

FACTUAL FINDINGS

Licensing and Jurisdictional Background

1. The medical board issued Physician and Surgeon's Certificate No. A 53927 to Dr. Singh on February 1, 1995. That certificate was in full force and effect at

all times herein and will expire on October 31, 2022, unless renewed. There is no history of discipline against Dr. Singh's medical license.

2. The accusation was signed by the Interim Executive Director, in her official capacity on April 30, 2020. Complainant alleged that in his care and treatment of one patient, Dr. Singh was grossly negligent in violation of Business and Professions Code section 2234, subdivision (b), because he prescribed Metformin (a diabetic medication) to the patient (First Cause for Discipline); was repeatedly negligent in violation of Business and Professions Code section 2234, subdivision (c), because he concurrently prescribed opioids and hypnotics (Second Cause for Discipline); and committed acts of dishonesty in violation of Business and Professions Code section 2234, subdivision (e), because he denied prescribing Metformin at his medical board interview (Third Cause for Discipline).

3. Dr. Singh timely submitted a notice of defense, and this hearing ensued.

Dr. Singh's Education and Employment History

4. Dr. Singh graduated from Maulana Azad Medical College in New Delhi, India, in 1982. He completed a rotating internship in each department and a "house job" in two selected specialties, six months in medicine and six months in surgery. In 1984 he came to United States. He completed an internal medicine residency at John H. Stroger Hospital of Cook County in Illinois from 1986 to 1989. Stroger Hospital is a teaching facility for both residents and medical students, and he also trained at the University of Illinois. In 1989 he was asked to join the faculty as an attending physician responsible for teaching residents and interns, which he did for the next two years.

In 1991 Dr. Singh began his cardiac fellowship at the University of Oklahoma Health Sciences Center, one of the leading cardiac electrophysiology centers in the

country. From 1991 to 1993 Dr. Singh did a general cardiology fellowship and from 1993 to 1995 he completed an electrophysiology fellowship. As he explained, electrophysiology involves placing devices in the heart such as pacemakers or performing ablations (a procedure to correct heart rhythm problems performed by scarring or destroying cardiac tissue). The University of Oklahoma fellowships are typically five years, but Dr. Singh was allowed to do his as a joint program in four years.

Towards the end of his fellowship, Dr. Singh reached out to David Cannom, M.D., a world renowned cardiac ablation surgeon who practiced at Good Samaritan Hospital in California. Dr. Cannom and the University of Oklahoma devised a special fellowship for Dr. Singh wherein Dr. Singh spent the last three months of his fellowship scrubbing in for all of Dr. Cannom's cardiac device surgeries. When his fellowship ended, Dr. Singh remained in California working with Dr. Cannom. Thereafter Dr. Singh joined a private practice in the Downey/Lynwood area (near Los Angeles) where he practiced internal medicine, cardiology, and intervention cardiology. He was the group's first electrophysiologist. Electrophysiology is a relatively new cardiology field that arose in the mid-1970s and many of its pioneers are still alive and present at conferences. Dr. Singh had privileges at Long Beach Memorial Hospital where he performed his electrophysiology cases, and at Lakewood Regional Medical Center and Presbyterian Intercommunity Center.

Over time, Dr. Singh decided he wanted to just practice at St. Francis Medical Center and Downey Hospital and he broke off from the group to establish his own practice. He chose to work in the Downey/Lynwood area, a slightly impoverished area, with a high indigent/low income patient population. These patients have a higher need for medical care. He stated he had always worked in underserved areas

beginning with his education in India, thereafter in Cook County, and now in California. He was "naturally drawn" to St. Francis Medical Center because of the patients who needed care and, at the time, it was owned and operated by the Daughters of Charity, and he found the presence of nuns "very comforting to me." Over the course of his career, Dr. Singh has had multiple opportunities to move to other places, to more lucrative areas, but he was drawn to this area and decided to stay.

During Dr. Singh's first several years in practice here, he practiced primarily internal medicine seven days per week. He took calls for both internal medicine and cardiology physicians. He slowly built up his practice from St. Francis Medical Center and Downey Hospital. After approximately 10 to 15 years, Dr. Singh decided to concentrate more on the cardiac and electrophysiology part of his practice, although he still had many internal medicine patients. As of 2016-2017, he primarily practiced cardiology.

Dr. Singh is triple medical board certified. He is board certified in internal medicine, board certified in cardiology and board certified in electrophysiology. He is also a certified device specialist, a distinction for which he had to take and successfully pass an examination. He is sub-specialized in the placement of pacemakers and cardiac rhythm devices. He is grandfathered for his internal medicine medical board certification, becoming board certified the last year that grandfathering was allowed. His cardiology and electrophysiology board certifications, as well as his device subspecialty, must be recertified every 10 years, and he has successfully recertified.

Dr. Singh has held numerous leadership positions. He was the Director of Electrophysiology at St. Francis Medical Center from 2007 to 2019 where his duties included running the pacemaker and implantable cardioverter defibrillator clinic and determining quality parameters. From 2008 to 2010 and again from 2014 to 2018, he

was the Chairman of Medicine at St. Francis Medical Center where he was responsible for quality and patient safety for internal medicine and internal medicine subspecialty patients and oversaw all major programs. From 2010 to 2012 he was the Chief of Staff at St. Francis Medical Center, where his duties included directly supervising departments, creating performance improvement programs, creating bylaws, and creating a peer review program. In this role, he was responsible for starting performance improvement programs in many specialties including gastrointestinal , surgery and cardiology; providing leadership in creating the Accountable Care Organization model (ACO model) for the hospital and associated clinics. (An ACO model is a new payment model where payers incentivize healthcare value and quality, with a focus on health outcomes; it is a plan designed to reward providers for working together on a patient's treatment no matter where the patient receives care.) Since August 2020, Dr. Singh has been the Medical Director of St. Francis Medical Center, its Chief Medical Officer.

Dr. Singh has received numerous awards and honors. He was a merit scholarship recipient in medical school. He received the Outstanding Attending Award in internal medicine for providing excellent teaching to residents and interns. He is a Fellow of the American College of Cardiology. He is a Fellow of the Heart Rhythm Society. He was recognized as a "Super Doctor" by superdoctors.com and received a California Medical Society "Meaningful Use Stage 1 Certification Allscripts MyWay EHR" from Allscripts in 2012. He is a member of several organization and has numerous publications to his name.

DR. SINGH'S EMPLOYMENT AT DOWNEY CARE CENTER

5. In 2016, Dr. Singh was involved in case management at several SNFs. He was approached by a nurse who told him that Downey, a SNF, needed a medical

director. The facility was not far from his office and he joined as its medical director in July or August 2016. Approximately two months later, the head of the facility resigned, so Downey did not have a CEO. For a number of months the position was vacant, until someone from a Huntington Park facility performed some of the CEO duties at Downey on a part-time basis.

At Downey Dr. Singh mainly interacted with the nurses. He initially went daily but was told that other physicians for the patients would come to the facility to examine their patients, so he did not need to be present every day. As result, Dr. Singh reduced his rounds at the facility to two days per week, Thursdays and typically Tuesdays. He went to Downey every Thursday, but some Tuesdays he did not go because of his other work obligations. On Tuesdays he would round in the morning before going to the hospital. On Thursdays he would round in the morning before going to the hospital and thereafter arrive at his office at approximately 2:00 p.m. to see patients.

6. The allegations in the accusation arose from Dr. Singh's care and treatment of one patient at Downey. The patient, noted in the various records as between the ages of 63 and 65, was extremely ill, had multiple medical comorbidities, was non-compliant, and was hospitalized numerous times for sepsis and other life-threatening illnesses. Dr. Singh testified that because of his position as the medical director, he was aware of this patient, even before she was assigned to his care. He also was aware of the patient because of both her and her family's numerous complaints (which were not explained at hearing, but the records documented that one of the patients' daughters had a "strong personality" and noted her displeasure with Downey), because of the patient's multiple medical conditions, and because he

had assessed the patient when he performed his regular rounds before he assumed her care.

Patient's Medical Treatment Between October 2016 and January 2017

ADMISSION TO LAC+USC MEDICAL CENTER

7. Before the patient came to Downey, she was admitted to LAC+USC (Los Angeles County+University Southern California) Medical Center on September 25, 2016, and discharged on September 30, 2016. Her age was listed in the records as both 63 and 65. She arrived by ambulance at 21:11 for right lower extremity pain following a "trip and fall landing onto right side." There was no loss of consciousness, both legs were tender to palpation, she was alert, awake, and oriented times four. There was no obvious trauma observed. The patient advised she uses a walker and a wheelchair for ambulation but she did not arrive at the emergency room with either device.

The intra-hospital transport equipment used was a blood pressure monitor, cardiac monitor/defibrillator, oxygen tank, pulse oximeter, and resuscitation drugs. When seen, the patient was in stable condition and "remains on [oxygen]," her respirations were even and unlabored. The patient's daughter was at her bedside. The patient's vital signs were recorded, and her oxygen saturation rate was 100 percent on an aerosol mask. She had no actual or suspected pain.

The patient's emergency department course noted that she was afebrile and hemodynamically stable. X-rays showed a comminuted closed tibia-fibula fracture. Her potassium was 6.5 without EKG changes. She was given Kayexalate (a medication used to treat a high level of potassium in the blood) and an albuterol nebulizer. She was

noted to be obese. She was evaluated by orthopedics and her right lower extremity was reduced and splinted.

8. The patient's "hospital course" documented:

> [History of Present Illness]: 63 [year-old woman] with [past medical history] CAD (coronary artery disease), [status post CABG (coronary artery bypass graft) 2011, [status post] PCI (percutaneous coronary intervention) with stenting (unclear type 9/216 for presumed ACS (acute coronary syndrome) at White Memorial, diabetes mellitus [complicated by] charcot joints (a progressive degenerative condition which results in weakening of the bones of the foot) and ESRD (end stage renal disease), hypotension (HTN), PAD (peripheral artery disease) [status post] femoral stenting, ESRD on [hemodialysis] [Monday Wednesday Friday] via RUE AVF (right upper extremity arteriovenous fistula) (this is an abnormal connection between an artery and a vein) [the past] 12 years presents after GLF (ground-level fall) with closed, comminuted (breakage of the bone into more than two fragments) [right lower extremity tibia-fibula fracture]. Patient states that she got up to use the restroom, but has been weak since previous discharge, and twisted while falling, breaking [right lower extremity] ankle. Denies dizziness or lightheadedness before, chest pain/pressure, [loss of consciousness], post-ictal confusion (altered mental state after a seizure), urinary incontinence, tongue biting. Of

> note, patient reports recent hospitalization at White Memorial after having had a "mini-heart attack" and having procedure done for it. Spoke with patient's daughter [name and address] who states that patient received PCI (percutaneous coronary intervention - a non-surgical revascularization technique of widening the coronary artery using a balloon catheter to dilate the artery from within) with stenting (unclear what type) with plans for second cardiac cath and further stenting as outpatient. Patient receives [hemodialysis Monday, Wednesday, Friday] via [right upper extremity] fistula, last two days prior (friday [*sic*]). On interview, patient reports not being able to feel either [bilateral lower extremity] and has weakness when walking although can move [bilateral] toes and feet.

(Definitions of acronyms added.)

9. The patient's "floor course" documented that she arrived on the floor with stable vital signs and was "satting well on" two liters of oxygen given via nasal cannula. She was started on Lantus (a long-acting insulin)and Lispro (a fast-acting insulin) for her diabetes and maintained on aspirin/Plavix (a medication to prevent blood clots). She received dialysis on September 26, 28, and 30, 2016. She underwent closed reduction of her right lower extremity fracture on September 27, 2016, (a procedure to set the bone without surgery). She was placed in a long leg cast. On the morning of September 27, 2016, she complained of severe chest pain. "Troponins were drawn and resulted 0.11, 0.12, 0.13, 0.11, and remain stable." (Troponins are a complex of three regulatory proteins that are integral to muscle contraction; measurements of cardiac troponins are used as diagnostic and prognostic indicators in the management

of myocardial infarction and acute coronary syndrome.) EKGs were trended (meaning her cardiac electrical activity was monitored) and did not demonstrate any acute ischemic changes (a sudden loss of blood circulation).

The patient's pain was relieved by sublingual nitroglycerin (a medication used to relieve chest pain for patients with coronary artery disease). Cardiology was consulted and determined the patient did not have acute coronary syndrome, unstable angina (chest pain), or other cardiac condition requiring acute intervention. She was maintained on nitroglycerin paste and did not complain of any subsequent chest pain. She was seen by physical therapy who worked with her on transfers to wheelchair and assisted with family training.

The patient's Hemoglobin A1c on September 26, 2016, was high at 9.8 percent. (Hemoglobin A1c (HbA1c or A1C) is a blood test used to measure a patient's average blood sugar over the past three months. This test is commonly used to diagnose prediabetes and diabetes.)

10. On September 30, 2016, the patient demonstrated adequate ability to transfer to the wheelchair with assistance and the family was given training by physical therapy. Home equipment was ordered. At the time of discharge, the patient was in stable clinical condition, had stable vital signs, was tolerating food by mouth, was unable to ambulate but able to transfer to a wheelchair, was sating well on two liters nasal cannula (baseline on home O2), with adequate pain control. The impressions were acute fractures of the right tibial and fibular diaphysis (the shaft or central part of a long bone) and old calcaneus fracture deformity (the large bone forming the heel) with osteoarthritis of the foot. The patient's numerous medications given while hospitalized were recorded. Included among them were several medications for her diabetes - Dextrose (a simple sugar used in IVs to help patients with low blood sugar),

intramuscular glucagon (a medication to treat low blood sugar), insulin glargine and insulin lispro (medications used to treat high blood sugar and diabetes mellitus). She also received Hydralazine (a medication to treat high blood pressure), Dilaudid (an opiate used to treat moderate to severe pain), Plavix (a medication used to prevent heart attacks and strokes in patients with heart disease), aspirin (used to treat new/worsening chest pain), sevelamer (used to control phosphorus levels in patients with chronic kidney disease who are on dialysis), omeprazole (used to treat acid reflux), sodium chloride (salt, used to treat sodium loss), and sodium citrate (used to treat acidosis caused by kidney disease; acidosis is excess acid in body fluids which occurs when the lungs and kidneys cannot keep the body's pH in balance; pH is a quantitative measure of the acidity or basicity of liquid).

11. The patient's discharge diagnoses were acute chest pain and closed fracture of the shaft of the tibia/fibula (a fracture that does not penetrate the skin). The "patient education information" section indicated that the following "instructions" were given: "Using Injected Insulin (Spanish); Long-Term Complications of Diabetes (Spanish); Diabetes: Learning About Serving and Portion Sizes (Spanish); Diabetes, General Info (Spanish); Ankle Fracture (Distal Fibula), closed." The patient should continue her Monday, Wednesday, Friday, dialysis at her own dialysis center and follow up with her primary care physician in two weeks. She was discharged with a standard slide medical board (an assistive device to help patients move from one location to another to prevent falls) and a wheelchair.

Her "medications that have not changed" while she was hospitalized were listed as: clotrimazole topical (a medication to treat vaginally yeast infections) and emollient topical (cream to soften or soothe skin). "Other medications" were noted to be: aspirin, cilostazol (medication to improve the symptoms of blood flow problems in the legs),

clopidogrel (Brand name Plavix, a medication used to prevent heart attacks and strokes in patients with heart disease, recent stroke or peripheral vascular disease, and also used with aspirin to treat new or worsening chest pain and to prevent blood clots), esomeprazole (NexIUM 20 mg oral delayed release capsule) (a medication used to treat symptoms of gastroesophageal reflux disease (GERD) and other conditions involving excessive stomach acid) which she was to take once a day at bedtime, esomeprazole (NexIUM 40 mg oral delayed release capsule) which she was to take daily, Gabapentin (a medication used to prevent and control seizures and to relieve nerve pain), hydromorphone (Dilaudid 2 mg oral tablet) (an opioid medication used to relieve moderate to severe pain) which she was to take every six hours as needed for pain, meclizine (an antihistamine used to prevent and treat nausea, vomiting, dizziness, and vertigo caused by motion sickness or inner ear problems), pantoprazole (medication used to treat stomach and esophagus problems such as GERD), and zolpidem (a medication used to treat insomnia, called a "hypnotic") which she was to take once a day at bedtime. She was no longer taking sevelamer (Renagel 800 mg oral tablet) (a medication used to treat low levels of calcium). She was discharged home with no restrictions and no future orders.

Insulin injection instructions written in Spanish were given to the patient. These instructions included information regarding using insulin and possible complications, diabetes information, and diet information. The patient was also given information regarding the care of her fractured distal fibula. There was a future appointment set for January 10, 2017, that identified the type of appointment as "ortho amputee," and location at "RLA Med Surg." The "future orders" identified an x-ray of the ankle complete bilateral on April 11, 2016, and an x-ray foot complete bilateral on April 11, 2016, both for pain in the joint, the reason for each was "Charcot" (a disorder of the foot that causes nerve damage).

The "discharge documentation" noted that the patient's chest pain had improved, she had a percutaneous coronary intervention to her right coronary artery, LIMA to LAD (a coronary artery bypass procedure that involves the left internal mammary artery (LIMA) and the left anterior descending artery (LAD)) patent, non-obstructive circulation, and that the other two graphs were "not found or were down." Per cardiology, her EKG and troponin levels were reassuring in the setting of ESRD, and she was to follow-up with White Memorial for a staged percutaneous coronary intervention (a percutaneous coronary intervention performed at a later date separate from the initial one of performed). She had likely mineral bone disease and hyperkalemia (high potassium) both of which were improved. She had anion gap metabolic acidosis secondary to ESRD which had improved (anion gap is a medical value based on the concentration of ions in the patient's serum; metabolic acidosis occurs when the body produces too much acid or when the kidneys are not removing enough acid from the body). She had ESRD for which she was on hemodialysis Monday, Wednesday, and Friday secondary to presumed diabetes mellitus and hypertension (high broad pressure). She was to continue at her regular dialysis center. Her leukocytosis (an increase in the number of white blood cells) was resolved and likely a stress response with no other signs or symptoms of sepsis. Her hypertension was currently normotensive (normal blood pressure) and she was on hydralazine (a medication to treat high blood pressure) as needed. She had normocytic anemia likely secondary to ESRD (a blood condition caused by a low number of normal-sized red blood cells). She had diabetes mellitus and was started on insulin glargine (a long acting insulin) every evening plus Lispro 6/6/6/ (a sliding scale of insulin) and Lispro insulin sliding scale, moderate, given for inadequate control (a short acting insulin given on a "sliding scale" basis depending on the patient's blood sugar levels). The patient was to have a follow-up hemoglobin A1c, continue with the Gabapentin,

continue her home insulin regimen, and follow up with her primary care physician for management. She had peripheral artery disease and was status post femoral stenting "ASA/Plavix as above."

12. On October 3, 2016, a LAC+USC physician entered an addendum that he electronically signed that day where he documented that on September 30, 2016, he saw and examined the patient and agreed with the resident's assessment and discharge plan. The physician reviewed the imaging, labs and prior history, and spent 35 minutes with the patient, half of which he spent counseling the patient regarding education, adverse drug reactions, pain management, and discharge planning.

OCTOBER 7, 2016, ADMISSION TO DOWNEY CARE CENTER

13. The patient was admitted to Downey Care Center (Downey), a skilled nursing facility (SNF), on October 7, 2016, at 23:08. (The accusation incorrectly identified the admission year as 2017.) It was not explained where the patient was between her discharge from LA+USC Medical Center and her admission to Downey. The patient was a 63-year-old female who was admitted via gurney from "LRMC" (this acronym was not explained at hearing, presumably this is a medical center) accompanied by two EMTs, "under the [illegible] of Dr. Fariba Shokoohy" with diagnoses of end-stage renal disease (ESRD), diabetes mellitus type II, hypotension, anemia and peripheral vascular disease. She had a history of myocardial infarction, coronary artery bypass surgery seven years ago. She fell 10 days ago at home and sustained a right leg fracture which was casted, no surgery was performed. She was on hemodialysis three times a week due to her ESRD and had an arteriovenous graft of her right upper arm to allow access for her hemodialysis.

14. The patient's admitting diagnoses were:

Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficit (Z86, 73), end stage renal disease (N18.6), hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease (112.0), type II diabetes mellitus with other diabetic kidney complication (E11.29), long-term (current) use of insulin (Z79.4), dependence on renal dialysis (Z99.2), anemia in chronic kidney disease (D63.1), secondary hyperparathyroidism of renal origin (N25.81), peripheral vascular disease, unspecified (173.9), hyperlipidemia, unspecified (E78.5), atherosclerotic heart disease of native coronary artery without angina pectoris (125.10), pure hypercholesterolemia, unspecified (E78.00), presence of aortocoronary bypass graft (Z95.1), old myocardial infarction (125.2), unspecified fracture of shaft of right fibula, subsequent encounter for closed fracture with routine healing (82.401D), pain in right knee (M25.561), pain in right ankle and joints of right foot (M25.571), chest pain, unspecified (R07.9), difficulty in walking, not elsewhere classified (R26.2), muscle weakness (generalized) (M62.81), severe sepsis without septic shock (R65.20), methicillin resistant staphylococcus aureus infection, unspecified site (A49.02), endocarditis, valve unspecified (138), unspecified atrial fibrillation (148.91), hypotension, unspecified (195.9), chronic obstructive pulmonary disease, unspecified (J44.9), insomnia, unspecified (G47.00), nonrheumatic mitral (valve)

insufficiency (134.0), tobacco use (272.0), abnormal posture (R 29.3), encounter for other orthopedic aftercare (Z47.89).

The numbers were not explained at hearing but presumably correspond to insurance billing and/or diagnostic codes. The records were replete with various orders given and treatments rendered to the patient because of her numerous conditions.

15. A Downey progress note created October 7, 2016, at 21:43, documented the following:

> Note text: The order you have entered
>
> Clopidogrel Bisulfate Tablet 75 MG (Brand name Plavix)
>
> Give 1 tablet by mouth one time a day for blood clot prevention
>
> Has triggered the following drug protocol alerts/a warning(s):

Drug to Drug Interaction

> The system has identified a possible drug interaction with the following orders:

The note then listed the orders for aspirin and Omeprazole, the dosages of those drugs that had been ordered, the severity of the interaction between each of those two drugs and Clopidrogel, and details regarding the interactions that can occur when each of those drugs is used with Clopidogrel. Dr. Singh testified that this was the type of warning that would come up on the screen and be in the records to warn about possible interactions between medications prescribed.

16. A November 9, 2016, note created at 15:05, documented that the patient is "experiencing a possible change in condition. The following areas of concern noted: Skin wound or ulcer Other change in condition. MD notified: yes. Dr. Singh in facility looked at sites at 11/09/2016 9:30 AM. See SBAR for further information." No explanation was given for why this note was created almost six hours after Dr. Singh examined the patient for her changes in condition.

17. A Downey progress note on November 9, 2016, noted the patient got one Dilaudid tablet as needed for pain management and the "PRN Administration was: Effective."

18. A November 11, 2016, Downey progress note documented the patient's nine pound weight gain over the past month which was due to good oral intake and fluid shifts caused by dialysis. She was examined, labs were noted, and her protein needs were reassessed. Labs from the hemodialysis center would be obtained so the dietitian could review them.

19. On November 23, 2016 at 11:00, the patient was given two tablets of acetaminophen for mild pain. The "PRN Administration was: Ineffective." Later at 11:55, the patient was given one Dilaudid tablet for pain management.

20. A third progress note on November 23, 2016, at 15:47, documented the patient's change in condition, noting: "[Patient] is experiencing a possible change in condition. The following areas of concern noted: Behavioral symptoms (e.g. Agitation, psychosis) Other change in condition. MD notified: dr. shokoohy [*sic*] @ 11/23/2016 11:00 AM. See SBAR for further information." Again, no explanation was given for why this note was created almost five hours after the physician was notified.

21. A Downey progress note created on November 23, 2016, at 21:20 by a nursing supervisor who did not testify in this hearing, documented: "Note Text: received a call from [the name of the nurse practitioner] with [no new orders], just continue to monitor, [name] daughter made aware."

22. A November 24, 2016, Downey progress note created at 9:32, effective at 9:25, indicated the type of note was a discharge summary and that the patient was "taken by the 911 paramedic to Downey regional medical center [*sic*] ER department via gurney. Accompanied by the daughter and several family members. paperwork [*sic*] handed to the paramedics."

23. An unsigned Downey Order Summary, which did not identify the ordering physician or the time of the order, documented a "Phone" order given on November 24, 2016, to "Transfer to the nearest hospital via 911 for altered level of consciousness and elevated temperature."

NOVEMBER 24, 2016, ADMISSION TO KAISER DOWNEY MEDICAL CENTER

24. On November 24, 2016, the patient was admitted to Kaiser Downey Medical Center (Kaiser) at 1:06 p.m. due to increasing lethargy/altered mental status. Her admitting diagnosis was sepsis. She was lethargic on arrival but became more alert. She complained of pain "all over," including her arms, legs, abdomen, head and neck. Her daughter was at her bedside and advised the patient did not have a recent cough, upper respiratory infection symptoms, nausea, vomiting, or diarrhea. The daughter stated the patient does not make any urine and had not complained of headache until arrival in the emergency room. The patient had a fever of 102 F with an elevated white blood count, lactic acid 3.1, was hypotensive with systolic blood pressure of less than 70 that had improved with an IVF bolus, and potassium of 6.2.

25. A November 27, 2016, Downey progress note created at 6:10, indicated the patient was at the hospital.

26. While at Kaiser, the patient had elevated white blood cell count and both low and no fever. A December 1, 2016, gallium scan (a diagnostic test that looks for inflammation, infection, and tumors) noted multiple abnormalities including possible infections in left AV fistula, right lower abdomen, left leg, right tibial fracture site, and an increased breast signal that was likely physiologic. It was determined the patient did not need a PICC line. (PICC is the acronym for peripherally inserted central catheter, a thin tube inserted in a vein and passed to the larger veins near the heart giving the physician access to those large central veins).

27. On December 5, 2016 the patient underwent surgery to remove two old left AV graphs, left axillary sin, and irrigation and drainage of her left antecubital fossa abscess. This was thought to be the main source of her bacteremia.

28. A chest, abdomen, and pelvis CT showed multiple pulmonary nodules, possible septic emboli versus malignancy, otherwise no intra-abdominal abscess. Her bilateral leg ultrasound and right arm ultrasound were negative for DVT. Regarding the pulmonary septic emboli versus malignancy noted on lung imaging, favor was given toward septic emboli given her sepsis presentation but lung malignancy was also considered given her smoking history and pleural based lung lesions. The pulmonologist agreed to continue IV antibiotics at this time and repeat imaging in the next four to six weeks. The patient was advised to have her primary care physician refer her for a follow-up with pulmonary clinic to consider repeat lung imaging and possible lung nodule biopsy if needed.

29. The patient's ESRD would be addressed with her hemodialysis schedule. Her diabetes mellitus 2 was treated by four units of NPH insulin every 12 hours which was increased to 10 units on November 26, 2016, and increased to 14 units on November 27, 2016, due to her elevated sugars. As of November 28, 2016 her blood sugars had overall improved, she was on 14 units NPH insulin twice a day, had act checks and regular insulin sliding scale (RISS - a method of treating diabetic patients with long acting insulin is given twice a day with short acting insulin given before meals and at bedtime). On November 29, 2016, her NPH insulin was increased to 18 units twice a day. On December 6, 2016, her sugars were stable in the 100-200 range and she was encouraged for oral intake.

30. The December 6, 2016, Kaiser discharge summary documented that the patient was thought to have severe sepsis to due to MRSA bacteremia/probable septic emboli/endocarditis/left antecubital fossa abscess. (MRSA is the acronym for Methicillin-resistant Staphylococcus aureus, a staph infection that is difficult to treat because of resistance to some antibiotics.) A six-week therapy was advised for presumed endocarditis. The patient would need a PICC line once the bacteremia cleared. The patient's left arm ultrasound was negative for DVT (deep vein thrombosis, the formation of blood clots deep in the veins) but showed a thrombosed (clotted) arteriovenous fistula which was chronic per the patient's daughter. Consideration was given for removal of the old left AV fistula if the bacteremia persisted and the gallium scan was consistent with an AV fistula infection.

The patient's coronary artery disease had been monitored while at Kaiser and was stable at discharge. She was to resume aspirin, Plavix, and statin (a drug used to lower cholesterol in patients at risk for stroke and heart disease). While hospitalized she had new onset atrial fibrillation with RVR (rapid ventricle response a condition

where the heart beats too fast) which was due to her sepsis, had now resolved and she had a NSR (normal sinus rhythm). She was continued on amiodarone 200 twice a day per cardiology while hospitalized (a medication to treat irregular heartbeat) and per the discussion with the pulmonologist, it was discontinued on December 2, 2016, since the patient remained in sinus rhythm and the atrial fibrillation was suspected to be caused by her underlying sepsis. At discharge she remained stable and was off amiodarone.

The patient was to remain immobilized and follow-up with orthopedics for her recent right tibia/fibula fracture. Her bilateral severe heel ulcers and coccyx pressure sore were present on admission, evaluated by both podiatry and wound care specialists, and she was to continue with wound care with no debridement or surgery planned at this time. The patient was seen by nutrition service for her moderate protein calorie malnutrition, was encouraged to do oral intake, and to add nutritional supplements to her diet.

31. The patient's discharge medications were: Vancomycin IV per pharmacy protocol through January 16, 2017, and was to be given with her dialysis (an antibiotic for intestinal infections); 81 mg of aspirin which she was to take orally every morning, 75 mg of clopidogrel (Plavix) which she was to take orally daily; 100,000 unit/gm powder of nystatin (used to treat fungal infections) was to be applied three times a day to her bilateral groin rash; 5 mL of nystatin solution (oral nystatin used for fungal and yeast infections) to be taken four times a day "swish and spit for oral thrush" (a fungal/yeast infection of the oral tissues); 18 units of insulin NPH subcutaneous to be taken twice a day (an intermediate-acting insulin to control blood sugar); one tablet of vitamin B complex vit C-FA one tablet to be taken daily; 8000 units subcutaneous of epoetin (a drug used to treat anemia in patients with long-term serious kidney

disease) to be taken every Monday, Wednesday, Friday; 667 mg of calcium acetate to taken orally three times a day with meals (a drug used to prevent high blood phosphate in patients on dialysis due to severe kidney disease); 2000 mg of oral pantoprazole to be taken daily (to treat acid reflux); 5000 units of heparin porcine to be taken every 12 hours (to prevent blood clots); 20 mg of oral atorvastatin to be given every evening (to lower cholesterol); 2 mg of hydromorphone (an opioid used to treat moderate to severe pain) to be given orally every six hours as needed for moderate pain (pain level of 4-6); one drop of carboxymethylcellulos to be given four times a day for dry eyes; and 4 mg of hydromorphone to be given orally every six hours as needed for severe pain (pain level of 7-10).

32. The patient could do activity as tolerated and her diet was ordered to be "finely ground renal/diabetic." The patient was not discharged with any durable medical equipment or oxygen. The discharge history section noted that the patient was a former smoker, having smoked three packs of cigarettes per day for 30 years beginning in 1968 and quitting in 2015. The patient's principal diagnoses were "severe sepsis due to MRSA bacteremia/probable septic emboli/endocarditis/left antecubital fossa abscess." Her secondary diagnoses were pulmonary septic emboli versus malignancy, ESRD, diabetes mellitus 2, coronary artery disease, new onset atrial fibrillation with rapid ventricular response, recent right tibia/fibula fracture, bilateral severe heel ulcers and coccyx pressure sore, and moderate protein calorie malnutrition.

The "principal procedures" the patient underwent at Kaiser were an infectious disease consult, vascular surgery consult, nephrology consult, telemetry monitoring, and removal of two old left AV graphs, left axillary stent, and irrigation and drainage of left antecubital fossa abscess on December 5, 2016. The patient underwent chest, left

foot, and left ankle x-rays; echocardiogram; left arm ultrasound, gallium scan, CT of the chest, abdomen and pelvis, bilateral leg ultrasound, and right arm ultrasound. At discharge the patient was transferred "to custodial care."

The discharge summaries indicated they were filed on December 6, 2016, the status was "signed," and the discharging physician did an addendum on December 14, 2016, eight days after discharge.

DECEMBER 6, 2016, RE-ADMISSION TO DOWNEY

33. A December 6, 2016, Downey progress note created at 22:54 documented the patient's readmission to Downey from Kaiser at 19:00 under the care of Fariba Shokoohy, M.D. Her diagnoses were "MDRO [multidrug resistant organisms] of blood, sepsis due to bacteremia, left antecubital fossa abscess (an abscess at the antecubital fossa, or "elbow pit," the small triangular depression in the arm which is formed by the connection of the humerus with the radius and ulna of the forearm) and endocarditis." The patient was documented to have a history of ESRD, diabetes mellitus, hypertension and coronary artery disease. She arrived via ambulance alert times four, in full code status. Her bladder and bowel were both incontinent. The patient and her daughter refused to undergo a body check assessment, despite having the risks and benefits explained to them. (Although not explained, presumably a "body check" is some type of physical assessment of the patient.) The daughter stated, "Let my mother rest first because she is tired." The Nurse Practitioner who was on call for Dr. Shokoohy returned the Downey nurse's page and ordered them to continue the patient's previous orders. The patient was advised and "okay with all the orders. [W]ill continue plan of care and will continue to monitor for any complications."

34. A December 6, 2016, Downey progress note created at 17:34 documented an order given for "Acetaminophen Tablet 325 MG Give by mouth every 6 hours as needed for Mild Pain [not to exceed] 3gms of Acetaminophen in 24 hours temp of 99.9." The patient had complaints of general body pain.

35. An unsigned Downey order summary, which did not identify the ordering physician or the time of the order, documented a "Phone" order given on December 6, 2016 to "transfer to Downey Kaiser via 911 [due to] increased temperature & lethargy."

DECEMBER 6, 2016, RE-ADMISSION TO KAISER DOWNEY MEDICAL CENTER

36. The patient returned to Kaiser on December 6, 2016, a few hours after being discharged. It was unclear what time she left Downey or what time she arrived at Kaiser, but some Kaiser labs were timed at 23:03, so it appears she arrived at Kaiser late in the evening. The emergency room history and physical was dated December 7, 2016, at 1:16 a.m., which would be consistent with a late arrival on December 6, 2016. The patient presented with fever and had been transferred from Downey due to a chief complaint of fever. She was given Tylenol prior to coming to Kaiser. The history and physical documented that she had just been discharged to SNF today and when she arrived at the outside facility she had a temperature of 101 and was told to come into the emergency department.

37. The patient reported feeling tired and had not ambulated since September 2016. She receives regular care from White Memorial Hospital and gets dialysis Monday, Wednesday, and Friday. She had a past medical history of pneumonia. The history and physical noted that on November 24, 2016, the patient was previously seen with a history of coronary artery bypass graft in 2010, myocardial infarction September 2016 status post stent of unknown vessel, history of subsequent

fall with right tibia-fibula fracture status post casting, ESRD on hemodialysis (Monday, Wednesday, Friday), who had been brought to the emergency department for increasing lethargy/altered mental status and was noted to have a fever of 102F in the emergency department. The patient had not complained of headache until arrival at Kaiser per the daughter and "does not make any urine." The patient had a fever, with elevated white blood cells, lactic acid of 3.1 (high), was hypotensive with systolic blood pressure less than 70 that improved with IVF bolus, and had elevated potassium levels of 6.2.

The discharge information for her prior hospitalization was listed and it was noted that when she "got to facility, was found to be febrile so daughter decided to bring patient back to ER." The patient's workup was unremarkable, her repeat blood culture was negative, there were no new findings on chest x-ray, and no new signs or symptoms of a new infection. Her condition was discussed with the infectious disease physician who noted that "intermittent fevers [are to be] expected with patient's multiple infections, ok to [discharge] home."

38. The December 8, 2016, discharge summary noted that the patient "will need to [follow up] with multiple issues post hospitalization." The Kaiser case manager had discussed this with the patient's case manager who would arrange appropriate follow-up including: contacting the patient's primary care physician as soon as possible, removing the suture in her left arm in one to two weeks from the surgery performed December 5, 2016, follow-up with orthopedics as soon as possible for her proximal fibula and distal tibia/fibula fractures from two months ago, follow-up with nutrition due to her poor appetite and risk for malnutrition, follow-up with podiatry for heel eschars (scabs/dead skin) and local wound care, have physical therapy for

deconditioning and increasing mobility, and continue IV vancomycin with hemodialysis until November 16, 2017.

The patient was not discharged from Kaiser with any durable medical equipment or oxygen. While hospitalized she had a chest x-ray which was unchanged from her prior findings and underwent a blood transfusion on December 7, 2016. The patient had diabetes mellitus, type 2, with diabetic chronic kidney disease, ESRD on dialysis, and hypotension. She was to continue her hemodialysis as an outpatient and continue her RISS until her appetite improved. (RISS is the acronym for regular insulin sliding scale and refers to a progressive increase in premium or nighttime insulin dose based on per-defined blood glucose ranges.) For her coronary artery disease, the patient was to continue aspirin, clopidogrel (Plavix), beta blockers (medications used to control heart rhythm, reduce chest pain and control blood pressure), angiotensin receptor blockers (medications used to treat diabetics with heart failure or kidney disease), and to follow up with cardiology. She was transfused for her anemia and her hemoglobin and her hematocrit increased as expected.

The patient was instructed to follow-up with orthopedics and resume physical therapy for her fractures. A nonweightbearing moon boot (a boot designed to reduce foot and ankle movement to promote bone healing) was applied to her right lower extremity. She was to continue with wound management of her bilateral severe heel eschars and coccyx pressure sore and was seen by nutrition service for her moderate protein calorie malnutrition for which oral intake was encouraged. On December 8, 2016, she was started on megace (a medication used to treat breast or uterine cancer). Significant lab results were documented including her high white blood count and her high and varying hemoglobin levels which ranged from 9.2 to 7.7. The patient and her

family were educated about her diagnoses, disease process, prognosis, and plan of care.

39. The patient's discharge medications were: vancomycin IV to be given with hemodialysis (antibiotic for intestinal infections); 81 mg aspirin to be taken orally once per day; 5000 units per milliliter injection solution, of heparin sodium, porcine (heparin porcine) 1 mm subcutaneous to be given every 12 hours (a medication used to prevent and treat blood clots); 400 mg per 10 mL oral suspension of megestrol (megace) to be given once daily ; 15 mg oral tablet of morphine (MSIR) (morphine sulfate immediate release - a short acting opioid to treat pain), one tablet to be given every eight hours as needed for pain; 667 mg calcium acetate (eliphos/phoslo), one tablet to be given three times a day with meals (a medication used to prevent high blood phosphate levels in patients on dialysis due to severe kidney disease); 3.125 mg oral tablet of carvedilol (coreg) (a beta blocker used to treat high blood pressure), one tablet to be given orally two times a day, hold for systolic blood pressure less than 100; 75 mg oral tablet of clopidogrel (Plavix) (a medication used to prevent heart attacks and strokes in persons with heart disease, recent stroke, or peripheral vascular disease) to be given once daily; 25 mg oral tablet of Losartan (Cozaar) (a medication used to treat high blood pressure and to protect the kidneys from damage due to diabetes) to be given once daily, hold for systolic blood pressure less than 110; Pantoprazole (Protonix) (a medication used to treat stomach and esophagus problems) 20 mg oral TBEC DR tablet to be taken once daily; 300 mg oral capsule of gabapentin (Neurontin) one tablet to be given two times a day. Patient could also be given 650 mg of acetaminophen by mouth every four hours for mild pain (less than 5 on a pain scale of 1-10), Colace twice a day as needed for constipation, and Dulcolax 10 mg suppository per rectum daily as needed for severe constipation. The patient's recommended diet was the American Diabetic Association diet and a renal diet.

40. The Kaiser discharge nursing home orders documented that the patient was discharged to custodial care, noted her principal diagnoses and that she was in full code status. Her diet was to be finely ground diabetic/renal with nutritional supplement such as a boost glucose control three times a day for poor oral intake. The wound care instructions included turning the patient every two hours and dressing instructions for her bilateral heels and left arms. She was to continue with her hemodialysis. Her accu check (the use of a glucometer to test a patient's blood sugar levels) was to be "qAC" (before every meal) and "qHS" (before bedtime). The Insulin Sliding Scale: subcutaneous with regular insulin was noted which included how many units of insulin to give or not give depending on the patient's blood sugar levels.

The Kaiser discharge documents were signed at 1:19 p.m., so it appears the patient was discharged on December 8, 2016, in the early afternoon.

DECEMBER 8, 2016, RE-ADMISSION TO DOWNEY

41. On December 8, 2016, the patient was readmitted to Downey from Kaiser at 21:48 under the care of Dr. Fariba Shokoohy. The time lag between her Kaiser discharge and Downey readmission was not explained at hearing. Her admitting diagnoses were fever, multi-drug-resistant organisms of blood, sepsis due to bacteremia, left antecubital fossa abscess with endocarditis. Patient has a history of ESRD, diabetes mellitus, hypotension, and coronary artery disease. She was transported via ambulance. She was alert times four "with episode of confusion." She had a full code status and was bowel and bladder incontinent. She refused a body check assessment despite having the risks and benefits explained, stating "I am tired, I want to rest. Do it tomorrow." She was reoriented to the facility, staff and the procedures, and verbalized her understanding. She was given dinner but refused to eat. Per her daughter, her patient has poor appetite since she was in the hospital.

42. The doctor was paged and the nurse practitioner on call for Dr. Shokoohy called back "and ordered to continue previous orders." The patient was made aware and was okay with all the orders. The plan of care will be continued and the patient will continue to be monitored for any complications. There is no documentation that the patient was on oxygen when she was readmitted and the Kaiser records stated she was not discharged with oxygen.

43. A December 8, 2016, Downey progress note entered by the licensed vocational nurse (LVN) documented that 100 unit/ml of NovoLog Solution (a fast acting insulin) would be injected per a sliding scale and the doctor would be contacted if it was less than 70 or greater than 400. It was to be given subcutaneously before meals and at bedtime for the patient's diabetes mellitus.

44. An unsigned Downey order summary, which did not identify the ordering physician or the time of the order, documented a "Phone" order given on December 12, 2016, to "Transfer to White Memorial Medical Center for further evaluation."

DECEMBER 12, 2016, ADMISSION TO WHITE MEMORIAL MEDICAL CENTER

45. On December 12, 2016, the patient was admitted at 21:43 to White Memorial Medical Center for altered mental status hypotension. Eleven different physicians consulted on the patient's care. Her admitting diagnosis was sepsis unspecified organ. She was noted to be a 64-year-old Hispanic female with recent MRSA bacteremia due to infective left upper extremity AV shunt who presented to the emergency department with altered mental status, hypotension, and fevers. She was noted to be obese. She was found to have sepsis and admitted to the intensive care unit (ICU) due to persistent hypotension. She responded well to IV antibiotics and IV fluid and underwent close monitoring in the ICU. She was noted to have an extensive

medical history including but not limited to coronary artery disease status post coronary artery bypass graft and percutaneous coronary intervention, ESRD on hemodialysis Monday, Wednesday, Friday, diabetes, hypertension, hyperlipidemia, and peripheral vascular disease. The patient's oxygen saturation rate was 100 percent.

46. The patient's hospital course noted the labs and exams requested and the numerous medications given. She was seen in the ICU for suspected severe sepsis/septic shock, treated with fluids and her blood pressure returned to normal. Her mental status also improved with normalization of her blood pressure. Her lactate of 1.0 suggested it was not severe sepsis but she may still harbor an infection so antibiotics were given. An echocardiogram was scheduled. It was determined she had ESRD due to diabetes and hypertension. Hemodialysis was recommended. "Restarting [antibiotics] and pancx (unknown what this acronym means) for hypertension, resume Procrit with hemodialysis for anemia were all recommended." The patient was also referred to cardiology. Her elevated troponin was likely due to her sepsis and renal failure. (Troponin is a complex of three proteins that are integral to muscle contraction in skeletal and cardiac muscle; blood troponin levels may be used as a diagnostic marker for stroke.) The patient did not show any evidence of congestive heart failure at this time. She was to continue with her dialysis plan and fluid removal. The patient was also diagnosed with nutrition alteration.

47. The patient had a central line insertion from medication delivery and an arterial line insertion for frequent arterial blood gas monitoring. She had hemodialysis and an infectious disease consult for further workup of her infectious process and to aid in the choice of antibiotics. The differential diagnoses included endocarditis (an infection of the inner lining of the heart) versus myocarditis (an inflammation of the heart muscle) given her persistent fevers at Downey. She had blood and urine cultures,

and her rate of flow and procalcitonin (a peptide naturally produced in the body that serves as a marker for sepsis) were obtained. Zosyn (an antibiotic) was discontinued, Vancomycin was continued, tobramycin (an antibiotic) was added "pharm to dose," and Bactrim suspension (an antibiotic) 25 cc per day was ordered. A TEE (a transesophageal echocardiography, a test that produces pictures of the heart using high-frequency sound waves) was recommended by cardiology to evaluate for endocarditis. The TEE performed on December 16, 2016, resulted in the patient being diagnosed with endocarditis of the mitral valve for which antibiotics were recommended.

48. X-rays of the right tibia/fibula because of the patient's right leg pain were taken and compared to previous films which had showed a right tibia fracture with angulation (a bend in the bone) and calcified vessels which appeared like a chronic fracture. Segmental fibula fractures were also noted. The patient was examined by orthopedics who determined the patient had right tibia and fibula fractures with delayed union status post injury in September 2016 and gave treatment recommendations. The patient also underwent a surgical consult and no significant infections were noted. The surgeon recommended the patient see the surgeon who had performed her prior surgery for her suture removal, but she was unable to recall where that operation had been performed. The patient also had a physical therapy evaluation.

49. The patient's final diagnoses at discharge were: sepsis; acute bacterial endocarditis; altered mental status secondary to sepsis; fracture of the right proximal and distal femoral shaft; end-stage renal disease; diabetes mellitus type 2; hypertension; anemia of chronic disease; MRSA infection; anemia; chronic kidney disease/mineral bone disorder; coronary artery disease, status post triple vessel

coronary artery bypass graft and percutaneous coronary intervention (a revascularization technique used in the treatment of coronary artery disease which involves the nonsurgical widening of the coronary artery using a balloon catheter to dilate the artery from within); and severe peripheral arterial disease, status post bilateral lower extremity bypass surgery in January 2015. The patient had 28 active or inactive medical problems including anemia (a condition caused by a lack of sufficient healthy red blood cells to carry adequate oxygen to the body's tissues), anuria (absence of urination often caused by kidney failure), body mass index of 30+, obesity; bronchitis (inactive); coronary artery disease, cataracts (inactive), chest pain (inactive), cholesterol serum elevated (inactive), chronic obstructive pulmonary disease, cerebrovascular accident (inactive), diabetes mellitus (inactive) [of note, it was unclear how this was listed as an inactive disease when she had active diabetes mellitus 2 at the time], dizziness, diabetes mellitus [of note, this entry conflicted with the one above identifying this disease as inactive, and that entry was clearly erroneous], emphysema of lung (inactive), end stage renal disease, headache, heart attack (inactive), heart disease (inactive) [again, this entry conflicted with her diagnoses of coronary artery disease and endocarditis], hemodialysis (inactive) [this was also inaccurate since she was actively undergoing hemodialysis three times a week], high blood pressure (inactive) [this entry conflicted with her diagnoses of hypertension], history of renal failure (inactive) [this entry conflicted with her diagnosis of end-stage renal disease], hypertension [this entry conflicted with the inactive high blood pressure entry which was clearly an erroneous entry], hyperlipidemia (a high level of lipids (fats) in the body), insomnia, migraine (inactive), peripheral artery disease, pneumonia (inactive), and sleep apnea (inactive).

A summary of the patient's labs noted her December 13, 2016, high hemoglobin A1c of 8.9 percent and her critical Troponin 1 level of 0.16 ng/mL. Several of the patient's other lab results were in the abnormal ranges.

50. The discharge summary included medications the patient took at home prior to her hospitalization, with a warning that she review the list as the instructions may have changed. Those medications included nitroglycerin 0.4 mg sublingual tablet under the tongue every five minutes "PRN as needed for chest pain," Gabapentin (Neurontin) 300 mg capsule to be taken orally at bedtime; 25 mg tablet of Sitagliptin (Januvia) (a medication used to control blood sugar levels) to be taken orally daily; cilostazol 50 mg oral tablet to be taken twice daily (a drug to improve blood flow in the legs); megestrol 40 mg/ml oral suspension to be taken daily (a drug to treat cancer of the breast or uterus); meclizine 25 mg oral tablet be taken three times a day PRN for dizziness, as needed; insulin aspart (brand name NovoLog) 0.04 mL beneath the skin three times daily with meals, the patient's "injection last dose" was December 19, 2016, at 17:57; epoetin alfa (Procrit – a drug to treat anemia) 0.2 mL = 4000 units beneath the skin every Monday, Wednesday, and Friday, her "injection last dose" was December 19, 2016, at 17:57; acetaminophen 3 to 25 mg oral tablet to be given every four hours PRN for mild pain (scale 1-3) as needed; carvedilol (Coreg, a drug to treat high blood pressure and heart failure) 3.125 mg oral tablet to be given twice daily; aspirin 81 mg chewable tablet to be given daily; zolpidem (Ambien) 5 mg oral tablet to be given at bedtime PRN for insomnia, as needed; sulfamethoxazole-trimethoprim 200 mg-40 mg/5 ml oral suspension, 20 mL oral to be given every 24 hours (an antibiotic combination used to treat bacterial infections); simethicone 80 mg chewable tablet to be given every six hours PRN flatulence (or gas) as needed; lactulose 10 g/15 mL oral syrup, 30 mL = 20 gm to be given orally every four hours PRN constipation as needed; menthol-zinc oxide topical (Calmoseptine ointment, used to treat minor skin

irritations) one application on the top of the skin in one area twice daily PRN as needed; insulin detemir (a long-acting insulin) beneath the skin twice daily; heparin (an anti-coagulant) 5000 units per mL injectable solution, one mL = 5000 units beneath the skin every 12 hours injection; atorvastatin (used to treat high cholesterol) 40 mg oral tablet to be given at bedtime; acetaminophen-hydrocodone (Norco 5/325) one tablet to be given every four hours PRN for moderate pain (scale 4-6), as needed; pantoprazole (used to treat acid reflux) 40 mg oral tablet to be given daily; ocular lubricant (Artificial Tears preserved ophthalmic solution) two drops bilaterally eye twice daily; losartan (used to treat high blood pressure) 25 mg tablet to be given daily; and clopidogrel (to prevent heart attack and stroke) 75 mg oral tablet to be given daily.

The patient's discharge physical exam was documented which noted that her lungs were clear to auscultation and her breath sounds were equal. She was oriented, her speech was clear and coherent. She was alert and oriented with no focal deficits.

51. The patient was discharged on December 19, 2016, at 21:28 to Downey. The discharge summaries were electronically signed by the hospital physician on December 27, 2016, eight days after the patient had been discharged.

DECEMBER 19, 2016, RE-ADMISSION TO DOWNEY

52. A December 19, 2016, Downey progress note with an effective time of 23:42, documented that the "64 years old Spanish-speaking" patient was readmitted to Downey under Dr. Singh's care, via ambulance. Dr. Singh testified that the family had issues with Downey and her prior physician, Dr. Shokoohy, so Dr. Singh was asked to assume her care, which he did. The patient's admitting diagnoses were altered level of consciousness, hypotension, altered mental status (AMS), lethargy, MRSA of shunt, CAD (coronary artery disease), IDDM (insulin-dependent diabetes mellitus), anemia,

peripheral vascular disease, right lower extremity fracture, and ERSD. The patient was in full code. She was alert and oriented with periods of confusion. She refused a body assessment stating, "I am tired right now can you please do the body assessment tomorrow." Dr. Singh was notified regarding her readmission and "ordered to continue the same orders." The patient's daughter was called and made aware that the patient had been readmitted and refused a body assessment. "All needs provided to the [patient], oriented to facility and staff, will continue plan of care."

53. An entry on December 19, 2016, at 20:07 with an effective time of 23:07 documented an order for Acetaminophen tablet 325 MG. Two tablets were to be given "by mouth every 6 hours as needed for Mild Pain [not to exceed] 3gms of Acetaminophen in 24 hours PRN Administration was: Effective. Follow up to: 12/19/2016 22:15 Orders - Administration Note [Author: [LVN's name]."

54. A December 20, 2016, Downey progress note created at 14:11, documented that skin/wound reassessment was carried out. The patient's IV sites, surgical sites, and rash/redness areas were noted. The patient had scabs on her left arm and knee, left buttocks pressure ulcer, and multiple vascular/diabetic ulcers to her feet. There was edema present to her left arm and bilateral lower extremities. "MD in facility made aware of findings and treatments." The patient's daughter was at the facility and made aware of the findings and treatment orders. The patient's granddaughter was at bedside during the skin assessment and looked at the sites. The patient was aware of the findings. She had a follow-up appointment with orthopedics on December 22, 2016. Staff "was aware to make transportation arrangements" and the daughter was aware.

55. A December 20, 2016, Downey progress note created at 14:38, with an effective time of 13:30, documented: "Dr. Singh in the facility and received orders as

follows: CBC, BMP, blood culture x 2 10 minutes apart @ dialysis center on 12/21/2016, Lipitor 40 mg 1 PO QHS for hyperlipidemia and skilled PT/OT therapy. Orders noted and carried out. [Name] (daughter) in the facility and made aware, communicated to 3-11 RN supervisor [name] to endorse to the 11-7 shift."

56. A December 28, 2016, Downey progress note documented that the patient was "alert and oriented in bed with visitor at bedside. [A]ll routine meds given and taken at will. Ongoing monitoring and [treatment] on coccyx [due to] deterioration. Kept clean and dry at all times. Will cont[inue] to monitor [each] shift." A later entry at 16:24 documented the daughter stated she spoke with the patient who had no complaints or concerns and "that everything is going well at this time."

57. December 29, 2016, Downey progress notes documented the patient's deteriorating coccyx skin condition but no infection was noted.

58. A Downey record containing several order summaries and the communication method, which was electronically signed by Dr. Singh on December 20, 2016, at 13:10, documented that on December 19, 2016, at 22:50, by "Phone," Dr. Singh ordered "Tobramycin IV to be given with hemodialysis for MRSA of shunt." The order was confirmed by a nursing supervisor who did not testify in this hearing. Of note, a different Downey document, an unsigned Order Summary, which did not identify the ordering physician or the time of the order, documented a "Phone" order given on December 19, 2016, that "Tobramycin IV to be given with hemodialysis for MRSA of shunt" was "Discontinued." This was not explained at hearing.

59. The same Downey order summary listing "Phone" orders given by Dr. Singh also documented that on December 19, 2016, at 22:52: "Per Dr. Singh to continue same orders in the hospital." At 22:56: "Ativan tablet 0.5 MG (Lorazepam)

give 1 tablet by mouth every 6 hours as needed for Anxiety" and below that was written "DISCONTINUE 12/19/2016 22:56 per MD order." The entry at 23:00 documented an order for "Ambien tablet 5 MG (Zolpidem Tartrate) Give 1 tablet by mouth as needed for [nightly at bedtime] PRN insomnia." At 23:29 there was an order for Norco tablet 5-325 MG (hydrocodone-acetaminophen) "Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain." Two orders given on December 20, 2016, related to the patient's left arm surgical site and left posterior knee scab.

December 2016 Medication Administration Records

60. Several Downey Medication Administration Records for the month of December 2016 were introduced. The patient had a Do Not Resuscitate (DNR) order in her file. The records documented the date the order was given and the date the medication was administered, with each date being divided into three rows, presumably representing whether the medication was given during the first, second, or third shift. No times of medication administration were recorded.

61. One medication administration record documented that Oxygen at 2 liters per minute via nasal cannula was ordered October 7, 2016, to be given "PRN as needed for [shortness of breath]." Oxygen was never administered to the patient in December. An order dated December 19, 2016, was given for Norco tablet 5-325 MG (hydrocodone-acetaminophen), one tablet to be given by mouth every four hours as needed for moderate to severe pain. Between December 20, 2016, and December 31, 2016, the patient received one Norco tablet during every first shift, one Norco tablet during four second shifts, and one Norco tablet twice during the third shift, when her pain levels were between 5 and 8 on a scale of 1 to 10. There was also an order for Robitussin DM ordered October 17, 2016, as need for cough, but it was never given during December.

62. Another Downey medication administration record documented that on December 8, 2016, the patient was prescribed Morphine Sulphate Tablet 15 mg, one tablet as needed for severe pain (Morphine Sulphate is an opioid). She was given that medication eight times before Dr. Singh assumed her care. She was given it twice after he assumed her care, on December 24, and 30, 2016.

63. A third Downey December 2016 medication administration record documented that Ambien Tablet 5 MG (Zolpidem Tartrate, is a hypnotic) 1 tablet by mouth as needed Q HS PRN (every night at bedtime as needed) for insomnia was ordered on October 8, 2016, at 00:30 and discontinued on December 8, 2016, at 20:49. A second entry indicates an order for Ambien Tablet 5 MG (Zolpidem Tartrate) 1 tablet by mouth as needed Q HS PRN for insomnia ordered on October 8, 2016, at 20:53 and discontinued on December 8, 2016, at 20:49. No explanation for this was offered at hearing. A third entry documented a December 19, 2016, order for Ambien Tablet 5 MG (Zolpidem Tartrate) 1 tablet by mouth as needed Q HS PRN for insomnia. The patient was given Ambien on December 23, 27, 28, 29, 30, and 31, 2016.

Downey Records for January 2017

64. Several Downey progress notes dated January 2, 2017, documented the administration of two tablets of acetaminophen at 19:45 and again at 22:45 for mild pain, and a blood draw at 22:45 "for ordered lab work." The patient's oxygen was intact via nasal cannula, no shortness of breath and no altered level of consciousness was noted. A note at 20:30, documented the administration of one Norco tablet for moderate to severe pain and the administration was "effective." A change of condition entry at 21:34, by nursing supervisor who did not testify in this hearing, documented that the patient was experiencing a possible change of condition. "The following area(s) of concern noted: Other change in condition. MD notified: DR. ANANJIT SIGNH

[*sic*] @ 01/02/2017 8:10 PM. See SBAR for further information." The note did not specify the change in condition the patient was experiencing and no explanation for this entry being 90 minutes after Dr. Singh was notified was offered. The acronym SBAR was also not explained at hearing, but presumably referred to "Situation, Background, Assessment, Recommendation," a template used to improve communications and integrated with electronic records.

65. A January 2, 2017, Downey progress note entered at 22:06 documented the patient's daughter was in the facility and requested that the patient's PICC line in the left groin and peripheral line on her right neck be removed. (A PICC line is a peripherally inserted central catheter used to deliver medications and other treatments directly to the large central veins near the heart.) The daughter complained that those lines had been there since the patient was in the hospital and the nursing supervisor reminded the daughter that when the patient was readmitted to Downey, she refused a body assessment. The nursing supervisor explained the risks and benefits of removing the PICC line, noting they might still be using it at the dialysis center because the patient still had an order for vancomycin IV to be given at the dialysis center. However the daughter still insisted the PICC line be removed as she feared her mother might get another infection. The nursing supervisor suggested they contact the dialysis center, but the daughter stated that they were probably closed now. The nursing supervisor spoke to Dr. Singh on the phone, advised him of the daughter's requests, and he acknowledged and approved removing the lines.

66. On January 2, 2017, at 19:30 one Norco tablet (an opioid) was given to the patient for complaints of general body pain.

67. A January 3, 2017, Downey progress note documented the "MD" was notified at 15:25 regarding the patient's change in condition of her "skin wound or

ulcer." At 18:14 the patient was offered but refused one Gabapentin capsule for pain three times. An entry at 19:00 noted that the patient was alert and verbally responsive with even and unlabored respirations and no shortness of breath. The entry at 15:03 noted the patient was alert and oriented, with no complaints of pain, and "pain management effective." She was tolerating her medications and had no shortness of breath or swelling.

68. A January 3, 2017, Downey progress note created at 15:25, effective 12:10 noted: "Paged dr. Singh [*sic*] to report abnormal lab values. Awaiting call back." An entry created at 15:27, effective 14:15, which was a follow-up to the 12:10 note, documented: "Paged dr. Singh [*sic*], a waiting for call back for the lab results." The entry at 15:28, effective 15:25, that was a follow-up to the 14:15 note, documented: "Endorsed to 3-11 shift supervisor [name] that MD did not call back to follow-up on lab results." No labs are referenced but a review of the notes that form the basis of the call suggests that it was the patient's temperature of 97.4 that prompted the call.

69. January 3 and 4, 2017, Downey progress notes document administration of Ambien for the patient's insomnia and inability to sleep and Norco for severe pain.

70. A January 4, 2017, Downey progress note created by a nursing supervisor at 00:26, effective January 3, 2017, at 22:23, stated: "received a message from Dr. Singh that the patient was very anemic and may need blood transfusion if possible. Spoke to daughter and made aware. Per MD to follow up in AM. Per daughter [name] will come to facility [tomorrow] and will call dialysis center to double check with her mom [tomorrow]. Noted and communicated."

71. A January 4, 2017, Downey progress note created at 7:05, effective 10:00, documented administration of one Norco tablet every four hours as needed for

moderate to severe pain. An entry at 9:32, effective 12:31, which was a follow-up on the 10:00 order, documented administration of one Norco tablet every four hours as needed for moderate to severe pain and that the PRN administration was effective. An entry at 13:37, effective 13:35, documented: "Dr. Singh called and ordered the blood transfusion to be done at dialysis center. Called dialysis center and they dsaid [*sic*] that they don't do blood transfusion there they usually send people to White Memorial for transfusion. Will let MD know."

72. A January 4, 2017, Downey progress note effective 13:50 documented a call to the patient's daughter to advise her that "SSD" was still working on authorization for transportation and that "MD ordered for her to have blood transfusion. Told her that we are waiting for the authorization once we get it" the facility would reschedule the patient for blood transfusion. An entry at 16:59, effective 16:29, documented the patient was experiencing a possible change of condition which was noted to be "other change in condition," with no explanation as to what that meant. Dr. Singh was notified at 4:00 p.m. "See SBAR for further information." An entry at 17:54, effective 17:00, documented that the patient was transferred via ambulance to acute care hospital.

73. A January 4, 2017, Downey progress note created at 19:43, effective at 19:10, documented the patient was picked up by ambulance, was on oxygen at two liters per minute continuous, was not in distress, was in stable condition, and was going to White Memorial Medical Center.

74. A January 4, 2017, Downey "eINTERACT Change in Condition Evaluation" form, timed at 16:29, documented the "other change in condition" which was "missed dialysis 1/4/2017 and abnormal labs." The change began on January 4, 2017 in the afternoon. The patient's lengthy "Primary diagnoses" were listed and the "additional

pertinent diagnosis(es)" section had the following boxes marked: COPD, diabetes and chronic renal failure/ESRD. Of note, these three diagnoses were also listed in the primary diagnoses section. There were no medication changes made in the past week. The patient was taking hypoglycemic medication(s)/insulin. The patient's DNR status was noted. Her most recent vital signs were recorded which included a 95 percent oxygen saturation rate with "oxygen via nasal" on January 4, 2017, at 16:40. Of note, this time is after the time this form was created. The patient's mental status evaluation, functional status evaluation, behavioral evaluation, respiratory evaluation, cardiovascular evaluation, abdominal/GI evaluation, genitourinary evaluation, and skin evaluation all had "no changes observed." The patient had no pain and there were "no changes observed" in her neurologic condition. Under the abnormal results of laboratory tests/diagnostic procedures, the box marked "complete blood count" was checked and her hematocrit result of 22.8 and her hemoglobin result of 7.2, both obtained on January 3, 2017, were noted. Since the change in condition, the patient's condition had "stayed the same." Things that made her condition worse were "hemodialysis, MRSA of shunt." This condition had occurred before and the treatment for it had been "transferred to hospital." The "other relevant information" section noted her low red blood count of 2.46, her low hemoglobin of 7.2 and her low hematocrit of 22.8. The "summarize your observations and evaluation" section stated: "[Patient] looks pale today and missed dialysis due to auth[orization] issues. Facility is working on the auth[orization]. Recommended to transfer to hospital for further evaluation/possible blood transfusion." Dr. Singh was notified of the change in condition at 16:00 and his recommendation was documented as "transfer to White Memorial Medical Center ER [due to] missed dialysis 1/4/16 [sic] and abnormal labs/possible blood transfusion." The patient's daughter was notified at 16:05.

75. An unsigned Downey Order Summary, which did not identify the times of the order or ordering physicians, documented "Phone" orders made between October 2016 and January 4, 2017. There was an order on January 4, 2017, to "Transfer [the patient] to White Memorial Medical Center ER [due to] missed dialysis 1/4/16 [*sic*] and abnormal labs." That order was "Discontinued." A second order on January 4, 2017, by "Phone," ordered "Transfer [the patient] to White Memorial Medical Center ER [due to] missed dialysis 1/4/16 [*sic*] and abnormal labs/possible blood transfusion." Why there were these two orders was not explained at hearing.

76. Another Downey record contained order summaries of "Phone" orders given by Dr. Singh between January 4, 2017, and January 6, 2017, which was electronically signed by him on January 12, 2017, at 11:07. On January 4, 2017, at 16:24 Dr. Singh ordered "Transfer to White Memorial Medical Center ER [due to] missed dialysis 1/4/16 [*sic*], and abnormal labs. The order was confirmed by a nursing supervisor who did not testify at this hearing. A second January 4, 2017, order documented that at 16:54 Dr. Singh ordered "Transfer to White Memorial Medical Center [due to] missed dialysis 1/4/16 [*sic*] and abnormal labs/possible blood transfusion." The order was confirmed by the same nursing supervisor. A third entry on January 4, 2017, at 16:55, noted that Dr. Singh ordered: "Transfer to White Memorial Medical Center ER [due to] missed dialysis on 1/4/16 [*sic*] and abnormal labs." Below that was an entry stating: "Discontinue 01/04/2017 16:53" which was again confirmed by the same nursing supervisor. No explanation was offered for why the nursing supervisor entered three orders in this summary for one order given by Dr. Singh to transfer the patient to White Memorial Medical Center.

JANUARY 4, 2017, ADMISSION TO WHITE MEMORIAL HOSPITAL

77. On January 4, 2017, the patient was transferred to White Memorial Hospital Center due to missed dialysis, abnormal labs, and possible blood transfusion. No records from White Memorial Hospital for this admission were introduced.

JANUARY 5, 2017, READMISSION TO DOWNEY

78. A Downey progress note of January 5, 2017, created at 17:46 with an effective time of 16:40, written by the nursing supervisor who entered the January 4, 2017, transfer orders referenced above, documented that the patient was readmitted to Downey from White Memorial Medical Center Emergency Room by ambulance. The patient's diagnosis was "ESRD on dialysis with anemia of renal disease." The nursing supervisor "was not able to receive a report from the hospital. Called hospital [three times] but was not able to reach the nurse in charge for [patient]."

The patient's daughter was notified that her mother was back at Downey. The daughter advised that her mother had a blood transfusion and dialysis at the hospital. "Notified Dr. Singh regarding re-admission and to resume all previous order [*sic*]." The patient's vital signs were recorded which documented her oxygen levels were at 97 percent at two liters per minute of continuous oxygen. The patient refused a body assessment stating, "Do it tomorrow, I do not want to be bothered for now," despite having the risks and benefits explained to her, she still refused that assessment. She would continue to be monitored status post blood transfusion.

79. Two different entries on January 5, 2017, documented the patient's refusal to take medication for her rash and her refusal to take medication for pressure ulcers on her coccyx. The risks and benefits of each medication was explained to her three times, each time, for each order, but she still refused the medications.

80. A January 5, 2017, Downey progress note documented the NovoLog sliding scale of insulin to be given subcutaneously before meals and at bedtime depending on the patient's insulin levels, for her diabetes mellitus.

81. The Downey Order Summary documenting several phone orders issued by Dr. Singh between January 4, 2017, and January 6, 2017, referenced above, also included a phone order on January 5, 2017, at 17:46 to "Continue previous orders per Dr. Singh." On January 6, 2017, at 13:30 Dr. Singh ordered physical therapy clarification to include the CPT codes and noted the patient's diagnoses of musculoskeletal weakness related to anemia in chronic kidney disease, pain in right ankle and joints of right foot, and ESRD. The patient would receive physical therapy three times per week for four weeks. This order was confirmed by the facility's rehabilitation director. A second entry on June 6, 2017, at 13:30, confirmed by the facility's rehabilitation director, documented a phone order by Dr. Singh for "physical therapy evaluation and treat[ment]," which was discontinued on January 6, 2017, at 13:29 because the evaluation was completed. No explanation for why there were two entries for one order was offered at hearing. Dr. Singh electronically signed this order summary on January 12, 2017 at 11:07.

82. Downey progress notes between January 6, 2017, and January 11, 2017, documented the wound care treatment administered, the medications and ointments applied to treat the patient's many wounds, and the medications given to treat her multiple medical conditions, including moderate to severe pain, insomnia, coronary artery disease, infections, constipation, hypertension, and to prevent blood clotting. None of these notes documented that the patient was on oxygen. The pain medications and the Ambien to prevent insomnia were noted to be "effective."

83. A January 11, 2017, Downey progress note documented at 8:05 the patient was experiencing a possible change of condition, weight loss. Dr. Singh was notified at 8:15 AM, "see SBAR for further information."

84. A January 11, 2017, Downey "eINTERACT Change in Condition Evaluation" form, timed at 8:00, documented the patient's change in condition was "weight loss" which started on January 11, 2017. The patient's "primary diagnoses" were listed as hypotension unspecified; chronic obstructive pulmonary disease, unspecified; insomnia, unspecified and non-rheumatic mitral (valve) insufficiency. Additional pertinent diagnoses were "COPD, diabetes and chronic renal failure/ESRD." Of note, COPD was also listed in the primary diagnoses section. The "medication changes made in the past week" section was blank. The patient was on an anticoagulant identified as "hypoglycemic medication(s)/insulin." Her DNR status was noted and her recent vital signs were documented. Her most recent oxygen saturation levels were 98 percent on room air. Her blood glucose was 292.0 mg/dl. (This is very high as anything above 200 indicates diabetes.) Her mental status evaluation, functional status evaluation, behavioral evaluation, respiratory evaluation, cardiovascular evaluation, abdominal/GI evaluation, genitourinary evaluation, and skin evaluation all had "no changes observed." The patient had no pain and no changes were observed in her neurological evaluation. There were no abnormal lab tests or diagnostic procedures to report. Since the change in her condition, the patient's symptoms had "stayed the same."

The "other relevant information" section contained the following: "weight loss of 9 lbs in a week (180-171 lbs), 5%, expected due to hemodialysis [three times per week], fluid shifts, and variable [by mouth] intake. [Patient] was seen with 3 empty cans of Coke on bedside table." (Presumably her family brought these to her when they

visited.) The "summarize your observations and evaluation" section stated: "She is non-compliant with the diet and fluids, [patient] is DNR, with trial periods of nutrition in case needed. [Patient] with supplements." Dr. Singh was notified of the change in condition at 8:15. The "recommendation of primary clinician(s)" section was blank, the "testing" section had the box marked "other" checked off, but the section below that which read "specify other" was blank and none of the boxes were checked off in the section marked "interventions (check all that apply)." The patient's daughter was notified of the patient's change in condition.

85. January 11, 2017, Downey progress notes documented that at 4:00 the patient was alert, left for hemodialysis and was not in distress. This note was a follow-up to the 00:46 orders, but those were not introduced. At 2:39, with effective time of 5:38, the patient's NovoLog sliding scale information was entered. At 3:16 she was given calcium acetate for supplementation. At 3:17, with an effective time of 6:16, it was noted that she had been given medication at hemodialysis for upset stomach.

86. A January 11, 2017, Downey progress at 22:56 noted the patient was alert and oriented with ongoing monitoring for her weight loss. There was no dehydration observed, she was afebrile, on hemodialysis three times a week, and she would continue to be monitored at each shift.

87. January 12, 2017, Downey progress notes at 9:44, 11:05, and 13:43 documented the patient's leaving the facility to attend a social services appointment. At an effective time of 12:01, the patient's NovoLog sliding scale for her diabetes was recorded. At 14:41, there was continued monitoring of her nine pound weight loss; a five percent weight loss was expected due to hemodialysis.

88. The January 12, 2017, 16:49, entry noted: "Pharmacy recommend HgbA1c 1/13/17 and [every] six months, [due to history] of diabetes, MD okeyed [*sic*], [patient] made aware, noted and carried out." An HgbA1c test, also known as a Hemoglobin A1c, HgA1c, or an A1C test, is a test used to evaluate a patient's level of blood sugar over a period of time, typically three months, to determine the degree of control of the patient's diabetes.

89. On January 12, 2017, at 17:23 the patient was given medication for constipation. At 17:27 she was given Norco for moderate to severe pain complaints of general body pain, "but after taking it she spit out meds, stating med is not Norco, but Norco was taken from ekit." (Presumably ekit is the electronic medication dispenser at the facility.)

90. A January 13, 2017, Downey progress note documented that at 3:30 the patient refused to go to dialysis, she was alert and oriented, able to make her needs known, the risks and benefits were explained to her, and she was in no pain or discomfort. At 6:00 the patient's daughter and the dialysis center were "made aware that [the patient] refused to go to dialysis." At 6:16 the patient was given milk of magnesia suspension for constipation.

91. January 13, 2017, Downey progress notes documented that at 11:59 the patient "refused dialysis transportation, and [name] took the [patient] to dialysis, she was not seen because she did not have a sling on her to be transferred into the chair, [name] had to bring the [patient] back; [patient] stated that she wants to switch dialysis centers to one closer to the facility but [name] from the dialysis center stated that they are happy with her and why does she have to change. Logistic care transportation was called; spoke with [name] and he gave reservation number [number]; and stated they will try their best to get an ambulance back out to pick her

up, and to call back in 1 hour to check on the trip; if they are able to pick her up her return home time will be 6pm."

92. The January 13, 2017, lab results of the Hemoglobin A1c ordered by Dr. Singh on January 12, 2017, referenced above in Factual Finding No. 88, indicated that the patient's specimen was collected at 6:33, received at 7:32, and resulted at 12:59. The test name was "Glycated HGB, A1C" and the results were "high" at 7.5. The report noted that a high risk for future diabetes was in the 5.7 to 6.4 percent range, diabetes mellitus was at or above 6.5 percent, and the target goal for most diabetics was below 7.0 percent. There is handwriting on the document that was placed there by a nurse on January 19, 2017, discussed below in Factual Finding No. 103.

93. A January 13, 2017, Downey progress note created at 14:44, effective at 14:42, stated: "Relayed lab work for HgbA1c to MD, notified MD that patient is non-compliant with diet regimen and sometimes refuses medication. No new orders given at this time." This note was created by an LVN who did not testify in this hearing.

94. A January 13, 2017, entry at 14:16 indicated the patient left for dialysis and "insisted on me not changing dressing until after she had her dialysis." At 14:26 the patient went to dialysis.

95. A January 13, 2017, Downey progress note at 17:30 documented a dietary weight review, noting that the patient's weight loss was due to fluid shifts with her hemodialysis treatment, recent hospital transfer with abnormal labs, BMI 31.3 obese (BMI is the acronym for Body Mass Index, a measurement of body fat based on height and weight, 31.3 is in the moderately obese range.) The rest of the sentence was illegible as it had been typed over. There were "episodes of non compliance [*sic*] with the diet." Some of the patient's abnormal lab results were documented. The plan

was to continue with her diet as prescribed, monitor her weight trend, and adjust her diet PRN.

96. A January 17, 2017, Downey progress note documented at 14:29 the patient was given morphine sulfate for severe pain which was "Effective." A note created at 18:44 documented that at 16:00 there was a change in condition and "Dr. Singh was notified at 4:00 PM. See SBAR for further information." It was not explained why this note was created almost three hours after Dr. Singh was notified.

97. The January 17, 2017, Downey "eINTERACT Change in Condition Evaluation" form, timed at 16:00, documented the patient's change in condition was "weight gain of 8 [pounds] in 7 days" which started on January 17, 2017. Of note, since the form is dated January 17, 2017, and references a weight gain of the past seven days, it was an error to document that it "started on January 17, 2017." All the patient's "primary diagnoses" were listed. The section marked "additional pertinent diagnoses" had the boxes marked COPD, diabetes, chronic renal failure/ESRD checked. Of note, these three diagnoses were also listed in the primary diagnoses section. The patient was on an anticoagulant identified as "hypoglycemic medication(s)/insulin." Her DNR status was noted. The resident or family preferences for care were: "for transfer to the hospital and for trial to tube feeding." The patient's recent vital signs were recorded, including her most recent blood glucose of 303.0 mg/dl and her oxygen saturation rate of 95 percent on room air. There were "no changes observed" in her mental, functional, or behavioral statuses. There were "no changes observed" in her respiratory, cardiovascular, abdominal/G.I., genitourinary, skin or neurological evaluation. The patient denied having pain. None of the boxes for abnormal results for laboratory tests/diagnostic procedures were checked. Since the change in her condition, the patient had "stayed the same." The condition had occurred before and

the treatment for the last episode was "RD recommendation and consult." ("RD" was not explained at hearing, but presumably meant Registered Dietician.) In the "other relevant information" section was written: "[Patient] has 8lbs weight gain or 4.6% or from 171lbs to 179lbs in 7 seven days, expected and unavoidable due to several factors. Pls see below. Had a 9lbs weight gain prior to this week." The "summarize your observations and evaluation" section noted: "Weight gain related to several factors such as the following: On hemodialysis 3/week causing fluid shifting and variable food intake. MD aware with new order." Dr. Singh was notified about the change in condition at 16:00 and his recommendation was "RD recommendation and consult." The patient's daughter was notified of the change in the patient's condition.

98. The January 17, 2017, entry at 16:10 documented that at 16:09 the weekly assessment of the patient's skin/wounds was carried out. She had a healed area to her left upper arm and no longer needed isolation precautions. "MD aware, treatments [discontinued]. [Patient] aware. Orders noted and carried out."

99. A January 17, 2017, Downey progress note at 16:46, documented the dietary weight review which noted the patient's eight pound weight gain in the past seven days due to fluid shifts caused by hemodialysis. The note further stated: "labs 1/13/17 Hga1c 7.5 poor [blood sugar] control, on sitagliptin (Januvia) and NovoLog for [blood sugar management]. Plan: continue with diet [restrictions]. Encourage compliance to diet. Monitor [weight]/intakes/labs." At 18:05 the patient was offered Gabapentin for pain and Enulose Solution for constipation, which she refused despite having the risks and benefits explained to her.

100. January 18, 2017, Downey progress notes documented the morphine sulfate given at 22:56 for severe pain and the Ambien given at 23:18 for insomnia.

101. A January 19, 2017, Downey progress note created and effective at 13:13, identified as a "social services" type note stated: "[Patient] will be going out on pass tomorrow to her daughters [*sic*] house at [address]. The name the transportation company, a pickup time of "10:30 AM," and return time of "5PM," were recorded.

102. The next entry on the January 19, 2017, Downey progress note was a key fact in dispute. The note was created at 13:57 with an effective time of 13:54. by Alexes Mielke, R.N., a Downey nurse supervisor (Nurse Mielke), and noted: "MD was here to see resident. dr. singh saw lab results and ordered to add Metformin to the medications."

103. Nurse Mielke testified that on January 19, 2021, she showed the January 13, 2017, HgbA1c labs, referenced above in Factual Finding No. 92, to Dr. Singh and handwrote his order on the lab report. Nurse Mielke deciphered her handwriting at hearing as follows: "Metformin 1000mg BID per Dr. Singh [her initials] 1/19/17." Of note, although no testimony was offered on this issue, upon review, the handwritten date appears to have been altered. The number 19 in "January 19" looks like it was written over the number 13. It also looks like it was written by a different instrument as it was much thicker and darker than the rest of the handwriting on the document. This raised concerns regarding its validity, even absent Dr. Singh's testimony, referenced below, that he did not give this order.

104. A January 19, 2017, Downey progress note created at 14:30 with an effective time of 14:28, identified as a "social services" type note stated: "Possible psychological change; [patient] stated that her [*sic*] and her daughter [name] got into an argument and she no longer has any space for her to live with her at home; [patient] started to tear up but stated that she would call her brother and sister because she is sure that they have space for her. Will refer to a psychologist."

105. A Downey Order Summary contained two orders reportedly given by Dr. Singh, one on January 19, 2017, and another on January 23, 2017, which is referenced below at Factual finding No. 112. The "Communication Method" of each order was "Phone." The order purportedly given on January 19, 2017, at 13:53, documented the "Order Summary" was: "Glucophage Tablet 100 MG Metformin HCl) Give 1 tablet by mouth two times a day for diabetes mellitus." The order was "Confirmed By Nurse Mielke. Dr. Singh electronically signed this order summary containing the two orders on February 8, 2017, at 9:28.

106. A January 20, 2017, Downey progress note documented that at 9:19 the patient was back from dialysis via two EMT's and was in stable condition. At 9:31 she was given Gabapentin for pain. The entry at 10:35 stated:

> Daughter [name] called and asked if her mom was getting discharged because [name] told her she was getting discharged and she was going to go stay with her brother if she did not want to take her back; [daughter] stated that she never told her she was not going to take her back simply that she was not prepared for her to come home at this moment; [daughter] was concerned about her mom going out today to go visit her sister who just came home from Mexico; [patient] did not go out today she is currently still in bed and stated that she is not going anywhere; daughter [name] made aware and also informed her that we can set up a discharge meeting to discuss planning.

107. A January 20, 2017, Downey progress note documented monitoring of the patient's weight gain at 20:56. No distress was noted, her respirations were even

and unlabored with no shortness of breath. Her medications and treatment continued, and her vital signs were noted. At 22:12 she was given Morphine Sulfate for severe pain which was "Effective."

108. On January 21, 2017, at 9:51 she was given medication for hypertension. At 10:12 the patient went out on a pass and will "be back at 3pm." The patient's NovoLog sliding scale entry noted it was "not taken [patient] went out on pass and be back at 3pm." Other entries indicated medications and assessments that were not given as the patient was still out on her pass. The 17:24 entry documented the NovoLog sliding scale, when to call the physician, and to administer it subcutaneously before meals and at bedtime for the patient's diabetes mellitus. Other entries documented the administration of Morphine Sulfate for the patient's severe pain.

109. January 22, 2017, Downey progress notes documented the Morphine Sulfate given for severe pain; that medication for hypertension was not given as the patient's blood pressure was 98/50; that Gabapentin for pain was offered, the risks and benefits were explained, but the patient refused; and Pro-Stat (a liquid protein used for wound healing) for the patient's hemodialysis wounds was offered, the risks and benefits were explained, but the patient refused.

110. A January 22, 2017, Downey progress note created at 14:43, effective 17:42, documented that medication was offered for the patient's constipation, the risks and benefits were explained, but she refused. An entry on January 23, 2017, created at 2:40, effective 00:12, documented that the patient was in bed, sleeping, no distress. A note at 2:18, effective at 2:40, documented a response to the call light and the patient verbalized generalized body pain that was 5-8/10 and she "requested morphine tab as indicated by MD." An entry at 2:09, effective at 3:15, documented the administration of Morphine Sulfate for severe pain. A note at 2:24, effective at 3:15, documented the

reassessment of the patient for pain. The patient verbalized her pain was 1 out of 10 and she was sleeping comfortably.

111. The January 23, 2017, Downey progress note at 2:30, effective at 4:05, documented that transportation from dialysis was here, the patient was alert, sleeping most of the time, in no respiratory distress, able to verbalize her needs, and going in stable condition. An entry at 4:20 documented a call from the dialysis center that the patient was transferred via 911 for altered level of consciousness during the dialysis process. The dialysis center request a copy of the POLST, which was faxed to the center. (This acronym was not explained at hearing.) Another entry at 8:09, effective at 8:06, also documented that the dialysis center called to advise that the patient was transferred to White Memorial via paramedics for altered level of consciousness and low blood pressure. This note stated that Dr. Singh was made aware and "called [patient's daughter] and made aware of the transfer." A note created at 11:34, effective at 10:30, documented a phone call from the daughter advising that her mother was not at White Memorial, but the charge nurse informed the daughter that the mother had been transferred there.

112. The Downey Order Summary referenced above at Factual finding No. 105, which contained the two orders reportedly given by Dr. Singh, listed a second order dated January 23, 2017, at 8:04. The "Order Summary" was "Transferred to White Memorial Hospital from dialysis center" and was also "Confirmed By" Nurse Mielke. As noted above, Dr. Singh electronically signed this order summary on February 8, 2017, at 9:28, which was 16 days after the patient died, as discussed below.

JANUARY 23, 2017, ADMISSION TO WHITE MEMORIAL MEDICAL CENTER

113. On January 23, 2017, at 6:13, the patient was admitted via ambulance to White Memorial Medical Center with an altered mental status and was hypotensive. She had presented at the dialysis center "altered and poorly responsive." Paramedics reported multiple failed attempts at accu-checks because their glucometer read "error" each time. (A glucometer is a device used to measure glucose (blood sugar) levels.) The patient was reportedly given 15 mg of Morphine prior to leaving the SNF for dialysis. A review of systems determined she had "altered mental status" and was "mentally impaired." Her prescription information obtained from the pharmacy indicated she was prescribed Januvia 25 mg, one tablet oral daily; Neurontin (Gabapentin) 300 mg oral capsule, one at bedtime; and Nitroglycerin 0.4 mg sublingual tablet as directed every five minute interval PRN as needed for chest pain. Her documented medications were Ambien, Artificial Tears, Calmoseptine, Coreg, Norco, Procrit, Acetaminophen, Aspirin, Atorvastatin, Cilostazol, Clopidrogel, Heparin, Insulin Aspart, Insulin Detemir, Lactulose, Losartan, Meclizine, Megestrol, Pantoprazole, Simethicone, and Sulfamethoxazole-Trimethoprim.

The patient's extensive "confirmed" past medical history and surgical history were noted. Vital signs were taken and a physical exam was performed. In general the patient was in "no acute distress, unresonsive [*sic*], grimaces to deep pain." Her cardiovascular and respiratory exam was normal. Labs and diagnostic tests were ordered. Many of her labs were extremely abnormal. Her lactic acid levels and white blood cell count were critical. An endotracheal tube was placed and there was an NG tube in place. The patient's "Course" was "worsening."

114. The emergency department "Critical care note" documented that the critical conditions addressed were impending deterioration of airway, respiratory,

cardiovascular, central nervous system, metabolic, and renal. Her associated risk factors were hypotension, shock, hypoxia, and dysrhythmia. Interventions included hemodynamic management and ventilator management. The patient was given D50 IV (a standard parenteral treatment for significant hypoglycemia) following an accucheck that reported random blood sugar too low to measure and immediately became "more awake and alert, answering questions. She did however remain very hypotensive and hypothermic." At 7:15 she failed to respond to fluid boluses and Levafed (or levophed is a vasoconstrictor used to treat life-threatening hypotension) was started. The Intensive Care Unit (ICU) was called for an evaluation and the patient was admitted to ICU at 7:22. Her diagnoses were altered mental status, hypoglycemia, hypotension, end stage renal disease on hemodialysis. Her condition was unstable. The Plan listed her numerous medical diagnoses and her "multiple serious and potentially high morbidity etiologies" of symptoms were considered. The patient was "septic and hypotensive, she is on pressers and will be admitted to the ICU for further evaluation and management." Her admitting diagnosis was septic shock likely secondary to endocarditis versus ischemic bowel versus osteomyelitis.

115. The ICU records noted the patient's past medical history for recent "MRSA endocarditis (vegetation on [blank])," coronary artery disease status post triple vessel coronary artery bypass graft and percutaneous coronary intervention, AV fistula removal from her left upper extremity approximately one week ago, and bilateral lower extremity arterial bypass with right femoral and left femoral stents placed in January 2015. The patient had peripheral vascular disease, ESRD on hemodialysis Monday, Wednesday, Friday, diabetes mellitus 2, hypertension, hyperlipidemia presenting with hypoglycemia and altered mental status. The patient had used tobacco since age 14, up to three packs per day, and stopped smoking six months ago. She resided in a SNF. She was brought in by ambulance from her hemodialysis center after she was found to

be altered. She had been previously admitted to White Memorial Medical Center ICU in December 2016 for fever and altered mental status. She was discharged to an outside SNF after that admission. Vital signs had been obtained in the emergency department, but no oxygen saturation was obtained. She was given 500 cc normal saline bolus and started on peripheral levophed. The patient's medications were listed. Of note, Metformin was not listed. The physician was unable to obtain a review of systems due to the patient's clinical condition and altered mental status. The patient's oxygen saturation rates were 99 percent at 9:07.

116. On physical exam the patient was alert and oriented times one, in acute distress, and unable to verbalize what was wrong. Her cardiac exam was normal, and her pulmonary exam had coarse upper airway congestion on expiration. In her extremities there were no pulses appreciated. On neurology exam she had a Glascow Coma Scale of 12. (This is a clinical scale used to measure an individual's level of consciousness after a brain injury. A score of 12 is at the lower end of the moderate brain injury range; a score of 13 indicates a minor brain injury.) The patient's labs were noted, almost all of which were abnormal. The impression was septic shock likely secondary to endocarditis versus ischemic bowel (blockage of blood flow to the arteries of the intestines) versus osteomyelitis (infection of the bone) given her white blood cell count of 42.8 and lactic acid of 21.6 and lactic acidosis secondary to severe sepsis and possible ischemic bowel given the ABG of 6.68/33/231 and HCO3 of 5. An associated diagnosis was "lactic acidosis; septic shock."

117. The ICU team found the patient "profoundly acidotic." She was "felt to possibly have sepsis, perhaps recurrent endocarditis. The acidosis, however, was out of proportion to sepsis oand [*sic*] renal dysfunction. Suspicious for ischemic bowel as an explanation." A central line was placed. An arterial line was unsuccessfully attempted

due to vasculopathy (vascular abnormalities caused by conditions, diseases, or disorders) and limited area to attempt (bilateral groin graphs, right arm fistula). The patient was intubated, started on bicarbonate drip and pushes, and hemodialysis was requested. It was then discovered the patient had a DNR advance directive. "At that point patient began to have progressive bradycardia and hypotension despite maximal levophed. Given the DNR, no upward titration of care was performed, although any further care was clearly futile. Patient became asystolic and expired." The time of death was 10:48. The "Cause of Death" in the ICU record noted: "Preliminary cause of death: Lactic acidosis. Due to: Septic shock."

118. The ICU treating physician made two addendums to the records on January 23, 2017. In one he noted the time spent with the patient and in the other he documented his independent exam of the patient and that he agreed with the note of another physician whom he supervised. The emergency department physician electronically signed the records on January 26, 2017, at 17:17.

Department of Public Health Investigation and Citation

119. Cecile Lim, R.N, a Health Facilities Evaluator Nursing Supervisor with the Los Angeles County Department of Public Health, was assigned to investigate the patient's death following a complaint from her family. Ms. Lim authored interview notes and testified in this hearing. She obtained her nursing degree in the Philippines and came to the United States in 2003. She received her master's degree from the University of Phoenix and has been in her current position with the county since 2013. She spoke with Nurse Mielke and Dr. Singh by telephone, spoke with Downey's Executive Director in person, and prepared "Surveyor Notes Worksheets" summarizing those conversations. She admitted her summaries are not transcripts of the conversations, but she said she tried to record all that was discussed. However, that

testimony made no sense given her summaries. These were in different fonts, some had handwriting on them, and it was never explained if she took notes that she then transcribed to her summaries, or if she was typing the summaries as she spoke with witnesses. Either way, the different fonts on her summaries raise questions about their reliability and accuracy.

120. When Ms. Lim was answering questions posed to her by complainant's counsel on direct examination, she testified in a straightforward and confident manner. However, on cross-examination, in response to Dr. Singh's attorney's questions, Ms. Lim's demeanor noticeably changed. She became quite unsettled, repeatedly asking Dr. Singh's attorney to "repeat the question" or "rephrase the question." Her inability to answer questions posed to her on cross-examination was notable. As more fully explained below, Ms. Lim's documentation was sloppy, not well organized, contained numerous inaccuracies, and was not reliable. It contained different fonts and handwriting that were not explained and made no sense given her testimony. Ms. Lim also failed to consider key medical records and evidence, and she made unfounded conclusions that she later included in the complaint she filed with the medical board.

Ms. Lim's Interview of Nurse Mielke

121. Ms. Lim's worksheet summarizing her March 31, 2017, telephone conversation with Nurse Mielke at 2:40 p.m., misspelled the nurse's last name, her notes contained several different fonts, and had handwritten entries, which made it appear her notes were edited at different times, none of which was explained at hearing. That note stated:

> During a telephone interview, [Nurse Mielke] stated [the patient's] attending physician came to the facility on

1/19/17 and reviewed the [patient's] high HgbA1c (diabetes blood test) laboratory results in order to start Glucophage 1000 mg twice a day. [Nurse Mielke] said that when she entered the medication order electronically, [Nurse Mielke] did not receive any calls for clarification of the medication from the facility's pharmacy.

She did not receive any calls or there were no records of calls messages [*sic*] from pharmacy Beacsue [*sic*] pharmacy shoulve [*sic*] reviewed it before dispense it [*sic*]. Usually they would hold it. Sometiimes [*sic*] the pharmacist will call the MD themselves.

[Nurse Mielke] stated that if there if there [*sic*] were important warnings than the facility pharmacy should have notified the facility or at times the pharmacy would call the ordering physician to clarify the medication order.

[Nurse Mielke] was asked what she knows about the [black box warning][2] for Glucophage and how does facility addresses [*sic*] this?

[Nurse Mielke] stated she is at a "blank" right now and could not answer . . . Im [*sic*] blank rt now . . . We rely on

---

[2] A black box warning is the Food and Drug Administration's (FDA) most stringent warning about serious side effects for drugs and medical devices.

our Pharmacy to remind us about this. Pharm will let us know.

What is the reference use [*sic*] by the facility to check medication side effects and contraindications And any other issues that needs [*sic*] to be addressed?

[Nurse Mielke] stated sometimes they use Google . . . And they do have educational reference [*sic*] from the pharmacy website called Omniview. [Nurse Mielke] was asked to pull out the Glucophage reference.

Was aksed [*sic*] to read under warnings or see if there are [black box warnings] in the reference material.

Was asked to read it to me. (Ms. Lim then handwrote the following:) [Nurse Mielke] reviewed [patient] care plans and did not find a [care plan] for Metformin - use and its' [*sic*] risk for lactic acidosis.

(Ms. Lim then typed:)[Nurse Mielke] read the facility's online educational reference and stated "It says here it rarely happens . . . Too much Metformin buildup in the body." However, [Nurse Mielke] stated she did not check the pharmacy website to refer on the contraindications or side effects of this medication.

[Nurse Mielke] will fax the educational reference.

> [Nurse Mielke] stated she did not check this that day she entered the medication order the doctor had Ordered [*sic*].

122. Ms. Lim testified that Nurse Mielke never told her she encountered a black box warning and overrode it. Nurse Mielke did not know there was a black box warning for this medication. When Ms. Lim asked Nurse Mielke about the black box warning that was when she went "blank" as Ms. Lim documented in her report.

Ms. Lim's Interview with Downey Executive Director

123. Ms. Lim met with Downey Executive Director, Charles Hoffman, who did not testify in this hearing. Before their meeting, Ms. Lim told him that she intended to cite the facility, something Mr. Hoffman did not want to happen. Ms. Lim admitted she reached that decision before she interviewed Dr. Singh.

124. Ms. Lim's worksheet summarizing her discussions with Mr. Hoffman contained five entries, which were somewhat confusing to understand given how she formatted them. At the top of the document, not next to a date or time, Ms. Lim documented that she faxed the intent to cite to Charles Hoffman, and "Informed him of the details of the investigation. [Director of nursing] not present at this time." The next entry is on April 4, 2017, at 12:50 p.m., documenting that "Charles stated he will acknowledge the receipt of the intent and fax it back to me. Called facility. Spoke with Charles and Ofelia – the [director of nursing]." An entry at 1:20 p.m. documented:

> Called Charles again to ask for [policies and procedures] for addressing black box warnings, clinical safety in Medications [*sic*] prior to dispensing and administration, and pharmacy services on medication reviews. Charles also asked a little bit more about what the facility failed to do so

> he can address it right away with his staff. I explained it to him thoroughly.
>
> Charles stated that he will call Dr. Singh so he can call me and explain to me what his reason was for prescribing this medication.
>
> Charles stated he will look for the policy [*sic*] and procedures.

On April 5, 2017, at 1:00 p.m., Ms. Lim made the following entry:

> Telephone interview regarding clarification of [policies and procedures] for Hemodialysis care - regarding the "monitoring of vital signs per facility protocol." [Director of nursing] stated the facility protocol for the monitoring of vital signs per facility protocol was already indicated in the Dialysis Communication/Coordination Form. The [director of nursing] Stated [*sic*], facility staff should follow all information being asked in the form to follow the protocol.
>
> [Director of nursing] stated her expectation is that the LN's [*sic*] are taking [vital signs] of dialysis residents an hour or 30 minutes prior to [pick up] by transportation going to dialysis center.

125. Ms. Lim testified that Mr. Hoffman told her there were policies and procedures regarding drug warnings and contraindications that nurses had access to when entering orders. Downey also had electronic records that the nurses and

physicians could access and this information was given to nurses at staff meetings. The electronic records manual also showed the black box warnings.

MS. LIM'S INTERVIEW OF DR. SINGH

126. Ms. Lim claimed that when she spoke with Dr. Singh, she was still in a "fact gathering phase," but that testimony was not credible given she had already decided to issue an intent to cite the facility and the summary of her discussion with Mr. Hoffman suggested she had already concluded Dr. Singh ordered Metformin. She admitted she never asked Dr. Singh to review the records and then discuss the case with her, but thinks he told her he needed to have the medical records in order discuss the patient with her. Ms. Lim and Dr. Singh each testified that their telephone conversation was brief, lasting less than five minutes.

127. Ms. Lim's worksheet summarizing their April 4, 2017, 4:58 p.m. "telephone interview" was in different fonts, which she did not explain at hearing. Given those fonts, it was unclear when she typed her summary. The different fonts suggested her note was not contemporaneously prepared. Her summary documented the following (punctuation as in original):

> During a telephone interview, with [patient's] physician, [Dr. Singh] stated that he ordered the Glucophage to [the patient] because he was presented by [Nurse Mielke] with [the patient's] high HgbA1c and because Glucophage was the first line of medication for diabetes. [Dr. Singh] stated he was not near the computer (electronic medical record) during that time so he did not have all the information with him like laboratory results, however he remembered that

> some of the blood works [*sic*] of [the patient] were normal from the last time (unable to recall when). But the Hgb A1c was 7.5.
>
> When we are ordering over the phones that is the problem you know.
>
> We do rely on our pharmacies to check for any medication concerns/issues, contraindications, They usually get back to us and call us and we resolve it. But I do not recall getting a phone call.

The next part of the note in a different font stated:

> Before when there are issues I would usually get a phone call from them before they dispense The new meds, you know like how they do it in the acute hospital.
>
> Then will take care of the problem . . . If any issues I need to address w/ the new medications.
>
> "When anew [*sic*] medication is prescribed the pharmacy are also supposed to review it."
>
> In the hospital - when you enter it in the electronic medical record - it will remind you electronically if There are any [black box warnings] for a medication so we can check it right away. I don't if [*sic*] there is one here.
>
> I just started caring for this resident January 2017 as the medical director as well.

> [Dr. Singh] stated he did not know there was a black box warning for the Glucophage during that time that if he had been told, "I would not have prescribed it."
>
> It was just that when you are not there - you do not have all information in your hand.
>
> Doctor was asked [*sic*] that [Nurse Mielke] told me that he came that day to the facility on 1/19/17.
>
> MD stated well I do not recall much but usually the nurses would just show me lab results and I am Not in the station or in front of the computer or did not have all the information given to me.
>
> I probably given [*sic*] a verbal order. Its [*sic*] not like when you are looking at the records you know.
>
> Doctor was asked his specialty. He is certified internist. A certified cardiologist.
>
> Doctor stated yes he knows this [patient] was a renal patient on dialysis.

128. Dr. Singh testified that the note inaccurately reflects their conversation. He went line by line through it pointing out the alleged inaccuracies. He never told Ms. Lim he ordered the Metformin (brand name Glucophage); when she asked him if he had ordered it, he told her he did not. He told her that Metformin was a first line medication, meaning it is the first medication to be given for new onset diabetes, and he knew that this patient already was on other diabetic medications. Thus, the part of

the note indicating that he ordered it as a first line of medication supports his testimony that he was explaining to Ms. Lim that Nurse Mielke called him about another patient with new onset diabetes and he ordered Metformin as the first line medication for that patient.

Dr. Singh explained Ms. Lim's notation that he was "not near the computer (electronic medical record) during that time so he did not have all the information with him like laboratory results," to mean he was not near a Downey computer, as he has no access to the patient records when he leaves the facility. He testified this entry further supports his position that he told Ms. Lim he received a telephone call about this patient, which would contradict Nurse Mielke's testimony that she and Dr. Singh talked about the patient in the facility. Also, when Ms. Lim called Dr. Singh, he was at his office, again without access to Downey records since he was not at the facility. This call occurred approximately two and one-half months after the patient died and he had no specific recollection of her lab results. Ms. Lim's notation about the Hemoglobin A1c being 7.5 was not discussed during the phone call; Ms. Lim may have known that value when she called Dr. Singh, but he did not. He and Ms. Lim never discussed any specific values during the call.

Ms. Lim's notation that some of the "blood works" were normal from the last time would also suggest they were discussing a different patient because none of the patient's blood works were normal. Ms. Lim's entries suggesting that when the labs were reviewed Dr. Singh was at the facility without access to the computer or medical records is a mischaracterization as he always had access to patient records while at the facility. He stressed that he did not have access when he left the facility. Dr. Singh believes Ms. Lim misunderstood what he was explaining to her. Ms. Lim's notations about not having all the information in hand when not there again referred to his

statements about leaving the facility. Ms. Lim's entries regarding giving verbal orders but not being in the station or in front of a computer or having all the information, is also incorrect. If he was at the facility, he would have access to the patient's records; when he is outside the facility and receives a telephone call, he does not. In those situations, he relies on the information the nurse gives him over the phone about the patient.

The next portion of her note, which is in a different font, appears to be Ms. Lim's attempt to summarize the gist of what Dr. Singh was trying to explain to her about how telephone orders took place. However, her summary is not the discussion they had. He was referring to how telephone orders work at acute care hospitals. In an acute care setting, when an order is placed, there will be a black box warning for any contraindications. Ms. Lim's entry that Dr. Singh told her he did not know there was a black box warning for Metformin is not correct. He was well aware of the warning for the medication; he has known about the black box warning "for years and years." His recollection of their discussion was that Ms. Lim asked him if he had ever received a warning after he gave his January 19, 2017, telephone order and he told her he did not, meaning no one ever notified him that there was a warning received about giving Metformin to this patient, which should have happened. He did not mean that he did not know there is a warning about giving metformin to ESRD patients. Dr. Singh has "no idea" what Ms. Lim's entry "I probably given a verbal order" means; that was not their discussion.

The part of Ms. Lim's note stating that Dr. Singh began caring for this patient "in January 2017 as the medical director as well" is also inaccurate because he became the medical director in the summer of 2016 and began caring for the patient in December 2016, although he had been involved in her care since he became the medical director.

Dr. Singh does not recall Ms. Lim asking him specifically about January 19, 2017, but he did tell her that he usually came to the facility in the mornings. Ms. Lim also failed to note all his specialties or that he knew the patient very well, not just that she was a renal patient on dialysis.

129. Ms. Lim testified about her discussion with Dr. Singh. Although she initially said she did not have an independent recollection of her witness interviews because they were "more than three years ago," and that her notes should reflect her interviews, she did recall the "general part" of speaking with Dr. Singh. She spoke with him for only "a few minutes," "pretty much" less than five minutes but did not recall discussing anything with him other than what is in her notes. Her testimony about whether she recalled their conversation from memory or from her notes was extremely confusing. Initially she denied recalling anything, then later said she did recall information, and even later claimed she recalled "most of it." She did not seem to understand the difference between having an independent memory of the conversation or simply remembering it based on what was written in her notes.

Ms. Lim admitted she did not consider that Dr. Singh was telling her he was not near a computer when he spoke with Nurse Mielke because he was talking to the nurse over the phone from another location. When asked what information Dr. Singh had when she interviewed him, Ms. Lim testified that he told her he knew the patient, he described the patient, and had just begun caring for this patient in January 2017, and he did not recall much interaction with the patient, all of which supported Dr. Singh's claim that he was talking to Ms. Lim about a different patient. Ms. Lim also recalled that the patient passed away the same month that Dr. Singh began caring for her which is incorrect because Dr. Singh treated the patient before then.

When Ms. Lim first spoke with Dr. Singh, he told her about a telephone order for Metformin after being presented with a high HgbA1c and he prescribed Metformin as the first line of medication to treat diabetes. In response thereto, Ms. Lim "prompted him" that he was at the facility when he made the order. Again, that testimony showed she did not understand what Dr. Singh was explaining to her, and supported Dr. Singh's claim that he was answering questions about a telephone order for a different patient with new onset diabetes who would be getting Metformin as a first line of treatment; he was not talking about this patient who had a prior history of diabetes and was on both insulin and Januvia, which are not first line medications.

Ms. Lim claimed she had no indication that Dr. Singh was discussing another patient when explaining using Metformin as a first line treatment. He never told her that the notes indicating he prescribed Metformin to this patient were a mistake, that he prescribed the medication to a different patient, that it was given by mistake to this patient, or that there was an error with that prescription. However, she recalled that Dr. Singh said he ordered Metformin because it is a first line medication used to treat diabetes. When Ms. Lim was shown that the patient was on advanced medications for diabetes, so Dr. Singh would not be discussing first line treatment regarding this patient, Ms. Lim completely unraveled, stating "rephrase your question I got confused." It was clear from her presentation and responses that she never put that thought together nor considered it during her investigation. Ms. Lim then admitted she could see how Dr. Singh was describing his treatment of a different patient to her when they spoke. Ms. Lim also did not know that Dr. Singh uses Metformin.

Ms. Lim did not "really focus" on the issue of why the black box warning was not caught when Metformin was prescribed for this patient. Ms. Lim also agreed that the records of a "Phone" order for metformin contradict Nurse Mielke's claim of a

verbal order. Ms. Lim looked at the physician order and "the handwritten order in the lab result" and concluded that Dr. Singh wrote it, but does not know if he or Nurse Mielke did. Of note, Nurse Mielke placed the handwriting on the lab report, although it was never explained why she wrote on a lab report, something that seemed unusual.

130. On cross-examination when Ms. Lim was shown the Downey progress note where an LVN who did not testify in this hearing documented that she notified Dr. Singh on January 13, 2017, at 14:42, of the patient's 7.5 Hgb A1c lab results and Dr. Singh gave "no new orders . . . at this time." Ms. Lim was clearly shocked by the existence of that note, admitting, "I do not think I have seen this." She then acknowledged that she "did not read each document," and she did "not remember seeing this page."

Ms. Lim's conflicting testimony, failure to consider key documents, coupled with her inaccurate notes and repeated requests to have questions rephrased or repeated, made her a very unreliable witness.

DR. SINGH'S LETTER TO THE COUNTY

131. Dr. Singh testified that Mr. Hoffman asked him to write a letter to the County Department of Public Health addressing the allegation that the patient's cause of death was due to the Metformin prescription. In response to that request, Dr. Singh authored a letter to the county on April 28, 2017, which stated:

> Patient was a 64 year old female with multiple medical problems including Coronary Artery Disease, s/p coronary artery bypass graft surgery, s/p percutaneous coronary intervention in the past, and-stage renal disease and hemodialysis on Monday, Wednesday and Fridays, diabetes

mellitus, hypertension, hyperlipidemia and history of endocarditis with MRSA and staff bacteremia who had multiple episodes of admission in acute hospitals due to recurrent sepsis. Because of her condition the family had made that patient DNR. She went to the dialysis center from Downey Care Center and was found to be altered and hypotensive. Patient was transferred to White Memorial Hospital and was found to be hypotensive and septic. Patient expired there.

The patient was admitted to Downey Care Center in October 2016 and since then had been admitted to Kaiser in Downey with severe sepsis and also in White Memorial Hospital in November 2016 with hypotension and altered level of consciousness and for endocarditis and septic shock.

In January during the index event the patient had a similar presentation hypotensive and altered. The white blood count was increased to 42.8 K and she was hypotensive. Patient's lactic acidosis was related to septic shock that is quite clear even from the hospital records. Patient had Metformin started on 1/19/17 with two times a day dosing. Essentially the doses which would cause any lactic acidosis were four doses between Saturday and Sunday as patient had Hemodialysis on 1/20/17. In this clinical scenario patient's presentation with a fulminant infection, multiple

> co-morbidities, and septic shock resulted in lactic acidosis. The contribution of lactic acidosis due to Metformin was negligible, if any.
>
> To correlate the mortality of this patient with Metformin and lactic acidosis due to Metformin would be very erroneous.
>
> I have also attached an article which puts this in clinical perspective.

The article Dr. Singh provided with this letter was not attached to this exhibit.

132. On May 1, 2017, Mr. Hoffman authored a letter to the Assistant Chief at the County Department of Public Health, requesting "an informal dispute resolution" of the "Federal tags . . . cited . . . following an abbreviated complaint survey concluding on 4/14/17." Of note, even Mr. Hoffman believed that Ms. Lim's investigation was "abbreviated." In his letter Mr. Hoffman wrote:

> We believe there is material evidence that was not reviewed or considered in evaluating the status of our compliance with this tag. To facilitate an objective review and impartial process, we request that members of the survey team not participate in the review of dispute resolution materials. We are requesting a face-to-face meeting with you, which would provide us the opportunity to discuss the details and respond to any additional questions you may have. . . .

> We ask that you give consideration to the additional information submitted, and if modifications are in order, we formally request an amended copy of [the form] reflecting your final determination. . . .

Mr. Hoffman attached several documents to his appeal, including literature espousing the use of Metformin, Dr. Singh's letter, and a letter from the pharmacist disputing that Metformin caused the patient's death.

133. Following Ms. Lim's investigation, the State of California, Health and Human Services, Department of Public Health, issued a citation to Downey documenting numerous violations against the facility, including one for "failure to coordinate pharmaceutical services and nursing services to identify that the newly ordered metformin . . . had a black box warning . . ." Again, this supports Dr. Singh's claim of not being advised that when the prescription had been mistakenly given to this patient, he was not notified of the black box warning. The outcome of that citation is unknown.

Medical Board Investigation

134. On May 10, 2017, Ms. Lim filed an online complaint against Dr. Singh with the medical board in which she described the following violation:

> The attending physician of one of the patients at a skilled nursing facility had prescribed Glucophage (Metformin HCL) 1000 mg twice a day regardless of the black box warning of the FDA that Metformin was contraindicated to the patient's condition of severe kidney impairment. The attending physician stated he was not aware of the black

> box warning of lactic acidosis and prescribed it to the patient. The patient died of lactic acidosis after receiving 7 doses of Metformin.

135. After receiving that complaint, the medical board opened an investigation, and on July 28, 2017, sent a letter to Dr. Singh advising him about the complaint. Pursuant to Business and Professions Code section 800, subdivision (c), the medical board provided a "comprehensive summary of the complaint filed against" him, stating:

> The complaint alleges the following: Dr. Singh was the patient's attending doctor at Downey Care Center Nursing Home. Dr. Singh prescribed Metformin which was contraindicated due to patient's kidney problems as well as a "black box warning" on the medications. The patient died after being administered the medications.

The letter further advised that the medical board was required to provide Dr. Singh with an opportunity to respond to the allegations and asked him to "please provide a written summary of the care and treatment rendered to this patient" and a copy of his curriculum vitae. He was told he could also provide any additional expert testimony or literature which he felt would be pertinent to the medical board in evaluating this complaint.

136. In response thereto, on August 4, 2017, Dr. Singh, who was not represented by counsel, authored a letter to the medical board. In it he wrote:

> Patient was a 64 year old female with multiple medical problems including Coronary Artery Disease, s/p coronary

artery bypass graft surgery, s/p percutaneous coronary intervention in the past, and-stage renal disease and hemodialysis on Monday, Wednesday and Fridays, diabetes mellitus, hypertension, hyperlipidemia and history of endocarditis with MRSA and staff bacteremia who had multiple episodes of admission in acute hospitals due to recurrent sepsis. Because of her condition the family had made that patient DNR. She went to the dialysis center from Downey Care Center and was found to be altered and hypotensive. Patient was transferred to White Memorial Hospital and was found to be hypotensive and septic. Patient expired there.

The patient was admitted to Downey Care Center in October 2016 and since then had been admitted to Kaiser in Downey with severe sepsis and also in White Memorial Hospital in November 2016 with hypotension and altered level of consciousness and for endocarditis and septic shock.

In January during the index event the patient had a similar presentation with hypotension and altered level of consciousness. The white blood count was increased to 42.8 K and she was hypotensive and blood c/s showed gram positive cocci. Patient's lactic acidosis was related to septic shock that is quite clear even from the hospital records. Patient had Metformin started on 1/19/17 with two times a

day dosing. Essentially the doses which would cause any lactic acidosis were four doses between Saturday and Sunday as patient had Hemodialysis on 1/20/17. In this clinical scenario patient's presentation with a fulminant infection, multiple co-morbidities, and septic shock resulted in lactic acidosis. The contribution of lactic acidosis due to Metformin was negligible, if any.

To correlate the mortality of this patient with Metformin and lactic acidosis due to Metformin would be very erroneous. I would highly recommend that you get all acute care hospital records from White Memorial Hospital and Kaiser Permanente Hospital.

I have also attached an article which puts this in clinical perspective.

137. Dr. Singh attached a June 2014 article from *Peritoneal Dialysis International*, titled: "Metformin in Chronic Kidney Disease: Time for a Rethink." The article references studies suggesting that "introduction of Metformin therapy to more advanced stages of [chronic kidney disease] may bring therapeutic benefits that outweigh the possible risks."

138. Dr. Singh's letter focused on the patient's cause of death, which was reasonable given the medical board's notification to him that the patient's death was due to Metformin. At no point in the letter did Dr. Singh ever state that he prescribed Metformin, his letter merely said that the patient "had Metformin started on 1/19/17." Dr. Singh never addressed any of the January 13, 2017 through January 19, 2017,

Downey records. In fact, he did not even address any of his care and treatment of the patient and it does not appear he had any of the patient's records. As such, nothing in this letter, let alone clear and convincing evidence, contradicted any statements Dr. Singh made at his medical board interview, as discussed below.

139. This matter was investigated by two investigators, as one was promoted before the investigation concluded. Special Investigator Regina Armstrong performed the initial investigation, and interviewed Ms. Lim who advised that the county public health investigation was opened after a complaint from the family regarding the care given to the patient. Nothing in the medical board's investigation report documented or detailed how Ms. Lim concluded that Dr. Singh prescribed Metformin to the patient. Special investigator Armstrong testified that she never came to learn there was an issue regarding the Metformin prescription.

140. On January 3, 2018, Dr. Singh's attorney, who represented him at this hearing, authored a letter to the medical board indicating that Dr. Singh had asked him "to provide supplemental information in response to the Medical Board's inquiry, which he initially responded to on August 4, 2017." Counsel referenced the patient's extensive medical history, the investigation that resulted from the family member's complaint, and noted that Dr. Singh's "summary covers the patient's medical care surrounding her death, so I will concentrate this supplemental response on his education, experience, and accomplishments contained in the attached curriculum vitae." Counsel then detailed Dr. Singh's education and experiences noting that, as of the date of the letter, Dr. Singh has been practicing cardiology in California for the past 22 years, and specializes in "general cardiology, clinical cardiac electrophysiology, cardiac devices, and cardiac arrhythmia ablations with special interest in atrial

fibrillation ablation." Counsel highlighted Dr. Singh's board certifications, leadership positions, research, and wrote:

> As shown above, Dr. Singh is an excellent cardiologist. As demonstrated by his summary, the patient's lactic acidosis was more likely related to her fulminant infection, multiple co-morbidities, and septic shock. The contribution of lactic acidosis due to Metformin was negligible, if any.
>
> I am confident that, after reviewing the curriculum vitae, summary previously provided, the medical records from White Memorial Hospital, your reviewer will conclude that Dr. Singh rendered appropriate care to [the patient]. If any additional information is needed, please do not hesitate to contact me.

141. Nothing in that letter claimed, either way, that Dr. Singh prescribed or did not prescribe Metformin to the patient. This letter merely provided Dr. Singh's educational and professional background, and again asserted that the patient's lactic acidosis was not due to Metformin. At no point in this letter did Dr. Singh's attorney claim that Dr. Singh prescribed the Metformin.

142. After Special Investigator Armstrong was promoted, the investigation was assigned to Investigator Tia Johnson. In October 2019 she called Dr. Singh's office and sent him an email to schedule an interview. On November 6, 2019, she received a letter of representation from his attorney. Thereafter, Dr. Singh was interviewed and a transcript of the interview was introduced at hearing. Investigator Johnson testified that the interview was the first time Dr. Singh raised the issue regarding the Metformin

prescription. However, he did not mention anything about a wrong dosage, or discussing the order with Nurse Mielke, or her overriding a black box warning.

Medical Board Interview of Dr. Singh

143. Dr. Singh was interviewed at the Tustin HQIU office on January 6, 2020. He stated that he knew the patient "very well" from his role as both Downey's medical director prior to when he began treating her and as her physician. Dr. Singh explained that there was a conflict with the family and her physician, the patient was extremely sick, and was in an out of hospitals, so Dr. Singh was asked to assume her care. Dr. Singh described the patient's extensive medical history, noting that he was managing her diabetes, hypertension, infections, and hemodialysis. He also discussed the patient's noncompliance.

144. Dr. Singh would visit Downey two days a week. Thursdays were his usual days and he would visit one other day in the week, usually Tuesdays. He would "round up" at Downey a couple times per week and would typically see this patient with her nurse. The nurses kept progress notes in the charts and physicians would countersign telephone orders that were given. Physician's electronically countersigned orders on the computer. Because of the patient's multiple comorbidities and number of hospital visits, in addition to examining her, Dr. Singh also regularly reviewed her labs and hospital records. Her glucose was being checked on a regular basis and she was being given NovoLog.

145. On Thursday, January 19, 2017, Dr. Singh made rounds and discussed several patients, including this patient. There were a few new patients at Downey. After completing his rounds, he went to his office. In the afternoon Nurse Mielke called him and said there was a patient whose diabetes was not under control. Dr. Singh

"distinctly" recalls, because it is his habit, that he would ask the patient's name and "who the patient is." Dr. Singh explained that when called about a patient, his custom and practice is to ask questions to ascertain some background information, but he does not recall the specific questions he asked Nurse Mielke. As far as he can remember, Nurse Mielke did not identify the patient as being the one at issue in this matter, a patient he knew "very, very well," and whenever her diabetes was not under control, it was due to her being noncompliant. Instead, Nurse Mielke called him about a new patient, with new onset diabetes, so he told her Metformin would be the first line drug of choice, to start the patient on that drug, and ordered Accu checks to monitor that patient's glucose. "That is the only conversation I had."

146. Dr. Singh explained that he did not realize Nurse Mielke was calling about this patient "because the lab which she was calling was three, four days back I had seen it. I kind of said patient should be continued on insulin and it never entered my head that this was the patient she was. She did not identify the patient as [patient name]. Because this [patient name] I knew very well, I knew very well." Dr. Singh knew about this patient's many medical problems and he had talked to her family. If Nurse Mielke had identified the patient as being this patient, "there's no way I would have given Metformin to a patient with end stage renal disease." Dr. Singh thought they were talking about one of the newer patients, one with "new onset diabetes mellitus." He stressed that Nurse Mielke identified a new patient, and she did not identify this patient.

147. Because his phone call with Nurse Mielke was on a Thursday, he was not back at Downey until the following Tuesday, and the patient died on Monday, so he never saw that the order had been entered in this patient's chart. If he had, "it would have been caught. But unfortunately in these three days, it was never - I was not there

in the facility." He also disputed the progress note claiming he had rounded on the patient and prescribed Metformin, stating that "never happened." His conversation regarding Metformin was in a phone call. He also explained that the dosage Nurse Mielke wrote is "not the dose which is a starting dose," so he is "totally flabbergasted" at this. He then revealed that he is a diabetic who takes Metformin and the starting dose he would give a patient is 500 mg and then increase to 500 mg twice a day. He would never start a patient at 1000 mg and "this order is kind of totally wrong." Dr. Singh pointed out that none of the orders were entered by him, they were all entered by Nurse Mielke, but admitted he countersigned the order on February 8, 2017, well after it had allegedly been given.

148. When Dr. Singh learned the patient had been transported to the hospital from dialysis, he assumed it was the same type of sepsis condition for which she had been previously hospitalized several times. He was shocked to learn the family had reported the issue to the state. Dr. Singh first learned the patient had been prescribed Metformin when he was contacted by Ms. Lim. When he was asked about it he "had no clue what they were talking about." Ms. Lim told him it was in the medical records and he told her he had never prescribed it. When Ms. Lim told him he prescribed Metformin for the patient, "I said I was shocked. I said, what are you talking about? I did not prescribe Metformin for [this patient]." He told Ms. Lim that he would "never prescribe Metformin for [the patient] because I knew her well."

149. After talking with Ms. Lim, Dr. Singh went back to Downey to find out what happened. Nurse Mielke told him that she had called him about a patient with uncontrolled sugar and he told her that she never identified it as this patient and with this patient they had a plan, she was on insulin, it was not this patient they discussed on the phone. He also told her there were other mechanisms such as alerts which

would tell the nurse the medicine is not indicated or pharmacy has a program that acts in a similar manner. Nurse Mielke said she saw the alerts, but ignored and overrode them. He asked her why she had not called him when there was an alert and she told him that alerts are normally on some of the medications, like ones for Lasix, and she just overrides them. [3] He said "it was just shocking" when Nurse Mielke told him that she had overridden the warning. Her not recognizing the issue with this order, is "totally flabbergasting to me." He does not know how the conversation about one patient got put in another patient's chart.

150. Dr. Singh then went to speak to the facility director and told the director it was a mistake that should never have happened. He told the director that the nurse told him there had been an alert and how it was like similar alerts they get with Lasix, "so we override them." Dr. Singh said that Nurse Mielke told him she did not call him about the alert, she simply overrode it.

151. Dr. Singh explained the safeguards in place at pharmacies when contraindicated medications are prescribed, as well as black box warnings and safeguards in records to prevent prescription errors. After this incident, where Nurse Mielke ignored all the alerts and the pharmacy did not catch it, it was "scary for me" and he soon left Downey. He described the safeguards in place in hospitals that are not in place in nursing homes, which led him to leave, because he did not want to work in such an "unsafe environment." In his time as the medical director, this is the only time he is aware of where a patient was given the wrong medication. "This was the first one and hopefully this will be the last kind of thing which will ever happen."

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[3] As noted below, Nurse Mielke denied this claim.

152. Dr. Singh reviewed the hospital records from the patient's last admission and saw the patient's high white blood cell count of 46,000, her bacteremia, and believed she was acidotic from that. The Metformin may have contributed to her lactic acidosis, but he is not sure because she only had started Metformin one or two days earlier. Dr. Singh's letter to HQUI did not reference the mistaken Metformin prescription because when he heard from the medical board, it "had been some time," and by then he knew the patient had been prescribed Metformin so he thought the medical board was asking him whether it was responsible for her demise. "I thought that was the question. I have never dealt with the Board before."

He "never got the impression" he should mention the Metformin mistake. He never prescribed it, it happened in the facility, and he thought the medical board was inquiring about the cause of death. He acknowledged that it was a mistake and he should have written "the whole thing and said this is what happened with this patient, this is how it was prescribed, but in spite of this prescription, it could not have [killed her]." However, he did not realize that was what he was supposed to do, he was merely explaining the cause of death given the hospital labs on January 23, 2017. He attached the article about rethinking Metformin not as an indication that he would prescribe it to an end stage renal patient, he would not; but rather to show that there is rethinking going on about prescribing Metformin to renal patients.

153. Nothing Dr. Singh said during his medical board interview contradicted his prior statements in the letters he or his attorney authored. There was no showing of dishonesty, let alone clear and convincing evidence of it.

Testimony of Alexes Mielke, R.N.

154. Alexes Mielke, R.N., was licensed as a nurse in the Philippines in 1995, having attended Visayas College. She got her medical degree in the Philippines at Iloilo Medical School in 2002. After moving to the United States, she was "able to challenge the NCLEX exam" and became a registered nurse in California since 2005. (NCLEX-RN is the acronym for the National Council Licensure Examination and tests the application and analysis using the nursing knowledge learned in school.) Nurse Mielke decided not to be a physician in the United States and began working at a skilled nursing facility, eventually working at Downey from 2015 to 2017. At Downey she was a nursing supervisor for the morning shift and later an Assistant Director of Nursing. She left Downey on good terms and was employed by hospice centers until laid off because of Covid-19.

155. Nurse Mielke recalled the patient, she was housed in the East station where short-term patients were placed. Nurse Mielke had "not that much" interaction with the patient because she was not the direct charge nurse for the nurses who provided care for the patient.

156. On January 19, 2017, she reviewed the patient's January 13, 2017, Hgb A1c lab result of 7.5 with Dr. Singh in person because he was at the facility. She had the lab results in her hand. At Downey, the custom and practice of reviewing abnormal lab results were to review the labs, discuss them with the physician, and get directives on how to address the abnormal results. Her custom and practice when discussing abnormal labs is to identify the patient, make sure she and the physician are talking about the same patient, make sure each one knows who the patient is, and she will carry out and document the order the physician gives.

She identified the patient with a high A1c as being this patient. She and Dr. Singh discussed the high lab results and she got an order from him to add Metformin twice a day 1000 mg. On January 19, 2017, she wrote on the January 13, 2017, lab report "about the time" she spoke to Dr. Singh, but never explained why she actually wrote on the lab report, which seemed odd. Dr. Singh never told her the prescription was for another patient. After he gave her this order, she went to the electronic medical records, accessed the patient's chart, placed the order and documented it in the notes. She also entered the January 19, 2017, Downey order summary at 13:53, documenting the Metformin order, that Dr. Singh countersigned on February 8, 2017. She explained that the system "defaults as verbal order to phone" which is why the communication method of the order states "phone" even though it was a verbal order Dr. Singh gave to her in person.

157. Nurse Mielke did not get any type of black box warning when she entered the order, so there was no black box warning that she overrode. The January 19, 2017, 13:54 progress note is the note she entered, as was her custom and practice, to document receiving an order and carrying it out. She denied that Dr. Singh ever told her that he meant the order for a different patient or that she told him she received a black box warning that she overrode.

158. Although Nurse Mielke appeared quite confident when answering questions on direct examination, during cross-examination when confronted with the records, her demeanor changed. She became flustered, was unable to answer many questions, could not explain what had occurred, and appeared very unsure of her answers. She repeatedly stated that she could not answer questions because "it has been a long time." Overall, her presentation cast doubt on her credibility.

159. She "was not normally" at the East Station and could offer no explanation for why, on January 19, 2017, six days after the lab results had been reviewed by Dr. Singh, charted in the records, and "no new orders" had been given, took it upon herself to discuss these abnormal labs with Dr. Singh. She claimed that abnormal labs needed to be "quickly brought to the attention" of the physician and, as the nursing supervisor, if there were abnormal labs that had not been addressed, she would follow up to make sure they were addressed with the physician. However, she did not know these labs had already been reviewed and addressed on January 13, 2017, by Dr. Singh with the patient's nurse or that they had also been addressed by the Downey dietician. Nurse Mielke was unable to explain where she got this report on January 19, 2017, and her testimony about bringing abnormal labs "quickly" to a physician's attention made no sense as these labs were six days old and already been reviewed and addressed.

Nurse Mielke did not know what brought these specific lab results to her attention. She could not recall how many labs she was following up on that day, but "we try to help each other out" and "I wanted to help out" even though doing so was not part of her duties. Lab results were faxed to Downey and "we try to communicate with the physician" about abnormal results. Downey's policy was to "call right away," but she could not explain why she was involved with this lab report on January 19, 2017, where she obtained it, or whether there had been any follow-up on it on January 13, 2017. Her practice was to immediately follow-up the same day on abnormal labs and she agreed that doing so six days later was unusual.

160. Nurse Mielke became extremely flustered when shown the January 13, 2017, progress note documenting Dr. Singh's review of the labs and "no new orders given," testifying, "I did not see that!" She did not document that Dr. Singh had been given the January 13, 2017, lab results on January 13, 2017, because "I did not know."

This further suggested she was confused, did not look at the patient's chart, and incorrectly relayed information to Dr. Singh on January 19, 2017. She was also unaware of the January 17, 2017, dietary note referring to the lab results. She was unable to explain why she intervened on January 19, 2017. Her custom and practice would have been to review the records to see if the labs had been addressed, but she cannot recall if she did so and she became very rattled.

161. It was clear that, for some inexplicable reason, Nurse Mielke had intervened in this patient's care with lab results that had already been addressed and had failed to realize her error. It was also clear that because Dr. Singh had reviewed these lab results on January 13, 2017, had given no new orders, had assessed the patient several times between then and January 19, 2017, and had never given any new orders, that the January 13, 2017, A1c lab results showed that the patient's condition was improving, and she was being treated with several other diabetic medications, that he reasonably believed that when Nurse Mielke told him about abnormal lab results for a patient with new onset diabetes, he thought she was referring to a different patient.

162. Nurse Mielke had "tens of thousands" of discussions with Dr. Singh regarding patients, so she is now relying on the Downey records to recall this incident. She has no specific recollection of their actual discussion, she just remembers getting an order from Dr. Singh for this patient. However, she does recall talking to him about the lab results at the station, and not during a phone call, but admitted she could have discussed other patients with him and cannot be sure unless she can review patient documents.

163. Nurse Mielke has had "not that much" experience with Metformin. She acknowledged she was never taught in medical school that Metformin is

contraindicated for renal disease, she only learned that because of this case. She was aware that the Metformin dosage is typically 500 mg twice a day, not 1000 mg, but did not ask Dr. Singh why he was prescribing such a high dosage. Nurse Mielke testified, "I had no concerns about that order."

164. Nurse Mielke could not recall any discussions between the patient's January 23, 2017, death and when she was interviewed by Ms. Lim in March 2017. She denied receiving any instructions about the interview, or being told she would be interviewed. She was working when she was called off the floor to speak to Ms. Lim, but cannot recall much else and does not recall preparing for the call. During the interview, Ms. Lim gave Nurse Mielke the date and time of the prescription, Nurse Mielke did not provide those details. She told Ms. Lim that the facility did not have black box warnings, there was no alert to her about the metformin prescription.

At the time, black box warnings were fairly new to Downey and she is not sure if they were available in January 2017. When asked about her statements in Ms. Lim's notes that she was "blank" when asked about seeing a black box warning, Nurse Mielke agreed, "Maybe I said that, maybe I was." She also acknowledged that pharmacists will typically call about prescriptions if there are contraindications and that the facility did have manuals regarding contraindications and it was also in the electronic record system. She does not recall if she got any such warnings as it has "been so many years" and explained, "We have our trust with the doctor, we let the doctor order it."

165. Despite her direct testimony, on cross-examination when asked if she had any discussions with Dr. Singh in April 2017, she could not recall as it has "been a long time." She could not recall telling him that, like a Lasix warning, she had disregarded the black box Metformin warning. Nor could she recall telling him that she

believed he had ordered the Metformin prescription for this patient. Nor could she recall discussing a phone call with Dr. Singh. As such, Dr. Singh's testimony about those discussions can be fully credited.

166. Nurse Mielke agreed that Dr. Singh was the "most present" physician at Downey. He was there two times per week. She recalled this patient was noncompliant, she was found drinking Coke, she was in and out of the hospital, and she was undergoing hemodialysis. The patient's daughter also came to the facility quite often. Nurse Mielke was not surprised the patient died. It was not unexpected, the patient had a DNR. Nurse Mielke recalled there were discussions after the patient died about a prescription, but was not sure of those discussions. She never attributed the patient's death to the Metformin prescription. The patient had a lot of comorbidities and she did not think Metformin was the reason for her death.

Dr. Singh's Testimony

167. Dr. Singh described his education and experience. When he joined St. Francis in 1995, he became very active with the Medical Executive Committee as he was concerned about patient care, patient safety, and all quality matrixes in the hospital for all patient care. He has continuously served on numerous committees, all elected positions, except for a few years ago when he took a short break. He described the work he did and programs he created to ensure high quality of care at St. Francis.

168. In 2016 he was approached by a nurse who told him that Downey needed a medical director. The facility was close to his office and so he joined the staff in July or August 2016. Approximately two months later, the head of the facility resigned, so they did not have a CEO at Downey and for several months an individual from another facility would "be there a little." Dr. Singh's main interactions were with

the Downey nurses. He initially went daily but was told that other doctors came to the facility, so there was no need for him to come so often and he reduced his rounds to two days a week. He went every Thursday and typically on Tuesdays, although sometimes he did not go on Tuesdays, depending on his work schedule. He would round in the morning. On Tuesdays he would round and then go to the hospital. On Thursdays he would round and then go to the hospital and then to his office by 2:00 p.m. for patient appointment.

169. The patient was in the facility "a very, very long time." The first time he became aware of her was as the medical director when she was under the care of Dr. Shokoohy, and was transferred to Downey from LAUSC hospital. The patient was very complicated, she had multiple comorbidities, multiple conditions. She was extremely sick and was in and out of the hospital a number of times because of multiple problems. She was a high risk for surgery because of her complications which is why her fractures could not be operated upon. Despite her condition, she was alert and oriented and could make her own decisions. She was a "very strong-willed patient" with "a very challenging family." The patient was very sure of herself and would do what she wanted to do. She refused treatment, she refused to follow diet rules, being "extremely noncompliant with diet intake." She also refused dialysis which resulted in fluid buildup in her body requiring oxygen.

170. Dr. Singh interacted with the patient on an "almost daily basis one way or another" from the time she came to the facility in October 2016. Dr. Singh was "called occasionally to check in on the patient a number of times" and called about her and her problems multiple times, so was "very familiar" with her. He knew she was in the hospital, that her daughter was upset with the treatment she was receiving at Downey, her mother's condition, and social issues regarding her interaction with her mother. As

the Downey medical director, the patient's general problems and difficult family issues came to his attention; she was also "brought up many times with the Director of Nursing." As Dr. Singh testified, "I was very much aware of the patient before I became" her physician in December 2016. When he assumed her care, he would round at the facility twice per week and would regularly round on the patient each time.

171. Dr. Singh's December 20, 2016, History and Physical Exam of the patient documented her readmission to Downey. He had been called quite late, approximately 11:00 p.m., the night before that she was readmitted to Downey and he reviewed the orders with the nurse on the phone. At this point in time, he was very familiar with the patient, and continued "a lot of the orders from before because she was stable on those" and he recalls giving a few new orders. He came in the next day to see the patient. His notation that she was on nasal cannula oxygen two liters PRN was an order for supplemental oxygen PRN, it does not mean that she was using or required oxygen all the time. Instead, if her oxygen saturation rates got low, she could be given oxygen. As he recalls, the patient did not require oxygen when he saw her.

172. The patient's chronic pain was exacerbated by her fractured leg. While under Dr. Shokoohy's care when she was first admitted to Downey, the patient had been prescribed Tramadol, Dilaudid, and Morphine Sulfate. She was an opiate tolerant patient who had been tried and titrated on a number of pain medications to achieve proper pain control. He discussed the risk and benefits of medications with her and continued the patient on Tylenol. He then introduced a lower opioid, Norco, for pain levels at 1 to 3; Norco and acetaminophen for pain levels 4 to 6; and morphine sulfate as needed for severe pain at 7 to 10 levels. Dr. Singh added Norco only as needed to be given before Tylenol or morphine so that the patient would have received a less potent medication if her pain got to a 4 to 6 level. The medications were required

because of her chronic condition and given PRN, so the patient would be assessed before they were administered. In December 2016, she was only given Morphine Sulphate on two occasions.

173. The other PRN medications the patient was prescribed were Ambien and Zolpidem. These are hypnotics because the patient had chronic insomnia. Patients with renal disease often have problems sleeping. Also, SNF facilities are typically loud, and that coupled with the patient's insomnia, was why the PRN Ambien was prescribed. These medications had been prescribed in the past, the patient by her other physicians. When she was given small doses of Norco and Ambien, she was comfortable for her pain and her insomnia, and was being monitored because of her condition. Each time she had altered levels of consciousness and required hospitalization was because of sepsis.

174. The patient had been receiving insulin for quite a long time and after her September 2016 hospitalization the medication Januvia (sitagliptin) was added. The lab report from the hemodialysis center documented that over time the patient's A1c levels were improving. Although A1c levels measure blood sugars over a three-month period, the patient had A1c labs drawn much more frequently. The patient's blood sugars were "coming down nicely" As the patient was at a SNF, and her A1c levels were decreasing. Dr. Singh decided to continue her on the same medications, keeping her on the sliding scale insulin which was checked four times per day.

175. Dr. Singh considered the risks and benefits of all of the medications before he prescribed them. He went through the records and saw the titrations given to the patient and at what levels she was noted to be comfortable. He had a very detailed discussion with the patient and her daughter when he assumed her care. He was especially concerned because of the sepsis which usually kills patients, especially

those with multiple medical conditions. This patient had been hospitalized a number of times because of sepsis and one bout of sepsis is enough to kill a patient. In fact, Downey staff and he were surprised each time the patient returned to the facility after a sepsis hospitalization. Because of these hospitalizations, he had a discussion with both the patient and her daughter and both decided to execute a DNR for the patient.

176. Dr. Singh was asked about several entries regarding telephone orders when he was called by nurses. He described his custom and practice of reviewing the patient care over the phone with the nurse, obtaining details regarding the patient, and how medications will be continued if he agrees with them. When he orders that prior orders be continued, it means he has read those prior orders. Dr. Singh often received calls about patients and gave orders over the phone after going through these steps with the nurse on the phone. Any time patients were admitted to Downey, their medications were reviewed.

177. Dr. Singh approved the January 12, 2017, pharmacy recommendation for an A1c lab and issued an order. He was notified of results on January 13, 2017. The patient's A1c level of 7.5 was an improved result, so there was no indication to give any treatment, which is why "no new orders" were given by him on January 13, 2017, as clearly charted.

178. The January 13, 2017 note, was on Friday and timed at 14:42, so Dr. Singh "was probably off-site." He was notified about the labs, but would not have seen the patient's chart since he was not at Downey. The patient was known to him, he had seen her "multiple, multiple times," and he had received "multiple calls and orders" about her. He was "so familiar with this patient, since October I was looking after her, I was familiar with everything about this patient," that he did not need to go to her medical records and he made no new orders because her A1c was improving.

179. Dr. Singh is very familiar with Metformin. The medication came out in the mid-1990s when he was practicing internal medicine and "we started using it as the first line prescription" for diabetes. There were "unique and revolutionary studies" showing that it lowered cardiac mortality in patients with diabetes. He has used Metformin since it first came on the market; it has been part of his practice for over 20 years. It is a first-line medication for patients with diabetes and does not have the side effects that other diabetic medications have. Dr. Singh explained how Metformin works and why it is contraindicated in patients with renal issues or on hemodialysis. He also knows about the risks of Metformin in his cardiac practice because contrast is used to perform diagnostic testing, so patients taking Metformin must stop using it for 48 hours because using contrast with Metformin can cause renal failure or lactic acidosis.

When Dr. Singh prescribes Metformin, he goes over the risks and complications with his patients. He is also aware of the black box warning that the FDA requires to be placed on labels of drugs regarding any conditions that can be harmful to the patient or cause death. A number of medications have mandatory black box warnings mandated by the FDA and he will review those black box warnings with his patients. Metformin is contraindicated in patients with end stage renal disease or in patients undergoing hemodialysis, although there has been some recent rethinking that in patients with mild to moderate kidney disease, Metformin may be allowed with the question being that "because Metformin is so beneficial to the patient's heart, is it really that harmful to give to a patient with renal dysfunction?"

180. Dr. Singh is also personally familiar with Metformin, having used it the past 11 years for his Type 2 diabetes. Over time, his dosage has increased given his lab results.

181. On January 19, 2017, Dr. Singh did not give an order for Metformin for this patient. He would never prescribe Metformin for this patient because she was an ESRD patient and the risk of insulin sensitivity increases because glucose levels can go down more than for patients with normal renal function. Further, she was already on two different prescriptions for insulin. Metformin is a first-line medication, so it would make no sense to order it and it is never prescribed for patients with ERSD.

182. Dr. Singh had "a very brief discussion, less than five minutes" with Ms. Lim, regarding phone orders, safety and safe measures for telephone orders. Her notes summarizing their discussion are "completely inaccurate." He did not know what the call would be about, he just knew Ms. Lim was calling to discuss a patient at Downey. Ms. Lim asked if he had prescribed Metformin to the patient and he denied it, telling her no. She told him the patient had an order from him for Metformin and asked whether he had received any warning about the prescription and told her he had not and had not even used Metformin for this patient. This phone call was the first time Dr. Singh heard about the Metformin prescription for the patient and "I was surprised." He told Ms. Lim Metformin was used as a first-line medication for new onset diabetes.

183. After Dr. Singh spoke with Ms. Lim, he "called up the facility" and spoke to Nurse Mielke. He told her about his discussion with Ms. Lim and wanted to know when he had given a Metformin order for this patient because he was very confused as to what was being claimed. During his call with Nurse Mielke it "triggered off" a memory of her calling him regarding a patient and him giving a prescription for Metformin, but it was for a new patient with new onset diabetes. He told Nurse Mielke that Metformin was not for this patient, it was for another patient, and she told him that she entered it in this patient's chart. He asked her then if she had gotten a warning and she told him, "Yes." He asked her why she had not called him and she

said that at the time she just overrode it. Dr. Singh "specifically" remembers her giving him the example of Lasix, and how that warning is overridden. She told him that she just ordered the Metformin and he told her that she should have called him.

184. Dr. Singh then went to Downey, he wanted to see the records and talk to the Director of Nursing. He told the director about the mistaken Metformin order. However, by then, the only records at Downey were the ones from the last hospitalization at White Memorial Hospital on January 23, 2017. Apparently, the records had been removed by Ms. Lim during her investigation. After Dr. Singh reviewed the hospital records, he believed the patient was in septic shock, the lactic acidosis was out of proportion to sepsis, but he felt it was tied to septic shock and not due to Metformin use. He had no records from Downey or the Metformin dosage, the hospital records were all that he knew at the time.

185. The interim CEO, Mr. Hoffman, discussed the case with him and "the mindset" was that the patient had taken Metformin and was her death due to her diseases or the Metformin. Dr. Singh felt her death was due to septic shock. Mr. Hoffman requested that he write a letter regarding the patient's cause of death because the state intended to issue a citation against Downey. Dr. Singh agreed and authored the letter referenced above. When he wrote it, he had "no clue" regarding the dose of Metformin given to the patient but assumed she was given "the typical starting dose of 500 mg twice a day" which is why he wrote nothing in his letter regarding the dosage.

186. Dr. Singh now felt the practices at Downey were "very unsafe, the processes were not well taken care of and they would not implement quality changes" he suggested. He likes the safeguards in place at acute care facilities. He was at

Downey more than any other physician yet still, this happened to him, and he thought "it was extremely dangerous," so he quit and returned to an acute care setting.

187. The medical board's letter was the first time Dr. Singh "ever received any kind of indication" that he was being blamed. He thought the medical board was implying the patient died because of his prescription, so he wrote an almost identical letter to the one he had written to the county, explaining why she did not. Had Dr. Singh "known the true nature" of the medical board's investigation, "I wish I had explained" what occurred. His "biggest regret" is that he did not detail those facts in his letters. He wished he had written that he did not prescribe Metformin, but he was "more concentrated on explaining the cause of death." It was "naïveté on my part" to write the letters about the cause of death, "I should have consulted with an attorney before I sent a letter."

188. The Metformin order Dr. Singh electronically signed on February 8, 2017, a few weeks after that order was allegedly given, was one of "lots of orders" he was electronically signing that day. There would be "a bunch of other orders" that he would collect, there was an electronic queue on the computer for all the patients he saw at Downey, and he would click on each order to sign it. His custom and practice was to look at and countersign orders. "Obviously, I did not look at this order carefully." If he had, and "had registered it in [his] mind," he "would not have signed it." He signed it "without looking at it appropriately as I should have and that is the reason I am here today."

189. When he signed this order, the patient was no longer in the facility, she was already dead, and this order was "with a bunch of other orders" because he "usually signs orders in bunches." He noted the document contains two orders; the first one is for Metformin, the second one, the one closer to his signature, is for the

transfer to White Memorial Hospital. He believes he only saw the second order which is why he signed the document. He does not think he noticed the first order for Metformin. He admitted signing this document "was a mistake."

190. Dr. Singh did not even know that he had signed an order for Metformin until his medical board interview when the district medical consultant pointed it out to him. It was the first time he learned this, and he was "shocked." He had not given that order for this patient with improving A1c levels, and he has never given 1000 mg as a starting dose "for any, any patient." As Dr. Singh credibly testified, "That order I would not have given in my right mind. There is no reason to give that dose for any purpose. That for me was very distressing." There was an order under his name for this patient when he never meant it to be given to this patient or for this incorrect dosage.

191. Dr. Singh's medical board interview was also the first time he was asked any specific questions or asked to detail his care and treatment of the patient. Before that, all he had was "a very brief" telephone call with Ms. Lim. During his medical board interview he "had a full discussion" with the district medical consultant and the investigator, and it was his first chance to explain "in full" what had occurred.

192. Dr. Singh did not have any type of formal interview with Ms. Lim, it was a five minute discussion. He did not know anything about the extent of her investigation. When they spoke, he thought she was investigating the incident and would find out what caused the error. He had no idea he was being accused of prescribing Metformin. Mr. Hoffman told Dr. Singh that the facility was going to be cited, so he thought "the state had investigated." As noted per Mr. Hoffman's request, Dr. Singh wrote a letter to the county about the cause of death. Based on his review of the hospital records, he was "quite certain" the patient died from septic shock.

193. Dr. Singh feels "badly" about this patient's demise, but he did not prescribe Metformin to her. He does not understand why the pharmacist did not recognize this order as being "out of line" or why Nurse Mielke was not paying attention to the dosage or did not call him regarding the warning. He does not know why the black box warning was ignored.

194. On cross-examination, complainant's counsel spent time asking Dr. Singh if he ever filed an incident report at Downey, attempting to undermine his testimony. Dr. Singh explained that he knew "the state" was investigating the matter and thought "all that had happened" would come out during the investigation. Any mistake made was made by the nurse for "putting the wrong order on the wrong patient." Nurse Mielke was someone he had worked with very closely, an error had been committed, "the state was investigating," he did not have access to the records, and his focus was on trying to find out whether the error caused the patient's death. Dr. Singh assumed all the witnesses would tell the truth. He did not know that Nurse Mielke did not tell Ms. Lim what had happened; he did not even know she had been interviewed.

There was no evidence introduced that Dr. Singh was required to file a complaint or request an investigation and his testimony that he notified the Downey Director of Nursing about the Metformin order error was unrefuted. There was no showing that he had to do anything more. Complainant's counsel also questioned Dr. Singh about whether he initiated any type of investigation to determine what had happened, but, as he explained, "the state was already investigating the matter" and he presumed that they would find out what occurred. The attempt to undermine Dr. Singh's credibility because he did not file some sort of independent request for an investigation was not persuasive.

Expert Witnesses

COMPLAINANT'S EXPERT

195. Doris Y. Chih, M.D., was claimant's expert. She authored a report, introduced her curriculum vitae, and testified at this hearing. Dr. Chih graduated summa cum laude from UCLA in 1994 with a Bachelor of Science in chemistry and biochemistry. She received her Doctor of Medicine and Ph.D. from UCLA School of Medicine in 2003. She did an internal medicine internship and residency from 2003 to 2006 and a Nephrology Fellowship from 2006 to 2008, both at Kaiser Permanente Los Angeles Medical Center. She is board certified in internal medicine and nephrology. Between 1982 and 2001, she participated in four different research projects.

Dr. Chih has been the Chief, Division of Hospital Medicine, City of Hope Medical Center, since November 2020. She is the first official chief for this new division of hospital medicine providing administrative oversight of the evaluation and treatment center, hospitalists, and nocturnists, as well as direct patient care. In 2020 she was the Lead Hospitalist of "Veterans Integrated Service Networks 22, Veterans Health Administrations." This was an inaugural role in a recently implemented position to improve communication and collaboration between Veterans Affairs' field offices and the central office. From 2017 to 2020 she was the first official Chief, Section of Hospital Medicine, Veterans Affairs Loma Linda, where her duties included creating policies and procedures, quality assurance monitoring, education and risk management, budgeting and staffing, and handling patient grievances.

From 2005 to 2008 she was a part-time hospitalist in the Department of Internal Medicine at Kaiser Permanente Los Angeles Medical Center. From 2008 to 2012 she was a nephrologist/internist at Pacific Nephrology Medical Group where she provided

direct patient care and negotiated IPA contracts. From 2012 to the present she has been an Attending Physician, Medical Service, Veterans Affairs Loma Linda where she is involved in direct patient care, supervision and education of staff, medical students and residents, and has also been an Associate Professor of Medicine for Loma Linda University/School of Medicine.

From 2015 to 2016 she was the Acting Chief, Intermittent, Section of Hospital Medicine, Veterans Affairs Loma Linda. From 2016 to 2020 she was a Physician Utilization Management Advisor, Veterans Affairs Loma Linda, where she identified the appropriateness of the level of care and services, provided information to assist with decision-making related to patient care management and discharge coordination processes, and identified delays in treatment and services to improve operational efficiencies.

From 2016 to the present, Dr. Chih has been a medical consultant/expert reviewer for the medical board where she reviews investigative cases reported to the medical board.

Dr. Chih has also served on several committees. From 2003 to 2006 she was a member of the Pharmacy and Therapeutic Committee at Kaiser Permanente Los Angeles Medical Center where she was involved in the "development and maintenance of the formulary." From 2014 to 2020 she was a member of the Pain Management Subcommittee for the Veterans Affairs Loma Linda where she formulated policies and procedures in compliance with Joint Commission Accreditation and Regulation. From 2017 to 2019 she was the Medical Director of the Critical-Care Response Team Committee for the Veterans Affairs Loma Linda. Her duties included ensuring compliance with Joint Commission accreditation and regulation. From 2018 to 2020

she was a member of the Peer Review Committee of the Veterans Affairs Loma Linda. Dr. Chih has nine publications, and nine presentations listed on her curriculum vitae.

196. Dr. Chih's opinions are incorporated in the evaluation of the causes for discipline addressed below.

DR. SINGH'S EXPERT

197. Jason A. Black, M.D., was Dr. Singh's expert. He authored a report, testified in this hearing, and introduced his curriculum vitae. Dr. Black graduated in 1992 from Pomona College with a Bachelor of Arts degree. He received his Doctor of Medicine in 1996 from University of Southern California School of Medicine. He did an internal medicine residency from 1996 to 1999 at Kaiser Permanente Los Angeles Medical Center. He was licensed in California in 1997 and his license is in good standing. Dr. Black is board certified in internal medicine and was recertified in 2010 and 2020.

In 1999 Dr. Black was a Physician Advisor for Utilization at Kaiser Permanente Los Angeles. He was recruited out of residency training to pilot this new administrative position at Kaiser. His duties included overseeing utilization in the inpatient, community, and emergency room settings, educating resident physicians in utilization management, and collecting data to identify utilization trends at the medical center.

From 1999 to 2003, Dr. Black practiced general internal medicine, joining a primary care group after residency where he "built a successful internal medicine practice from scratch and became a physician partner." He worked as a hospitalist providing inpatient care to patients at several medical centers from 2001 to 2004. He practiced general internal medicine with William H. Cherry, M.D., from 2004 to 2010. While there he served as the group's hospitalist for patients admitted to Menifee

Valley Medical Center. From 2008 to 2011, he provided hospitalist coverage for Inpatient Physicians Network, providing weekend coverage for a group serving both Inland Valley Regional Medical Center and Rancho Springs Medical Center. From 2010 to 2011, he was an Associate Medical Director at Charter Hospice where he supervised the care of patients through both phone consultations and in-home visits.

Since 2011, Dr. Black has owned Valley Internal Physicians, an internal medicine and primary care practice. His practice includes providing primary care to a large senior population and is equipped with an on-site medication dispensary. From 2014 to the present, he has been a board member of Temecula Valley Physicians Medical Group where he participates in policy, financial, and group specialist network selection decisions. Beginning in 2018, Dr. Black has served as the Medical Director for Companion Home Health and Hospice where he oversees patient care services in both Riverside and San Bernardino counties, and has also served as the Regional Medical Director for Pacific Accountable Care, where he provides clinical oversight to ACO providers and helps formulate and implement ACO patient strategies. He also promotes the ACO care delivery model to ACO providers and provides strategic direction to the ACO regarding clinical matters.

Dr. Black was a principal investigator for ACCESS 2008, a landmark study undertaken by King Pharmaceuticals regarding the use of Avinza for the management of chronic pain in primary care settings. (Avinza, an opioid, is an extended release capsule for oral use that contains pellets of Morphine Sulfate prescribed for the management of severe pain.) From 2013 to 2017 he was a Clinical Sub-Investigator for Elite Clinical Trials. He worked with a team of nurses and research coordinators, partnering with top pharmaceutical companies to conduct research studies for

patients with a variety of medical conditions. He has also been retained as a physician presenter to promote the products of several pharmaceutical companies

From 2009 to 2014, Dr. Black was a District Medical Consultant for the medical board, assigned to the San Bernardino office. He resigned when his practice became too busy, but since 2014 he has been an expert reviewer for the medical board.

198. Dr. Black's opinions are incorporated in the evaluation of the causes for discipline addressed below.

Evaluating Expert Testimony

199. In determining the weight of each expert's testimony, the expert's qualifications, credibility and bases for the opinions were considered. California courts repeatedly underscore that an expert's opinion is only as good as the facts and reason upon which that opinion is based: "Like a house built on sand, the expert's opinion is no better than the facts on which it is based." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923.)

An expert's failure to consider all of the facts may make his opinions less persuasive (*People v. Coddington* (2000) 23 Cal.4th 529, 614) and the expert may be examined about whether the expert sufficiently took into account matters arguably inconsistent with the expert's conclusions. (*People v. Ledesma* (2006) 39 Cal.4th 641, 695.) An expert's opinion may be rejected if the reasons given for it are unsound. (*Kastner v. Los Angeles Metropolitan Transit Authority* (1965) 63 Cal.2d 52, 58.)

Evaluation of First Cause for Discipline: Gross Negligence

200. The accusation had 21 paragraphs under the heading "First Cause for Discipline (Gross Negligence)." Paragraphs 5 through 24 set forth complainant's

version of the facts. Paragraph 25 alleged Dr. Singh "committed gross negligence in his care and treatment of [the patient], which included, but was not limited to, prescribing Metformin to a patient with ESRD and associated high risk state for Metformin-associated lactic acidosis." Of note, the phrase "but not limited to" does not comply with Government Code section 11503 which requires the accusation to "set forth in ordinary and concise language the acts or omissions with which the respondent is charged, to the end that the respondent will be able to prepare his or her defense." Despite the "but not limited to" language, the only allegation of gross negligence complainant presented at hearing was the contention regarding the improper Metformin prescription.

201. Both experts agreed that prescribing Metformin to this patient would be an extreme departure from the standard of care. In fact, Dr. Chih repeatedly testified that "even a medical student" knows that prescribing Metformin to patients with renal disease is wrong. That testimony was curious in light of that fact that Nurse Mielke received her medical degree in the Philippines yet testified she had "no concerns" about the Metformin prescription and was unaware of any contraindications at the time she recorded the order.

202. The issue in this matter was whether Dr. Singh prescribed Metformin to this patient. Complainant asserted that the medical records, the statements given to the county public health investigator, and Nurse Mielke's chart notes, statements, and testimony that Dr. Singh prescribed Metformin, supported the allegation that he did. Dr. Singh asserted he did not prescribe Metformin to this patient, is well aware of the risks of prescribing it to a patient in her condition, ordered Metformin for a different patient, and when this matter was investigated had a conversation with Nurse Mielke in which she admitted that she placed the Metformin order in the wrong patient's

chart and overrode the "black box warning." The evidence each side presented in support of their respective positions will be evaluated below.

DR. CHIH'S REPORT AND TESTIMONY

203. Dr. Chih's report referenced the patient's many medical conditions, that she was being "managed non-operatively for her right tibular/fibular [*sic*] fracture due to the significant cardiac risk for surgery," and that she was noncompliant with several recommended medications and treatments. Dr. Chih wrote that "in the absence of contraindications, Metformin is generally considered a first line treatment choice for hyperglycemia in type 2 diabetes." It is contraindicated in patients with factors predisposing them to lactic acidosis and "although rare, Metformin-associated lactic acidosis is has [*sic*] a high mortality rate. Clinically significant lactic acidosis almost always occurs in the presence of comorbid conditions, including impaired renal function . . . unstable or acute heart failure . . . hemodynamic instability . . . or serious acute illness." Dr. Chih referenced the FDA changes to Metformin labeling after April 2016 but noted it "is still contraindicated in ESRD patients per FDA label."

204. Dr. Chih testified that the goal is to get a patient's hemoglobin A1c level below 7 and as seen on the January 13, 2017, labs, the patient's results were 7.5. The typical starting dose for Metformin is 500 mg twice per day, sometimes higher depending on the patient. Typically Metformin is started at a low dose and titrated upwards as the patient's condition is monitored. Metformin is contraindicated in patients with renal conditions. A buildup of lactic acid in the body, lactic acidosis, can be fatal. The FDA has a black box warning on Metformin advising that it is contraindicated in patients with kidney disease.

205. In concluding that prescribing Metformin for this patient was an extreme departure from the standard of care, Dr. Chih wrote in her report:

> Metformin at 1000 mg twice daily was prescribed for this ESRD patient. This patient also was on oxygen and is chronically volume overloaded due to noncompliance with dietary guidelines and HD [presumably this meant hemodialysis]. Furthermore, she was frequently hospitalized for sepsis. These are all conditions shown to predispose patients to Metformin-associated lactic acidosis. Metformin is absolutely contraindicated in this patient, especially at the dose prescribed. Dr. Singh mentioned during the interview that he did not give the verbal order for the Metformin for this patient. However, the verbal order was countersigned by Dr. Singh, indicating that he was responsible for this order.

Dr. Chih believed that Dr. Singh gave the Metformin order because he countersigned the orders on February 8, 2017, and countersigning "means I gave the order." Of note, in this regard, Dr. Chih often testified about what she would do, not what the standard of care requires. Dr. Chih stated that signing lots of orders, and the tedium of doing so, does not make physicians less responsible for the orders and does not excuse them for inaccuracies. Orders must be taken seriously as patients' lives are in physicians' hands.

206. Dr. Chih's report contained a "Summary of Care" section with several dated entries which she explained were referenced because she "looks at things that can cause problems and I put it in my report." In that section, she had the following:

> On 1/3/17, nursing charted that Dr. Singh was paged for abnormal labs but no callback was received. Shift supervisor was notified [page reference].

This is the only notation regarding January 3, 2017, that Dr. Chih made in her report. She did not reference the subsequent January 3, 2017, entries reporting that Dr. Singh called the facility and discussed the patient's condition with staff. When asked why she did not include the January 3, 2017, progress note documenting that at 22:23 Dr. Singh called the facility and discussed the patient's condition and future care, Dr. Chih testified, "I did not realize they were the same thing because it was quite a few hours later he responded." This testimony was not persuasive because, although written on different pages, all the progress notes were in the same format and written chronologically. Thus, Dr. Chih's failure to be aware of that note indicated she had not carefully read the records. Also, given that she made a point to document that Dr. Singh did not return a phone call, a finding that was incorrect, it was disconcerting that she made that notation based on her incomplete reading of the records.

207. When Dr. Chih was questioned further about her noting the alleged failure to return the nurse's call, she acknowledged that the nurse could have been calling the wrong person or the wrong number so she "did not make a big deal of it," stating, "Who knows how good the charting was so I did not make a big deal of it." Given that charting was the basis for her conclusion that Dr. Singh ordered the Metformin, her questioning the accuracy of the charting was puzzling. If the charting was inaccurate regarding phone calls, then it could also be inaccurate regarding orders. To conclude it was accurate in one part that was adverse to Dr. Singh while acknowledging it could be inaccurate in others, made her appear biased. Moreover,

her acknowledgment of the inaccuracy of the charting, given other concerns raised by the records, lent further credence to Dr. Singh's position.

208. More importantly, Dr. Chih did not consider all of the evidence. She made absolutely no mention in her report of the January 12, 2017, progress note regarding the pharmacy's recommendation to perform Hgb A1c labs, or notably Dr. Singh ordering those labs, or the January 13, 2017, progress note that Dr. Singh reviewed those lab results and gave "no new orders," or the dietician's note of those labs. Dr. Chih's failure to leave out such critical facts from her report suggested she was not a fair or impartial expert and had not carefully considered all of the Downey records.

209. Dr. Chih also did not recall seeing the lab report from the hemodialysis center, that documented the patient's Hgb A1c results on three different dates. Dr. Chih did not list those records as having been reviewed in her report and did not think they were provided to her. That report showed that on January 4, 2017, the patient's A1c result was 8.0. The report also contained past values documenting that her results on September 23, 2016, were 10.1 and her results on December 9, 2016, were 9.0, which showed that over time, the patient's A1c levels were improving. Dr. Singh was aware of these labs when he was treating the patient.

210. When asked why she did not reference such key points in her report, Dr. Chih fumbled through her answer stating how there are "lots of contacts," she has "to summarize the care," and "stick to the key facts," none of which made sense given that Dr. Singh's review of the January 13, 2017, lab results on January 13, 2017, and making no new orders were important factors in Dr. Singh's favor, as was his knowledge of the patient's improving A1c labs. Dr. Chih also did not report that the January 13, 2017, lab results were referenced again in a January 17, 2017, dietician note and twice on that

day Dr. Singh was advised of the patient's condition; once regarding wound care and once regarding a change in condition. At neither time on that day did he order Metformin. Dr. Chih omitting these critical facts from her report made her appear biased and her opinions unreliable.

211. Instead, after Dr. Chih noted the patient's January 5, 2017, readmission to Downey, her next reference was the January 19, 2017, entry where she reported:

> On 1/19/17 at 13:54, nursing documented that Dr. Singh saw lab results and added Metformin [page reference]. Verbal order for Metformin in an illegible amount twice a day per Dr. Singh was documented [page reference]. On 2/9/17 [*sic*], Dr. Singh electronically signed the verbal order taken on 1/19/17 for Metformin 1000 mg twice daily [page reference].

212. Dr. Chih agreed that Nurse Mielke claimed it was a verbal order given for Metformin, but documented it as a phone order. Dr. Chih testified that a telephone order is not consistent with a verbal order, although it would depend on the facility's electronic medical record keeping system; the two are not mutually exclusive. Dr. Chih's report also summarized the January 23, 2017, course of treatment at the hospital where the patient expired. She noted that "no autopsy was requested."

213. Much of Dr. Chih's direct examination was little more than her being asked leading questions to which she merely answered "Yes" or "No," or read from the records. While it is permissible to ask an expert leading questions (*People v. Campbell* (1965) 233 Cal. App. 2d 38, 44–45), doing so repeatedly, even regarding foundational matters, as was done here with Dr. Chih, made her testimony much less persuasive

than had she been asked open-ended, non-leading questions. Her report contained selected entries that cast Dr. Singh in a poor light and she omitted entries that were favorable to him. Although she testified that she was being fair and impartial, and was simply documenting important entries in her report, that testimony was not credible and sounded disingenuous.

214. On cross-examination, Dr. Chih agreed that most SNF physicians typically visit a facility only once per month, perhaps twice; and Dr. Singh going to Downey twice a week was "far, far more frequent" than other physicians. Dr. Chih also admitted that the records showed that Dr. Singh had numerous contacts with the patient.

DR. BLACK'S REPORT AND TESTIMONY

215. Dr. Black used a more common sense approach when analyzing the records and he had considered all of the evidence. In his report, Dr. Black documented the patient's extensive medical history. He noted the January 12, 2017, pharmacy recommendation for an Hgb A1c test, and the January 13, 2017, notes documenting that the results were relayed to Dr. Singh and "no new orders" were given after the lab result was reported. Dr. Black also documented the January 17, 2017, dietitian note which again documented the January 13, 2017, A1c results, and that the patient was on sitagliptin (a medication for diabetes sold under the brand name Januvia) and NovoLog for blood sugar management, and the plan was to continue with her diet as prescribed and encourage compliance.

216. Dr. Black referenced the January 19, 2017, nursing notes and order and the "somewhat illegible" handwriting on the January 13, 2017, lab report. He detailed the patient's January 23, 2017, admission to White Memorial Hospital where she had a temperature of 92.3 and blood pressure of 64/51. Her labs showed a WBC count of

42,800, hemoglobin 9.2, lactic acid level of 21.6, blood gas pH<6.91, albumin 2.2, and Hemoglobin A1c 7.6. She was diagnosed with septic shock and lactic acidosis secondary to severe sepsis and possible ischemic bowel. She was admitted to ICU where she was intubated and started on bicarbonate drip. However, the vasopressors initiated in the emergency department began to fail and further aggressive treatment was withheld due to the patient having a DNR on file.

217. Dr. Black testified there was a great amount of support in the records for Dr. Singh's claim he did not order the Metformin. The patient was on Januvia and a sliding scale insulin program, both of which, unlike Metformin, are not first-line medications for diabetes. The sequence of the A1c results showed the patient was improving. Dr. Singh did not change his orders when her A1c labs were worse, so it would not make any sense that when he got "the best" A1c lab result on January 13, 2017, he would suddenly change the patient's medications, let alone change them to a "first line" medication. "That simply goes against common sense." Dr. Singh also made no changes when the labs were reported to him on January 13, 2017, so Dr. Black asked rhetorically, Why would he make changes six days later for the same lab results?

218. Dr. Singh also had numerous contacts with this patient, making him well aware of her condition, so he would know not to prescribe Metformin to her. The dosage recorded is not a starting dosage, so it would not make sense that Dr. Singh would have ordered 1000 mg twice a day, especially on a patient who was undergoing hemodialysis and had kidney disease. Thus, Dr. Black "finds it very unusual" that Dr. Singh gave this order. Everything else Dr. Singh did for this patient was appropriate; all of it was within the standard of care. There "are no outliers," but "all of a sudden" there is this Metformin order, "one small little thing that makes no sense whatsoever" that is "intentionally glaring." There were also inconsistencies in the records, including

documentation of a phone order but the nurse claiming it was a verbal order. Dr. Black does not know if Metformin was ordered because of a miscommunication, misidentification, or an error, but does not believe Dr. Singh ordered it for this patient.

219. Dr. Black addressed the gross negligence and dishonesty allegations in his report. The dishonesty claim was based, in part, on Dr. Chih's opinion that because Dr. Singh countersigned the order, he was responsible for it. In evaluating those allegations, Dr. Black wrote:

> There are several points to consider when weighing the validity of Dr. Singh's claim [that he did not give that order]:
>
> a. [The patient] had been a patient at Downey Care Center for over three months before the event in question and, as pointed out in the above summary, her glucose was consistently elevated. Yet, her medication regimen for diabetes never deviated from the low-dose Januvia 25 mg daily and the insulin sliding scale. This would not have been the first time Dr. Singh was made aware of the patient's diabetes status, and if he did not change her regimen before, he would have had no reason to change it for hemoglobin A1c of 7.5
>
> b. There is documentation that the hemoglobin A1c result of 7.5 was relayed to Dr. Singh on 01/13/2017, and no change to the treatment was ordered. Why then would he be contacted six days later to be given the same result on the same patient? And if he did know he was being given

results on [patient] again, why this time would he make a different decision and start new medication?

c. There is inconsistency in the nursing notes. The note entered on a 1/19/2017 at 13:53 says that communication with Dr. Singh was by phone, whereas the note from 13:57 states that Dr. Singh ordered the Metformin when he came to see the [patient].

d. According to [Ms. Lim], Dr. Singh had stated to her that he was not near the computer when he gave the order for Metformin, so he did not have all the information with him such as the patient's creatinine clearance. With [patient] being an end stage renal patient receiving hemodialysis three times per week, it would not have been necessary for Dr. Singh to look up her creatinine clearance in order to know Metformin was contraindicated. This is further evidence that Dr. Singh thought he was being called about a different patient.

e. [Ms. Lim's] assertion that "the patient died of lactic acidosis after receiving 7 doses of Metformin" is not supported by the evidence. The markedly elevated WBC count strongly suggests overwhelming sepsis as the cause of death, as well as the reason for lactic acidosis. This is largely academic, however, since outcome would not be a factor in determining whether the standard of care was followed.

f. As any physician who has worked in a hospital or nursing facility knows, signing off on verbal orders can be a time-consuming and tedious process. A large stack of charts or cluttered inbox on the computer makes it exceedingly difficult to closely examine each and every order for accuracy. Providers very often speed their way through the signing process, trusting that the orders they have given were taken down correctly. While technically true that Dr. Singh was responsible for the order he countersigned, if the objective of this investigation is to arrive at the truth than the notion that a countersigned order somehow proves Dr. Singh's dishonesty is an absurd proposition.

220. In his conclusion section analyzing these causes for discipline, he wrote:

For Dr. Chih to have concluded there was an extreme departure and for the Medical Board to accuse Dr. Singh of gross negligence and corruption/dishonesty, one would expect there to be ironclad proof that events transpired as suggested in the accusation. On the contrary, the evidence seems to point more toward Dr. Singh's claim being true, that the information he was given over the phone by a nurse at the SNF was pertaining to a different patient and not [the patient]. It is impossible that Dr. Singh was not aware of [the patient's] renal status and it is almost inconceivable that a physician of his experience would not have known to avoid Metformin in such a patient. This

> unfortunate event was the result of poor communication, but *there was no departure from the standard of care.* (Emphasis in original.)

Accordingly, Dr. Black determined there was insufficient evidence to conclude that Dr. Singh gave this order or acted below the standard of care.

221. Dr. Black further opined that the evidence suggests that Dr. Singh believed he was being asked about a different patient when he was interviewed by Ms. Lim. His responses that he did not look up her creatinine levels and was not near a computer would suggest that he believed he was being asked about another patient as Dr. Black is confident Dr. Singh knew this patient was a dialysis patient.

222. On cross-examination complainant's counsel questioned Dr. Black about the medical board expert reviewer guidelines, requiring that experts not be advocates and not make various determinations, none of which was persuasive because Dr. Black was not retained as the medical board's expert in this matter and he was not advocating. Simply arriving at a different opinion and setting forth the bases for it, did not make him an advocate. Moreover, his report did not violate those tenets. Nothing in Dr. Black's presentation or report made him appear biased or unfair. His use of the word "absurd" was amply justified given the evidence presented. As Dr. Black credibly explained, he reviewed all the records, analyzed the case in the context of how physicians work in a SNF, spoke with Dr. Singh, and used a "common sense" approach when formulating his opinions. Based upon his evaluation, the evidence more strongly supported Dr. Singh's position than the evidence to the contrary.

223. Dr. Black testified that he applies the medical board expert reviewer tenets when evaluating matters, as he sees his role as getting to the truth, and using

fairness. He acknowledged there may be times when he is more subjective in his opinions as a respondent's expert, but overall, he is always trying to be "fair and equitable and get to the truth." He does not make pronouncements regarding guilt or innocence, but he may comment if he feels someone is being treated unfairly. He disagreed with complainant's counsel that he did not apply the tenets when working on this matter.

224. Dr. Black claimed he is not advocating for Dr. Singh when he concludes that Dr. Singh did not prescribe the Metformin. Instead, he reviewed the evidence and concluded that Dr. Singh's claim was more likely than the alternative. Just because he arrived at that conclusion, does not make him an advocate. Further, he explained that when he performs evaluations as the medical board's expert, he only arrives at an opinion regarding an extreme departure if it is very clear that an extreme departure occurred, because he knows the consequences of rendering that opinion. He believes that in order to formulate such an opinion, he needs proof that what he thinks occurred, actually occurred, and reading these records, he could not come to a conclusion that the events transpired as complainant alleges.

This is why he does not think that the records support a finding of an extreme departure from the standard of care. He believes the medical board should have had more proof before reaching an extreme departure finding. Dr. Black did not see anything in the records that was below the standard care, let alone an extreme departure. Instead, he saw what he would expect to see from a physician providing proper care. He does not know how Dr. Chih could find an extreme departure based on these records.

225. Dr. Black testified that countersigning orders is a time-consuming and tedious process. It is clear that Dr. Singh did not examine the order closely or he would

have noticed the Metformin issue. To conclude that a countersigned order is "proof" that Dr. Singh issued the order and is being dishonest is "an absurd proposition." Knowing how orders are signed and countersigned, and knowing how the process works, "to conclude that when a physician signs every order he knows when, who, what, etc. was ordered and if he later says anything different he is lying, is ridiculous. You cannot draw conclusions from a signed order."

Dr. Black stated that orders are often grouped together, an assumption borne out by Dr. Singh's testimony, and, especially when they are signed electronically, it is easy to make mistakes. He also noted the length of time between the order being given and when it was electronically countersigned and there are issues about what the physician's schedule might look like the day he is signing the orders and whether the physician has an opportunity to research each order he is countersigning to ensure its accuracy. Dr. Black explained that lots of factors go into countersigning orders and it is not realistic to conclude that a countersigned order is proof the physician gave the order. This is a "more absurd and ridiculous" conclusion.

226. Further, given Dr. Singh's specialty, experience, expertise, and his position, he would have known not to give Metformin to this patient. And while it is true that mistakes happen, a reading of the records does not support complainant's version and it is most likely that this error occurred because of poor communication, probably by the nurse, but Dr. Black is not able to determine where the breakdown happened. He can theorize which individual miscommunicated, and does not want to "throw anyone under the bus," but based on his review of the records, it is unlikely it was Dr. Singh.

227. On balance, Dr. Black's opinions were more reliable, reasonable and persuasive than Dr. Chih's. He had also considered all the evidence. Although

complainant argued that Dr. Black's use of the word "absurd" indicated that he was an advocate for Dr. Singh and not a fair and impartial expert, his use of that word did not so indicate. Rather he used it to express his disbelief with Dr. Chih's opinions which, given the evidence, was not far off. Additionally, he had spoken with Dr. Singh and, using that information, determined that Dr. Singh's version of events was supported by the records. Dr. Black's common sense approach made much more sense than Dr. Chih's opinions to the contrary and was amply supported by the evidence.

228. Complainant did not establish that Dr. Singh ordered Metformin for this patient or committed any departure from the standard of care, let alone an extreme departure from the standard of care.

Evaluation of Second Cause for Discipline: Repeated Negligent Acts

229. In the "Second Cause for Discipline (Repeated Negligent Acts)" at Paragraph 26 of the accusation, complainant alleged:

> [Dr. Singh] committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged hereinafter:
>
> (a) Paragraphs 5 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein; and
>
> (b) Prescribing opiates and hypnotics to a patient with a baseline oxygen requirement and renal impairment.

As noted above, paragraphs 5 through 24 set forth facts and paragraph 25 contained the alleged act of gross negligence.

DR. CHIH'S REPORT AND TESTIMONY

230. In her report, Dr. Chih wrote that "opiates and hypnotics both cause central nervous system depression and can decrease respiratory drive." Concurrent use of opiates and hypnotics "is likely to place patients at greater risk for potentially fatal overdose." She referenced an August 2016 FDA drug safety communication which advised healthcare professionals to limit prescribing opioid pain medications with other central nervous system depressants only to patients for whom alternate treatment options were inadequate. She wrote: "If these medications are prescribed together, the dosages and duration should be kept at the minimum possible while achieving the desired clinical effect. Patients and caregivers should be warned about the risks of sedation and respiratory compromise."

231. In concluding that it was a simple departure from the standard of care to concurrently prescribe opiates and hypnotics, Dr. Chih wrote:

> This patient already had a baseline oxygen requirement at least partly due to chronic volume overload from dietary noncompliance and nonadherence to HD regimen. She was also on morphine sulfate, the metabolite of which can accumulate in the setting of renal impairment, and zolpidem. She is at very high risk of respiratory compromise with concurrent prescriptions of both [central nervous system] depressants. No documentation on evaluation of dose reduction of either medication was seen. However, she was at a SNF so monitoring would be better than if she was at home. She also appeared to have tolerated the

combination of opiates and hypnotics in the past under the previous position in the SNF.

232. Dr. Chih testified that the patient was on oxygen, had renal failure, and other risk factors, so prescribing opiates and hypnotics was a simple departure from the standard of care because the patient had been on these medications before and she was being treated in a monitored environment. Dr. Chih explained that Morphine Sulfate and Norco are narcotics and Ambien is a hypnotic, both of which depress the respiratory system. A patient on supplemental oxygen, already has a compromised respiratory system, so a physician should stop or not order medications that depress respirations. Additionally, Morphine Sulfate is metabolized by the kidneys which can cause prolonged effects on the renal system and this patient already had a compromised renal system. The patient also had chronic fluid overload which makes it difficult for the exchange of oxygen, another reason not to prescribe these drugs.

233. As a basis for her opinion, Dr. Chih assumed that the patient was on supplemental oxygen. However, that opinion was not borne out by the records. Although the patient was noted to be on oxygen when discharged from the hospital and a few times while at Downey, nothing in the records supported a finding that she was on supplemental oxygen throughout her stay at Downey. In fact, the records demonstrated that she was not on oxygen for the majority of her time at Downey, and her oxygenation levels were very good On cross examination, Dr. Chih acknowledged that it was "not clear" from the records when oxygen was administered to the patient and did not know whether the patient was routinely on oxygen or room air and admitted there were entries in the records that the patient was on room air with oxygen saturation levels of 95 or 98 percent.

234. Dr. Chih also acknowledged that long before Dr. Singh cared for the patient, she had been on opioids and hypnotics, but she does not believe those medications were as severe for renal patients as was the Morphine Sulfate. However, when asked how often the patient was given the Morphine Sulfate, which had been ordered PRN, she was unable to answer that question; nor could she answer that question for the Ambien prescription. When she was directed to the Downey records, Dr. Chih agreed that after Dr. Singh assumed care of this patient, she only received Morphine Sulfate twice in December; before he assumed her care, she received it eight times at Downey. She noted that the patient had been prescribed benzodiazepines but had not received those while at Downey, so she did not include those in her report. Dr. Chih was unaware of any of the patient's prior medical treatment other than what she read in the hospital and facility records provided to her.

235. Dr. Chih agreed that treating physicians do not want the SNF physician discontinuing medications and that when the patient was discharged from the various hospitals, none of the discharging physicians recommended discontinuing her medications. She also admitted that the patient was prescribed opiates and hypnotics the entire time she was at Downey. The only change she saw was that the patient was discharged from Kaiser on Dilaudid not Morphine Sulfate, which she interpreted to mean that the discharging physician did not recommend Morphine Sulfate. However, that was merely her assumption, she had no evidence to support it.

236. Dr. Chih was not aware of Downey's pain criteria, but facilities do evaluate patients for pain. The use of opioids and hypnotics put the patient at "very high risk" but she could not quantify that number. As to whether the patient had any side effects from the opioids and hypnotics, she did have constipation which can be

caused by opioids but "in terms of respiratory depression," Dr. Chih did not see that the patient had any side effects caused by these medications.

DR. BLACK'S REPORT AND TESTIMONY

237. In his report, Dr. Black addressed the use of opiates and hypnotics and opined that there was no departure from the standard of care. He noted the concessions Dr. Chih made in her report that the patient was being monitored at a SNF and had tolerated the combination of opiates and hypnotics in the past as prescribed by prior physicians. Dr. Black then wrote:

> The management of patients in a skilled nursing facility is not the same as in an acute care setting such as a hospital, or even as in the outpatient clinic. Patients are usually rehabilitating from acute illness, and is not expected that physicians in the SNF will make major changes to patients' treatment regimens. In fact, primary care physicians in the community generally prefer their treatment plans not be altered by SNF doctors who are not as familiar with the patients. In this particular case, reducing the dosage of one or both of the medications the patient was tolerating could easily have precipitated withdrawal symptoms, which nursing facilities are ill-equipped to handle.

238. Dr. Black opined that the patient had been receiving opioids and Ambien before, prescribed by other physicians, and Dr. Singh made no changes to that order, which was within the standard of care. The patient only received two doses of Morphine Sulfate, one on December 24 and one on December 30, because the

medication was prescribed "PRN." 15 mg of morphine sulfate is an immediate release and "the lowest dose the medication comes in." It is "a rather small dose," so one dose per day is not very consequential, it is a low dose. The records showed that the patient was given the option of Norco or other medication for pain, there had been titrating of her medications, different medications had been tried, and she received the best pain relief from the Morphine Sulfate.

239. Pain medications were not contraindicated for this patient who had chronic pain. Prescribing medications "all boils down to the fundamental question - do the benefits outweigh the risks?" A physician tries to mitigate or minimize risk. A patient with severe pain for whom a prescription works well, and someone like this patient who is at the end of life, and in a SNF bed, the risk was very acceptable. It was a small dose given infrequently with no significant contraindications, and fell within acceptable pain management guidelines.

240. Dr. Black opined that there was no departure from the standard of care by prescribing opioids and hypnotics to this patient. The patient was being monitored in a facility, there was no change to other orders given for these medications, and the low dosage was a minimal risk. The records showed there was an adequate basis for the prescriptions and Dr. Singh complied with the standard of care.

241. Dr. Black's opinions were more persuasive than Dr. Chih's to the contrary. She based her opinions on possible risks, and likely outcomes, and failed to take into account the long-standing history of the patient taking these medications or that the records repeatedly documented her obtaining successful pain relief. Dr. Singh's orders were consistent with other physician's orders, his addition of Morphine Sulphate was adequately explained, and his sliding scale of pain relief and when to administer which pain medication PRN was properly documented.

242. Complainant did not establish that Dr. Singh engaged in any departures from the standard of care when he prescribed hypnotics and narcotics to this patient, let alone a simple departure from the standard of care.

Evaluation of Third Cause for Discipline: Dishonesty

243. In the Third Cause for Discipline, at paragraph 27, Complainant alleged Dr. Singh was dishonest because during the California Department of Health investigation of the patient's death, and in his summaries of care sent to the medical board, he did not deny prescribing Metformin, but at his medical board interview, he denied prescribing it and claimed the nurse made an error.

DR. CHIH'S REPORT AND TESTIMONY

244. Although Dr. Chih's report contained a section entitled "Issue of verbal orders," wherein she discussed the standard of care for issuing verbal orders and rendered opinions, complainant did not charge this as a cause for discipline. Instead, complainant alleged that Dr. Singh was dishonest during his board interview when he claimed that he did not prescribe Metformin for this patient. Dr. Chih did not offer any specific testimony regarding this allegation, but did note in her report:

> During the interview, it appeared that Dr. Singh reported initially that the nurse did not identify the patient with diabetes not under control called to him (phrasing was not clear). He mentioned that Metformin would be the drug of choice for this condition. Then he said that the nurse identified one of the new patients as the patient needing the Metformin. He reported that he always asked specific

sets of questions when giving verbal orders, but did not remember what they were in this case. . . .

DR. BLACK'S REPORT AND TESTIMONY

245. As noted more fully above in Factual Finding Nos. 215-228, Dr. Black did not find that Dr. Singh had been dishonest.

DR. SINGH'S LETTERS TO THE COUNTY AND THE MEDICAL BOARD

246. In the two letters that Dr. Singh authored, he merely wrote: "Patient had Metformin started on 1/19/17 with two times a day dosing." He never referenced the dosage nor stated who issued the Metformin order. As he credibly explained, it was his understanding that the investigations centered on the patient's cause of death and he was writing letters opining that she did not die because of the Metformin. Nothing in those letters contradicted his statements given during his board interview. There is a vast difference between not stating all the facts and stating two different versions of the facts. Here, as the letters clearly demonstrated, Dr. Singh was focused on the patient's cause of death and not how she came to be prescribed Metformin. He adequately and credibly explained why he wrote the letters he did and stated this at the HQIU interview. He was not dishonest

247. Dr. Singh also credibly testified that his phone call with Ms. Lim was the first time he was aware of the Metformin prescription issue. His testimony that he reported this matter to the Downey Director of Nursing was unrefuted. While it is true that both Nurse Mielke and Dr. Singh would have reason to blame the other for the Metformin order, the records more clearly supported Dr. Singh's version of what occurred.

248. Nurse Mielke could not explain why six days later she came to possess this lab report or contact Dr. Singh about it. Her presentation at this hearing was extremely poor and she made a non-credible witness. In contrast, Dr. Singh never wavered in his testimony, no reliable documents demonstrated that he ordered Metformin for this patient; the only document "authored" by him was his countersigning an order, but that document contained two orders on it, was executed weeks after the patient had died, and did not "prove" that he ordered Metformin. On balance, his several months of treating this patient, and the consistent orders he gave, makes it improbable that he would have ordered Metformin for this patient.

249. The evidence also supported a finding that the Metformin order was given by telephone. Given that he received a call about this patient six days later with information about "new onset diabetes," it is completely plausible and reasonable that Dr. Singh gave an order for a different patient and Nurse Mielke erroneously placed that order in this patient's chart. On balance, this was the much more likely scenario, then the assertion to the contrary.

250. Dr. Singh's testimony was also unrefuted that the medical board interview was the first time he was ever given an opportunity to fully discuss his care and treatment of the patient and the events surrounding the Metformin order. His statements during that interview were consistent with his testimony at this hearing and supported by the records. There was nothing dishonest about those statements. Further, it can hardly be concluded that his "brief, less than five minutes" telephone call with Ms. Lim, where he had no access to records, and where her summary of the conversation contained numerous errors and was unreliable, provides any basis to find that he was dishonest.

251. Nothing in these records or in the investigations demonstrated that Dr. Singh was ever dishonest. Complainant failed to establish that cause for discipline.

Character Witnesses' Testimony and Letters of Support

252. Dr. Singh described the extensive length of time, between eight and 25 years, that he has known the individuals who testified and/or wrote letters on his behalf. He has worked "very closely" with most of them on both committees and providing patient care.

MEHER TABATABAI, M.D.

253. Meher Tabatabai, M.D., testified in this hearing, wrote a letter to the board, and a copy of her curriculum vitae was introduced. She graduated from St. Joseph College in Karachi, Pakistan. She received her medical degree from Dow Medical College, M.B.B.S., in Karachi, Pakistan. She was a junior resident in 1996 at Civil Hospital in Pakistan. She did an internal medicine residency at Franklin Square Hospital in Baltimore, Maryland from 1978 to 1981, and was the Chief Resident there from October 1981 to June 1982. She worked in private clinics in 1982 in 1983 and then did a fellowship in infectious diseases at Rancho Los Amigos Hospital from 1984 to 1987. She is board certified in both internal medicine and infectious disease.

Dr. Tabatabai was a Clinical Fellow in infectious disease at the University of Southern California School of Medicine from 1984 to 1987 and has been a Clinical Associate Professor of Medicine there since 1987. She has served as both a member and chair of numerous committees, including chairing the Infection Control Committees at both PIH Downey, Kindred and Promise Hospital, serving on the Executive Committee at several hospitals, serving on the Medical Policy Committee at PIH Downey, the Credential Committee at Promise Hospital and the Peer Review

Committees at both Promise Hospital and Kindred Hospital. She received the American Top Physician Award in 2007, 2008, 2009, 2010, 2011, 2012 and 2013. She has been published in several peer-reviewed journals and lectured more than 50 times.

254. Dr. Tabatabai authored an undated letter on Dr. Singh's behalf, noting she "takes great pride in writing this letter" and has known Dr. Singh for over 20 years. He is "a very qualified doctor." "His dedication and devotion to his patients is exemplary. I have worked with him on numerous cases and he is absolutely committed to providing the best [patient] care." She wrote further that Dr. Singh "possesses exceptional leadership qualities and has served as our Chairman of Medicine and Chief of Staff. He is a valued member of our [Medical Executive Committee]." Dr. Singh "is a devoted family man, a loving and kind father, loyal friend and a superb doctor." He "is a very well respected physicians [*sic*] and is liked by his colleagues, nurses and paramedical staff and his patients, simply love him."

255. Dr. Tabatabai testified about Dr. Singh in extremely glowing terms. She first met him in 1995 when he joined her private practice group. They were "very good colleagues" and they worked together on multiple internal medicine and cardiac patients. She values his "honesty, skills and dedication to his work." Over the years he has become a "dear friend of mine." She described his career as "pretty amazing," both for his medical and his leadership skills. He is triple board certified. She has worked with him on a number of cases and he always "provided excellent care." He is "honest to a fault" and "will correct people." From 1995 to the present, he is the only physician who has been elected as Chief for four different tenures. He has been the Chief of Staff and the Medical Director at St. Francis. Dr. Tabatabai explained that this "speaks volumes about him; no one would be elected to so many leadership positions if we did not believe he is a good person."

Dr. Tabatabai explained that St. Francis is a huge hospital, it has "a big trauma center which is excellent for strokes and myocardial infarctions" and there is a pretty large medical staff. Dr. Singh was elected unanimously four times. He is a very fair person, extremely honest, and she has never had any negative interactions with him either on a professional or personal basis. Professionally he is "an excellent physician, dedicated and hard-working." He is also "a great family man, he is a father, a devoted husband, and a great friend."

Dr. Tabatabai was not paid to testify and traveled from Diamond Bar to Dr. Singh's attorney's office in Irvine, giving up half a day of her practice, because she felt it was "something needed, I owe it to him, he is a good physician." She explained that she has "worked so closely with Dr. Singh on so many patients and he is very hard-working, very honest, and very dedicated. I cannot say enough about him, he is truly a physician's physician."

256. On cross-examination she admitted she only learned of this matter within the past year. She learned recently that Dr. Singh was working at Downey, but this did not surprise her as a lots of her colleagues practice in acute care facilities.

MICHAEL SCOTT, M.D.

257. Michael Scott, M.D. testified in this hearing, authored a letter to the board, and a copy of his curriculum vitae was introduced. Dr. Scott was born in Guyana. He graduated from Stanford University in 1967 with a Bachelor of Arts in Biological Sciences. He graduated from Northwestern University Medical School in 1971. At Los Angeles County-University of Southern California Medical Center, he did his internship in straight surgery from 1971 to 1972, and his residency in urology from 1972 to 1976, where he was Chief Resident from 1975 to 1976. He did a fellowship at

Los Angeles County-University of Southern California Medical Center-Rancho Los Amigos Hospital in neuro-urology and reconstructive urology from 1976 to 1977. Dr. Scott is board certified in urology, and a fellow of both the American College of Surgeons and the International College of Surgeons. In 1976 he received a First Award at the National Medical Association Meeting for his paper entitled "Diagnosis and Management of Undescended Testes."

Dr. Scott was an Associate Clinical Professor of Surgery, Division of Urology, University of Southern California from 1978 to 1998. He was Chief of Surgery at St. Francis Medical Center from 1988 to 1982 and again from 1994 to 1995, and served there as the Chief of Urology on two separate occasions. He was a member of the Board of Directors of the California Medical Review, Inc., from 1985 to 1992, serving as the Secretary from 1990 to 1992. He was the Chairman of the Urologic Program for the National Medical Association Convention in 1987. He has given many lectures and presentations, authored several peer-reviewed publications, and is a member of several medical societies.

258. Dr. Scott authored a letter to the board on August 22, 2020. Dr. Scott joined the St. Francis Medical Center medical staff in 1977 after completing his residency in urology and fellowship in neuro-urology at USC Rancho Los Amigos Medical Complex. He has served in many capacities at St. Francis Medical Center, including being Chief of Surgery twice and being Chief of Staff. Dr. Scott has also served on various organizations, including the Board of California Medical Review Institute, PSRO/PRO, the review organization which evaluates the practices of hospitals and medical practitioners for Medicare, ultimately serving as Secretary. In his many roles, he has been involved in the review of many physicians' practices. Dr. Scott

described Dr. Singh's board certifications and practices and has known him for more than 30 years. Dr. Scott wrote:

> Dr. Singh is a dedicated cardiologist who always utilizes his best clinical skills to give effective treatment to all of his patients. He consistently communicates with his patients and addresses all of their concerns. He maintains an active role in establishing and keeping open communication with his peers, the nursing staff and all entities responsible for the care of his patients. He is exemplary and his effort to create a very positive patient environment [*sic*]. Most of all he is very empathetic and maintains easy accessibility to his patients, staff and peers.
>
> Dr. Singh has balanced the demands of his patients with dedication to the medical staff leadership roles. During his tenure at St. Francis he served the medical staff with distinction in various capacities and was elected by his peers to serve as chairperson in the Division of Cardiology and Department of Medicine. He was elected Chief of Staff-Elect and subsequently, affirmed as Chief of Staff. He served unselfishly in these positions with dedicated professionalism. In these capacities, Dr. Singh played a vital role in the quality assurance program of our hospital and led the medical staff in obtaining high praises from the medical review bodies.

> Personally I have been involved in jointly caring for many patients. His professionalism is paramount, his knowledge base excellent and his technical skills are unbeatable. So much so that when I developed a cardiac issue, my cardiologist referred me to Dr. Singh to perform the intervention. My family sings praises to him.
>
> I can, therefore, personally attest to his compassion, dedication, competence and professionalism with enthusiasm.

259. Dr. Scott testified that he met Dr. Singh in 1992 when the latter joined the St. Francis staff. If Dr. Scott's patients needed a cardiac evaluation, he would refer them to Dr. Singh or his group. Dr. Singh would refer patients requiring urology evaluations to Dr. Scott. Dr. Singh and Dr. Scott shared multiple patients. All patient reports that Dr. Scott received over the years were positive. Both Dr. Singh and Dr. Scott had the same approach to treating patients, they treat them as if they are members of their family. Dr. Scott observed that Dr. Singh treats patients with great kindness and a great degree of affection. He is very endeared to his patients. Dr. Singh's competence has never been in doubt, the difference is how kindly he treats his patients and that is very important to them.

Dr. Scott and Dr. Singh have "shared many capacities" at St. Francis. Dr. Singh was very interested in the basic functioning of the medical staff, medical staff activities, qualifications and expertise. He and Dr. Singh participated in the Utilization Committee which evaluated the quality of care rendered to patients, alternately chairing the committee. Dr. Singh served on the Executive Committee which is responsible for chairing the departments and he was very involved in the quality of care evaluations.

He was elected to leadership positions, which are not compensated positions, require lots of time and devotion, and made Dr. Singh responsible for taking care of all issues affecting the medical staff. Some of the issues are discipline, some are education, and some are reviewing medical practices. In those roles, Dr. Singh "epitomizes what we would all like to be in the role of leadership. He participated in developing the medical staff, extended himself, and extended all things necessary that are required to become a leader." Dr. Singh performed these duties in combination with his medical practice and kindness to patients and did it with "a tremendous amount of enthusiasm."

Dr. Singh's professionalism "is second to none." Dr. Scott has admired Dr. Singh's development of the medical staff and the very innovative ways he has brought things to the medical staff which has improved the function of the medical staff. Dr. Scott traveled from Pasadena to Irvine to testify because, "Dr. Singh represents one of the stalwarts in the medical staff and he is very supportive of me in leadership and I am very supportive of him in his role of leadership staff."

260. On a personal note, Dr. Scott advised that he has atrial fibrillation and was referred to a cardiologist and selected Dr. Singh who ordered the necessary angiographic exam. Dr. Scott "had a wonderful experience, my family sings his praises, my sons were there when the results were obtained and Dr. Singh's professionalism was second to none." Dr. Scott is "just so grateful to him."

261. On cross-examination Dr. Scott testified that he became aware of this matter approximately two months ago. He did not know Dr. Singh practiced at Downey until that time. He and Dr. Singh are very close professionally, but do not share a personal relationship outside of socializing at medical staff events. Dr. Singh did not discuss the Metformin prescription issues with Dr. Scott.

DOUGLAS SEGAL, M.D.

262. Douglas Segal, M.D., testified in this hearing, wrote a letter to the board, and a copy of his curriculum vitae was introduced. Dr. Segal graduated with honors from New College of the University of Florida, Honors College for the Florida State School System, with a Bachelor of Arts degree in 1991. He received his medical degree under the auspices of the New York State Board of Regents from Sackler School of Medicine, New York American Program, University of Tel Aviv, Israel. He did his residency in internal medicine at Montefiore Medical Center, Albert Einstein College of Medicine from 1996 to 1999. He did a cardiology fellowship from 1999 to 2002 at University of Iowa Hospitals and Clinics. He did an interventional fellowship from 2004 to 2005 at George Washington University Hospital in Washington, DC.

Dr. Segal is board certified in internal medicine and board eligible in interventional cardiology. He is adult echocardiogram certified, nuclear cardiology certified, and ABIM cardiovascular disease board certified. He has received several awards including the Cardiovascular Interdisciplinary Research Fellowship-Institutional NRSA funded by NIH in 2000-2001, and was granted a position in the Clinical Epidermiology Curriculum and a seat on the Faculty Journal Club in medical school. He has been involved in several research projects and has a publication regarding vasoconstriction. Since 2007, Dr. Segal has practiced cardiology in Lynwood and Downey. He has been the Chief of Cardiology since 2015, the Director of STEMI (ST-elevation myocardial infarction) since 2014, and the Chief of the Cath Lab, all at St. Francis Medical Center.

263. Dr. Segal authored a letter to the board on July 23, 2020, which was consistent with his testimony. He identified himself as a interventional cardiologist who has been practicing in Southern California for the past 15 years. He has been a

colleague of Dr. Singh's for the past 14 years and is currently the director of the STEMI program at St. Francis Medical Center. He was the past Chief of Cardiology. He wrote:

> My impression of Dr. Singh is that of an excellent cardiologist, clinician, and care giver. He is Brilliant, with an incredible breath [*sic*] clinical knowledge he has excellent clinical and critical thinking skills that make him among the top doctors in our hospital. He has demonstrated his leadership skills as Chief of Staff at our hospital and head of internal medicine. He was outstanding in this capacity and supervised several large projects that expanded medical services at our hospital. These included the initiation of a STEMI program and stroke program.
>
> In every capacity Dr. Singh has had, I have found him to be exceedingly reliable and dependable. Regarding patient care, he has demonstrated many times over the years that patient care is primary. He is an advocate for his patients. He has provided services at the hospital including pacemaker and ICD implantation gratis for indigent patients. His notes and instructions are noticeably clear, his handwriting is legible. He always contacts me regarding our mutual patients and updates me on patient care.
>
> In conclusion Dr. Singh is an extraordinary clinician who has been a mentor and role model. He has always displayed all the tenants [*sic*] of a doctor we strive for including clinical

judgment, empathy, clear patient communication and appropriate follow-up and outlined care plans.

264. Dr. Segal met Dr. Singh "almost immediately" when Dr. Segal moved to California in 2007, stating, Dr. Singh "is one of the more comforting people I encountered in the hospital." In every experience he has had with him, Dr. Singh "has been a mentor, listened to my thoughts when there were some difficulties with the practice I was in, or other issues." Dr. Segal explained that he went through a difficult time with his former medical group and Dr. Singh listened when he vented and guided him from a place where he did not know if he could be a success to where he is comfortable practicing cardiology. Dr. Singh is "very selfless." In his administrative roles, Dr. Singh has shown the same compassion. He will listen, then advise, and he is the same way with his friendships. Dr. Singh is not someone who "jumps the gun and tells you how it is," he listens and then provides thoughtful responses.

Dr. Segal acknowledged that he and Dr. Singh are "competitors" in the sense that they both practice cardiology in the same area, but Dr. Singh has always told physicians that there is enough work in the hospital "for all of us to be here." If Dr. Singh is treating a patient in the hospital and discovers it is a patient of Dr. Segal, he will call him to advise him that his patient has been hospitalized. There has never been a feeling of competition with Dr. Singh. Even Dr. Singh's other competitors will tell him that he is "probably the best Chief of Staff we have ever had at St. Francis."

265. On cross-examination Dr. Segal acknowledged that he heard about this matter approximately three months ago when Dr. Singh told him about it. They briefly discussed what was transpiring and as the hearing approached, Dr. Segal was filled in on more specifics by Dr. Singh's attorney. Prior to three months ago, Dr. Segal did not know that Dr. Singh worked at Downey. However, each of the practitioners with whom

Dr. Segal works hold roles at multiple places or institutions, all practice at places other than St. Francis, and he has seen all these physicians every day for the past 14 years, and he is not aware of what they do outside of their hospital, but he does know that all physicians have "outside gigs."

266. Each of these physicians who testified on Dr. Singh's behalf traveled several hours roundtrip to get to Dr. Singh's attorney's office. Even though their testimony lasted only a few minutes, their willingness to spend so much time traveling so they could testify on Dr. Singh's behalf was a testament to how highly they regard him. Moreover, their respect and admiration for Dr. Singh was palpable, even though each one testified via computer screen.

Character Witnesses' Letters of Support

267. Paiboon Mahalsavariya, M.D., FACC, Chief of the Cardiology Department at St. Francis Hospital, authored a letter to the medical board, dated September 23, 2020. Dr. Mahalsavariya has practiced cardiology for the past 26 years in Downey, California. He has known Dr. Singh for the past 25 years, having worked in the same area hospitals and frequently covering each other's patients, which has given Dr. Mahalsavariya "the opportunity to closely observe the type and quality of care Dr. Singh provides." Dr. Mahalsavariya wrote that Dr. Singh "exhibits great professionalism and responsibility, as evidenced by his numerous positions in the hospital over these many years." He had many responsibilities in these leadership roles and "delivered it in an excellent manner." Dr. Singh is a member in good standing in the American College of Cardiology, the Heart Rhythm Society and the American Medical Association, as well as at least four other hospitals in the LA County area. Dr. Mahalsavariya has observed Dr. Singh's "abilities and demeanor over these years and have found him to be competent and professional. He possesses good communication skills, and he shows

great compassion and concern for his patients." "Dr. Singh provides quality care to all of his patients regardless of their background or insurance status, as I witnessed this first hand when I refer patients to him for consultations."

268. Adrian H. Shandling, M.D., FACC, Assistant Clinical Professor of Medicine, University of California, Irvine, authored a letter to the medical board, dated July 27, 2020. Dr. Shandling is a cardiologist and electrophysiologist who practices in Los Alamitos California. He has known Dr. Singh for over a decade, and has "worked with him personally, including side-by-side in the electrophysiology laboratory." Dr. Singh's "training record is excellent as are his clinical and in-lab skills. He has empathy, the highest integrity, and dedication. I offer my support unequivocally." Dr. Shandling noted that he consults with Dr. Singh "on difficult electrophysiological cases and routinely works with him on complex in-lab electrophysiological cases." Dr. Shandling invited the medical board to contact him with any further questions.

269. Ricardo McKenzie, M.D., authored a letter on October 12, 2020. He has known Dr. Singh for "the better part of twenty years." Dr. Singh "is one of the premier cardiologists, to whom I have had the honor and pleasure of referring a large number of my patients. Amongst other qualities, he is knowledgeable, responsible, caring and communicative, which makes it easy to render excellent care to our patients." Dr. McKenzie wrote, "I recommend Dr. Singh without any reservation."

270. Reza Sharafi, M.D., is an internist with a primary care group in Downey, California, who has been active in several hospitals in the area. Dr. Sharafi authored a letter on October 26, 2020, noting that he has known Dr. Singh for more than eight years as a cardiology and electrocardiography consultant, Chief of Medicine and Chief of Staff at St. Francis. Dr. Singh "distinguishes himself as an exceptionally dedicated physician with passion for medicine in general." He always works very well with other

physicians and consultants and has had an exceptionally successful and respected career. He has served our medical community in different capacities including Chief of Staff and Chief of Medicine and is very well known in this community." He wrote:

> [Dr. Singh] is humble and gets along very well with his peers and staff and patients. He is a valuable physician in this community and has many patients who are reliant upon his care.
>
> Dr. Singh is a dedicated physician and is always up-to-date with current knowledge and practice of medicine. He is always professional and courteous and caring I have always received positive feedback from my patients that I have referred to him for consultation.
>
> His work habits are excellent, he is dependable, loyal and responsible.
>
> He is a kind of physician who other physicians rely upon his advice and guidance in unresolved or serious issues n [*sic*] medical field.
>
> He is an honorable person and is a great asset to our medical community in Downey, Lakewood, and Lynwood area where he practices.

Dr. Sharafi invited further contact for additional information if needed.

271. Arunpal Sehgal, M.D., authored a letter on July 29, 2020. Dr. Sehgal is board certified in internal medicine, pulmonary critical care and palliative care. He

works closely with Dr. Singh and "find[s] him to be a very caring physician. He is very well qualified. He provides excellent care to my patients." Dr. Sehgal described Dr. Singh's resume as "very impressive." He is "very proud to call him my colleague and my friend." Dr. Sehgal has "worked on numerous cases with him and I find him extremely professional, kind and he is always up-to-date with his knowledge. I find his medical knowledge and technical skills impeccable. He is a great leader, well respected physician, much liked by his colleagues and loved by his patients."

272. David Berger, M.D., F.A.C.P, F.A.C.E, practices endocrinology and metabolism and is the Chief of Staff at PIH Downey. He Authored a letter on August 2, 2020. He has known Dr. Singh since 1995, when he began his career in cardiology. "Over the years we have shared many patients together. The cardiac care he provided was exemplary. I have had complete confidence in his diagnostic acumen as well as therapeutic skills." He wrote that in addition to his medical practice, Dr. Singh "has been very supportive of the hospital as evidenced by his activity in various committees" which he then detailed. "On a professional level, I trust his judgment and common sense approach to patient care. I have always felt my patients were 'in good hands' under his very capable care. He continues to follow many of my patients for ongoing cardiac care. I find he is the utmost professional and his character is beyond reproach."

273. Maxine M. Anderson, M.D., F.A.C.S., authored a letter August 17, 2020, to the medical board. Dr. Anderson is a board certified general trauma surgeon and Chief of Staff at St. Francis Medical Center. She has known Dr. Singh since July 2005 when she joined the staff at St. Francis Medical Center. "Dr. Singh has been an exemplary profession [*sic*] and person. He has served on numerous leadership committees at the hospital from director to Chief of Staff." She described his work as both a physician

and Chief of Staff as "excellent." She wrote that "Dr. Singh has had no issues with his clinical decision-making or bedside manner. There has only been positive feedback. He continues to serve as a leader for our medical staff. I would recommend Dr. Singh without reservation to treat myself and my family members." She provided her contact information should the medical board require anything further.

274. Muhammed J. Memon, M.D., authored a letter on February 8, 2021. He has been practicing internal medicine in Southern California for the past 25 years and has been colleagues with Dr. Singh at the St. Francis Medical Center for more than 20 years. "Dr. Singh is an exceedingly reliable and dependable physician. He has demonstrated many times over the years that he is an advocate for his patients and their care is primary. He has provided services at the hospital as cardiologist and [electrophysiologist] specialist." He wrote that Dr. Singh "has exhibited his leadership skills as Chief of Staff at our hospital and is currently medical director. He is outstanding in this capacity and has supervised many large projects that expanded adequate services at the hospital, which include the initiation of a STEMI program and stroke program." He wrote further: "Dr. Singh has excellent clinical skills that make him one of the top doctors in our hospital. He is an excellent cardiologist and great human being and he has established himself as a great physician with excellent qualities. I highly recommend Dr. Singh for any position."

275. Odette Tawadrous, M.D., authored a letter to the medical board on February 4, 2021. She is an internist practicing in Southern California for the last 14 years and has been a colleague of Dr. Singh's for 11 years, working with him at St. Francis Medical Center and PIH Downey Hospitals. "He has been taking care of my patients as an excellent cardiologist. He always updates me on our mutual patient care. He has demonstrated his leadership skills as Chief of Staff at our hospital and is

head of internal medicine." She wrote that he has supervised several large projects that expanded medical services at St. Francis Medical Center, initiating the STEMI and stroke programs. "He has excellent clinical and critical thinking skills that make him among the top doctors in our hospitals. Regarding patient care, he has demonstrated many times over the years that patient care is his priority. In conclusion Dr. Singh is an extraordinary physician, one of our best cardiologists in the hospital. He has excellent clinical judgment, excellent patient communication and follow-up."

276. Hanh Thi Nguyen-Clark, M.D., President/CEO, Landmark Anesthesia Medical Group, and former Chief of Staff at St. Francis Medical Center, authored a letter to the medical board on February 11, 2021. He met Dr. Singh in 2012 when he joined the Department of Anesthesia as an independent contractor. He worked closely with Dr. Singh in the Cath Lab whenever he needed support for pacemaker/AICD placement. Dr. Nguyen-Clark wrote:

> I really appreciate his skills in providing the electrophysiology services to the hospital. I noticed that he was very congenial and approachable. He got along well with his team. As a physician, he was very gentle and thorough when he had direct dealings with his patients. They always seemed to be informed of the planned procedure as Dr. Singh had already covered all the risks and benefits with them and their families. Also, Dr. Singh was very careful and meticulous in preparing his procedures. I remember he would rather cancel a case when there was any worsening of the patient' [*sic*] condition then just go

ahead with it. He would take time to optimize them to give them a best possible outcome.

In 2013, I became chairman of the Department of Anesthesia and now, I am the current hospital Chief of Staff. Based on my closed [*sic*] working relationship with Dr. Singh on the matter of hospital and medical staff administration, I can attest to his dedication to provide high-quality care administered in accordance with current evidence-based care guidelines. For many years, Dr. Singh was part of the hospital Utilization Review as the medical staff representative. He put in countless extra hours to make rounds in all floors and to ensure that patients were getting the care that they needed, as appropriately and efficiently as possible (a key component of a value-based approach for healthcare). He worked closely with various departments to prepare the patients and their families thoroughly for discharge. His work has been acknowledged by the new owners of [St. Francis Medical Center] and he is now promoted to be its [Chief Medical Officer].

Based on my extensive encounters with Dr. Singh, I have witnessed his tremendous dedication, skills, and compassion in providing high quality care to his patients as a physician. As a longtime member of the [Medical Executive Committee], he is hard-working and tireless in his commitment to the well-being and rights of the medical

> staff. I fully support his services at the [St. Francis Medical Center] and its surrounding community in Lynwood, CA.

Dr. Singh's Other Documents

277. Dr. Singh received an honorable mention award in 1990-1991 from Cook County Hospital Department of Medicine, "In honor of outstanding clinical skills among faculty" which was "given in recognition of extraordinary teaching skills, consideration of house staff, and exemplary behavior in caring for patients as an attending physician." The award was signed by the Chairman, Department of Medicine.

278. On September 8, 2020, St. Francis Medical Center was "pleased to announce" Dr. Singh as the new Medical Director, effective immediately. He "will oversee Utilization Management, Quality, Service Line Enhancement, and Growth while promoting Medical Staff physician engagement and alignment." The announcement stated further:

> Dr. Singh is one of our highly skilled cardiovascular medicine physicians. His specialties include internal medicine, cardiovascular disease, and cardiac electrophysiology. He joined the St. Francis Medical Staff in 1995 and is recognized for his collaboration with many hospital teams and for facilitating excellent communication across the physician staff. Throughout his 25-year tenure, Dr. Singh has been an involved and influential medical staff leader, advancing hospital programs and service lines to support comprehensive treatment, the latest technology

> and techniques, and the safest care and outcome for patients.

The announcement detailed Dr. Singh's education, experience, and board certifications, and concluded:

> We appreciate the expertise and leadership Dr. Singh brings to St. Francis Medical Center in his new role. Please join us in congratulating and supporting him as we advance our mission of delivering compassionate, quality care to patients and bettering healthcare for the communities we serve.

The Medical Board's Disciplinary Guidelines

279. Official Notice was taken of the medical board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016).

Closing Arguments

280. Complainant argued that he met his burden of proof on all causes for discipline and requested that Dr. Singh's license be revoked, the revocation stayed, and he be placed on probation for five years with several terms and conditions including a thirty day suspension, 40 hours of community service, ethics and prescribing practices courses, and be prohibited from working in SNFs.

281. Dr. Singh argued that complainant had not met its burden of proof. Dr. Singh did not order Metformin, he was not dishonest, and the pain medications and hypnotics prescribed were within the standard of care.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

2. Business and Professions Code section 2229 states: "Protection of the public shall be the highest priority" for the medical board."

The Burden and Standard of Proof

3. Complainant bears the burden of establishing that the causes pled in the accusation are true. (*Martin v. State Personnel Medical Board* (1972) 26 Cal.App.3d 573, 582.)

4. The standard of proof in an administrative action seeking to suspend or revoke a physician and surgeon's certificate is "clear and convincing evidence." (*Ettinger v. Medical board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.

5. Clear and convincing evidence requires a finding of high probability; or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.) The requirement to prove by clear and convincing evidence is a "heavy burden, far in excess of the preponderance sufficient in most civil litigation. [Citation.]" (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.) "The burden of proof by clear and convincing evidence 'requires a finding of high

probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind.' [Citation.]" (*Ibid.*)

Applicable Code Sections

6. Business and Professions Code section 2227 authorizes the medical board to discipline a licensee.

7. Business and Professions Code section 2234, states in part:

> The medical 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:
>
> [¶] . . . [¶]
>
> (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.
>
> [¶] . . . [¶]
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

Regulation Defining Substantially Related

8. California Code of Regulations, title 16, section 1360, provides that a crime or act is substantially related to the qualifications, functions, or duties of a physician and surgeon if, to a substantial degree, it evidences present or potential unfitness to perform the functions of a physician and surgeon in a manner consistent with the public health, safety, or welfare.

Permissible Expert Testimony

9. Evidence Code section 720, subdivision (a), permits expert testimony if an individual "has special knowledge, skill, experience, training, or education sufficient to qualify him as an expert on the subject to which his testimony relates." Where the subject matter of the expert opinion testimony is within the common knowledge of laymen, even though it is uncontradicted, it is not binding upon the fact finder who may give it the weight to which it is entitled so long as the fact finder does not act arbitrarily. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.)

10. "The general rule is that an expert may not give an opinion whether a witness is telling the truth, for the determination of credibility is not a subject sufficiently beyond common experience that the expert's testimony would assist the trier of fact; in other words, the [fact finder] generally is as well-equipped as the expert to discern whether the witness is being truthful." (See *People v. Curl* (2009) 46 Cal.4th 339, 359, quoting *People v. Coffman and Marlow* (2004) 34 Cal.4th 1, 82; *People v. Cole* (1956) 47 Cal.3d 99, 103; Evid. Code, 801, subd. (a).)

11. Even though Evidence Code section 805 provides that "[t]estimony in the form of an opinion that is otherwise admissible is not objectionable because it embraces the ultimate issue to be decided by the trier of fact," the Court of Appeal

explained in *Summers v. A.L. Gilbert Co.* (1999) 69 Cal.App.4th 1155, 1178, that "the admissibility of opinion evidence that embraces an ultimate issue in a case does not bestow upon an expert carte blanche to express any opinion he or she wishes."

Case Law Regarding Standard of Care

12. The standard of care requires that physicians exercise in diagnosis and treatment that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care is a matter peculiarly within the knowledge of experts; it presents the basic issue in a malpractice action and can only be proved by their testimony, unless the conduct required by the particular circumstances is within the common knowledge of the layman. (*Williamson v. Prida* (1999) 75 Cal.App.4th 1417, 1424; *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal. 4th 992, 1001.)

13. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.)

14. "The party offering the expert must demonstrate that the expert's knowledge of the subject is sufficient, and the determinative issue in each case is whether the witness has sufficient skill or experience in the field so his testimony would be likely to assist" the trier of fact. (*Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 219.) The expert's qualifications must establish that he or she has "the education, training, experience, or knowledge necessary to testify to the standards to be upheld in the practice" of the profession on which he or she is opining. (*Cooper v. Medical Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 947.)

Case Law Regarding Negligence

15. A physician is not necessarily negligent due to every "untoward result which may occur." (*Norden v. Hartman* (1955) 134 Cal.App.2d 333, 337.) A physician is negligent only where the error in judgment or lack of success is due to failure to perform any of the duties required of reputable members of the medical profession practicing under similar circumstances. (See *Black v. Caruso* (1960) 187 Cal.App.2d 195, 200-202.)

16. So far as the phrase has any accepted meaning, "gross negligence" is "merely an extreme departure from the ordinary standard of care." *(Franz v. Medical Board of Medical Quality Assurance* (1982) 31 Cal. 3d 124, 138, citing *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196 and *Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941.)

17 Courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Medical Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. (*Id.* at 1054).

18. A repeated negligent act involves two or more negligent acts or omissions. No pattern of negligence is required; repeated negligent acts means two or more acts of negligence. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

Case Law Regarding Dishonesty

19. California courts have considered the term "dishonesty" within various statutory schemes and have relied on the common understanding involving fraud,

deception, betrayal, faithlessness, absence of integrity, a disposition to cheat, deceive, or defraud. (*Chodur v. Edmonds* (1985) 174 Cal.App.3d 565, 572.)

20. Fraud and dishonesty are closely synonymous. Fraud is defined as a dishonest stratagem. It may consist in the misrepresentation or the concealment of material facts, or a statement of fact made with consciousness of its falsity. It is not essential that the person charged with fraud should have received any benefit therefrom. Liability is predicated upon the fact that another has been misled to his prejudice, and not that individual profited by his wrong. (*Fort v. Board of Medical Quality Assurance* (1982) 136 Cal.App.3d. 12, 19-20.)

21. "The term 'dishonesty' has been defined in . . . disciplinary proceedings as follows: '"Dishonesty" necessarily includes the element of bad faith. As defined in the dictionaries and in judicial decisions, it means fraud, deception, betrayal, faithlessness. . . . "'Dishonesty' denotes an absence of integrity; a disposition to cheat, deceive, or defraud; deceive and betray."'" (*Lone Star Sec. & Video, Inc. v. Bureau of Sec. & Investigative Services* (2012) 209 Cal. App. 4th 445, 458, citing *Small v. Smith* (1971) 16 Cal.App.3d 450, 456.)

Causes for Discipline Were Not Established

GROSS NEGLIGENCE NOT ESTABLISHED

22. Complainant did not prove by clear and convincing evidence that Dr. Singh was grossly negligent in his care and treatment of the patient in violation of Business and Professions Code section 2234, subdivision (b). Dr. Singh did not prescribe Metformin to the patient. His care and treatment of the patient met the standard of care.

REPEATED NEGLIGENCE NOT ESTABLISHED

23. Complainant did not prove by clear and convincing evidence that Dr. Singh was repeatedly negligent in his care and treatment of the patient, in violation of Business and Professions Code section 2234, subdivision (c), by prescribing opioids and hypnotics to her. His prescriptions of these medications met the standard of care.

DISHONESTY NOT ESTABLISHED

24. Complainant did not prove by clear and convincing evidence that Dr. Singh was dishonest, in violation of Business and Professions Code section 2234, subdivision (e), when he wrote letters to the county and the medical board and at his medical board interview. At all times, Dr. Singh was forthright and honest.

ORDER

The accusation against respondent, Anantjit Singh, M.D., is dismissed.

DATE: May 24, 2021

Mary Agnes Matyszewski (May 24, 2021 00:03 PDT)

MARY AGNES MATYSZEWSKI
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Accusation Against:	Case No. 800-2017-032626
ANANTJIT SINGH, M.D. **11544 Downey Avenue** **Downey, CA 90241-4955** **Physician's and Surgeon's Certificate No. A 53927,** Respondent.	**A C C U S A T I O N**

PARTIES

1. Christine J. Lally (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about February 1, 1995, the Medical Board issued Physician's and Surgeon's Certificate No. A 53927 to Anantjit Singh, 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 October 31, 2020, unless renewed.

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JURISDICTION

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

4. Section 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.
>
> ...
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> ...

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

5. Respondent has subjected his Physician's and Surgeon's Certificate No. A53927 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patient A,[1] as more particularly alleged hereinafter:

6. Respondent is Board Certified in Internal Medicine, Cardiovascular Disease, and Cardiac Electrophysiology. Between in and around 2016 and 2017, he served as the Medical Director of Downey Care Center (Downey), a skilled nursing facility. As Medical Director,

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[1] To protect the privacy of the patient involved, the patient's name has not been included in this pleading. Respondent is aware of the identity of the patient referred to herein.

Respondent was responsible for, among other things, rounding on his assigned patients residing in the facility and making necessary medication adjustments.

7. On or about October 7, 2017, Patient A, a then sixty-three (63) year old female, was admitted to Downey for long-term care after having recently undergone a closed reduction of a right tibular/fibular fracture. Patient A's medical history involved multiple comorbidities, including but not limited to, end stage renal disease (ESRD), diabetes mellitus, hemodialysis three times each week, hypertension, anemia of chronic disease, secondary hyperparathyroidism, dyslipidemia, peripheral vascular disease, and coronary heart disease.

8. Between on or about October 7, 2017, and on or about January 23, 2017, Patient A resided at Downey and received care and treatment from Respondent. Respondent prescribed various medications to Patient A, including but was not limited to, tramadol,[2] Dilaudid,[3] gabapentin,[4] Ambien,[5] Norco,[6] and morphine.[7] While at Downey, Patient A was transported multiple times each week to receive dialysis, and was noted to be non-compliant with her diet.

9. On or about November 24, 2016, Patient A was transferred from Downey to Kaiser Permanente emergency department with an arteriovenous graft infection and an altered level of

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[2] Tramadol (brand name Ultram) is an opioid medication used to treat pain. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, and a dangerous drug pursuant to Business and Professions Code section 4022.

[3] Dilaudid (brand name for hydromorphone), is an opioid medication used to treat pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Gabapentin is a nerve pain medication and anticonvulsant. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Ambien (brand name for zolpidem), is a sedative hypnotic medication used for the short-term treatment of insomnia. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[6] Norco (brand name for hydrocodone/acetaminophen combination product) is an opioid medication used to treat pain. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Morphine is an opioid medication used to treat pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

consciousness. Patient A was admitted to the hospital and treated for severe sepsis due to methicillin-resistant staphylococcus aureus (MRSA) bacteremia. Patient A was discharged on or about December 6, 2016, back to Downey.

10. On or about December 6, 2016, Patient A returned to Kaiser Permanente emergency department with complaints of fever. Patient A received additional treatment for MRSA and was discharged on or about December 8, 2016, back to Downey.

11. On or about December 12, 2016, Patient A was transferred from Downey to White Memorial Medical Center (White Memorial) emergency department with complaints of fever, lethargy, and decreased responsiveness. Patient A was admitted to the hospital and treated for sepsis with septic shock. While at White Memorial, Patient A's lactate was never elevated and she responded to simple fluids. Patient A was discharged on or about December 19, 2016, back to Downey.

12. On or about January 4, 2017, Patient A was transferred to White Memorial emergency department from her dialysis appointment after she was found to be significantly anemic. Patient A was admitted to the hospital and received a blood transfusion and dialysis, and was discharged on or about January 5, 2017, back to Downey.

13. On or about January 5, 2017, Patient A was readmitted back to Downey under the care of Respondent, who resumed all previous orders, including continuous oxygen.

14. On or about January 13, 2017, Patient A had labs conducted, which revealed an HgA1C result of 7.5.

15. On or about January 19, 2017, Respondent was informed about Patient A's lab results by phone and verbally ordered the patient be given metformin[8] 1000 mg twice per day.

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[8] Metformin (brand name Glucophage) is an anti-diabetic medication that helps control blood sugar levels, and is a dangerous drug pursuant to Business and Professions Code section 4022. Metformin contains a Black Box warning that indicates that lactic acidosis is a rare, but potentially severe, consequence of therapy with metformin. Risk factors for metformin-associated lactic acidosis include renal impairment, concomitant use of certain drugs (eg, carbonic anhydrase inhibitors such as topiramate), age 65 years old or greater, having a radiological study with contrast, surgery and other procedures, hypoxic states (e.g., acute congestive heart failure), excessive alcohol intake, and hepatic impairment; if metformin-associated lactic acidosis is suspected, immediately discontinue.

Respondent electronically signed off on this verbal medication order in the patient's chart on or about February 9, 2017.

16. Between on or about January 19, 2017, and on or about January 23, 2017, Patient A received approximately seven (7) doses of metformin 1000 mg.

17. On or about January 23, 2017, Patient A was transferred to White Memorial emergency department from her dialysis appointment after she was found hypotensive and with an altered mental state. Patient A was admitted to the Intensive Care Unit (ICU) in acute distress, and was diagnosed with acute respiratory failure and profound metabolic acidosis. The ICU noted that the patient's acidosis was out of proportion to sepsis and renal dysfunction. Patient A had a central line placed, was intubated, and provided Levophed,[9] but died shortly thereafter.

18. Sometime after Patient A's death, the California Department of Public Health (CDPH) initiated an investigation into the care and treatment she received at Downey.

19. On or about April 4, 2017, Respondent was interviewed by a CDPH Health Facilities Evaluator. During the interview, Respondent stated that he was aware that the patient was a renal patient on dialysis, and that he ordered the metformin after the nurse informed him of the patient's high HgA1C results, and because metformin is the first line of medication for diabetes. Respondent further stated that he was not near the computer at the time he prescribed the metformin and did not know there was a black box warning for the medication, or else he would not have prescribed it.

20. On or about April 28, 2017, Respondent provided a letter to the CDPH explaining his care and treatment of Patient A. In this letter, Respondent claimed the patient's lactic acidosis was likely related to her septic shock and comorbidities, and that any contribution from metformin was negligible. Respondent did not deny prescribing metformin to the patient or describe an error in the prescription order in any way.

21. On or about July 28, 2017, the Board sent a letter to Respondent informing him that it received a complaint that he prescribed metformin to Patient A, which was contraindicated due to

[9] Levophed (brand name for norepinephrine), is a nonselective adrenergic agonist medication used to treat low blood pressure and heart failure.

the patient's kidney problems as well as a 'black box warning" on the medications. The letter requested Respondent provide a summary of the care and treatment he rendered to Patient A.

22. On or about August 4, 2107, Respondent provided his summary of care letter to the Board regarding Patient A. In this letter, Respondent claimed the patient's lactic acidosis was likely related to her septic shock and comorbidities, and that any contribution from metformin was negligible. Respondent did not deny prescribing metformin to the patient or describe an error in the prescription order in any way.

23. On or about January 3, 2018, on Respondent's behalf, Respondent's attorney submitted a supplemental letter to the Board in response to the Board's inquiry regarding Patient A. In this letter, Respondent did not deny prescribing metformin to the patient or describe an error in the prescription order in any way.

24. On or about January 6, 2020, Respondent was interviewed by an investigator on behalf of the Board, with his attorney present. At this interview, Respondent denied prescribing metformin to Patient A, denied he would ever prescribe metformin to a patient with ESRD, and claimed the nurse made an error in the order.

25. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to, prescribing metformin to a patient with ESRD and associated high risk state for metformin-associated lactic acidosis.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

26. Respondent has further subjected his Physician's and Surgeon's Certificate No. A53927 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient A, as more particularly alleged hereinafter:

(a) Paragraphs 5 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Prescribing opiates and hypnotics to a patient with a baseline oxygen requirement and renal impairment.

THIRD CAUSE FOR DISCIPLINE

(Dishonesty or Corruption)

27. Respondent has further subjected his Physician's and Surgeon's Certificate No. A53927 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (e), of the Code, in that he has committed an act or acts of dishonesty or corruption, as more particularly alleged in paragraphs 5 through 25, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 53927, issued to Anantjit Singh, M.D.;

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

3. Ordering Anantjit Singh, 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: APR 30 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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