

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

In the Matter of the Accusation)
Against:)
)
)
KIMBERLY T. LE, M.D.)
)
Physician's and Surgeon's)
Certificate No. G 72879)
)
Respondent)
_____)

Case No. 800-2013-000921

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on May 25, 2017.

IT IS SO ORDERED May 18, 2017.

MEDICAL BOARD OF CALIFORNIA

By: 
Kimberly Kirchmeyer
Executive Director

1 XAVIER BECERRA
Attorney General of California
2 MATTHEW M. DAVIS
Supervising Deputy Attorney General
3 JOHN S. GATSCHET
Deputy Attorney General
4 State Bar No. 244388
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5 1300 I Street, Suite 125
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6 Sacramento, CA 94244-2550
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8 *Attorneys for Complainant*

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

13 In the Matter of the Accusation Against:

Case No. 800-2013-000921

14 **KIMBERLY T. LE, M.D.**
P.O. Box 1939
15 Carmichael, CA 95609

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

16 Physician's and Surgeon's Certificate No. G 72879,
17 Respondent.

18
19
20 **IT IS HEREBY STIPULATED AND AGREED** by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical
24 Board of California ("Board"). She brought this action solely in her official capacity and is
25 represented in this matter by Xavier Becerra, Attorney General of the State of California, by John
26 S. Gatschet, Deputy Attorney General.

27 2. Kimberly T. Le, M.D. ("Respondent") is represented in this proceeding by attorney
28 Thomas M. Garberson, whose address is:

1 Thomas M. Garberson
2 Low, McKinley, Baleria & Salenko
3 2150 River Plaza Dr., Ste. 250
4 Sacramento, CA 95833

5 3. On or about November 5, 1991, the Board issued Physician's and Surgeon's
6 Certificate No. G 72879 to Respondent. That Certificate was in full force and effect at all times
7 relevant to the charges brought in Accusation No. 800-2013-000921 and will expire on October
8 31, 2017, unless renewed.

9 JURISDICTION

10 4. Accusation No. 800-2013-000921 was filed before the Board, and is currently
11 pending against Respondent. The Accusation and all other statutorily required documents were
12 properly served on Respondent on October 20, 2016. Respondent timely filed her Notice of
13 Defense contesting the Accusation.

14 5. A copy of Accusation No. 800-2013-000921 is attached as Exhibit A and
15 incorporated by reference.

16 ADVISEMENT AND WAIVERS

17 6. Respondent has carefully read, fully discussed with counsel, and understands the
18 charges and allegations in Accusation No. 800-2013-000921. Respondent also has carefully read,
19 fully discussed with counsel, and understands the effects of this Stipulated Surrender of License
20 and Order.

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

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

///

1 **CULPABILITY**

2 9. Respondent understands that the charges and allegations in Accusation No. 800-2013-
3 000921, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and
4 Surgeon's Certificate.

5 10. For the purpose of resolving the Accusation without the expense and uncertainty of
6 further proceedings, Respondent does not contest that, at an administrative hearing, complainant
7 could establish a prima facie case with respect to the charges and allegations contained in the
8 Accusation No. 800-2013-000921 and that she has thereby subjected her Physician's and
9 Surgeon's Certificate No. G 72879 to disciplinary action.

10 11. Respondent understands that by signing this stipulation she enables the Board to issue
11 an order accepting the surrender of her Physician's and Surgeon's Certificate without further
12 process.

13 12. Respondent further understands and agrees that if she ever files an application for
14 licensure or a petition for reinstatement in the State of California, the Board shall treat it as a
15 petition for reinstatement. Respondent must comply with all the laws, regulations and procedures
16 for reinstatement of a revoked license in effect at the time the petition is filed, and all of the
17 charges and allegations contained in Accusation No. 800-2013-000921 shall be deemed to be
18 true, correct and admitted by Respondent when the Board determines whether to grant or deny the
19 application and/or petition.

20 **RESERVATION**

21 13. Respondent's agreement to not contest Accusation No 800-2013-000921, by signing
22 this stipulation and the extent it evidences any admissions, if at all, made by Respondent herein
23 are only for the purposes of this proceeding, or any other proceeding in which the Medical Board
24 of California or other professional licensing agency is involved, and shall not be admissible in
25 any other criminal or civil proceeding.

26 **CONTINGENCY**

27 14. This Stipulated Surrender of License and Disciplinary Order shall be subject to
28 approval of the Executive Director on behalf of the Medical Board. The parties agree that this

1 Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive
2 Director for her consideration in the above-entitled matter and, further, that the Executive
3 Director shall have a reasonable period of time in which to consider and act on this Stipulated
4 Surrender of License and Disciplinary Order after receiving it. By signing this stipulation,
5 respondent fully understands and agrees that she may not withdraw her agreement or seek to
6 rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board,
7 considers and acts upon it.

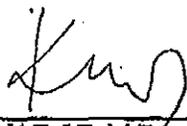
8 15. The parties agree that this Stipulated Surrender of License and Disciplinary Order
9 shall be null and void and not binding upon the parties unless approved and adopted by the
10 Executive Director on behalf of the Board, except for this paragraph, which shall remain in full
11 force and effect. Respondent fully understands and agrees that in deciding whether or not to
12 approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive
13 Director and/or the Board may receive oral and written communications from its staff and/or the
14 Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the
15 Executive Director, the Board, any member thereof, and/or any other person from future
16 participation in this or any other matter affecting or involving respondent. In the event that the
17 Executive Director on behalf of the Board does not, in her discretion, approve and adopt this
18 Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it
19 shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied
20 upon or introduced in any disciplinary action by either party hereto. Respondent further agrees
21 that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason
22 by the Executive Director on behalf of the Board, respondent will assert no claim that the
23 Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review,
24 discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or
25 of any matter or matters related hereto.

26 16. The parties understand and agree that Portable Document Format (PDF) and facsimile
27 copies of this Stipulated Surrender of License and Order, including Portable Document Format
28 (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

1 this stipulation, that she is permanently waiving any and all claims of laches or statute of
2 limitation defenses as they relate to Investigation Nos. 800-2014-010186, and 800-2016-026641.

3 ACCEPTANCE

4 I have carefully read the Stipulated Surrender of License and Order and fully discussed it
5 with my attorney, Thomas M. Garberson. I understand the stipulation and the effect it will have
6 on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License
7 and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and
8 Order of the Medical Board of California.

9
10 DATED: 5/1/2017 

KIMBERLY T. LE, M.D.
Respondent

11
12 I have read and fully discussed with Respondent Kimberly T. Le, M.D. the terms and
13 conditions and other matters contained in this Stipulated Surrender of License and Order. I
14 approve of its form and content.

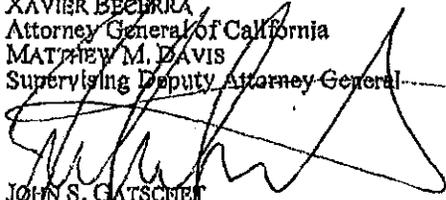
15
16 DATED: 5/1/2017 

THOMAS M. GARBERSON

17 ENDORSEMENT

18 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
19 for consideration by the Medical Board of California of the Department of Consumer Affairs.

20 Dated: 5/1/17

21 Respectfully submitted,
22 XAVIER BECERRA
Attorney General of California
23 MATTHEW M. DAVIS
Supervising Deputy Attorney General
24 
25 JOHN S. GATSCHER
26 Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2013-000921

1 KAMALA D. HARRIS
Attorney General of California
2 MATTHEW M. DAVIS
Supervising Deputy Attorney General
3 JOHN S. GATSCHE
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8 *Attorneys for Complainant*

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO, CALIFORNIA
OCTOBER 30, 2016
BY: [Signature] ANALYST

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

13 In the Matter of the Accusation Against:	Case No. 800-2013-000921
14 KIMBERLY T. LE, M.D.	ACCUSATION
15 PO Box 1939 Carmichael, California 95609	
16 Physician's and Surgeon's Certificate No: G72879,	
17 Respondent.	

19 Complainant alleges:

20 **PARTIES**

- 21 1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official
22 capacity as the Executive Director of the Medical Board of California, Department of Consumer
23 Affairs ("Board").
- 24 2. On or about November 5, 1991, the Medical Board issued Physician's and Surgeon's
25 Certificate Number G72879 to Kimberly T. Le, M.D. ("Respondent"). The Physician's and
26 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
27 herein and will expire on October 31, 2017, unless renewed.

28 ///

1 ibuprofen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title
2 21 section 1308.13(e).² Hydrocodone with ibuprofen is a dangerous drug pursuant to California
3 Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to
4 California Health and Safety Code section 11055, subdivision (b).

5 12. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet
6 is a short acting opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II
7 controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet
8 is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a
9 Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

10 13. Hydromorphone hydrochloride – Generic name for the drug Dilaudid.
11 Hydromorphone hydrochloride (“hcl”) is a potent opioid agonist that has a high potential for
12 abuse and risk of producing respiratory depression. Hydromorphone hcl is a short-acting
13 medication used to treat severe pain. Hydromorphone hcl is a Schedule II controlled substance
14 pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone hcl is a
15 dangerous drug pursuant to California Business and Professions Code section 4022 and is a
16 Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

17 14. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic
18 opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl
19 transdermal patch is used for long term chronic pain. It has an extremely high danger of abuse
20 and can lead to addiction as the medication is estimated to be 80 times more potent than morphine
21 and hundreds of times more potent than heroin.³ Fentanyl is a Schedule II controlled substance
22 pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug
23 pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled
24 substance pursuant to California Health and Safety Code section 11055(e).

25 ///

26 ² On October 6, 2014, Hydrocodone combination products were reclassified as Schedule
27 II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations
28 Title 21 section 1308.12.

³ http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

1 15. Tramadol -- Generic name for the drug Ultram. Tramadol is an opioid pain
2 medication used to treat moderate to moderately sever pain. Effective August 18, 2014,
3 Tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of
4 Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and
5 Professions Code section 4022.

6 16. Oxycodone – Generic name for Oxycontin, Roxicodone, and Oxecta. High risk for
7 addiction and dependence. Can cause respiratory distress and death when taken in high doses or
8 when combined with other substances, especially alcohol. Oxycodone is a short acting opioid
9 analgesic used to treat moderate to severe pain. Oxycodone is a Schedule II controlled substance
10 pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous
11 drug pursuant to California Business and Professions Code section 4022 and is a Schedule II
12 controlled substance pursuant to California Health and Safety Code section 11055(b).

13 17. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal
14 muscle relaxant. On January 11, 2012, Carisoprodol was classified a Schedule IV controlled
15 substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a dangerous
16 drug pursuant to Business and Professions Code section 4022.

17 18. Zolpidem Tartrate – Generic name for Ambien. Zolpidem Tartrate is a sedative and
18 hypnotic used for short term treatment of insomnia. Zolpidem Tartrate is a Schedule IV
19 controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a
20 Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision
21 (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

22 19. Alprazolam – Generic name for the drug Xanax. Alprazolam is a short acting
23 benzodiazepine used to treat anxiety. Alprazolam is a Schedule IV controlled substance pursuant
24 to Code of Federal Regulations Title 21 section 1308.14. Alprazolam is a dangorous drug
25 pursuant to California Business and Professions Code section 4022 and is a Schedule IV
26 controlled substance pursuant to California Health and Safety Code section 11057(d).

27 20. Lorazepam – Generic name for Ativan. Lorazepam is a member of the
28 benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term

1 management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to
2 Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section
3 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section
4 4022.

5 21. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the
6 benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a
7 Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section
8 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug
9 pursuant to Business and Professions Code section 4022.

10 22. Promethazine with codeine syrup – Generic for the drug Phenergan with Codeine and
11 others. Promethazine with codeine syrup is an antihistamine and antitussive agent used to
12 temporarily relieve cough and upper respiratory symptoms associated with allergy or the common
13 cold. Promethazine with codeine syrup is a Schedule V Controlled Substance pursuant to Code
14 of Federal Regulations Title 21 Section 1308.15(c). Promethazine with codeine syrup is a
15 Dangerous Drug as defined by California Business and Professions Code section 4022 and a
16 Schedule V Controlled Substance pursuant to California Health and Safety Code section
17 11058(c).

18 FIRST CAUSE FOR DISCIPLINE

19 (Gross Negligence)

20 23. Respondent's license is subject to disciplinary action under section 2234, subdivision
21 (b), in that she committed gross negligence by providing prescriptions to undercover
22 investigators, Patients J.T. and R.G., without proper medical justification and falsely documented
23 their medical records. The circumstances are as follows:

24 24. On June 5, 2014, Patients J.T. and R.G. went to the medical clinic operated by
25 Respondent and pretended they were patients. Patients J.T. and R.G. were working in an
26 undercover law enforcement capacity on behalf of the Board to investigate whether Respondent
27 improperly provided controlled substances to patients. All undercover operations described

28 ///

1 involving Patients J.T. and R.G. were video and audio-recorded.⁴ Patient J.T. stated that she
2 needed a pre-employment physical and was seen by Respondent. Following the pre-employment
3 physical, Patient J.T. asked Respondent for a prescription for Xanax. Respondent stated that she
4 could have a prescription for Xanax but she needed to come back for a further evaluation.
5 Respondent also stated she had not taken, "a full history for all that." Respondent told Patient
6 J.T. that the prescription appointment would cost \$100.00.

7 25. On December 18, 2014, Patients J.T. and R.G. returned to Respondent's medical
8 practice. Patient J.T. requested a prescription for Xanax as they had discussed at the previous
9 visit. Respondent asked if Patient J.T. had anxiety. Patient J.T. stated, "Yeah, I like to chill."
10 Patient J.T. said she used her sister's prescription previously. Respondent wrote Patient J.T. a
11 prescription for fifteen tablets of .5 mg Xanax. Patient J.T. paid Respondent \$100.00.
12 Respondent documented a lengthy progress note that did not match the audio and video recorded
13 examination that she actually conducted on the patient.

14 26. Patient R.G. then asked if Respondent "could save him some time" and give him
15 something for his back discomfort. Respondent gave Patients J.T. and R.G. a discount for seeing
16 them at the same time and had Patient R.G. fill out initial paperwork. Respondent performed a
17 brief history and physical. Patient R.G. stated he had back pain, "once in a while." Respondent
18 asked Patient R.G. what medications he took when he previously has had back pain. Patient R.G.
19 said he steals his pills from Patient J.T. Respondent wrote Patient R.G. a prescription for five
20 tablets of 5/325 mg. Norco and seven tablets of 350 mg. Soma. Respondent documented a
21 lengthy progress note in Patient R.G.'s medical records that did not match the audio and video
22 recorded examination that she actually conducted on the patient.

23 27. On January 22, 2015, Patient R.G. returned to Respondent's medical practice. Patient
24 R.G. stated he was doing, "great". Patient R.G. stated he had run out of medications and wanted
25 a refill. Respondent challenged Patient R.G. on whether he actually needed the medications

26
27 ⁴ On May 27, 2014, the Sacramento County District Attorney's Office provided
28 authorization to surreptitiously record undercover operations investigating Respondent's medical
clinic.

1 because Patient R.G. told Respondent that the medications make him "feel good". Respondent
2 told Patient R.G. he needed to get an x-ray or MRI if Respondent was going to write him more
3 prescriptions. Respondent explained to Patient R.G. that if she didn't have tests on file, that she
4 could not prescribe further medications. Respondent asked Patient R.G. to give his pain level on
5 a scale of 0 to 10, and he replied, "2, 3". In the medical records for Patient R.G., Respondent
6 noted that his pain level was "6 to 8", on a scale of 0 to 10. Patient R.G. further stated that he
7 doesn't have a lot of pain, and only deals with back pain "sometimes". In the medical records for
8 Patient R.G., Respondent noted that the pain was a "constant, localized, aching sensation."
9 Respondent noted that the, "(p)atient reported insomnia due to severity of the pain." Patient R.G.
10 never mentioned having a hard time sleeping during the examination. Respondent did not
11 document that Patient R.G. may be abusing or possibly diverting his prescriptions based on his
12 answers. Respondent provided Patient R.G. with a prescription for 14 pills of 5/325 mg. Norco
13 and 14 pills of 350 mg. Soma. Respondent also provided Patient R.G. with an x-ray order form.
14 Respondent documented that an MRI was pending in the medical records despite not ordering
15 one. Patient R.G. paid \$100.00.

16 28. On March 5, 2015, Patients J.T. and R.G. returned to Respondent's medical practice.
17 Both Patients J.T. and R.G. requested controlled substances. Patient J.T. requested Respondent
18 prescribe more Xanax to her so she could "chill." Respondent asked if Patient J.T. had anxiety
19 and asked when Patient J.T. usually takes the medication. Patient J.T. responded, "Oh, I just take
20 it to whenever I need to chill out a little bit." When asked what she does for a living, Patient J.T.
21 told Respondent that she does copying for a tax preparer. Respondent documented in the medical
22 records that Patient J.T. had stated, "she was stressed out due to her financial situation and 'pre-
23 tax season'." Respondent also documented that Patient J.T. has insomnia due to anxiety.
24 Respondent provided Patient J.T. with a prescription for 15 pills of .5 mg Xanax.

25 29. After Patient J.T.'s examination, Patient R.G. asked for a medication refill of his
26 controlled substances. Respondent asked if Patient R.G. had gotten an x-ray, and he stated that he
27 had not. Respondent stated, "if you want me to write more and more of those, you need some x-
28 rays. You know that? Otherwise, I can fill only a few tablets for you." After a brief discussion of

1 where he could get an x-ray, Respondent stated, "If you, um, you want, you know, me to write
2 more for you, uh, I need, you know, documentation, like, okay, if you have arthritis in your back,
3 then you know, it gives me more, you know, leverage to write more." Respondent documented in
4 the medical records for Patient R.G. that his pain level was "4-6" on a scale of 0 to 10 and that the
5 pain was a "constant, localized, aching sensation." Patient R.G. was not asked his pain level or
6 the type of pain that he had during the video and audio recorded visit. Respondent documented
7 that an MRI was pending in the medical records despite not ordering one. Respondent then
8 provided Patient R.G. with a prescription for 14 pills of 5/325 mg. Norco and 14 pills of 350 mg.
9 Soma. Patients J.T. and R.G. paid \$100.00.

10 30. On April 7, 2015, Patient R.G. returned to Respondent's medical practice. Patient
11 R.G. brought a fake x-ray to give to Respondent. Patient R.G. requested a prescription for a
12 controlled substance. Respondent kept the x-ray, but did not provide a prescription for controlled
13 substances, and provided another x-ray referral form to Patient R.G. Respondent documented in
14 the medical records that Patient R.G. had a pain level of "7-8" on a scale of 0 to 10. Respondent
15 documented that Norco and Soma were on his medication list despite not providing him with a
16 prescription at that visit.

17 31. On September 22, 2015, Patient R.G. returned to Respondent's medical practice.
18 Respondent had not seen Patient R.G. in approximately 5 months. Patient R.G. requested a
19 medication refill. He requested Soma and stated that he takes it, "to relax." He requested Norco
20 because, "it relaxed me and I sleep better." Respondent told him that Norco was really for pain
21 and suggested that he take Ambien for sleeping. Patient R.G. requested Ambien and a few pills
22 of Norco and Xanax. Respondent then asked if Patient R.G. still had back pain. Patient R.G.
23 stated, "No. No." Respondent stated that Patient R.G. didn't need Norco. Patient R.G. asked for
24 Norco to have as a reserve in case he needed it later. Patient R.G. stated that he "likes to take
25 Norco." Respondent wrote Patient R.G. a prescription for 7 pills of 10 mg. Ambien, 7 pills of
26 5/325 mg. Norco, and 7 pills of 350 mg. Soma. In the medical record, Respondent documented
27 that Patient R.G. has a pain level of "3-7" on a scale of 0 to 10. Respondent documented that
28 Patient R.G. described the pain as a "constant, localized, aching sensation." Patient R.G. did not

1 give a pain level and denied having back pain during the audio and video recorded undercover
2 visit. Respondent documented that an MRI was pending but failed to document that Patient R.G.
3 had not gotten an MRI. Respondent did not document that Patient R.G. had mentioned that the
4 medications made him relax and that he liked to take the medications. Patient R.G. paid \$100.00.

5 32. Respondent failed to perform a complete initial history and physical examination of
6 Patient J.T. While she documented a complete assessment of pain and a complete assessment of
7 physical function, the undercover recordings revealed that Respondent did not perform the
8 examination as documented on Patient J.T. Respondent failed to document prior pain treatments,
9 and failed to document detailed information related to anxiety, depression, and insomnia.
10 Respondent failed to provide or follow up with consultation for a psychiatric referral.
11 Respondent failed to obtain a medication contract with Patient J.T. despite providing controlled
12 substances. Respondent failed to obtain and/or document that she obtained informed consent.
13 Respondent failed to develop a treatment plan for Patient J.T. Respondent kept legible medical
14 records in an electronic medical record system but the documented records do not match the
15 video recordings of the undercover investigation that show what the Respondent actually
16 performed.

17 33. Respondent documented an assessment of pain and physical function in the
18 medication records for Patient R.G. However, the undercover video shows that Respondent
19 failed to perform a complete history and physical of Patient R.G. as she had documented.
20 Respondent failed to develop and record a treatment plan for Patient R.G. Respondent failed to
21 obtain a medication contract with Patient R.G. despite providing controlled substances.
22 Respondent failed to obtain and/or document that she obtained informed consent. Respondent did
23 not perform periodic review/ and or document that she performed a periodic review of Patient
24 R.G.'s progress. Respondent did not refer Patient R.G. for a consultation with a mental health
25 professional. Respondent kept legible medical records in an electronic medical record system but
26 the documented records do not match the video recordings of the undercover investigation that
27 show what the Respondent actually performed.

28

Patient B.D.

1
2 36. On May 2, 2014, Respondent began treating Patient B.D. Patient B.D.'s chief
3 complaint was listed as, "(l)eft knee pain. Lower back pain. Anxiety. Depression. Post
4 traumatic disorder. Insomnia." According to the records, Patient B.D. noted that he had left knee
5 and back pain and stated that it was a "7-9" on a pain scale level of 0-10. Respondent referred
6 Patient B.D. for an MRI. The records do not mention that there was consultation or follow-up
7 regarding specialty referrals. There were no screening tools for depression, despite on-going
8 benzodiazepine prescriptions. The records do not contain any documentation of Patient B.D.'s
9 specific substance abuse history or prior treatments. Respondent started Patient B.D. on
10 controlled substances and prescribed 15 tablets of 10/325 mg. hydrocodone with acetaminophen,
11 and 7 tablets of 350 mg. carisoprodol. On May 2, 2014, Patient B.D. signed a medication
12 contract that stated he would take one tablet of 10/325 mg. hydrocodone with acetaminophen
13 every 8 hours, and one tablet of Soma every night as needed. However, the medication
14 agreement in Patient B.D.'s medical records was not modified as new controlled substances were
15 titrated and/or as dosages were increased. Respondent did not develop and record a treatment
16 plan in the medical records. An MRI performed on May 7, 2014, revealed "(m)oderate
17 degenerative changes...(s)evere facet sclerosis in the lower lumbar spine..." and,
18 "atherosclerotic disease." On May 8, 2014, Respondent again saw Patient B.D. in her clinic and
19 prescribed 8 tablets of 10/325 mg. oxycodone with acetaminophen. The record is silent on why
20 Respondent began Patient B.D. on controlled substances and why she changed his medication
21 after each appointment. The progress notes do not document why multiple short acting narcotics,
22 including, hydrocodone with acetaminophen, oxycodone with acetaminophen, and
23 hydromorphone hcl, were prescribed at the same time during Patient B.D.'s treatment.

24 37. The Medical Board reviewed 492 pages of records related to the care of Patient B.D.
25 through February 11, 2016. Between May 2, 2014, and December 26, 2014, Respondent saw
26 Patient B.D. in her medical office for 36 appointments. In 2014, Respondent prescribed 862
27 tablets of 10/325 mg. hydrocodone with acetaminophen, 280 tablets of 350 mg. carisoprodol, 35
28 tablets of 2 mg. alprazolam, 7 tablets of 1 mg. alprazolam, 14 tablets of .5 mg. tablets of

1 alprazolam, and 83 10/325 mg. tablets of oxycodone with acetaminophen to Patient B.D. Of
2 note, on November 1, 2014, Respondent prescribed three classes of medication, an opiate, a
3 benzodiazepine, and carisoprodol, to Patient B.D. at the same time.

4 38. Respondent received the results of an MRI conducted on Patient B.D. on February 7,
5 2015, that indicated mild disc bulging at L3-L4, mild disc bulging at L4-L5, mild generalized disc
6 bulging at L5-S1. Respondent received the results of a urine test provided by Patient B.D. on
7 June 29, 2015, that were consistent for carisoprodol and hydrocodone. Between January 2, 2015,
8 and December 28, 2015, Respondent saw Patient B.D. in her medical office for 55 appointments.
9 In 2015, Respondent prescribed 2368 tablets of 10/325 mg. of hydrocodone with acetaminophen,
10 1143 tablets of 350 mg carisoprodol, 360 ml. of promethazine cough syrup with codeine, 56
11 tablets of 4 mg. hydromorphone hcl, 14 tablets of 8 mg. hydromorphone hcl, 48 tablets of
12 oxycodone with acetaminophen, 28 tablets of 1 mg. alprazolam, 10 tablets of 2 mg. alprazolam,
13 and 37 tablets of an unknown quantity of alprazolam to Patient B.D. Respondent repeatedly
14 prescribed two short acting narcotics to Patient B.D. at the same time. Of note, on March 4,
15 2015, Patient B.D. filled a prescription from Respondent for 15 4 mg. tablets of hydromorphone
16 hcl. The medical records from February 27, 2015, and March 27, 2015, are silent regarding this
17 prescription and do not mention that Patient B.D. was prescribed hydromorphone hcl, nor provide
18 an explanation for why he was receiving this medication.⁵ Also of note, on February 8, 2015,
19 February 23, 2015, March 15, 2015, and April 4, 2015, Respondent prescribed three classes of
20 medication, an opiate, a benzodiazepine, and a muscle relaxant carisoprodol, to Patient B.D. at
21 the same time. Respondent did not obtain a written consent and/or document a detailed
22 discussion with Patient B.D. regarding the potential dangers of taking opioids, benzodiazepines,
23 and muscle relaxants at the same time.

24 39. Between January 4, 2016, and February 11, 2016, Respondent saw Patient B.D. in her
25 medical office for 8 appointments. From January 1, 2016, to February 26, 2016, Respondent
26 prescribed 378 tablets of 10/325 mg. hydrocodone with acetaminophen, 15 tablets of 1 mg.

27 ⁵ Respondent did document that she prescribed hydromorphone hcl on January 8, 2015,
28 but did not provide a rationale for why she was changing medications.

1 alprazolam, 56 tablets of 2 mg. alprazolam, and 21 tablets of 1 mg. lorazepam. In the medical
2 records from 2016, Respondent stopped documenting the addition of and stopped providing a
3 medical indication for new controlled substances. For example, on January 4, 2016, Respondent
4 prescribed 21 1 mg. tablets of lorazepam to Patient B.D. but failed to document the prescription in
5 the RX List and provide a rationale for the new prescription in the medical records. On February
6 11, 2016, Respondent prescribed 15 1 mg. tablets of alprazolam to Patient B.D. but failed to
7 document the prescription in his RX List and/or provide a rationale for renewing this prescription
8 in the medical records.

9 40. Respondent continually modified Patient B.D.'s prescriptions but did not document
10 why changes were being made. Respondent monitored the patient on an almost weekly basis but
11 there is no rationale given in the records for why the patient needed to be seen on such a regular
12 basis or so often. Respondent failed to run a CURES⁶ report. Despite Patient B.D. having a
13 complex pain problem, Respondent's records do not show if consultation with specialists was
14 ever considered or undertaken. Respondent documented that Patient B.D. had significant anxiety,
15 insomnia and PTSD, but there are no referrals for mental health consultation apparent in the
16 medical records. Respondent repeatedly prescribed significant doses of benzodiazepines to
17 Patient B.D. without seeking consultation with a mental health professional. While the medical
18 records were legible and documented in an electronic medical record system, the records for
19 Patient B.D. do not provide any clear rationale for the medications prescribed and/or for the
20 dosages used.

21 41. Respondent's treatment of Patient B.D. as described above was grossly negligent in
22 that each of the following represents a separate and extreme departure from the standard of care:

23 (A.) by failing to properly manage Patient B.D.'s chronic pain condition, anxiety and
24 insomnia by providing multiple controlled substances without performing a proper screening for
25

26 ⁶ CURES (Controlled Substance Utilization Review and Evaluation System) is a database
27 of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the
28 public health, regulatory oversight agencies, and law enforcement. CURES is committed to the
reduction of prescription drug abuse and diversion without affecting legitimate medical practice
or patient care.

1 depression, without performing a substance abuse history, without documenting why multiple
2 short acting narcotics were prescribed at the same time, without following up with consultations,
3 without obtaining a detailed informed consent reviewing the risks of taking muscle relaxants and
4 benzodiazepines while on narcotics, without documenting a treatment plan, without modifying
5 the medication contract as medications changes, without documenting the appropriateness of
6 continuing controlled medications, and without documenting why medications were prescribed or
7 increased; and

8 (B.) by failing to consult with and/or refer a patient with a complex pain problem and with
9 complex mental health issues to proper specialists and mental health professionals.

10 Patient D.E.

11 42. The Medical Board reviewed Respondent's medical records for Patient D.E. from
12 October 2, 2013, to February 15, 2016. Patient D.E. was treated by Respondent's office partner
13 before October 2, 2013. On October 7, 2013, Patient D.E. signed a medication contract with
14 Respondent that allowed for 3 to 4 tablets of 2 mg. hydromorphone hcl per day and 1 tablet of
15 350 mg. carisoprodol per day. The medical records do not contain any other medication
16 agreements despite Respondent prescribing and titrating additional controlled substances to
17 Patient D.E. during the course of treatment. On October 2, 2013, Respondent noted that Patient
18 D.E.'s back pain was a "7-10" on a pain scale of 0-10. Patient D.E.'s pain was described as,
19 "constant, burning, stabbing, sharp, throbbing sensation with radiation of pain, numbness and
20 tingling to the left leg down to the toes." The medical records documented two MRI's that were
21 conducted on June 17, 2013, and April 1, 2015. Both MRI's indicated that Patient D.E. had
22 degenerative disc changes to the L4-L5 region of his back that included bulging discs, and a
23 narrowing of canals.

24 43. Respondent routinely noted that the patient had a complex pain problem and had
25 significant mental health issues. Respondent noted that additional consultations with other
26 providers were needed. However, the records do not show any evidence that follow-up with
27 outside specialists was undertaken and there is no evidence that Respondent ever referred Patient
28 D.E. to a mental health professional despite prescribing large quantities of benzodiazepines. The

1 progress notes do not provide a clear rationale for why medications were prescribed and why
2 dosages were increased.

3 44. Between October 2, 2013, and, December 27, 2013, Respondent saw Patient D.E. in
4 her medical office 20 times. Between October 2, 2013, and December 31, 2013, Respondent
5 prescribed 314 pills of 10/325 mg. hydrocodone with acetaminophen, 68 pills of 350 mg.
6 carisoprodol, 5 pills of 2 mg. hydromorphone hcl, 14 pills of 10/325 mg. oxycodone with
7 acetaminophen, and 25 pills of 1 mg. alprazolam to Patient D.E. In October, November, and
8 December 2013, Patient D.E. received hydrocodone with acetaminophen from a physician other
9 than Respondent in violation of his medication agreement.

10 45. In 2014, Respondent saw Patient D.E. in her medical office 74 times. In 2014,
11 Respondent prescribed 1516 pills of 10/325 mg. hydrocodone with acetaminophen, 849 pills of 2
12 mg. hydromorphone hcl, 90 pills of 350 mg. carisoprodol, and 15 pills of .5 alprazolam.
13 Respondent had been prescribing tramadol throughout 2013, and continued prescribing in 2014.
14 Between August 14, 2014 and December 31, 2014, Respondent prescribed 720 pills of 50 mg.
15 tramadol to Patient D.E. On December 1, 2014, Respondent prescribed 45 pills of 2 mg.
16 hydromorphone hcl, and 60 50 mg. pills of tramadol to Patient D.E. On December 5, 2014,
17 Respondent prescribed 60 pills of 10/325 mg. hydrocodone with acetaminophen to Patient D.E.
18 These prescriptions were filled at Raley's Pharmacy number 416. On December 12, 2014,
19 Respondent prescribed 45 pills of 2 mg. hydromorphone hcl, and 60 50 mg. pills of tramadol to
20 Patient D.E. On December 16, 2014, Respondent prescribed 60 pills of 10/325 mg. hydrocodone
21 with acetaminophen to Patient D.E. These prescriptions were filled at Rite Aid Pharmacy
22 number 06000. Based on the refills, the prescriptions on December 1, 2014, and December 5,
23 2014, were supposed to last 11 days. Assuming Patient D.E. was consuming 4 pills of
24 hydromorphone hcl a day, 5 pills of tramadol a day, and 5 pills of hydrocodone with
25 acetaminophen a day as prescribed, Patient D.E. was at a morphine equivalent⁷ dose ("MED") of

26 ⁷ An MED is a numerical standard against which most opioids can be compared, yielding
27 an apples-to-apples comparison of each medication's potency. Morphine is used as the basis for
28 this comparison and other opioids with higher potencies are converted to their MED to provide
the comparison. All MED doses are in a comparable mg. amount of morphine.

1 107 by December 2014. The progress notes do not document why Patient D.E. was receiving
2 multiple short acting narcotics at the same time. The progress notes do not show that a written
3 consent was obtained or that a detailed discussion took place with Patient D.E. regarding the risks
4 of taking benzodiazepines and muscle relaxants while he was on narcotic pain medication.

5 46. In 2015, Respondent saw Patient D.E. in her medical office 95 times. In 2015,
6 Respondent prescribed 2260 pills of 10/325 mg. acetaminophen, 495 pills of 2 mg.
7 hydromorphone hcl, 337 pills of 4 mg. hydromorphone hcl, 913 pills of 50 mg. tramadol, 156
8 pills of 1 mg. alprazolam, 19 pills of .5 mg alprazolam, 89 pills of oxycodone with
9 acetaminophen, 240 ml. of promethazine with codeine, 5 25 mcg./hr. fentanyl patches, 5 50
10 mcg./hr. fentanyl patches, 35 75 mcg./hr. fentanyl patches, and 35 100 mcg./hr. fentanyl patches
11 to Patient D.E. Of note, on July 14, 2015, and July 28, 2015, Respondent prescribed 5 100
12 mcg./hr. fentanyl patches to Patient D.E. This prescription was filled at Bel Air Pharmacy #519.
13 On July 18, 2015, Respondent prescribed 60 tablets of 10/325 mg. hydrocodone with
14 acetaminophen and 7 tablets of 1 mg. alprazolam to Patient D.E. This prescription was filled at
15 Walgreens Pharmacy #5152. On July 24, 2015, Respondent prescribed 60 tablets of 10/325 mg.
16 hydrocodone with acetaminophen and 7 tablets of 1 mg. alprazolam to Patient D.E. This
17 prescription was filled at Raley's Pharmacy #416.⁸ Assuming that Patient D.E. was consuming 1
18 fentanyl patch every three days, 10 pills of hydrocodone with acetaminophen, and 1 alprazolam a
19 day as prescribed based on refills, Patient D.E. was at a MED of 340 while taking a
20 benzodiazepine in July 2015. The medical records are silent as to why Patient D.E.'s MED had
21 tripled in six months from December 2014 to July 2015.

22 47. Between January 3, 2016, and, February 15, 2016, Respondent saw Patient D.E. in
23 her medical office 14 times. Between January 1, 2016, and February 29, 2016, Respondent

24 ⁸ Health and Safety Code section 11153, subdivision (a) provides, in pertinent part: "A
25 prescription for a controlled substance shall only be issued for a legitimate medical purpose by an
26 individual practitioner acting in the usual course of his or her professional practice. The
27 responsibility for the proper prescribing and dispensing of controlled substances is upon the
28 prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the
prescription." The practice of concurrent use of multiple pharmacies is known as "pharmacy
shopping" which is intended to avoid suspicion of improper prescribing by pharmacists cognizant
of their obligations under this statute.

1 prescribed 195 pills of hydrocodone with acetaminophen, 127 pills of 50 mg. tramadol, 5 75
2 mcg./hr. fentanyl patches, 41 pills of 10/325 mg. oxycodone with acetaminophen, 129 pills of 4
3 mg. dilaudid, 25 pills of 1 mg. alprazolam, and 180 ml. of promethazine with codeine cough
4 syrup.

5 48. The progress notes do not contain specific screening tools for mental health
6 evaluation. The progress notes do not contain any specific substance abuse history or a reference
7 to prior pain treatments that Patient D.E. underwent. The records do not contain specific orders
8 or consultation notes and there is no record of physician follow-up with specialists. The progress
9 notes appear to be similar templates and despite the patient being seen almost weekly, fail to note
10 new objectives and plans, even when the patient had complaints of increased pain. The progress
11 notes do not contain a treatment plan. The progress notes do not mention whether medications
12 were withheld or whether discontinuation of treatment was ever discussed with Patient D.E.
13 There is no clear indication in the records that Respondent was aware that Patient D.E. was
14 receiving controlled medications from multiple pharmacies and multiple providers, and the
15 records do not contain a printout from CURES.

16 49. Respondent's treatment of Patient D.E. as described above represents a separate and
17 extreme departure from the standard of care in each of the following:

18 (A.) by failing to properly manage Patient D.E.'s chronic pain condition, anxiety and
19 insomnia by providing multiple controlled substances without performing a proper screening for
20 depression, without modifying the medication contract as new medications were added and
21 dosages were changed, without performing a substance abuse history, without documenting why
22 multiple short acting narcotics were prescribed at the same time, without following up with
23 consultations, without documenting a treatment plan, without obtaining a detailed informed
24 consent reviewing the risks of taking muscle relaxants and benzodiazepines while on narcotics,
25 without documenting the appropriateness of continuing controlled medications, and without
26 documenting why medications were prescribed or increased; and,

27 (B.) by failing to consult with and/or refer a patient with a complex pain problem and with
28 complex mental health issues to proper specialists and mental health professionals.

Patient E.S.

1
2 50. The Medical Board reviewed a complete set of Respondent's medical records for
3 Patient E.S. from March 2, 2013, to December 23, 2014. Respondent noted at the first visit on
4 March 2, 2013, that Patient E.S. suffered from neck/back pain, shoulder pain, and insomnia. A
5 CT scan and a MRI report from July 11, 2007, indicated there were degenerative changes in the
6 patient's back. Patient E.S. had almost weekly visits with Respondent and multiple medications
7 were provided. Respondent provided pain management treatment to Patient E.S. During Patient
8 E.S.'s course of treatment Respondent prescribed hydrocodone with acetaminophen, oxycodone
9 with acetaminophen, and carisoprodol. A medication contract was signed on October 30, 2013,
10 that included carisoprodol and hydrocodone with acetaminophen. There were no other
11 medication contracts contained in the record despite changes in dosing and changes in
12 medications.

13 51. Respondent prescribed high doses of carisoprodol and opioids at the same time to
14 Patient E.S. Patient E.S. filled the prescriptions at multiple pharmacies. For example, on May 5,
15 2013, Respondent prescribed 40 pills of 350 mg. carisoprodol and 40 pills of 10/325 mg.
16 hydrocodone with acetaminophen. The prescription was filled at Walgreen's Pharmacy # 04136.
17 On May 8, 2013, Respondent prescribed 90 pills 350 mg. carisoprodol and 60 pills of 10/325 mg.
18 hydrocodone with acetaminophen. The prescription was filled at Capitol Pharmacy. On May 21,
19 2013, Respondent prescribed 90 pills of 350 mg. carisoprodol and 60 pills of 10/325 mg.
20 hydrocodone with acetaminophen. The prescription was filled at Med-Aid Pharmacy.
21 Respondent refilled both the hydrocodone with acetaminophen and carisoprodol on June 3, 2013.
22 Assuming that Patient E.S. consumed all 220 350 mg. pills of carisoprodol between May 5, 2013,
23 and June 2, 2013, Patient E.S. was taking 7.5 pills a day or a total of 2625 mg. of carisoprodol.
24 The maximum daily recommended dose is 1050 mg.

25 52. On September 2, 2014, Respondent prescribed 90 tablets of 350 mg. carisoprodol and
26 60 tablets of hydrocodone with acetaminophen to Patient E.S. The prescription was filled at
27 Vang's Pharmacy. On September 5, 2014, Respondent prescribed 90 tablets of 350 mg.
28 carisoprodol and 60 tablets of hydrocodone with acetaminophen to Patient E.S. The prescription

1 was filled at CVS Pharmacy # 09992. On September 10, 2014, Respondent prescribed 90 tablets
2 of 350 mg. carisoprodol and 60 tablets of hydrocodone with acetaminophen to Patient E.S. The
3 prescription was filled at Jefferson Pharmacy. On September 17, 2014, Respondent prescribed 90
4 tablets of 350 mg. carisoprodol and 60 tablets of hydrocodone with acetaminophen to Patient E.S.
5 The prescription was filled at CVS Pharmacy # 09992. On September 23, 2014, Respondent
6 prescribed 90 tablets of 350 mg. carisoprodol and 60 tablets of hydrocodone with acetaminophen
7 to Patient E.S. The prescription was filled at Jefferson Pharmacy. Respondent refilled
8 prescriptions for both hydrocodone with acetaminophen and carisoprodol on October 4, 2014.
9 Assuming that Patient E.S. consumed all 450 350 mg. pills of carisoprodol between September 2,
10 2014, and October 3, 2014, Patient E.S. was taking 14 pills a day or 4900 mg. carisoprodol. The
11 maximum daily recommended dose is 1050 mg. Respondent failed to obtain a written consent or
12 document a detailed discussion with Patient E.S. regarding the risks of taking muscle relaxants
13 together with opioids.

14 53. Respondent prescribed two short acting opioid medications at the same time to
15 Patient E.S. For example, on July 25, 2014, Respondent prescribed 15 pills of 10/325 mg.
16 oxycodone with acetaminophen and 60 pills of 10/325 mg. hydrocodone with acetaminophen to
17 Patient E.S. On April 13, 2014, Respondent prescribed 60 pills of 10/325 mg. hydrocodone with
18 acetaminophen. Three days earlier, on April 10, 2014, Respondent had prescribed 24 pills of
19 10/325 mg. oxycodone with acetaminophen. On December 6, 2013, Respondent prescribed 60
20 pills of 10/325 mg. hydrocodone with acetaminophen. Just one day earlier, on December 5, 2013,
21 Respondent prescribed 24 pills of 10/325 mg. oxycodone with acetaminophen. On June 3, 2013,
22 Respondent prescribed 60 pills of 10/325 mg. hydrocodone with acetaminophen and 20 pills of 5
23 mg. oxycodone. All of these multiple short-acting opioid prescriptions were provided while
24 Patient E.S. was on carisoprodol.

25 54. Respondent documented an assessment of pain and physical function in Patient E.S.'s
26 medical records. Respondent failed to document specific orders or consultation notes in the
27 medical records and failed to document physician follow-up. Respondent failed to document
28 prior pain treatments in Patient E.S.'s medical records. Respondent failed to create and/or

1 document a treatment plan in Patient E.S.'s medical records. Respondent failed to update Patient
2 E.S.'s medication contract despite changing dosages and medications. Respondent failed to
3 review and/or document reviewing whether Patient E.S. was benefitting from being on controlled
4 medications. Respondent failed to follow-up or consult with other specialists despite noting that
5 Patient E.S. needed to be seen by outside consultants. Respondent failed to document why
6 medications were changed and dosages were changed in the medical records.

7 55. Respondent's treatment of Patient E.S. as described above was grossly negligent, and
8 represents a separate and extreme departure from the standard of care in each of the following:

9 (A.) by failing to properly manage Patient E.S.'s chronic pain condition, without
10 performing a substance abuse history, without documenting why two short acting narcotics were
11 prescribed at the same time, without following up with consultations, without documenting a
12 treatment plan, without modifying the medication contract as medications changes, without
13 obtaining a detailed informed consent reviewing the risks of taking muscle relaxants, while on
14 narcotics without documenting the appropriateness of continuing controlled medications, and
15 without documenting why medications were prescribed or increased; and,

16 (B.) by failing to consult with and/or refer a patient with a complex pain problem with
17 complex mental health issues to proper specialists and mental health professionals.

18 Patient J.L.

19 56. The Medical Board reviewed a complete set of Respondent's medical records for
20 Patient J.L. from December 2, 2013, to February 15, 2016. Patient J.L. became a patient at
21 Respondent's clinic on November 16, 2012. Respondent provided pain management treatment to
22 Patient J.L. During Patient J.L.'s course of treatment, Respondent prescribed hydrocodone with
23 acetaminophen, oxycodone with acetaminophen, carisoprodol, lorazepam, and codeine with
24 promethazine. Patient J.L. received thousands of pills from Respondent. On December 2, 2013,
25 Patient J.L. signed a medication agreement with Respondent which stated that Patient J.L. would
26 take one pill of 10/325 mg. oxycodone with acetaminophen every twelve hours. Despite
27 increasing dosages and titrating new medications, there are no other medication agreements
28 contained in the Patient J.L.'s medical records. Respondent provided Patient J.L. with two short-

1 acting narcotics at the same time during treatment. For example on February 2, 2015,
2 Respondent prescribed 30 pills of 10/325 mg. hydrocodone with acetaminophen to Patient J.L.
3 The prescription was filled at Raley's Pharmacy # 416. On February 7, 2015, the Respondent
4 prescribed 15 pills of 10/325 mg. oxycodone with acetaminophen to Patient J.L. The prescription
5 was filled at Rite Aide # 6403. On August 28, 2015, Respondent prescribed 20 pills of 10/325
6 mg. hydrocodone with acetaminophen to Patient J.L. On August 31, 2015, Respondent
7 prescribed 20 pills of 10.325 mg. oxycodone with acetaminophen to Patient J.L. Both
8 prescriptions were filled at Rite Aide # 6403.

9 57. Patient J.L. filled prescriptions from Respondent at twenty separate pharmacies when
10 obtaining controlled substances.⁹ Patient J.L. received lorazepam from physicians other than
11 Respondent while she was under Respondent's care. For example, on November 24, 2014,
12 Patient J.L. received 30 pills of 10/325 mg. hydrocodone with acetaminophen and 30 pills of 1
13 mg. lorazepam from Respondent. The prescription was filled at Raley's Pharmacy # 416. Patient
14 J.L. also received 90 pills of .5 mg. lorazepam from a separate physician on November 7, 2014.
15 This prescription was filled at CVS Pharmacy # 9992. Also, on February 14, 2014, and February
16 19, 2014, Respondent prescribed 15 pills of .5 mg. lorazepam to Patient J.L. These two
17 prescriptions were filled at Rite Aid Pharmacy #6403. On February 20, 2014, Patient J.L.
18 received 90 pills of 1 mg. lorazepam from another physician. Respondent's medical records are
19 silent regarding the facts that Patient J.L. filled prescriptions at twenty separate pharmacies during
20 treatment and received lorazepam from other physicians while Respondent was prescribing
21 lorazepam.

22 58. Respondent prescribed three classes of controlled substances, an opioid, a
23 benzodiazepine, and carisoprodol, to Patient J.L. at the same time. For example, Patient J.L.
24 received 15 pills of .5 mg. lorazepam, and 14 pills of 350 mg. carisoprodol on April 2, 2014. On

25 ⁹ Raley's Pharmacy #416, CVS Pharmacy #2124, CVS Pharmacy #5225, CVS Pharmacy
26 #9809, CVS Pharmacy #9823, CVS Pharmacy #9992, Rite Aid Pharmacy #6079, Rite Aid
27 Pharmacy #6043, Rite Aide Pharmacy #33090, Wal-Mart Pharmacy #10-5982, Wal-Mart
28 Pharmacy #10-5230, Wal-Mart Pharmacy #10-4393, Wal-Mart Pharmacy 10-2457, Tri-Star
Pharmacy, Raley's Pharmacy #420, Safeway Pharmacy #1746, Safeway Pharmacy #2684,
Safeway Pharmacy #1530, Target Pharmacy #312, and Anderson Brothers Pharmacy.

1 April 3, 2014, Patient J.L. received 15 pills of 10/325 mg. oxycodone with acetaminophen. On
2 April 7, 2014, Patient J.L. received 15 pills of .5 mg lorazepam, 14 pills of 350 mg. carisoprodol,
3 and 15 pills of 10/325 mg. oxycodone with acetaminophen. On April 28, 2014, Patient J.L.
4 received 15 pills of 350 mg. carisoprodol. On May 1, 2014, Patient J.L. received 15 pills of .5
5 mg. lorazepam, and 15 pills of 10/325 mg. oxycodone with acetaminophen. All of these
6 prescriptions were written by Respondent and filled at Rite Aid Pharmacy # 6403. The medical
7 records are silent in explaining why Patient J.L. was on an opioid, a benzodiazepine, and
8 carisoprodol at the same time. Respondent failed to obtain and/or document obtaining a detailed
9 informed consent from Patient J.L. that explained the risks of taking carisoprodol and lorazepam
10 while he was also taking narcotics.

11 59. On June 24, 2015, Respondent had Patient J.L. provide a urine sample. On June 29,
12 2015, the urine sample was tested and provided a positive result for lorazepam, oxycodone,
13 oxycodone metabolites, methadone, and methadone metabolites. At the time, Respondent was
14 prescribing oxycodone with acetaminophen and lorazepam. Respondent was not prescribing
15 methadone. The results were provided to Respondent on or about June 29, 2015. A review of the
16 June 24, 2015, June 29, 2015, July 4, 2015, and July 10, 2015, medical records for Patient J.L.
17 created by Respondent do not indicate that this positive test for methadone was noted by
18 Respondent or discussed with Patient J.L. Despite being in violation of his pain medication
19 agreement, Respondent continued to prescribe controlled substances to Patient J.L. The medical
20 records also do not contain any further urine tests for Patient J.L.

21 60. Respondent documented performing an assessment of pain and an initial history and
22 physical. Respondent failed to document specific orders for consultation and perform physician
23 follow-up. Respondent failed to document Patient J.L.'s past pain treatments, and failed to full
24 assess Patient J.L.'s anxiety. Respondent failed to document a treatment plan. Respondent failed
25 to modify or update Patient J.L.'s medication contract as new medications were added and
26 dosages were changed. Respondent failed to perform periodic reviews to determine whether
27 Patient J.L. should remain on controlled substances, especially when confronted with a urine test
28 that indicated Patient J.L. was taking methadone without a prescription from Respondent and in

1 violation of the patient's medication agreement. Respondent failed to follow-up with consultation
2 with pain medicine specialists and failed to consult a mental health professional despite
3 prescribing large quantities of lorazepam to Patient J.L. Respondent failed to provide reasons for
4 why medications were provided and why dosages were changed.

5 61. Respondent's treatment of Patient J.L. as described above was grossly negligent and
6 represents a separate and extreme departure from the standard of care in each of the following:

7 (A.) by failing to properly manage Patient J.L.'s chronic pain condition, without performing
8 a substance abuse history, without documenting why two short acting narcotics were prescribed at
9 the same time, without following up with consultations, without documenting a treatment plan,
10 without modifying the medication contract as medication changed, without obtaining a detailed
11 informed consent reviewing the risks of taking muscle relaxants and benzodiazepines while on
12 narcotics, without documenting the appropriateness of continuing controlled medications, and
13 without documenting why medications were prescribed or increased; and,

14 (B.) by failing to consult with and/or refer a patient with a complex pain problem and with
15 complex mental health issues to proper specialists and mental health professionals.

16 Patient P.F.-W.

17 62. The Board reviewed a complete set of Respondent's medical records for Patient P.F.-
18 W. between June 24, 2013 and January 9, 2016. In the progress note dated June 24, 2013,
19 Respondent noted that Patient P.F.-W. had chronic low back pain after a cerebrovascular accident
20 three years prior with hemiparesis. Respondent provided pain management treatment to Patient
21 P.F.-W. During treatment Respondent prescribed carisoprodol, hydromorphone hcl, hydrocodone
22 with acetaminophen, oxycodone with acetaminophen, diazepam, alprazolam, and zolpidem
23 tartrate. Respondent continually changed dosages, prescribed multiple medications, and titrated
24 new medications during treatment. The records contained two MRI reports, one from November
25 20, 2015, and one from April 25, 2013, that showed minimal degenerative changes. The record
26 contained orders for a urine drug screen but no specific results. It is unknown when the drug
27 screen was ordered.

28 ///

1 63. The medical records contain a patient registration sheet that was filled out by Patient
2 P.F.-W. on March 4, 2016, almost three years after Patient P.F.-W. began receiving treatment
3 from Respondent. The records contain a medication contract that was signed on March 4, 2016
4 by Patient P.F.-W., that lists hydrocodone with acetaminophen and flexeril. This document was
5 signed almost three years after Respondent began providing treatment and does not mention any
6 of the other medications that Patient P.F.-W. had previously received. A review of pharmacy
7 records shows that Patient P.F.-W. was receiving controlled substances from other providers
8 while receiving treatment from Respondent. For example, on October 15, 2015, and October 13,
9 2014, Patient P.F.-W. filled diazepam prescriptions from other providers at Rite Aid Pharmacy #
10 06228. Also, on July 29, 2014, Patient P.F.-W. filled a hydrocodone with acetaminophen
11 prescription at Walgreens Pharmacy # 15602 from another provider. On April 19, 2015, Patient
12 P.F.-W. filled a hydrocodone with acetaminophen prescription at Rite Aid Pharmacy #06228
13 from another provider. The medical records are silent as to whether Respondent was aware of
14 and/or took action regarding Patient P.F.-W. filling prescriptions in addition to the prescriptions
15 she was receiving from Respondent.

16 64. Respondent prescribed three classes of controlled substances, an opioid,
17 benzodiazepine, and carisoprodol to Patient P.F.-W. at the same time. Respondent also
18 prescribed two short-acting opioid medications at the same time and also prescribed zolpidem
19 tartrate to Patient P.F.-W. For example, on March 25, 2015, Respondent prescribed 10 pills of 10
20 mg. zolpidem tartrate, 75 pills of 10/325 mg. hydrocodone with acetaminophen, and 75 pills of 8
21 mg. hydromorphone hcl to Patient P.F.-W.¹⁰ On April 6, 2015, Respondent prescribed 90 pills of
22 350 mg. carisoprodol. On April 7, 2015, Respondent prescribed 75 pills of 10/325 mg.
23 hydrocodone with acetaminophen, and 75 pills of 8 mg. hydromorphone hcl to Patient P.F.-W.
24 On April 19, 2015, as noted above, Patient P.F.-W. filled a prescription for 10 pills of 5/325 mg.
25 hydrocodone with acetaminophen from an outside provider. On April 20, 2015, Respondent

26 ¹⁰ Assuming that these prescriptions for 75 pills were supposed to last twelve days based
27 on refills that occurred on April 7, 2015, Patient P.F.-W. would have been taking 6 pills a day.
28 By consuming 6 8 mg. hydromorphone hcl and 6 10/325 mg. hydrocodone with acetaminophen,
Patient P.F.-W.'s MED would have been approximately 250.

1 prescribed 20 pills of 1 mg. alprazolam, 75 pills of 10/325 mg. hydrocodone with acetaminophen,
2 and 75 pills of 8 mg. hydromorphone hcl to Patient P.F.-W. On May 4, 2015, Respondent
3 prescribed 15 pills of mg. alprazolam, 76 pills of 10/325 mg. hydrocodone with acetaminophen,
4 and 76 pills of 8 mg. hydromorphone hcl to Patient P.F.-W. On May 19, 2015, Respondent
5 prescribed 45 pills of 350 mg. carisoprodol. All of these prescriptions were filled at Rite Aid
6 Pharmacy # 06228. Respondent failed to obtain and/or document obtaining a detailed informed
7 consent from Patient P.F.-W. regarding the risks of taking carisoprodol and benzodiazepines
8 while being prescribed narcotic medications.

9 65. The progress notes do not contain specific screening tools for mental health
10 evaluation. The progress notes do not contain any specific substance abuse history or a reference
11 to prior pain treatments that Patient P.F.-W. underwent. The records do not contain specific
12 orders or consultation notes and there is no record of physician follow-up with specialists. The
13 progress notes appear to be similar templates and despite the patient being seen almost weekly,
14 fail to note new objectives and plans, even when the patient had complaints of increased pain.
15 The progress notes do not contain a treatment plan. The progress notes do not mention whether
16 medications were withheld or discontinuation was discussed with Patient P.F.-W. There is no
17 clear indication in the records that Respondent was aware that Patient P.F.-W. was receiving
18 controlled medications from multiple pharmacies and multiple providers, and the records do not
19 contain a printout from CURES. There is no evidence that Respondent ever referred Patient P.F.-
20 W. to a mental health professional despite prescribing large quantities of benzodiazepines to
21 Patient P.F.-W. There is an order for a urine drug test in the medical records but no results were
22 located in the chart.

23 66. Respondent's treatment of Patient P.F.-W. as described above was grossly negligent
24 and represents a separate and extreme departure from the standard of care in each of the
25 following:

26 (A.) by failing to properly manage Patient P.F.-W.'s chronic pain condition, anxiety and
27 insomnia by providing multiple controlled substances without performing a proper screening for
28 depression, without performing a substance abuse history, without documenting why two short

1 acting narcotics were prescribed at the same time, without following up with consultations,
2 without documenting a treatment plan, without obtaining a detailed informed consent reviewing
3 the risks of taking muscle relaxants and benzodiazepines while on narcotics, without documenting
4 the appropriateness of continuing controlled medications, and without documenting why
5 medications were prescribed or increased;

6 (B.) obtaining a medication contract for hydrocodone with acetaminophen with Patient
7 P.F.-W. almost three years after prescribing controlled substances including, carisoprodol,
8 hydromorphone hcl, oxycodone with acetaminophen, diazepam, alprazolam, and zolpidem
9 tartrate; and,

10 (C.) by failing to consult with and/or refer a patient with a complex pain problem with
11 complex mental health issues to proper specialists and mental health professionals.

12 **THIRD CAUSE FOR DISCIPLINE**

13 **(Repeated Negligent Acts)**

14 67. Respondent's license is subject to disciplinary action under section 2234, subdivision
15 (c), in that she committed repeated negligent acts during the care of Patients J.T., R.G., B.D.,
16 D.E., E.S., J.L., and, P. F.-W. by failing to properly prescribe controlled substances. The
17 circumstances are as follows:

18 68. Complainant realleges paragraphs 23 through 66, and those paragraphs are
19 incorporated by reference as if fully set forth herein.

20 69. Respondent's license is subject to disciplinary action because she committed the
21 following repeated negligent acts during the care of Patients J.T., R.G., B.D., D.E., E.S., J.L., and,
22 P. F.-W.:

23 a.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
24 Patient J.T. by failing to detail previous pain treatments, failing to fully assess whether Patient
25 J.T. suffered from anxiety, depression, and insomnia, and failing to properly perform a history
26 and physical examination, represents a departure from the standard of care;

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1 b.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
2 Patient J.T. by failing to develop a treatment plan and failing to obtain past treatment records,
3 represents a departure from the standard of care;

4 c.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
5 Patient J.T. by failing to obtain a medication contract and/or informed consent, represents a
6 departure from the standard of care;

7 d.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
8 Patient J.T. by failing to perform periodic review represents a departure from the standard of care;

9 e.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
10 Patient J.T. by failing to consult with a mental health professional despite prescribing large
11 quantities of benzodiazepines represents a departure from the standard of care;

12 f.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
13 Patient J.T. by falsely documenting treatment in the progress notes that was not actually
14 performed represents a departure from the standard of care;

15 g.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
16 R.G. by failing to detail previous pain treatments, failing to fully assess whether Patient R.G.
17 suffered from anxiety, and insomnia, and failing to properly perform a history and physical
18 examination, represents a departure from the standard of care;

19 h.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
20 R.G. by failing to develop a treatment plan and failing to obtain past treatment records, represents
21 a departure from the standard of care;

22 i.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
23 R.G. by failing to obtain a medication contract and/or informed consent, represents a departure
24 from the standard of care;

25 j.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
26 R.G. by failing to perform periodic review represents a departure from the standard of care;
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1 k.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
2 R.G. by failing to consult with a mental health professional despite prescribing large quantities of
3 benzodiazepines represents a departure from the standard of care;

4 l.) As more fully described in paragraphs 23 through 34, Respondent's treatment of
5 R.G. by failing documenting treatment in the progress notes that was not actually performed
6 represents a departure from the standard of care;

7 m.) As more fully described in paragraphs 36 through 41, Respondent's treatment of
8 Patient B.D. by prescribing multiple short acting narcotics at the same time, and by failing to use
9 screening tools for depression, anxiety, and insomnia despite prescribing large quantities of
10 benzodiazepines represents a departure from the standard of care;

11 n.) As more fully described in paragraphs 36 through 41, Respondent's treatment of
12 Patient B.D. by failing to obtain prior treatment records and failing to ensure proper physician
13 follow-up with medical specialists represents a departure from the standard of care;

14 o.) As more fully described in paragraphs 36 through 41, Respondent's treatment of
15 Patient B.D. by failing to develop and record a treatment plan represents a departure from the
16 standard of care;

17 p.) As more fully described in paragraphs 36 through 41, Respondent's treatment of
18 Patient B.D. by failing to review and/or update the medication contract as medications changed or
19 dosages changed represents a departure from the standard of care;

20 q.) As more fully described in paragraphs 36 through 41, Respondent's treatment of
21 Patient B.D. by failing to perform periodic review to assess if Patient B.D. should remain on
22 controlled substances despite almost weekly visits represents a departure from the standard of
23 care;

24 r.) As more fully described in paragraphs 36 through 41, Respondent's treatment of
25 Patient B.D. by failing to adequately and accurately keep medical records explaining why
26 medications were prescribed and/or increased represents a departure from the standard of care;

27 s.) As more fully described in paragraphs 36 through 41, Respondent's treatment of
28 Patient B.D. by failing to have a detailed discussion and/or failing to document having a detailed

1 discussion regarding the risks of taking benzodiazepine medications and muscle relaxants at the
2 same time narcotic medications are being prescribed represents a departure from the standard of
3 care;

4 t.) As more fully described in paragraphs 42 through 49, Respondent's treatment of
5 Patient D.E. by prescribing multiple short acting narcotics at the same time, and by failing to use
6 screening tools for depression, anxiety, and insomnia despite prescribing large quantities of
7 benzodiazepines represents a departure from the standard of care;

8 u.) As more fully described in paragraphs 42 through 49, Respondent's treatment of
9 Patient D.E. by failing to obtain prior treatment records and failing to ensure proper physician
10 follow-up with medical specialists represents a departure from the standard of care;

11 v.) As more fully described in paragraphs 42 through 49, Respondent's treatment of
12 Patient D.E. by failing to develop and record a treatment plan represents a departure from the
13 standard of care;

14 w.) As more fully described in paragraphs 42 through 49, Respondent's treatment of
15 Patient D.E. by failing to review and/or update the medication contract as medications changed or
16 dosages changed represents a departure from the standard of care;

17 x.) As more fully described in paragraphs 42 through 49, Respondent's treatment of
18 Patient D.E. by failing to perform periodic review to assess if Patient D.E. should remain on
19 controlled substances despite almost weekly visits represents a departure from the standard of
20 care;

21 y.) As more fully described in paragraphs 42 through 49, Respondent's treatment of
22 Patient D.E. by failing to adequately and accurately keep medical records explaining why
23 medications were prescribed and/or increased represents a departure from the standard of care;

24 z.) As more fully described in paragraphs 42 through 49, Respondent's treatment of
25 Patient D.E. by failing to have a detailed discussion and/or failing to document having a detailed
26 discussion regarding the risks of taking benzodiazepine medications and muscle relaxants at the
27 same time narcotic medications are being prescribed represents a departure from the standard of
28 care;

1 aa.) As more fully described in paragraphs 50 through 55, Respondent's treatment of
2 Patient E.S. by failing to make specific orders and document physician follow-up with specialists
3 and failing to document prior pain treatments represents a departure from the standard of care;

4 bb.) As more fully described in paragraphs 50 through 55, Respondent's treatment of
5 Patient E.S. by failing to develop and record a treatment plan represents a departure from the
6 standard of care;

7 cc.) As more fully described in paragraphs 50 through 55, Respondent's treatment of
8 Patient E.S. by failing to review and/or update the medication contract as medications changed or
9 dosages changed represents a departure from the standard of care;

10 dd.) As more fully described in paragraphs 50 through 55, Respondent's treatment of
11 Patient E.S. by failing to perform periodic review to assess if Patient E.S. should remain on
12 controlled substances despite almost weekly visits represents a departure from the standard of
13 care;

14 ee.) As more fully described in paragraphs 50 through 55, Respondent's treatment of
15 Patient E.S. by failing to adequately and accurately keep medical records explaining why
16 medications were prescribed and/or increased represents a departure from the standard of care;

17 ff.) As more fully described in paragraphs 50 through 55, Respondent's treatment of
18 Patient E.S. by failing to have a detailed discussion and/or failing to document having a detailed
19 discussion regarding the risks of taking muscle relaxants at the same time narcotic medications
20 are being prescribed represents a departure from the standard of care;

21 gg.) As more fully described in paragraphs 50 through 55, Respondent's treatment of
22 Patient E.S. by prescribing multiple short acting narcotics at the same time represents a departure
23 from the standard of care;

24 hh.) As more fully described in paragraphs 56 through 61, Respondent's treatment of
25 Patient J.L. by failing to make specific orders and document physician follow-up with specialists
26 and failing to document prior pain treatments represents a departure from the standard of care;

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1 ii.) As more fully described in paragraphs 56 through 61, Respondent's treatment of
2 Patient J.L. by failing to develop and record a treatment plan represents a departure from the
3 standard of care;

4 jj.) As more fully described in paragraphs 56 through 61, Respondent's treatment of
5 Patient J.L. by failing to review and/or update the medication contract as medications changed or
6 dosages changed represents a departure from the standard of care;

7 kk.) As more fully described in paragraphs 56 through 61, Respondent's treatment of
8 Patient J.L. by failing to perform periodic review to assess if Patient J.L. should remain on
9 controlled substances despite almost weekly visits represents a departure from the standard of
10 care;

11 ll.) As more fully described in paragraphs 56 through 61, Respondent's treatment of
12 Patient J.L. by failing to adequately and accurately keep medical records explaining why
13 medications were prescribed and/or increased represents a departure from the standard of care;

14 mm.) As more fully described in paragraphs 56 through 61, Respondent's treatment
15 of Patient J.L. by failing to have a detailed discussion and/or failing to document having a
16 detailed discussion regarding the risks of taking benzodiazepine medications and muscle relaxants
17 at the same time narcotic medications are being prescribed represents a departure from the
18 standard of care;

19 nn.) As more fully described in paragraphs 56 through 61, Respondent's treatment of
20 Patient J.L. by prescribing multiple short acting narcotics at the same time represents a departure
21 from the standard of care;

22 oo.) As more fully described in paragraphs 62 through 66, Respondent's treatment of
23 Patient P.F.-W. by failing to obtain prior treatment records, failing to ensure proper physician
24 follow-up with medical specialists and by failing to use screening tools for depression, anxiety,
25 and insomnia despite prescribing large quantities of benzodiazepines, represents a departure from
26 the standard of care;

1 pp.) As more fully described in paragraphs 62 through 66, Respondent's treatment of
2 Patient P.F.-W. by failing to develop and record a treatment plan represents a departure from the
3 standard of care;

4 qq.) As more fully described in paragraphs 62 through 66, Respondent's treatment of
5 Patient P.F.-W. by failing to perform periodic review to assess if Patient P.F.-W. should remain
6 on controlled substances despite almost weekly visits represents a departure from the standard of
7 care;

8 rr.) As more fully described in paragraphs 62 through 66, Respondent's treatment of
9 Patient P.F.-W. by failing to adequately and accurately keep medical records explaining why
10 medications were prescribed and/or increased represents a departure from the standard of care;

11 ss.) As more fully described in paragraphs 62 through 66, Respondent's treatment of
12 Patient P.F.-W. by failing to have a detailed discussion and/or failing to document having a
13 detailed discussion regarding the risks of taking benzodiazepine medications and muscle relaxants
14 at the same time narcotic medications are being prescribed represents a departure from the
15 standard of care; and

16 tt.) As more fully described in paragraphs 62 through 66, Respondent's treatment of
17 Patient P.F.-W. by prescribing multiple short acting narcotics at the same time represents a
18 departure from the standard of care.

19 **FOURTH CAUSE FOR DISCIPLINE**

20 **(Prescribing without Conducting an Appropriate Prior Examination)**

21 70. Respondent's license is subject to disciplinary action under section 2242 of the Code
22 in that Respondent prescribed dangerous drugs without performing an appropriate prior
23 examination and without medical indication. The circumstances are as follows:

24 71. Complainant realleges paragraphs 23 through 34, and those paragraphs are
25 incorporated by reference as if fully set forth herein.

26 72. Respondent's license is subject to disciplinary action because she repeatedly provided
27 controlled substances to Patients J.T. and R.G. without performing an appropriate prior
28 examination and without medical indication.

1 **FIFTH CAUSE FOR DISCIPLINE**

2 **(False Representations in Medical Records)**

3 73. Respondent's license is subject to disciplinary action under section 2261 of the Code,
4 in that she made false representations when she knowingly signed electronic medical charts that
5 contained false and misleading information.

6 74. Complainant realleges paragraphs 23 through 34, and those paragraphs are
7 incorporated by reference as if fully set forth herein.

8 75. As more fully described above, Respondent made false representations when she
9 knowingly signed electronic medical charts that contained false and misleading information.

10 **SIXTH CAUSE FOR DISCIPLINE**

11 **(Creation of False Medical Records)**

12 76. Respondent's license is subject to disciplinary action under section 2262 of the Code,
13 in that she created false medical records with fraudulent intent. The circumstances are as follows:

14 77. Complainant realleges paragraphs 23 through 34, and those paragraphs are
15 incorporated by reference as if fully set forth herein.

16 78. As more fully described above, Respondent created false medical records to justify
17 prescribing controlled substances to Patients J.T. and R.G.

18 **SEVENTH CAUSE FOR DISCIPLINE**

19 **(Inadequate Record Keeping)**

20 79. Respondent's license is subject to disciplinary action under section 2266 of the Code,
21 in that she failed to maintain adequate and accurate records relating to the provision of services to
22 her patients.

23 80. Complainant realleges paragraphs 23 through 69, and those paragraphs are
24 incorporated by reference as if fully set forth herein.

25 81. As more fully described above, Respondent failed to maintain adequate and accurate
26 records relating to the provision of services to her patients.

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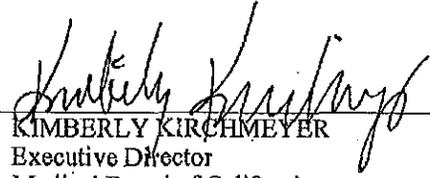
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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G72879, issued to Kimberly T. Le;
2. Revoking, suspending or denying approval of Kimberly T. Le's authority to supervise physician assistants, pursuant to section 3527 of the Code;
3. Ordering Kimberly T. Le, 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: October 20, 2016



KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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