XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
LYNETTE D. HECKER
Deputy Attorney General
State Bar No. 182198
California Department of Justice
2550 Mariposa Mall, Room 5090
Fresno, CA 93721
Telephone: (559) 705-2320
Facsimile: (559) 445-5106
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Manolito Velasquez Castillo, M.D.** **2111 O Street** **Merced, CA 95340** Physician's and Surgeon's Certificate No. A 67937, Respondent.	Case No. 800-2017-039398 **A C C U S A T I O N**

PARTIES

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

2. On or about April 2, 1999, the Medical Board issued Physician's and Surgeon's Certificate Number A 67937 to Manolito Velasquez Castillo, 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 June 30, 2022, unless renewed.

///

///

JURISDICTION

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

4. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

5. Section 2234 of the Code, states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

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

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

DEFINITIONS

6. Acetaminophen (Tylenol®) is a pain reliever and a fever reducer. It is used to treat many conditions including headache, muscle aches, arthritis, backache, toothaches, colds, and fevers. Acetaminophen is not a controlled substance.

7. Ativan® (lorazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that 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. When properly prescribed and indicated, it is used for the management of anxiety disorders or for short-term relief of anxiety or anxiety associated with depressive symptoms. Concomitant use of Ativan® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Ativan®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

8. Benzodiazepines are a class of agents that work on the central nervous system, acting on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain. Valium, diazepam, alprazolam, and temazepam are all examples of benzodiazepines. All benzodiazepines are Schedule IV controlled substances and have the potential for abuse, addiction, and diversion.

9. Klonopin® (clonazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that 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. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. Concomitant use of Klonopin® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Klonipin®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.) Klonopin® has a half-life of 20-50 hours such that twice daily dosing is usually sufficient to prevent a build-up of bioavailable medication. Caution is advised when prescribed in combination with hydromorphone due to an increased risk of respiratory depression.

10. Hydromorphone (Dilaudid®), an opioid analgesic, 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. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. The Drug Enforcement Administration (DEA) has identified hydromorphone, such as Dilaudid®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.) The Federal Drug Administration has issued black box warnings for Dilaudid® which warn about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warnings also caution about the risks associated with concomitant use of Dilaudid® with benzodiazepines or other central nervous system (CNS) depressants.

11. Invega Sustenna® (paliperidone palmitate) is used to treat certain mental/mood disorders (such as schizophrenia, schizoaffective disorder, bipolar disorder). Paliperidone is an antipsychotic drug (atypical type). It works by helping to restore the balance of certain natural chemicals (neurotransmitters) in the brain. Among others, known side effects include drowsiness, dizziness, lightheadedness, fainting, slow heartbeat, seizures, difficulty swallowing, restlessness, muscle spasms, interrupted breathing during sleep, and difficulty breathing.

12. Morphine is a non-synthetic narcotic, derived from opium, which is used for the treatment of pain. Morphine's effects include euphoria and relief of pain. Chronic use of

morphine results in tolerance and physical and psychological dependence. Morphine use results in relief from physical pain, decrease in hunger, and inhibition of the cough reflex. Overdose effects include: cold and clammy skin; lowered blood pressure; sleepiness; slowed breathing; slow pulse rate; coma; and possible death. There are known risks associated with concomitant use of morphine with benzodiazepines or other central nervous system (CNS) depressants. Morphine is a Schedule II narcotic under the Controlled Substances Act. The Drug Enforcement Administration has identified morphine, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2017 Edition), at p. 45.)

13. Ondansetron (Zofran®, Zofran ODT®, Zuplenz®) is a medication that blocks the actions of chemicals in the body that can trigger nausea and vomiting. It is used to prevent nausea and vomiting that may be caused by surgery, cancer chemotherapy, radiation treatment, or other medications. Ondansetron is not a controlled substance.

14. Bioavailability is the proportion of a drug or other substance which enters the circulation when introduced into the body and so is able to have an active effect on the person.

15. The half-life of a drug or medication is the amount of time that it takes for half of the drug to be metabolized and eliminated from the body. Or, put another way, the half-life of a drug is the time it takes for it to be reduced by half. For example, a drug that is to be taken every four hours, such as ibuprofen, generally has a half-life of two hours – half of it will have been metabolized in the first two hours.

16. Bipolar disorder, formerly called manic depression, is a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression). When one who is bipolar becomes depressed, they may feel sad or hopeless and lose interest or pleasure in most activities. When their mood shifts to mania or hypomania (less extreme than mania), they may feel euphoric, full of energy or unusually irritable. These mood swings can affect sleep, energy, activity, judgment, behavior and the ability to think clearly. Episodes of mood swings may occur rarely or multiple times a year. While most people will experience some emotional symptoms between episodes, some may not experience any. Although bipolar disorder is a lifelong condition, mood swings and other symptoms can be

managed by following a treatment plan. In most cases, bipolar disorder is treated with medications and psychological counseling (psychotherapy).

17. Long Q-T syndrome (LQTS) is a heart rhythm condition that can potentially cause fast, chaotic heartbeats. These rapid heartbeats might trigger the sufferer to suddenly faint. Some people with the condition have seizures. In some severe cases, LQTS can cause sudden death. LQTS may occur because of a genetic mutation (congenital) or it may be caused by certain medications, mineral imbalances or medical conditions (acquired).

18. Sleep apnea is a potentially serious sleep disorder in which breathing repeatedly stops and starts. One who snores loudly and feels tired even after a full night's sleep might have sleep apnea. The main types of sleep apnea are: obstructive sleep apnea, the more common form that occurs when throat muscles relax; central sleep apnea, which occurs when the brain doesn't send proper signals to the muscles that control breathing; and complex sleep apnea syndrome, also known as treatment-emergent central sleep apnea, which occurs when someone has both obstructive sleep apnea and central sleep apnea.

19. Polypharmacy is the practice of administering many different medicines, especially concurrently, for the treatment of a single disease. It is also the concurrent use of multiple medications by a patient to treat usually coexisting conditions and which may result in adverse drug interactions.

20. Respiratory depression (hypoventilation) is a breathing disorder characterized by slow and ineffective breathing. During a normal breathing cycle, one inhales oxygen into his/her lungs. Blood carries the oxygen around the body, delivering it to body tissues. The blood then takes the carbon dioxide, a waste product, back to the lungs. The carbon dioxide exits the body when one exhales. During hypoventilation, the body cannot adequately remove carbon dioxide. This can lead to poor use of oxygen by lungs. The result is a higher level of carbon dioxide and too little oxygen available to the body. Symptoms of respiratory depression vary. Mild or moderate symptoms may include: tiredness; daytime sleepiness; shortness of breath; slow and shallow breathing; and depression. Respiratory depression can occur as a side effect of certain medications and large doses of central nervous system depressant drugs may slow down the

respiratory system. Medications that can have this effect on the body include: alcohol; barbiturates; sedatives; opioids; and benzodiazepines.

21. Seen on a prescription, p.r.n. means "as needed." It is an abbreviation for "*pro re nata*" which in Latin means as needed. The abbreviation p.r.n. is sometimes written without a period either in lower-case letters as "prn" or in capital letters as "PRN."

22. Seen on a prescription, b.i.d. means "twice (two times) a day." It is an abbreviation for "*bis in die*" which in Latin means twice a day. The abbreviation b.i.d. is sometimes written without a period either in lower-case letters as "bid" or in capital letters as "BID."

23. Seen on a prescription, t.i.d. means "three times a day." It is an abbreviation for "*ter in die*" which in Latin means three times a day. The abbreviation t.i.d. is sometimes written without a period either in lower-case letters as "tid" or in capital letters as "TID."

24. Seen on a prescription, q.i.d. means "four a day." It is an abbreviation for "*quater in die*" which in Latin means four times a day. The abbreviation q.i.d. is sometimes written without a period either in lower-case letters as "qid" or in capital letters as "QID."

25. Seen on a prescription, q[x]h means "take every [x] hours." If a medicine is to be taken every two hours, for instance, it is written "q2h"; the "q" standing for "quaque" and the "h" indicating the number of hours.

FACTUAL ALLEGATIONS

26. On or about August 13, 2017, and on or about August 15, 2017, a patient[1] received medical evaluations for abdominal pain at the Emergency Department of Community Regional Medical Center (CRMC-ED).

27. On or about August 16, 2017, at 2:34 p.m., while still at CRMC, the patient requested admission to the Community Behavioral Health Center (CBHC) for anxiety and depression. Though another physician admitted the patient, Respondent was assigned as her attending provider. The admitting physician approved the patient's admission to CBHC on a voluntary status on or about August 16, 2017, at or about 4:23 p.m. Respondent electronically signed the admitting order and ordered a medical group consultation for the patient on or about August 17,

[1] The patient's name is not being used to maintain patient confidentiality.

2017, at or about 12:47 p.m. A registered nurse (RN) interviewed the patient on her admission to CBHC and noted that the patient had Long Q-T Syndrome associated with psychotropic medication and substance abuse.

28. On or about August 17, 2017, a medical nurse practitioner (MNP) at CBHC completed an intake note documenting that the patient had been off her psychotropic medication. As a result, her mental health symptoms worsened and she felt unsafe outside the hospital. The MNP noted the patient's medications as: Trazadone, Topamax, lithium, Prozac, Wellbutrin, Cogentin and Lipitor. The MNP's physical examination of the patient was unremarkable. The MNP's recommended plan was for the patient to resume her regular home medication regimen and for her to return on an as needed basis.[2]

29. On or about that same day, Respondent performed a psychiatric evaluation of the patient, noting that she had been diagnosed with Bipolar disorder, had a history of substance abuse, and was admitted to CBHC as being a danger to herself. Respondent also noted that, in the patient's visit to the CRMC-ED two days earlier she had verbalized that she had lost the will to live. Respondent further noted that the patient remained depressed and anxious when Respondent saw her and indicated to Respondent that she still had suicidal thoughts. Respondent noted the patient's current medications as: Gabapentin, lithobid, propranolol, cogentin, Wellbutrin XL, Hydroxyzine, and Invega Sustenna. Respondent either did not realize that his list of the patient's current medications differed from those listed by the MNP, or did nothing to reconcile the differences. Respondent did not conduct a review of the patient's records from her visit to the CRMC-ED that preceded her admission to CBHC. Respondent did not convert the patient's status to a 5150[3] psychiatric involuntary hold, nor did he make any notation that a change in her status should be considered upon any transfer/discharge.

30. Later, on or about that same day, August 17, 2017, an RN documented that the patient claimed she lost consciousness before walking to the nurse's station, but that it was unwitnessed.

---

[2] The MNP's plan also included topical antibiotics for the patient's conjunctivitis which is irrelevant to the causes in this Accusation.

[3] California Welfare and Institutions Code section 5150 allows an adult experiencing a mental health crisis to be detained for a 72 hour psychiatric hospitalization.

The RN notified the MNP who had examined the patient earlier that day and the MNP ordered the patient be sent out for medical clearance. The patient was transported by ambulance to CRMC-ED. There was no communication between Respondent and the MNP regarding whether the patient should be transferred/discharged to CRMC-ED on voluntary status or if she should be converted to a 5150 involuntary psychiatric hold due to suicidal ideation reported on admission and psychiatric evaluation. Consequently, the patient was only on a voluntary status at CRMC-ED and was not on a 5150 involuntary psychiatric hold. While in CRMC-ED, at or about approximately an hour before midnight, the patient decided that she wanted to go home. Though nursing staff requested she wait for the physician to see her, the patient left against medical advice as she was not being monitored for safety under a 5150 involuntary psychiatric hold.

31. The next morning, on or about August 18, 2017, in the early morning hours, at or about 1:20 am, the patient returned to CBHC to obtain her personal items. An RN evaluated the patient, found her not to be a danger to self or others, and allowed her to obtain her personal items and leave. That day when Respondent became aware of the patient's discharge, he did not take any actions to ensure the safety of the patient either by confirming her safety in a treatment setting, or by providing information to law enforcement to substantiate a 5150 involuntary psychiatric hold for danger to self and to request that the patient be brought to a 5150 receiving facility for psychiatric evaluation.

32. Later that same day, on or about August 18, 2017, the patient attempted suicide by ingesting 50 Tylenol, and was taken to the Emergency Department at St. Agnes Medical Center (SAMC).

33. After medical stabilization, on or about August 21, 2017, the patient was readmitted to CBHC directly from SAMC on a 5150 involuntary psychiatric hold and Respondent was again assigned as her attending physician.

34. On or about August 21, 2017, the MNP who had examined the patient back on or about August 17, 2017, conducted the intake of the patient and deferred history and physical exam since "done within 30 days." The MNP noted the patient's attempted overdose with acetaminophen and that the patient had subsequently been having severe liver pain. The MNP

prescribed hydromorphone, 4 mg q 6 hrs PRN for the patient on or about August 21, 2017. The admitting physician ordered vital signs to be followed per routine frequency. Respondent was assigned as the patient's attending physician again and, on or about the next day, he examined the patient, prescribed clonazepam 1 mg TID for her, and continued her other medications. Respondent did not review the risks and benefits with the patient of clonazepam before he prescribed it for her. Respondent did not order a change in vital sign monitoring frequency. Respondent either neglected to review or reviewed and dismissed the nurse practitioner's prescription of an opioid for the patient when he decided to prescribe clonazepam at the dose he prescribed. Respondent did not consider any of the patient's unique factors that may have changed with medical co-morbidities and concurrent medications. Respondent did not implement a safety protocol for the combined prescribing by himself and the MNP, nor did Respondent ask the MNP if the hydromorphone was essential or if there was a safer alternative when Respondent wanted to add a psychotropic medication, clonazepam, to the patient's medications. Respondent did not conduct a review of the patient's records from her stay at SAMC that preceded her admission to CBHC. Respondent did not reconcile the patient's medications from her stay at SAMC with those ordered for her to receive at CBHC.

35. On or about August 22, 2017, late in the evening, the patient appeared at the CBHC nursing station crying, indicating that she was awakened by severe pain in her abdomen, specifically in her upper right quadrant. Her vital signs were taken and the MNP on call ordered the patient be transferred to the emergency department for medical treatment due to her recent Tylenol overdose with unresolved liver pain despite treatment with hydromorphone. The patient was taken by ambulance to CRMC-ED. The patient's 5150 hold was given to ambulance personnel.

36. The patient remained at CRMC for medical treatment until the next morning. During her time at CRMC, the patient was administered morphine 8 mg intramuscular injection and ondansetron 4 mg orally at 1:08 am and lorazepam 1 mg orally at 4:09 am.

37. Less than two hours later, at or about 5:45 am, on or about August 23, 2017, the patient was transferred back to CBHC where an RN documented that she was cooperative and

requesting pain medication, but that she understood the need to get her back in the system and to notify her attending physician, Respondent, of her return to review medication. Approximately 35 minutes later, at or about 6:20 am, an MNP ordered the patient's medications from her previous admission at CBHC be continued – including the hydromorphone prescribed by the prior MNP and the clonazepam previously ordered by Respondent. The vital sign order was similarly updated to the prior level frequency, per routine. The MNP also ordered 15-minute checks, which was authorized by the admitting physician. Respondent did not conduct a review of the patient's records from her stay at CRMC that preceded this re-admission to CBHC. Respondent did not reconcile the patient's medications from her stay at CRMC with those ordered for her to receive at CBHC in this re-admission.

38. A little over an hour later, at or about 6:58 am, the patient approached an RN at the nursing station and requested her pain medication. The RN assessed the patient, administered pain medications as ordered, and endorsed the oncoming shift to reassess for effectiveness.

39. That same day, at or about 8:10 am, the patient went to the nurse station to get her medications from the RN. She denied pain and discomfort and took her scheduled medications. Later that same day, the patient requested to be excused from groups because she did not sleep the prior night. The patient was encouraged to join the groups, but when the RN attempted to ask her assessment questions, the patient declined to respond, indicating she just wanted to go to sleep. At or about 9:40 am that same day, a clinical nurse assistant (CNA) called the patient from the door of her room to attend a goal group therapy session. The patient was on her bed. She opened her eyes, looked at the CNA, and went back to sleep. At or around 10:20 am, an RN went to check on the patient. She was snoring in her sleep with a wedge in place, her respirations were unlabored, and no distress was noted. At or about 11:00 am, the patient was called for group therapy by the therapist who peeked in the patient's room and called for group. In response, the patient merely mumbled something and went back to sleep. A CNA observed the patient sleeping and snoring in her room at or about 11:15 am. At or about 11:30 am, Respondent entered the patient's room to interview her and found her pulseless and not breathing. He initiated a code blue and a 911 call, leading to ambulance transport of the patient to a local medical hospital

where she did not recover. Respondent did not conduct a review of the patient's records from her stay at CRMC that preceded her final admission to CBHC. Respondent did not reconcile the patient's medications from her stay at CRMC with those ordered for her to receive at CBHC.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

40. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in act(s) or omission(a) amounting to gross negligence. The circumstances are set forth in paragraphs 25 through 38, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

41. The standard of care requires that a review of medical records be included in a psychiatric evaluation. This is required to ensure, in part, that medication is ordered with considerations for contraindications such as an allergy or dosing modifications due to co-morbid medical conditions such as an impairment in liver functioning that might alter metabolism of medication. In addition, every time a patient initiates a new contact with a medical provider, regardless of whether the patient is a new patient or a continuing patient who may have a concurrently prescribing medical provider, the process of medication reconciliation is required to ensure accurate and safe prescribing of medication. The process of medication reconciliation includes documenting a list of medications from medical records and reviewing each medication with the patient at the time of evaluation to determine if each medication is being taken or not and when the last dose was taken as well as adding any missing medications and subtracting any incorrect or obsolete medications. The purpose is to provide a current, accurate list of medication to inform a safe, appropriate treatment plan moving forward including both psychotropic and non-psychotropic medication. The clinical outcome magnifies, but is not essential to rendering an opinion on a departure from the standard of care regarding medical record review and medication reconciliation. Respondent's repeated failure to review the medical record on three occasions (the patient's first CBHC admission on or about August 16, 2017; her second CBHC admission, on or about August 21, 2017 after her attempted suicide by overdosing on Tylenol; and her return to CBHC, on or about August 23, 2017, from a six-hour emergency medical evaluation due to

severe abdominal pain) constitutes gross negligence. Similarly, Respondent's repeated failure to reconcile medications both from outside facilities and between concurrent prescribers within the same episodes of care constitutes gross negligence.

42. The standard of care for prescription of psychotropic medication requires informed consent. Informed consent for psychotropic medication includes discussing the diagnosis, risks and benefits of medications, alternatives to treatment, and likely results of not receiving the treatment. It is the responsibility of the physician to accurately represent how the risks may be different between patients based on unique factors such as medical comorbidities and concurrent medications. Respondent's choice to initiate a high dose and high dosing frequency for clonazepam (a medication with a long half-life), his lack of attention to medical risks when prescribing clonazepam to a patient with a recent medical evaluation for "liver pain" and concurrently prescribed an opioid medication, and his lack of documented discussion of risks, benefits, and alternatives culminating in obtaining of the patient's signature on an informed consent document, resulted in inadequate informed consent, which constitutes gross negligence.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

43. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated acts of negligence. The circumstances are set forth in paragraphs 25 through 41, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

44. Admitting a patient to a psychiatric hospital on a voluntary status meets the standard of care irrespective of whether the patient also meets the criteria for a 5150 involuntary psychiatric hold for danger to self (suicidal), danger to others (homicidal), or grave disability (unable to provide or utilize provided food, clothing, shelter) which would be required if the patient met these criteria but declined to voluntarily consent for services. Nevertheless, when a voluntary patient is transferred/discharged from a psychiatric hospital, the standard of care requires the attending psychiatrist at the time of transfer/discharge to conduct a risk assessment to determine that the patient is safe from a psychiatry perspective for transfer/discharge and does not

meet criteria for a 5150 involuntary psychiatric hold. This applies whether the patient requests a transfer/discharge or is recommended for transfer/discharge by the psychiatrist either routinely or emergently such as when a patient has a medical emergency that cannot be treated in a psychiatric hospital. Based on a risk assessment at the time of transfer/discharge, the standard of care for a patient who was admitted on a voluntary status would be to initiate a 5150 involuntary psychiatric hold for danger to self to be re-evaluated by a psychiatrist following the resolution of the medical emergency. Upon discovering that his patient had been discharged from CBHC, on or about August 17, 2017, by a non-psychiatric colleague without an indicated risk assessment for suicide, Respondent's failure to ensure that the patient receive this risk assessment constitutes negligence.

45. The standard of care requires increased monitoring when prescribing medications that in combination increase the risk of respiratory suppression. This monitoring would include increasing the frequency of vital sign checks and a sedation protocol to decrease the risk of a patient falling asleep and stopping breathing. Respondent's failure to initiate increased monitoring of a patient at risk for respiratory suppression, particularly when he prescribed clonazepam while the patient was already receiving hydromorphone that had been prescribed by the MNP, constitutes negligence.

///

///

///

///

///

///

///

///

///

///

///

///

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 67937, issued to Manolito Velasquez Castillo, M.D.;

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

3. Ordering Manolito Velasquez Castillo, 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: DEC 0 8 2020

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

FR2020302499
95367211.docx