Final Order No. DOH-00-2057-FO -MQA
FILED DATE - 11-9-00
Department of Health
By: [signature]
Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

BOARD:	Medicine
CASE NUMBER:	1992-03218
COMPLAINT MADE BY:	DPR (Anonymous)
DATE COMPLAINTS RECEIVED:	March 3, 1992
COMPLAINT MADE AGAINST:	Richard Morales 6809 Azul Court Jacksonville, Florida 32210
INVESTIGATED BY:	James Nunez
REVIEWED BY:	John E. Terrel/jlm
STAFF RECOMMENDATION:	Dismiss (PL-82)

NOTICE OF DISMISSAL/CLOSING ORDER

THE COMPLAINT: Complainant alleges that the Respondent violated Chapter 458.331(1)(m) twelve counts, (q) twelve counts and (t) thirteen counts, Florida Statutes, in that Respondent failed to keep adequate medical records, inappropriately prescribed and failed to practice medicine with the level of care, skill and treatment.

THE FACTS: There are thirteen patients involved in this case, Patients JZ, SA, GP, RW, SE, CC, SL, AB, DH#1, DH#2, CW, SC and JB. The allegations concern inappropriate prescribing, inadequate medical records and below standard treatment for all patients except the case involving Patient D.H.#1 and D.H.#2, which involved inadequate records and below standard treatment.

On or about March 1, 1990 through January 28, 1991 Patient A.Z. presented to the Respondent's office for various complaints. Respondent prescribed Fioricet approximately 60 times to Patient A.Z. during this period. This drug is a barbiturate and habit forming. Respondent failed to keep adequate medical records concerning the treatment, and failed to prescribe the medication in an appropriate manner.

On or about January 4, 1990, Patient SA presented to the Respondent's office with trouble concentrating. During this visit, Respondent performed a history and physical examination on Patient S.A. Respondent treated Patient S.A. approximately seven other times on or about between January 11, 1990 through February 23, 1990. During this time, Respondent prescribed Ritalin, Prozac, Pamelor and Buspar. Respondent failed to document in the medical records justification for the use of Ritalin. Respondent did not diagnose Patient S.A. with Adult Attention Deficit Disorder. On or about March 5, 1990, Patient S.A. was admitted to St. Pete General Hospital for convulsions. Patient SA was diagnosed with seizure disorder induced by a combination of antidepressant medications. On or about March 7, 1990, Patient S.A. was discharged with a diagnosis of convulsions secondary to medications. Respondent inappropriately prescribed medication, kept inadequate records and practiced medicine below the applicable standard for this patient.

On or about August 27, 1990 through October 10, 1991, Patient G.P. presented to Respondent's office. During this visit, Respondent prescribed Lithonate, Fiorcet, Diazepan and Prozac. Respondent failed to document in the medical records any diagnosis, symptoms or course of treatment for Patient G.P. concerning the medication. Respondent inappropriately prescribed medication, kept inadequate records and practiced medicine below the applicable standard for this patient.

On or about April 24, 1990 through February 7, 1992, Respondent treated Patient R.W. for chronic pain syndrome, major depressive reaction and cervical disc syndrome. Respondent prescribed Roxicodone, Diazepam, Elavil, Klonopin and Amitriptyline for Patient RW. Respondent prescribed these medications in excessive amounts. Respondent billed Patient R.W. for physical therapy services that he was not qualified to perform. Respondent should have referred Patient R.W. to an orthopedic specialist. Respondent inappropriately prescribed medication, kept inadequate records and practiced medicine below the applicable standard for this patient.

On or about April 30, 1990 through May 29, 1992, Respondent prescribed Percocet, Tylox, Roxicodone and Percodan for Patient S.E. Respondent's prescriptions total over 11,500 tablets totaling 15 tablets per day. Respondent failed to document in the medical records any diagnosis, symptoms or course of treatment for Patient S.E. Respondent inappropriately prescribed medication, kept inadequate records and practiced medicine below the applicable standard for this patient.

On or about September 26, 1990 through June 29, 1991, Respondent prescribed Anexsia, Klonoppin and Prometh with Codeine syrup for Patient C.C. Respondent failed to document in the medical records any diagnosis, symptoms or course of treatment for Patient C.C.

On or about December 1, 1989 through June 29, 1992, Respondent prescribed Oxycodone, Roxicodone and Methadone to Patient S.L. Respondent failed to document in the medical records any diagnosis, symptoms or course of treatment for Patient C.C. Respondent inappropriately prescribed medication, kept inadequate records and practiced medicine below the applicable standard for this patient.

On or about November 27, 1990 through April 29, 1993, Respondent treated Patient A.B. with a working diagnosis of post-traumatic pain disorder, schizo-affective disorder with auditory hallucinations, and severe depressive symptomatology. While treating A.B., Respondent billed for kinetic activities, which he is not qualified to perform. Respondent billed for services that were performed on or about December 21, 1992 and these services included two biofeedbacks therapies, electromyography, cognitive testing, two types of kinetic activities, and supplies, but failed to document progress notes from the services rendered on or about December 21, 1992. On or about November 27, 1990, through April 23, 1993, Respondent prescribed Klonopin, Prozac, Desyrel, Synthroid, Ritalin and Parafon Forte for Patient A.B. without adequate justification. Respondent inappropriately prescribed medication, kept inadequate records and practiced medicine below the applicable standard for this patient.

From July 3, 1990 through August 21, 1990 Patient D.H. has been a patient at Fairwinds Treatment Center with an admitting diagnosis of bipolar disorder mixed and alcohol abuse. During Patient D.H.'s treatment at Fairwinds Treatment Center, Respondent was the treating physician. Respondent failed to perform an admitting evaluation or write admitting orders or treatment plan for Patient D.H. Respondent failed to maintain medical records on Patient D.H. and has been unable to produce medical records for Patient D.H. during this investigation. Respondent kept inadequate records and practiced medicine below the applicable standard for this patient.

On or about April 5, 1990 through May 29, 1990, Respondent prescribed Tegretol, Fioricet, Prozac, Depakote and Sinequan for Patient DH#2. During this time, Respondent failed to document in the medical records any diagnosis, symptoms or course of treatment for Patient D.H.#2. Respondent kept inadequate records and practiced medicine below the applicable standard for this patient.

On or about October 12, 1990 through October 18, 1991, and February 18, 1992, through May 19, 1992, Respondent prescribed Percocet, Percodan and Oxycodone for Patient C.W. Respondent's prescriptions total over 2, 700 tablets. During this time, Respondent failed to document in the medical records any diagnosis, symptoms or course of treatment for Patient C.W. Respondent inappropriately

prescribed medication, kept inadequate records and practiced medicine below the applicable standard for this patient.

On or about October 21, 1990 through May 24, 1992, Respondent prescribed Diazepam, Methylphenidate, Fiorinal, Oxycodone and Roxicet for Patient S.C. Respondent's prescriptions totaled over 7,400 tablets in consumption over a period of 19 months averaging 134 tablets per day. During this time, Respondent failed to document in the medical records any diagnosis, symptoms or course of treatment for Patient S.C. and failed to justify the medication or treatment. Respondent inappropriately prescribed medication, kept inadequate records and practiced medicine below the applicable standard for this patient.

On or about August 7, 1990 through May 15, 1992, Respondent prescribed Oxycodone, Percocet and Roxicodone for Patient J.B. During this time, Respondent failed to document in the medical records any diagnosis, symptoms or course of treatment for Patient J.B. and failed to justify the medications and treatment Respondent inappropriately prescribed medication, kept inadequate records and practiced medicine below the applicable standard for this patient.

Respondent's license to practice medicine was delinquent on January 31, 1998, and due to Respondent's inability or lack of willingness to renew such, has subsequently become null and void as of February 19, 2000.

Based on the foregoing, the Department has determined that it does not have jurisdiction to proceed in this case.

THE LAW: Pursuant to Section 456.073(2), Florida Statutes, the Department, by and through the Agency for Health Care Administration, pursuant to the provisions of Section 20.43(3), Florida Statutes, finds that it does not have jurisdiction to proceed in this case.

It is, therefore, ORDERED that this matter should be and the same is hereby DISMISSED.

DONE and ORDERED this 8th day of November, 2000.

Robert G. Brooks, M.D., Secretary

Kathryn L. Kasprzak
Chief Medical Attorney
Agency for Health Care Administration

PCP: November 3, 2000