STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2005-54680
LICENSE NO.: ME0072159

RITA ABISLAIMAN, M.D.,

Respondent.
_____/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57(4), Florida Statutes, on October 1, 2010, in Orlando, Florida, for the purpose of considering a Settlement Agreement (attached hereto as Exhibit A) entered into between the parties in this cause. Upon consideration of the Settlement Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED AND ADJUDGED that the Settlement Agreement as submitted be and is hereby approved and adopted in toto and incorporated herein by reference with the following clarification:

The costs set forth in Paragraph 3 of the Stipulated Disposition shall be set at $13,000.00.

Accordingly, the parties shall adhere to and abide by all the terms and conditions of the Settlement Agreement as clarified above.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 12 day of OCTOBER, 2010.

BOARD OF MEDICINE

Larry McPherson, Jr., Executive Director
For Onelia Lage, M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to RITA ABISLAIMAN, M.D., 8874 SW 112th Place, Miami, Florida 33176; by email to Philip E. Goss, Esquire, at philgosslaw@gmail.com; and by interoffice delivery to Veronica Donnelly, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3253 this 13th day of October, 2010.

Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v. **DOH Case No. 2005-54680**

RITA ABISLAIMAN, M.D.,

Respondent,
_____/

SETTLEMENT AGREEMENT

Rita Abislaiman, M.D., referred to as the "Respondent," and the Department of Health, referred to as "Department" stipulate and agree to the following Agreement and to the entry of a Final Order of the Board of Medicine, referred to as "Board," incorporating the Stipulated Facts and Stipulated Disposition in this matter.

Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes, and Chapter 456, Florida Statutes, and Chapter 458, Florida Statutes.

STIPULATED FACTS

1. At all times material hereto, Respondent was a licensed physician in the State of Florida having been issued license number ME 72159.

2. The Department charged Respondent with an Administrative Complaint that was filed and properly served upon Respondent with violations of

Chapter 458, Florida Statutes, and the rules adopted pursuant thereto. A true and correct copy of the Administrative Complaint is attached hereto as Exhibit A.

3. Respondent neither admits nor denies the allegations of fact contained in the Administrative Complaint for purposes of these proceedings only.

STIPULATED CONCLUSIONS OF LAW

1. Respondent admits that in her capacity as a licensed physician she is subject to the provisions of Chapters 456 and 458, Florida Statutes, and the jurisdiction of the Department and the Board.

2. Respondent admits that the facts alleged in the Administrative Complaint, if proven, would constitute violations of Chapter 458, Florida Statutes, as alleged in the Administrative Complaint.

3. Respondent agrees that the Stipulated Disposition in this case is fair, appropriate and acceptable to Respondent.

STIPULATED DISPOSITION

1. **Letter Of Concern** - Respondent shall receive a Letter of Concern from the Board of Medicine.

2. **Fine** - The Board of Medicine shall impose an administrative fine of ***five thousand dollars ($5,000.00)*** against the license of Respondent, to be paid by Respondent to the Department of Health, HMQAMS/Client Services, Post Office Box 6320, Tallahassee, Florida 32314-6320, Attention: Board of Medicine Compliance Officer, within thirty-days (30) from the date of filing of the Final Order

accepting this Agreement. All fines shall be paid by check or money order. The Board office does not have the authority to change the terms of payment of any fine imposed by the Board.

RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE FINE IS HER LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE FINE IS NOT PAID AS AGREED TO IN THIS SETTLEMENT AGREEMENT, SPECIFICALLY: IF WITHIN 45 DAYS OF THE DATE OF FILING OF THE FINAL ORDER, RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE FULL AMOUNT OF THE FINE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY RESPONDENT FROM THE BOARD.

3. **Reimbursement Of Costs** - Pursuant to Section 456.072, Florida Statutes, Respondent agrees to pay the Department for any costs incurred in the investigation and prosecution of this case. Such costs exclude the costs of obtaining supervision or monitoring of the practice, the cost of quality assurance reviews, and the Board's administrative cost directly associated with Respondent's probation, if any. The agreed upon amount of Department costs to be paid in this case is currently ***eleven thousand four hundred sixty-three dollars and forty-nine cents ($11,463.49), but shall not exceed thirteen thousand dollars ($13,000.00)***. Respondent will pay costs to the Department of Health, HMQAMS/Client Services, P.O. Box 6320, Tallahassee, Florida 32314-6320,

Attention: Board of Medicine Compliance Officer within thirty-days (30) from the date of filing of the Final Order in this cause. Any post-Board costs, such as the costs associated with probation, are not included in this agreement.

RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE COSTS IS HER LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE COSTS ARE NOT PAID AS AGREED TO IN THIS SETTLEMENT AGREEMENT, SPECIFICALLY: IF WITHIN 45 DAYS OF THE DATE OF FILING OF THE FINAL ORDER, RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE FULL AMOUNT OF THE COSTS NOTED ABOVE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY RESPONDENT FROM THE BOARD.

4. **Drug Course** - Respondent shall complete the course, "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls of Misprescribing," sponsored by the University of South Florida, or a Board-approved equivalent, within one year of the date of filing of the Final Order.

5. **Records Course** - Respondent shall complete the course, "Quality Medical Record Keeping for Health Care Professionals," sponsored by the Florida Medical Association, or a Board-approved equivalent, within one year of the date of filing of the Final Order.

6. **Continuing Medical Education** - Within one year of the date of the filing of a Final Order in this cause, Respondent shall attend five (5) hours of

Continuing Medical Education (CME) in the assessment and treatment of psychiatric patients.

7. **Restriction Language** - Respondent is restricted in that she may not treat private patients, unless or until Respondent has documented successful completion of all three CME courses listed above to the Compliance Officer of the Board of Medicine.

STANDARD PROVISIONS

1. **Appearance**: Respondent is required to appear before the Board at the meeting of the Board where this Agreement is considered.

2. **No force or effect until final order** - It is expressly understood that this Agreement is subject to the approval of the Board and the Department. In this regard, the foregoing paragraphs (and only the foregoing paragraphs) shall have no force and effect unless the Board enters a Final Order incorporating the terms of this Agreement.

3. **Continuing Medical Education** - Unless otherwise provided in this written agreement Respondent shall first submit a written request to the Probation Committee for approval prior to performance of said continuing medical education course(s). Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical course within one (1) year of the date of filing of the Final Order in this matter. All such documentation shall be sent to the Board of Medicine, regardless of whether some or any of such

documentation was provided previously during the course of any audit or discussion with counsel for the Department. These hours shall be in addition to those hours required for renewal of licensure. Unless otherwise approved by the Board, said continuing medical education course(s) shall consist of a formal, live lecture format.

4. **Addresses** - Respondent must keep current residence and practice addresses on file with the Board. Respondent shall notify the Board within ten (10) days of any changes of said addresses.

5. **Future Conduct** - In the future, Respondent shall not violate Chapter 456, 458 or 893, Florida Statutes, or the rules promulgated pursuant thereto, or any other state or federal law, rule, or regulation relating to the practice or the ability to practice medicine. Prior to signing this agreement, the Respondent shall read Chapters 456, 458 and 893 and the Rules of the Board of Medicine, at Chapter 64B8, Florida Administrative Code.

6. **Violation of terms considered** - It is expressly understood that a violation of the terms of this Agreement shall be considered a violation of a Final Order of the Board, for which disciplinary action may be initiated pursuant to Chapters 456 and 458, Florida Statutes.

7. **Purpose of Agreement** - Respondent, for the purpose of avoiding further administrative action with respect to this cause, executes this Agreement. In this regard, Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent prior to or in conjunction with

consideration of the Agreement. Respondent agrees to support this Agreement at the time it is presented to the Board and shall offer no evidence, testimony or argument that disputes or contravenes any stipulated fact or conclusion of law. Furthermore, should this Agreement not be accepted by the Board, it is agreed that presentation to and consideration of this Agreement and other documents and matters by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation, consideration or resolution of these proceedings.

8. **No preclusion of additional proceedings** - Respondent and the Department fully understand that this Agreement and subsequent Final Order incorporating same will in no way preclude additional proceedings by the Board and/or the Department against Respondent for acts or omissions not specifically set forth in the Administrative Complaint attached as Exhibit A.

9. **Waiver of attorney's fees and costs** - Upon the Board's adoption of this Agreement, the parties hereby agree that with the exception of costs noted above, the parties will bear their own attorney's fees and costs resulting from prosecution or defense of this matter. Respondent waives the right to seek any attorney's fees or costs from the Department and the Board in connection with this matter.

10. **Waiver of further procedural steps** - Upon the Board's adoption of this Agreement, Respondent expressly waives all further procedural steps and expressly waives all rights to seek judicial review of or to otherwise challenge or

contest the validity of the Agreement and the Final Order of the Board incorporating said Agreement.

SIGNED this 22nd day of July, 2010.

Rita Abislaiman, M.D.

STATE OF FLORIDA
COUNTY OF Miami-Dade

Before me, personally appeared Rita Abislaiman, whose identity is known to me or by _____ (type of identification) and who, under oath, acknowledges that her signature appears above.

Sworn to and subscribed before me this 22nd day of July, 2010.

NOTARY PUBLIC

My Commission Expires:

MAYDA A. PEREZ
MY COMMISSION # DD 955811
EXPIRES: March 19, 2014
Bonded Thru Budget Notary Services

APPROVED this 4th day of AUGUST, 2010.

Ana M. Viamonte Ros, M.D., M.P.H.
Secretary, Department of Health

By: David G. Pius
Assistant General Counsel
Department of Health

ELECTION OF RIGHTS

DOH v. Rita Abislaiman, M.D.. Case No. 2005-54680

PLEASE SELECT ONLY 1 OF THE 3 OPTIONS

An Explanation of Rights is attached. If you do not understand these options, please consult with your attorney or contact the attorney for the Prosecution Services Unit at the address/phone number listed at the bottom of this form.

OPTION 1. _____ **I do not dispute the allegations** of fact in the Administrative Complaint, but do wish to be accorded a hearing, pursuant to Section 120.57(2), Florida Statutes, at which time I will be permitted to submit oral and/or written evidence in mitigation of the complaint to the Board.

OPTION 2. ✓ **I do not dispute the allegations** of fact contained in the Administrative Complaint and **waive my right** to object or to be heard. I request that the Board enter a final order pursuant to Section 120.57, Florida Statutes.

OPTION 3._____ **I do dispute the allegations** of fact contained in the Administrative Complaint and request this to be considered a petition for formal hearing, pursuant to Sections 120.569(2)(a) and 120.57(1), Florida Statutes, before an Administrative Law Judge appointed by the Division of Administrative Hearings. **I specifically dispute the following paragraphs of the Administrative Complaint:**

_____

_____

_____

In addition to the above selection, I also elect the following:

(✓) I accept the terms of the Settlement Stipulation, have signed and am returning the Settlement Stipulation or I am interested in settling this case.

( ) I do not wish to continue practicing, have signed and returned the voluntary relinquishment of licensure form, if it has been provided.

Regardless of which option I have selected, I understand that I will be given notice of time, date, and place when this matter is to be considered by the Board for Final Action. Mediation under Section 120.573, Florida Statutes, is not available in this matter.

(Please sign and complete all the information below.) R Abislaiman M.D.

Rita Abislaiman, M.D.
Address: 8874 SW 112th Place
Miami, FL 33176
Lic. No. ME 72169
Phone No. 305-992-3252
Fax No. 305-468-6564

STATE OF FLORIDA
COUNTY OF Miami-Dade

Before me, personally appeared Rita Abislaiman, whose identity is known to me or by _____ (type of identification) and who, acknowledges that her signature appears above.
Sworn to or affirmed by Affiant before me this 22nd day of July 2010.

Mayda A Perez
Notary Public-State of Florida

My Commission Expires

MAYDA A. PEREZ
Type or Print Name

MAYDA A. PEREZ
MY COMMISSION # DD 955811
EXPIRES: March 19, 2014
Bonded Thru Budget Notary Services

PLEASE MAIL AND/OR FAX COMPLETED FORM TO: David G. Plus, Assistant General Counsel, DOH, Prosecution Services Unit, 4052 Bald Cypress Way, Bin C-65, Tallahassee, Florida 32399-3265. Telephone Number: (850) 245-4640; FAX (850) 245-4681; TDD 1-800-955-8771.

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STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2005-54680**

RITA ABISLAIMAN, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, the Florida Department of Health, by and through its undersigned counsel, and hereby files this Administrative Complaint before the Board of Medicine against the Respondent, Rita Abislaiman, M.D., and in support thereof states:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME 72159. The Respondent concentrates on the practice of psychiatry but is not certified by any specialty board. The Respondent

currently works for the Florida Department of Corrections and does not currently treat private patients.

3. The Respondent's address of record is 8874 S.W. 112 Place, Miami, Florida 33176.

4. At all times material to this Complaint the Respondent prescribed various legend drugs (drugs available only by prescription). Among the legend drugs were psychotropic drugs and controlled substances.

5. Artane is the brand name for trihexyphenidyl HCl, a medication indicated in the treatment of parkinsonism. It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the manufacturer, psychiatric side effects have included confusion, disorientation, agitation, excitation, memory impairment, delusions and hallucinations.

6. Ativan is the brand name for lorazepam, a benzodiazepine, that is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, lorazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of

the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

7. Benadryl is the brand name for diphenhydramine hydrochloride, an antihistamine with anticholinergic and sedative effects. It is available in oral form without a prescription.

8. Depakote is the brand name for divalproex sodium, a medication used alone or together with other medicines to control certain types of epileptic seizures. Depakote is also used to treat the manic phase of bipolar disorder and treat migraine headaches. It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. Hepatic failure and pancreatitis have been reported in persons taking Depakote and it is recommended that patients have liver function tests prior to therapy being initiated and at frequent intervals thereafter.

9. Geodon is the brand name for ziprasidone, an atypical antipsychotic used to treat symptoms of certain mental disorders, such as schizophrenia, mania, or bipolar disorder. It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the manufacturer, however, it may increase the risk of death

when used to treat mental problems caused by dementia in elderly patients.

10. Glucophage is the brand name for metformin hydrochloride, an oral drug used in the management of type 2 (non-insulin-dependent) diabetes. According to the manufacturer it should be used with caution in the presence of renal disease, in the elderly or debilitated, or in patients with chronic alcohol use.

11. Klonopin is the brand name for clonazepam, a benzodiazepine that is commonly prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, clonazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of clonazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

12. Lexapro is the brand name for escitalopram oxalate, a selective serotonin reuptake inhibitor (SSRI) used to treat major depression and also to treat anxiety disorder. It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the

manufacturer it should be used cautiously in patients with a history of mania, seizures, liver impairment, or renal impairment.

13. Paxil is the brand name for paroxetine hydrochloride, a selective serotonin reuptake inhibitor (SSRI) used to treat depression, anxiety disorder, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder (PTSD). It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the manufacturer it should be used cautiously in patients with a history of mania, suicide attempts, and liver or renal impairment.

14. Restoril is the brand name for temazepam, a benzodiazepine that is prescribed to treat insomnia. According to Section 893.03(4), Florida Statutes, temazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of temazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

15. Risperdal is the brand name for risperidone, an atypical antipsychotic used in the treatment of schizophrenia. It is also sometimes used for the short-term treatment of mania associated with bipolar

disorder. It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the manufacturer it should be used cautiously in geriatric patients, patients with a history of suicide attempts and patients with liver impairment. It can cause an irreversible condition known as Tardive Dyskinesia.

16. Seroquel is the brand name for quetiapine fumarate, a medication used in the treatment of schizophrenia. It is also used for the treatment of manic and depressive episodes associated with bipolar disorder. It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the manufacturer it should be used cautiously in geriatric patients and patients with liver impairment. It can cause weight gain and also can cause Tardive Dyskinesia.

17. Starlix is the brand name for nateglinide, an oral drug used in the management of type 2 (non-insulin-dependent) diabetes. It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the manufacturer it should be used with caution in the presence of liver disease, in the elderly, or in patients with pituitary or adrenal insufficiency.

18. Surfak is the brand name for docusate, a stool softener used to treat constipation. It is available without a prescription.

19. Topamax is the brand name for topiramate, a sulfamate-substituted monosaccharide used to control both partial seizures and grand mal seizures. It is typically added to a treatment regimen when other drugs fail to fully control a patient's attacks. It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the manufacturer it should be used cautiously in patients with renal or liver impairment.

20. Trazodone is a medication used to treat major depression. It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the manufacturer it should be used cautiously in geriatric patients and patients with cardiovascular disease, suicidal behavior, or severe liver or renal disease.

21. Xanax is the brand name for alprazolam, a benzodiazepine that is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, alprazolam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of

the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

22. Zoloft is the brand name for sertraline hydrochloride, a medication used to treat depression or obsessive-compulsive disorder. It may also be used to treat panic disorder or post-traumatic stress disorder (PTSD). It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the manufacturer it should be used cautiously in patients with a history of mania, suicide attempts, and liver or renal impairment.

23. Zyprexa is the brand name for olanzapine, an atypical antipsychotic medication used to treat schizophrenia and bipolar disorder. It is a legend drug, but it is not a controlled substance listed in Section 893.03(4), Florida Statutes. According to the manufacturer it should be used cautiously in geriatric patients and patients with liver impairment. It can also cause weight gain and Tardive Dyskinesia.

PATIENT C.P.

24. Patient C.P. was a then fifty-three-year-old female who first treated with the Respondent on March 26, 2004. She was hospitalized on March 25, 2004, at which time she became a patient of the Respondent.

25. C.P. was treated as an outpatient by the Respondent on at least three (3) occasions between July 28, 2004, and December 2, 2004. During those visits the Respondent completed a Progress Note on each visit. The Progress Note used by the Respondent provides an area for an initial subjective statement followed by a checklist of mental status items. This is followed by an assessment section involving Axis I, II, and III (referring to the system which allows the characterization of different aspects of a psychiatric disorder or disability). The final section of the form is an area for the treatment plan, with a box that may be checked to indicate that the patient is to continue the same treatment, and lines for additional notes.

26. A Progress Note for Patient C.P. was completed on the following dates with the following treatment plan information:

a. 07/28/04 The treatment plan portion of the Note only indicates the following medications: Klonopin increased to 2mg, Restoril 30mg, Seroquel 300mg, and Zoloft 100mg.

b. 08/26/04 The box "continue same treatment" is checked; no prescriptions are specified.

c. 12/02/04 The box "continue same treatment" is checked; no prescriptions are specified.

27. Even though there is no Progress Note for December 3, 2004, there is a copy of a prescription with that date in the Respondent's medical records for C.P. for Klonopin 1mg, Restoril 30mg, Seroquel 300mg, and Zoloft 150 mg.

28. While the care provided by the Respondent in the hospital setting is adequate and sufficiently documented, the care she provided to her patient in the outpatient setting is not adequate and not properly documented.

29. The assessment of Patient C.P. is inadequate in that it fails to sufficiently address the patient's complaints and symptoms.

30. The treatment plan is inadequate in that it focuses almost entirely on medication and fails to make referrals for individual psychotherapy, group therapy, nutrition changes, or other modalities or specialties that would have been appropriate. Although sleep is a chronic problem the Respondent did not refer the patient to a sleep specialist. Alternatively, if there were such referrals the Respondent failed to document that in the medical records.

31. The medical records do not justify the course of treatment of the patient and are inadequate in that it is impossible to review the Progress Notes done in the outpatient setting and have a treatment planning sense of what the Respondent was thinking.

32. The medical records fail to comment on the patient's overall condition from the physical, psychological, social, or occupational perspective. Axis II (underlying personality conditions such as mental retardation) is always listed as "undetermined."

33. The only treatment documented involves changing doses of medication, and even then the dosages are questionable. For example, the use of Klonopin (clonazepam) and Restoril (temazepam) together is generally considered unnecessary. If the Respondent had a valid medical reason for her use of the two long-acting benzodiazepines it is not discernable from the medical records.

PATIENT R.D.

34. Patient R.D. was a then fifty-six-year-old male who first treated with the Respondent on March 6, 2003. He was hospitalized while under the Respondent's care on September 29, 2004, and October 5, 2004.

35. R.D. was treated as an outpatient by the Respondent on at least four (4) occasions between July 28, 2004, and December 2, 2004. During those visits the Respondent completed a Progress Note, as previously described, on each visit.

36. A Progress Note was completed on the following dates with the following treatment plan information:

a. 07/28/04 The box "continue same treatment" is checked; no prescriptions are specified.

b. 08/26/04 The treatment plan portion of the Note only indicates the following medications: Restoril 30mg, Depakote 500mg, Seroquel 600mg, Xanax 1mg, Topamax 25mg, Zoloft 50mg, and Artane 2mg.

c. 10/28/04 The treatment plan portion of the Note only indicates the following medications: Restoril 30mg, Depakote 500mg, Topamax 25mg, Seroquel 300mg, Xanax 1mg, Zoloft 50mg, and Artane 2mg.

d. 12/02/04 The box "continue same treatment" is checked; no prescriptions are specified.

37. Even though no medications are specified in the December 2, 2004 Progress Note, the Respondent's medical records for R.D. include a copy of a prescription written on that date for Restoril 30mg, Depakote 500mg, Topamax 25mg, Seroquel 300mg, Xanax 1mg, Zoloft 50mg, and Artane 2mg.

38. A prescription in the Respondent's medical records for R.D. dated October 28, 2004, for Restoril 30mg, Depakote 500mg, Topamax 25mg, Seroquel 300mg, Xanax 1mg, Zoloft 50mg, and Artane 2mg, confirms the Progress Note entry of that date.

39. The Respondent tended to be much more thorough with her documentation in the hospital setting. The care she provided to her patient in the outpatient setting, however, is not adequate and not properly documented.

40. The assessments of Patient R.D. are inadequate in that, in an outpatient setting, they fail to sufficiently address the patient's complaints and symptoms.

41. The treatment plan is inadequate in that it focuses almost entirely on medication and fails to make referrals for individual psychotherapy, group therapy, nutrition changes, or other modalities or

specialties that would have been appropriate. Alternatively, if there were such referrals the Respondent failed to document that in the medical records.

42. The Respondent was prescribing two benzodiazepines to a patient with a long history of alcohol abuse/dependence, which is generally avoided. If the Respondent had a valid medical reason for prescribing benzodiazepines in that manner it is not discernable from the medical records.

43. The medical records do not justify the course of treatment of the patient and are inadequate in that it is impossible to review the Progress Notes done in the outpatient setting and have a treatment planning sense of what the Respondent was thinking.

44. The medical records fail to comment on the patient's overall condition from the physical, psychological, social, or occupational perspective. Axis II is always listed as "undetermined."

PATIENT T.M.R.

45. Patient T.M.R. was a then twenty-eight year-old female who first treated with the Respondent on January 15, 2004. She was hospitalized while under the Respondent's care on December 27, 2004.

46. T.M.R. was treated as an outpatient by the Respondent on at least three (3) occasions between August 5, 2004, and November 3, 2004. During those visits the Respondent completed a Progress Note, as previously described, on each visit.

47. A Progress Note for Patient T.M.R. was completed on the following dates with the following treatment plan information:

a. 08/05/04 The treatment plan portion of the Note only indicates the following medications: Zoloft 100mg, Seroquel 300mg, Seroquel 200mg, Risperdal 2mg, and Restoril 30mg.

b. 10/05/04 The box "continue same treatment" is checked; no prescriptions are specified.

c. 11/03/04 The box "continue same treatment" is checked; no prescriptions are specified.

48. Even though there is no Progress Note for September 13, 2004, there is a copy of a prescription with that date in the Respondent's medical records for T.M.R. for Seroquel 200mg, Risperdal 2mg, Seroquel 300mg, and Zoloft 100mg.

49. Even though no medications are specified in the November 3, 2004 Progress Note, the Respondent's medical records for T.M.R. include a

copy of a prescription written on that date for Seroquel 200mg, Seroquel 300mg, Zoloft 100, Restoril 30mg, Risperdal 2mg, Benadryl 150, and Surfak 240.

50. A prescription in the Respondent's medical records for T.M.R. dated August 5, 2004, for Restoril 30mg, Zoloft 100mg, Seroquel 300mg, Seroquel 200mg, and Risperdal 2mg, confirms the Progress Note entry of that date.

51. While the care provided by the Respondent in the hospital setting is adequate and sufficiently documented, the care she provided to her patient in the outpatient setting is not adequate and not properly documented.

52. The assessment of Patient T.M.R. is inadequate in that it fails to sufficiently address the patient's complaints and symptoms.

53. The treatment plan is inadequate in that it focuses almost entirely on medication and fails to make referrals for individual psychotherapy, group therapy, nutrition changes, or other modalities or specialties that would have been appropriate. Alternatively, if there were such referrals the Respondent failed to document that in the medical records.

54. The medical records do not justify the course of treatment of the patient and are inadequate in that it is impossible to review the Progress Notes done in the outpatient setting and have a treatment planning sense of what the Respondent was thinking.

55. The medical records fail to comment on the patient's overall condition from the physical, psychological, social, or occupational perspective. Axis II is always listed as "undetermined."

PATIENT D.M.

56. Patient D.M. was a then seventy-two-year-old female who first treated with the Respondent on June 13, 2000.

57. D.M. was treated as an outpatient by the Respondent on at least six (6) occasions between July 7, 2004, and December 07, 2004. During those visits the Respondent completed a Progress Note, as previously described, on each visit.

58. A Progress Note for Patient D.M. was completed on the following dates with the following treatment plan information:

a. 07/07/04 The box "continue same treatment" is checked; no prescriptions are specified.

b. 08/10/04 The box "continue same treatment" is checked; no prescriptions are specified.

c. 09/09/04 The treatment plan portion of the Note only indicates the following medications: Restoril 15mg, Ativan 2mg, Trazodone 100mg, and Paxil 25mg.

d. 10/07/04 The box "continue same treatment" is checked; no prescriptions are specified.

e. 11/04/04 The treatment plan portion of the Note only indicates the following medications: Restoril 15mg, Ativan 2mg, Trazodone 100mg, and Paxil 25mg.

f. 12/07/04 The treatment plan portion of the Note only indicates the following medications: Restoril 15mg, Ativan 2mg, Trazodone 100mg, and Paxil 25mg.

59. Even though no medications are specified in the July 7, 2004 Progress Note, the Respondent's medical records include a copy of a prescription written on that date for Paxil 25mg, Ativan 2mg, Restoril 7.5mg, and Trazodone 100mg.

60. The care the Respondent provided to her patient in the outpatient setting is not adequate and not properly documented.

61. The assessment of Patient D.M. is inadequate in that it fails to sufficiently address the patient's complaints and symptoms.

62. The treatment plan is inadequate in that it focuses almost entirely on medication and fails to make referrals for individual psychotherapy, group therapy, nutrition changes, or other modalities or specialties that would have been appropriate. Alternatively, if there were such referrals the Respondent failed to document that in the medical records.

63. The medical records do not justify the course of treatment of the patient and are inadequate in that it is impossible to review the Progress Notes and have a treatment planning sense of what the Respondent was thinking.

64. The medical records fail to comment on the patient's overall condition from the physical, psychological, social, or occupational perspective. Axis II is always listed as "undetermined."

PATIENT A.R.

65. Patient A.R. was a then seventy-six-year-old male who first treated with the Respondent on February 15, 2001.

66. A.R. was treated as an outpatient by the Respondent on at least five (5) occasions between June 23, 2004, and December 16, 2004. During those visits the Respondent completed a Progress Note, as previously described, on each visit.

67. A Progress Note for Patient A.R. was completed on the following dates with the following treatment plan information:

a. 06/23/04 The box "continue same treatment" is checked; no prescriptions are specified.

b. 07/29/04 The treatment plan portion of the Note only indicates the following medications: Restoril 15mg, Zyprexa 10mg, Xanax 2mg, and Lexapro 20mg.

c. 09/23/04 The treatment plan portion of the Note only indicates the following medications: Zyprexa 20mg, Restoril 15mg, Xanax 1mg, and Lexapro 20mg.

d. 10/28/04 The treatment plan portion of the Note only indicates the following medications: Xanax 1mg, Restoril 15mg, and Lexapro 20mg.

e. 12/16/04 The box "continue same treatment" is checked; no prescriptions are specified.

68. Even though there is no progress Note for August 18, 2004, there is a copy of a prescription in the Respondent's medical records for Zyprexa 20mg, Xanax 1mg, Zoloft 100mg, and Restoril 15mg.

69. Even though no medications are specified in the December 16, 2004 Progress Note, the Respondent's medical records include a copy of a prescription written on that date for Xanax 1mg, Lexapro 20mg, and Restoril 15mg.

70. The care the Respondent provided to her patient in the outpatient setting is not adequate and not properly documented.

71. The assessment of Patient A.R. is inadequate in that it fails to sufficiently address the patient's complaints and symptoms.

72. The treatment plan is inadequate in that it focuses almost entirely on medication and fails to make referrals for individual psychotherapy, group therapy, nutrition changes, or other modalities or specialties that would have been appropriate. Although pain was an issue for the patient there was no referral for pain management. Alternatively, if there were such referrals the Respondent failed to document that in the medical records.

73. The medical records do not justify the course of treatment of the patient and are inadequate in that it is impossible to review the Progress Notes and have a treatment planning sense of what the Respondent was thinking.

74. The medical records fail to justify medication changes made. It is likely that an elderly patient receiving the many different medications being administered to this patient would complain of side effects but no discussion regarding side effects was held, or alternatively, if one was held it was not documented in the medical records.

75. There was inadequate care in addressing the issues of the patient's pain, conflict with his son, and loss of his wife. Alternatively, if the Respondent did address these issues she failed to record that fact in the medical records.

76. The medical records fail to comment on the patient's overall condition from the physical, psychological, social, or occupational perspective. Axis II remained "undetermined" for five years.

COUNT ONE

1. Petitioner re-alleges and incorporates paragraphs one (1) through seventy-six (76) as if fully restated herein.

2. Section 458.331(1)(t), Florida Statutes (2004), provides that failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances is grounds for discipline.

3. Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in her outpatient care and treatment of Patients C.P., R.D., T.M.R., D.M., and A.R., in one or more of the following ways:

a) by failing to adequately assess her patients' complaints and symptoms, or alternatively by failing to document making such assessments;

b) by failing to make appropriate referrals, or alternatively by failing to document making such referrals;

c) by failing to properly manage her patients' medications, or alternatively by failing to document justification for her medication management;

d) by failing to adequately plan for her patients' treatment, or alternatively by failing to document her plans.

4. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes (2004), by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT TWO

5. Petitioner re-alleges and incorporates paragraphs one (1) through seventy-six (76) as if fully restated herein.

6. Section 458.331(1)(m), Florida Statutes (2004), provides that failing to keep legible medical records that justify the course of treatment of the patient constitutes grounds for disciplinary action by the Board of Medicine.

7. Respondent failed to keep medical records that justify the course of the outpatient treatment of Patients C.P., R.D., T.M.R., D.M., and A.R., in one or more of the following ways:

a) by failing to document making adequate assessments on her patients, if she did, in fact, make such assessments;

b) by failing to document making appropriate referrals, if she did, in fact, make such referrals;

c) failing to document justification for her medication management;

d) by failing to adequately document her plans for her patients' continued treatment;

e) by failing to keep sufficiently detailed progress notes that adequately document her patients' progress;

f) by failing to enter comments on her patients' overall condition from the physical, psychological, social, and/or occupational perspective;

g) by failing to document an Axis II diagnosis even after extended treatment.

8. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2004), by failing to keep medical records that justify the course of treatment of the patient.

WHEREFORE, Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of

practice, imposition of an administrative fine, issuance of a reprimand, placement of Respondent on probation, corrective action and/or any other relief that the Board deems appropriate.

SIGNED this 25TH **day of** JUNE **, 2010.**

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

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PCP Members: El-Bahri and Farmer
PCP: June 25, 2010

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Sections 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition any other discipline imposed.