STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2009-21127**

STEVEN L. KAPLAN, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against Respondent, Steven L. Kaplan, M.D., and in support thereof alleges:

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 46745.

3. Respondent's address of record is 9075 SW 87th Avenue, Suite 411, Miami, Florida 33176.

4. At all times material to this Complaint, Respondent practiced psychiatric medicine. At least one quarter to one third of Respondent's patients were and are developmentally disabled and many of his patients resided in residential facilities. Approximately 25% of Respondent's patients were minors.

5. Developmental disability is a term used to describe life-long, disabilities attributable to mental and/or physical impairments, manifested prior to age 18. The term is used most commonly to refer to disabilities affecting daily functioning in three or more of the following areas: capacity for independent living, economic self-sufficiency, learning, mobility, receptive and expressive language, self-care, and self-direction. Section 393.063(9), Florida Statutes, defines developmental disability as a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

6. In or about May of 2006, David Glatt, the owner and operator of Rainbow Ranch Group Home, contacted Respondent and asked him to provide psychiatric services to several residents at Rainbow Ranch. Rainbow Ranch was a residential facility for the developmentally disabled located in Weston, Florida. Mr. Glatt was not a licensed health care provider.

7. Between May 27, 2006, and May 10, 2007, Respondent provided psychiatric services to Patient DM, a developmentally disabled eleven (11) year- old male.

8. On or about May 27, 2006, Patient DM presented to Respondent for the first time. Mr. Glatt was present during Patient DM's appointment gave Respondent a verbal history on Patient DM. Mr. Glatt informed Respondent that Patient DM had a long history of hospitalizations, changes in living arrangements, and repeated violent episodes. In addition, Patient DM presented with a history of seizures.

9. Prior to his initial visit with Respondent, Patient DM had previously been prescribed numerous medications by various psychiatrists and other doctors to address his behavior and illness.

Patient DM was currently prescribed 750 mg of Depakote, 600 mg of Seroquel, 20 mg of Zyprexa and 0.5 mg of clonazepam by a psychiatrist at Children and Adolescents Psychiatric Clinic at Jackson Memorial Hospital.

10. Depakote is used to treat seizure disorders, certain psychiatric conditions (manic phase of bipolar disorder), and may also be used for other mental disorders such as schizophrenia.

11 Seroquel (generic quetiapine) is an oral antipsychotic drug used for treating schizophrenia and bipolar disorder. Although the mechanism of action of quetiapine is unknown, like other anti-psychotics, it inhibits communication between nerves of the brain.

12. Zyprexa (generic olanzipine) is used to treat schizophrenia and bipolar disorder. The use of the drug for extended periods should periodically be re-evaluated to determine the long-term usefulness of the drug for an individual patient. There may be an increased risk of increased blood sugar levels and diabetes with this medication. Therefore, patients should be tested during treatment for elevated blood sugar. Additionally, persons with risk factors for diabetes, including obesity or a family history of diabetes,

should have their fasting levels of blood sugar tested before starting treatment.

13. Clonazepam 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, and abuse of clonazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

14. Respondent's notes for Patient DM's visit on May 27, 2006, indicate previous diagnosis as "pervasive developmental disorder, seizures, schizophrenia, depression, psychosis, mild MR [mild mental retardation], and IED, Intermitten Explosive Disorder."

15. After a brief discussion with Patient DM and Mr. Glatt, Respondent continued the previously prescribed medication for Patient DM and gave him 3 prescription refills for Zyprexa, Seroquel and Depakote and 11 refills for clonazepam.

16. Respondent did not conduct a physical examination of Patient DM, did not create a treatment plan, did not document a

complete mental health history or medical history, and did not conduct a psychiatric assessment.

17. Respondent did not request or review any of Patient DM's medical or Respondent did not request or review any of Patient DM's medical or hospitalization records prior to prescribing the above listed medications. Respondent was aware when Patient DM presented to him the first time that the child had been seen by other psychiatrists and he made no attempt to contact any of them to determine their basis for diagnosis and prescribing.

18. In addition, Respondent was told by David Glatt that Patient DM's mother had abandoned the child. However, Respondent had an extensive history of treating developmentally disabled children and knew that consent from a parent or guardian was required for treatment. Respondent made no attempt to verify who had the legal authority to consent to treatment for Patient DM or verify that the mother had in fact abandoned DM and was not available to assist in the treatment of her child. Respondent received no consent for treatment of Patient DM.

19. At the time Respondent initially prescribed medication for Patient DM, Respondent did not have or review recent blood test results and he did not order blood tests or levels to determine the effects of medication on Patient DM. Respondent never saw results of any blood tests, he never asked if the tests were being done and he never discussed such tests with Patient DM's primary care physician. In fact, there were no blood tests done to determine the effects of the prescribed medication on Patient DM during the time that Respondent treated him.

20. Respondent asserts that his next visit with Patient DM was on June 10, 2006, but his only documentation regarding the visit is a notation on his appointment book with the name "Glatt."

21. Respondent did not conduct or document a physical or mental examination on Patient DM and he did not order any blood tests to determine medication blood levels. Respondent made no arrangements for a follow-up visit with Patient DM

22. On or about June 10, 2006, Respondent wrote prescriptions for all of Patient DM's previously prescribed medications with refills.

23. Respondent asserts that he saw Patient DM on July 8, 2006, but his only documentation regarding the visit is a notation on his calendar with "Glatt, ALF."

24. Respondent did not conduct or document a physical or mental examination on Patient DM and he did not order any bloods test to determine medication blood levels. Respondent made no arrangements for a follow-up visit with Patient DM.

25. Prescription records for July 8, 2006, document that Respondent changed the instructions regarding the time that Patient DM was to take Depakote. There are not medical records that list the previously prescribed medication or document the medical justification for the change in the instructions for administration of the medication.

26. On or after July 24, 2006, a Medicaid contract company notified Respondent that a review of his prescribing practices for four (4) minors, including Patient DM, indicated that he was prescribing an anti-psychotic at a higher than recommended dose for 45 or more days. Because Respondent was prescribing two (2) anti-psychotic drugs to Patient DM, he did not know which of the two (2) drugs the

notice was referring to and made no attempt to find out. Respondent did not respond to the notice, nor did he follow-up with Patient DM through laboratory testing, communication with DM's former psychiatrists, or further assessment.

27. On or about August 4, 2006, Patient DM was admitted to Baptist Children's Hospital with complaints of vomiting and bleeding from the gums. Patient DM was diagnosed with symptoms of mild thrombocytopenia – probably due to Depakote. The treating physician reduced Patient DM's dosage of Depakote for the three (3) days that Patient DM was hospitalized.

28. Contrary to statements made previously, Respondent asserts that on August 11, 2006, David Glatt brought Patient DM to his office. Respondent did not document DM's office visit on that day.

29. Respondent did not conduct or document a physical or mental examination on Patient DM and he did not order any bloods test to determine medication blood levels. Although Respondent did not document the prescriptions he wrote for Patient DM on August 11, 2006, prescription records indicate that Respondent did write

prescriptions for the previously prescribed medication for Patient DM. Respondent made no arrangements for a follow-up visit with Patient DM

30. On or about August 21, 2006, Rainbow Ranch personnel took Patient DM to Respondent's office for a prescription refill for Zyprexa. Respondent wrote a prescription for Patient DM for Zyprexa with refills for 11 months, even though he had written a 30 day prescription for Zyprexa with 3 refills on June 20, 2006.

31. Respondent did not document Patient DM's visit that day, nor did he document any explanation as to why Patient DM needed refills when he had already written sufficient prescription refills through September of 2006. Respondent did not conduct or document a physical or mental examination and he did not order blood tests to determine medication blood levels. Respondent made no arrangements for a follow-up visit with Patient DM in an appropriate period of time.

32. On or about November 29, 2006, Respondent wrote prescriptions for Patient DM without seeing him or documenting any information about his current condition. Respondent issued a refill

authorization for 0.5 mg of clonazepam with 11 refills even though Respondent had written Patient DM a prescription for 0.5 mg of clonazepam with 11 refills on May 27, 2006. Respondent did not document justification for his authorization for refills of clonazepam on November 29, 2006, when he had already prescribed enough clonazepam refills to last through May of 2007.

33. On January 3, 2007, Respondent wrote prescriptions for Patient DM for Depakote and Seroquel with 11 refills. Respondent wrote these prescriptions even though he had not seen Patient DM since August of 2006. Respondent did not document any information indicating Patient DM's current condition.

34. On or about May 10, 2007, Respondent saw Patient DM. Respondent's medical notes document reports of "increased sleep in the day, school feels he's over medicated. Hyper. Needy. Pesty. Needs redirection. Will make a couple of changes so he won't be sleepy in school." In response to the reports from Patient DM's school, Respondent adjusted the time medication was administered.

35. Respondent made no arrangements for a follow-up visit with Patient DM after the May 10, 2007, visit. Respondent did not

inquire about whether changing the times that Patient DM had been getting his medication had resulted in any effect on Patient DM's sleepiness during the school day. Respondent did not order blood work or medication levels to determine the effect of the prescribed medication on Patient DM.

36. At no time during the Respondent's prescribing Depakote to Patient DM did Respondent obtain laboratory values (liver function tests, complete blood count, complete metabolic panel and Depakote level) to monitor the drug levels and potential physiologic side effects on Patient DM.

37. At no time during the time Respondent treated Patient DM did Respondent attempt to contact the patient's mother for consent for treatment and patient history.

38. A reasonably prudent similar health care provider would not have provided treatment to Patient DM without obtaining relevant data, such as medical records, laboratory tests, records of hospitalizations, from previous health care providers.

39. A reasonably prudent similar health care provider would have conducted or made arrangements for a physical examination,

including laboratory tests, a complete patient history, and obtained some evidence relevant to Patient DM's diagnosis prior to prescribing medication with known serious side effects.

40. A reasonably prudent similar health care provider would not have relied solely on the owner of the facility where the patient was residing for all health care, behavioral, physical, and mental reports regarding Patient DM.

41. A reasonably prudent similar health care provider would have documented more than two (2) visits with Patient DM over the course of a year.

42. A reasonably prudent similar health care provider would have conducted regular physical examinations or insured that they were conducted by another health care provider independent of the residential facility where Patient DM was residing in light of Patient DM's diagnosis and residential status.

COUNT ONE

43. Petitioner realleges and incorporates paragraphs one (1) through forty-two (42) as if fully set forth herein.

44. Section 458.331(1)(t)1. Florida Statutes (2005-2006), subjects a licensee to discipline for committing medical malpractice. Medical malpractice is defined in Section 456.50, Florida Statutes, to mean the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. For purposes of Section 458.331(1)(t)1., Florida Statutes, the Board shall give great weight to the provisions of Section 766.102, Florida Statutes, which provide that the prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

45. Respondent failed to practice medicine within the prevailing professional standard of care in one or more of the following ways:

a. By providing treatment to Patient DM without obtaining relevant data, such as medical records, laboratory tests, records of hospitalizations, from previous health care providers and by failing to contact Patient DM's mother regarding his history and treatment;

b. By not conducting or making arrangements for a physical examination, including laboratory tests, a complete patient history, and obtaining some evidence relevant to Patient DM's diagnosis prior to prescribing medication with known serious side effects;

c. By relying solely on the owner of the facility where the patient was residing for all health care, behavioral, physical, and mental reports regarding Patient DM;

d. By prescribing Depakote without obtaining laboratory values (liver function tests, complete blood count, complete metabolic panel and Depakote level) to monitor the drug levels and potential phsyiologic side effects on Patient DM.

e. By failing to see the patient 4 times in one year, only having seen him twice in that period.

47. Based on the foregoing, Respondent has violated Section 458.331(1)(t)1., Florida Statutes (2005-2006), for committing medical malpractice.

COUNT TWO

48. Petitioner reallages and incorporates paragraphs one (1) through forty-two (42) and paragraph forty-five (45) as if fully set forth herein

49. Section 458.331(1)(m), Florida Statutes (2005-2006), subjects a licensee to discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that justify the course of treatment of the patient including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

50. Respondent failed to keep legible medical records that justify his course of treatment for Patient DM by one of more of the following:

a. By failing to identify the patient in records;

b. By failing to document support for his diagnosis;

c. By failing to document a complete patient history, physical or mental examination and results of any examinations;

d. By failing to justify his course of treatment for Patient DM; and

e. By failing to document any evidence of his diagnosis of psychosis and seizure disorder.

f. By failing to document more two patient visits in the one year

51. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2005-2006), by failing to keep legible, as defined by department rule in consultation with the board, medical records that justify the course of treatment of the patient including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations

WHEREFORE, the 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 the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 8th **day of** May 2010, **2010.**

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CLG

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