STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case Nos. 13-0595PL
14-0514PL
NEELAM TANEJA UPPAL, M.D., 14-0515PL

Respondent.
_____/

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in these consolidated cases on July 14 and 15, 2014, in Largo, Florida, before Lynne A. Quimby-Pennock, a designated Administrative Law Judge of the Division of Administrative Hearings (Division).

APPEARANCES

For Petitioner: Andre Christopher Ourso, Esquire
Department of Health
Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265

For Respondent: Sean Michael Ellsworth, Esquire
Ellsworth Law Firm, P.A.
420 Lincoln Road, Suite 601
Miami Beach, Florida 33139

STATEMENT OF THE ISSUE

Whether Respondent violated sections 458.331(1)(m), (q), and (t), Florida Statutes (2007-2011), and, if so, what discipline should be imposed.

PRELIMINARY STATEMENT

These are consolidated cases involving three Department of Health (DOH or Petitioner) cases: DOH Case No. 2009-13497; DOH Case No. 2011-06111; and DOH Case No. 2011-17799. Each case will be set forth individually; however, the cases were consolidated for the hearing.

DOH Case No. 2009-13497 (DOAH Case No. 13-0595PL)

On December 17, 2012, DOH filed a three-count Amended Administrative Complaint (AAC) against Respondent, Neelam Taneja Uppal, M.D., in DOH Case No. 2009-13497, alleging she violated sections 458.331(1)(m), (q), and (t), Florida Statutes (2008).

Respondent timely filed a Petition for Formal Administrative Hearing and Response to Administrative Complaint. On February 18, 2013, DOH referred the case to the Division for assignment to an Administrative Law Judge (ALJ). This case was originally scheduled to be heard on April 23, 2013. However, after a lengthy abeyance and multiple continuances, the case was re-scheduled to June 2, 2014.

On January 30, 2014, DOH filed a Motion for Leave to File Second Amended Administrative Complaint (Motion to Amend).

Thereafter, on February 3, DOH filed a Motion to Consolidate (Consolidation Motion) this case with two other cases that had recently been filed. Respondent filed an objection to the consolidation motion. A telephonic motion hearing was held on February 12, 2014. Immediately prior to the telephonic hearing, a Notice of Appearance was entered by an attorney,[1/] and a Motion to Continue Telephone Conference was filed.[2/] The Motion to Continue the Telephone Conference was denied. Respondent's counsel voiced no objection to the Motion to Amend, which was granted. The Consolidation Motion was granted only to the extent that the three cases were consolidated for discovery purposes.[3/] On February 12, DOH filed the Second Amended Administrative Complaint (2AAC). The 2AAC alleged the same violations of sections 458.331(1)(m), (q), and (t), Florida Statutes (2008), but provided different factual allegations.

On February 25, Respondent's Notice to Produce for Trial was filed and the undersigned issued a Notice of Ex-parte Communication. On March 3, Respondent's then-counsel filed a Notice of Withdrawal citing irreconcilable differences, including Respondent's continual filing of additional pleadings without his knowledge. An Order granting the withdrawal was issued on March 4. Respondent, in her pro se capacity, continued to file additional pleadings until her current counsel filed his Notice of Appearance on May 29, 2014.

DOH Case No. 2011-06111 (DOAH Case No. 14-0514PL)

On April 23, 2013, DOH filed an Administrative Complaint against Respondent in DOH Case No. 2011-06111. On July 16, 2013, Respondent filed a Petition for Formal Administrative Hearing and Response to Administrative Complaint.[4/] On January 31, 2014, DOH referred the matter to the Division for the assignment of an ALJ.

On February 3, 2014, DOH filed a Motion to Consolidate (Consolidation Motion) this case with two other cases. On February 4, Respondent filed a Motion to Strike and Dismiss. On February 5, DOH filed a Unilateral Response to the Initial Order averring that Respondent had not provided "any available dates and other relevant information regarding the final hearing."

On February 7, a Notice of Telephonic Motion Hearing was issued for a February 12 hearing. Immediately prior to the telephonic hearing, a Notice of Appearance was entered by an attorney,[5/] and a Motion to Continue Telephone Conference was filed.[6/] The Motion to Continue the Telephone Conference was denied. The Consolidation Motion was granted only to the extent that the three cases were consolidated for discovery purposes.[7/]

On February 25, Respondent filed an Objection to Plaintiff's Notice to Produce as Untimely and the undersigned issued a Notice of Ex-parte Communication. On March 3, Respondent's then-counsel filed a Notice of Withdrawal citing irreconcilable differences, including Respondent's continual filing of additional pleadings

without his knowledge. An Order granting the withdrawal was issued on March 4. After multiple continuances, the case was re-scheduled to be heard on June 3. Respondent, in her pro se capacity, continued to file additional pleadings until her current counsel filed his Notice of Appearance on May 29.

DOH Case No. 2011-17799 (DOAH Case No. 14-0515PL)

On April 22, 2013, DOH filed an Administrative Complaint against Respondent in DOH Case No. 2011-17799. On July 16, 2013, Respondent filed a Petition for Formal Administrative Hearing and Response to Administrative Complaint. On January 31, 2014, DOH referred the matter to the Division for the assignment of an ALJ.

On February 3, 2014, DOH filed a Motion to Consolidate this case with two other cases. On February 4, Respondent filed a Motion to Strike and Dismiss.

On February 5, DOH filed a Unilateral Response to the Initial Order averring that Respondent had not provided "any available dates and other relevant information regarding the final hearing." On February 7, a Notice of Telephonic Motion Hearing was issued for a February 12 hearing. Immediately prior to the telephonic hearing, a Notice of Appearance was entered by an attorney,[8/] and a Motion to Continue Telephone Conference was filed.[9/] The Motion to Continue the Telephone Conference was denied. The Motion to Consolidate was granted only to the extent that the three cases were consolidated for discovery purposes.[10/]

On February 25, Respondent filed an Objection to Plaintiff's Notice to Produce as Untimely and the undersigned issued a Notice of Ex-parte Communication. On March 3, Respondent's then-counsel filed a Notice of Withdrawal, citing irreconcilable differences, including Respondent's continual filing of additional pleadings without his knowledge. An Order granting the withdrawal was issued on March 4. Respondent, in her pro se capacity, continued to file additional pleadings until her current counsel filed his Notice of Appearance on May 29.

On March 13, DOH filed a Motion for Leave to File Amended Administrative Complaint.[11/] An Order was issued allowing DOH to file the AAC. After multiple continuances, the case was re-scheduled to be heard on June 4, 2014.

May 29, 2014 to July 15, 2014

On May 29, 2014, Sean Ellsworth, Esquire, entered an appearance on behalf of Respondent, two business days prior to the scheduled start of the hearings. Also, on May 29, the parties filed a Joint Motion for Continuance (Joint Continuance) of all three cases. A telephonic motion hearing was held on May 30, and the continuance was granted. The cases were rescheduled to be heard on three consecutive days beginning on July 14, 2014. Additionally, the parties agreed and were directed to complete any additional discovery within 20 days of service in order to accommodate the hearing dates.

At various times throughout the administrative proceedings, both Petitioner and Respondent (when represented by counsel and in her pro se capacity) filed various motions and notices, which were dealt with in a timely manner.[12/]

On July 3, 2014, the parties filed a Joint Motion to Consolidate (Second Consolidation Motion) the three pending cases into one. The Second Consolidation Motion was granted on July 7. On July 3, DOH filed a Notice of Dismissal of Count One of the Amended Administrative Complaint in DOH Case 2011-17799, removing section 458.331(1)(t) as an allegation.

On July 8, 2014, DOH filed a Motion for Leave to File Amended Administrative Complaint in DOH Case No. 2011-06111, and a Motion for Leave to File Second Amended Administrative Complaint (AAC2) in DOH Case No. 2011-17799. In both instances DOH set forth the reasoning and changes that would be made. Additionally, DOH filed a Request for Official Recognition or Judicial Notice to be taken of the various statutes and rules alleged in the various administrative complaints.

On July 9, DOH filed a Motion to Sever and Relinquish Jurisdiction (Sever Motion) in DOH Case No. 2011-06111, averring that following the deposition of Respondent and Respondent's expert, DOH became aware of additional allegations that necessitated that case to be reconsidered by the Board of Medicine's Probable Cause Panel. All the outstanding Motions

were noticed for hearing on Monday, July 14. Following argument by counsel, DOH was granted permission to file the AAC in 2011-06111 and AAC2 in 2011-17799; the Sever Motion was denied.

The parties' Joint Pre-hearing Stipulation was filed on July 11, 2014.[13/] To the extent relevant, the stipulated facts have been incorporated in this Recommended Order.

At hearing, the parties offered Joint Exhibits 1, 2 and 3 which were received into evidence. DOH presented the testimony of two former DOH Investigators: Kathy Liles (DOH Case Nos. 2009-13497 and 2011-17799) and Mitch Turner (DOH Case No. 2011-06111); C.B., a patient of Respondent; and Jamie Carrizosa, M.D., DOH's expert. Petitioner's Exhibits 2 through 7 and 9 through 12 were admitted over objection.[14/] Respondent was not present, but testified via her deposition which was entered into evidence without objection (Petitioner's Exhibit 2). Respondent's Exhibits 1 and 2 were admitted into evidence without objection. Official recognition was taken of the following Florida Statutes: 458.331(1)(t), Fla Stat. (2008, 2010); 456.50, Fla. Stat. (2008, 2010); 766.102, Fla. Stat. (2008-2010); 458.331(1)(m), Fla. Stat. (2007-2011); 458.331(1)(q), Fla. Stat. (2008); and Florida Administrative Code Rule 64B8-9.003 (2006-2011).[15/]

At the conclusion of the hearing, DOH requested an expanded page limitation for its proposed recommended order (PRO) and an additional 10 days from when the transcript was filed in which to

file its PRO. Respondent's counsel did not object to either request, and each was granted. The parties were allowed 60 pages for their PROs, and were granted 20 days after the filing of the transcript to file their PROs.

The two-volume Transcript was filed on July 29, 2014. Both parties timely filed their PROs, and each has been duly considered in the preparation of this Recommended Order.

FINDINGS OF FACT

The Parties

1. DOH is the state agency charged with regulating the practice of licensed physicians pursuant to section 20.43 and chapters 456 and 458, Florida Statutes. DOH is pursuing sanctions against Respondent based on her provision of medical care to patients A.M., C.B., and P.A.

2. At all times relevant to this case, Respondent was licensed as a medical doctor within the State of Florida, having been issued license number ME 59800.

3. Respondent is board certified by the American Board of Internal Medicine with a specialty in Infectious Disease. Respondent received her medical degree from Christian Medical College in India in 1984. Her medical career, according to her curriculum vitae, includes the following places of employment:

1996 Bay Area Primary Care

1997 American Family and Geriatrics

1998 Faculty appointment at University of South Florida – voluntary

2/99-11/99 Veteran's Administration (Medical Officer on Duty)

1993-present Private Practice

4. Respondent's June 30, 2014, deposition testimony was that she is currently working as a medical provider at Fort Tryon Rehab and Nursing Home in New York, and prior to that she was working at a walk-in clinic in Queens, New York. Respondent testified that she currently resides in Pinellas Park, Florida.

5. In 2008, Respondent's Florida practice, Bay Area Infectious Disease (BAID), was located at 5840 Park Boulevard, Pinellas Park, Florida, and most recently at 1527 South Missouri Avenue, Clearwater, Florida. Each practice location is now closed. Respondent later testified that she had a practice located at 6251 Park Boulevard, Pinellas Park, Florida, which is also closed.

6. Jamie Carrizosa, M.D. (Dr. Carrizosa) is a board-certified internal medicine and infectious disease physician who testified as an expert for DOH. Prior to his retirement in July 2011, Dr. Carrizosa had an active medical practice including hospital privileges. He is currently an Associate Professor of Medicine at the University of Central Florida, teaching first and second year students in the areas of microbiology and immunology. While in private practice, he treated patients with suspected

skin infections, MRSA skin infections, candidiasis and other types of skin diseases.

7. Issa Ephtimios, M.D. (Dr. Ephtimios) is a board-certified physician in internal medicine, infectious diseases and infection control who testified as an expert for Respondent. He is an attending physician at Sacred Heart Hospital, West Florida Hospital, Baptist Hospital, and Select Specialty Hospital in Pensacola, Florida.

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8. On October 8, 2008, A.M. presented to Respondent with complaints of fatigue, headaches, and moodiness, according to a History and Physical Medi-Forms document. A BAID contract for services and an authorization for BAID to disclose protected health information (PHI) were executed on October 8. Within the records there was a diagram that contained pictures of a front and back body diagram and the handwritten words: "fatigue cold sweats fevers headaches." Neither A.M.'s name nor the date appeared on the diagram, yet Respondent identified the diagram as belonging to A.M. and showing A.M.'s small lesions. On October 9, A.M. executed a Bay Area Infectious Disease and Infusion, PLC, "CONSENT FOR TREATMENT" form.

9. Respondent's progress notes are generally listed in the S.O.A.P. format.[16/] The following appeared on one of A.M.'s October 9th Progress Notes:

S: Complaint: MRSA,[17/] headecha [sic], she like [sic] to talk W Dr. Pimple on but [sic] 3 rounds Zyvox, [illegible] c/o lethargic, gain wt, fatigue, headaches Pale, feets [sic] not Percocet –[illegible].”

O: Exam: Ht 5.6” Wt 172 Age 16 M/F
BMI_____ T___ BP 118/64 P 65 R____PO2 99
Gluc ___

A: General Appearance: WNL[/18]
HEENT: WNL
Neck: WNL
Chest: WNL
Breast: WNL
Heart: WNL
Lungs: WNL
Abdomen: WNL
Genitalia: WNL
Skin: WNL + multiple abcees [sic]
Spine: WNL
Extremities: WNL
[All the “WNL” were typed capital letters.]
DIAGNOSIS:
Skin Abcess- Buttock, leg
MRSA – Community Acquired

P: PLAN:
Vancomycin 1 gr daily
[illegible]

10. A second Progress Note for A.M., also dated October 9, contains the same information in the “S” and “O” portions, but at the “A” portion, it has no notations other than the pre-printed “WNL” at the “Skin” section, and it does not contain a “Diagnosis.” Respondent admitted that there were times when she would “complete records later on.”

11. Respondent's progress notes for A.M. from October 10 through October 16 were in a slightly different SOAP format. A.M.'s October 10 Progress Note reflects the following:

S: Complaint: Vanco reaction

O: Examination: BP ____ P ____ T____ R____
HT____ WT____ PO2_____Glucose _____

General Appearance; Awake alert,orientedx3
Head: Normocephalic atraurmatic
EENT: PERLA, EOMI,Sclera-non-icteric,
conjunctiva-pink
Neck: Supple, no JVD. No Lymph nodes
Heart: S1 S2 normal, __murmurs
Lungs: clear
Abdomen: Soft, no masses, no tenderness,
BS+, no hepatomegaly, no splenomegaly
Left Lymph-inguinal: WNL
Right Lymph-inguinal: WNL
Extremities: No clubbing, cyanosis, edema
Neurological: Motor-5/5, sensory-5/5, Deep
tendon reflexes 2+
Cranial nerves Intact
Skin: ~~no ra~~shes + circled Abscess
Muskuloskeletal: WNL

CLINICAL ASSESSMENT:
MRSA, Skin Abcess
CVIO

PLAN:
Zyvox

12. A.M.'s progress notes between October 11 and 31, 2008, reflect various subjective complaints regarding her skin conditions. The physical examinations for each day do not contain consistent information regarding A.M.'s blood pressure, her height, weight, respirations, PO2, and glucose. On two days the "skin" section reflected "no rashes," yet the clinical

assessment reported "Skin Abces – improvely" [sic] or just "skin abcess." On three progress notes (October 17, 18 and 20, 2008), there is a hand-written notation at the "Heart" section which indicates that A.M. might have a heart murmur, yet in the diagnosis section there is no mention of a heart issue or endocarditis.[19/] All other progress notes regarding the "heart" contain the pre-printed "WNL."

13. A.M.'s IV/IM procedure notes beginning on October 10 and continuing through October 31, each reflect "heart murmur" in the diagnosis section along with "MRSA Skin abcess." Respondent testified that she felt justified in using IV Vancomycin because A.M. was "doing the heart murmur." However, Respondent's initial plan included Vancomycin before any heart murmur was detected or assessed.

14. Vancomycin is a prescription medication used to treat staphylococcal infections, and is usually utilized for more serious infections such as endocarditis.

15. Zyvox is a prescription medication that comes in either an IV or oral form used to treat infections.

16. Respondent claimed that there were missing medical records for A.M. However, with respect to patient A.M., Respondent claimed a progress note (part of the history and physical exam) from October 8 was the only medical record that was missing. Respondent then asserted that A.M. brought in her

primary doctor's referral which reflected A.M.'s treatment, including the medication prescribed; yet those medical records are not present. Respondent further testified that she "usually" puts prior treatment provider records in her patient's file.

17. Respondent maintained that she kept a lot of A.M.'s medical records on a computer that was bought in January 2001. However, that computer crashed in October 2011. A computer crash is plausible; however, the DOH subpoena was properly issued and served on Respondent on January 28, 2010, more than nine months before the alleged computer crash. Respondent then claimed that she "did not have access to that computer, which later crashed," followed by her claim that "that practice was closed and when they came here, we only had the old, whatever, paper records." Respondent's position on these records was disingenuous at best. Respondent claimed that A.M. was seen and her medical records were at a different location (6251 Park Boulevard) than where the subpoena was served (5840 Park Boulevard).[20/] Respondent then claimed the records that were moved from one facility to another facility could not be located. Respondent alluded to a potential police report regarding an alleged theft of medical records and other office items; however, nothing substantiated that, and Respondent's testimony about possible criminal activity is not credible.

18. Respondent admitted that some of A.M.'s medical records, specifically progress notes, were pre-printed, and that she wrote on some of the progress notes. In the progress notes dated October 10, 11, 13 through 18, 20 through 25, and 27 through 30, the handwriting appears to be the same, except for the change in each date. Further, Respondent confirmed A.M.'s 18 pages of progress notes of Vancomycin administration, yet distanced herself from them by saying "sometimes the charts were completed later on, so it's possibility that it -- that it -- you know, it's progress notes for the IV administration, but – um . . . the dates are written by nurses, so I don't -- I don't know." Respondent's inability or unwillingness to identify who may have written on A.M.'s progress notes and her avoidance in answering direct questions or claiming she did not recall the patient (and then discussing the patient) greatly diminished her credibility.

19. Respondent claimed that there were "some verbal changes" she gave that were in a "set of nursing records," which were not present. Any "changes" or directions given by Respondent should have been contained within her medical records for the care of A.M.

20. Respondent maintained that her diagnosis of A.M. was based on Respondent's total clinical picture of A.M., including A.M.'s "symptoms, her presentation, her lesions, her course --

she'd had repeated courses of oral antibiotics, and was getting recurrence." Yet, Respondent also claimed A.M. "came in with these culture results from the primary, and that's how the staff . . . it states MRSA, because it was already documented MRSA."

Standard of Care

21. Respondent was required to practice medicine in her care of A.M. with "that level of care, skill, and treatment which is recognized in general law related to health care licensure." Based on the credited opinions of Dr. Carrizosa, Respondent's treatment and care of A.M. violated the standard of care for the following reasons.

22. A reasonably prudent health care provider suspecting a patient has MRSA would observe the abrasion(s), culture the abrasion (MRSA), send the culture out for laboratory confirmation, prescribe oral antibiotics, and if the MRSA does not respond to the oral antibiotics, prescribe and administer IV antibiotics. Dr. Carrizosa noted that Respondent did not provide a description of A.M.'s abscesses, did not indicate that A.M.'s abscesses were drained, incised, cleaned or bandaged, or that Respondent provided any patient education to A.M. Although labs were ordered, there was no request for a bacterial culture or for an antimicrobial susceptibility test to be completed. Dr. Carrizosa expressed concern that young people can eliminate antibiotics within six to eight hours and there is a need for

monitoring their medications to ensure they maintain a therapeutic level.

23. Dr. Carrizosa opined that Respondent did not meet the standard of care in her treatment of A.M. The evidence clearly and convincingly establishes that Respondent violated the standard of care applicable to an infectious disease practitioner.

24. Respondent presented the deposition testimony of Dr. Ephtimios. Dr. Ephtimios reviewed the same records as Dr. Carrizosa. Dr. Ephtimios admitted he had several lengthy conversations with Respondent during which time she provided additional information to Dr. Ephtimios that was not in A.M.'s written records regarding "the rationale for using the Vancomycin." Respondent shared additional information with Dr. Ephtimios yet failed to recall or remember the patient during her own deposition testimony. Dr. Ephtimios' opinion is not credible. Respondent's deposition behavior lessens her credibility.

Medical Records

25. Medical records are maintained for a number of reasons. Primarily, medical records are necessary for the planning of patient care; for continuity of treatment; and to document the course of the patient's medical evaluation, treatment, and progression through treatment. Further, medical records should

document any communications between health care providers, and they serve as a basis for health care providers to be paid by either the patient or another party. See, rule 64B8-9.003.

26. The medical records of A.M.'s contact with Respondent's office between October 8, 2008, and October 31, 2008, do not meet Florida's standards for medical records. A.M.'s records do not describe the abscesses, do not indicate if any of the abscesses were drained, incised, or cultured. Respondent failed to provide any assessment of a staph infection or provide any laboratory support for the use of the medication administered. Respondent did not document A.M.'s possible heart murmur, and failed to provide a diagnostic basis for endocarditis. Further portions of the medical record are illegible. There is no clear indication that Respondent provided A.M. with any education on her condition.

Inappropriate Drug Therapy

27. Respondent authorized the administration of Vancomycin and/or Zyvox to a 16-year-old female without adequately monitoring A.M.'s condition, or documenting the need for such use. Respondent's failure to document the need for Vancomycin through appropriate or adequate testing was not in the best interest of A.M.

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28. On February 28, 2011, patient C.B., a 42-year-old female, presented to Respondent with complaints of food allergy issues, and gastrointestinal problems, gas, bloating, and other stomach issues.[21/] When she presented to Respondent in February 2011, C.B. did not have any concerns about candida or thrush.[22/] Respondent prescribed a Medrol Pak (a steroid) and directed C.B. to have lab tests for the candida antibody and an immune system panel.

29. One week later, C.B. again presented to Respondent. C.B. did not have any of the symptoms for a chronic yeast infection such as vaginal itching or thrush. Respondent advised C.B. that she had a chronic yeast infection and her immune system required treatment. However, Respondent did not prescribe any medication to C.B. at that time.

30. On March 14, 2011, C.B. returned to Respondent's office and received Immunoglobulin[23/] via an intravenous (IV) line. On March 22, 24 and 25, 2011, C.B. received IV Ambisome.[24/] Thereafter, C.B. developed a rash on her arm where the IV had been placed and a papule on her stomach. C.B. declined further IV treatments because she did not think the medication was working. On March 29, Respondent prescribed VFEND[25/] to C.B.

31. On March 30 and 31 and April 1, 2011, C.B. was a "no show" at Respondent's office. Yet each of C.B.'s progress notes

contained information regarding C.B.'s general appearance. Respondent testified that those progress notes are preprinted forms and would be adjusted upon a patient's examination.

32. On April 4, 2011, Respondent's progress note for C.B. reflects "Discuss with patient in detail, patient complains of one papule, advised patient about candidiasis, GI tract not responding to azoles. Complains of diarrhea, abdominal symptoms, wants IV meds." C.B.'s progress note dated April 5, 2011, reflects under the "S: COMPLAINT: No show - Refused to get PICC line out. Patient walked out yesterday. Patient was told to wait for dressing change. Patient states to receptionist she will come today." Respondent elected to document on April 5, something that happened on April 4, despite the fact that the progress note for April 4 reflected a discussion with C.B.

33. On April 11, 2011, C.B. presented a request for her medical records to Respondent's staff. C.B. received copies of her medical records and provided them to DOH.

34. Respondent testified as to C.B.'s 2011 presentation and Respondent's course of treatment, including what medications were prescribed. Respondent confirmed that an undated "History and Physical" (H&P) for C.B. was C.B.'s "initial history and physical" created from a template. This H&P purports to reflect that C.B. was "discharged [from Respondent's practice] for misbehavior . . . was in jail. . . [and] begging [for Respondent]

to help her." This H&P also contained Respondent's physical examination of C.B., which was recorded on a "Progress Note" of the same date. Differences in the two records of the same date exist.

35. C.B. testified that she has never been in jail and that she had not been discharged from Respondent's practice. C.B. is found to be a credible witness. Respondent's testimony is not credible.

36. Respondent averred that she discussed C.B.'s vaginal itching with C.B. during the March 7, 2011, office visit, yet Respondent did not prescribe any medications for C.B. C.B.'s first IV immunoglobulin was administered on March 14, a week later.

37. Respondent claims she discussed her care and treatment with C.B. on Wednesday, March 23, 2011. C.B. did not see Respondent on March 23, as C.B. went to Respondent's office located on Park Boulevard in Pinellas Park and that location was closed. C.B. found out that Respondent was working at an address in Clearwater. C.B. did not have adequate time to get to that Clearwater location before it closed for the day. Thus, C.B. missed the appointment on that day. C.B.'s candid and succinct testimony is credible.

38. Respondent testfied that certain medical records for C.B. were missing:

> anything that was documented electronic or anything -- any reports or any old records, old reports, it doesn't contain anything. And she came in for the treatment of a disease that's been existing since 2006, so a lot of workup that's done in the prior years for -- which is the relevant basis of the treatment at this point is not there.

39. Respondent was not clear which medical records were missing. C.B. had not been a patient of Respondent for approximately two years. Respondent's reliance or purported reliance on C.B.'s "old records, old reports" without adequate confirmation of C.B.'s current health issues via appropriate work-ups, laboratory studies and tests falls below the reasonably prudent similar health care provider standard.

Standard of Care

40. Respondent was required to meet the same standard of care as outlined in paragraph 25 above. Dr. Carrizosa's testimony was clear, concise, and credible. He did not appear to have any prejudice against Respondent as a person, but was concerned about how she was practicing medicine. Based on the credited opinions of Dr. Carrizosa, Respondent's treatment and care of C.B. violated the standard of care for the following reasons.

41. Respondent failed to practice in such a manner as to determine within a reasonable degree of medical certainty that C.B. had systemic candida as was diagnosed by Respondent.

Further, the laboratory results were not positive for an antimicrobial sensitivity culture taken from C.B. Additionally, C.B.'s complete blood count (CBC) and the differential count, which included neutrophils and lymphocytes, were normal. The administration of Ambisome, the most expensive of all the drugs available, was not warranted as C.B. did not have systemic candidiasis. Further, the immunoglobulin treatment was inappropriate as there was no evidence that C.B. had an immune dysfunction.

Medical Records

42. Dr. Ephtimios also provided an opinion on behalf of Respondent. Dr. Ephtimios had a discussion with Respondent regarding the care and treatment provided to C.B. outside the medical records provided. Dr. Ephtimios admitted that he does not use a Medrol Pak in his practice; he does not feel comfortable practicing immunology (and would have referred C.B. out to an immunologist.) Dr. Ephtimios would not have ordered the laboratory tests that Respondent ordered; his understanding of what candidiasis means may differ from Respondent's, and he speculated on what he thought Respondent "meant" in several instances. Dr. Ephtimios provided a somewhat exhaustive approach to the various forms of candidiasis; however, he qualified each approach. Each physician practices medicine using their own skill set and different methods of providing clinical assessments

and treatment. However, Dr. Ephtimios provided various qualifiers to his opinion which rendered it less credible.

43. The basis for creating, maintaining and retaining medical records is expressed in paragraph 25 above.

44. The medical record of C.B.'s contact with Respondent's office during this time does not meet Florida's standards for medical records. C.B.'s records do not reflect an appropriate evaluation, as they fail to analyze C.B.'s main complaints, they fail to analyze the previous evaluations of C.B., and her physical exams were incomplete.

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45. According to Respondent, patient P.A., a 38-year-old female, was "an ongoing patient [of hers] for over ten years." Respondent saw P.A. between February 2008 and December 2011. Respondent provided medical records to DOH regarding P.A. However, Respondent admitted she did not provide all P.A.'s medical records because "a lot of records were missing," and Respondent knew "at one point when they were very old records in the 6251 office some of them were also shredded." Respondent further claimed in response to additional questioning about her shredding statement,

> [B]ecause the statute says, you know, after three years, so I'm not sure if the -- because I know some of the records were shredded by one of the secretaries.

* * *

> The one [statute] which says once a practice is closed retain records for three years.

46. Respondent identified one of P.A.'s progress notes (dated January 26, 2011) as "our procedure note," but when asked "What was going on here according to these notes," Respondent answered: "It's hard to say. It's not my handwriting." Respondent could read the handwriting, but had "no clue" who wrote the progress note. Further, Respondent was unable to state if P.A. was administered either the gentamicin 40 milligrams or the clindamycin 600 milligrams as listed on the progress note.

Medical Records

47. The basis for creating, maintaining and retaining medical records is expressed in paragraph 25 above.

48. In this instance, the testimony of Respondent clearly and convincingly proves Respondent violated section 458.331(1)(m) and rule 64B8-9.003.

49. No evidence was presented that Respondent has been previously disciplined.

CONCLUSIONS OF LAW

50. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to sections 120.569 and 120.57.

51. The Department is the state agency charged with regulating the practice of medicine. § 20.43 and chapters 456 and 458, Fla. Stat.

52. Section 458.331(1) authorizes the Board of Medicine to impose penalties ranging from the issuance of a letter of concern to revocation of a physician's license to practice medicine in Florida, if a physician commits one or more acts specified in that section.

53. The Department has the burden to establish the allegations contained in the charging documents by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern and Co., 670 So. 2d 932, 935 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292, 294 (Fla. 1987).

54. In Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983), the Court developed a "workable definition of clear and convincing evidence" and found that of necessity such a definition would need to contain "both qualitative and quantitative standards." The Court held that:

> [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Id. The Florida Supreme Court later adopted the Slomowitz court's description of clear and convincing evidence. See In re Davey, 645 So. 2d 398, 404 (Fla. 1994). The First District Court of Appeal has added the interpretive comment that "[a]lthough this standard of proof may be met where the evidence is in conflict . . . it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., Inc., 590 So. 2d 986, 988 (Fla. 1st DCA 1991); rev. denied, 599 So. 2d 1279 (Fla. 1992) (citations omitted).

55. Section 458.331(1) provides in relevant part as follows:

> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (m) Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and 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.
>
> * * *

(q) Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.

* * *

(t) Notwithstanding s. 456.072(2) but as specified in s. 456.50(2):

1. Committing medical malpractice as defined in s. 456.50. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. Medical malpractice shall not be construed to require more than one instance, event, or act.

2. Committing gross medical malpractice.

3. Committing repeated medical malpractice as defined in s. 456.50. A person found by the board to have committed repeated medical malpractice based on s. 456.50 may not be licensed or continue to be licensed by this state to provide health care services as a medical doctor in this state.

Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross medical malpractice," "repeated

medical malpractice," or "medical malpractice," or any combination thereof, and any publication by the board must so specify.

56. Subsection 456.50(1)(g) defines medical malpractice as follows:

> "Medical malpractice" means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. Only for the purpose of finding repeated medical malpractice pursuant to this section, any similar wrongful act, neglect, or default committed in another state or country which, if committed in this state, would have been considered medical malpractice as defined in this paragraph, shall be considered medical malpractice if the standard of care and burden of proof applied in the other state or country equaled or exceeded that used in this state.

57. Rule 64B8-9.003 provides in pertinent part the parameters of adequate medical records as follows:

> (2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.
>
> (3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the

request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

(4) All entries made into the medical records shall be accurately dated and timed. Late entries are permitted, but must be clearly and accurately noted as late entries and dated and timed accurately when they are entered into the record. However, office records do not need to be timed, just dated.

(5) In situations involving medical examinations, tests, procedures, or treatments requested by an employer, an insurance company, or another third party, appropriate medical records shall be maintained by the physician and shall be subject to Section 456.061, F.S. However, when such examinations, tests, procedures, or treatments are pursuant to a court order or rule or are conducted as part of an independent medical examination pursuant to Section 440.13 or 627.736(7), F.S., the record maintenance requirements of Section 456.061, F.S., and this rule do not apply. Nothing herein shall be interpreted to permit the destruction of medical records that have been made pursuant to any examination, test, procedure, or treatment except as permitted by law or rule.

58. In DOAH Case No. 13-0595PL, the Department alleged Respondent violated sections 458.331(1)(t). Specifically, the Department alleged in paragraph 34 of the 2AAC that:

> Respondent failed to meet the prevailing professional standard of care regarding the treatment of patient A.M. in one or more of the following ways:
>
> a. By failing to determine and verify whether the patient had a non-resistant staphylococcal infection or a MRSA infection;

b. By failing to incise, drain and culture A.M.'s lesions;

c. By failing to initiate treatment with antimicrobial soap and instruct the patient to use antimicrobial soup;

d. By failing to treat A.M. with an oral antibiotic before initiating intravenous infusion treatment;

e. By inappropriately treating A.M. with IV Vancomycin;

f. By treating A.M. with both oral and IV Zyvox without medical justification;

g. By failing to order appropriate tests to confirm that A.M. had a heart valve infection; or

h. By failing to appropriately monitor A.M.'s pharmacology when A.M. went through infusion.

59. The Department has proven by clear and convincing evidence that Respondent violated the standard of care as alleged in paragraph 34 of the 2AAC.

60. In DOAH Case No. 14-0514PL, the Department has alleged Respondent violated section 458.331(1)(t). Specifically, the Department alleged in paragraph 39 of the AAC that:

Respondent fell below the acceptable standard of care in one or more of the following ways:

a. The Respondent's examination and evaluation of Patient C.B. was inadequate and inappropriate in that the examination did not support a diagnosis of one of the following conditions: systemic Candida infection, hyperimmune dysfunction, immunodeficiency or decreased immune response;

b. The Respondent's [sic] inappropriately treated the patient with one or more of the following drugs; AmBisome, immunoglobulin, Vfend or Diflucan although the patient did not have any conditions which would indicate their use.

c. The Respondent failed to discontinue treatment with AmBisome or immunoglobulin despite the patient having signs of negative side effects.

61. The Department has proven by clear and convincing evidence that Respondent violated the standard of care as alleged in paragraph 39 (a) and (b). The Department failed to establish that Respondent violated the standard of care as alleged in paragraph 39 (c).

62. In DOAH Case No. 13-0595PL, Count Two of the 2AAC, the Department alleged that Respondent violated section 458.331(1)(m). Specifically, the Department alleged in paragraph 38 of the 2AAC that:

Respondent failed to keep legible medical records for A.M. in one or more of the following ways:

a. by failing to document a complete and appropriate history and physical examination;

b. by failing to adequately document the condition of A.M.'s abscesses;

c. by failing to adequately document the doses of Vancomycin, and Zyvox ordered for the patient;

d. by failing to document the justification of the course of treatment provided;

e. by failing to keep A.M.'s complete medical records.

63. The Department has adopted rule 64B8-9.003, which defines "Standards for Adequacy of Medical Records" as set forth above. Based on the findings of fact herein, the Department has proven by clear and convincing evidence that Respondent failed to keep adequate medical records in violation of section 458.331(1)(m).

64. In DOAH Case No. 14-0514PL, the Department has alleged Respondent violated section 458.331(1)(m). Specifically, the Department alleged in paragraph 43 of the AAC that:

> Respondent failed to keep appropriate medical records in one or more of the following ways:
>
> a. The medical records did not justify one or more of the following diagnoses: systemic Candida infection, hyper immune dysfunction, combined immunodeficiency or decreased immune response.
>
> b. The medical records did not justify the Respondent's treatment of the patient.
>
> c. The medical records had conflicting accounts of the patient's treatment.
>
> d. By failing to keep and/or maintain C.B.'s complete medical records.

65. Based on the findings of fact herein, the Department has proven by clear and convincing evidence that Respondent failed to keep adequate medical records, as alleged in paragraph 43, in violation of section 458.331(1)(m).

66. In DOAH Case No. 14-0515PL, the Department has alleged Respondent violated section 458.331(1)(m). Specifically, the Department alleged in paragraph 27 of the AAC2 that:

> Respondent failed to keep medical records in one or more of the following ways:
>
> a. The medical records did not contain adequate documentation of physical examinations.
>
> b. The medical record did not contain sufficient documentation of the course and results of treatment accurately.
>
> c. The medical records do not contain documentation of consultations and follow-ups.
>
> d. The Respondent failed to keep and maintain the complete medical records for patient P.A.

67. Based on the findings of fact, the Department has proven by clear and convincing evidence that Respondent failed to keep adequate medical records, as alleged in paragraph 27, in violation of section 458.331(1)(m).

68. In DOAH Case No. 13-0595PL, Count Three of the 2AAC, the Department alleged that Respondent violated section 458.331(1)(q). Specifically, the Department alleged in paragraph 42 of the 2AAC that:

> Respondent prescribed, administered, or prepared legend drugs inappropriately to patient A.M. in one or more of the following ways:

a. by prescribing IV Vancomycin without sufficient medical justification;

b. by prescribing doses of Vancomycin only once a day; or

c. by prescribing both oral and IV Zyvox.

69. Based on the findings of fact herein, the Department proved by clear and convincing evidence that Respondent violated section 458.331(1)(q).

Penalty

70. Section 458.331(1) provides for the discipline of health care professionals who violate their respective practice acts. According to section 456.072(2), Florida Statutes:

> When the board . . . finds any person guilty of . . . any grounds set forth in the applicable practice act, including conduct constituting a substantial violation of subsection (1) . . . it may enter an order imposing one or more of the following penalties:
>
> (a) Refusal to certify, or to certify with restrictions, an application for a license.
>
> (b) Suspension or permanent revocation of a license.
>
> (c) Restriction of practice or license, including, but not limited to, restricting the licensee from practicing in certain settings, restricting the licensee to work only under designated conditions or in certain settings, restricting the licensee from performing or providing designated clinical and administrative services, restricting the licensee from practicing more than a designated number of hours, or any other restriction found to be necessary for

the protection of the public health, safety, and welfare.

(d) Imposition of an administrative fine not to exceed $10,000 for each count or separate offense. If the violation is for fraud or making a false or fraudulent representation, the board, or the department if there is no board, must impose a fine of $10,000 per count or offense.

(e) Issuance of a reprimand or letter of concern.

(f) Placement of the licensee on probation for a period of time and subject to such conditions as the board, or the department when there is no board, may specify. Those conditions may include, but are not limited to, requiring the licensee to undergo treatment, attend continuing education courses, submit to be reexamined, work under the supervision of another licensee, or satisfy any terms which are reasonably tailored to the violations found.

(g) Corrective action.

(h) Imposition of an administrative fine in accordance with s. 381.0261 for violations regarding patient rights.

(i) Refund of fees billed and collected from the patient or a third party on behalf of the patient.

(j) Requirement that the practitioner undergo remedial education.

In determining what action is appropriate, the board, . . . must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the practitioner. All costs

> associated with compliance with orders issued under this subsection are the obligation of the practitioner.

71. The Board of Medicine imposes penalties upon licensees in accordance with the disciplinary guidelines prescribed in Florida Administrative Code Rule 64B8-8.001. Rule 64B8-8.001 provides in pertinent part:

> (1) Purpose. Pursuant to Section 456.079, F.S., the Board provides within this rule disciplinary guidelines which shall be imposed upon applicants or licensees whom it regulates under Chapter 458, F.S. The purpose of this rule is to notify applicants and licensees of the ranges of penalties which will routinely be imposed unless the Board finds it necessary to deviate from the guidelines for the stated reasons given within this rule. The ranges of penalties provided below are based upon a single count violation of each provision listed; multiple counts of the violated provisions or a combination of the violations may result in a higher penalty than that for a single, isolated violation. Each range includes the lowest and highest penalty and all penalties falling between, including appropriate continuing medical education (CME). The purposes of the imposition of discipline are to punish the applicants or licensees for violations and to deter them from future violations; to offer opportunities for rehabilitation, when appropriate; and to deter other applicants or licensees from violations.
>
> (2) Violations and Range of Penalties. In imposing discipline upon applicants and licensees, in proceedings pursuant to Sections 120.57(1) and (2), F.S., the Board shall act in accordance with the following disciplinary guidelines and shall impose a penalty within the range corresponding to the violations set forth below. The verbal

identification of offenses are descriptive only; the full language of each statutory provision cited must be consulted in order to determine the conduct included.

VIOLATION

* * *

(m) Failure to keep appropriate written medical records. (Section 458.331 (1)(m), F.S.)

(FIRST OFFENSE)
(m) From a reprimand to denial or two (2) years suspension followed by probation, and an administrative fine from $1,000.00 to $10,000.00.

(SECOND OFFENSE)
(m) From probation to suspension followed by probation or denial, and an administrative fine from $5,000.00 to $10,000.00.

* * *

(q) Inappropriate or excessive prescribing. (Section 458.331(1)(q), F.S.)

(FIRST OFFENSE)
(q) From one (1) year probation to revocation or denial and an administrative fine from $1,000.00 to 10,000.00.

(SECOND OFFENSE)
(q) From suspension, to be followed by a period of probation, to revocation or denial and an administrative fine from $5,000.00 to $10,000.00.

* * *

(t) Failure to practice medicine in accordance with appropriate level of care, skill and treatment recognized in general law related to the practice of medicine.
(Section 456.50(1)(g), F.S.)
(Section 458.331(1)(t), F.S.)

(FIRST OFFENSE)
(t) From one (1) year probation to revocation or denial and an administrative fine from $1,000.00 to $10,000.00.

(SECOND OFFENSE)
(t) From two (2) years probation to revocation or denial and an administrative fine from $5,000.00 to $10,000.00.

* * *

(3) Aggravating and Mitigating Circumstances. Based upon consideration of aggravating and mitigating factors present in an individual case, the Board may deviate from the penalties recommended above. The Board shall consider as aggravating or mitigating factors the following:

(a) Exposure of patient or public to injury or potential injury, physical or otherwise: none, slight, severe, or death;

(b) Legal status at the time of the offense: no restraints, or legal constraints;

(c) The number of counts or separate offenses established;

(d) The number of times the same offense or offenses have previously been committed by the licensee or applicant;

(e) The disciplinary history of the applicant or licensee in any jurisdiction and the length of practice;

(f) Pecuniary benefit or self-gain inuring to the applicant or licensee;

> (g) The involvement in any violation of Section 458.331, F.S., of the provision of controlled substances for trade, barter or sale, by a licensee. In such cases, the Board will deviate from the penalties recommended above and impose suspension or revocation of licensure.
>
> (h) Where a licensee has been charged with violating the standard of care pursuant to Section 458.331(1)(t), F.S., but the licensee, who is also the records owner pursuant to Section 456.057(1), F.S., fails to keep and/or produce the medical records.
>
> (i) Any other relevant mitigating factors.

72. Some of the factors listed above have no application to this case. For example, Respondent was under no legal constraints at the time of these incidents (subsection (3)(b)), no disciplinary history of the licensee was presented (subsection (3)(e)), or no pecuniary benefit or self-gain inuring to the licensee was presented subsection (3)(f)).

73. The Department asserts that the appropriate penalty in these combined cases consist of revocation and an administrative fine of $30,000.00.

74. Having considered that the findings of fact with respect to the violation of section 458.331(1)(q) are in large part duplicative of the violation of section 458.331(1)(t), a penalty within the guidelines, but at the lower end, is appropriate.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Medicine enter a Final Order finding that Respondent, Neelam Uppal, M.D., violated section 458.331(1)(m), (q) and (t), Florida Statutes; suspending her license for six months followed by two years probation with terms and conditions to be set by the Board of Medicine; imposing an administrative fine of $10,000.00; requiring the successful completion of a course or courses to make, keep and maintain medical records; requiring a course in professional responsibility and ethics, and such other educational courses as the Board of Medicine may require; and assessing costs as provided by law.

DONE AND ENTERED this 17th day of September, 2014, in Tallahassee, Leon County, Florida.

LYNNE A. QUIMBY-PENNOCK
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
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Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of September,2014.

ENDNOTES

[1/] On February 7, the Notice for Telephonic Motion Hearing was issued setting February 12, at 2:15 p.m. for the hearing; the attorney's notice was filed at 2:14 p.m.

[2/] This motion was filed at 2:16 p.m.

[3/] The parties were advised they could file another request to consolidate for hearing purposes.

[4/] This Petition reflects a different DOH Case Number on page 2, line 2; however, the Petition's content addresses C.B., the patient in DOH Case Number 2011-06111. Further, the Petition provides answers to an "Amended Administrative Complaint." DOH did not object.

[5/] See 1 above.

[6/] See 2 above.

[7/] See 3 above.

[8/] See 1 above.

[9/] See 2 above.

[10/] See 3 above.

[11/] Respondent filed an objection to DOH's Motion for Leave to Amend on March 12, 2014.

[12/] On May 23, 2014, Respondent, in her pro se capacity, filed a (proposed) "Order to Show Cause for Objection to Subpoena and Petitioner's Contempt" and a (proposed) "Order to Show Cause for Objection to Co-Counsel" in each of the three cases. At hearing, Respondent's Counsel withdrew these pleadings.

[13/] The Order of Pre-hearing Instructions directed the parties to file the Pre-hearing Stipulation no later ten days before the hearing in DOAH Case No. 13-0595PL or six days before the hearing in 14-0514PL or 14-0515PL.

[14/] Respondent did not object to Exhibits 2, 6, or pages 1 through 3 and 163 of Exhibit 9.

[15/] A review of each statutory section and rule reflects no significant changes for the years listed.

[16/] This is the common method taught to health care professionals to create medical records: Subjective, Objective, Assessment, and Plan.

[17/] MRSA (Methicillin-resistant Staphylococcus aureus) is a bacteria that is resistant to many antibiotics, including penicillin or beta-lactams group.

[18/] WNL means "within normal limits."

[19/] Endocarditis is a specific infection of the heart valves or inner lining of the heart, caused by infections passing through the blood stream. In order to diagnosis endocarditis, the detection of an infection in the bloodstream is necessary, and the patient may have other indications such as a fever, malaise, or other infections.

[20/] A.M.'s records reflect she was seen at the 5840 Park Boulevard location between October 8 and 16, 2008, while the other records fail to reflect the location of the practice where she was treated.

[21/] It was noted that in 2009 and earlier, C.B. had previously been a patient of Respondent.

[22/] Thrush is a yeast infection that causes white patches in the mouth and on the tongue. You can get thrush when a yeast called candida grows out of control.

[23/] Immunoglobulin is a prescription medication used to treat immunodeficiencies that are related to the body's inability to produce antibodies for fighting infections.

[24/] Ambisome is a prescription medication used to treat serious fungal infections, such as systemic yeast infections.

[25/] VFEND, a/k/a Voriconazole, is a broad spectrum antifungal prescription medication that can be administered either orally or via an IV.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.