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ACUPUNCTURE BOARD

BEFORE THE
ACUPUNCTURE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **NATALYA B. MINER, L.AC.** 900 N. San Antonio Road, Suite 103 Los Altos, CA 94022 **Acupuncture License No. AC 11313** Respondent.	Case No. 1A-2018-91 **ACCUSATION**

Complainant alleges:

PARTIES

1. Benjamin Bodea (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Acupuncture Board, Department of Consumer Affairs.

2. On or about October 3, 2006, the Acupuncture Board issued Acupuncture License Number AC 11313 to Natalya B. Miner, L.Ac. (Respondent). The Acupuncture License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2020, unless renewed.

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JURISDICTION

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

4. Section 4955.1 of the Code states, in relevant part:

"The board may deny, suspend, revoke, or impose probationary conditions upon the license of any acupuncturist if he or she is guilty of committing a fraudulent act including, but not be limited to, any of the following:

". . . ."

"(e) Failing to maintain adequate and accurate records relating to the provision of services to their patients."

5. Section 4955.2 of the Code states:

"The board may deny, suspend, revoke, or impose probationary conditions upon the license of any acupuncturist if he or she is guilty of committing any one of the following:

"(a) Gross negligence.

"(b) Repeated negligent acts.

"(c) Incompetence."

6. California Code of Regulations, title 16, section 1399.453, states:

"An acupuncturist shall keep complete and accurate records on each patient who is given acupuncture treatment, including but not limited to, treatments given and progress made as a result of the acupuncture treatments."

COST RECOVERY

7. Section 4959 of the Code states:

"(a) The board may request the administrative law judge, under his or her proposed decision in resolution of a disciplinary proceeding before the board, to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed actual and reasonable costs of the investigation and prosecution of the case.

"(b) The costs to be assessed shall be fixed by the administrative law judge and shall not in any event be increased by the board. When the board does not adopt a proposed decision and remands the case to an administrative law judge, the administrative law judge shall not increase the amount of any costs assessed in the proposed decision.

"(c) When the payment directed in the board's order for payment of costs is not made by the licensee, the board may enforce the order for payment in the superior court in the county where the administrative hearing was held. This right of enforcement shall be in addition to any other rights the board may have as to any licensee directed to pay costs.

"(d) In any judicial action for the recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

"(e) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the Acupuncture Fund."

CAUSE FOR DISCIPLINE

(Unprofessional Conduct, Gross Negligence, and/or Repeated Negligent Acts, and/or Incompetence; and/or Inaccurate Medical Records)

8. Respondent is subject to disciplinary action under sections 4955.1(e) [failing to keep accurate medical records], and/or 4955.2(a) [gross negligence], and/or 4955.2(b) [repeated negligent acts], and/or 4955.2(c) [incompetence], and/or California Code of Regulations, title 16, section 1399.453 [failing to keep accurate medical records] based on the case provided to Patient A.[1] The circumstances are as follows:

9. On or about March 31, 2016, Patient A, a then 33 year old female, began seeing Respondent for migraines, lower back pain, neck spasms, and bloating following a motor vehicle accident. From March 31, 2016 to May 9, 2016, Respondent treated Patient A nine times. Respondent's handwritten progress notes for the care provided to Patient A are difficult to read. Additionally, for all nine visits, Respondent failed to document the length of the needles, angle of insertion, and the depth of insertion.

[1] The patient is identified herein as Patient A to protect her privacy. Respondent will learn the identity of the Patient during discovery.

10. On or about May 18, 2016, Patient A again went to Respondent for treatment. According to Patient A, Respondent placed needles in her right and left chest area. As with prior appointment notes, Respondent did not document the length of the needles used, the angle of insertion, or the depth of the insertion.

11. Within 30 minutes of leaving Respondent's office, Patient A began experiencing shortness of breath and had sharp pain on the right side of her chest. Patient A was seen at Urgent Care and was sent home with pain medication. Overnight, Patient A began coughing and could not lay flat on her back.

12. On or about May 19, 2016, Patient A was seen by her primary care provider, who then referred Patient A to an orthopedist. This doctor ordered a chest x-ray which showed a right sided pneumothorax caused by the acupuncture.[2] Patient A was then sent to the Stanford emergency room, where she was hospitalized for treatment.

13. During Patient A's treatment, she notified Respondent of the injury. Respondent apologized and informed Patient A that she had malpractice insurance. Respondent also texted Patient A while she was in the hospital to check on her. Respondent did not document in the medical record these interactions with the Patient or that the patient had a pneumothorax.

14. Respondent provided a statement to the Board indicating that on May 18, 2016, she placed Patient A in a supine position and that she inserted "1.5 inch needles obliquely (about 30 degree) laterally at points stomach 13, 14, 15 at a depth of less than 0.5 inches of the needle length."

15. Respondent's overall conduct, acts, and/or omissions with regard to Patient A constitute unprofessional conduct through gross negligence, and/or repeated negligent acts, and/or incompetence, and failure to keep accurate medical records. More specifically, Respondent is guilty of unprofessional conduct as follows:

a. Respondent's use of 1.5 inch length needles in the thoracic region;

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[2] A pneumothorax, or a collapsed lung, is a potentially life threating condition. A pneumothorax occurs when air leaks into the space between the lung and chest wall. A pneumothorax can be caused by a blunt or penetrating chest injury.

b. Respondent failed to document in Patient A's medical records the length of the needles and the needling depth-angle used; and

c. Respondent failed to document the follow-up communication with Patient A regarding the pneumothorax diagnosis.

PRAYER

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

1. Revoking or suspending Acupuncture License Number AC 11313, issued to Natalya B. Miner, L.Ac.;

2. Ordering Natalya B. Miner, L.Ac. to pay the Acupuncture Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 4959; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: FEB 11 2019

BENJAMIN BODEA
Executive Officer
Acupuncture Board
Department of Consumer Affairs
State of California
Complainant

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