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BEFORE THE
ACUPUNCTURE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against**:** **ERIKA NOVAK, L.AC.** **5222 Balboa Avenue Fl-6** **San Diego, CA 92117** **Acupuncturist License No. 4544** Respondent.	Case No. 1A-2021-18 **ACCUSATION**

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 August 26, 1993, the Acupuncture Board issued Acupuncturist License Number 4544 to Erika Novak, L.AC. (Respondent). The Acupuncturist License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2022, 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 (Code) unless otherwise indicated.

4. Section 4955 of the Code states:

> The board may deny, suspend, or revoke, or impose probationary conditions upon, the license of any acupuncturist who is guilty of unprofessional conduct.
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> Unprofessional conduct shall include, but not be limited to, the following:
> ...
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> (d) Aiding or abetting in, or violating or conspiring in, directly or indirectly, the violation of the terms of this chapter or any regulation adopted by the board pursuant to this chapter.
> ...
>
> (i) Any action or conduct that would have warranted the denial of the acupuncture license.
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> ….

5. Section 4955.1 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 a fraudulent act including, but not limited to, any one of the following:
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> …
>
> (e) Failing to maintain adequate and accurate records relating to the provision of services to their patients.

6. 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.

7. Section 4979 of the Code states, in pertinent part:

> The board may adopt and reinforce regulations to carry out the purposes and objectives of this article…

8. California Code of Regulations, title 16, section 1399.451, states:

In treating a patient, an acupuncturist shall adhere to the following procedures:

…

(e) Any complication, including but not limited to, hematoma, peritonitis or pneumothorax arising out of acupuncture treatment shall be referred immediately to a physician or dentist or podiatrist, if appropriate, if immediate medical treatment is required.

….

9. 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 progress made as a result of the acupuncture treatments.

COST RECOVERY

10. 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 investigation and prosecution of the case.

….

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

11. Respondent is subject to disciplinary action under Code section 4955.2, subdivision (a), of the Code, in that she committed gross negligence in her care and treat of Patient A,[1] as more particularly alleged hereinafter:

12. On or about February 21, 2020, patient A, a then-60-year-old male, had his initial visit with Respondent for acupuncture and electrical stimulation (ES) on his right lower back to address muscle pain. According to patient A, after he entered a small treatment room he was directed to remove his outer clothing and lie face down on a treatment table, which he did. Acupuncture needles were placed on his lower right back, feet and hands. After the acupuncture needles were placed, the ES wires were placed and Respondent began the ES treatment. Patient

[1] Patient A is being used in place of the patient's names or initials to maintain patient confidentiality. Respondent is aware of the identity of the patient referred to herein.

A was told not to move with Respondent exiting the treatment room and advising patient A that she would return in approximately 20 minutes. After several minutes of lying on his side, patient A started feeling heat on the lower right side of his back (from a heat lamp that Respondent used as part of her treatment). The heat intensified and Respondent shifted his body several times to minimize the heat being applied to his body. Respondent returned to the treatment room approximately 25 minutes later with patient A commenting "I have never felt heat when I had electrical stimulation," or words to that effect, with no response from Respondent. Respondent massaged the area where the excessive heat had been applied and some skin sloughed off which she claimed (but did not document in her procedure note) was the result of Patient A having "sensitive skin." Shortly thereafter, Patient A got dressed and left Respondent's office. Respondent's procedure note for this visit, not signed until March 5, 2020, is cursory and inadequate, because among other things, it is missing relevant information.

13. On or about February 21, 2020, after leaving Respondent's office, Patient A began experiencing more pain which caused him to inspect his lower back/buttocks area where he observed an apparent burn injury. After discovering the burn injury, patient A went to an Urgent Care facility for evaluation and treatment. The Urgent Care certified medical records document the following findings regarding physical examination of the skin, "Skin: open wound of back noted [and] erythema across R [right] buttock with smaller area of peeled back blistered skin and epidermal layer is removed." The diagnosis was "burn of second degree of buttock." Patient A was prescribed Silvadene cream 1% to be applied 1-2 times per day to the burn area until healed.[2] The treatment plan was documented as including, among other things, return to clinic in three days, if not better; "Large area of 1st degree burn with smaller 5 x 5 cm area of second degree burn exposed tissue covered with silvadene and sent for more to apply at home[;]" follow up with primary care physician if symptoms worsen or do not improve; and take medications as prescribed.

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[2] Silvadene cream 1% (silver sulfadiazine) is a topical antimicrobial drug indicated as an adjunct for the prevention and treatment of wound sepsis in patients with second and third degree burns.

14. On or about February 24, 2020, Patient A had an office visit at his primary care physician's office where he was seen by a nurse practitioner (NP). The certified medical record for this visit indicates the following regarding physical examination of the skin: "Skin: 2.5 cm x 1.5 cm open shallow burn wound with bright red vascular bed, and slight flap at bottom half of the wound noted to right upper (proximal buttock). The impression was a second degree burn. The treatment plan included Telfa (an adhesive dressing) and tape applied to the wound; continue using antibiotic ointment, and return to clinic as needed.

15. On or about March 4, 2020, Patient A had an office visit at his primary care physician's office where he was seen by a NP. The certified medical record for this visit indicates the following regarding physical examination of the skin: "Skin: 3 small wounds to right medial buttock. Middle lesion open with fresh bright wound bed. Wound bed of middle lesion is clean, no erythema or drainage to the surrounding tissue. Hydrocolloid [wound] dressing applied." The impression remained second degree burn with an assessment of "Improved." The treatment plan included "[discontinue] Erythromycin as no [infection] is seen; maintain Hydrocolloid dressing [for] five days; report any fevers, chills, or other signs of infection[;]" and return to clinic as needed.

16. On or about March 4 or 5, 2020, Respondent documented she had received a complaint from Patient A on March 4, 2020, claiming that "I caused him second degree burn with the electrical stimulation and he had to seek emergency help." In this note, Respondent provided her version of events regarding her initial visit with Patient A on February 21, 2020. As part of this note, Respondent documented, among other things, that "[t]here was nothing used during treatment that could have caused a burn. The patient indicated on intake form he had [two medical conditions]. Perhaps his skin sensitivity is a result from having a compromised immune system."

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17. Respondent committed gross negligence in her care and treatment of Patient A, which included, but was not limited to, the following:

(a) Respondent used a heat lamp on Patient A without adequate screening for risk-elevating presentations and despite a potentially contradicting presentation;

(b) Respondent failed to provide proper informed consent pertaining to her use of a heat lamp on Patient A by, among other things, failing to disclose the probable risks and consequences associated with the heat lamp and by failing to obtain informed consent prior to using the heat lamp;

(c) Respondent failed to suspect, recognize or acknowledge the likelihood of a burn injury and/or abnormal skin lesion following massage; and failed to immediately refer Patient A to physician care; and

(d) Respondent failed to maintain complete and accurate records in regard to her procedure note for February 21, 2020, which lacked adequate documentation pertaining to, but not limited to, past medical history, adverse reactions, family history, flow sheets, narrative notes, informed consent, proper formatting such as the standard SOAP format, and was not electronically signed until May 5, 2020. Additionally, Respondent made inconsistent assertions in the various documents contained within her certified medical record for Patient A and her response letter provided to the Board dated July 30, 2021.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

18. Respondent is further subject to disciplinary action under Code section 4955.2, subdivision (b), of the Code, in that she committed repeated negligent acts in her care and treatment of Patient A, as more particularly alleged in paragraphs 11 through 17, which are hereby incorporated by reference and realleged as if fully set forth herein.

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THIRD CAUSE FOR DISCIPLINE

(Incompetence)

19. Respondent is further subject to disciplinary action under Code section 4955.2, subdivision (c), of the Code, in that she exhibited incompetence in her care and treatment of Patient A, as more particularly alleged in paragraphs 11 through 16 and 17 (c), which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Complete and Accurate Records)

20. Respondent is further subject to disciplinary action under Code section 4955.1, subdivision (e), of the Code, and section 4979, as defined by California Code of Regulations, title 16, section 1399.453, in that she failed to maintain complete and accurate records pertaining to the care and treatment she provided to Patient A, as more particularly alleged in paragraphs 11 through 16 and 17 (d), which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Refer Patient to Physician)

21. Respondent is further subject to disciplinary action under Code section 4979, as defined by California Code of Regulations, title 16, section 1399.451, subdivision (e), in that she failed to refer Patient A to a physician immediately after a complication arose from acupuncture treatment, as more particularly alleged in paragraphs 11 through 16 and 17 (c), which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

22. Respondent is further subject to disciplinary action under Code section 4955, of the Code, in that she exhibited unprofessional conduct in her care and treatment of Patient A, as more particularly alleged in paragraphs 11 through 16 and 17 (c) and (d), which are hereby incorporated by reference and realleged as if fully set forth herein.

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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 Acupuncturist License Number 4544, issued to Respondent;

2. Ordering Respondent 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: 12/09/2021

Original Signature on File
BENJAMIN BODEA
Executive Officer
Acupuncture Board
Department of Consumer Affairs
State of California
Complainant

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