These charges are only allegations which may be contested by the licensee in an administrative hearing.

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF CHETAN SATI, D.O.	STATEMENT OF CHARGES

CHETAN SATI, D.O., the Respondent, was authorized to practice medicine in New York State on or about August 3, 2000, by the issuance of license number 218705 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent undertook the care and treatment of Patient A (the identity of all patients herein charged is set forth in Appendix "A") from on or about January 17, 2012 through on or about January 17, 2017 at his office, South Shore Family Practice, P.C., located at 1000 Park Blvd., Rear Annex, Massapequa Park, NY 11762, (hereinafter referred to as "his office"). Patient A had a history of opioid addiction and enrollment in a methadone maintenance program. He was treated by Respondent for complaints of pain associated with orthopedic hardware in his leg, back pain, insomnia, hypertension, and GERD. Throughout his care and treatment of Patient A, Respondent continuously prescribed a controlled substance, Oxycodone, to Patient A, as well as maintaining him on Zolpidem. Respondent's care and treatment of Patient A deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note a complete, accurate and appropriate past medical/surgical history for Patient A.
2. On multiple occasions, failed to obtain and/or note an appropriate history of the patient's presenting and/or ongoing complaints and/or condition(s).

3. On multiple occasions, failed to perform and/or note an appropriate physical examination.

4. Inappropriately prescribed Oxycodone and Zolpidem to Patient A, in that Respondent:

   a. Failed to provide and/or note the appropriate management of the patient's use of controlled substances, to wit: failed to apply appropriate risk evaluations and mitigation strategies (REMS) over the course of his treatment with controlled substances;

   b. Failed to appropriately and timely respond to and manage the patient's exhibited signs of substance abuse;

   c. Continually renewed these prescriptions without the appropriate inquiry into the patient's symptoms, functional status nor response to the controlled substances and/or failed to note the responses to these inquiries.

   d. Failed to maintain a clear and accurate account of prescription dates, pill counts, and refill intervals.

   e. Failed to adequately and appropriately pursue conservative therapies for Patient A's complaints prior to the use of controlled substances.

5. Failed to maintain an appropriate and complete record which accurately reflects the care, evaluation and treatment rendered Patient A.

B. Respondent undertook the care and treatment of Patient B at his office from on or about January 17, 2012 through on or about January 17, 2017, the same time period Respondent was treating Patient A. Patient B is Patient A's mother and they live in the same household. Patient B suffered from multiple co-morbid medical problems, and while under Respondent's care, had multiple hospitalization for, inter alia, shortness of breath, chest pain, exacerbation of congestive heart failure and falls. Throughout his care and treatment of Patient B, Respondent continuously prescribed a controlled substance, Oxycodone, to Patient B as well as maintaining her on Zolpidem. Respondent also prescribed Fentanyl on/or about 3 occasions. Respondent's care and treatment of Patient B deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note a complete, accurate and appropriate past medical/surgical history for Patient B.
2. On multiple occasions, failed to obtain and/or note an appropriate history of the patient's presenting and/or ongoing complaints and/or condition(s).
3. On multiple occasions, failed to perform and/or note an appropriate physical examination.
4. Inappropriately prescribed Oxycodone, Fentanyl and Zolpidem to Patient B, in that:

   a. Failed to provide and/or note the appropriate management of the patient's use of controlled substances, to wit: failed to apply appropriate risk evaluations and mitigation strategies (REMS) over the course of his treatment with controlled substances;

   b. Failed to appropriately respond to and manage the markedly elevated risk of diversion of prescribed controlled substances to her son, Patient A.

   c. Continually renewed these prescriptions without the appropriate inquiry into the patient's symptoms, functional status nor response to the controlled substances and/or failed to note the responses to these inquiries.

   d. Failed to maintain a clear and accurate account of prescription dates, pill counts, and refill intervals.

   e. Failed to adequately and appropriately pursue conservative therapies for Patient B's complaints prior to the use of controlled substances.
5. Failed to maintain an appropriate and complete record which accurately reflects the care, evaluation and treatment rendered Patient B.

C. Respondent undertook the care and treatment of Patient C at his office from on or about July 12, 2007 through on or about January 9, 2017. Throughout his care and treatment, Respondent treated Patient C with high doses of opioids, (Vicodin, Percocet and Oxycodone) for numerous pain complaints to his neck, back, shoulder, knee and ankle, and, simultaneously, with benzodiazepines (Alprazolem and Diazepam) for anxiety. Respondent's care and treatment of Patient C deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note a complete, accurate and appropriate past medical/surgical history for Patient C.
2. On multiple occasions, failed to obtain and/or note an appropriate history of the patient's presenting and/or ongoing complaints and/or condition(s).
3. On multiple occasions, failed to perform and/or note an appropriate physical examination.
4. Inappropriate prescribed opioids and benzodiazepines to Patient C, in that Respondent:

   a. Failed to provide and/or note the appropriate management of the patient's use of controlled substances, to wit: failed to apply appropriate risk evaluations and mitigation strategies (REMS) over the course of his treatment with controlled substances;

   b. Failed to appropriately and timely respond to and manage the patient's exhibited signs of substance abuse;

   c. Continually renewed these prescriptions without the appropriate inquiry into the patient's symptoms, functional status nor response to the controlled substances and/or failed to note the responses to these inquiries.

   d. Inappropriately escalated doses of controlled substance without medical indication nor justification, and/or without noting same.

   e. Failed to maintain a clear and accurate account of prescription dates, pill counts, and refill intervals.

   f. Failed to adequately and appropriately pursue conservative therapies for Patient C's complaints prior to the use of controlled substances.
5. Failed to maintain an appropriate and complete record which accurately reflects the care, evaluation and treatment rendered Patient C.

D. Respondent undertook the care and treatment of Patient D at his office from on or about June 16, 2009 through on or about January 12, 2017. Throughout his care and treatment, Respondent simultaneously treated Patient D with multiple controlled substances, to wit: Hydrocodone, for pain; Alprazolam for anxiety; Ambien for insomnia

and Amphetamines for Attention Deficit Disorder ("ADD"). Respondent's care and treatment of Patient D deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note a complete, accurate and appropriate past medical/surgical history for Patient D.
2. On multiple occasions, failed to obtain and/or note an appropriate history of the patient's presenting and/or ongoing complaints and/or condition(s).
3. On multiple occasions, failed to perform and/or note an appropriate physical examination.
4. Inappropriate prescribed Hydrocodone, Alprazolam, Ambien and Amphetamines to Patient D, in that Respondent:

   a. Failed to provide and/or note the appropriate management of the patient's use of controlled substances, to wit: failed to apply appropriate risk evaluations and mitigation strategies (REMS) over the course of his treatment with controlled substances;

   b. Failed to appropriately and timely respond to and manage the patient's exhibited signs of substance abuse;

   c. Continually renewed these prescriptions without the appropriate inquiry into the patient's symptoms, functional status nor response to the controlled substances and/or failed to note the responses to these inquiries.

   d. Inappropriately escalated doses of controlled substance without medical indication nor justification, and/or without noting same.

   e. Failed to maintain a clear and accurate account of prescription dates, pill counts, and refill intervals.

   f. Failed to adequately and appropriately pursue conservative therapies for Patient D's complaints prior to the use of controlled substances.

5. Failed to maintain an appropriate and complete record which accurately reflects the care, evaluation and treatment rendered Patient D.

E. Respondent undertook the care and treatment of Patient E at his office from on or about May 24, 2012 through on or about March 17, 2014. Throughout his care and treatment, Respondent treated Patient E with Oxycodone for complaints of back and

joint pain; Alprazolam for anxiety and Amphetamines for ADD. Patient E also presented, on occasion, with complaints of headache and palpitations. Respondent's care and treatment of Patient E deviated from accepted standards of care in that Respondent:

1. Failed to obtain and/or note a complete, accurate and appropriate past medical/surgical history for Patient E.
2. On multiple occasions, failed to obtain and/or note an appropriate history of the patient's presenting and/or ongoing complaints and/or condition(s).
3. On multiple occasions, failed to perform and/or note an appropriate physical examination.
4. Inappropriate prescribed Oxycodone, Alprazolam and Amphetamines to Patient E, in that Respondent:

   a. Failed to provide and/or note the appropriate management of the patient's use of controlled substances, to wit: failed to apply appropriate risk evaluations and mitigation strategies (REMS) over the course of his treatment with controlled substances;

   b. Continually renewed these prescriptions without the appropriate inquiry into the patient's symptoms, functional status nor response to the controlled substances and/or failed to note the responses to these inquiries.

   c. Inappropriately escalated doses of controlled substance without medical indication nor justification, and/or without noting same.

   d. Failed to maintain a clear and accurate account of prescription dates, pill counts, and refill intervals.

   e. On multiple occasions, inappropriately provided Patient E with early prescription refills for Oxycodone and Adderall.

   f. Failed to adequately and appropriately pursue conservative therapies for Patient D's complaints prior to the use of controlled substances.

5. Failed to maintain an appropriate and complete record which accurately reflects the care, evaluation and treatment rendered Patient E.

F. Respondent has failed, since 2004, to update his Physician Profile in violation of Pub. Health Law Section 2995-a(4) and 10 NYCRR 1000.5.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

1. Paragraphs A, A.1 – A.3, A.4 and subparagraphs, A.5, B, B.1 – B.3, B.4 and subparagraphs, B.5, C, C.1 – C.3, C.4 and subparagraphs, C.5, D, D.1 – D.3, D.4 and subparagraphs, D.5, E, E.1 – E.3, E.4 and subparagraphs, E.5

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

2. Paragraphs A, A.1 – A.3, A.4 and subparagraphs, A.5, B, B.1 – B.3, B.4 and subparagraphs, B.5, C, C.1 – C.3, C.4 and subparagraphs, C.5, D, D.1 – D.3, D.4 and subparagraphs, D.5, E, E.1 – E.3, E.4 and subparagraphs, E.5

THIRD THROUGH SEVENTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. Paragraphs A, A.1 – A.3, A.4 and subparagraphs, A.5
4. Paragraphs B, B.1 – B.3, B.4 and subparagraphs, B.5
5. Paragraphs C, C.1 – C.3, C.4 and subparagraphs, C.5
6. Paragraphs D, D.1 – D.3, D.4 and subparagraphs, D.5
7. Paragraph E, E.1 – E.3, E.4 and subparagraphs, E.5

EIGHTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

8. Paragraphs A, A.1 – A.3, A.4 and subparagraphs, A.5, B, B.1 – B.3, B.4 and subparagraphs, B.5, C, C.1 – C.3, C.4 and subparagraphs, C.5, D, D.1 – D.3, D.4 and subparagraphs, D.5, E, E.1 – E.3, E.4 and subparagraphs, E.5

NINTH THROUGH THIRTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

9. Paragraphs A.1 – A.3, A.4.a, A.4.c, A.4.d, A.5
10. Paragraphs B.1 – B.3, B.4.a, B.4.c, B.4.d, B.5
11. Paragraphs C.1 – C.3, C.4.a, C.4.c, C.4.e, C.5
12. Paragraphs D.1 – D.3, D.4.a, D.4.c, D.4.d, D.4.e, D.5
13. Paragraphs E.1 – E.3, E.4.a – E.4.d, E.5

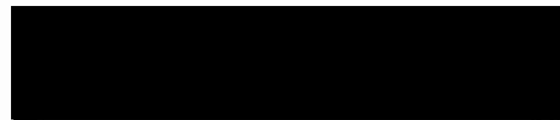
FOURTEENTH SPECIFICATION

FAILING TO FILE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully making or filing a false report, or failing to file a report required by law or by the Department of Health or the Education Department, as alleged in the facts of paragraph:

14. Paragraph F

DATE: August 24, 2017
New York, New York



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