**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<br><br>OF<br><br>LEELAND JONES, M.D. |
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STATEMENT

OF

CHARGES

LEELAND JONES, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 5, 1988, by the issuance of license number 176412 by the New York State Education Department.

## FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (each patient is identified in the attached Appendix A), a twenty two year old female patient, on over seventy-five (75) occasions while Patient A was admitted into Kaleida Health Buffalo General Hospital, 100 High Street, Buffalo, New York 14203 (hereinafter "Buffalo General") at various times from on or about August 16, 2010 to, at least, October 8, 2011. Respondent also provided medical care to Patient A at Respondent's Office at 3871 Harlem Drive, Buffalo, New York 14215 (hereinafter "Respondent's Office") on about twenty-three occasions from on or about September 10, 2010 to, at least, March 19, 2012.

Respondent's care of Patient A deviated from accepted standards of care as follows:

1. Respondent's progress notes in Patient A's hospital chart failed to adequately make an assessment of Patient A's diagnosis or detail a treatment plan.

2. Respondent, during his documentation of care at his office, failed to complete and maintain a complete Mental Status Examination.

3. Respondent, during his documentation of care at his office, failed to maintain complete medical records which accurately reflected the evaluation and treatment of Patient A.

4. Respondent, during his documentation of care at his office, failed to document any communication with other mental health care providers.

B. Respondent provided medical care to Patient B, a twenty five year old female patient, on over seventy-five (75) occasions while Patient A was admitted into Buffalo General at various times from July 21, 2010 to October 11, 2012 at Buffalo General on or about July 21, 2010 to, at least, September 22, 2012. Respondent also provided medical care to Patient B at Respondent's Office on at least eight occasions from on or about September 2, 2010 to, at least, November 22, 2011. Respondent's care of Patient B deviated from accepted standards of care as follows:

1. Respondent's progress notes in Patient B's hospital chart failed to adequately make an assessment of Patient B's diagnosis or detail a treatment plan.

2. Respondent, during his documentation of care at his office, failed to maintain a record that accurately reflected the evaluation and treatment of Patient B.

C. Respondent provided medical care to Patient C, a seventy three year old female patient at Respondent's Office at various times from on or about October 10, 1995 to, at least, October 3, 2011. Respondent's care of Patient C deviated from accepted standards of care as follows:

1. Respondent, despite prescribing Lithium to Patient C on an ongoing basis throughout his course of treatment, failed to obtain and/or monitor Patient C's Lithium levels during the period Respondent treated Patient C from June 3, 2005 to August 1, 2011.

D. Respondent provided medical care to Patient D, a twenty five year old female patient at Buffalo General at various times from on or about February 24, 2012 to February 27, 2012. Respondent further provided medical care to Patient D at Respondent's Office at various times from on or about March 5, 2012 to, at least, April 23, 2012. Respondent's care of Patient D deviated from accepted standards of care as follows:

1. Respondent changed Patient D's medication multiple times without adequate medical indication and/or without documenting such indication.

2. Respondent, despite being aware Patient D had a prior history of cocaine use and that Patient D "liked cocaine", prescribed an Amphetamine to Patient D on multiple occasions.

## 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. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.3, C and C.1, D and D.1 and/or D and D.2

## 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. The facts in paragraphs C and C.1, D and D.1 and/or D.2

**THIRD SPECIFICATION**

**FAILURE TO MAINTAIN RECORDS**

Respondent is charged with committing professional misconduct as defined in New York Education 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:

3. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, and/or C and C.1

DATE: October 18, 2016
Albany, New York

[redacted]
MICHAEL A. HISER
Deputy Counsel
Bureau of Professional Medical Conduct