IN AND BEFORE THE OKLAHOMA STATE BOARD
OF MEDICAL LICENSURE AND SUPERVISION
STATE OF OKLAHOMA

IN THE MATTER OF THE EX REL., THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
v.	)	Case No. 14-06-4978
DARNELL ERIC BLACKMON, SR., M.D., LICENSE NO. 22856,	)	
Defendant.	)	

VERIFIED COMPLAINT

The State of Oklahoma, *ex rel.* the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through the undersigned counsel, alleges and states as follows for its Complaint against the Defendant Darnell Eric Blackmon, Sr., M.D.:

I. JURISDICTION

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 O.S. § 480, *et seq.*

2. The Defendant holds Oklahoma medical license no. 22856.

3. The acts and omissions complained of herein occurred while the Defendant was acting as a physician pursuant to his medical license conferred upon him by the State of Oklahoma. Such acts and omissions occurred within the physical territory of the State of Oklahoma.

II. ALLEGATIONS OF UNPROFESSIONAL CONDUCT

4. This action arises out of a complaint of a patient of the Enhance Spa (the "Spa"), for which the Defendant is the medical director. *See* Exhibit 1 (Medical Director Agreement executed 9 June 2011). The complainant made inquiry about an invasive medical procedure known as Hormone Replacement Therapy ("HRT") and was advised by TH, an unlicensed employee of the Spa, that the procedure is invasive and would be conducted with no physician oversight. Rather, the procedure would be conducted by registered nurses in conjunction with unlicensed staff. The complainant was advised the

Defendant was not on the physical premises of the Spa. The complainant declined the procedure and left the Spa.

THE UNDERCOVER OPERATION AT THE SPA

5. On 13 June 2014, Board Investigator RR called the Spa to enquire about HRT and spoke with TH about the procedure. TH advised she would be surprised if RR did not qualify for HRT, although a licensed physician would find otherwise. RR asked TH about the physician on staff. TH advised the Defendant was not on location. TH advised this was not a problem.

6. On 1 July 2014, RR visited the Spa for a scheduled appointment. RR completed paperwork had her blood drawn by PK, a registered nurse. RR asked PK if the Defendant was present at the Spa, to which PK responded in the negative. RR asked PK who would conduct the procedure. PK responded that she would do so and offered that she personally had performed over 400 pellet implant procedures.

7. On 2 July 2014, TH called RR to report the blood chemistry test results. TH reported RR's testosterone normal but RR would benefit from HRT. RR made an appointment for the HRT procedure to be conducted on 10 July 2014. During this phone call, RR again made inquiry as to who would be performing the procedure. TH advised that herself and PK will perform the procedure

8. On 10 July 2014, RR returned to the Spa accompanied by Board Investigator JL. This visit was video recorded, and shows PK practicing medicine by making diagnoses, representing that she can "call in" prescriptions, and attempting to conduct medical procedures. PK interpreted RR's blood chemistry results and stated that HRT would benefit RR. PK advised RR that PK would call in a prescription for Doxycycline, which PK noted in RR's file. PK stated the Defendant was not in the office. PK told RR that she would be conducting the HRT procedure and had done so for both the Defendant and the Defendant's wife. PK stated that she would mix up some Lidocaine without Epinephrine and add a buffer (sodium bromide) in it so it would not burn. PK took out a syringe and began mixing liquid ingredients. RR asked PK how an emergency would be handled if RR had a reaction to the injection. PK advised that she would take care of RR. At that time, RR stopped the procedure, advised of her identity, and requested to speak with the Defendant. PK stated that she needed to speak with ES, a registered nurse and owner of the Spa, and left the room. A short time later, PK re-entered the room and asked RR if she still wanted the HRT procedure.

9. While waiting for PK to return to the room, RR reviewed her chart, which was on a table in the room. The chart had not been signed anywhere by the Defendant. The order form for the HRT treatment had the initials of "LT," which upon subsequent investigation was determined to be a salesperson for the Spa. RR had never met LT. Pictures were taken of the open chart and the medical supplies on the tray, which included the pellet insertion kit, syringe and a bottle of testosterone. *See* Exhibit 2 (10 July 2014 Photos taken by Investigator JL).

10. When ES entered the room, RR explained to ES that she needed to speak with Dr. Blackmon. RR explained she also had a subpoena and needed to review records (RR's chart, the complainant's chart, a schedule for Dr. Blackmon, and list of patients for the past thirty days). ES agreed to provide the documents to RR. It took Spa staff nearly one hour to provide a computer-generated copy of the patient list and another 45 minutes to provide five patient charts. When asked why it took so long to provide the documents requested, ES stated she was with a Botox patient. ES offered that she would not alter the documents as doing so would result in revocation of her nursing license.

THE FORGED CHARTING

11. RR reviewed her patient chart on the way to the Defendant's clinical practice to speak with him about the matter. The chart given to RR by ES was obviously forged. *See* Exhibit 3 (redacted RR patient chart) at Bates No. 000002. The altered document bore the apparent signature of the Defendant (who was not present at the Spa at the time), has different handwriting, does not bear the name "Thea" at the upper left, has no lines filled in second row of the order form, is not dated in the upper left had corner of the order form portion of the order form section, contains a different date format, is not partly written in blue ink, and does not indicate that Doxycycline was ordered. *Compare id. with* Exhibit 2.

12. When the Defendant was presented with this evidence, he admitted that he had not reviewed RR's chart. The Defendant stated that he was not aware the Spa staff possessed a stamp of his signature. The Defendant admitted he had meetings with Spa staff every other week. He reviews charts and sees patients only after patients are seen and evaluated by Spa staff. Upon inquiry, the Defendant could not say when the next Spa staff meeting would take place. The Defendant admitted that he does not see most patients of the Spa face-to-face.

DEA AND OBNDD AUDIT ACTIVITIES

13. On 22 July 2014, RR accompanied Drug Enforcement Agency (DEA) and Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) agents to audit and take inventory of the Spa's medications. Record keeping and inventory control violations were uncovered. All vials of testosterone were confiscated by the OBNDD. *See* Exhibit 4 (log of confiscated items and photographs).

14. On 24 July 2014, RR met with OBNDD and DEA agents met with the Defendant. When asked how patients receive their prescription medications, the Defendant responded that ES calls in the scripts under his DEA number for testosterone and weight loss medications to a pharmacy out-of-state. The pharmacy fills each script, labels the bottles and ships the prescriptions back to the Spa which then dispenses the prescription medications to patients. The Defendant is not registered to dispense, let alone at the Spa. The Defendant stated he was unaware that testosterone and phentermine were controlled dangerous substances ("CDS") and was unaware of the DEA and OBNDD dispensing requirements. The Defendant stated he was unaware that face-to-face visits with patients

by him were required. The DEA informed the Defendant of numerous violations, including not registering a separate DEA number for dispensing at the Spa, prescribing CDS to himself and his wife. The Defendant admitted to prescribing CDS to himself and his wife. Yet, the Defendant's prescription history reflects *no* CDS prescriptions. The Defendant also offered a sample of his signature. *See* Exhibit 5.[1]

PATIENT INTERVIEWS AND CHART REVIEWS

15. Investigators RR and JL called several patients of the Spa. Each stated they had never seen the Defendant. The weight loss patients, KY and IY, stated they received Qsymia and Phentermine (both are Schedule IV CDS) from employee TH. TH possesses no healthcare license of any kind and yet actively monitored and dispensed medications to patients who never saw the Defendant. *See* Exhibit 6 (prescriptions for patients KY and IY). Yet, patients of the Spa were receiving CDS prescriptions allegedly executed by the Defendant without ever seeing him. *See e.g.* Exhibit 7 (portions of patient charts).

16. A review of six patient charts revealed the following:

    a. Patent BB (employee of the Spa) – has orders for multiple procedures written by PK; the Defendant's alleged signature is nowhere in the chart except for on a prescription for progesterone. *See* Exhibit 8 (redacted chart for patient BB).

    b. Patient TH (employee of the Spa) – has orders for multiple procedures written by ES; PK performed HRT procedure on TH; the only place in TH's chart that allegedly evidences the Defendant's signature is an order for massage therapy. *See* Exhibit 9 (redacted chart for patient TH).

    c. Patient PK (employee of the Spa) – chart contains records for Botox and laser treatments with no physician orders; shows patient performed her own hair removal. *See* Exhibit 10 (redacted chart for patient PK).

    d. Patient AA (employee of the SPA) – chart contains records of laser treatment performed without physician orders; prescribed a topical compound by "LT" but not prescribed by the Defendant. *See* Exhibit 11 (redacted chart for patient AA).

[1] There is no room for doubt that the signatures on the charts obtained from the Spa are not the Defendant's actual signature. *Compare, e.g.*, Exhibit 1 (Bates No. 000008; Medical Director Agreement), Exhibit 5 (Bates No. 000006; handwriting sample), and Exhibit 16 (Bates No. 000228; prescription issued by the Defendant with a written signature for a non-spa patient) *with* Bates Nos. 000002, 000044, 000095, 000103, 000129, 000172, 000173, 000205, 000209, 000210, 000225, 000226, and 000227. The latter Bates numbered documents contained virtually identical signatures and it was confirmed that most of these signatures are in patients' charts the Defendant never saw.

e. Patient DB – shows patient received HRT by allowing the drug to be ordered under his DEA number and procedure performed on him by PK. *See* Exhibit 12 (redacted chart for patient DB).

f. Patient ES (employee and owner of the Spa) – chart shows numerous procedures performed by staff without the Defendant's orders and prescriptions called in by PK; the only part of the chart allegedly showing the Defendant's alleged signature is on prescriptions for Zolpidem (a Schedule IV CDS) and Spironolactone (Aldactone). *See* Exhibit 13 (redacted chart for patient ES).[2]

FAILURE TO MAKE PROPER MEDICAL LICENSE RENEWAL DISCLOSURES

17. The Defendant made application for the renewal of his medical license (the "Renewal") on 8 May 2014. *See* Exhibit 15. Therein, the Defendant responded "no" to the question of whether he has been reported to the National Practitioner Database ("NPDB"). The NPDB shows that the Defendant was reported for a $30,000.00 medical malpractice lawsuit settlement. The Defendant also stated in his Renewal that he does not wish to dispense CDS. *See id.* The actions discussed above clearly show the contrary.

III. VIOLATIONS

18. Based on the foregoing, the Defendant is guilty of unprofessional conduct as follows:

a. Engaging in the dishonorable or immoral conduct which is likely to deceive, defraud, or harm the public, in violation of 59 O.S. 2011, § 509(8) and Okla. Admin. Code § 435:10-7-4(11);

b. Failing to keep complete and accurate records for the purchase and disposal of CDS, in violation of 59 O.S. 2011, § 509(10) and Okla. Admin. Code § 475:25-1-3;

c. Prescribing, dispensing or administering CDS in a manner prohibited by:

i. 59 O.S. 2011, § 509(12),

ii. 59 O.S. 2011, § 509(16),

iii. Okla. Admin. Code § 435:10-7-4(1),

iv. Okla. Admin. Code § 435:10-7-4(2),

v. Okla. Admin. Code § 435:10-7-4(6),

vi. Okla. Admin. Code § 435:10-7-4(7),

[2] *See also* Exhibit 14 (redact chart for patient DK).

vii. Okla. Admin. Code § 435:10-7-4(24),

viii. Okla. Admin. Code § 435:10-7-4(26),

ix. Okla. Admin. Code § 435:10-7-4(27), and

x. Okla. Admin. Code § 435:10-7-4(49);

d. Failing to provide a proper and safe medical facility setting and qualified assistive personnel for a recognized medical act, in violation of 59 O.S. 2011, § 509(20) and Okla. Admin. Code § 435:10-7-4(41);

e. Failing to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient, in violation of 59 O.S. 2011, § 509(18);

f. Failing to maintain adequate medical records to support diagnosis, procedure, treatment or prescribed medications, in violation of 59 O.S. 2011, § 509(20) and Okla. Admin. Code § 435:10-7-4(41);

g. Engaging in the improper management of medical records, in violation of Okla. Admin. Code § 435:10-7-4(36);

h. Violating OBN and DEA rules and regulations regarding dispensing CDS at the Spa, in violation of Okla. Admin. Code § 435:10-7-4(27);

i. Allowing another person or organization to use the Defendant's license to practice medicine, in violation of Okla. Admin. Code 435:10-7-4(22);

j. Prescribing CDS to himself and his wife, in violation of Okla. Admin. Code § 435:10-7-4(5), (27) and 63 O.S. 2011, § 2-304(A)(8);

k. Making a misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic re-registration of a medical license, in violation of Okla. Admin. Code § 435:10-7-4;

l. Failing to register as a dispenser of CDS, in violation of Okla. Admin. Code § 435:10-7-1(1) and 63 O.S. 2011, § 2-302(A);

m. Failing to maintain records regarding the dispensing of CDS, in violation of Okla. Stat. Ann. § 435:10-7-1(2);

n. Failing to maintain effective controls against diversion of CDS, in violation of 63 O.S. 2011, § 2-303(A)(1) and 21 CFR § 1301.71(a);

o. Failing to comply with dispenser reporting requirements, in violation of 63 O.S. 2011, § 2-309C(A); and

p. Failing to establish a physician-patient relationship and performing a sufficient examination prior to administering treatment, in violation of 59 O.S. 2011, § 509(12).

V. CONCLUSION

Given the foregoing, the undersigned requests the Executive Director of the Board issue the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to the Defendant's professional license, including an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

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VERIFICATION

I, Robbin Roberts, under penalty of perjury under the laws of the State of Oklahoma, state as follows:

1. I have read the above Complaint regarding the Defendant, Darnell Eric Blackmon, M.D.; and

2. The factual statements contained therein are true and correct to the best of my knowledge and belief.

Robbin Roberts, Investigator
Oklahoma State Board of Medical Licensure & supervision

3-20-15
Date

Oklahoma County, Ok
Place of Execution