COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2027

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY CAROLYN V. SMITH, M.D., LICENSE NO. 31089, 2109 EASTWAY DRIVE, LEXINGTON, KENTUCKY 40502

ORDER OF REVOCATION

On March 17, 2022, the Kentucky Board of Medical Licensure (hereinafter "the Board"), acting by and through its Hearing Panel B, took up this case for final action. The Panel reviewed the Complaint, filed December 1, 2021; the Emergency Order of Restriction, filed November 17, 2021; the Motion for Default Ruling, filed January 6, 2022; the hearing officer's Findings of Fact, Conclusions of Law and Recommended Order Upon Default, dated February 10, 2022; and a memorandum from Board counsel, dated February 25, 2022. The licensee, Carolyn V. Smith, M.D., did not file exceptions.

Having considered all the information available and being sufficiently advised, Hearing Panel B ACCEPTS AND ADOPTS the hearing officer's findings of fact and conclusions of law and ADOPTS and INCORPORATES them BY REFERENCE into this Order; Hearing Panel B FURTHER ACCEPTS and ADOPTS the hearing officer's recommended order upon default. (Attachment)

Having considered all statutorily available sanctions and the nature of the violations in this case, Hearing Panel B hereby **ORDERS**:

1. The license to practice medicine held by Carolyn V. Smith, M.D., is hereby REVOKED and she shall not perform any act which constitutes the "practice of medicine," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – in the Commonwealth of Kentucky;

2. The provisions of KRS 311.607 SHALL apply to any petition for reinstatement filed by the licensee; and

3. Pursuant to KRS 311.565(1)(v), the licensee SHALL REIMBURSE the costs of these proceedings in the amount of $7,175.00, prior to filing any petition for reinstatement of her license to practice medicine in the Commonwealth of Kentucky.

SO ORDERED on this 21st day of March, 2022.

DALE E. TONEY, M.D.
CHAIR, HEARING PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Order of Revocation was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Keith Hardison, Esq., Hearing Officer, 2616 Bardstown Road, Louisville, Kentucky 40205 and copies were mailed to the licensee, Carolyn V. Smith, M.D., License No. 31089, 2109 Eastway Drive, Lexington, Kentucky 40502, and also via electronic mail to compmedlex@gmail.com on this 21st day of March, 2022.

Leanne K. Diakov
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

EFFECTIVE DATE AND APPEAL RIGHTS

Pursuant to KRS 311.593(1) and 13B.120, the effective date of this Order will be thirty (30) days after this Order of Revocation is received by the licensee.

The licensee may appeal from this Order, pursuant to KRS 311.593 and 13B.140-.150, by filing a Petition for Judicial Review in Jefferson Circuit Court within thirty (30) days after this Order is mailed or delivered by personal service. Copies of the petition shall be served by the licensee upon the Board and its General Counsel or Assistant General Counsel. The Petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested, along with a copy of this Order.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2027

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY CAROLYN V. SMITH M.D. LICENSE NO. 31089, 210 EASTWAY DRIVE, LEXINGTON, KENTUCKY, 40502

FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDED ORDER UPON DEFAULT

This action is before the hearing officer on the *Motion for Default Ruling* (hereinafter the "Motion") filed by the Kentucky Board of Medical Licensure (hereinafter "the Board"). Dr. Carolyn V. Smith, the licensee, has not filed a response opposing the motion. After reviewing the motion and applicable law, the hearing officer finds that, by operation of law, the material facts in this matter are taken as admitted. Therefore the hearing officer recommends the Board grant the *Motion for Default Ruling,* find Dr. Smith in violation of KRS 311.595(9), as illustrated by KRS 311.597(4) and KRS 311.595 (12) and take any other appropriate action against Dr. Smith's license for these violations.

In light of this recommendation, the administrative hearing scheduled for May 2 - 4, 2022, is hereby **CANCELLED.**

In support of this recommendation the hearing officer submits the following Findings of Fact, Conclusions of Law and Recommended Order:

FINDINGS OF FACT

Procedural Facts

1. On December` 1, 2021, The Board issued a Complaint against Dr. Smith's license to practice medicine in the Commonwealth of Kentucky alleging violations of KRS 311.595(9), as illustrated by KRS 311.597(4) and KRS 311.595 (12). *Complaint generally*

2. This Complaint directed Dr. Smith to `respond to the allegations contained in the Complaint within 30 days and put her on notice that her failure to do so may be taken as an admission of the charges. *Complaint ¶ 19*

3. Dr. Smith had two (2) addresses on record with the Board. One was 2109 Eastway Drive, Lexington, Kentucky 40502 and the other was 2011 Liberty Road, Lexington, Kentucky 40509. She also had an email address on file which had been used for prior correspondence concerning an emergency hearing. *Motion ¶ 5*

4. On December 1, 2022, the Board served the Complaint by email to this email address. It was not returned or otherwise designed as undeliverable. *Motion ¶ 6 Attachment 1*

5. Also on or about December 1, 2021, the Board served the Complaint by certified mail, return receipt requested, to 2109 Eastway Drive, Lexington, Kentucky 40502. It was delivered and signed for on December 7, 2021. *Motion ¶ 7 Attachment 2*

6. The envelope was returned to the Board and received on January 3, 2022, marked "return to sender". When received some material were not included in the envelope, including the Boards statute and regulations. *Motion ¶ 7*

7. Also on or about December 1, 2021, the Board served the Complaint by certified mail, return receipt requested, to 2011 Liberty Road, Lexington, Kentucky 40509. It was not delivered because the forwarding order had expired. *Motion ¶ 8 Attachment 3*

8. Dr. Smith has failed to respond to the allegations made in the Complaint. See *Administrative Record generally*

9. Furthermore Dr. Smith has failed to respond to the instant Motion despite being ordered to do so on or before January 28, 2022. *Order dated January 10, 2022.*

10. In a related matter, Dr. Smith failed to appear to defend against an Emergency Order of Restriction issued against her license despite having requested a hearing on that Board action. Dr. Smith requested a "formal review" of the Emergency Order via email sent on November 26, 2021, to the Board from compmedlex@gmail.comp, an address to which the Emergency Order had been sent. See *email dated 11/26/21 from Carolyn Smith M.D. to Leanne Dialov, Board General Counsel.*

11. The requested hearing was scheduled for December 10, 2021, at 9:00 a.m. and the required Notice of Hearing was issued and sent to the two street addresses on file for Dr. Smith as well as electronically transmitted via the e-mail address also used by her. *Notice of Hearing filed November 29, 2021*

12. Dr. Smith failed to appear for this hearing and the hearing was held in her absence pursuant to KRS 13B. 080. *Findings of Fact, Conclusions of Law and Final Order entered December 13, 2021.*

Substantive Facts

13. The findings that follow are based upon the allegations contained in the Complaint.

14. At the time of her alleged misconduct Dr. Smith was licensed to practice medicine in the Commonwealth of Kentucky. Her specialty is Urology. *Complaint ¶ 1-2*

15. Dr. Smith was a party to previous Board actions. Specifically she was a party to an Agreed Order dated June 4, 2009, in which she stipulated certain facts. She stipulated that she had entered into a Letter of Agreement with the Board relative to her treatment for substance abuse. She agreed to maintain a written contract with the Kentucky Physicians Health Program – Impaired Physician Program and the Kentucky Physician Health Foundation. Dr. Smith was to maintain sobriety, attend specific support groups at specific intervals and document her attendance. *Complaint ¶ 3*

16. She further stipulated in this Agreed Order that the Board received information from her employer and one of the organizations monitoring her conduct, that she had inconsistent attendance at her recovery group meeting and was not doing well in her employment at the University of Louisville, Department Of Urology. Dr. Smith was interviewed by a Board investigator and provided information about the reasons for her participation and attendance problems. *Complaint ¶ 3*

17. Pursuant to this Agreed Order (Case # 1202) Dr. Smith was required to maintain her contractual relationship with the Kentucky Physician Health Foundation and comply with the conditions of that contractual relationship, including abstaining from the consumption of mood altering substances, including alcohol. She was subject to random unannounced breathalyzers and drug analysis. She was to pay a fine of $500. *Complaint ¶ 3*

18. On October 28, 2009, at Dr. Smith's request, and so as to facilitate her seeking employment upon leaving the University of Louisville, the Board terminated this Agreed Order contingent upon her entering into a new "Letter of Agreement" which required her to maintain a written contract with and be an active participant in the Kentucky Physicians Health Program – Impaired Physician Program. She executed that letter that day. *Complaint ¶ 3*

19. Dr. Smith was again a party to Board action on October 24, 2012, when she entered into an Agreed Order in Case #1436. In this matter she again stipulated certain facts. She stipulated that she was non-compliant with her contract with the recovery agency in that she was repeatedly late with her required monthly report, missed individual therapy appointments, was past due on administrative fees and had, more than once, submitted diluted urine specimens for drug testing. *Complaint ¶ 4*

20. Pursuant to this Agreed Order Dr. Smith was required to maintain a contractual relationship with the Kentucky Physician Health Foundation and fully comply with the conditions thereof, including abstaining from the consumption of mood altering substances, including alcohol. She was subject to random unannounced breathalyzers and drug analysis and was to pay a fine of $1000. This Agreed Order expired on October 24, 2017. *Complaint ¶ 4*

21. In or around April 2020 the Cabinet for Health and Family Services, Office of Inspector General, received an anonymous complaint regarding Dr. Smith's prescribing of controlled substances. The complaint was that she might be prescribing controlled substances in quantities and combinations which may not be appropriate. *Complaint ¶ 5*

22. On or around July 6, 2021, Investigator Paula York, R.Ph., of the Cabinet for Health and Family Services, Office of Inspector General, completed a review of Dr. Smith's KASPER records for the period April 3, 2020, through April 3, 2021, and noted certain patterns including patients with the long term use of one or more controlled substances, combinations of controlled substances favored by persons who abuse or divert controlled substances and patients traveling long distances to obtain these substances. *Complaint ¶ 6*

23. Ms. York identified sixteen (16) patients that illustrated the concerns above and recommended further review to determine if Dr. Smith provided appropriate medical care. She also reported that while Dr. Smith had requested 133 KASPER reports during the review period she was not in compliance with the 201 KAR 9:260 KASPER requirements for 14 of the above identified patients. *Complaint ¶ 6*

24. Dr. Smith's "KASPER Prescriber Report Card" for 2020 revealed that 96.77% of her patients filled prescriptions for opioid analgesics from her, 19 out of 31 total patient filled three days or more of overlapping opioid prescriptions from all prescriber and two of her patients filled overlapping opioid and benzodiazepine/sedative prescriptions from all prescribers. This indicated that she far exceeded opioids prescriptions averages for peers within her specialty and overall statewide. *Complaint ¶ 7*

25. The majority of Dr. Smith's patients received controlled substances for the treatment of pain. She is not a registered pain management facility and she is not qualified to be an owner or owner designee of such a facility as required by KRS 218A.175 and 201 KAR 9:250. *Complaint ¶ 8*

26. The Board learned that in or around February 2019 pharmacists in the Lexington area had been interviewed by agents of the U.S. Drug Enforcement Administration (DEA) regarding prescriptions written by Dr. Smith. *Complaint ¶ 9*

27. Pharmacists at the C & C Pharmacy in Lexington advised the DEA agents that Dr. Smith had written several prescriptions for patients and attached notes telling the pharmacist to fill them early due to the patient traveling and notes advising patients to take an extra half pill for pain. She had written these notes on one patient's prescription so often that made him approximately 9 days early and as a result he had gotten almost one extra prescription fill. The patients had indicated to the pharmacist that while they were using Medicaid to pay for their prescriptions, they were paying cash for their visits to Dr. Smith. The DEA agents further learned that Dr. Smith had called the C & C Pharmacy angry about a particular patient who was denied

an early refill on a Hydrocodone prescription. She advised that she was changing the patient's prescription from Hydrocodone to Percocet so that the prescription could be filled that day. (This patient was also refused a refill at CVS Pharmacy) Dr. Smith threatened to not send any more patients to C &C Pharmacy because they were questioning her prescriptions. *Complaint ¶ 10*

28. The DEA also contacted a pharmacist at CVS Pharmacy in Lexington. The pharmacist there advised the DEA agents that, as to the patient in question who appeared there after being refused a refill at C & C Pharmacy, they had called C & C and been advised that he was seeking to refill his prescription early. According to their report the DEA agents were further advised that the pharmacy initially would not fill prescriptions from Dr. Smith because she was part of a problematic medical practice in the area. They only resumed filling her prescriptions upon being advised that she was no longer part of that practice. *Complaint ¶ 11*

29. A Board investigator visited Dr. Smith's practice address and observed no signage and observed that it appeared that she was living there. There was very little medical equipment inside; just a stethoscope, a set of scales and scattered medical files. The medical investigator served a subpoena for the medical records of sixteen (16) patients. Dr. Smith was unable to produce them, stating that the records were in storage as she had just moved into that location. *Complaint ¶ 12*

30. Dr. Smith sent the requested medical records approximately three weeks after the investigators visit and submitted a written response to the allegations against her. She advised that she follows Kentucky guidelines regarding the writing of prescriptions. She further advised that many of her patients work full time and work in physically demanding jobs which they could not perform if they were unable to control their pain. She advised that four (4) of the patients whose charts had been reviewed are no longer under her care because she refused dosage increases for them. She refers patients to other physicians when needs require it. She works with numerous other specialists. She does not advertise her practice. She reduces controlled substances to a minimum and uses alternative medication as much as possible. Patients travel long distances to receive care from her because they previously resided in Lexington and received care at "this practice" prior to her arrival. *Complaint ¶ 13*

31. In October of 2021 a consultant engaged by the Board completed a review of the sixteen (16) patient charts submitted by Dr. Smith in response to the subpoena. The Board consultant found that Dr. Smith departed from or failed to conform to acceptable and prevailing medical practices within the Commonwealth. He specifically noted the following "disturbing" patterns and issues:

- Patients traveling long distances for their medications
- Patients had seen board certified pain management specialists prior to Dr. Smith
- History taking and physical exams were lacking in several cases
- No imaging studies were obtained to diagnose or monitor disease processes
- Patients not being referred to other specialties to properly diagnose, alleviate or resolve problems
- Many patients with back pain had little or no imaging studies to accurately diagnose condition and were not seeing appropriate specialists.
- Lack of urine drug screens
- "Cloned" notes in the records
- No documented medical treatment plan
- No objective or subjective pain questionnaires being utilized.
- Use of dangerous drug "cocktails"
- Callous disregard for and enabling drug dependence

Complaint ¶ 14

32. The Board consultant went on to opine that:

> Dr. Smith does constitute a danger to the health and welfare of these patients and the general public. High quantities of schedule 2 drugs were prescribed indiscriminately with poor or no monitoring. These drugs are highly addictive and are apt to create dependence. They are also very likely to be distributed/sold and abused. These drugs individually, and moreover on a cocktail form, can very easily lead to overdoes and death.

Complaint ¶ 14

33. Attempts to locate Dr. Smith to obtain a response to the Board consultant's report were unsuccessful and her practice location in Lexington appeared to be unoccupied as of November 15, 2021. *Complaint ¶ 15 – 16*

CONCLUSIONS OF LAW

1. The Board has jurisdiction over this action pursuant to KRS 311.591 and KRS 311.595.

2. This proceeding is governed by and was conducted in accordance with KRS Chapter 311, KRS Chapter 13B and related regulations promulgated under KRS Chapter 311.

3. KRS 311.591(4) provides:

> The inquiry panel shall cause a complaint to be served on the charged physician by personal delivery or by certified mail to the physician's last address of which the Board has record. The physician shall submit a response within thirty (30) days after service. Failure to submit a timely response or willful avoidance of service may be taken by the Board as an admission of the charges.

4. Under KRS 13B.090 (7) the Board has the burden to prove by a preponderance of the evidence the allegations against the licensee.

5. Dr. Smith, the licensee, having failed to file a timely response to the Complaint issued by the Board's Inquiry Panel A in this matter on December 1, 2021, and served on her by certified mail on December 7, 2021, the allegations contained in that Complaint are deemed to be admitted. KRS 311.591(4)

6. Based upon the above findings of fact, the preponderance of the evidence supports the conclusion that Dr. Smith has engaged in dishonorable unethical or unprofessional conduct likely to brings the medical profession into disrepute and cause harm to the public, specifically by her failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky as they relate to the prescribing of controlled substances. This thereby establishes a violation of KRS 311.595 (9) as illustrated by KRS 311.597 (4).

7. Based upon the above findings of fact, the preponderance of the evidence supports the conclusion that Dr. Smith has also violated KRS 311.595 (12) by her conduct in distributing controlled substances on numerous occasions in a manner that violates the provisions of KRS 218A.175, 201 KAR 9:250, which contains the Boards regulations regarding the operation of a pain management facility and 201 KAR 9:260, which contains the Board's regulations regarding the utilization of controlled substances.

8. Upon finding that a licensee has violated the provisions of KRS 311.595 the Board has the power to:

> ...place a licensee on probation for a period not to exceed five (5) years; suspend a license for a period not to exceed five (5) years; limit or restrict a license for an indefinite period; or revoke any license heretofore issued by the Board

RECOMMENDED ORDER

Based upon the foregoing findings of fact and conclusions of law, the hearing officer recommends the Board find Dr. Carolyn V. Smith guilty of violating KRS 311.595(9), as illustrated by KRS 311.597 (4) and KRS 311.595 (12) and impose any appropriate sanction for these violations.

NOTICE OF RIGHT TO FILE EXCEPTIONS AND TO APPEAL

Pursuant to KRS 13B.110 (4), a party has the right to file exceptions to this recommended decision.

A copy of the hearing officer's recommended order shall also be sent to each party in the hearing and each party shall have fifteen (15) days from the date the recommended order is mailed within which to file exceptions to the recommendations with the agency head. Transmittal of a recommended order may be sent by regular mail to the last known address of the party. Failure to file exceptions will result in preclusion of judicial review of those issues not

specifically excepted to. On appeal the circuit court will consider only the issues a party raised in written exceptions.

A party also has the right to appeal the Final Order of the agency pursuant to KRS 13B.140 (1 - 2) which states:

(1) Except as provided in KRS 452.005, all final orders of an agency shall be subject to judicial review in accordance with the provisions of this chapter. A party shall institute an appeal by filing a petition in the Circuit Court of venue, as provided in the agency's enabling statutes, within thirty (30) days after the date of the final order of the agency is mailed or delivered by personal service. If venue for appeal is not stated in the enabling statutes, a party may appeal to Franklin Circuit Court or the Circuit Court of the county in which the appealing party resides or operates a place of business. Copies of the petition shall be served by the petitioner upon the agency and all parties of record. The petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested. The petition shall be accompanied by a copy of the final order.

(2) A party may file a petition for judicial review only after the party has exhausted all administrative remedies available within the agency whose action is being challenged, and within any other agency authorized to exercise administrative review.

Pursuant to KRS 23A.010 (4), "Such review (by Circuit Court) shall not constitute an appeal but an original action." Some courts have interpreted this language to mean that summons must be served upon filing an appeal in circuit court.

So ORDERED this 10th day of February 2022.

Keith Hardison

KEITH HARDISON
HEARING OFFICER
2616 BARDSTOWN RD.
LOUISVILLE KY 40205
(502) 432-2332
keithdiver@bellsouth.net

CERTIFICATE OF SERVICE

I hereby certify that the original of this **FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDED ORDER** was mailed this 10th day of February 2022, by first-class mail, postage prepaid, to:

JILL LUN
KY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK STE 1B
310 WHITTINGTON PKWY
LOUISVILLE KY 40222

for filing; and a true copy was sent by first-class mail, postage prepaid, to:

LEANNE K. DIAKOV
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Keith Hardison
KEITH HARDISON

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COMPLAINT

Comes now the Complainant Waqar A. Saleem, M.D., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel A, and on behalf of the Panel pursuant to 201 KAR 9:240 Section 1(3)(b), states for its Complaint against the licensee, Carolyn V. Smith, M.D., as follows:

1. At all relevant times, Carolyn V. Smith, M.D. ("the licensee"), was licensed by the Board to practice medicine in the Commonwealth of Kentucky.

2. The licensee's medical specialty is urology.

3. On or about June 4, 2009, the licensee entered into an Agreed Order, KBML Case No. 1202, in which she stipulated facts, including the following:

    - On December 5, 2005, as a result of her treatment for substance abuse (alcoholism), the licensee entered into a Letter of Agreement (LOA) with the Kentucky Board of Medical Licensure. At that time, the licensee was stationed at Fort Knox, Kentucky. The LOA required that "should the licensee practice in Kentucky, she shall enter into and maintain a written contract with and be an active participant in the activities of the Kentucky Physicians Health Program—Impaired Physician Program (IPP)."

    - The licensee entered into a contract with the Kentucky Physicians Health Foundation ("Foundation") on August 1, 2006, at which time she had taken a position at the Department of Urology at the University of Louisville.

    - In addition to maintaining sobriety, the licensee was required to and agreed to the following conditions pursuant to her Foundation contract:

        > I agree to attend support or professional group(s), for a total of 3 meetings per week. A list of these meetings must be submitted to our office by the 8th day of each month for the preceding month's meetings. This list must be signed by your sponsor and must be accompanied by a cover sheet.

I agree to the following special terms concerning my disease: Weekly attendance at the Physicians Therapy Group at the Morton Group, Med. Mgmt. with Dr. Charlie Francke, and all other treatment to be determined by your Treatment Team. You will never be seen less than monthly at The Morton Center.

- On March 11, 2009, James T. Jennings, M.D., Medical Director of the Foundation, reported to the Board that the licensee was not in compliance with the Foundation's program.

- Dr. Jennings was interviewed by the Board investigator, and stated that he did not have information that the licensee was drinking. However, the licensee was having attitude problems at work, was issuing late reports, had only inconsistent attendance at her recovery group meetings, and had been unresponsive to telephone calls from the Foundation.

- By letter of February 20, 2009, Dr. Jennings had pointed out to the licensee that "your AA reports for October and November were late. Additionally, we don't have reports from August and December of 2008, or for January, 2009."

- In a second letter dated March 3, 2009, Dr. Jennings again explained to the licensee that "we are yet to receive your AA reports from August and December of 2008, and January of 2009." In addition, Dr. Jennings informed the licensee that "the Morton Center reported to us at the most recent treatment team meeting that lately your attendance is spotty at best. When you do show up, you are usually very late and your participation is poor." The licensee was told that she had until March 9, 2009, to contact the office, but failed to do so.

- The licensee's supervisor at University of Louisville, Tony Casale, M.D., was contacted by the Foundation on March 5, 2009. Dr. Casale reported that the licensee "is not doing well at all." Dr. Casale indicated that the licensee is consistently late on her dictation of medical charts, to the point where she hired a coach to help with her organization. The licensee was almost suspended by the hospital last year due to the problem of her late dictations. Additionally, Dr. Casale indicated that he had to go over to the hospital on two occasions to apologize for the licensee's rude behavior. He stated that the licensee arrives late and does not show up at all for meetings that would allow them to discuss these problems. He concluded by stating that basically he saw the licensee as "very angry" most of the time.

- The licensee was interviewed by the Board investigator. She admitted to being late with her AA reports, but claimed that she had hand delivered what was required. She stated that her group meetings at the Morton Center conflicted with her surgeries at University of Louisville, and that she had previously been under the understanding that she could arrive late for such

meetings as long as she called ahead to notify Morton. The licensee indicated that she was "happier and more fulfilled than I can remember being in a long time" and asserted that she had engaged in no untoward behavior.

- The licensee also asserted that any absences or tardiness resulted from her work conflicting with the Morton Center schedule. Karen Smith of the Morton Center verified the licensee's appropriate participation in a letter dated May 18, 2009. The licensee also asserted that she prepared all required AA reports within a few days of the due date and that her AA sponsor signed off on them; that her medical charts were late as a result of dictation delays at the University of Louisville Hospital; that she was never notified of any behavior problems at work prior to the evaluation; and that she has not been informed of any specific incidence of objectionable behavior. The licensee expressed a willingness to correct any deficiencies brought to her attention.

Pursuant to the Agreed Order, KBML Case No. 1202, the licensee was required to maintain her contractual relationship with the Foundation and fully comply with all conditions of that contractual relationship, including that she completely abstain from the consumption of mood-altering substances, including alcohol; that she be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis; and that she pay a fine in the amount of $500.00. On or about September 10, 2009, the licensee requested that the Agreed Order be terminated so that she would be able to seek other employment upon expiration of her contract with the University of Louisville in November 2009. On or about October 28, 2009, the Board terminated the Agreed Order, KBML Case No. 1202, contingent upon the licensee entering into a new LOA with the Board, which required that the licensee maintain a written contract with and be an active and compliant participant in the activities of the Kentucky Physicians Health Foundation - Impaired Physician Program (IPP). The licensee entered into the LOA on the same date.

4. On or about October 24, 2012, the licensee entered into an Agreed Order, KBML Case No. 1436, in which she stipulated facts, including the following:

- On June 14, 2012, Greg Jones, M.D., the Foundation's Medical Director, reported that the licensee has become non-compliant with her Foundation contract in the following ways:
  - The licensee has been late multiple times in turning in her required Monthly Report;
  - The licensee has missed more than one of her required Morton Center appointments for individual therapy;
  - The licensee has become past due on owed administrative fees; and
  - The licensee has had more than one dilute test result, despite requests that she avoid excessive water intake on days she is chosen for testing.

Pursuant to the Agreed Order, KBML Case No. 1436, the licensee was required to maintain a contractual relationship with the Foundation and fully comply with all conditions of that contractual relationship, including that she completely abstain from the consumption of mood-altering substances, including alcohol; that she be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis; and that she pay a fine in the amount of $1,000.00. On or about October 24, 2017, the Agreed Order, KBML Case No. 1436 expired.

5. In or around April 2020, the Cabinet for Health and Family Services, Office of Inspector General ("OIG"), received an anonymous complaint relaying concerns regarding the licensee's prescribing of controlled substances. According to OIG, the caller advised that the licensee may be prescribing controlled substances in quantities and combinations which may not be appropriate.

6. On or around July 6, 2021, OIG Investigator, Paula York, R. Ph., completed a review and analysis of the licensee's KASPER records (for the period of April 3, 2020 through April 3, 2021) and noted several patterns of concern, including:

   - Long-term use of one or more controlled substances;
   - Combinations of controlled substances favored by persons who abuse or divert controlled substances; and
   - Patients traveling long distances to obtain medications

Ms. York identified sixteen (16) patients illustrative of these concerns and recommended further review to determine if the licensee provided appropriate medical care. Ms. York also stated that although the licensee had requested approximately 133 KASPER reports on patients during the reviewed period, she was not in compliance with 201 KAR 9:260 KASPER requirements relative to fourteen (14) of the identified patients.

7. A KASPER Prescriber Report Card on the licensee for the Annual 2020 period showed that 96.77% of her patients filled a prescription for opioid analgesics from her; 19 out of 31 total patients filled three days or more of overlapping opioid prescriptions from all prescribers; two of her patients filled overlapping opioid and benzodiazepine/sedative prescriptions from all prescribers; and that she far exceeded opioid prescribing averages of peers within her specialty and overall statewide.

8. Although the majority of patients received controlled substances for the treatment of pain, the licensee's practice is not a registered pain management facility and the licensee is not qualified to be an owner or owner designee of a pain management facility as required by KRS 218A.175 and 201 KAR 9:250.

9. During the course of the Board's investigation, it was learned that, in or around February 2019, pharmacists in the Lexington area had been approached and interviewed by the U.S. Drug Enforcement Administration ("DEA") in regard to prescriptions written by the licensee.

10. On or about February 22, 2019, pharmacists at C & C Pharmacy, 3122 Mapleleaf Drive, Lexington, Kentucky relayed to the DEA that:

    - The licensee had written several prescriptions to patients in which she had annotated notes on their prescriptions telling the pharmacy to fill prescriptions early due to the patients travelling for work and also made notations directing patients to take an extra half pill daily for pain;

- The licensee had written Patient MS these notes on his prescriptions so often, which were about 9 days early on the fills that he had almost gotten a full extra prescription fill because of this and the pharmacists had cautioned him to schedule his appointments with the licensee every 28 days rather than 24 days to avoid this problem;
- There were red flags with the licensee because the patients indicated that they paid cash for their visits to the licensee, but had Medicaid pay for their prescriptions;
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- The licensee threatened to not send any more of her patients to C & C Pharmacy because they were questioning her prescriptions.

11. On or about February 23, 2019, a pharmacist at CVS Pharmacy, 3097 Todds Road, Lexington, Kentucky relayed to the DEA that:

- When a patient who had never filled a prescription at CVS Pharmacy presented a prescription from the licensee, the pharmacist called C & C Pharmacy to inquire why the prescription had not been filled there and was told that the patient was trying to fill it too early;
- CVS Pharmacy did not fill the licensee's prescriptions because she was part of the "Grigsby problem" and that CVS would not fill for anyone associated with that practice; and
- After the licensee called the pharmacy and stated that she was no longer part of the "Grigsby" practice, CVS then allowed for her prescriptions to be filled.

12. On or about May 13, 2021, the Board's Medical Investigator, Billy Madden, visited the licensee's practice address, 2109 Eastway Drive, Lexington, Kentucky, and noted that was no signage at the location; it appeared that the licensee was living at the practice location; inside there was very little medical equipment, there being a stethoscope and a set of scales lying on a desk and scattered medical files. When Mr. Madden served a subpoena for medical records on the sixteen (16) patients identified by Ms. York, OIG, the licensee was unable to produce the medical records, stating that they were just moving into the location and most of the records were in storage.

13. Approximately three (3) weeks after Mr. Madden's visit, the licensee sent Mr. Madden the medical records and a written "response" in which she stated, in part,

> ... I follow the guidelines as outlined by the state of Kentucky. I go above and beyond that by only writing prescriptions in two week increments, which was very labor intensive prior to electronic prescribing. Many of my patients are over age 40 and work full time. They work in physically demanding jobs and most admit they would be unable to care for themselves or their families if unable to control the painful conditions for which they have been treated for one or more decades.
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> Of the patient charts requested, four (4) of these patients are no longer under my care, due to the fact that I refused to increase dosages of medication without a clear medical necessity. It has been my habit to refer patients to other physicians when their needs require it. I work with cardiologists, internists, orthopaedic surgeons, neurosurgeons and other medical experts. I do not advertise my practice in any capacity.
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> It has been my habit to reduce controlled substances to a minimum and use alternative medications as much as possible. With regard to patients travelling some distance to receive care, most of those who do were under care of this practice prior to my arrival. Most were Lexingtonians initially and it seems unreasonable to discharge an established and stable patient based upon change of address.

14. In or around October 2021, a Board consultant completed review of the sixteen (16) patient charts and found that the licensee departed from or failed to conform to acceptable and prevailing medical practices within the Commonwealth of Kentucky. Overall, the Board Consultant noted

> ... There is a disturbing pattern that emerges after reviewing these charts. Most of these patients traveled long distances for their medications. They had already exhausted other options, including in most cases, board certified pain management experts before they started seeing Dr. Smith. The history taking and physical examinations were inadequate in several cases. In several patients no imaging studies were obtained to either diagnose or to monitor their disease processes. Additionally, they were not referred to other specialties who could have helped appropriately diagnose, alleviate or resolve their problems. Strikingly, most patients had back pain with little or no imaging studies over several years to accurately diagnose their conditions. They were not under the care of a spine surgeon, physical therapist or orthopedic surgeons.

> What is also troubling is that I don't see any evidence of urine drug screens. None of these patients had drug screens over 2 years. Most notes I reviewed appeared to be cloned notes with little to no change over 2 years. It appears that these patients showed up every 2 weeks for their pain medications and left with NO medical plan except to follow-up in 2 weeks for more pain medicines. I did not see a single objective or subjective pain questionnaire to quantify their pain severity and response to medications. ... Dr. Smith used cocktails of pain medications/gabapentin/benzodiazepines among other drugs that can be very dangerous.
>
> ... [T]here seemed to be a callous disregard and mentality to enable these patients of their continued dependence of such potent drugs.
>
> Dr. Smith does constitute a danger to the health and welfare of these patients and the general public. High quantities of schedule 2 drugs were prescribed indiscriminately with poor or no monitoring. These drugs are highly addictive and are apt to create dependence. They are also very likely to be distributed/sold and abused. These drugs individually, and moreover on a cocktail form, can very easily lead to overdoses and death. ...

The Board Consultant's report, including review worksheets, is adopted and incorporated herewith in its entirety by reference.

15. Attempts to locate the licensee for a response to the Board consultant's report were unsuccessful.

16. On or about November 15, 2021, the licensee's practice address at 2109 Eastway Drive, Lexington, Kentucky, appeared to be unoccupied.

17. On or about November 17, 2021, an Emergency Order of Restriction was issued against the licensee's license to practice medicine in the Commonwealth of Kentucky.

18. By her conduct, the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12). Accordingly, legal grounds exist for disciplinary action against her license to practice medicine in the Commonwealth of Kentucky.

19. The licensee is directed to respond to the allegations delineated in the Complaint within thirty (30) days of service thereof and is further given notice that:

(a) Her failure to respond may be taken as an admission of the charges;

(b) She may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in her defense.

20. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for May 2, 3 & 4, 2022, at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure and pursuant to KRS Chapter 13B. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice medicine in the Commonwealth of Kentucky held by Carolyn V. Smith, M.D.

This 1st day of December, 2021.

W. Saleem.

WAQAR A. SALEEM, M.D.
CHAIR, INQUIRY PANEL A

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Keith Hardison, Esq., Hearing Officer, 2616 Bardstown Road, Louisville, Kentucky 40205 and copies were mailed via certified mail return-receipt requested to the licensee, Carolyn V. Smith, M.D., License No. 31089, 2109 Eastway Drive, Lexington, Kentucky 40502, and 2100 Liberty Road, Lexington, Kentucky 40509, and also via electronic mail to compmedlex@gmail.com on this 15th day of December, 2021.

Leanne K. Diakov
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 2027

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY CAROLYN V. SMITH, M.D., LICENSE NO. 31089, 2109 EASTWAY DRIVE, LEXINGTON, KENTUCKY 40502

EMERGENCY ORDER OF RESTRICTION

The Kentucky Board of Medical Licensure ("the Board"), acting by and through the Chair of its Inquiry Panel A, considered a memorandum by Billy Madden, Medical Investigator, dated November 16, 2021; an Investigative Report from the Cabinet for Health and Family Services, Office of Inspector General, written by Paula York, R. Ph., dated April 6, 2021; U.S. Drug Enforcement Administration Reports of Investigation, written by Benjamin S. Shirley, TFO, dated February 25 and March 1, 2019; an e-mail subject titled "Suspected Pill Mill," sent to Lieutenant Jesse Harris, Lexington Police Department, dated July 7, 2017; photographs of the licensee's practice location, 2109 Eastway Drive, Lexington, Kentucky; a written statement of "Overview" and "Treatment Strategies" from the licensee, undated; a Board Consultant Report (and Expert Review Worksheets), dated October 2021; the Annual 2020 KASPER Prescriber Report Card on the licensee; and prior agreed orders from KBML Case Nos. 1202 and 1436.

Having considered this information and being sufficiently advised, the Chair of Inquiry Panel A ENTERS the following EMERGENCY ORDER OF RESTRICTION, in accordance with KRS 311.592(1) and 13B.125(1):

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available to him, the Chair of Inquiry Panel A concludes there is probable cause to make the following Findings of Fact, which support this Emergency Order of Restriction:

1. At all relevant times, Carolyn V. Smith, M.D. ("the licensee"), was licensed by the Board to practice medicine in the Commonwealth of Kentucky.

2. The licensee's medical specialty is urology.

3. On or about June 4, 2009, the licensee entered into an Agreed Order, KBML Case No. 1202, in which she stipulated facts, including the following:

    - On December 5, 2005, as a result of her treatment for substance abuse (alcoholism), the licensee entered into a Letter of Agreement (LOA) with the Kentucky Board of Medical Licensure. At that time, the licensee was stationed at Fort Knox, Kentucky. The LOA required that "should the licensee practice in Kentucky, she shall enter into and maintain a written contract with and be an active participant in the activities of the Kentucky Physicians Health Program—Impaired Physician Program (IPP)."

    - The licensee entered into a contract with the Kentucky Physicians Health Foundation ("Foundation") on August 1, 2006, at which time she had taken a position at the Department of Urology at the University of Louisville.

    - In addition to maintaining sobriety, the licensee was required to and agreed to the following conditions pursuant to her Foundation contract:

        > I agree to attend support or professional group(s), for a total of 3 meetings per week. A list of these meetings must be submitted to our office by the 8th day of each month for the preceding month's meetings. This list must be signed by your sponsor and must be accompanied by a cover sheet.
        >
        > I agree to the following special terms concerning my disease: Weekly attendance at the Physicians Therapy Group at the Morton Group, Med. Mgmt. with Dr. Charlie Francke, and all other treatment to be determined by your Treatment Team. You will never be seen less than monthly at The Morton Center.

    - On March 11, 2009, James T. Jennings, M.D., Medical Director of the Foundation, reported to the Board that the licensee was not in compliance with the Foundation's program.

    - Dr. Jennings was interviewed by the Board investigator, and stated that he did not have information that the licensee was drinking. However, the licensee was having attitude problems at work, was issuing late reports, had only inconsistent attendance at her recovery group meetings, and had been unresponsive to telephone calls from the Foundation.

- By letter of February 20, 2009, Dr. Jennings had pointed out to the licensee that "your AA reports for October and November were late. Additionally, we don't have reports from August and December of 2008, or for January, 2009."

- In a second letter dated March 3, 2009, Dr. Jennings again explained to the licensee that "we are yet to receive your AA reports from August and December of 2008, and January of 2009." In addition, Dr. Jennings informed the licensee that "the Morton Center reported to us at the most recent treatment team meeting that lately your attendance is spotty at best. When you do show up, you are usually very late and your participation is poor." The licensee was told that she had until March 9, 2009, to contact the office, but failed to do so.

- The licensee's supervisor at University of Louisville, Tony Casale, M.D., was contacted by the Foundation on March 5, 2009. Dr. Casale reported that the licensee "is not doing well at all." Dr. Casale indicated that the licensee is consistently late on her dictation of medical charts, to the point where she hired a coach to help with her organization. The licensee was almost suspended by the hospital last year due to the problem of her late dictations. Additionally, Dr. Casale indicated that he had to go over to the hospital on two occasions to apologize for the licensee's rude behavior. He stated that the licensee arrives late and does not show up at all for meetings that would allow them to discuss these problems. He concluded by stating that basically he saw the licensee as "very angry" most of the time.

- The licensee was interviewed by the Board investigator. She admitted to being late with her AA reports, but claimed that she had hand delivered what was required. She stated that her group meetings at the Morton Center conflicted with her surgeries at University of Louisville, and that she had previously been under the understanding that she could arrive late for such meetings as long as she called ahead to notify Morton. The licensee indicated that she was "happier and more fulfilled than I can remember being in a long time" and asserted that she had engaged in no untoward behavior.

- The licensee also asserted that any absences or tardiness resulted from her work conflicting with the Morton Center schedule. Karen Smith of the Morton Center verified the licensee's appropriate participation in a letter dated May 18, 2009. The licensee also asserted that she prepared all required AA reports within a few days of the due date and that her AA sponsor signed off on them; that her medical charts were late as a result of dictation delays at the University of Louisville Hospital; that she was never notified of any behavior problems at work prior to the evaluation; and that she has not been informed of any specific incidence of objectionable behavior. The licensee expressed a willingness to correct any deficiencies brought to her attention.

Pursuant to the Agreed Order, KBML Case No. 1202, the licensee was required to maintain her contractual relationship with the Foundation and fully comply with all conditions of that contractual relationship, including that she completely abstain from the consumption of mood-altering substances, including alcohol; that she be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis; and that she pay a fine in the amount of $500.00. On or about September 10, 2009, the licensee requested that the Agreed Order be terminated so that she would be able to seek other employment upon expiration of her contract with the University of Louisville in November 2009. On or about October 28, 2009, the Board terminated the Agreed Order, KBML Case No. 1202, contingent upon the licensee entering into a new LOA with the Board, which required that the licensee maintain a written contract with and be an active and compliant participant in the activities of the Kentucky Physicians Health Foundation - Impaired Physician Program (IPP). The licensee entered into the LOA on the same date.

4. On or about October 24, 2012, the licensee entered into an Agreed Order, KBML Case No. 1436, in which she stipulated facts, including the following:

    - On June 14, 2012, Greg Jones, M.D., the Foundation's Medical Director, reported that the licensee has become non-compliant with her Foundation contract in the following ways:
        - The licensee has been late multiple times in turning in her required Monthly Report;
        - The licensee has missed more than one of her required Morton Center appointments for individual therapy;
        - The licensee has become past due on owed administrative fees; and
        - The licensee has had more than one dilute test result, despite requests that she avoid excessive water intake on days she is chosen for testing.

Pursuant to the Agreed Order, KBML Case No. 1436, the licensee was required to maintain a contractual relationship with the Foundation and fully comply with all conditions of that contractual relationship, including that she completely abstain from

the consumption of mood-altering substances, including alcohol; that she be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis; and that she pay a fine in the amount of $1,000.00. On or about October 24, 2017, the Agreed Order, KBML Case No. 1436 expired.

5. In or around April 2020, the Cabinet for Health and Family Services, Office of Inspector General ("OIG"), received an anonymous complaint relaying concerns regarding the licensee's prescribing of controlled substances. According to OIG, the caller advised that the licensee may be prescribing controlled substances in quantities and combinations which may not be appropriate.

6. On or around July 6, 2021, OIG Investigator, Paula York, R. Ph., completed a review and analysis of the licensee's KASPER records (for the period of April 3, 2020 through April 3, 2021) and noted several patterns of concern, including:

   - Long-term use of one or more controlled substances;
   - Combinations of controlled substances favored by persons who abuse or divert controlled substances; and
   - Patients traveling long distances to obtain medications

   Ms. York identified sixteen (16) patients illustrative of these concerns and recommended further review to determine if the licensee provided appropriate medical care. Ms. York also stated that although the licensee had requested approximately 133 KASPER reports on patients during the reviewed period, she was not in compliance with 201 KAR 9:260 KASPER requirements relative to fourteen (14) of the identified patients.

7. A KASPER Prescriber Report Card on the licensee for the Annual 2020 period showed that 96.77% of her patients filled a prescription for opioid analgesics from her; 19 out of 31 total patients filled three days or more of overlapping opioid prescriptions from all prescribers; two of her patients filled overlapping opioid and

benzodiazepine/sedative prescriptions from all prescribers; and that she far exceeded opioid prescribing averages of peers within her specialty and overall statewide.

8. Although the majority of patients received controlled substances for the treatment of pain, the licensee's practice is not a registered pain management facility and the licensee is not qualified to be an owner or owner designee of a pain management facility as required by KRS 218A.175 and 201 KAR 9:250.

9. During the course of the Board's investigation, it was learned that, in or around February 2019, pharmacists in the Lexington area had been approached and interviewed by the U.S. Drug Enforcement Administration ("DEA") in regard to prescriptions written by the licensee.

10. On or about February 22, 2019, pharmacists at C & C Pharmacy, 3122 Mapleleaf Drive, Lexington, Kentucky relayed to the DEA that:

- The licensee had written several prescriptions to patients in which she had annotated notes on their prescriptions telling the pharmacy to fill prescriptions early due to the patients travelling for work and also made notations directing patients to take an extra half pill daily for pain;
- The licensee had written Patient MS these notes on his prescriptions so often, which were about 9 days early on the fills that he had almost gotten a full extra prescription fill because of this and the pharmacists had cautioned him to schedule his appointments with the licensee every 28 days rather than 24 days to avoid this problem;
- There were red flags with the licensee because the patients indicated that they paid cash for their visits to the licensee, but had Medicaid pay for their prescriptions;
- The licensee had called and was angry when a particular patient was refused an early refill for a Hydrocodone prescription and then went to CVS and was also refused after they had consulted with C & C pharmacists about why they hadn't filled the prescription. The licensee asked C & C Pharmacy to fill the prescription because she was changing the patient from Hydrocodone to Percocet in order to get the prescription filled that day; and
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- When a patient who had never filled a prescription at CVS Pharmacy presented a prescription from the licensee, the pharmacist called C & C Pharmacy to inquire why the prescription had not been filled there and was told that the patient was trying to fill it too early;
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12. On or about May 13, 2021, the Board's Medical Investigator, Billy Madden, visited the licensee's practice address, 2109 Eastway Drive, Lexington, Kentucky, and noted that was no signage at the location; it appeared that the licensee was living at the practice location; inside there was very little medical equipment, there being a stethoscope and a set of scales lying on a desk and scattered medical files. When Mr. Madden served a subpoena for medical records on the sixteen (16) patients identified by Ms. York, OIG, the licensee was unable to produce the medical records, stating that they were just moving into the location and most of the records were in storage.

13. Approximately three (3) weeks after Mr. Madden's visit, the licensee sent Mr. Madden the medical records and a written "response" in which she stated, in part,

> ... I follow the guidelines as outlined by the state of Kentucky. I go above and beyond that by only writing prescriptions in two week increments, which was very labor intensive prior to electronic prescribing. Many of my patients are over age 40 and work full time. They work in physically demanding jobs and most admit they would be unable to care for themselves or their families if unable to control the painful conditions for which they have been treated for one or more decades.
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care of this practice prior to my arrival. Most were Lexingtonians initially and it seems unreasonable to discharge an established and stable patient based upon change of address.

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> … There is a disturbing pattern that emerges after reviewing these charts. Most of these patients traveled long distances for their medications. They had already exhausted other options, including in most cases, board certified pain management experts before they started seeing Dr. Smith. The history taking and physical examinations were inadequate in several cases. In several patients no imaging studies were obtained to either diagnose or to monitor their disease processes. Additionally, they were not referred to other specialties who could have helped appropriately diagnose, alleviate or resolve their problems. Strikingly, most patients had back pain with little or no imaging studies over several years to accurately diagnose their conditions. They were not under the care of a spine surgeon, physical therapist or orthopedic surgeons.
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> Dr. Smith does constitute a danger to the health and welfare of these patients and the general public. High quantities of schedule 2 drugs were prescribed indiscriminately with poor or no monitoring. These drugs are highly addictive and are apt to create dependence. They are also very likely to be distributed/sold and abused. These drugs individually, and moreover on a cocktail form, can very easily lead to overdoses and death.
> …

The Board Consultant's report, including review worksheets, is adopted and incorporated herewith in its entirety by reference.

15. Attempts to locate the licensee for a response to the Board consultant's report were unsuccessful.

16. On or about November 15, 2021, the licensee's practice address at 2109 Eastway Drive, Lexington, Kentucky, appeared to be unoccupied.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available, the Chair of Inquiry Panel A finds there is probable cause to support the following Conclusions of Law, which serve as the legal bases for this Emergency Order of Restriction:

1. The licensee's Kentucky medical license is subject to regulation and discipline by this Board.

2. KRS 311.592(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician's license at any time an inquiry panel has probable cause to believe that a physician's practice constitutes a danger to the health, welfare and safety of patients or the general public.

3. There is probable cause to believe that the licensee has violated KRS 311.595(9), as illustrated by KRS 311.597(4), and KRS 311.595(12).

4. 201 KAR 9:240 §1 provides,

> (1) An inquiry panel or the panel's chair, acting on behalf of the inquiry panel, may issue an emergency order restricting or suspending a physician's license to practice medicine or osteopathy within the Commonwealth of Kentucky in accordance with KRS 311.592 and 13B.125.
> (2) ...
> (3) (a) An inquiry panel's chair may act on behalf of the inquiry panel and issue an emergency order restricting or suspending a physician's license to practice medicine or osteopathy within the Commonwealth of Kentucky if the panel chair determines that a basis for an emergency order as established in subsection (1) of

this section exists and the circumstances of the specific case warrant emergency action prior to the next regularly scheduled meeting of the inquiry panel.

5. The Inquiry Panel Chair concludes there is probable cause to believe this licensee's practice constitutes a danger to the health, welfare and safety of her patients or the general public.

6. The Board may draw logical and reasonable inferences about a licensee's practice by considering certain facts about a licensee's practice. If there is proof that a licensee has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the licensee will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a licensee's practice presents representative proof of the nature of that licensee's practice in general. Accordingly, probable cause to believe that the licensee has committed certain violations in the recent past presents probable cause to believe that the licensee will commit similar violations in the near future, during the course of the licensee's osteopathic practice.

7. The United States Supreme Court has ruled that it is no violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and, 2) the statute provides for a prompt post-deprivation hearing. Barry v. Barchi, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); FDIC v. Mallen, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and Gilbert v. Homar, 520 U.S. 924 (1997), 117 S.Ct. 1807 (1997). Cf. KRS 13B.125(1).

KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by

the licensee. The licensee has been advised of her right to a prompt post-deprivation hearing under this statute.

EMERGENCY ORDER OF RESTRICTION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Chair of Inquiry Panel A hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by Carolyn V. Smith., is RESTRICTED and Dr. Smith is prohibited from prescribing, administering, dispensing, or otherwise professionally utilizing any and all controlled substances, until resolution of the Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

The Chair of Inquiry Panel A further declares that this is an EMERGENCY ORDER, effective upon receipt by the licensee.

SO ORDERED this 17th day of November, 2021.

W. Saleem

WAQAR A. SALEEM, M.D.
CHAIR, INQUIRY PANEL A

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Restriction was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and copies were mailed via certified mail return-receipt requested to the licensee, Carolyn V. Smith, M.D., License No. 31089, 2109 Eastway Drive, Lexington, Kentucky 40502, and 2100 Liberty Road, Lexington, Kentucky 40509, and also via electronic mail to compmedlex@gmail.com on this 17th day of November, 2021.

Leanne K. Diakov

Leanne K. Diakov
General Counsel
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