

State of Rhode Island  
Department of Health  
Board of Medical Licensure and Discipline



**IN THE MATTER OF:  
Bassam Khabbaz, MD  
License No.: MD 10573  
Case No.: C200416C**

**CONSENT ORDER**

Bassam Khabbaz, MD (“Respondent”) is licensed as a physician in Rhode Island. The Rhode Island Board of Medical Licensure and Discipline (“Board”) makes the following

**FINDINGS OF FACT**

1. Respondent has been a licensed physician in Rhode Island since May 9, 2001. Respondent graduated from the Faculty of Medicine, Damascus University, in 1983.
2. Respondent was the attending physician for Patient A (alias), a resident at Hebert nursing home.
3. The Board received a complaint from the Rhode Island Department of Health (“RIDOH”) Center for Health Facilities Regulations (“CHFR”) regarding Respondent’s care of Patient A, reporting deficiencies in quality of care at the nursing home, including wound care..
4. Respondent submitted a written response to the Board, which the Investigative Committee reviewed, in addition to the relevant medical records. Respondent appeared before the Investigative Committee on August 6, 2020.
5. Patient A had a leg wound that was not clearly documented in the medical record. The Investigative Committee noted that progress notes from Respondent were dated, but not timed,

and included the name of the patient, but no other identifier. Also, the name of the treating physician was not legible. The Investigative Committee noted that the progress notes for each visit were nearly identical, but did not include documentation of relevant medical problems, such as the leg wound and related wound management. At his appearance, Respondent stated that the wound was caused by a leg brace that should have been on for no more than four hours, but was left on overnight. Absent from the medical record was an explanation for the brace being left on so long, or any subsequent action taken by Respondent to advocate for Patient A relative to this error. For example, there was no documentation to the effect that Respondent consulted with nursing on this matter. However, Respondent also stated that once he learned about the leg wound, he spoke to the nurse in charge regarding nursing home staff's failure to follow his order in not timely removing the leg brace. The patient's nursing home record contains an order for a wound consult and multiple entries made by the Nursing Home Administrator herself referencing interventions ordered by Respondent to treat the wound.

6. The investigative committee concluded the leg wound was an important medical problem and should have been documented in the progress note, additionally, there should have been a relevant plan documented for this problem and clinical justification for the course of treatment and referrals. The progress note of February 17<sup>th</sup>, 2020 should have had all of this information clearly documented and it was not done. The Investigative committee concluded Respondent violated the above referenced statute. However, the Committee did not find that the Respondent's medical management of the leg wound was substandard.

7. The Investigative Committee concluded that the leg wound was an important medical problem and should have been documented in a progress note. Additionally, the Investigative Committee concluded that Respondent should have documented a relevant plan for this problem

and clinical justification for the course of treatment and referrals. The progress note for February 17, 2020 should have included all of this information, but did not. During his appearance, however, Respondent advised the Committee (and the nursing home record reflects) that in response to the notification of the leg wound he ordered a consultation with a medical wound specialist and also placed telephone orders including an x-ray of the affected extremity, blood work, and Prevalon boots to be on at all times. Nevertheless, the Investigative Committee concluded that Respondent violated Section 1.5.12(D) of the rules and regulations pertaining to the Licensure and Discipline of Physicians (216-RICR-40-05-1) (“Regulations”), on “*Medical Records*,” which provides, “*Medical Records shall be legible and contain the identity of the physician or physician extender and supervising physician by name and professional title who is responsible for rendering, ordering, supervising or billing each diagnostic or treatment procedure. The records must contain sufficient information to justify the course of treatment, including, but not limited to: active problem and medication lists; patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.*”

8. The Investigative Committee determined that by failing to satisfy the requirements of Section 1.5.12(D) of the Regulations, Respondent failed to meet the standard of care and that, therefore, Respondent violated R.I. Gen. Laws § 5-37-5.1(19), which defines “unprofessional conduct” as including, “[i]ncompetent, negligent, or willful misconduct in the practice of medicine, which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board,” and R.I. Gen. Laws § 5-37-5.1(24), which defines “unprofessional conduct” as including, “[v]iolating any provision or

*provisions of [R.I. Gen. Laws § 5-37] or the rules and regulations of the board or any rules or regulations promulgated by the director or of an action, stipulation, or agreement of the board.”*

**Based on the foregoing, the parties agree as follows:**

1. Respondent admits to and agrees to remain under the jurisdiction of the Board.
2. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board and is not binding on Respondent until final ratification by the Board.
3. If ratified by the Board, Respondent hereby acknowledges and waives:
  - a. The right to appear personally or by counsel or both before the Board;
  - b. The right to produce witnesses and evidence on his behalf at a hearing;
  - c. The right to cross examine witnesses;
  - d. The right to have subpoenas issued by the Board;
  - e. The right to further procedural steps except for those specifically contained herein;
  - f. Any and all rights of appeal of this Consent Order;
  - g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review; and
  - h. Any objection to the fact that this Consent Order will be reported to the National Practitioner Data Bank and Federation of State Medical Boards and posted to the RIDOH public website.
4. Respondent agrees to pay, within 60 days of the ratification of this Consent Order, an administrative fee of \$1100.00 for costs associated with investigating the above-referenced complaint. Such payment shall be made by certified check, made payable to “**Rhode Island General Treasurer,**” and sent to Rhode Island Department of Health, 3 Capitol Hill, Room 205, Providence, RI 02908, Attn: Lauren Lasso. Respondent will send notice of compliance with this

condition to [DOH.PRCCompliance@health.ri.gov](mailto:DOH.PRCCompliance@health.ri.gov) within 30 days of submitting the above-referenced payment.

5. Respondent hereby agrees to this reprimand on his physician license.

6. Within six months of ratification of this Consent Order, Respondent shall, at his own expense, successfully complete the Case Western Reserve University Intensive Course in Medical Documentation: Clinical, Legal and Economic Implications for Healthcare Providers, or other course, including an online course, of equivalent value acceptable to the Board. Respondent will send notice of compliance with this condition to [DOH.PRCCompliance@health.ri.gov](mailto:DOH.PRCCompliance@health.ri.gov) within 30 days of completing this course.

7. If Respondent violates any term of this Consent Order after it is signed and accepted, the Director of RIDOH ("Director") shall have the discretion to impose further disciplinary action, including immediate suspension of Respondent's medical license. If the Director imposes further disciplinary action, Respondent shall be given notice and shall 20 days from the suspension and/or further discipline to request an administrative hearing. The Director shall also have the discretion to request an administrative hearing after notice to Respondent of a violation of any term of this Consent Order. The Administrative Hearing Officer may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensing period if the alleged violation is proven by a preponderance of evidence.

Signed this 21 day of October, 2020.

  
Bassam Khabbaz, MD

Ratified by the Board of Medical Licensure and Discipline on the 14<sup>th</sup> day of October, 2020.



Nicole Alexander-Scott, MD, MPH  
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