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

IN THE MATTER OF:
William J. Beliveau, MD
License No.: MD 06932
Case No.: C190276

CONSENT ORDER

William Beliveau, 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 the State of Rhode Island since August 20, 1986 and has never been disciplined by the Board. Respondent is Board certified in internal, pulmonary, critical care and hospital medicine.

2. Respondent was the Medical Director and attending physician for Patient 1, a patient at Briarcliffe Manor ("Briarcliffe"), which is a health-care facility licensed by the Rhode Island Department of Health ("RIDOH").

3. The Board received a complaint from the Center for Health Facilities Regulation ("CHFR") alleging that Respondent had produced an illegible medical record for Patient 1. CHFR was investigating the unanticipated death of Patient 1, a 90-year old female. Because the medical record at issue was illegible, CHFR claims it was unable to complete its investigation. The medical record at issue was made at the time of Patient 1's admission to Briarcliffe on December 6, 2018. Patient 1 was thereafter discharged from Briarcliffe on January 26, 2019. Patient 1 was re-admitted

to Briarcliffe on January 31, 2019 and died on February 28, 2019 at which time CHFR conducted an investigation regarding the death of Patient 1 who was found dead on the floor next to her bed at a time when Respondent was not at the facility.

4. Respondent's medical record for Patient 1 includes an admitting history and physical that is undated. It contains Patient 1's name and room number and no other identifier. The Chief Complaint section of the medical record is blank. There are two lines of illegible information for the Present Illness. There are illegible entries for Past History and Family History. The Physical Exam section contains no vital signs and what little is documented is illegible. There is no diagnosis or assessment and the Plan is illegible. A progress note dated January 19, 2019 contains the patient's name and room number and no other identifier. The progress note is brief and illegible. There is no evidence of medical decision making regarding this patient, no documentation of a treatment plan, no assessment, no list of medications, and no evidence of medication reconciliation. There was also no legible signature or printed name of the attending physician. The medical record at issue, in itself, did not justify the course of treatment. The records of Patient 1 upon admission to Briarcliffe on December 6, 2018 do contain legible and detailed documents from Miriam Hospital which discharged Patient 1 to Briarcliffe including, without limitation, Discharge Summary, Continuity of Care – Post Acute Facility, H&P and a Baseline Care Plan completed by Briarcliffe, all of which include detailed information including history & physical, vital signs, listing of medications and care plans for Patient 1. At the time the medical records for Patient 1 were written, Respondent had ulnar radiculopathy and there was no electronic medical record capability for physician document at Briarcliffe.

5. The Investigative Committee obtained and reviewed other medical records for Patient 1 from other licensed health care providers, which records indicate that Patient 1 was a 90-year-old

female with several chronic medical conditions, including acute respiratory failure, pneumonia, congestive heart failure, atrial fibrillation, chronic kidney disease, gout, hypertension, gastroesophageal reflux disease, hypothyroidism, thrombocytopenia, depression and other important health conditions.

6. The Investigative Committee concluded that the standard of care includes a comprehensive assessment of each patient's medical problems and a thoughtful treatment plan to address each problem, and, therefore, the care given to Patient 1 was below the minimum standard of care.

7. Based on the foregoing, the Investigative Committee concluded that 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 the Rules and Regulations for the Licensure and Discipline of Physicians (216-RICR-40-05-1.5.12(D)), relative to "Medical Records," which provide, "*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 mediation lists; patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.*"

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. This Consent Order is neither an admission of liability by Respondent nor a concession by the Board that its claims are not well founded.

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 5 days of the ratification of this Consent Order, an administrative fee of $1057.00 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.PRCompliance@health.ri.gov within 30 days of submitting the above-referenced payment.

5. Respondent acknowledges that an illegible record was created and, accordingly, agrees to this reprimand on his physician license.

6. Within six months of ratification of this Consent Order, Respondent will complete a Board approved course in medical records, such as but not limited to the Case Western Reserve University Intensive Course in Medical Documentation or other online medical documentation course. Respondent will send notice of compliance with this condition to DOH.PRCompliance@health.ri.gov within 30 days of completing the 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 such action is warranted pursuant to Rhode Island General Laws § 15-37-8. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request an administrative hearing within 20 days of the suspension and/or further discipline. 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 Board 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 5 day of February, 2020.

William Beliveau MD

William Beliveau, MD

Ratified by the Board of Medical Licensure and Discipline on the 12th day of February, 2020.

Nicole Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health
3 Capitol Hill, Room 401
Providence, RI 02908

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