

**BEFORE THE IOWA BOARD OF PODIATRY**

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**IN THE MATTER OF THE  
EMERGENCY ADJUDICATIVE ORDER  
AND STATEMENT OF CHARGES  
FILED AGAINST:**

**DIA NO. 11IBP002  
CASE NO. 10-012**

**JOHN REDENIUS, DPM**

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW,  
DECISION AND ORDER**

**Respondent**

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On February 10, 2011, the Iowa Board of Podiatry (Board) found probable cause to file a Notice of Hearing and Statement of Charges against John Redenius, DPM (Respondent) charging him with the following four counts:

Count I: Failure to conform to the minimal standard of acceptable and prevailing practice of a podiatrist in this state, in violation of Iowa Code section 272C.10(2) and 645 IAC 224.2(2)(d).

Count II: Violation of a regulation or law of this state, another state, or the United States, which relates to the practice of the profession, in violation of Iowa Code section 272C.10 and 645 IAC 224.2(13).

Count III: Betrayal of a professional confidence, in violation of Iowa Code section 272C.10 and 645 IAC 224.2(29)(c).

Count IV: Failure to comply with the terms of a board order, in violation of Iowa Code section 272C.10 and 645 IAC 242.2(20).

The Board also filed an Emergency Adjudicative Order, pursuant to its authority under Iowa Code section 17A.18A and 645 IAC 11.28. The Emergency Adjudicative Order immediately suspended Respondent's license until such time as he could affirmatively demonstrate an ability to maintain a safe and sanitary treatment environment.

A hearing was held on October 14, 2011 in the Lucas State Office Building, fifth floor conference room in Des Moines, Iowa. The state was represented by Assistant Attorney General September Lau. Respondent was represented by

attorney Gregory Witke. The following Board members presided at the hearing: Eric Barp, DPM, Chairperson; Denise Mandi, DPM; Kelly Kadel, DPM; Gregory Lantz, DPM; John Bennett, DPM; Gerald Edgar and Bridget Maher, public members. Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing. The hearing was closed to the public at Respondent's request, pursuant to Iowa Code section 272C.6(1)(2011), and was recorded by a certified court reporter.

After hearing all the evidence and examining the exhibits, the Board convened in closed session, pursuant to Iowa Code section 21.5(1)(f)(2011), to deliberate its decision. The administrative law judge was instructed to prepare the Board's written decision, in accordance with its deliberations.

### **THE RECORD**

The record includes the Notice of Hearing and Statement of Charges; the Emergency Adjudicative Order; State Exhibits 1-8 (see Exhibit Index for description) Respondent Exhibits A-C (see Exhibit Index for description). The record also included the testimony of DIA Investigator Kimberly Groves and Respondent John Redenius, DPM. Respondent also submitted an Application for Reinstatement, and the state submitted a draft order rescinding the emergency order.

### **FINDINGS OF FACT**

1. Respondent is a 1973 graduate of the Illinois College of Podiatric Medicine. Following graduation, Respondent practiced podiatry in Philadelphia, Pennsylvania for five years. In 1979, Respondent returned to Iowa in order to provide care for his elderly parents.

In 1980, Respondent opened Black Hawk Podiatry at 123 Plaza Circle in Waterloo, Iowa. Respondent owns the building where his practice is located. The Waterloo office has approximately 1000 square feet and includes an examination/ treatment room, waiting room, private office, two bathrooms, and a hallway. The office also has additional examination rooms and a surgery room. Respondent currently uses these rooms to store records, unused equipment, supplies, and other personal items. Respondent generally sees patients at his Waterloo office two days a week. (Testimony of Respondent)

Respondent opened a second podiatry office in Iowa Falls, Iowa in 1981. Respondent has always rented his office space in Iowa Falls. Respondent has been at his current location (210 Main Street) in Iowa Falls for five or six years. This office is approximately 200 square feet and consists of a small waiting room, treatment room, and bathroom. Respondent generally sees patients at the Iowa Falls office one day a week. (Testimony of Respondent)

Respondent has a general podiatry practice. He performs no surgeries. He estimates that he treats 10-12 patients a week in his office practice. Respondent works alone and has no employees or assistants. In addition to his office practice, Respondent treats patients at several nursing homes and also makes approximately ten house calls a month. (Testimony of Respondent)

2. On March 16, 2011, DIA Investigator Kimberly Groves made an unannounced visit to Respondent's Waterloo office. Ms. Groves was assigned to investigate a complaint made by a member of the public about the condition of Respondent's office. During her inspection, Ms. Groves made the following pertinent observations:

- Throughout the office there were several missing, hanging, and yellow or brown stained ceiling tiles in the dropped ceiling. Some of the tiles had areas of black within the stains. Respondent told Ms. Groves that the building's flat roof leaked every spring. In the hallway leading to the exam rooms, there was a large plastic garbage container partially filled with water and floating debris. Respondent indicated that the garbage can was there because of the leaking roof. In the unused surgery room, there was a basketball sized hole above the ceiling tiles. The floors, walls, and a table were all heavily spackled with a black substance, which Respondent identified as tar used to fix the ceiling. There was a foul odor in the room, which Respondent thought might be from the tar.
- The reception desk in the waiting room was piled high and cluttered with magazines, paperwork, boxes, mail, etc. Only a small area of the desk top was visible. The floor area behind the desk was also cluttered.
- In exam room #1, the yellow exam chair head rest was brown and light black in appearance. An exam paper roll behind the head rest was barely visible, and the paper was dusty and yellowed. Respondent started cleaning the exam chair with wipes while he spoke to Ms. Groves. Although Respondent told Ms. Groves that he had not treated any

patients prior to her arrival that day, the metal tray at the end of the exam chair contained nail clippings, debris, and dust.

- When asked about his cleaning supplies, Respondent pointed to a box of Goldicide Plus packets, which had expired in September 2003. When asked where he kept his sanitized supplies, Respondent pointed to a metal sterilizing container where instruments like scissors, nippers, curettes, pliers, etc. were submersed in liquid containing floating debris. Several of the soaking supplies were extremely rusty.
- The floor was littered with nail clippings, dust, and debris. There was garbage on top of the garbage lid. The closed drawers in the exam room were cluttered with numerous podiatry supplies that were mixed with used, unclean and outdated items. The bottoms of the drawers were dirty. Ms. Groves found several small bottles of Marcaine that expired in 1988, several small vials of Xylocaine that expired in 2004, and a tube of ointment (name illegible) that expired in 1977.
- The glass cabinet in exam room #1 was cluttered with a number of supplies, medicine bottles (empty, full, labeled, and unlabeled), cans of household oil, etc. The shelves were extremely dusty.
- The counter next to the sink was extremely cluttered with supplies and bottles and its surface was barely visible. On the counter was an expired medicine (Isordil Titrados) and a bottle of peroxide that expired in 2001. There was a bur holder containing bits and discs that were dusty and appeared used. When the investigator asked Respondent where he kept his new and/or cleaned bits, discs, and sandpaper bands, he replied that they were "around here someplace."
- The window blinds were coated with dust, and there were cobwebs hanging from the ceiling and the blinds.
- One of the restroom faucets was missing and the room had an odor. The restroom had cobwebs hanging from the light fixture and the ceiling.
- The investigator observed two smoke detectors. One had an empty battery compartment and the other did not respond when the test button was pressed. The fire extinguisher on the wall had a tag dated 2004/2005. Respondent had two boxed fire extinguishers with Menards receipts taped to them. Respondent reported that he had recently been visited by the Waterloo fire inspector and was required to purchase new fire extinguishers before the fire inspector returned.
- Respondent had a disheveled appearance. When he treated a patient during the investigator's visit he wore a white lab coat that was heavily stained.

- There was a small bulletin board hanging near the reception desk that was visible to patients standing at the desk. Several stapled pages were hanging on the bulletin board. The top page was entitled “Names of debtors 06-11-2007” and listed the names of several patients, some of which were highlighted. There was also partial documentation of a patient’s red health insurance claim pinned to the bulletin board.
- Respondent told the investigator that he had a cleaning lady who had cleaned his office approximately ten days earlier. He had worked in the office about four times since it was last cleaned, and he did not have a regular cleaning schedule.
- The office was extremely cluttered with boxes, collectibles, antiques, plants, paperwork, books, magazines, etc. The items were stacked high and lined the hallways, the closet, two exam rooms, the desk area, and Respondent’s personal office.

When Ms. Groves told Respondent that she was extremely concerned about the condition of his office, he asked her why she was concerned. He asked her if he should have the ceiling tiles fixed and asked her to write down her concerns for him.

Ms. Groves also spoke to the fire inspector from Waterloo Fire and Rescue. The fire inspector explained that fire extinguishers must have tags or receipts indicating their inspection, servicing, and/or purchase date. The fire inspector reported his concerns that Respondent was hoarding and also reported that Respondent stored guns in his office. (Testimony of Kimberly Groves; State Exhibit 8)

3. On March 22, 2011, DIA Investigators Kimberly Groves and Tamara Adams made an unannounced visit to Respondent’s podiatry office in Iowa Falls at the Board’s request. Respondent told the investigators that he had treated four patients prior to their arrival. During their inspection of the office, the investigators observed the following:

- The closed supply drawers all contained items that could not be sanitized (pens, calculator, nameplate, etc.) along with podiatry supplies (unwrapped toe cushions, demonstration socks, unwrapped gauze, etc.) There were individually wrapped stainless steel and carbon steel blades inside the drawers that had expired in 1989 and 2006.

- Respondent reported that his clean supplies were soaking in the cold sterilizer. The pink liquid in the sterilizer was clear but the instruments in it were quite rusty. Respondent showed the investigators a clear unlabeled gallon jug containing his sterilizing liquid. The investigators observed unlabeled bottles on top of the supply cabinet. There was also a bottle of Lumicaine topical that expired in 1998.
- The metal tray at the foot of the exam chair was covered in yellow exam paper. The paper was covered with dust and nail clippings. The exam paper roll behind the head rest was not visible, and the paper was yellow and dusty. The metal exam light above the chair was coated with dust.
- The waiting area did not have a reception desk. There was a small desk to the side of the exam chair in the treatment room. The desk was cluttered with paperwork and magazines. Paperwork with patient signatures and one patient's home address were visible on the desk. One patient's file was open and visible. Respondent reported that he had been reviewing the file before treating the patient that day.
- Some areas of the office, including floorboards, walls, carpeting, ceiling tiles, and the bottom of a door had "water-like" stains. One area of the wall had black spots within the stain. The walls and corners of the floor had cobwebs. The corners of the carpeted floor were laden with debris such as nail clippings and dust.
- The restroom floor, sink, and toilet were unclean. Respondent reported that he only works at this location on Tuesdays, and the restroom was cleaned approximately a week to ten days earlier. There was an undated fire extinguisher in the restroom.

(Testimony of Kimberly Groves; State Exhibit 8)

4. Respondent told the DIA investigators that he had been cleaning his Waterloo office since Ms. Grove's visit. Respondent reported that he had: discarded all expired supplies, replaced the bathroom faucet, replaced the battery in the fire detector, cleaned up some of the tar, and planned to have the ceiling tiles fixed. He asked the investigators to make another visit to his Waterloo office to see the progress he made.

On March 23, 2011, DIA Investigators Kimberly Groves and Tamara Adams made an unannounced return visit to Respondent's Waterloo office. They observed the following:

- The missing and stained ceiling tiles had not been replaced. Respondent told them that he planned to hire a handyman who he had used before to do this type of work. Respondent intended to buy “special white paint” to paint the ceiling tiles. The investigator expressed concern about painting tiles that might have mold or mildew.
- The investigator touched one of the stained ceiling tiles in exam room #2 and it was wet and spongy to the touch. Respondent told the investigator that he did not have the \$12,000 that it would cost to replace his roof. In the past, he and the handyman had patched the flat roof of the building with tar. There had been a lot of rain the previous evening and the roof had leaked again. There was a garbage container in the hallway that was being used to catch the water leaking from the ceiling.
- Some of the black tar had been removed from the surgery room. There was still a basketball sized hole in the ceiling and the room still had an odor.
- The reception desk and the area around it was less cluttered.
- In exam room #1, the yellow exam chair still appeared to have brown areas within the surface. The investigator suggested that Respondent should cover the chair with new exam paper when seeing patients. The exam light was coated with dust. There were several new bottles of disinfectant in the room. The cold sterilization tray contained rusty instruments that were soaking. Respondent told the investigator that he still used these instruments because they were very expensive but planned to buff off the rust. The metal tray at the end of the exam table was clean and the floor had been swept. The drawers, cabinet, and counter appeared somewhat organized. However, the plastic supply tray was still stained and dirty. New supplies were still mixed with old supplies in the drawers.
- The glass cabinet in the exam room was more organized but the shelves were still coated with dust. There were unlabeled plastic bottles and Respondent could not recall what they contained. One of the bottles was labeled “navel jelly” and Respondent reported that he used it for ultrasound. There were a number of expired items in the cabinet, including a bottle of Phenobarbital that expired in 1977, a bottle of Atarax syrup that expired in 1980, and a spray bottle of TBC that expired in 1981.
- The counter in exam room #1 was more visible and had two biohazard containers. One of the containers was nearly full of sharps. Respondent told the investigator that when the container is full he buries the sharps

at his farm. When Respondent realized that the investigator was writing down his response, he told her "I suppose a company does it."

- Some of the cobwebs and some of the dust had been removed. The other exam rooms were just as cluttered as the previous visit.
- The patient restroom had a new faucet and had been cleaned. The plumber had worked on the plumbing so it was not constantly running.
- The fire extinguisher with the 2004/2005 inspection tag was still hanging on the wall. When asked why he kept it, Respondent explained that it still worked, had not been used, and it was expensive to replace it every year. Respondent had two fire extinguishers still in their boxes. One had a purchase receipt in 2009, the other was purchased on 02-26-2011.
- Respondent had five guns on a wooden bench in his personal office and a small pistol behind the reception desk. He had six empty gun clips and 50 rounds of ammunition. Respondent told the investigators that the antique gun had belonged to his mother, and he enjoys attending gun shows. Respondent could not explain why he kept the guns in his office instead of at home.
- Respondent had not treated any patients that day. The lab coat that he identified as the one he would wear if he did treat a patient was extremely yellowed and stained.
- The bulletin boards still had patient information posted on them.
- The hallways still had items piled high and lining the walls. Respondent told the investigators that some of the items were antiques. The closed closet was stacked high with supplies.
- In Respondent's personal office, several ceiling tiles were missing and several were hanging from the grid. The drywall above the tiles appeared heavily stained with areas of black, brown, and yellow.

On March 31, 2011, Kimberly Groves completed a written Investigative Report detailing the findings from her three visits to Respondent's offices. (Testimony of Kimberly Groves; State Exhibit 8)

5. On June 7, 2011, the Board found probable cause to order Respondent to undergo a comprehensive mental health evaluation to address his competency, his ability to make prudent judgments in decision making, and his ability to practice with reasonable skill and safety related to his mental faculties. The Order required Respondent to complete the evaluation within 60 days. (Exhibit 5)

Respondent did not complete the mental health evaluation within 60 days. Respondent acknowledged receiving the Board's Order for Evaluation by certified mail but did not open the envelope containing the Order until after the Board suspended his license. (Testimony of Respondent)

6. On September 30, 2011, the Board issued its Emergency Adjudicative Order and Notice of Hearing and Statement of Charges to Respondent. Respondent's license to practice podiatry was immediately suspended, pending a hearing before the Board. (Exhibits 4, 5)

7. Respondent reported for the required mental health evaluation in Minneapolis on October 8, 2011. The evaluator issued a written report dated October 9, 2011. (Exhibit 7) The evaluator did not find any evidence that Respondent has a psychiatric disorder and did not believe that Respondent has any mental health condition requiring treatment or rehabilitation. The evaluator believed that the condition of Respondent's office was chronic, rather than the result of a recent breakdown. Other than "longstanding bad habits," the evaluator saw no obstacle to Respondent cleaning up his office and practice. The evaluator questioned whether lack of resources may play a role in Respondent's situation. The evaluator recommended that Respondent develop a clear list of expectations and obtain any help necessary to maintain his office in an appropriate fashion, with follow-up inspections by the Board. (Exhibit 7)

8. At hearing on October 14, 2011, Respondent presented a video depicting the current condition of both his Waterloo podiatry office and his Iowa Falls podiatry office. Based on the video, the condition of both offices appears to have improved significantly.

- Respondent testified that his handyman found and sealed the leak in the flat roof of his Waterloo office. The handyman also replaced the falling and stained ceiling tiles. The handyman told Respondent that he did not see any mold when he fixed the roof and repaired the ceiling.
- Respondent hired two cleaning women to help him clean both offices. The cleaning women will continue to clean the offices every 7-10 days. Respondent plans to do the daily cleaning of the offices. Respondent, his handyman, and the cleaning women threw out all of the outdated supplies, medications, magazines, and journals in both offices.
- Respondent and the cleaning women have cleaned the furniture and carpets and have painted the walls in both offices.

- Respondent has removed all of the guns and ammunition from his Waterloo office.
- Respondent has placed all sterile items in one cabinet.
- Respondent has installed two smoke detectors in the Waterloo office and has operational fire extinguishers in both offices.
- Respondent has removed the lists of patients from the bulletin board. He still has a patient sign in sheet, but it is folded over after each patient so that patients cannot see the names of other patients.

The video submitted by Respondent does show significant improvements in the physical condition of the two offices. The video raises some additional patient privacy concerns because the door to the treatment room at the Iowa Falls office has windows. (Testimony of Respondent; Respondent Exhibit C)

9. Respondent also submitted a copy of the Waterloo Fire and Rescue re-inspection report. Respondent's Waterloo office passed its re-inspection on May 4, 2011. (Exhibit B). Respondent also provided the receipt for the purchase of a new fire extinguisher. (Exhibit A; Testimony of Respondent)

10. Respondent has never received a patient complaint concerning the treatment he has provided. Respondent does not know of any patients that have developed complications or infections due to the unsanitary or cluttered conditions in his offices. Respondent does not administer narcotics and does not keep medication samples in his office. (Testimony of Respondent)

## CONCLUSIONS OF LAW

### *I. Emergency Adjudicative Order*

Pursuant to Iowa Code section 17A.18A and 645 IAC 11.28, the Board is authorized to issue an Emergency Adjudicative Order to suspend a license in whole or in part when necessary to prevent or avoid immediate danger to the public health, safety or welfare. The Board issued an Emergency Adjudicative Order suspending Respondent's license on September 30, 2011. The Order provided that the suspension would continue until Respondent could affirmatively demonstrate an ability to maintain a safe and sanitary treatment environment. Following Respondent's presentation at hearing, the state submitted a draft Order Rescinding the Emergency Adjudication for the Board's consideration. The state took the position that the emergency suspension should

be rescinded based on the current condition of Respondent's offices and based on Respondent's compliance with the Evaluation Order. Respondent joined in this request.

After reviewing the evidence, the Board agreed that the Emergency Adjudicative Order could be rescinded. The Board determined that Respondent's podiatry practice no longer posed an immediate danger to the public requiring emergency suspension. The Board further determined that its ongoing concerns about deficiencies in Respondent's practice could be addressed through the provisions of this Decision and Order. The Order Rescinding the Emergency Adjudication was signed and issued by the Board on October 14, 2011.

## *II. Statement of Charges*

### *A. Professional Incompetency-Count I*

Pursuant to Iowa Code section 272C.10(2), the Board is authorized to revoke or suspend a license for professional incompetency. 645 IAC 224.2(2) provides, in relevant part:

**645-224.2(149,272C) Grounds for discipline.** The board may impose any of the disciplinary sanctions provided in rule 645-224.3(147,272C) when the board determines that the licensee is guilty of any of the following acts or offenses:

...

**224.2(2)** Professional incompetency. Professional incompetency includes, but is not limited to:

...

*d.* Failure to conform to the minimal standard of acceptable and prevailing practice of a podiatrist in this state.

The preponderance of the evidence established that Respondent violated Iowa Code section 272C.10(2) and 645 IAC 224.2(2)(d) by failing to maintain his two podiatric offices in a sanitary and safe condition for patients. The testimony and report of Investigator Groves provided overwhelming proof that Respondent's two offices were in a dangerously cluttered and dirty condition. The countertops, window coverings, floors and light fixtures were extremely dusty and dirty. There were nail clippings and other debris on the floor and in the

metal tray at the foot of the exam chair. The exam chair was dirty and stained, and the exam paper used to cover the chair did not appear to be in use.

In addition, Respondent failed to dispose of outdated and expired medications and supplies. Some of the supplies and medications in Respondent's offices were more than 20 years old. Respondent failed to keep sanitary supplies separate from contaminated supplies. The leaking roof and obvious water damage at the Waterloo office presented both a sanitary hazard and a safety hazard for patients. A large garbage pail was being used to collect dripping water in an already narrow hallway to the examination room.

Ms. Groves' own observations and other evidence in this record established that the leaky roof has been a chronic problem. This raises serious concern that there may be mold above the dropped ceiling or elsewhere that needs to be remediated for the protection of patients. Respondent failed to take adequate measures to ensure that there is no mold in the building. There is no evidence that the handyman conducted a thorough examination of the building or that he has any training or expertise in identifying or remediating mold.

Of equal concern is the fact that Respondent appeared surprised that the physical condition of his offices fell far below minimum standards for a safe and sanitary medical office. While Respondent has made sufficient improvements to remove the immediate risk to the public health and safety, further remedial measures are clearly necessary to ensure that all hazardous conditions have been eliminated and that Respondent's offices do not return to their former poor condition.

***B. Violation of Regulation or Law Relating to Practice of the Profession and Betrayal of a Professional Confidence- Counts II and III***

It is a violation for a licensee to violate a regulation or law of this state, another state, or the United States that relates to the practice of the profession. Iowa Code section 272C.10(8); 645 IAC 224.2(13). In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). Federal regulations were adopted to implement the Act. Pursuant to those regulations, health care providers are prohibited from disclosing the protected health information of individuals, included deceased individuals, except as specifically permitted by statute. 45 CFR 164.502.

Respondent posted some of his patient's names on a bulletin board in the reception area of his Waterloo office with the heading "list of debtors." In addition, Respondent failed to protect the privacy of his patients by displaying their names and addresses on a patient sign in sheet on his reception desk. These actions violated 645 IAC 224.2(13) and 45 CFR 164.502 and constituted a betrayal of professional confidence. Finally, Respondent violated federal law when he left patient records on the desk in his Iowa Falls treatment room where they were visible to other patients and visitors.

*C. Failure to Comply With a Board Order-Count IV*

The preponderance of the evidence established that Respondent violated Iowa Code section 272C.10(8) and 645 IAC 224.2(20) when he failed to timely comply with the Board's Order For Evaluation issued on June 7, 2011. The Board's Evaluation Order was served on Respondent by certified mail, but he did not even open the envelope until after the Board took its action to suspend his license. The Order required Respondent to complete the mental health evaluation within 60 days. Respondent did not comply with the Order until October 8, 2011.

The mental health evaluation report dated October 9, 2011 concluded that Respondent does not have a psychiatric disorder or any condition requiring treatment or rehabilitation. Nevertheless, some of the findings in the report do suggest that Respondent has personal issues that may have been a factor in his failure to recognize and address the deteriorating condition of his offices. The Board strongly encourages Respondent to voluntarily obtain counseling from a licensed mental health provider to assist him in addressing these personal issues as well as the "long-standing bad habits" referenced in the evaluation report.

**DECISION AND ORDER**

IT IS THEREFORE ORDERED that Respondent John Redenius, DPM is hereby CITED for his violations under Counts II, III, and IV and WARNED that further violations will result in additional disciplinary action. IT IS FURTHER ORDERED that Respondent shall pay a civil penalty of one thousand dollars (\$1,000) within thirty (30) days of the issuance of this Decision and Order.

IT IS FURTHER ORDERED, that for the violations under Counts I, II, and III, License Number 00322, issued to Respondent John Redenius, DPM, is hereby

placed on PROBATION for a period of five (5) years. IT IS FURTHER ORDERED that Respondent's probation is subject to the following terms and conditions:

1. Within thirty (30) days of the issuance of this Decision and Order, Respondent's Waterloo office shall be thoroughly inspected by a licensed building inspector for the presence of mold or any other environmental hazard. Respondent shall tell the building inspector about the chronic leaking roof and his recent repairs to the ceiling. The building inspector shall provide a written report to the Board with his/her findings and any recommendations to remediate any environmental problems, including mold, in the building. Respondent shall fully comply with any recommendations to remediate mold or any other environmental hazard in his building. Respondent is responsible for all costs of the inspection and any required remediation.

2. Respondent's offices in Waterloo and Iowa Falls will be subject to follow-up investigations, which will be randomly conducted at least twice during the first year of probation and thereafter at least annually.

3. Within sixty (60) days of issuance of this Decision and Order, Respondent must obtain Board approval for a practice monitor and for a written practice monitoring plan. The approved practice monitor must be a licensed podiatrist in the state of Iowa. The approved practice monitor must sign an agreement to provide monitoring services as outlined in this Decision and Order and to provide written quarterly reports to the Board. At a minimum, the practice monitoring plan shall provide that the practice monitor will:

a. During the first year of probation, visit both of Respondent's offices at least *monthly* and review conditions and practices at the offices for cleanliness, absence of clutter or other hazards to patients, sterilization practices, proper handling of medical waste and outdated supplies and medications, and compliance with the Health Insurance Portability and Accountability Act (HIPAA). After the first year of probation has been successfully completed the practice monitor shall visit both offices on a *quarterly* basis.

b. File written quarterly reports with the Board according to a schedule to be outlined in the monitoring plan. Topics to be

addressed by the practice monitor in the quarterly written reports shall include, but not necessarily be limited to: office cleanliness, sterilization practices, handling of medical waste and outdated supplies, and compliance with Health Insurance Portability and Accountability Act (HIPAA). The practice monitor shall immediately report any conditions deemed to be hazardous to patients.

c. Respondent shall be responsible for all costs associated with the practice monitoring plan.

4. During the first year of probation, Respondent shall complete twenty (20) continuing education hours on the topics of sterilization, medical waste, and HIPAA. These twenty hours of continuing education are in addition to the hours required for license renewal.

IT IS FURTHER ORDERED that if Respondent does not fully comply with the requirements of this Decision and Order, the Board may take further disciplinary action against him, as authorized by Iowa Code section 272C.3(2)(a)(2011).

IT IS FURTHER ORDERED, pursuant to Iowa Code section 272C.6, that Respondent shall pay \$75.00 for fees associated with the disciplinary hearing and \$110 for the court reporter fees. The total fees of \$185.00 shall be paid within thirty (30) days of receipt of this decision.

Dated this 1st day of November, 2011.