OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against KOFI EBENEZER SARFO, M.D., Respondent.	**Case No. 12-29257-1**

FILED
AUG 2 2 2012
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee ("IC") of the Nevada State Board of Medical Examiners ("Board"), comprised of, at the time of authorizing the filing of this Complaint, Theodore B. Berndt, M.D., Chairman, Valerie J. Clark, BSN, RHU, LUTCF, Member, and Michael J. Fischer, M.D., Member, by and through its counsel, Bradley O. Van Ry, Esq., Board General Counsel, having a reasonable basis to believe that Kofi Ebenezer Sarfo, M.D., hereinafter referred to as "Respondent," has violated the provisions of Nevada Revised Statutes (NRS) 630 (Medical Practice Act), hereby issues its formal Complaint, stating the IC's charges and allegations, as follows:

1. Respondent is currently licensed in active status (License No. 11205), and has been so licensed since November 3, 2004, by the Board pursuant to the provisions of NRS 630.

2. The true identity of any patients referenced herein has not been disclosed to protect their privacy, but their identities are disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. Patient A was a sixteen (16)-year-old female at the time of the incidents in question. Upon information and belief, Patient A sought medical care and treatment for pain, headache, dizziness and low back pain from September 15, 2008, to August 27, 2010. Respondent

prescribed Lortab and Soma to Patient A with monthly refills without a thorough history of the back pain and without a thorough medical workup for the etiology of the back pain. Subsequently, the Lortab and Soma was repeatedly refilled by Respondent.

4. No documentation exists in the medical record of a thorough medical history and medical work-up of the back pain to determine the etiology and/or rule out other causes. Additionally, no attempt was made to treat the pain in this young patient with anything other than narcotics and muscle relaxers.

5. Lastly, the Electronic Medical Records "EMRs" were not signed by Respondent in a timely manner. The medical records were electronically signed up to nine (9) months after providing the medical care and treatment.

6. Patient B was an eighteen (18)-year-old male at the time of the incidents in question. Upon information and belief, Patient B sought medical care and treatment for shortness of breath, chest discomfort, back pain and headache from September 24, 2009, to January 8, 2010. Respondent prescribed Lortab, and later prescribed Soma, repeated with monthly refills.

7. No documentation exists in the medical record of a thorough medical history and medical work-up of the back pain to determine the etiology and/or rule out other causes. Additionally, no attempt was made to treat the pain in this young patient with anything other than narcotics and muscle relaxers.

8. The medical records also contain identical phrases and templates from visit to visit. On the October, November and December, 2009 records, the same, exact history is listed, "[t]he back pain has been present for 6 days and is currently moderate in intensity."

9. Lastly, the EMRs are not signed by Respondent in a timely manner. Some medical records were signed up to eight (8) months after providing the medical care and treatment, and it appears that most of the EMRs were not electronically signed by Respondent but by others.

10. Patient C was a twenty-five (25)-year-old male at the time of the incidents in question. Upon information and belief, Patient C sought medical care and treatment for chronic low back pain from November 4, 2009, to July 21, 2010. Respondent prescribed Lortab for pain with monthly refills throughout the course and scope of treatment.

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11. No documentation exists in the medical record of a thorough medical history and medical workup of the back pain to determine the etiology and/or rule out other causes. Additionally, no attempt was made to treat the pain in this patient with anything other than narcotics and physical therapy.

12. The medical records also contain identical phrases and templates from visit to visit. On November 4, 2009 and March 22, 2010, the history entries are almost the same, exact entries, "[t]he back pain has been present for 7 [6] weeks and is currently moderate in intensity." On the January 23, 2010 and April 15, 2010 entries, the same history is utilized. The entries include an identical reference to hypertension and low back pain.

13. Lastly, the EMRs were not signed by Respondent in a timely manner. The medical records were signed up to six (6) months after providing the medical care and treatment, and it appears that the records were not electronically signed by Respondent but by others.

14. Patient D was a twenty (20)-year-old female at the time of the incidents in question. Upon information and belief, Patient D sought medical care and treatment for shortness of breath, chest discomfort, back pain, abdominal pain, fatigue and severe weight loss from June 3, 2009, to July 15, 2009. Respondent prescribed numerous laboratory tests, as well as Lortab for pain with monthly refills throughout the course and scope of treatment.

15. No documentation exists in the medical record of a thorough medical history and medical work-up of the back pain to determine the etiology and/or rule out other causes. Additionally, no attempt was made to treat the pain in this patient with anything other than narcotics.

16. The medical records contain identical phrases and templates from visit to visit, as well as inconsistent information. For example, on June 9, 2009 and June 29, 2009, the histories contain the exact, same entries in the third paragraph. On June 29, 2009 and July 29, 2009, the histories contain the exact, same entries in the first paragraph. On September 30, 2009, October 26, 2009 and May 12, 2010, the histories contain the exact, same entries in the third paragraph.

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17. On the first visit with Respondent, Patient D's Progress Note contains a Chief Complaint of Abdominal Pain, but in the second paragraph of the History it states, "She denies abdominal pain."

18. Lastly, the EMRs were not signed by Respondent in a timely manner. The medical records were signed up to eleven (11) months after providing the medical care and treatment, and it appears that the records were not electronically signed by Respondent but by others.

19. Patient E was a forty-three (43)-year-old female at the time of the incidents in question. Upon information and belief, Patient E sought medical care and treatment for hypertension, hyperlipidemia, and shortness of breath, chest discomfort, anxiety, back pain and headache from August 3, 2009, to August, 2010. Respondent prescribed numerous laboratory tests and Lortab for pain with monthly refills.

20. The medical records also contain identical phrases and templates from visit to visit as well as inconsistent information. On several of the EMRs, it is not clear who electronically signed the records, Respondent or someone else. At a minimum, at least five (5) of the medical records were electronically signed up to nine (9) months after providing the medical care and treatment.

21. Patient F was a twenty-nine (29)-year-old female at the time of the incidents in question. Upon information and belief, Patient F sought medical care and treatment for hypertension, hyperlipidemia, and shortness of breath, obesity, back pain, claudication and hyperthyroidism from March 25, 2009, to August, 2010. Respondent prescribed numerous laboratory tests, Lortab and Soma with monthly refills.

22. The medical records contain identical phrases from visit to visit, as well as inconsistent information. Lastly, the EMRs were no electronically signed by Respondent in a timely manner, and it appears that the records were not electronically signed by Respondent but by others.

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Count I

Six Counts

23. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

24. Nevada Administrative Code (NAC) 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

25. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

26. Respondent's care and treatment of Patients A-F as described above shows a failure to use reasonable care, skill, or knowledge ordinarily used under similar circumstances.

27. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

Count II

28. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

29. NRS 630.3062(1) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating discipline against a licensee.

30. Respondent's aforementioned incomplete documentation of patient histories and patient physical examinations constitutes the failure to maintain accurate and/or complete medical records relating to the diagnosis, treatment and care of Patients A-F.

31. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the IC prays:

1. That the Board give Respondent notice of the charges herein against him and notice that he may file an answer to the formal Complaint herein as set forth in NRS 630.339 within twenty (20) days of service of the formal Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine the sanctions it will impose if it determines Respondent violated the Medical Practice Act (NRS Chapter 630);

4. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

5. That the Board take such other and further action as may be just and proper in these premises.

DATED this 22nd day of August, 2012.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Bradley O. Van Ry, Esq.
General Counsel
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Theodore B. Berndt, M.D., hereby deposes and states under penalty of perjury under the laws of the state of Nevada that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the formal Complaint against the Respondent herein; that he has read the foregoing formal Complaint; and that based upon information discovered during the course of the investigation into a complaint against Respondent, he believes the allegations and charges in the foregoing formal Complaint against Respondent are true, accurate and correct.

Dated this 2nd day of August, 2012.

Theodore B. Berndt
THEODORE B. BERNDT, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 22nd day of August 2012, I served a filed copy of the Complaint, Patient Designation & Fingerprint information via USPS e-certified mail return receipt to the following:

Kofi Sarfo, M.D.
2909 W. Charleston Blvd.
Las Vegas, NV 89102

Dated this 22nd day of August 2012.

Angelia L. Donohoe
Legal Assistant

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