OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
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THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against CHRISTINA LYNNE KUSHNIR, M.D., Respondent.	**Case No. 19-32717-1**

COMPLAINT

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this Complaint (Complaint) against Christina Lynne Kushnir, M.D. (Respondent), a licensed physician in Nevada. After investigating this matter, the IC[1] has a reasonable basis to believe that Respondent has violated provisions of Nevada Revised Statutes (NRS) Chapter 630 and the Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act). The IC alleges the following facts:

1. Respondent was licensed by the Board, pursuant to the provisions of the Medical Practice Act, on June 7, 2012, and is currently licensed in active status (License No. 14396).

2. Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

3. On June 1, 2015, Patient A was seen at the Women's Cancer Center of Nevada (WCCN) for a fibroid uterus and pelvic pain. Previously, Patient A had two prior open myomectemies, diabetes, high blood pressure, and obesity and a known history of severe adhesive disease (well-documented within Respondent's notes and Valley Health Systems). Following a discussion of the benefits/risks of surgery, Patient A consented for Respondent to perform an exploratory laparotomy, total abdominal hysterectomy, and bilateral salpingo-oophorectomy. Patient A's incision was closed with a monocryl suture when Respondent was present; however,

[1] At the time filing of the Complaint was approved, the IC was composed of Wayne Hardwick, M.D., Chairman, Mr. M. Neil Duxbury and Aury Nagy, M.D.

when the tape was applied to Patient A's incision, she was not present and did not know how Patient A developed burns. Postoperatively, Patient A developed pneumonia and was placed on antibiotics. Additionally, Patient A's creatinine levels rose and all nephrotoxic agents were discontinued.

4. On June 5, 2015, Respondent ordered a renal ultrasound due to Patient A's elevated serum creatinine levels, conducted Patient A's abdominal exam, and at 7:13 p.m. that evening, Respondent documented such within the hospital entry progress notes. Patient A's preoperative level of creatinine was 89 and, on this date, it reached a high of 1.72.

5. On June 6, 2015, Patient A was discharged following Respondent's renal ultrasound being performed that morning. Results of the aforementioned ultrasound indicated a mild hydronephrosis, and the attending radiologist recommended a CT considered for further evaluation. The medical records do not indicate whether Respondent knew of these results prior to Patient A's discharge.

6. On June 17, 2015, Respondent dictated her surgical report and commented the following: "I perform complicated cancer procedures three days a week. In addition to that I specialize in complicated benign gyn procedures (5/24/15)." Details of this report differ from those recorded by the nursing staff, the treating anesthesiologist and physicians involved in Patient A's postoperative care; specifically, the Respondent's report does not comment on the repair of a small bowel injury nor does it indicate completing a bilateral hypogastric artery ligation – all of which are well-documented in the hospital records. Additionally, Respondent stated that she used monocryl sutures to close Patient A's incision but her operative dictation done on 6/1/2015 states that staples were used to close the incision on Patient A.

7. On June 23, 2015, Respondent's physician assistant examined Patient A, who expressed no complaints. However, Patient A's vital signs indicated HR of 118 and blood pressure of 188/125. Assessment was that Patient A was suffering from gastrointestinal symptoms, with elevated blood pressure and she was advised to go to the emergency room. There was no discussion or medical record annotation of whether the ultrasound results (from the 6/5/2015 order) were reviewed or known by Respondent prior to Patient A's discharge.

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8. On July 3, 2015, Patient A was examined (vaginal cuff evaluation) by Respondent's physician assistant and it was determined that Patient A suffered from gastrointestinal symptoms, with severely elevated blood pressure. Respondent instructed Patient A to get to the emergency room. There was no discussion or medical record annotation of whether the ultrasound results (from the 6/5/2015 order) were reviewed or known by Respondent prior to Patient A's discharge.

9. On July 6, 2015, Patient A was admitted with a complaint of shortness of breath and was diagnosed with pulmonary embolism and started on a heparin treatment. A nephrostomy tube was placed within Patient A due to a recent left ureteral obstruction and nephrosis. Patient A's previous renal ultrasound revealed hydronephrosis.

10. On July 28, 2015, Patient A was readmitted to the hospital for nephrostomy tube placement. A cystoscopy, left retrograde pyelogram, and left antegrade nephrogram and cystogram were performed. From these procedures, it was found that there was a complete obstruction of Patient's A distal ureter. On the antegrade nephrogram, there was complete obstruction at the mid to mid-distal ureter with a significant gap between the two obstructed areas. A wire could not be placed through the areas of obstruction.

11. Previous to the preparation of this Complaint, the Board solicited the services of an independent medical expert (IME) to review Patient A's medical records and the medical care provided to such patient by Respondent. This IME opined that Respondent's medical care of Patient A violated the Medical Practice Act due to her acts and omissions when rendering care to Patient A.

Count I

(Malpractice)

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

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

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14. 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.

15. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A.

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

Count II

(Failure to Maintain Complete Medical Records)

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

18. NRS 630.3062(1)(a) 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.

19. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document her actions when she treated Patient A, whose medical records were not timely, legible, accurate, or complete.

20. 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 her and give her notice that she may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the 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 what sanctions to impose if it finds and concludes that there has been a violation or violations of the Medical Practice Act committed by Respondent;

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

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

DATED this 29th day of March, 2019.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

Robert Kilroy, Esq.
General Counsel
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Wayne Hardwick, 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 foregoing Complaint against the Respondent herein; that he has read the foregoing 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 Complaint against Respondent are true, accurate and correct.

Dated this 29th day of March, 2019.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

Wayne Hardwick

Wayne Hardwick, M.D., Chairman

CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 9th day of April, 2019, I served a filed copy of the formal COMPLAINT, via USPS e-certified, return receipt mail to the following:

Christina Lynne Kushnir, M.D.
3131 La Canada Street, Suite 241
Las Vegas, NV 89117

Dated this 9th day of April, 2019.

Sheri L. Quigley

Sheri L. Quigley, Legal Assistant

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