OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 G725, 669, 2520

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and

Complaint Against

CYNTHIA V. IVEY, CRT,

Respondent.

Case No. 19-30399-1

FILED

JAN 15 2019

NEVADA STATE BOARD OF MEDICAL EXAMINERS

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners ("Board") hereby issues this formal Complaint against Cynthia V. Ivey, CRT (hereinafter referred to as Respondent), a licensed Certified Respiratory Therapist (CRT) in Nevada. After investigating this matter, the IC has a reasonable basis to believe that Respondent has violated provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act).

The IC alleges the following facts:

- 1. Respondent is currently licensed in active status (License No. RC1108). Respondent was issued her license from the Board on April 18, 2005, pursuant to the provisions of NRS Chapter 630.
- 2. Patient A was a 61-year-old female at the time of the events at issue. Her 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 or about November 15, 2014, Patient A, who was in critical condition and recently intubated, was admitted to the Medical Intensive Care Unit (MICU) of Desert Springs

¹ The Investigative Committee of the Nevada State Board of Medical Examiners, at the time the filing of this Complaint was approved, was composed of Rachakonda D. Prabhu, M.D., Ms. Sandy Peltyn and Victor M. Muro, M.D.

Hospital in Las Vegas, Nevada. Patient A was then transported from the MICU to receive a CT scan and back to the MICU on the same day.

- 4. Respondent was the CRT assigned to accompany the patient and provide her respiratory expertise and necessary respiratory equipment to ensure safe transport.
- 5. Another medical provider was also assigned to accompany Patient A and provide medical expertise, monitoring equipment and medications that may have been necessary to ensure a safe transport.
- 6. Upon information and belief, during transport of Patient A back from the CT scan, the supplemental oxygen supply apparently ran out and a manual resuscitation bag was not available to continue necessary ventilation.
- 7. Following these events, Respondent failed to document this information in Patient A's medical records as required by NRS 630.3062(1)(a) at the end of her shift on or about November 15, 2014.
- 8. Upon information and belief, two days later, on or about November 17, 2014, at the request and direction of Respondent, Michelle Clouthier, RRT made an entry into Patient A's medical records, using Respondent's electronic signature (logon ID and password), which Respondent provided to Ms. Clouthier.
- 9. Upon information and belief, Respondent made that request to Ms. Clouthier via text message to Ms. Clouthier that stated, "Pt. in MICU 10 add note for yesterday 5:30 pm that Patient desaturated on the way back from CT bagged Patient till oxygen came back up then put patient back on vent."
- 10. Ms. Clouthier did not provide or observe the patient care of Patient A, provided by Respondent, on or about November 15, 2014.

COUNT I

Failure to Maintain Timely, Legible, Accurate and Complete Medical Records Patient A - NRS 630.3062(1)(a)

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

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- 12. 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 constitutes grounds for initiating disciplinary action.
- 13. Respondent failed to maintain timely, legible, accurate and complete medical records/notes relating to the diagnosis, treatment, and care of Patient A when she left work without entering the required Respiratory Therapy Note.
- By reason of the foregoing, Respondent is subject to discipline by the Board as 14. provided in NRS 630.352.

COUNT II

Misrepresentation in Obtaining or Renewing License NRS 630.304(1)

- 15. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- NRS 630.304(1) provides that obtaining, maintaining or renewing or attempting to 16. obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement constitutes grounds for initiating disciplinary action.
- Desert Springs Hospital investigated Respondent as a result of the events described 17. herein.
- Respondent failed to disclose that Desert Springs Hospital investigated the events 18. contained herein when on Respondent's 2015 renewal application, she answered "no" to the question, "[h]ave you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; e) convicted of any violation of a statute, rule or regulation governing your practice as a practitioner of respiratory care by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?"
- By reason of the foregoing, Respondent is subject to discipline by the Board as 19. provided in NRS 630.352.

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WHEREFORE, the Investigative Committee prays:

- That the Nevada State Board of Medical Examiners give Respondent notice of the 1. 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;
- That the Nevada State Board of Medical Examiners set a time and place for a 2. formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);
- That the Nevada State Board of Medical Examiners determine what sanctions to 3. impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;
- That the Nevada State Board of Medical Examiners make, issue and serve on 4. Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and
- That the Nevada State Board of Medical Examiners take such other and further 5. action as may be just and proper in these premises.

day of January, 2019. DATED this

> INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

Donald K. White, Esq., Deputy General Counsel Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners

VERIFICATION

STATE OF NEVADA)
	: SS
COUNTY OF CLARK)

Rachakonda D. Prabhu, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate, and correct.

DATED this 15th day of January, 2019.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

Rachakonda D. Prabhu, M.D., Chamman