BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against STEPHANIE COLLEEN JACKSON, M.D., Respondent.	**Case No. 20-41027-1**

FILED
JUL 15 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert Kilroy, Esq., General Counsel and attorney for the IC, having a reasonable basis to believe that Stephanie Colleen Jackson, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 14922). Respondent was originally licensed by the Board on August 13, 2013.

A. Respondent's Treatment of Patient A

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

3. Respondent treated Patient A from July 6, 2015, to February 28, 2017, during 11 visits. Diagnoses were migraine, epilepsy, anxiety, constipation, obsessive compulsive disorder, and acute back pain. Patient A's initial visit (7/6/15) encounter included Respondent noting a recent fall with a head injury, an elevated blood pressure, and mention of needing urgent

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Rachakonda D. Prabhu, M.D., Chairman, Ms. Sandy Peltyn, and Victor M. Muro, M.D.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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diagnostic imaging ("STAT MRI") for intracranial pathology. Respondent did not follow up with regard to the STAT MRI imaging for potential head trauma sequelae, or hypertension as it related to the elevated blood pressure condition. Patient A's medical records within the narrative mentioned new neurologic symptoms, and signs of urgent concern such as syncope, word-finding difficulty, agitation and behavior change. Respondent documented the following: 1) Patient A is a relapsed alcoholic with no reference to associated risks or referral for substance use evaluation and treatment; 2) Patient A's other physician is cutting down the dosage of oxycodone/xanax, and Patient A is "out of oxycodone early because he has been cut down over months," and Patient A has "been on suboxone but didn't like it." Respondent adjusted Patient A's opioid regimen from fentanyl/hydrocodone/oxycodone to acetaminophen/cocaine, carisoprodol, diazepam, and butalbital/acetaminophen/caffeine/codeine. Respondent did not order serum or urine drug tests.

COUNT I

NRS 630.306(1)(b)(2)

(Violation of Standards of Practice)

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

5. Violation of a standard of practice adopted by the Board is grounds for initiating disciplinary action against a licensee pursuant to NRS 630.306(1)(b)(2).

6. The Board adopted by reference the Model *Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,* July 2013, published by the Federation of State Medical Boards of the United States, Inc. (Model Policy).

7. NAC 630.187 sets forth the professional standards for the prescription of opioid analgesics.

8. Respondent prescribed to Patient A in a manner that violated the professional standards for the prescription of opioid analgesics.

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

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OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

COUNT II

NRS 630.3062(1)(a)

(Failure to Maintain Complete Medical Records)

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

11. 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 disciplinary action against a licensee.

12. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A.

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

B. Respondent's Treatment of Patient B

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

15. Respondent treated Patient B from September 4, 2016, through January 27, 2017, over five (5) visits. Patient A's diagnoses included chronic pain, chronic intractable migraine and epilepsy. Respondent's narrative charting indicated Patient B suffered from anxiety and had herniated disks. On Patient B's initial visit (9/4/2016), the medical records mention ordering diagnostic tests; however, there is no documentation of these tests being ordered and no results of tests documented. Respondent prescribed controlled substances, including, but not limited to, benzodiazepines (lorazepam, clonazepam) and opioids (oxycodone, tapentadol), with a morphine equivalent daily dose (MME) greater than 260 mg, and oxymorphone to tramadol (MME less than 40 mg). Additionally, Respondent documented large amounts of medical marijuana being consumed by Patient B, and she also prescribed duloxetine and topiramate. Within Patient B's medical records, there was no documentation of any discussion of any indications, risk/benefits of those prescribed controlled substances, and any combination of the aforementioned prescriptions, and there was no serum or urine drug screening tests.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
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COUNT III

NRS 630.306(1)(b)(2)

(Violation of Standards of Practice)

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

17. Violation of a standard of practice adopted by the Board is grounds for initiating disciplinary action against a licensee pursuant to NRS 630.306(1)(b)(2).

18. The Board adopted by reference the Model *Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,* July 2013, published by the Federation of State Medical Boards of the United States, Inc. (Model Policy).

19. NAC 630.187 sets forth the professional standards for the prescription of opioid analgesics.

20. Respondent prescribed to Patient B in a manner that violated the professional standards for the prescription of opioid analgesics.

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

COUNT IV

NRS 630.3062(1)(a)

(Failure to Maintain Complete Medical Records)

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

23. 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 disciplinary action against a licensee.

24. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient B.

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

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
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C. Respondent's Treatment of Patient C

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

27. Patient C was treated by Respondent from February 11, 2016, through June 22, 2017, over six (6) visits. In Patient C's medical records, Respondent indicated the following diagnoses: a) chronic pain, gastrointestinal reflux disease; b) low back pain and knee pain without examination or diagnostic testing; c) aortic aneurysm without any follow-up testing; d) no documentation or discussion of the potential for excessive sedation from the prescribed medications of benzodiazepine, opioid, carisoprodol, and zolpidem being simultaneously prescribed. Respondent added another controlled substance (tramadol) without any discussion of risks/benefits. Patient C's opioid daily dosage was greater than MME 300 mg. Pursuant the Nevada Prescription Monitoring Program (PMP), Respondent wrote a prescription for Patient C on October 27, 2017, (statewide holiday-Nevada Day). There was no medical record for the aforementioned prescription. Respondent did not review or document her review of the PMP for Patient C. Respondent did not order any urine drug screenings.

COUNT V

NRS 630.306(1)(b)(2)

(Violation of Standards of Practice)

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

29. Violation of a standard of practice adopted by the Board is grounds for initiating disciplinary action against a licensee pursuant to NRS 630.306(1)(b)(2).

30. The Board adopted by reference the Model *Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,* July 2013, published by the Federation of State Medical Boards of the United States, Inc. (Model Policy).

31. NAC 630.187 sets forth the professional standards for the prescription of opioid analgesics.

32. Respondent prescribed to Patient C in a manner that violated the professional standards for the prescription of opioid analgesics.

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

COUNT VI

NRS 630.3062(1)(a)

(Failure to Maintain Complete Medical Records)

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

35. 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 disciplinary action against a licensee.

36. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient C.

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

WHEREFORE, the Investigative Committee 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 determines 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, 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 14 day of July, 2020.

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 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 July, 2020.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: D Prabhu Rachakonda MD
Rachakonda D. Prabhu, M.D., Chairman

CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 15th day of July, 2020, I served a filed copy of the formal COMPLAINT, via USPS e-certified, return receipt mail to the following:

Stephanie Colleen Jackson, M.D.
2111 W. Clearview Trail
Phoenix, AZ 85086

Dated this 15th day of July, 2020.

Sheri L. Quigley

Sheri L. Quigley, Legal Assistant

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(775) 688-2559