Reno, Nevada 89521

(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint

Against:

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JESSICA GORDON KINGSBERG, M.D.,

Respondent.

Case No. 21-45789-1

FILED

AUG - 5 2021

NEVADA STATE BOARD OF MEDICAL EXAMINERS By:

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through Donald K. White, J.D., Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Jessica Gordon Kingsberg, 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. 16603). Respondent was originally licensed by the Board on July 18, 2016.
- 2. Patient A² was a seventy-eight (78) year old female at all times relevant to this Complaint.
- 3. Patient A suffered a right proximal humerus fracture on August 3, 2018 due to a fall and was seen at Sunrise Hospital Medical Center where Respondent performed an open reduction internal fixation surgery on Patient A's right shoulder.

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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 Victor M. Muro, M.D., Ms. April Mastroluca, and Weldon Havins, M.D.

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.

- 4. Respondent continued treating Patient A after her release from Sunrise Hospital and ordered Patient A to undergo physical therapy. However, Patient A was in inexplicable, unimproving pain during the entire course of her physical therapy with pain scale rating of 8/9 out of 10 continually.
- 5. On October 8, 2018, Respondent reviewed x-rays taken on September 25, 2018 at Steinberg Diagnostic Center and noted "[a] possible intra-articular perforation of screw" and mentioning the patient did not have the improvement she would expect by this time in her recovery. Respondent did not address any further investigation into the perforation of the screw and instead treated the patient with additional physical therapy.
- 6. Patient A discontinued her medical care with Respondent and received a second opinion from a different orthopedic physician who identified the penetrated screw and performed a revision surgery to correct it relieving the patient from the pain from which she was suffering.
- 7. The IC requested a copy of all medical records and diagnostic tests within the file kept for the patient by Respondent. The x-rays taken September 25, 2018 and evaluated by Respondent were not included, nor was the report, in her response to the IC's request.

COUNT I

NRS 630.301(4) - Malpractice

- 8. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- 9. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.
- 10. 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."
- 11. 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 by failing to fully investigate, diagnose or treat the screw perforation identified in the x-rays dated September 25, 2018.

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

COUNT II

NRS 630.3062(1)(a) - Failure to Maintain Complete Medical Records

- 13. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- 14. 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" constitute grounds for initiating discipline against a licensee.
- 15. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to maintain the x-ray report or films when she treated Patient A.
- 16. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT III

NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation

- All of the allegations contained in the above paragraphs are hereby incorporated by 17. reference as though fully set forth herein.
- 18. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).
- NAC 630.210 requires a physician to seek consultation with another provider of 19. health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services."
- Respondent failed to timely seek consultation with regard to Patient A's medical 20. condition. Respondent should have consulted with an appropriate care provider to address the doubtfulness of the diagnosis of Patient A's medical condition and such a timely consultation would have confirmed or denied such a diagnosis and may have enhanced the quality of medical care provided to the Patient with regard to the screw perforation in her shoulder.

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21. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners 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 him 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);
- That the Board determine what sanctions to impose if it determines there has been 3. a violation or violations of the Medical Practice Act committed by Respondent;
- 4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400:
- 5. 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
- That the Board take such other and further action as may be just and proper in these 6. premises.

DATED this /// day of August, 2021.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

DONALD K. WHITE, J.D. Deputy General Counsel

9600 Gateway Drive Reno, NV 89521

Tel: (775) 688-2559

Email: dwhite@medboard.nv.gov

Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners

VERIFICATION

STATE OF NEVADA)
	: ss
COUNTY OF CLARK)

Victor M. Muro, 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 Hay of August, 2021.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

VICTOR M. MURO, M.D.

Chairman of the Investigative Committee