BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and

Complaint Against:

RANDI FULTZ GRINSELL, M.D.,

Respondent.

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Case No. 21-27634-1

FILED

JUN 28 2021

NEVADA STATE BOARD OF MEDICAL EXAMINERS

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, Esq., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Randi Fultz Grinsell, 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. 10448). Respondent was originally licensed by the Board on April 9, 2003.
- On July 2, 2015, Patient A² had her first encounter with Respondent as she was 2. transferred from another provider. Respondent obtained her prior medical history, family history, and reviewed her immunization record. During the visit, Patient A denied any family history of cancer. Respondent acknowledged that Patient A was scheduled for a pap smear test (PAPT) as a part of her examination.

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 Prabhu, M.D., Mr. M. Neil Duxbury, and Victor M. Muro, 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.

- 3. On July 13, 2015, Patient A submitted her endocervical sample for the PAPT. Respondent rendered no further medical services or treatments with Patient A, but for referring her to a gynecologist since she indicated her interest in a possible ablation procedure.
- 4. On July 16, 2015, Patient A's PAPT results were received and indicated the following cytology: "epithelial cell abnormality with atypical glandular cells" documented by the pathologist Dr. Delrosario (M.D.). Respondent did not inform Patient A regarding the aforementioned PAPT results because she did not know where to locate the cytology results in Patient A's electronic medical records.
- 5. On July 17, 2015, Respondent generated a letter for Patient A with the following, "Your PAP test was normal...There is no need for further testing at this time." It is unknown whether Respondent sent the letter or whether Patient A actually received this misinformation.
- 6. On July 18, 2016, Patient A had subsequent PAPT from a different medical provider, who noted that Patient A had atypical glandular cells on her 2015 PAPT cytology report from the PAPT performed by Respondent. During this encounter, Patient A was notified of the aforementioned 2015 PAPT results.

COUNT I

NRS 630.301(4) (Malpractice)

- 7. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- 8. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.
- 9. 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.
- 10. 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 she provided medical services to Patient A, because she did not timely inform Patient A of the 2015 PAPT results.

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11. 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)

- 12. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate 13. and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating disciplinary action against a licensee.
- Respondent failed to maintain complete medical records relating to the diagnosis, 14. 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, and complete. Specifically, she failed to document and inform the patient of the 2015 PAPT results.
- By reason of the foregoing, Respondent is subject to discipline by the Board as 15. 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 16. 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).
- NAC 630.210 requires a physician to seek consultation with another provider of 18. health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services.
- Respondent failed to seek consultation and such a consultation could have 19. enhanced treatment of Patient A's medical condition by addressing Patient A's medical condition after the 2015 PAPT results indicated "epithelial cell abnormality."

20. 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;
- 4. That the Board award fees and costs for the investigation and prosecution of this matter 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
- 6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 28th day of June, 2021.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

ROBERT G. KILROY, J.D.

Senior Deputy General Counsel

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Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners

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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 28th day of June, 2021

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: / M MUN ME

VICTOR M. MURO, M.D.

Chairman of the Investigative Committee