

1 **BEFORE THE BOARD OF MEDICAL EXAMINERS**
2 **OF THE STATE OF NEVADA**

3 * * * * *

4
5 **In the Matter of Charges and Complaint**

Case No. 20-41027-1

6 **Against:**

FILED

7 **STEPHANIE COLLEEN JACKSON, M.D.,**

JAN 22 2021

8 **Respondent.**

**NEVADA STATE BOARD OF
MEDICAL EXAMINERS**

By: 

9
10 **FIRST AMENDED COMPLAINT**

11 The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners
12 (Board), by and through Robert Kilroy, Esq., General Counsel and attorney for the IC, having a
13 reasonable basis to believe that Stephanie Colleen Jackson, M.D. (Respondent) violated the
14 provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code
15 (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its First Amended
16 Complaint, stating the IC's charges and allegations as follows:

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

20 **A. Respondent's Treatment of Patient A**

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

23 3. Respondent treated Patient A from July 6, 2015 through February 28, 2017.
24 Documented diagnoses were migraine, epilepsy, anxiety, constipation, obsessive compulsive disorder,
25 and acute back pain. Patient A's medical records contained little information about patient history,
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27 ¹ The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal
28 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.

1 physical examinations, and treatment plans. Respondent did not sign the initial visitation
2 (July 6, 2015) medical record until August 26, 2015. Respondent did not order nor document within
3 the medical records any serum or urine drug screen tests. Respondent's documentation of Patient A's
4 anticonvulsant medication prescription history only stated Depakote in the narrative note. However, in
5 the prescription record, Respondent documented carbamazepine (Tegretol) without a record of dosage
6 amounts or measurements of the therapeutic levels during this treatment cycle. Respondent prescribed
7 the aforementioned controlled substances without the adequate documentation of the indications,
8 risks/benefits discussion, and/or monitoring in Patient A's medical record.

9 **COUNT I**

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

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

13 5. NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate
14 and complete medical records relating to the diagnosis, treatment and care of a patient is grounds
15 for initiating disciplinary action against a licensee.

16 6. Respondent failed to maintain timely, legible, accurate and complete medical
17 records relating to the diagnosis, treatment and care of Patient A.

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

20 **B. Respondent's Treatment of Patient B**

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

24 9. Respondent treated Patient B from September 4, 2016 through January 27, 2017.
25 Patient B's diagnoses included chronic pain, chronic intractable migraine and epilepsy.
26 Respondent's narrative charting indicated Patient B suffered from anxiety and had herniated disks.
27 On Patient B's initial visit (September 4, 2016), the medical records indicated ordering of
28 diagnostic tests; however, there is no documentation of these tests being ordered and no results of

1 these tests being documented. Respondent prescribed controlled substances, including, but not
2 limited to, benzodiazepines (lorazepam, clonazepam) and opioids (oxycodone, tapentadol), and
3 oxymorphone to tramadol. Additionally, Respondent documented large amounts of medical
4 marijuana being consumed by Patient B and she also prescribed duloxetine and topiramate. Within
5 Patient B's medical records, there was no documentation of any discussion regarding indications
6 and/or risk/benefit analysis of those prescribed controlled substances or any combination thereof.
7 Further, there was also no serum or urine drug screening tests noted or provided within the
8 records.

9 **COUNT II**

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

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

13 11. NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate
14 and complete medical records relating to the diagnosis, treatment and care of a patient is grounds
15 for initiating disciplinary action against a licensee.

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

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

20 **C. Respondent's Treatment of Patient C**

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

24 15. Patient C was treated by Respondent from February 11, 2016, through June 22,
25 2017. In Patient C's medical records, Respondent indicated the following diagnoses: a) chronic
26 pain, gastrointestinal reflux disease; b) low back pain and knee pain without examination or
27 diagnostic testing; c) aortic aneurysm without any follow-up testing. No documentation or
28 discussion of the potential for excessive sedation from the prescribed medications of

1 benzodiazepine, opioid, carisoprodol, and zolpidem being simultaneously prescribed were located.
2 Respondent added another controlled substance (tramadol) without any discussion of
3 risks/benefits. Pursuant to the Nevada Prescription Monitoring Program (PMP), Respondent wrote
4 a prescription for Patient C on October 27, 2017, (Nevada Day which is a statewide holiday).
5 There were no corresponding medical records for the aforementioned prescription. Respondent
6 did not review nor document her review of the PMP report for Patient C. Respondent did not order
7 any urine drug screenings.

8 **COUNT III**

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

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

12 17. 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
14 for initiating disciplinary action against a licensee.

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

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

19 **WHEREFORE**, the Investigative Committee prays:

20 1. That the Board give Respondent notice of the charges herein against her and give
21 her notice that she may file an answer to the Complaint herein as set forth in NRS 630.339(2)
22 within twenty (20) days of service of the Complaint;

23 2. That the Board set a time and place for a formal hearing after holding an Early
24 Case Conference pursuant to NRS 630.339(3);

25 3. That the Board determine what sanctions to impose if it determines there has been
26 a violation or violations of the Medical Practice Act committed by Respondent;


27 4. That the Board make, issue and serve on Respondent its findings of fact,
28 conclusions of law and order, in writing, that includes the sanctions imposed; and

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

DATED this 12 day of January, 2021.

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)

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 22nd day of January, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 
Victor M. Muro, M.D., Chairman

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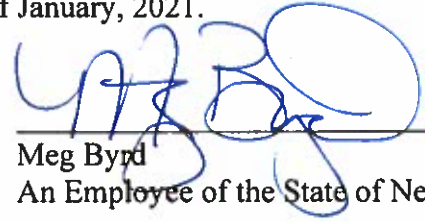
CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on January 22, 2021; I mailed via USPS e-certified return-receipt mail, postage pre-paid, a file-stamped copy of the following document: **FIRST AMENDED COMPLAINT**

LYN E. BEGGS, ESQ.
Law Offices of Lyn E. Beggs, PLLC
316 California Ave. #863
Reno, NV 89509
Attorney for Respondent

Certified Mail Tracking No.: 9171 9690 0935 0243 8322 67

Dated this 22nd day of January, 2021.


Meg Byrd
An Employee of the State of Nevada Board of Medical Examiners