## OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners 9600 Gateway Drive 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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ABRILL MARIE JONES, M.D.

Respondent.

Case No. 23-48593-1

FILED

NOV 1 7 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS

### **COMPLAINT**

The Investigative Committee<sup>1</sup> (IC) of the Nevada State Board of Medical Examiners (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Abrill Marie Jones, 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 physician holding an active license to practice medicine in the State of Nevada (License No. 18096). Respondent was originally licensed by the Board on July 16, 2018.
  - 2. Patient A<sup>2</sup> was a twenty-nine (29) year-old male at the time of the events at issue.
- 3. On September 1, 2019, Patient A was transferred from a hospital in Arizona to Sunrise Hospital and Medical Center (Sunrise) in Las Vegas, Nevada, after exhibiting symptoms consistent with spinal cord compression, including urinary incontinence and severe lower back pain accompanied by lower extremity numbness and weakness. Patient A reported that he injured his back on August 30, 2019, after lifting a heavy object.

<sup>&</sup>lt;sup>1</sup> 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., Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Ms. Pamela J. Beal.

<sup>&</sup>lt;sup>2</sup> 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.

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- Patient A was specifically transferred from the Arizona hospital to Sunrise for a CT 4. myelogram and further evaluation of Patient A's back pain accompanied by lower extremity weakness and numbness.
- Upon arrival at Sunrise on September 1, 2019, an Emergency Department 5. physician ordered magnetic resonance imaging (MRI) of Patient A's lumbar spine.
- After presenting to the Emergency Department at Sunrise, Patient A was admitted 6. to the care of Respondent on September 2, 2019.
- On September 2, 2019, at or about 4:23 p.m., Respondent performed a physical 7. examination of Patient A, including a test of motor strength. Respondent noted that Patient A moved all his extremities, except his lower left extremity. Respondent further noted that, according to the Arizona hospital, Patient A had urinary retention.
- 8. According to Respondent's notes from the September 2, 2019, physical examination, Respondent did not document Patient A's rectal sphincter tone via digital rectal exam, perineal sensation, or a neurological examination consisting of palpation of the spine, reflexes, sensation gait, and straight leg testing.
- Respondent's notes from the physical examination further do not indicate that 9. Respondent contacted a neurosurgeon on September 2, 2019, despite Patient A's history of urinary retention and lower extremity weakness.
- An MRI of Patient A's lumbar spine was taken later on September 2, 2019. The 10. MRI report, written at or about 10:01 p.m., showed cauda equina compression at the L2-L3 disc level.
- On September 3, 2019, Respondent again evaluated Patient A, and requested a 11. neurosurgery consultation after learning of the MRI report.
- On September 4, 2019, Patient A was evaluated by a neurosurgeon. Patient A then 12. received surgery to decompress his spinal cord on the same day.

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### **COUNT I**

### NRS 630.301(4) - Malpractice

- All of the allegations contained in the above paragraphs are hereby incorporated by 13. reference as though fully set forth herein.
- NRS 630.301(4) provides that malpractice of a physician, is grounds for initiating 14. disciplinary action against a licensee.
- NAC 630.040 defines malpractice as "the failure of a physician, in treating a 15. patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."
- As demonstrated by, but not limited to, the above-outlined facts, Respondent failed 16. to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A. After Patient A presented to Respondent with back pain, lower left leg numbness and weakness, and a history of possible urinary retention; Respondent failed to conduct a thorough examination of Patient A in order to rule out the possibility of spinal cord compression. The examination should have included the documentation and performance of measuring Patient A's rectal sphincter tone via digital rectal exam, testing his perineal sensation, and conducting a neurological examination consisting of palpation of the spine, reflexes, sensation gait, and straight leg testing. Respondent further failed to timely contact a neurosurgeon once Respondent discovered Patient A's lower extremity weakness, and failed to aggressively follow up on the results of Patient A's MRI taken on September 2, 2019.
- By reason of the foregoing, Respondent is subject to discipline by the Board as 17. provided in NRS 630.352.

### **COUNT II**

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

- All of the allegations contained in the above paragraphs are hereby incorporated by 18. reference as though fully set forth herein.
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- NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate 19. and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.
- Respondent failed to maintain complete medical records relating to the diagnosis, 20. treatment and care of Patient A, by failing to correctly document her actions when she treated Patient A, whose medical records were not timely, legible, accurate, and complete. On September 2, 2019 Respondent did not document that she conducted a thorough examination of Patient A, including performance of measuring Patient A's rectal sphincter tone via digital rectal exam, testing perineal sensation, and conducting a neurological examination consisting of palpation of the spine, reflexes, sensation gait, and straight leg testing.
- By reason of the foregoing, Respondent is subject to discipline by the Board as 21. provided in NRS 630.352.

### **COUNT III**

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

- All of the allegations contained in the above paragraphs are hereby incorporated by 22. reference as though fully set forth herein.
- Violation of a standard of practice adopted by the Board is grounds for disciplinary 23. action pursuant to NRS 630.306(1)(b)(2).
- NAC 630.210 requires a physician to "seek consultation with another provider of 24. 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 25. condition on or about September 2, 2019. Upon discovery of Patient A's lower extremity weakness during Patient A's physical examination, Respondent should have immediately consulted with an appropriate care provider, such as a neurosurgeon, to address the diagnosis of Patient A's medical condition. Such a timely consultation may have enhanced the quality of medical care provided to Patient A.

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26. 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 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
- 6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

WILLIAM P. SHOGREN

Deputy General Counsel

9600 Gateway Drive Reno, NV 89521

Tel: (775) 688-2559

Email: <a href="mailto:shogrenw@medboard.nv.gov">shogrenw@medboard.nv.gov</a>
Attorney for the Investigative Committee

# OFFICE OF THE GENERAL COUNSEL

### Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521

### VERIFICATION

STATE OF NEVADA	)
	: SS.
COUNTY OF CLARK	)

Chowdhury H. Ahsan, M.D., Ph.D., FACC, 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 17th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE NEVADA, STATE BOARD OF MEDICAL EXAMINERS

By:

CHOWDHURY H. AHSAN, M.D., PN.D., FACC Chairman of the Investigative Committee

### **CERTIFICATE OF SERVICE**

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 20th day of November, 2023, I served a file-stamped copy of the foregoing COMPLAINT and PATIENT DESIGNATION via U.S Certified Mail to:

ABRILL MARIE JONES, M.D. c/o Chelsea R. Hueth, Esq. McBride Hall 8329 W. Sunset Road, Suite 260 Las Vegas, NV 89113

Tracking No.:

9171 9690 0935 0241 5620 98

DATED this

day of November, 2023.

MERCEDES FUENTES

Legal Assistant

Nevada State Board of Medical Examiners