BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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Against:

KASEY LAZJR ABANONU, M.D.,

In the Matter of Charges and Complaint

Respondent.

Case No. 23-39319-1 FILED

OCT 16 2023

NEVADA STATE BOARD OF MEDICALEXAMINERS

COMPLAINT

The Investigative Committee¹ (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 Kasey Lazir Abanonu, 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:

- Respondent was at all times relative to this Complaint a medical doctor holding an 1. active license to practice medicine in the State of Nevada (License No. 14139). Respondent was originally licensed by the Board on October 13, 2011.
 - Patient A^2 was a fifty (50) year-old female at the time of the events at issue. 2.
- Patient A was initially diagnosed with advanced, end-stage liver disease consistent 3. with cirrhosis on September 10, 2017. Patient A presented to St. Rose Dominican Hospital Siena Campus (St. Rose) on multiple occasions between September 10, 2017, and December 11, 2017, for treatment of her liver disease.

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¹ The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal 27 Complaint was authorized for filing, was composed of Board members Mr. M. Neil Duxbury, Aury Nagy, M.D., and Michael C. Edwards, M.D., FACS. 28

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.

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Patient A required multi-disciplinary care during her frequent visits to St. Rose 4. starting on September 10, 2017, including gastroenterology and liver transplant specialty consultations and input. During Patient A's hospital stays between November 23, 2017, and December 4, 2017, the care of her liver disease was directed by gastroenterology consultants at the request of emergency room and hospitalist physicians.

- 5. During Patient A's multiple emergency room visits and hospitalizations at St. Rose between September 10, 2017, and December 11, 2017, Patient A was noted to have chronically low sodium levels (hyponatremia) and chronically low blood pressure readings (hypotension).
- 6. On December 23, 2017, Patient A presented to the emergency room at St. Rose with complaints of abdominal pain and distention. At this time, Patient A still suffered from advanced, end-stage liver disease.
- 7. Patient A was then admitted to the care of Respondent in St. Rose's observation unit, on or about 6:01 a.m., on December 23, 2017. Respondent diagnosed Patient A as being dehydrated with hyponatremia and having an altered mental status.
- Upon her presentation to St. Rose on December 23, 2017, Patient A also had a new 8. onset of acute kidney failure, as evidenced by lab results showing low urine output and rising creatinine as well as impending sepsis from infection.
- Respondent planned to rehydrate Patient A with IV fluids to correct Patient A's 9. dehydration and hyponatremia but did not order or perform any other additional diagnostic tests or therapeutic interventions to address Patient A's acute kidney failure, or Patient A's end-stage liver disease with altered mental status. Respondent did not order standard coagulation tests, such as an international normalized ratio (INR) blood test, despite Patient A's end-stage liver disease.
- Respondent further did not initially order or perform a small volume diagnostic 10. paracentesis, to rule out possible causes of Patient A's infection, such as spontaneous bacterial peritonitis (SBP).
- Respondent did not request consultations with an ICU critical care physician, 11. nephrologist, or gastroenterologist on December 23, 2017, or December 24, 2017.

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- During Patient A's presentation to St. Rose on December 23, 2017, Patient A also 12. had a high bilirubin level of 5, which would have produced obvious jaundice of the skin and yellowing of the eyes (scleral icterus). Respondent's notes regarding Patient A did not mention jaundice or scleral icterus. Respondent's notes further did not mention abdominal tenderness or distension.
- During Patient A's stay at St. Rose starting on December 23, 2017, her urine output 13. remained negligible, and her creatinine climbed from 1.9 on admission to 2.75 after use of IV fluids, suggesting hepatorenal syndrome as a probable cause of her kidney failure.
- 14. Despite the implementation of IV fluids, Patient A's urine output, blood pressure level, and creatinine level did not improve during her stay at St. Rose.
- Patient A also had persistent hypotension that required pressor blood pressure 15. support in the ICU.
- By noon on December 24, 2017, Patient A developed a severe metabolic acidosis 16. (buildup of acid in the body due to kidney disease or kidney failure), consistent with lactic acidosis, which required an ICU level of care.
- Despite Patient A's new onset acute kidney failure, impending sepsis, and liver 17. failure, Respondent opted to keep Patient A on observation status, rather than transferring Patient A to a higher level of care, such as the ICU.
- Respondent's progress notes on the evening of December 24, 2017, indicated that 18. "patient states is getting better" and "no new issues reported." Respondent's reports and physical exam at the time documented no abnormalities.
- On December 24, 2017, after Respondent's examination of Patient A, Patient A 19. became unresponsive, and a medical emergency rapid response was called. Patient A was then transferred to the ICU, where her clinical condition continued to deteriorate with worsening septic shock, renal failure, and developing disseminated intravascular coagulation.
- Patient A had remained in her ER room and the observation unit for approximately 20. thirty (30) hours under Respondent's care before being transferred to the ICU by other responding physicians.

21. Patient A passed away on December 26, 2017.

COUNT I

NRS 630.301(4) - Malpractice

- 22. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- 23. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.
- 24. 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."
- 25. 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. Respondent failed to assess multiple important diagnoses, including hepatorenal syndrome and septic shock, and failed to order laboratory tests, including an INR, lactic acid, and an analysis of Patient A's ascites fluid to look for SBP. Respondent further failed to act in a timely fashion to Patient A's hypotension, septic shock, worsening acute kidney failure, and worsening metabolic acidosis, including failing to timely transfer Patient A to a higher level of care, such as the ICU.
- 26. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

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

Failure to Consult

- 27. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- 28. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

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	29.	NAC 630.210 requires a physician to "seek consultation with another provider of
health	care in	doubtful or difficult cases whenever it appears that consultation may enhance the
quality	of med	lical services."

- 30. Respondent failed to timely seek consultation with regard to Patient A's medical condition on December 23 and 24, 2017, and Respondent should have consulted with a gastroenterologist or a nephrologist 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 Patient A.
- 31. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT III

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

- 32. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- 33. 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.
- 34. Respondent failed to maintain complete and proper medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete. Respondent failed to accurately document Patient A's condition, including documenting "no abnormalities" during a physical examination of Patient A on December 24, 2017, and failing to note in Patient A jaundice, scleral icterus, abdominal tenderness, or distension.
- 35. 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 Gareway Drive Reno, Nevada 89521

WHEREFORE, the Investigative Committee prays:

- 1. That the Board give Respondent notice of the charges herein against him and give him notice that he 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 16th day of October, 2023.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

WILLIAM P. SHOCKEN

Deputy General Counsel

9600 Gateway Drive

Reno, NV 89521

Tel: (775) 688-2559

Email: <u>shogrenw@medboard.nv.gov</u>
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 WASHOE)

Bret W. Frey, 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 16th day of October, 2023.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

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 16th day of October, 2023, I served a file-stamped copy of the foregoing COMPLAINT and PATIENT DESIGNATION via U.S Certified Mail to:

KASEY LAZJR ABANONU, M.D. 10017 Fox Springs Drive Las Vegas, NV 89117

Tracking No.:	9171 9690 0935 0241 5574 69	

DATED this ______day of October, 2023.

MERCEDES FUENTES

Legal Assistant

Nevada State Board of Medical Examiners