BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **KASEY LAZJR ABANONU, M.D.,** **Respondent.**	**Case No. 23-39319-2**

FILED

OCT 16 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Ismail

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
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COMPLAINT

The Investigative Committee[1] (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 Lazjr 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:

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. 14139). Respondent was originally licensed by the Board on October 13, 2011.

2. Patient A[2] was a forty (40) year-old male at the time of the events at issue.

3. On June 27, 2018, Patient A underwent an elective lumbar spine fusion surgery at St. Rose Dominican Hospital (St. Rose).

4. After the procedure, Respondent assumed short-term, post-operative care of Patient A.

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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 Bret W. Frey, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Carl N. Williams, Jr., M.D.

[2] 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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5. On June 27, 2018, Patient A was placed on opioid pain medications for postoperative pain management.

6. During his stay at St. Rose, Patient A's heart rate was almost entirely in the sinus tachycardia range, i.e. a heart rate above 100 beats per minute (BPM). Respondent did not note or comment on Patient A's elevated heart rate in his medical records.

7. During Patient A's stay at St. Rose, daily chemistry studies showed patterns consistent with dehydration. These patterns indicated how much vomiting Patient A was having during his stay at St. Rose. Respondent did not mention these chemistry study patterns in his notes for Patient A.

8. Additionally, during the surgery, Patient A suffered two small dural tears that required closure with sutures. Patient A's surgeon instructed that Patient A had to lie flat on his bed for three days after the surgery, to allow the tears to heal. In such a setting, there is a risk of aspiration, which requires patients such as Patient A to be positioned with the head of the bed elevated to prevent regurgitation or backwards flow of gastrointestinal contents into the airway.

9. On June 29, 2018, Patient A complained of abdominal distension. Imaging studies taken on June 29, 2018, suggested that Patient A was developing a progressively worsening ileus, or a bowel obstruction. Patient A's last bowel movement had been on June 27, 2018, the day of his surgery.

10. On the night of June 29, 2018, a nurse spoke with Respondent concerning Patient A's vomiting.

11. On the night of June 30, 2018, Patient A complained of difficulty breathing. Nursing notes indicated that Patient A's heart rate was very rapid, despite being given metoprolol to slow his heart rate. Respondent was informed of Patient A's heart rate and told the nursing staff to only call him if Patient A's heart rate was above 130 BPM and Patient A was symptomatic.

12. Respondent was later called on July 1, 2018, due to complaints of difficulty breathing and a heart rate of between 110-139 BPM. Respondent ordered Xopenex and Xanax 1 mg, to be administered to Patient A.

13. Xopenex is only indicated for bronchospasms, which Patient A did not shown signs of during his stay at St. Rose.

14. Further imaging was obtained on July 1, 2018, and results showed progressive multiple loops of dilated large and small bowel with gaseous extension of the stomach, all of which is consistent with aggressive ileus.

15. On July 1, 2018, Respondent observed the imaging results and spoke with Patient A, who reported ongoing nausea, vomiting, and abdominal pain, with no improvement.

16. Also, on July 1, 2018, Respondent conducted a post imaging physical examination of Patient A, and Respondent described Patient A as in no acute distress. Respondent's findings on an abdominal exam of Patient A were "soft, slightly distended." Respondent recorded Patient A's course as improving. Respondent further did not note that the July 1, 2018, imaging results described gaseous distention of the stomach.

17. On the night of July 1, 2018, Respondent was notified that Patient A continued to have shortness of breath and an elevated heart rate. Respondent ordered Xopenex and metoprolol for Patient A's breathing and heart rate.

18. Also, on July 1, 2018, Respondent ordered oral medications for Patient A, including miralax, docusate, and Maalox for constipation. Administration of these medications, combined with additional fluid in Patient A's stomach, could have caused Patient A's increasing nausea and vomiting, and increased the risk of aspiration.

19. On July 2, 2018, Patient A complained of severe shortness of breath. A CT angiogram of the chest was taken, demonstrating infiltrates in the right mid and lower lung, consistent with aspiration, and significant distension of the stomach.

20. A patient with progressive ileus, ongoing opioid pain medication administration, oral administration of constipation medication, physical limitations, clinical evidence of abdominal distension corroborated by radiological findings, and the absence of bowel movements would normally alert providers to aspiration risks.

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21. On July 2, 2018, Patient A displayed progressively worsening shortness of breath and oxygen desaturation. Patient A was then transferred to the Intensive Care Unit at St. Rose. Patient A then developed pulseless electrical activity cardiac arrest and passed away.

22. Hospital staff noted Patient A's cause of death to be cardiopulmonary arrest secondary to pulseless electrical activity secondary to aspiration.

COUNT I

NRS 630.301(4) - Malpractice

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

24. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

25. 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."

26. 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 (1) failing to properly and timely address Patient A's condition, including progressively worsening ileus, continuous vomiting, elevated heart rate, and gaseous distention of the stomach; (2) failing to order more diagnostic studies; and (3) failing to note the aggregated risks of aspiration in light of Patient A's clinical presentation. Respondent's failure to properly and timely address Patient A's worsening condition includes, but is not limited to, the failure to order diagnostic studies on the night of July 1, 2018, such as a CT angiogram of the chest.

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

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COUNT II

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

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

29. 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.

30. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document his actions and Patient A's condition when he treated Patient A, whose medical records were not timely, legible, accurate, and complete. Respondent failed to note Patient A's continuing tachycardia, note the findings from Patient A's July 1, 2018, abdominal x-ray report describing gaseous distention of the stomach, and failed to note Patient A's daily chemistry studies showing a pattern consistent with dehydration and likely an indication of how much vomiting Patient A was having. Further, despite imaging studies showing increasing distention of Patient A's bowels, and Patient A's complaints of abdominal pain, Respondent merely noted that Patient A's abdomen was soft and slightly distended.

31. 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 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;

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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. SHOGREN
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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: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee

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