

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. 24-30931-1

6 **Against:**

**FILED**

7 **JUNG-TAEK YOON, M.D.**

**JAN 26 2024**

8 **Respondent.**

**NEVADA STATE BOARD OF  
MEDICAL EXAMINERS**

By: \_\_\_\_\_

9  
10                                   **COMPLAINT**

11                   The Investigative Committee<sup>1</sup> (IC) of the Nevada State Board of Medical Examiners  
12 (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC,  
13 having a reasonable basis to believe that Jung-Taek Yoon, 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 Complaint, stating  
16 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. 12310). Respondent was  
19 originally licensed by the Board on June 1, 2007.

20                   2.       Patient A<sup>2</sup> was a thirty-eight (38) year-old male at the time of the events at issue.

21                   3.       Patient A presented to the emergency department at Summerlin Hospital on  
22 November 12, 2018, at approximately 7:40 a.m. with complaints of low back pain, testicle pain,  
23 and dysuria.

24                   4.       At the emergency department, a physician assistant under Respondent's  
25 supervision examined Patient A and wrote orders for IV fluids, urinalysis, urine culture, a  
26

27                   <sup>1</sup> 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 Bret W. Frey, M.D., Col. Eric D. Wade,  
USAF (Ret.), and Carl N. Williams, Jr., M.D., FACS.

<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.

1 testicular ultrasound, a complete blood count, basic metabolic panel, and a computed tomography  
2 (CT) scan of the abdomen and pelvis. The physician assistant also wrote orders for various  
3 analgesics.

4 5. On November 12, 2018, the urinalysis demonstrated sixteen (16) white blood cells,  
5 nineteen (19) red blood cells, and no bacteria. The CT scan demonstrated an obstructing ureteral  
6 stone and excessive urine in the ureter and kidney.

7 6. A white blood cell count over five (5) in urine is typically abnormal and indicative  
8 of a possible urinary tract infection. A possible urinary tract infection, combined with an  
9 obstructing ureteral stone, typically mandates treatment with antibiotics.

10 7. Patient A's urinalysis results, and the need for a culture, indicated a possible  
11 urinary tract infection.

12 8. On November 12, 2018, Respondent, acting as the supervising physician for the  
13 physician assistant, signed a note stating that he personally interviewed and examined Patient A,  
14 that he discussed the findings, diagnostic studies, interventions and treatment plan with the  
15 physician assistant, that he reviewed the clinical notes and test results, and that he agreed with the  
16 physician assistant's assessment, management, and disposition.

17 9. Patient A was discharged on November 12, 2018, at approximately 10:30 a.m.,  
18 with instructions to follow-up with a urologist.

19 10. During Patient A's stay at the emergency department on November 12, 2018,  
20 Respondent did not document a urinary tract infection or administer or prescribe antibiotics to  
21 Patient A.

22 11. Patient A presented again to the emergency department at Summerlin Hospital on  
23 November 14, 2018, and was diagnosed with severe sepsis resulting from a urinary tract infection.

24 12. Due to the infection, Patient A developed severe medical complications resulting in  
25 a lengthy hospitalization.

26 13. Additionally, the urine culture from November 12, 2018, was reported on  
27 November 14, 2018, demonstrating an abnormal amount of Escherichia coli in Patient A's urine.

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**COUNT III**

**NRS 630.306(1)(r) - Failure to Adequately Supervise**

23. All of the allegations in the above paragraphs are hereby incorporated as if fully set forth herein.

24. NRS 630.306(1)(r) provides that a failure to adequately supervise a physician assistant pursuant to the regulations of the Board is an act that constitutes grounds for initiating disciplinary action.

25. By the conduct described herein, Respondent failed to adequately supervise, or supervise in any way, physician assistants in their performance of medical tasks, including but not limited to the physician assistant's assessment, management, and disposition of Patient A on November 12, 2018.

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 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

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OFFICE OF THE GENERAL COUNSEL

Nevada State Board of Medical Examiners  
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6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 26<sup>th</sup> day of January, 2024.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Will Shogren

WILLIAM P. SHOGREN  
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*Attorney for the Investigative Committee*

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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 26th day of January, 2024.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:   
\_\_\_\_\_  
BRET W. FREY, M.D.  
*Chairman of the Investigative Committee*