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

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In the Matter of Charges and Complaint Against: **SARA KABSOUN, M.D.,** **Respondent.**	**Case No. 24-43198-1**

FILED
APR 10 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Alexander J. Hinman, Deputy General Counsel, and attorney for the IC, having a reasonable basis to believe that Sara Kabsoun, 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. 15735). Respondent was originally licensed by the Board on February 23, 2015.

2. Patient A[2] was a sixty (60) year-old female at the time of the events at issue, with a medical history of arthritis, hypercholesterolemia, hypertension, and neuropathy.

3. On April 29, 2021, at 10:10 a.m., Patient A presented to the Henderson Hospital Emergency Room (ED), with a chief complaint of vision loss, which started at 9:15 a.m., that day. Patient A also complained of shortness of breath, chest pain, and lower right back pain.

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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 Aury Nagy, M.D., Ms. Maggie Arias-Petrel, and Nicola (Nick) M. Spirtos, M.D., F.A.C.O.G.

[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.

4. Patient A's vision loss resolved within twenty (20) minutes of onset, and there were no other neurological symptoms reported.

5. Vital signs taken in the ED at 10:17 a.m., showed Patient A's blood pressure of 99/40 in the left arm, and 123/65 in the right arm at 10:34 a.m., and 140/60 in the right arm at 10:46 a.m. Additionally, Patient A's EKG was read to be sinus bradycardia, and her troponin levels, at 10:34 a.m., were 8.7 nanograms per liter which was within normal limits.

6. Upon reevaluation of the patient, the ED physician noted that Patient A would be admitted for a "full cardiac evaluation".

7. Respondent's notes for Patient A on April 29, 2021, show the presence of a history and physical exam and was mostly consistent with the other ED physician's notes. However, Respondent failed to note which arm Patient A's blood pressure readings were coming from and never addressed the differential blood pressures between Patient A's left and right arm, even though the data had shown vastly different results. Further, Respondent's notes document that Patient A stated her pain level was a 10/10, but there is no reference to which part of the body this pain was coming from, and Respondent specifically noted that Patient A had "no abdominal pain."

8. On April 29, 2021, at approximately 2:00 p.m., an assessment and plan noted that Patient A was experiencing abdominal pain, and Respondent ordered a STAT CT without contrast. Respondent did not read the results of the CT until the next morning on April 30, 2021, at 7:38 a.m., and without IV contrast, the diagnosis was unclear and warranted a further workup to exclude aortic dissection.

9. On April 29, 2021, at 8:21 p.m., Patient's A's troponin level had increased from the initial value of 8.7 to a critical value of 220.1, however, Patient A was not transferred to a higher level of care.

10. On April 30, 2021, at 5:01 a.m., a nurse's note stated Patient A had, "trending troponin with no order given." It is further noted that Patient A was complaining of abdominal pain and heartburn. Patient A was also not eating due to the abdominal pain she was experiencing and had an inability to tolerate food.

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11. On April 30, 2021, at 10:19 a.m., an occupational therapist noted that Patient A's support level was moderate due to chest pain and dizziness. It is also noted again that Patient A had an up-trending troponin level.

12. The final nurse's note, dated April 30, 2021, at 11:13 a.m., stated Patient A fainted while the CNA was changing her bed. A rapid response was called and the "code blue team" was called. The note goes on to state that the patient had not complained of chest pain that morning.

13. On April 30, 2021, at 11:31 a.m., Patient A was pronounced deceased from an acute myocardial infraction due to hypertension induced by diabetes; however, nowhere in the record, including the discharge summary drafted by Respondent, was Patient A ever listed as having diabetes, past or present.

14. Respondent's work-up of Patient A's past medical history, her cardiovascular risk factors, and her symptoms when presenting to Respondent should have led to a potential diagnosis of aortic dissection. Because of the missed diagnosis and the failure to follow up on the CT results in a timely manner, Patient A's treatment was jeopardized.

COUNT I

NRS 630.301(4) - Malpractice

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

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

17. 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."

18. 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 correctly diagnose Patient A, despite multiple indicators being present of possible aortic dissection, and by failing to both follow up on, and order the STAT CT of Patient A's abdomen *with* contrast.

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

COUNT II

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

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

21. 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.

22. Respondent failed to maintain complete medical records relating to the diagnosis, treatment, and care of Patient A, by failing to document which arm the blood pressure readings were coming from, failing to address the differential blood pressures between Patient A's left and right arm, and by listing diabetes as a contributing factor to Patient A's death, despite there being nothing in the medical record to substantiate a diagnosis of diabetes.

23. 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

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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 10th day of April, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Alexander J. Hinman

ALEXANDER J. HINMAN
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Aury Nagy, 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 10th day of April, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
AURY NAGY, M.D.
Chairman of the Investigative Committee

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