

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint

Case No. 25-37813-1

Against:

SONIA MICHELLE CEBALLOS, M.D.,

Respondent.

FILED

DEC 10 2025

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: 

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through Ian J. Cumings, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Sonia Michelle Ceballos, 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. 13633). Respondent was originally licensed by the Board on July 12, 2010. Respondent's specialty is listed with the Board as Obstetrics and Gynecology.

2. Patient A² was a fifty (50) year-old female at the time of the events at issue.

3. Patient A had a relevant medical history of uterine fibroids and an enlarged uterus.

4. On May 25, 2023, Patient A presented to Respondent's practice for surgery. Respondent performed an open abdominal hysterectomy to treat an enlarged fibroid uterus.

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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 Chowdhury H. Ahsan, M.D., PH.D., FACC, Ms. Pamela J. Beal, and Irwin B. Simon, M.D., FACS.

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.

1 During the procedure, Respondent inadvertently damaged Patient A's left ureter and post-
2 operatively failed to discover the injury to the adjacent structure.

3 5. On June 2, 2023, Patient A presented for her first post-operative visit. Respondent
4 documented that Patient A denied any issues, and the wound was healing well without any signs
5 of infection. Following the June 2, 2023, appointment, Patient A called the Respondent's practice
6 stating that she was having gas pains, bloating, constipation, and nausea every day since her
7 surgery.

8 6. June 29, 2023, Patient A presented for a second post-operative visit with
9 documented complaints of lower abdominal pain when going to the bathroom, constipation, and
10 hemorrhoids.

11 7. On July 17, 2023, Patient A presented to the emergency room with complaints of
12 diffuse abdominal pain, bloating, shortness of breath, nausea and pain. A computed tomography
13 (CT) scan, with and without contrast was obtained. The CT scan demonstrated moderate
14 abdominal ascites, two (2) small lesions on the liver, and left-sided swelling of the kidney and a
15 delay in excretion of contrast material from the left kidney. Patient A was admitted to the
16 hospital, and two (2) paracentesis procedures were performed to remove six (6) liters of fluid.
17 After this procedure, Patient A noted improvement in her pain.

18 8. On July 20, 2023, Respondent was consulted on Patient A's condition. No
19 evaluation of the patient's kidney or left hydronephrosis or decreased kidney function was
20 requested, and Patient A was referred to gastroenterology. Respondent failed to diagnose the
21 injury to Patient A's left ureter, despite the imaging showing the left renal collecting system
22 abnormality.

23 9. Patient A was correctly diagnosed by a hepatologist as having kidney damage
24 following the injury to her ureter and ultimately required removal of her left kidney.

25 COUNT I

26 **NRS 630.301(4) - Malpractice**

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

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

12. 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.”

13. 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 failing to consider or diagnose injury to Patient A’s ureter following the July 17, 2023, CT scan which demonstrated left-sided swelling of the kidney, and impaired kidney function.

14. 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

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

16. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

17. 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 medical services.”

18. Respondent failed to timely seek consultation with regard to Patient A’s medical condition after July 17, 2023. Respondent should have consulted with an appropriate care provider 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 with regard to her impaired kidney function, which was evident on the July 17, 2023 CT scan.

OFFICE OF THE GENERAL COUNSEL

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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

WHEREFORE, the IC 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;

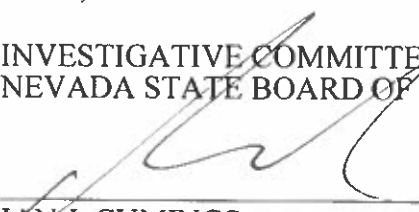
5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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

DATED this 10th day of December, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:


IAN J. CUMINGS
Senior Deputy General Counsel
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Attorney for the Investigative Committee

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 10th day of December, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:


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