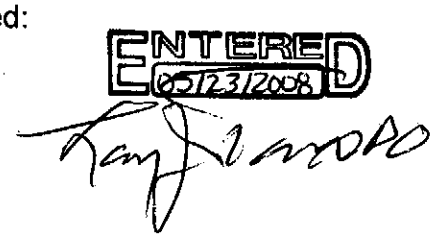
ORIGINAL

BEFORE THE NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

IN THE MATTER OF THE COMPLAINT
AGAINST
KIAN KAVEH, D.O.,
RESPONDENT.

Case No.: PB-06-3-718

Filed:



COMPLAINT FOR DISCIPLINARY ACTION

AND NOTICE OF HEARING

The NEVADA BOARD OF OSTEOPATHIC MEDICINE ("Board"), by and through its counsel, Catherine Cortez Masto, Attorney General of the State of Nevada, and NANCY D. SAVAGE, Senior Deputy Attorney General, and its Investigative Board Member, James Anthony, D.O., hereby notifies RESPONDENT KIAN KAVEH, D.O. of an administrative hearing, which is to be held pursuant to Chapters 633, 622 and 233B of the Nevada Revised Statutes ("NRS") and Chapter 633 of the Nevada Administrative Code ("NAC"). The purpose of the hearing is to consider the allegations stated below and to determine if discipline will be imposed on the RESPONDENT pursuant to the provisions of NRS 633.651 and/or NRS 633.527. The Board asserts and alleges as follows:

JURISDICTION

1. RESPONDENT is and has at all relevant times been licensed to practice medicine in the State of Nevada, by the Board of Osteopathic Medicine of the State of Nevada pursuant to the provisions of NRS Chapter 633.

2. At all relevant times, RESPONDENT was engaged in the practice of osteopathic medicine in the County of Clark, State of Nevada.

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3. Based upon information and belief, RESPONDENT engaged in the practice of medicine at or through the Shiraz Clinic ("RESPONDENT'S clinic").

4. At all relevant times, RESPONDENT held himself out as knowledgeable concerning the treatment and procedures being rendered to Patient A.

5. The Board has jurisdiction over the discipline of RESPONDENT for violations of law during RESPONDENT'S practice of osteopathic medicine.

FACTUAL ALLEGATIONS

6. On or about March 8, 2005, Patient A, a female in her thirties, became a patient of RESPONDENT.

7. Patient A continued to be under the care and treatment of RESPONDENT until sometime in or about October of 2005.

8. On or about March 8, 2005, Patient A appeared for her first appointment at RESPONDENT'S clinic, accompanied by her husband.

9. During her appointment on or about March 8, 2005, Patient A was not seen, and did not have an opportunity to confer with RESPONDENT or any other physician.

10. Patient A went to RESPONDENT'S clinic ("clinic") for the purpose of obtaining a lip augmentation or enhancement.

11. During the course of her appointment on or about March 8, 2005, Patient A was seen by and met with an individual named Denise, who injected Radiesse or Radiance into Patient A's upper and lower lips.

12. Patient A was not advised, by anyone at RESPONDENT'S clinic, that there were any risks associated with receiving an injection(s) of Radiesse or Radiance at any time prior the receiving an injection from Denise.

13. Patient A did not give an informed consent to undertake any risks associated with the procedure/treatment provided to her at the RESPONDENT'S clinic on or about March 8, 2005.

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14. On or about March 8, 2005, Denise injected the amount of Radiesse or Radiance remaining after Patient A's lip augmentation procedure into her husband's forehead.

15. Within days following the Radiesse/Radiance injections, Patient A felt lumps forming in her lips.

16. On or about March 25, 2005, Patient A returned to the clinic, complaining about the lumps in her lips.

17. On or about March 25, 2005, Patient A was told by RESPONDENT, for the first time, that there were risks associated with the injection of Radiesse or Radiance, including the risk of formation of calcium deposits.

18. RESPONDENT advised Patient A on March 25, 2005 calcium deposits had formed in her lips, causing the lumps that she felt.

19. Patient A's office visit with RESPONDENT on or about March 25, 2005 is not noted in her chart or records maintained by RESPONDENT.

20. RESPONDENT advised Patient A that Kenalog injections would help break up the calcium deposits.

21. On or about April 1, 2005, Patient A was given an injection of Kenalog by Denise, at RESPONDENT'S clinic.

22. On or about April 22, 2005 Patient A received another Kenalog injection, at RESPONDENT'S clinic from Denise.

23. On or about September 7, 2005 Patient A returned to the clinic at which time she met with Roxanna Kaveh, discussed her displeasure with the services provided and requested a refund.

24. Patient A was not given a refund and was instead convinced to return to the clinic for further treatment.

25. Patient A's medical records from the clinic do not have an entry or notes of any kind concerning the September 7, 2005 visit.

26. On or about September 22, 2005, Patient A returned to the clinic, at which time

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Denise injected additional Restylane and Sculptra into her upper.

27. The label from the Restylane, provided by the manufacturer to be attached to the patient's chart, was not attached to Patient A's chart or medical record for the injection that she received on or about September 22, 2005.

28. RESPONDENT failed to accurately and completely document the appropriate information concerning the Restylane, contained on the label, in any manner in Patient A's medical records, at any time.

29. RESPONDENT failed to completely and accurately document appropriate information concerning the Sculptra injected into Patient A's lips during her September 22, 2005 office visit.

30. Patient A has subsequently undergone multiple surgeries by other physicians to remove the Radiesse from her lips.

31. Patient A was not advised by RESPONDENT or his staff of any risks associated with having Radiesse injected into her lips, and did not provide an informed consent, or any consent for being exposed to any such risks, prior to being given injections of Restylane and/or Radiesse at RESPONDENT'S clinic.

32. Patient A was not advised by RESPONDENT or his staff of any risks associated with having Restylane injected into her lips, and did not provide an informed consent, or any consent for being exposed to any such risks, prior to being given injections of Restylane and/or Radiesse at RESPONDENT'S clinic.

33. Patient A was not advised by RESPONDENT or his staff of any risks associated with having Sculptra injected into her lips, and did not provide an informed consent, or any consent for being exposed to any such risks, prior to being given injections of Sculptra at RESPONDENT'S clinic.

34. RESPONDENT knew or should have known, in and prior to 2005, that Kenalog would not to be effective for dissolving or breaking up nodules or calcium formations caused by injections of Radiesse or Radiance.

35. RESPONDENT held himself out to Patient A as a knowledgeable physician,

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experienced in the services and treatments prescribed, and provided to her at RESPONDENT'S clinic.

36. In or about October of 2005, Patient A sought to contact "Denise", the staff member at RESPONDENT'S clinic who had given her the injections, to ask questions pertaining to Patient A's treatment and the resulting condition.

37. Although Patient A had been told she could contact Denise with such questions, she was not permitted to speak with Denise and, instead subsequently received a letter from RESPONDENT'S attorney demanding that she cease and desist any attempts to contact RESPONDENT or his staff.

38. Through the November 4, 2005 letter, RESPONDENT, acting through his representative explicitly refused to provide further care and treatment to Ms. Torres for the condition that his Clinic, under his supervision, had created.

39. In the November 4, 2005 letter made false and accusatory statements concerning Patient A and threatened that RESPONDENT would sue her if she attempted further contact with RESPONDENT.

40. RESPONDENT was copied on his counsel's November 4, 2005 letter to Patient A,

41. RESPONDENT has taken no action to correct or retract that which was stated in his counsel's November 4, 2005 letter.

42. On or about January 11, 2006, Patient A filed a complaint with the Board concerning the matters set forth herein.

43. On or about January 25, 2006, the Board of Osteopathic Medicine ("Board") sent a letter to RESPONDENT advising that an investigation had been opened concerning the above matter, and requesting that he provide the Board, pursuant to NRS 629.061, with Patient A's medical records.

44. On or about March 8, 2006, the Board sent a second request to RESPONDENT for Patient A's medical records.

45. RESPONDENT failed to respond to either the January 25, 2006 letter or to the

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March 8, 2006 letter.

46. RESPONDENT has failed to cooperate with the Board in its investigation of the instant case.

47. During the course of investigation into the allegations of Patient A's Complaint, it was discovered that RESPONDENT had failed to report to the Board multiple medical malpractice actions filed against him.

48. On or about September 30, 2004, a medical malpractice action was filed against RESPONDENT in the State District Court in Clark County, Nevada, in Case No. A492958.

49. RESPONDENT failed to report to the Board that he had been sued for malpractice in Case No. A492958.

50. On or about August 16, 2005, a medical malpractice action was filed against RESPONDENT in the State District Court in Clark County, Nevada, in Case No. A508624.

51. RESPONDENT failed to report that he had been sued for medical malpractice in Case No. A508624 to the Board.

52. On or about September 28, 2006, a medical malpractice lawsuit was filed against RESPONDENT in State District Court, Clark County, Nevada, in Case No. A528974.

53. RESPONDENT failed to report to the Board that he had been sued for medical malpractice in Case No. A528974.

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VIOLATIONS OF LAW

Pursuant to the allegations above, RESPONDENT has committed the following violations of law:

COUNT ONE

RESPONDENT committed unprofessional conduct pursuant to NRS 633.131(f)(2) by failing to explain the possible risks of Radiesse and/or Radiance to Patient A in or

about March of 2005.

COUNT TWO

RESPONDENT committed unprofessional conduct pursuant to NRS 633.131(f)(2) by failing to obtain a knowing consent from Patient A, for procedure(s) performed upon and/or treatment provided to Patient A in or about March 8, 2005.

COUNT THREE

RESPONDENT committed unprofessional conduct pursuant to NRS 633.131(f)(2) by failing to explain to Patient A the possible risks of Restylane in or about September of 2005.

COUNT FOUR

RESPONDENT committed unprofessional conduct pursuant to NRS 633.131(f)(2) by failing to obtain a knowing consent from Patient A for procedure(s) performed upon and/or treatment provided to Patient A, involving Restylane, in or about September of 2005.

COUNT FIVE

RESPONDENT committed unprofessional conduct pursuant to NRS 633.131(f)(2) by failing to explain the possible risks of Sculptra in or about September of 2005.

COUNT SIX

RESPONDENT committed unprofessional conduct pursuant to NRS 633.131(f)(2) by failing to obtain her knowing consent for procedure(s) and/or treatment provided to Patient A, involving Sculptra, in or about September of 2005.

COUNT SEVEN

RESPONDENT committed unprofessional conduct pursuant to NRS 633.131(f)(1) when he advised Patient A, in or about 2005, that injections of Kenalog would break up the nodules or calcium formation caused by the Radiesse or Radiance injections.

COUNT EIGHT

RESPONDENT committed unprofessional conduct pursuant to NRS 633.131(f)(1) by

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treating Patient A with injections of Kenalog, which he knew or should have known would not break up the calcium formations or nodules, which Patient A had developed as a result of the course of treatment provided by RESPONDENT, and/or under his direction.

COUNT NINE

RESPONDENT committed professional incompetence, pursuant to NRS 633.511(1) in the utilizing of Radiesse (aka Radiance) and/or Kenalog in the treatment of Patient A, which conduct evidenced a lack of knowledge and/or training in the area of practice in which he held himself as having expertise.

COUNT TEN

RESPONDENT committed unprofessional conduct, pursuant to NRS 633.131(1)(m) by failing to maintain timely, accurate and complete medical records of the diagnosis, treatment and care of Patient A at or about the time of her office visit of March 8, 2005.

COUNT ELEVEN

RESPONDENT committed unprofessional conduct, pursuant to NRS 633.131(1)(m) by failing to maintain timely, accurate and complete medical records of the diagnosis, treatment and care of Patient A at or about the time of her office visit of March 25, 2005.

COUNT TWELVE

RESPONDENT committed unprofessional conduct, pursuant to NRS 633.131(1)(m) by failing to maintain timely, accurate and complete medical records of the diagnosis, treatment and care of Patient A at or about the time of her office visit of April 1, 2005.

COUNT THIRTEEN

RESPONDENT committed unprofessional conduct, pursuant to NRS 633.131(1)(m) by failing to maintain timely, accurate and complete medical records of the diagnosis, treatment and care of Patient A at or about the time of her office visit of April 22, 2005.

COUNT FOURTEEN

RESPONDENT committed unprofessional conduct, pursuant to NRS 633.131(1)(m) by

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failing to maintain timely, accurate and complete medical records of the diagnosis, treatment and care of Patient A at or about the time of her office visit of September 7, 2005.

COUNT FIFTEEN

RESPONDENT committed unprofessional conduct, pursuant to NRS 633.131(1)(m) by failing to maintain timely, accurate and complete medical records of the diagnosis, treatment and care of Patient A at or about the time of her office visit of September 22, 2005.

COUNT SIXTEEN

RESPONDENT committed unprofessional conduct, pursuant to NRS 633.131(1)(m) by failing to maintain timely, accurate and complete medical records of the diagnosis, treatment and care of Patient A at or about the time of her office visit of October 3, 2005.

COUNT SEVENTEEN

RESPONDENT violated NRS 629.061(1)(g) by failing to provide Patient A's records to the Board of Osteopathic Medicine when requested by letter dated January 25, 2006.

COUNT EIGHTEEN

RESPONDENT violated NRS 629.061(1)(g) by failing to provide Patient A's records to the Board of Osteopathic Medicine when requested a second time by letter dated March 8, 2006.

COUNT NINETEEN

RESPONDENT violated NAC 633.350(2) by refusing any communication from Patient A concerning the conditions which continued as a result of RESPONDENT'S treatment.

COUNT TWENTY

RESPONDENT violated NAC 633.350(5) by failing to create or generate a record concerning Patient A's office visit on or about March 25, 2005.

COUNT TWENTY-ONE

RESPONDENT violated NAC 633.350(5) by failing to create or generate a record

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concerning Patient A's office visit on or about September 7, 2005.

COUNT TWENTY-TWO

RESPONDENT committed professional incompetence pursuant to NRS 633.511 by failing to safely and skillfully practice osteopathic medicine premised upon the totality of his acts and omissions in the matter described hereinabove.

COUNT TWENTY-THREE

RESPONDENT did not see, examine, or have any communication with Patient A as a new patient, before she underwent Radiesse/Radiance injections in the clinic, and thereby committing professional incompetence pursuant to NRS 633.511(1).

COUNT TWENTY-FOUR

RESPONDENT did not see, examine, or have any communication with Patient A as a new patient, before she underwent Radiesse/Radiance injections in the clinic, and thereby committed gross malpractice pursuant to NRS 633.511(4).

COUNT TWENTY-FIVE

RESPONDENT violated NRS 633.527 by failing to report a District Court complaint for medical malpractice filed against him on or about September 30, 2004.

COUNT TWENTY-SIX

RESPONDENT violated NRS 633.527 by failing to report a District Court complaint for medical malpractice filed against him on or about August 16, 2005.

COUNT TWENTY-SEVEN

RESPONDENT violated NRS 633.527 by failing to report a District Court complaint for medical malpractice filed against him on or about September 28, 2006.

COUNT TWENTY-EIGHT

RESPONDENT violated NRS 633.511(4) and committed gross negligence by permitting Patient A's husband to be injected with the Restylane or Radiesse which remained after Patient A's injection was complete on or about March 8, 2005.

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COUNT TWENTY-NINE

RESPONDENT violated NRS 633.511(1) and engaged in unprofessional conduct in violation of NRS 633.131(f)(2) by permitting the staff under his supervision and direction to inject the Restylane or Radiesse remaining at the completion of the procedure on Patient A into her husband.

DISCIPLINE

WHEREFORE, Counts One through Twenty-nine, inclusive, and each of them, constitute a basis for the initiation of disciplinary action by the Board of Osteopathic Medicine pursuant to NRS 633.511, the Board of Osteopathic Medicine prays that appropriate discipline be imposed upon RESPONDENT as follows:

1. The Nevada State Board of Osteopathic Medicine or its hearing officer conduct a hearing on this Complaint;

2. Pursuant to NRS 633.651 discipline be imposed upon RESPONDENT, KIAN KAVEH, D.O. for each violation that he has committed, which discipline may include a public reprimand and/or licensee revocation or suspension, which can be limited to a specified branch of osteopathic medicine, and/or probation with such conditions and terms as are deemed just and proper and which are not inconsistent with law;

3. For RESPONDENT'S violation of NRS 633.527, as described in Count Twenty-Five, that RESPONDENT be fined $5000, pursuant to NRS 633.527(2);

4. For RESPONDENT'S violation of NRS 633.527, as described in Count Twenty-Six, RESPONDENT be fined $5000, pursuant to NRS 633.527(2);

5. For RESPONDENT'S violation of NRS 633.527, as described in Count Twenty-Six, RESPONDENT be fined $5000, pursuant to NRS 633.527(2);

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5. That RESPONDENT be required to pay all attorney's fees, investigative costs, and all other amounts recoverable to the Board, pursuant to NRS 622.400;and

6. For such other penalties or relief as may be deemed just and proper in the circumstances.

HEARING

A hearing officer will be assigned to hear your case. You will be notified of the assignment of a hearing officer and of the scheduling of the hearing in this matter, as well as any pre-hearing conferences.

YOUR RIGHTS AT THE HEARING: As a RESPONDENT, have the right to appear and be heard in your own defense, either personally or through your counsel of choice. At the hearing, the Board, through its counsel, has the burden of proving the allegations in the Complaint and will call witnesses, introduce exhibits, and present evidence against you. You have the right to respond and to present relevant evidence and argument on all issues involved. You have the right to call and examine witnesses, introduce exhibits, and cross-examine opposing witnesses on any matter relevant to the issues involved. The hearing will be recorded by a certified court reporter, and you will be entitled to a copy of the transcript, if desired, at your expense.

You have the right to request that the hearing officer issue subpoenas to compel witnesses to testify and/or evidence to be offered on your behalf. In making this request, you may be required to demonstrate the relevance of the witness' testimony and/or evidence.

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Other important rights and obligations, including your obligation to answer the complaint, are listed in NRS Chapter 633, NRS Chapter 622, NRS Chapter 233B, and NAC 633.

DATED this 23rd day of May 2008

NEVADA BOARD OF OSTEOPATHIC MEDICINE

By _____
James Anthony, D.O.
Investigating Member of the
Nevada Board of Osteopathic Medicine

Submitted by:

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By _____
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