9600 Gateway Drive Reno, Nevada 89521 (775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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5 In the Matter of Charges and Complaint

Against 6

CHARLES WAYNE FLEISHER, M.D.,

Respondent.

Case No. 20-11931-1

FILED

SEP - 2 2020

NEVADA STATE BOARD OF MEDICAL EXAMINERS

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert Kilroy, Esq., General Counsel and attorney for the IC, having a reasonable basis to believe that Charles Wayne Fleisher, 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:

- Respondent was at all times relative to this Complaint a medical doctor holding an 1. active license to practice medicine in the State of Nevada (License No. 8351). Respondent was originally licensed by the Board on August 6, 1997.
- Patient A's true identity is not disclosed herein to protect her privacy, but is 2. disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.
- 3. On March 28, 2014, Patient A underwent a repeat ultrasound at Respondent's office. That ultrasound result revealed a large pelvic mass that was palpable, mobile and very tender. According to the Respondent, this "new mass" needed to be removed as soon as possible. Respondent recommended a robot-assisted laparoscopic hysterectomy (RALH) with an excision of the pelvic mass and a possible oophorectomy. Respondent did not document whether he offered alterative testing (CT

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 Rachakonda D. Prabhu, M.D., Chairman, Ms. Sandy Peltyn, and Victor M. Muro, M.D.

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scan) to determine exactly where Patient A's mass was located, and he did not specifically indicate whether the mass might be either in the uterus or her ovaries. Patient A signed several different consent forms that were not documented in the medical record of Patient A.

4. On April 7, 2014, Respondent performed the RALH. He documented that there was found a mildy enlarged uterus with a simple cyst in the right ovary, a simple paratubal cyst on the left, with no notable fibroids, and large firm areas of the sigmoid colon that could be consistent with impacted fecal material or some other colon mass. Based upon the aforementioned, Respondent sought a consultation from Dr. Laura Dacks, a general surgeon, who was called into the operating room as a consulting physician, as documented in the OR Nursing Document. The examination conducted by Dr. Dacks indicated that there didn't appear to be any acute process going on with the bowel that required any immediate intervention, and she advised Respondent that once Patient A was out of the hospital, then Patient A needed to see a gastroenterologist and have a colonoscopy. However, Respondent's operative report failed to document this intraoperative consultation from Dr. Danks. Respondent found uterine hypertrophy, and documented in the operative report that he decided to proceed with the RALH. Respondent noted in his operative report that the palpable masses during exam under anesthesia were "probably pedunculated fibrioids based on the bimanual exam." The uterine pathogy indicated "chronic endocervicitis with focal squamous mataplasia and proliferative endometrium and normal myometrium." Respondent noted the abnormality of Patient A's colon, which he concluded was the new mass identified preoperatively. Respondent informed Patient A and her husband of the intraoperative findings, and advised that she would need to follow up with a gastroenterologist. Discharge instructions also advised the patient to make follow up office visits with Respondent and her primary care physician.

Count I

(Failure to Maintain Complete Medical Records)

(NRS 630.3062(1)(a))

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

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6.	NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate
and complet	e medical records relating to the diagnosis, treatment and care of a patient is ground
for initiating	disciplinary action against a licensee.

- 7. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete.
- 8. 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 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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5. That the Board take such other and further action as may be just and proper in these premises.

DATED this ____day of September, 2020.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 144

Robert Kilroy, Esq., General Counsel Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners

VERIFICATION

STATE OF NEVADA)
	: ss.
COUNTY OF CLARK)

Rachakonda D. Prabhu, 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 **2nd** day of September, 2020.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

Rachakonda D. Prabhu, M.D., Chairman

OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners

CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 2nd day of September, 2020; I served a filed copy of the COMPLAINT and Fingerprint documents via USPS e-certified return receipt mail to the following:

> Charles Wayne Fleisher, M.D. c/o Jill Chase, Esq. Lewis Brisbois Bisgaard & Smith 6385 So. Rainbow Blvd, Ste 600 Las Vegas, Nevada 89118

Dated this 2nd day of September, 2020.

Laun Udawen Solclibe
Dawn DeHaven Gordillo

Legal Assistant