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**BEFORE THE BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF NEVADA**

\* \* \* \* \*

**In the Matter of Charges and  
Complaint Against  
HANS-JORG WALTER ROSLER, M.D.,  
Respondent.**

**Case No. 19-26862-1**

**FILED**

**OCT - 8 2019**

NEVADA STATE BOARD OF  
MEDICAL EXAMINERS  
By: 

**COMPLAINT**

The Investigative Committee<sup>1</sup> (IC) of the Nevada State Board of Medical Examiners (Board), by and through Aaron Bart Fricke, Esq., Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Hans-Jorg Walter Rosler, 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 relevant to this Complaint, a physician licensed to practice medicine in the State of Nevada (License No. 10364). His license was originally issued by the Board on November 26, 2002.

**A. Respondent's Failure to Supervise a Physician Assistant**

2. At all times relevant to this Complaint, Respondent supervised Steven Lee Olenchak, PA-C, a physician assistant licensed by the Board (Olenchak), pursuant to a formal notice of supervision provided to the Board in accord with NAC 630.360(4), wherein Respondent certified that he had read and was aware of all provisions of NRS Chapter 630 and NAC Chapter 630 concerning his duties as a physician supervising Olenchak.

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<sup>1</sup> The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), at the time this formal Complaint was authorized for filing, was composed of Board members Mr. M. Neil Duxbury, Chairman, Aury Nagy, M.D., and Michael C. Edwards, M.D., FACS.

1 3. Pursuant to NAC 630.370(5), Respondent was required to develop and carry out a  
2 program to ensure the quality of care provided by Olenchak, and to maintain accurate records and  
3 documentation regarding his program of supervision of Olenchak.

4 4. Respondent failed to develop and carry out a program to ensure the quality of care  
5 provided by Olenchak, and to maintain accurate records and documentation regarding his program  
6 of supervision of Olenchak.

7 **COUNT I**

8 **NRS 630.3065(2)(a) (Knowing Failure to Comply With A Regulation of the Board)**

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

11 6. Pursuant to NRS 630.3065(2)(a), knowingly failing to comply with a regulation of  
12 the Board is grounds for disciplinary action against a licensee.

13 7. As demonstrated by, but not limited to, the above-outlined facts, Respondent  
14 knowingly failed to comply with NAC 630.370(5).

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

17 **B. Respondent's Responsibility for Improper Care by Supervisee Physician Assistant**

18 9. Patient A's true identity is not disclosed herein to protect his or her privacy, but is  
19 disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

20 10. Patient A was a close personal friend of Olenchak, who also treated Patient A for  
21 chronic pain with opioid analgesics, along with amphetamines and other controlled substances.

22 11. Patient A suffered from opioid dependence, polysubstance abuse disorder,  
23 substance-induced mood disorder, and depressive disorder, among other ailments.

24 12. On July 27, 2014, Patient A died in a motor vehicle collision from multiple blunt  
25 force injuries to the head. At the time of the crash, Patient A was under the influence of the  
26 controlled substances that Olenchak prescribed.

27 13. Pursuant to the Board's Order of September 6, 2019, in Case No. 19-22430-1,  
28 Olenchak admitted, and the Board formally found, that Olenchak violated standards of practice

1 regarding the prescription of opioid analgesics to Patient A (*see* NRS 630.306(1)(b)(2)), and failed  
2 to maintain proper records for Patient A (*see* NRS 630.3062(1)(a)), for which conduct Olenchak  
3 was formally disciplined by the Board.

4 14. Pursuant to NAC 630.370, as Olenchak’s supervising physician, Respondent is  
5 responsible for all the medical activities of Olenchak, including his care of Patient A and  
6 maintenance of medical records for Patient A.

7 15. Pursuant to NAC 630.375, Olenchak is considered to be and is deemed the agent  
8 of Respondent in the performance of all medical activities, including his care of Patient A and  
9 maintenance of medical records for Patient A.

10 **COUNT II**

11 **NRS 630.306(1)(b)(2) (Violation of Standards of Practice)**

12 16. All of the allegations in the above paragraphs are hereby incorporated by reference  
13 as though fully set forth herein.

14 17. A physician assistant is subject to discipline for violating a provision of NRS  
15 630.301 through 630.3065 inclusive, pursuant to NAC 630.380(1)(m).

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

18 19. The Board adopted by reference the *Model Policy on the Use of Opioid Analgesics*  
19 *in the Treatment of Chronic Pain*, July 2013, published by the Federation of State Medical Boards  
20 of the United States, Inc. (Model Policy).

21 20. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of  
22 writing prescriptions for controlled substances to treat chronic pain in a manner that deviates from  
23 the policies set forth in the *Model Policy on the Use of Opioid Analgesics in the Treatment of*  
24 *Chronic Pain* adopted by reference in NAC 630.187.

25 21. Olenchak wrote prescriptions to Patient A for opioid analgesics to treat chronic  
26 pain in a manner that deviated from the Model Policy.

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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);

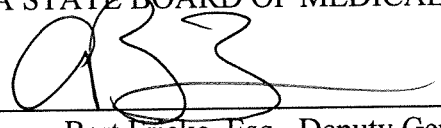
3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

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

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

DATED this 7 day of October, 2019.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:   
Aaron Bart Fricke, Esq., Deputy General Counsel  
Attorney for the Investigative Committee

VERIFICATION

1 STATE OF NEVADA )  
2 : ss.  
3 COUNTY OF WASHOE )

4 Mr. M. Neil Duxbury, having been duly sworn, hereby deposes and states under penalty of  
5 perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of  
6 Medical Examiners that authorized the Complaint against the Respondent herein; that he has read  
7 the foregoing Complaint; and that based upon information discovered in the course of the  
8 investigation into a complaint against Respondent, he believes that the allegations and charges in  
9 the foregoing Complaint against Respondent are true, accurate and correct.

10 DATED this 7<sup>th</sup> day of October, 2019.

11 INVESTIGATIVE COMMITTEE OF THE  
12 NEVADA STATE BOARD OF MEDICAL EXAMINERS

13 M. NEIL DUXBURY

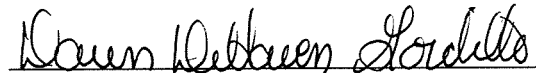
14 M. Neil Duxbury, Chairman

**CERTIFICATE OF MAILING**

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 8th day of October, 2019; I served a filed copy of the COMPLAINT (19-26862-1), via USPS e-certified return receipt mail to the following:

Hans-Jorg Walter Rosler, M.D.  
815 S. Rampart Blvd., Ste 100  
Las Vegas, NV 89145-4883

Dated this 8th day of October, 2019.

  
Dawn DeHaven Gordillo  
Legal Assistant