BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **KATRINA NIKOLE HASLETT, M.D., Respondent.**	**Case No. 21-34045-1**

FILED
NOV 0 1 2021
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 BRANDEE MOONEYHAN, J.D., Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that KATRINA NIKOLE HASLETT, 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. 12811). Respondent was originally licensed by the Board on July 11, 2008, and specializes in obstetrics and gynecology.

2. Patient A[2] was a twenty-nine (29) year-old female when she first presented to Respondent on March 28, 2013, to establish prenatal care.

3. On April 4, 2013, Patient A had a follow-up appointment at which Respondent performed a Pap test. Respondent sent the resulting specimen to a lab for screening.

4. On April 11, 2013, the lab reported to Respondent that Patient A's specimen indicated "low grade squamous intraepithelial lesion" (LGSIL).

[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 Rachakonda D. Prabhu, M.D., Chair, Victor M. Muro, M.D., and Ms. April Mastroluca.

[2] Patient A's name is not disclosed in this Complaint to protect her identity, but is disclosed in the Patient Designation contemporaneously served on Respondent with a copy of this Complaint.

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5. The American Society for Colposcopy and Cervical Pathology recommends that a pregnant woman with a diagnosis of LGSIL receive a colposcopy, and notes that in such a circumstance it is acceptable to defer a colposcopy to approximately six (6) weeks postpartum.

6. Respondent did not list the LGSIL results or need for colposcopy on Patient A's chart.

7. Respondent eventually delivered Patient A's baby by Caesarean delivery on November 4, 2013. Between learning of Patient A's Pap test results on April 11, 2013, and delivering her baby on November 4, 2013, Respondent saw Patient A in her medical office ten (10) times. Respondent's records do not reflect that she ever notified Patient A that her Pap test results were abnormal or that she needed a colposcopy after her baby was born.

8. On or about November 21, 2013, Patient A visited Respondent for a post-operative check of the incision made during the Caesarean delivery. At this visit, Respondent did not inform Patient A that her Pap test results were abnormal or that she needed a colposcopy in approximately four (4) weeks. Respondent did not document the November 21, 2013, visit in Patient A's medical record.

9. Patient A was scheduled for an additional follow-up visit with Respondent on December 17, 2013, however, Patient A canceled the appointment the day before. Respondent made no attempt to reschedule the visit or inform Patient A that her Pap test had been abnormal or that she needed a colposcopy as soon as possible.

10. Respondent next saw Patient A in her office on October 9, 2014, to address Patient A's complaints of irregular vaginal bleeding. Contrary to this being the reason for Patient A's visit, Respondent's record of the visit stated that the patient "denie[d] . . . metrorrhagia." Respondent still did not inform Patient A that her Pap test in April 2013 indicated a diagnosis of LGSIL, nor did she perform another Pap test on Patient A.

11. Respondent saw Patient A on October 20, 2014, "for evaluation of menometrorrhagia"; Respondent noted that she reviewed Patient A's blood test results with her, which were normal, and they were "now awaiting [ultrasound appointment]."

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12. On October 30, 2014, a pelvic ultrasound was performed on Patient A pursuant to Respondent's orders. The resulting medical imaging report showed that Patient A's cervix had a hyperechoic mass with blood flow, and the radiologist's differential diagnosis included "cervical polyp or cervical fibroid, however, cervical malignancy cannot be excluded."

13. On November 4, 2014, Respondent saw Patient A to follow up on the results of the ultrasound. Respondent still did not inform Patient A that her Pap test in April 2013 indicated a diagnosis of LGSIL, nor did she perform another Pap test.

14. Respondent's records do not reflect a treatment plan to address Patient A's irregular vaginal bleeding, but at some point after the October 30, 2014, ultrasound, Respondent determined to perform a dilation and curettage procedure (D&C) and hysteroscopy.

15. On December 22, 2014, Patient A visited Respondent for a preoperative consultation for the upcoming D&C/hysteroscopy. The record of this visit does not reflect that Respondent performed a pelvic exam, nor does it reflect a treatment plan.

16. On January 14, 2015, Respondent undertook to perform the planned D&C and hysteroscopy on Patient A but "upon visualization of the cervix, the cervix appeared large and friable with a somewhat posterior mass." According to her operative notes, Respondent decided to perform a biopsy.

17. The subsequent surgical pathology report revealed that Patient A had "invasive keratinizing squamous cell carcinoma with stromal invasion." Respondent referred Patient A to a gynecologist-oncologist, but Patient A asked to be referred to the Mayo Clinic.

18. On or about February 13, 2015, Patient A was diagnosed with stage IIB squamous cell carcinoma of the cervix with positive lymph node involvement.

19. Respondent's records do not document that Respondent ever discussed with Patient A that her April 2013 Pap test showed a diagnosis of LGSIL.

20. Patient A's diagnosis of LGSIL required that a colposcopy be performed approximately six (6) weeks postpartum. Respondent failed to inform Patient A of the necessity and importance of a colposcopy, failed to schedule such a procedure, and failed to follow up with Patient A when she canceled her second postpartum appointment. Even when Patient A returned

for care for irregular bleeding approximately ten (10) months after her previous visit, Respondent did not inform her of her LGSIL diagnosis or perform another Pap test.

21. Respondent's failure to properly follow up on Patient A's LGSIL diagnosis resulted in Patient A's diagnosis and treatment for cervical cancer being significantly delayed.

22. On or about January 4, 2016, a complaint for medical malpractice in which Respondent was named as a defendant was filed in a state district court. Respondent was timely served with the complaint and filed a timely answer thereto.

23. On her 2017 application for biennial renewal of her medical license, Respondent falsely answered "no" to Question Four, which asked whether during the period of July 1, 2015, through June 30, 2017, she had been "named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability [or] malpractice, including any military tort claims if applicable."

COUNT I

NRS 630.301(4) - Malpractice

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

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

26. 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."

27. 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 when she failed to make sufficient efforts to ensure that Patient A had a timely postpartum colposcopy.

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

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COUNT II

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

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

30. 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.

31. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient A when she failed to list the results of Patient A's Pap test and need for postpartum colposcopy in the patient's chart; failed to document that she ever informed Patient A of the Pap test results and need for postpartum colposcopy; made contradictory statements in her medical records; failed to document treatment plans; and failed to document at least one interaction at all.

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

COUNT III

NRS 630.304(1) – Misrepresentation in Obtaining or Renewing License

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

34. NRS 630.304(1) provides that obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement constitutes grounds for initiating disciplinary action.

35. In her 2017 application to renew her medical license, Respondent falsely answered "N" or "no" to a question asking whether she had been "named as a defendant . . . to a legal action involving professional liability [or] malpractice" from July 1, 2105, through June 30, 2017, when she had been named as a defendant in such a legal action in January 2016.

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36. 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 him 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 1st day of November, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

BRANDEE MOONEYHAN, J.D.
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Victor M. Muro, 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 1st day of November, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
VICTOR M. MURO, M.D.
Chairman of the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 1st day of November, 2021, I served a file-stamped copy of the foregoing **COMPLAINT** via U.S. Certified Mail, to the following parties:

KATRINA NIKOLE HASLETT, M.D.
5380 S. Rainbow Blvd., #306
Las Vegas, NV 89118
Tracking No. 9171 9690 0935 0252 1577 64

with a copy sent by regular mail to:

KATRINA NIKOLE HASLETT, M.D.
Spanish Ridge Ave., Ste. 202
Las Vegas, NV 89148

Courtesy copy by electronic mail to:

CHELSEA R. HUETH, ESQ.
crhueth@mcbridehall.com

DATED this 1st day of November, 2021.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners