BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against:	Case No. 22-24456-1
MARK TAYLOR, M.D.,	
Respondent.	

FILED

SEP 0[illegible] 2022

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 Ian J. Cumings, J.D., Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Mark Taylor (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. 10081). Respondent was originally licensed by the Board on February 5, 2002.

2. Patient A[2] was a 56-year-old male at the time of the events at issue.

3. On June 13, 2005, Patient A presented to the emergency department with shortness of breath. Patient A was admitted to the hospital and diagnosed with congestive heart failure and cardiomyopathy.

4. On June 17, 2005, Respondent performed a left heart catheterization and coronary angiogram on Patient A. Following completion of the catheterization and angiogram, Respondent

[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 Bret W. Frey, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Col. Eric D. Wade (USAF) Ret.

[2] Patient A's true identity is not disclosed herein to protect his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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instructed a cardiovascular technician to deploy an Angio-Seal (medical device used in closing arterial puncture site) which is deployed using a guidewire. The cardiovascular technician was unsuccessful and failed to properly remove the guidewire utilized in the Angio-Seal placement. Patient A was discharged with the guidewire still in his left subclavian artery.

5. On June 11, 2010, Patient A underwent a chest X-ray which demonstrated the presence of a retained guidewire in the Patients left subclavian artery.

6. On April 15, 2015, further imaging demonstrated the presence of the retained guidewire in Patient A's subclavian artery.

7. On October 13, 2015, CT imaging showed the retained guidewire was within Patient A's aorta extending to the right inguinal region, The measurements were consistent with the 70 cm wire supplied with the Angio-Seal device utilized in the June 17, 2005, procedure performed by the Respondent.

8. As the interventional cardiologist who performed the procedure, it was Respondent's duty to provide supervision and oversight of the procedures performed by the cardiovascular technician during the placement of the Angio-Seal device. Respondent therefore failed to ensure the guidewire was removed following the Angio-Seal device insertion.

COUNT I

NRS 630.301(4) - Malpractice

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

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

11. 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."

12. 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 appropriately supervise the cardiovascular

technician, his medical assistant, when he failed to extract the guidewire while placing the Angio-Seal leading to the retention of the guidewire inside Patient A's left subclavian artery.

13. 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)(r) - Failure to Adequately Supervise

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

15. NRS 630.306(1)(r) provides that a failure to adequately supervise a medical assistant pursuant to the regulations of the Board is an act that constitutes grounds for initiating disciplinary action.

16. By the conduct described herein, Respondent failed to adequately supervise the cardiovascular technician, his medical assistant, during the June 17, 2005, procedure in the performance of medical tasks assigned to them by the Respondent.

17. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners 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 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

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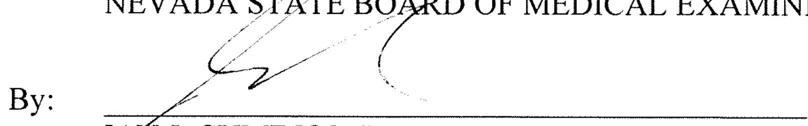
6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 15th day of September, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



By: ______________________________

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, 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 September, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

BRET W. FREY, M.D.
Chairman of the Investigative Committee