

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

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In the Matter of Charges and Complaint

Case No. 22-8666-1

Against:

MICHAEL SCOTT MALL, M.D.,

Respondent.

FILED

MAY - 5 2022

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
By: 

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through Donald K. White, J.D., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Michael Scott Mall, 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. 6074). Respondent was originally licensed by the Board on July 1, 1990.

PATIENT A

2. Patient A was a twenty-nine (29) year old female patient during the events in question. Her identity is not disclosed herein to protect her privacy but is disclosed in the Patient Designation served upon Respondent, along with a copy of this Complaint, and filed under seal.

3. Patient A visited Respondent, a family practice physician, for treatment on or about October 1, 2013, until approximately January 6, 2014.

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¹ The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing on May 14, 2021 and was composed of Board members Mr. M. Neil Duxbury, Aury Nagy, M.D., and Michael C. Edwards, M.D., FACS.

1 4. Patient A was seen for back pain, depression, anxiety, sleeplessness, parenting
2 conflicts and mood swings.

3 5. The medical records do not contain a patient history, physical exam notes, a list of
4 medications, nor was a psychiatric exam performed on Patient A during her visits. Urine drug
5 screening was conducted with no documented evidence as to why the screen was performed nor
6 how the test was to be used.

7 6. Additionally, there is no evidence that Respondent consulted a mental health
8 practitioner for the medical treatment and plan of care for Patient A.

9 **COUNT I**

10 **NRS 630.301(4) - Malpractice**

11 7. All the allegations contained in the above paragraphs are hereby incorporated by
12 reference as though fully set forth herein.

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

15 9. NAC 630.040 defines malpractice as “the failure of a physician, in treating a
16 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar
17 circumstances.”

18 10. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
19 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
20 treating Patient A.

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

23 **COUNT II**

24 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

25 12. All the allegations contained in the above paragraphs are hereby incorporated by
26 reference as though fully set forth herein.

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1 13. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate
2 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute
3 grounds for initiating discipline against a licensee.

4 14. Respondent failed to maintain complete medical records relating to the diagnosis,
5 treatment, and care of Patient A, by failing to correctly document his actions when he treated
6 Patient A.

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

9 **PATIENT B**

10 16. All the allegations contained in the above paragraphs are hereby incorporated by
11 reference as though fully set forth herein.

12 17. Patient B was a nine (9) year old male patient during the events in question. His
13 identity is not disclosed herein to protect his privacy but is disclosed in the Patient Designation
14 served upon Respondent along with a copy of this Complaint and filed under seal.

15 18. Patient B was seen by Respondent for medical treatment from on or about
16 March 27, 2014, until on or about August 24, 2016.

17 19. The medical records in Patient B’s chart do not contain vital sign checks, evidence
18 of a physical exam, any indication that weight or growth was followed, nor an adequate patient
19 history. Respondent diagnosed Patient B with Attention Deficit Hyperactivity Disorder (ADHD),
20 Mood Disorder, and Autism, but there is no analysis, criteria or testing for how these diagnoses
21 were reached by Respondent.

22 20. Respondent prescribed Abilify and Risperidone to Patient B, while he was already
23 taking Stratera, but there is no indication of the child’s size or why both drugs were started instead
24 of only one. Additionally, there were no notes regarding a discussion of risks, benefits, side
25 effects or potential drug interactions with Patient B’s parents.

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COUNT III

NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation

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

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

23. NAC 630.210 requires a physician to "seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services."

24. Respondent failed to timely seek consultation of a mental health provider regarding Patient B's medical conditions from March 27, 2014, through August 24, 2016. Respondent should have consulted with an appropriate mental health care provider to address the doubtfulness and difficulty of Patient B's diagnoses and medical conditions, which may have enhanced the quality of medical care provided to Patient B.

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

COUNT IV

NRS 630.306(1)(e) - Practice Beyond Scope of License

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

27. NRS 630.306(1)(e) provides that practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform, or which are beyond the scope of his or her training constitutes grounds for initiating disciplinary action.

28. Patient B required a comprehensive psychiatric evaluation, which was beyond the scope of Respondent's training as a family practice physician. Instead, Patient B should have been referred to a mental health practitioner for this evaluation.

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

3 **COUNT V**

4 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

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

7 31. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate
8 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute
9 grounds for initiating discipline against a licensee.

10 32. Respondent failed to maintain legible and complete medical records relating to the
11 diagnosis, treatment, and care of Patient B, and by failing to correctly document his actions when
12 he treated Patient B.

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

15 **PATIENT C**

16 34. All the allegations contained in the above paragraphs are hereby incorporated by
17 reference as though fully set forth herein.

18 35. Patient C was a nine (9) year old male patient during the events in question. His
19 identity is not disclosed herein to protect his privacy but is disclosed in the Patient Designation
20 served upon Respondent along with a copy of this Complaint and filed under seal.

21 36. Patient B visited Respondent for treatment from on or about May 2013 until
22 approximately December 26, 2013.

23 37. The medical records kept in the normal course of business by Respondent for
24 Patient C do not contain an adequate medical or psychiatric history, vital sign notes, weight or
25 growth assessment, nor evidence of a physical exam. Respondent utilized an inadequate mental
26 status examination by checking boxes on a form to diagnose Patient C.

27 38. It is unclear why Respondent prescribed Saphris to this child. Typically, Saphris is
28 prescribed for children with bipolar disorder. However, in this case there is no documented

1 analysis for the prescribed medicine, nor is there any documentation to reflect that a parent of
2 Patient C was informed of the risks, benefits, drug interactions or diagnosis for treatment through
3 the intake of this medication.

4 **COUNT VI**

5 **NRS 630.301(4) - Malpractice**

6 39. All the allegations contained in the above paragraphs are hereby incorporated by
7 reference as though fully set forth herein.

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

10 41. NAC 630.040 defines malpractice as “the failure of a physician, in treating a
11 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar
12 circumstances.”

13 42. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
14 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
15 treating Patient C, when Respondent did not justify prescribing of Saphris, did not discuss the
16 risks and benefits with a parent, and did not document the justification or analysis for prescribing
17 Saphris to Patient C.

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

20 **COUNT VII**

21 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

22 44. All the allegations contained in the above paragraphs are hereby incorporated by
23 reference as though fully set forth herein.

24 45. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate
25 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute
26 grounds for initiating discipline against a licensee.

27 46. Respondent failed to maintain legible, accurate, and complete medical records
28 relating to the diagnosis, treatment, and care of Patient C, by failing to correctly document his

1 actions when he treated Patient C, the justification for prescribing Saphris to the patient, nor
2 documenting a discussion of the risks and benefits with the parents of Patient C.

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

5 **PATIENT D**

6 48. All the allegations contained in the above paragraphs are hereby incorporated by
7 reference as though fully set forth herein.

8 49. Patient D was a nine (9) year old female patient during the events in question. Her
9 identity is not disclosed herein to protect her privacy but is disclosed in the Patient Designation
10 served upon Respondent along with a copy of this Complaint and filed under seal.

11 50. Patient D visited Respondent for treatment on or about April 2, 2013.

12 51. The sole medical record, which is nearly illegible, does not contain documentation
13 of vital signs, current weight, notes of a physical examination or relevant past medical history.

14 52. Respondent started Patient D on a prescription for 50 mgs of Vyvance, rather than
15 the usual starting dose of 30 mgs. Respondent did not document the patient's weight, provided no
16 documentation or justification for the reason(s) he prescribed a higher dosage. Additionally, there
17 was no documentation that cardiac risk factors, benefits, contra-indications, nor medication side
18 effects were ever discussed with the parents of Patient D.

19 53. Further, Respondent prescribed Seroquel, a medication usually prescribed for
20 schizophrenia or bipolar disorder with no documentation or justification for prescribing this kind
21 of medication for Patient D. Moreover, Seroquel should not be prescribed to patients under ten
22 (10) years of age.

23 **COUNT VIII**

24 **NRS 630.301(4) - Malpractice**

25 54. All the allegations contained in the above paragraphs are hereby incorporated by
26 reference as though fully set forth herein.

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

1 65. NRS 630.306(1)(e) provides that practicing or offering to practice beyond the
2 scope permitted by law or performing services which the licensee knows or has reason to know
3 that he or she is not competent to perform, or which are beyond the scope of his or her training
4 constitutes grounds for initiating disciplinary action.

5 66. Patient D required a comprehensive psychiatric evaluation by a physician
6 specializing in psychiatric medical care, which was beyond the scope of Respondent's training as
7 a family practice physician.

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

10 **COUNT XI**

11 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

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

14 69. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate
15 and complete medical records relating to the diagnosis, treatment and care of a patient" constitute
16 grounds for initiating discipline against a licensee.

17 70. Respondent failed to maintain legible, accurate, and complete medical records
18 relating to the diagnosis, treatment, and care of Patient D, by failing to correctly document his
19 actions, analysis and justifications for diagnoses and treatment when he provided medical care to
20 Patient D.

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

23 **PATIENT E**

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

26 73. Patient E was a seven (7) year old female patient during the events in question.
27 Her true identity is not disclosed herein to protect her privacy but is disclosed in the Patient
28 Designation served upon Respondent along with a copy of this Complaint and filed under seal.

1 83. Respondent failed to maintain legible, accurate, and complete medical records
2 relating to the diagnosis, treatment, and care of Patient E, by failing to correctly document his
3 actions when he treated Patient E.

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

6 **PATIENT F**

7 85. All the allegations contained in the above paragraphs are hereby incorporated by
8 reference as though fully set forth herein.

9 86. Patient F was a thirty-six (36) year old female patient during the events in question.
10 Her identity is not disclosed herein to protect her privacy but is disclosed in the Patient
11 Designation served upon Respondent along with a copy of this Complaint and filed under seal.

12 87. Patient F visited Respondent for treatment from approximately April 23, 2013,
13 until on or about April 2, 2015.

14 88. The medical records are nearly illegible and do not contain vital signs taken at the
15 time of treatment, a medical history, a physical examination, a comprehensive psychiatric
16 examination, nor justification for prescriptions of hydrocodone/Tylenol, MS Contin and Xanax.

17 89. Patient F was prescribed Viibyrd, but there is no indication in the medical records
18 of a discussion with Patient F that an increased risk of suicide can occur.

19 **COUNT XIV**

20 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

21 90. All the allegations contained in the above paragraphs are hereby incorporated by
22 reference as though fully set forth herein.

23 91. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate
24 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute
25 grounds for initiating discipline against a licensee.

26 92. Respondent failed to maintain legible and complete medical records relating to the
27 diagnosis, treatment, and care of Patient F, by failing to correctly document his actions when he
28 treated Patient F.

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

3 **PATIENT G**

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

6 95. Patient G was a five (5) year old female patient during the events in question. Her
7 identity is not disclosed herein to protect her privacy but is disclosed in the Patient Designation
8 served upon Respondent along with a copy of this Complaint and filed under seal.

9 96. Patient G visited Respondent for treatment on or about October 17, 2013.

10 97. In the one (1) medical note provided, there are no growth measurements, vital
11 signs, or a physical examination.

12 98. The mental examination of Patient G was inadequate and merely provided a
13 diagnosis of ADHD. Respondent prescribed Clonidine to Patient G and provided no justification
14 or medical analysis describing his actions for writing the prescription for this patient in any of the
15 medical records.

16 99. There was only one (1) medical note on file for Patient G's visit, making the
17 medical records for this patient incomplete.

18 **COUNT XV**

19 **NRS 630.301(4) - Malpractice**

20 100. All the allegations contained in the above paragraphs are hereby incorporated by
21 reference as though fully set forth herein.

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

24 102. NAC 630.040 defines malpractice as "the failure of a physician, in treating a
25 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar
26 circumstances."

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1 103. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
2 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
3 treating Patient G.

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

6 **COUNT XVI**

7 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

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

10 106. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate
11 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute
12 grounds for initiating discipline against a licensee.

13 107. Respondent failed to maintain complete medical records relating to the diagnosis,
14 treatment, and care of Patient G, by failing to correctly document his actions when he treated
15 Patient G.

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

18 **PATIENT H**

19 109. All the allegations contained in the above paragraphs are hereby incorporated by
20 reference as though fully set forth herein.

21 110. Patient H was a fifty-six (56) year old female patient during the events in question.
22 Her identity is not disclosed herein to protect her privacy but is disclosed in the Patient
23 Designation served upon Respondent along with a copy of this Complaint and filed under seal.

24 111. Patient H visited Respondent for treatment from on or about January 4, 2013, until
25 on or about January 8, 2015.

26 112. Respondent’s notes are illegible and incomplete, and the intake note merely states
27 “Hx of suicide.”

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1 113. On May 22, 2014, medications are listed in the medical record, but it does not
2 contain vital signs or a physical examination. The medical record merely states that Patient H is
3 “alert happy.”

4 114. Other notes minimally state that Patient H is bipolar and to increase Zoloft, with no
5 indication when Respondent started prescribing Zoloft to Patient H with no further mention of
6 suicide risk nor provided a suicidal assessment.

7 **COUNT XVII**

8 **NRS 630.301(4) - Malpractice**

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

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

13 117. NAC 630.040 defines malpractice as “the failure of a physician, in treating a
14 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar
15 circumstances.”

16 118. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
17 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
18 treating Patient H.

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

21 **COUNT XVIII**

22 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

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

25 121. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate
26 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute
27 grounds for initiating discipline against a licensee.

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1 122. Respondent failed to maintain legible and complete medical records relating to the
2 diagnosis, treatment, and care of Patient H.

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

5 **PATIENT I**

6 124. All the allegations contained in the above paragraphs are hereby incorporated by
7 reference as though fully set forth herein.

8 125. Patient I was a fifty-eight (58) year old female patient during the events in
9 question. Her true identity is not disclosed herein to protect her privacy but is disclosed in the
10 Patient Designation served upon Respondent along with a copy of this Complaint and filed under
11 seal.

12 126. Patient I visited Respondent for treatment from on or about May 8, 2014, until on
13 or about December 3, 2015.

14 127. Patient I's medical records are incomplete relating to the prescriptions written for
15 Patient I and further do not contain vital sign information, no indication a physical examination
16 was performed, nor did the records include the patient's medical history.

17 **COUNT XIX**

18 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

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

21 129. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate
22 and complete medical records relating to the diagnosis, treatment and care of a patient" constitute
23 grounds for initiating discipline against a licensee.

24 130. Respondent failed to maintain complete medical records relating to the diagnosis,
25 treatment, and care of Patient I.

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

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PATIENT J

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2 132. All the allegations contained in the above paragraphs are hereby incorporated by
3 reference as though fully set forth herein.

4 133. Patient J was a seventeen (17) year old female patient during the events in question.
5 Her identity is not disclosed herein to protect her privacy but is disclosed in the Patient
6 Designation served upon Respondent along with a copy of this Complaint and filed under seal.

7 134. Patient J visited Respondent on or about March 13, 2014, however, that one (1)
8 medical note contains the incorrect date and mentions intake of the patient on or about December
9 2013.

10 135. The one (1) medical note for Patient J is not legible and contains no vital signs, or
11 any indication that a physical examination was performed, or the patient's past medical history
12 was taken.

13 136. The mental health examination states that Patient J was cooperative, with no
14 mention of suicide risk or the potential for Patient J to harm herself or others, despite prior
15 documentation to the contrary.

16 137. Lamictil, Seroquel, and Lexapro are prescribed with no rationale or any indication
17 that risks were discussed. There is no evidence in Patient J's medical records that Respondent
18 attempted to consult with a psychiatric physician about the care and treatment of Patient J when he
19 prescribed three (3) psychotropic medications in his role as a family physician.

20 138. There is also no indication that Respondent discussed the results of a concerning
21 urine drug screen with Patient J.

22 **COUNT XX**

23 **NRS 630.301(4) - Malpractice**

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

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

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1 141. NAC 630.040 defines malpractice as “the failure of a physician, in treating a
2 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar
3 circumstances.”

4 142. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
5 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
6 treating Patient J.

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

9 **COUNT XXI**

10 **NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation**

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

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

15 146. NAC 630.210 requires a physician to “seek consultation with another provider of
16 health care in doubtful or difficult cases whenever it appears that consultation may enhance the
17 quality of medical services.”

18 147. Respondent failed to seek consultation regarding Patient J’s medical condition
19 December 2013 through March 13, 2014. Respondent should have consulted with an appropriate
20 care provider to address the doubtfulness of the diagnosis of Patient J’s medical condition and
21 such a timely consultation could have confirmed or denied such a diagnosis and may have
22 enhanced the quality of medical care provided to Patient J regarding psychiatric care.

23 148. By reason of the foregoing, Respondent is subject to discipline by the Nevada State
24 Board of Medical Examiners as provided in NRS 630.352.

25 **COUNT XXII**

26 **NRS 630.306(1)(e) - Practice Beyond Scope of License**

27 149. All the allegations contained in the above paragraphs are hereby incorporated by
28 reference as though fully set forth herein.

1 150. NRS 630.306(1)(e) provides that practicing or offering to practice beyond the
2 scope permitted by law or performing services which the licensee knows or has reason to know
3 that he or she is not competent to perform or which are beyond the scope of his or her training
4 constitutes grounds for initiating disciplinary action.

5 151. Patient J was treated with three (3) psychotropic agents without an in-depth
6 psychiatric evaluation or consultation. Due to the severity of this patient's psychiatric condition, a
7 psychiatric evaluation would be indicated and beyond the scope of a family practitioner.

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

10 **COUNT XXIII**

11 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

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

14 154. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate
15 and complete medical records relating to the diagnosis, treatment and care of a patient" constitute
16 grounds for initiating discipline against a licensee.

17 155. Respondent failed to maintain legible and complete medical records relating to the
18 diagnosis, treatment, and care of Patient J.

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

21 **PATIENT K**

22 157. All the allegations contained in the above paragraphs are hereby incorporated by
23 reference as though fully set forth herein.

24 158. Patient K was a six (6) year old male patient during the events in question. His
25 identity is not disclosed herein to protect his privacy but is disclosed in the Patient Designation
26 served upon Respondent along with a copy of this Complaint and filed under seal.

27 159. The only medical note, dated August 28, 2014, does not contain a patient name,
28 date of birth or patient identifier, and is illegible. Also, the record does not contain growth

1 metrics, vital signs, a physical examination, or medical history, therefore, making it nearly
2 impossible to understand the ultimate diagnosis of ADHD.

3 **COUNT XXIV**

4 **NRS 630.301(4) - Malpractice**

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

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

9 162. NAC 630.040 defines malpractice as “the failure of a physician, in treating a
10 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar
11 circumstances.”

12 163. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
13 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
14 treating Patient K.

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

17 **COUNT XXV**

18 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

19 165. All the allegations contained in the above paragraphs are hereby incorporated by
20 reference as though fully set forth herein.

21 166. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate
22 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute
23 grounds for initiating discipline against a licensee.

24 167. Respondent failed to maintain legible and complete medical records relating to the
25 diagnosis, treatment, and care of Patient K.

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

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PATIENT L

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

170. Patient L was a fifty-four (54) year old female patient during the events in question. Her identity is not disclosed herein to protect her privacy but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint and filed under seal.

171. Patient L visited Respondent from approximately May 14, 2013, to on or about September 24, 2015. However, there is a gap in the medical records from approximately October 8, 2013, to on or about August 13, 2015.

172. The medical records do not contain a reasonable medical history of Patient L, a physical examination nor vital signs. Additionally, the medical records do not contain Patient L's other concerning medical issues including a history of the chronic use of narcotics and benzodiazepines.

COUNT XXVI

NRS 630.301(4) - Malpractice

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

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

175. 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."

176. 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 treating Patient L.

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

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COUNT XXVII

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

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

179. 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.

180. Respondent failed to maintain legible and complete medical records relating to the diagnosis, history, treatment, and care of Patient L.

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

PATIENT M

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

183. Patient M was an approximately nine (9) year old male patient during the events in question. His 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 and filed under seal.

184. Patient M visited Respondent from approximately May 15, 2013, to on or about November 13, 2014.

185. Most of the medical records are primarily illegible and do not contain the patient’s medical history, his vital signs, a physical examination, weights, nor growth metrics. Further, the medical records contain little to no mental health examinations and no justification for the diagnoses reached and medications prescribed.

186. On or about May 15, 2013, when Patient M was still eight (8) years old, Respondent started him on Seroquel² (100 mg), but there is no diagnosis(es) of schizophrenia or bipolar disorder. Then, the dose of Seroquel was doubled to 200 mg on June 20, 2013, by

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² Seroquel is not recommended for patients under the age of ten (10) years old.

1 Respondent without proper growth metrics, analysis, or justification for the rapid increase in
2 medication.

3 **COUNT XXVIII**

4 **NRS 630.301(4) - Malpractice**

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

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

9 189. NAC 630.040 defines malpractice as “the failure of a physician, in treating a
10 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar
11 circumstances.”

12 190. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
13 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
14 treating Patient M.

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

17 **COUNT XXIX**

18 **NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation**

19 192. All the allegations contained in the above paragraphs are hereby incorporated by
20 reference as though fully set forth herein.

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

23 194. NAC 630.210 requires a physician to “seek consultation with another provider of
24 health care in doubtful or difficult cases whenever it appears that consultation may enhance the
25 quality of medical services.”

26 195. Respondent failed to timely seek consultation regarding Patient M’s medical
27 condition from approximately May 5, 2013, through on or about November 13, 2014. Respondent
28 should have consulted with an appropriate care provider to address the doubtfulness of the

1 diagnosis(es) of Patient M's medical condition and such a timely consultation could have
2 confirmed or denied such a diagnosis and may have enhanced the quality of medical care provided
3 to Patient M regarding psychiatric care.

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

6 **COUNT XXX**

7 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

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

10 198. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate
11 and complete medical records relating to the diagnosis, treatment and care of a patient" constitute
12 grounds for initiating discipline against a licensee.

13 199. Respondent failed to maintain legible and complete medical records relating to the
14 diagnosis, treatment, and care of Patient M. Respondent did not track the child's growth metric,
15 but prescribed him Seroquel, a medication not intended for his age group, then doubled the
16 amount of medication without justification for the increase.

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

19 **WHEREFORE**, the Investigative Committee prays:

20 1. That the Board give Respondent notice of the charges herein against him and give
21 him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2)
22 within twenty (20) days of service of the Complaint;

23 2. That the Board set a time and place for a formal hearing after holding an Early
24 Case Conference pursuant to NRS 630.339(3);

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

27 4. That the Board award fees and costs for the investigation and prosecution of this
28 case as outlined in NRS 622.400;

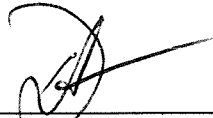
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5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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

DATED this 5th day of May, 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 5th day of May, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

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