

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

3 \* \* \* \* \*

4  
5 **In the Matter of Charges and Complaint**

**Case No. 23-9713-1**

6 **Against:**

**FILED**

7 **CHARLES FARNSWORTH HALES, M.D.,**

**APR 12 2023**

8 **Respondent.**

NEVADA STATE BOARD OF  
MEDICAL EXAMINERS  
By: \_\_\_\_\_

9  
10 **COMPLAINT**

11 The Investigative Committee<sup>1</sup> (IC) of the Nevada State Board of Medical Examiners  
12 (Board), by and through Donald K. White, Senior Deputy General Counsel and attorney for the IC,  
13 having a reasonable basis to believe that Charles Farnsworth Hales, M.D. (Respondent) violated the  
14 provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC)  
15 Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's  
16 charges and allegations as follows:

17 1. Respondent was at all times relative to this Complaint a medical doctor holding an  
18 active license to practice medicine in the State of Nevada (License No. 5485). Respondent was  
19 originally licensed by the Board on February 21, 1987.

20 2. Patient A<sup>2</sup> was a fifty-six (56) year-old female at the time of the events at issue.

21 3. On February 13, 2017, Patient A presented to the emergency department at  
22 Centennial Hills Hospital and Medical Center complaining of left leg pain for about a week with  
23 some swelling.

24 4. Patient A had a history of deep vein thrombosis (DVT) in her right leg.

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27 <sup>1</sup> The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal  
28 Complaint was authorized for filing, was composed of Board members Bret W. Frey, M.D., Col. Eric D. Wade,  
USAF (Ret.), and Carl N. Williams, Jr., M.D.

<sup>2</sup> Patient A's true 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.

1 5. Patient A was evaluated and examined by an APRN who diagnosed superficial  
2 thrombophlebitis and no swelling of the left leg was noted.

3 6. The APRN ordered a venous duplex ultrasound to rule out a DVT.

4 7. On February 13, 2017 at approximately 1:46 p.m., Respondent read the venous  
5 doppler ultrasound results as “No DVT is identified.”

6 8. The ultrasound results were conveyed to the attending emergency department  
7 physician who also examined the patient.

8 9. Based on the radiology report, the APRN’s evaluation and the attending emergency  
9 physician’s own evaluation, Patient A was discharged to home with instructions to see her primary  
10 care physician in 1-2 days.

11 10. In fact, a DVT was present in the posterior tibial vein of Patient A’s left leg.

12 11. On the morning of February 14, 2017, Patient A was found unresponsive.

13 12. EMS was called, however Patient A suffered a cardiac arrest just prior to arrival to  
14 the emergency department.

15 13. Patient A was resuscitated and treated with Heparin for a pulmonary embolism.

16 14. On February 17, 2017, Patient A suffered another cardiac arrest but could not be  
17 resuscitated.

18 15. On February 17, 2017, Patient A expired due to a massive pulmonary embolism.

19 **COUNT I**

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

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

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

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

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1           19.     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     rendering medical services to Patient A.

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

6    **COUNT II**

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

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

10          22.     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          23.     Respondent failed to maintain accurate medical records relating to the diagnosis,  
14     treatment and care of Patient A, by failing to correctly document his actions when he treated  
15     Patient A, and inaccurately reported in the medical records that no DVT was present when in fact  
16     Patient A was suffering from a DVT of the posterior tibial vein of her left leg.

17          24.     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  
22     NRS 630.339(2) 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;

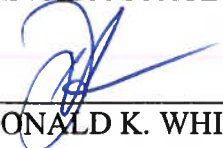
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5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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

DATED this 12<sup>th</sup> day of April, 2023.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

DONALD K. WHITE  
Senior Deputy General Counsel  
9600 Gateway Drive  
Reno, NV 89521  
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*Attorney for the Investigative Committee*

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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 12 day of April, 2023.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:   
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BRET W. FREY, 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 12th day of April 2023, I served a file-stamped copy of the foregoing **COMPLAINT**, as well as the **PATIENT DESIGNATION** and required fingerprinting materials, via USPS Certified Mail , postage pre-paid, return receipt requested, to the following parties:

CHARLES FARNSWORTH HALES, M.D.  
3356 King Edwards Ct.  
Eugene, OR 97401

Tracking No.: 9171 9690 0935 0254 7677 01

DATED this 12<sup>th</sup> day of April, 2023.

  
\_\_\_\_\_  
MERCEDES FUENTES  
Legal Assistant  
Nevada State Board of Medical Examiners