Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 (775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

5 In the Matter of Charges and Complaint

Against:

1

2

3

4

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

WARREN S. BASILAN, RRT,

Respondent.

Case No. 23-39155-1 FILED

JUN 2 6 2023

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, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Warren S. Basilan, RRT (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 respiratory therapist holding an active license to practice respiratory therapy in the State of Nevada (License No. RC1999). Respondent was originally licensed by the Board on August 10, 2011.
- 2. Pursuant to NRS 630.309 and NAC 630.540 (23), Respondent is subject to the same disciplinary measures as a practitioner of medicine.
 - 3. Patient A^2 was a sixty-nine (69) year-old male at the time of the events at issue.
- 4. On September 4, 2020, Patient A was transferred to AMG Specialty Hospital for treatment of pneumonia and respiratory failure, after spending several days at North Vista Hospital.

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.

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

	5.	Patier	nt A re	quired	a ver	ntilator	for	resp	oiratory	support,	as	he	had	a 1	history	0
chronic	respi	ratory	failure,	conge	estive	heart	failu	ıre,	chronic	obstruc	tive	pu	ılmor	nary	y disea	ıse
pulmonary hypertension, sleep apnea, morbid obesity, and metabolic encephalopathy.																

- Patient A was ventilated through a tracheostomy tube placed in his tracheostomy 6. site.
- 7. On September 21, 2020, sometime during the early morning hours, Respondent had placed Patient A's ventilator settings on Pressure Support Ventilation (PSV) 10cmH20 over Peak End Expiratory Pressure (PEEP) 5cmH20, or PSV 10/5.
- On September 21, 2020, a dayshift respiratory therapist (RT) found Patient A in 8. respiratory distress at approximately 0640 hours with a bleeding tracheotomy site and blood in the ventilator circuit, after receiving a report from Respondent, who was on the night shift. Upon information and belief, the dayshift RT had received that report approximately between 0600 and 0620 hours.
 - 9. The dayshift RT noted that Patient A's ventilator settings were PSV 10/5.
- Respondent's last charting showed Patient A to be on Assist Control (AC) 10. ventilation, and he did not chart that he changed Patient A's ventilator setting back to PSV 10/5.
- 11. Patient A was required to be on AC because he was not tolerating PSV well. Therefore Respondent placed Patient A on an unsafe ventilator setting.
- Respondent further did not monitor Patient A when he went into a different room 12. to work on his patient charts and placed Patient A on PSV in an effort to silence any alarms coming from the ventilator.
- At approximately 0735 hours, the dayshift RT called an emergency medical 13. transport for Patient A to transfer him to a hospital, where Patient A later expired.

COUNT I

NRS 630.301(4) - Malpractice

All of the allegations contained in the above paragraphs are hereby incorporated by 14. reference as though fully set forth herein.

///

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

- NRS 630.301(4) provides that malpractice of a [respiratory therapist] is grounds for 15. initiating disciplinary action against a licensee.
- NAC 630.040 defines malpractice as "the failure of a [respiratory therapist], in 16. treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."
- 17. 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 respiratory services to Patient A. More specifically, Respondent placed Patient A on an unsafe ventilator setting that was not appropriate for Patient A and then further did not adequately monitor Patient A.
- By reason of the foregoing, Respondent is subject to discipline by the Board as 18. provided in NRS 630.352.

COUNT II

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

- All of the allegations contained in the above paragraphs are hereby incorporated by 19. reference as though fully set forth herein.
- NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate 20. and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.
- Respondent failed to maintain accurate and complete medical records relating to 21. the diagnosis, treatment and care of Patient A, by failing to document that he changed Patient A's ventilator setting from AC to PSV 10/5.
- By reason of the foregoing, Respondent is subject to discipline by the Board as 22. provided in NRS 630.352.

COUNT III

NRS 630.306(1)(p) (Unsafe or Unprofessional Conduct)

All of the allegations in the above paragraphs are hereby incorporated as if fully set 23. forth herein.

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

26

27

28

2	4.	Engaging in any act that is unsafe or unprofessional conduct in accordance wit
regulatio	ns ad	opted by the Board is grounds for disciplinary action against a licensee pursuant t
NRS 630	0.306(1)(p).

- 25. As demonstrated by, but not limited to, the above-outlined facts, Respondent placed Patient A on an unsafe ventilator setting without documenting it in the records.
 - 26. Respondent's conduct was unsafe and unprofessional.
- By reason of the foregoing, Respondent is subject to discipline by the Board as 27. provided in NRS 630.352.

COUNT IV

NRS 630.301(7) - Violation of Patient Trust and Exploitation of Physician and Patient Relationship for Financial or Personal Gain

- 28. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- 29. NRS 630.301(7) provides that "engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain" is grounds for initiating discipline against a licensee.
- As demonstrated by, but not limited to, the above-outlined facts, Respondent 30. violated the trust of a patient and exploited the relationship between the Respondent and Patient A by placing Patient A on an unsafe ventilator setting so that he did not have to hear any alarms coming from the ventilator.
- 31. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

- That the Board give Respondent notice of the charges herein against him and give 1. 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
- 6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 26 day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

DONAZD K. WHITE

Senior Deputy General Counsel

9600 Gateway Drive Reno, NV 89521

Tel: (775) 688-2559

Email: dwhite@medboard.nv.gov

Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners

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 day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE STATE BOARD OF MEDICAL EXAMINERS

By:

W. FREY, M.D.

Chairman of the Investigative Committee