BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against:

RENCHELL JOHN ACHAVAL ANDRES, M.D.,

Respondent.

Case No. 24-33670-1

FILED
MAY 10 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: ______

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Alexander J. Hinman, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Renchell John Achaval Andres, 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. 12739). Respondent was originally licensed by the Board on July 1, 2008, with a specialty in anesthesiology.

2. Patient A[2] was a sixty-three (63) year-old female at the time of the events at issue, with a medical history of a coronary by-pass surgery, diabetes, and a kidney transplant.

3. On the morning of January 17, 2018, Patient A presented to the Las Vegas Endoscopy Center for an elective endoscopy procedure for evaluation of chronic heartburn and constipation.

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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, was composed of Board members Victor M. Muro, M.D., Aury Nagy, M.D., and Ms. Maggie Arias-Petrel.

[2] 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.

4. On January 17, 2018, at 9:40 a.m., Patient A was seen preoperatively by the nursing staff, where, amongst other things, her home medication list was verified and her vital signs were taken.

5. Respondent was the anesthesiologist assigned to Patient A's procedure. In the medical records for Patient A, Respondent noted that he interviewed Patient A preoperatively and noted the vital signs taken by the nursing staff, which were fairly normal except for minimally elevated blood pressure, a BMI of 31 indicating Class 1 obesity, and a slightly decreased oxygen saturation level.

6. In Respondent's preoperative notes, however, he only marked hypertension and penciled in that Patient A had high cholesterol but did not mark or indicate Patient A's coronary artery disease, stents, or coronary artery bypass grafts. Further, Respondent inappropriately indicated that Patient A did not have renal issues, despite the fact Patient A presented with an AV Fistula (an artery connected to a vein for dialysis). Lastly, Respondent indicated that Patient A had endocrine issues including obesity and non-insulin dependent diabetes, but Patient A was on insulin and had taken some as recently as the night before the procedure, clearly indicating the presence of insulin dependent diabetes.

7. Based on Respondent's examination of Patient A, he incorrectly indicated that Patient A was an ASA II classification (a patient with mild systemic disease), when in fact Patient A was at a minimum an ASA III classification (a patient with severe systemic disease), possibly even an ASA IV classification (a patient with severe systemic disease that is a constant threat to life).

8. On January 17, 2018, at 10:33 a.m., Patient A was taken to the procedural suite, and the procedure was performed. The procedure itself lasted from 10:35 a.m. to 10:42 a.m.

9. Respondent used Propofol 200 mg mixed with lidocaine for Patient A's sedation. Despite the record appearing to show that all were given at once, upon information and belief, Respondent administered the medications in small, titrated amounts; however, there is no documentation of the actual administration, doses, or timing.

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10. Patient A's vital signs were documented as stable throughout the procedure, without any complications noted, and Patient A was taken to the post-anesthesia recovery unit (PACU), at 10:43 a.m.

11. Upon arrival at the PACU at 10:43 a.m., Patient A was noted to be somnolent but stable on three (3) liters of oxygen and Respondent transferred het care to the recovery nurses. Unfortunately, one (1) minute later Patient A's health began to decline rapidly.

12. At 10:44 a.m., the recovery nurse noted that Patient A "is cyanotic with no spontaneous breathing," and a "Code Blue" was called.

13. The nursing staff immediately sought out and found Respondent who was preparing for his next procedure, and he returned to Patient A's recovery room.

14. At 10:45 a.m., assisted bag-mask ventilation was said to be provided by "nursing staff members," but there is no documentation on who was actually providing this care, if it was effective, or being done by someone trained in airway management.

15. There are no medical notes documenting any of Patient A's vital signs from 10:43 a.m. until 11:09 a.m.

16. According to the Code Blue record, at 11:07 a.m., assisted bag-mask ventilation was ceased and Patient A was intubated by Respondent.

17. At 11:09 a.m., a blood pressure of 98/54 was recorded which is the first vital sign documented since the Code Blue had been called twenty-five (25) minutes prior. At this time, it was noted that respirations were being assisted, chest compressions were continuing, heart rhythm was uninterpretable due to the compressions and 1 mg of epinephrine was given.

18. At 11:12 a.m., another 1 mg of epinephrine was given, but Patient A's blood pressure was not recorded. The Chest compressions continued and Patient A's heart rhythm was still uninterpretable.

19. At 11:14 a.m., Patient A recovered her circulations and compressions were held. Her rhythm was noted to be in supraventricular tachycardia (SVT) and her blood pressure was recorded as 230/120.

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20. At 11:17 a.m., paramedics arrived and transported Patient A to St. Rose Dominican Hospital, where she was admitted and thereafter transferred to a long-term care facility for treatment. Patient A passed away April 9, 2018, from complications related to her January 17, 2018, procedure.

COUNT I

NRS 630.301(4) - Malpractice

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

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

23. 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."

24. 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 he improperly characterized Patient A as an ASA II classification, and not making the appropriate treatment and precautions decisions appropriate thereto, despite Patient A's history of coronary by-pass surgery, diabetes, and having a kidney transplant.

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

COUNT II

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

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

27. 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.

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28. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by using templated forms that fail to properly document his actions, care, and assessment. Respondent's notes lack specific details of the case, such as what amounts of Propofol were given at one time and failing to document Patient A's vital signs for a period of twenty-five (25) minutes. Further, Respondent failed to take notes with any specificity of Patient A's medical history and his physical assessment when he treated Patient A, whose medical records were not timely, legible, accurate, and complete.

29. 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 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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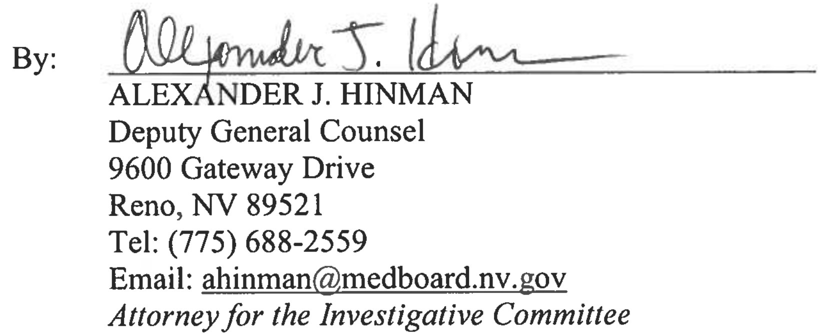
6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 10th day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



By: ______________________

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Chowdhury H. Ashan, M.D., Ph.D., FACC 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 10th day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

CHOWDHURY H. ASHAN, M.D., PH.D., FACC
Chairman of the Investigative Committee

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