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

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| **In the Matter of Charges and Complaint Against:**<br>**REYNOLD LOUIS RIMOLDI, M.D.,**<br>**Respondent.** | **Case No. 24-8952-1** |

FILED
APR 11 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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Reynold Louis Rimoldi, 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. 6287). Respondent was originally licensed by the Board on July 1, 1991.

2. Patient A[2] was a 72-year-old female at the time of the events at issue.

3. On May 4, 2016, Patient A was initially seen and evaluated by Respondent with complaints of back pain and lower extremity pain. Respondent reviewed Patient A's previous MRI dated July 18, 2015, that revealed lumbar canal stenosis, degenerative joint disease, and a disc protrusion at the L4-L5 level. Respondent then ordered a new MRI of the spine and

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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 Bret W. Frey, M.D., Carl N. Williams, Jr., M.D., and Col. Eric D. Wade, USAF (Ret.).

[2] Patient A's 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.

scheduled Patient A for an L2-L5 laminectomy with an L4-L5 transforaminal lumbar interbody fusion.

4. On May 12, 2016, Patient A received an MRI of the lumbar spine in preparation for her surgery. The new study confirmed the multi-level neuroforaminal stenosis.

5. On June 17, 2016, Respondent performed an L2-L5 (lumbar spinal location) decompressive laminectomy procedure followed by an L4-L5 fusion for degenerative L4-L5 spondylolisthesis.

6. On June 18, 2016, Respondent evaluated Patient A and noted she was stable and had movement in both lower extremities with sensation. Patient A was then transferred to the hospitalist to follow her care until she was discharged. On this same date, Patient A suffered a narcotics overdose and became confused, disoriented, and hypotensive and was transferred to the Intensive Care Unit (ICU). Patient A's blood pressure dropped, which was thought to be related to a hemorrhage, and subsequently, underwent a blood transfusion. Respondent did not return or further evaluate Patient A until July 6, 2016.

7. On July 6, 2016, Respondent evaluated Patient A and noted a neurological status change during her post-operative follow-up visit on June 18, 2016. Respondent found that Patient A had diffuse weakness in her lower extremities. Despite the knowledge of the neurological status change, Respondent did not order any further diagnostic studies or imaging to explain and identify the causes of Patient A's diminished neurological function and weakness in her lower extremities. Respondent failed to pursue MRI or CT testing during this visit in furtherance of evaluating Patient A's medical condition postoperatively.

8. On July 18, 2016, Respondent evaluated Patient A and noted her wound from the operation was doing well. There was no consideration of pursuing any revision surgery by Respondent. Respondent, again, did not evaluate Patient A's lumbar spine and did not investigate the etiology of the diffuse weakness involving her lower extremities. Once more, Respondent failed to pursue MRI or CT testing during this visit in furtherance of evaluating the etiology of Patient A's new neurologic deficits.

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9. Patient A sought a second opinion and obtained a postoperative MRI which demonstrated a large evolved epidural hematoma at the surgical site with canal stenosis associated with the hematoma. Ultimately Patient A had a revision surgery in November of 2016 with evacuation of the fluid collected in the epidural space.

**COUNT I**

**NRS 630.301(4) - Malpractice**

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

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

12. 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."

13. As demonstrated by, but not limited to, the above-outlined facts, Respondent committed malpractice with respect to the treatment of Patient A when he, on July 6, 2016, and again on July 18, 2016, failed to order any diagnostic studies, including an MRI or CT scan, for Patient A who demonstrated diminished neurologic function and diffuse weakness in her lower extremities.

14. 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)(g) - Continual Failure to Exercise Skill or Diligence**

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

16. Continual failure by the Respondent to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(g).

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17. Respondent continually failed to exercise skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing, practicing in the same specialty or field, as demonstrated by his repeated failure to order diagnostic testing in Patient A who was experiencing worsening neurologic deficits and diffuse weakness following a decompressive laminectomy procedure at both post-operative follow-up visits on July 6, 2016, and again on July 18, 2016, respectively.

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

**COUNT III**

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

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

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

21. 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."

22. Respondent failed to timely seek consultation regarding Patient A's medical condition (diminished neurological status and diffuse weakness of the lower extremities) from July 6, 2016, through July 18, 2016. Respondent should have consulted with an appropriate care provider to address the doubtfulness of the diagnosis of Patient A's medical condition and such a timely consultation would have confirmed or denied such a diagnosis and could have enhanced the quality of medical care delivered to Patient A. Due to Patient A's neurological status change documented on July 6, 2016 and again on July 18, 2016, Respondent should have proceeded with a diagnostic workup with the goal of explaining the etiology behind the deterioration in the neurologic status and diffuse weakness of the lower extremities of Patient A.

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

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**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

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

DATED this 11th day of April, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
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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 11th day of April, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
*Chairman of the Investigative Committee*

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