9600 Gateway Drive Reno, Nevada 89521 (775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint

Against:

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

SAVITA M. CHANDER, M.D.,

Respondent.

Case No. 24-25391-1

FILED

JUL 2 4 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through Ian J. Cumings, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Savita M. Chander, 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:

- Respondent was at all times relative to this Complaint a medical doctor holding an 1. active license to practice medicine in the State of Nevada (License No. 12012). Respondent was originally licensed by the Board on August 23, 2006.
 - Patient A² was a seventy-five (75) year-old male at the time of the events at issue. 2.
- Patient A had relevant medical history of prostate cancer with metastasis to his 3. spine, causing spinal fractures.
- On December 20, 2019, Patient A underwent a decompressive laminectomy of his spine at the L4 and the T6-T7 levels.

111

26

27

28

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

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.

1

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

- On December 24, 2019, following Patient A's spinal surgery, he was transferred to 5. a transitional care center and placed in the charge of the Respondent.
- 6. Patient A was admitted at 2:25 p.m. to the care center with an elevated temperature and heart rate and was noted to have below-average hygiene. Additionally, the post-surgical incision dressings were noted as "bulky" and "foul smelling." The nursing staff at the care center administered a fever reducing medication to Patient A.
- 7. At 6:27 p.m., the nursing staff documented Patient A as having a persistently elevated temperature of 101.7 degrees Fahrenheit for four (4) hours after Patient A was administered the fever reducer.
- 8. Respondent was contacted by the nursing staff who left a message at 7:24 p.m., at which time Patient A's temperature had risen to 102 degrees Fahrenheit.
- 9. Respondent returned the nursing staff's phone call at 10:24 p.m. and was informed of Patient A's raised temperature and admitting diagnosis. Respondent did not come into the transitional care facility to examine Patient A herself, nor did she instruct staff to transfer Patient A to an emergency room.
- On December 25, 2019, the nursing staff coordinated Patient A's transfer back to 10. the hospital. Patient A succumbed to complications from severe sepsis following his surgery on December 27, 2019.

COUNTI

NRS 630.301(4) - Malpractice

- All of the allegations contained in the above paragraphs are hereby incorporated by 11. reference as though fully set forth herein.
- NRS 630.301(4) provides that malpractice of a physician is grounds for initiating 12. disciplinary action against a licensee.
- NAC 630.040 defines malpractice as "the failure of a physician, in treating a 13. patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

111

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

- 14. 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 by failing to appropriately examine Patient A to rule out sepsis or send Patient A to the emergency room, despite Patient A's persistent fever and high-risk clinical presentation following a complex surgery.
- 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)(b)(2) - Violation of Standards of Practice Established by Regulation – Failure to Consult

- 16. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- Violation of a standard of practice adopted by the Board is grounds for disciplinary 17. action pursuant to NRS 630.306(1)(b)(2).
- NAC 630,210 requires a physician to "seek consultation with another provider of 18. health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services."
- 19. Respondent failed to seek consultation in a timely manner with regard to Patient A's serious medical presentation on December 24, 2019. Respondent should have consulted with an appropriate care provider to address the doubtfulness of the diagnosis of Patient A's medical condition. A timely consultation would have confirmed or denied such a diagnosis and may have enhanced the quality of medical care provided to Patient A with regard to the detection of his sepsis diagnosis.
- By reason of the foregoing, Respondent is subject to discipline by the Nevada State 20. Board of Medical Examiners as provided in NRS 630.352.

26 111

27 111

28 111

OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners

8 9 10 11 12 9600 Gateway Drive Reno, Nevada 89521 13 14 15 16 17 18 19 20 21 22 23 24 25

26

27

28

1

2

3

4

5

6

7

WHEREFORE, the Investigative Committee prays:

- 1. That the Board give Respondent notice of the charges herein against her and give her notice that she 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 24 day of July, 2024.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

IAN J. CUMINGS

Senior Deputy General Counsel

9600 Gateway Drive

Reno, NV 89521

Tel: (775) 688-2559

Email: <u>icumings@medboard.nv.gov</u>
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL

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

VERIFICATION

STATE OF NEVADA)
COUNTY OF WASHOE	: ss.

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 24th day of July, 2024.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

REY, M.D.

Chairman of the Investigative Committee