BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint

Against:

TEENA TANDON, M.D.,

Respondent.

Case No. 24-32692-1

FILED

FEB 2 3 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through Deonne E. Contine, General Counsel and attorney for the IC, having a reasonable basis to believe that Teena Tandon, 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. 13573). Respondent was originally licensed by the Board on July 1, 2010.
 - Patient A² was a forty-seven (47) year-old female at the time of the events at issue. 2.
- On or about January 1, 2019, Patient A presented to the emergency room via 3. ambulance with a complaint of pain over her entire body. It was determined, through conversations with Patient A's family that she was suffering from alcohol withdrawal and was currently under the influence of opioid medication and had fallen and cut her face.

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. and Carl N. Williams, Jr., M.D.

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.

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- Patient A was given one (1) liter of saline before lab results were received. 4.
- 5. Results of a serum sodium lab test showed Patient A had hyponatremia or a low sodium concentration.
- Between approximately 1:00 pm and 2:21 pm on January 1, 2019, Patient A's 6. serum sodium level began at 107 and raised to 110, which is considered a rapid correction. Despite the rapid correction, the saline treatment was not stopped when the lab reports were received.
- Later in the day on January 1, 2019, another physician admitted Patient A to the 7. hospital and despite the rapid correction, continued the saline treatment until she could be transferred to Mountain's Edge Hospital.
- Upon admission to Mountain's Edge Hospital, Patient A was displaying multiple 8. symptoms of rapid correction, but another serum sodium lab test was not taken until approximately midnight on January 1, 2019, and the level had risen again from 109 to 118, amounting to a 9 mEq correction in a ten (10) hour span.
- Respondent assumed care of Patient A on January 1, 2019, but did not adhere to the 9. standards of care for hyponatremia.
- On January 1, 2019, Respondent failed to identify Patient A's rapid correction and 10. did not order a serum sodium laboratory report immediately. Instead, Respondent ordered the sodium serum test three (3) to four (4) hours after Patient A's arrival.

COUNT I

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."

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- As demonstrated by, but not limited to, the above-outlined facts, Respondent failed 14. to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when she did not adhere to the standard of care for a patient with hyponatremia by not recognizing Patient A had started rapid correction or that the patient was at risk for rapid correction. Additionally, Respondent failed to order a sodium serum laboratory report quickly when Patient A was showing signs of rapid correction.
- By reason of the foregoing, Respondent is subject to discipline by the Board as 15. provided in NRS 630.352.

COUNT II

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

- All of the allegations contained in the above paragraphs are hereby incorporated by 16. 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."
- Respondent failed to timely seek consultation with regard to Patient A's medical 19. condition and rapid correction on January 1, 2019, and 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 may have enhanced the quality of medical care provided to Patient A regarding treatment of her hyponatremia. A nephrology consult was requested, but long after Patient A had been exhibiting symptoms of rapid correction in her serum sodium levels.
- By reason of the foregoing, Respondent is subject to discipline by the Board as 20. provided in NRS 630.352.

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OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners

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WHEREFORE, the Investigative Committee prays:

- That the Board give Respondent notice of the charges herein against her and give 1. 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;
- That the Board set a time and place for a formal hearing after holding an Early 2. Case Conference pursuant to NRS 630.339(3);
- That the Board determine what sanctions to impose if it determines there has been 3. a violation or violations of the Medical Practice Act committed by Respondent;
- That the Board award fees and costs for the investigation and prosecution of this 4. case as outlined in NRS 622.400;
- That the Board make, issue and serve on Respondent its findings of fact, 5. conclusions of law and order, in writing, that includes the sanctions imposed; and
- That the Board take such other and further action as may be just and proper in these 6. premises.

DATED this 232 day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

DONALD K. WHITE

Senior Deputy General Counsel

9600 Gateway Drive

Reno, NV 89521

Tel: (775) 688-2559

Email: dcontine@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 February, 2024.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

FREY, M.D.

Chairman of the Investigative Committee