BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: SAMUEL RODOLFO CHACON, M.D., Respondent.	Case No. 23-12762-1

FILED

MAR 27 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

FIRST AMENDED COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through its counsel, Ian J. Cumings, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Samuel Rodolfo Chacon, 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 First Amended Complaint (Complaint), stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a physician holding an active license to practice medicine in the State of Nevada (License No. 9105). Respondent was originally licensed by the Board on July 27, 1999, with a specialty in Obstetrics/Gynecology.

2. Patient A[2] was a twenty-six (26) year-old female at the time of the events at issue.

3. On January 26, 2022, Patient A established care with Respondent for routine gynecological care.

4. On September 9, 2022, Patient A was seen by a physician at Respondent's practice who diagnosed her with a twin pregnancy via ultrasound testing and referred her to a perinatologist at a high-risk pregnancy center for her twin pregnancy, which is classified as a

[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 Aury Nagy, M.D., Chairman, Nick M. Spirtos, M.D., F.A.C.O.G., 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.

high-risk pregnancy. Patient A's pregnancy was monitored closely by the specialists at the high-risk pregnancy center with serial ultrasounds and testing every two (2) to three (3) weeks.

5. On November 11, 2022, when Patient A was approximately sixteen (16) weeks pregnant, she began seeing Respondent for obstetric care following the departure of her previous physician from Respondent's practice.

6. Respondent only held hospital privileges to deliver pregnancies at Saint Mary's Hospital and Renown Regional Medical Center (Renown) in Northern Nevada.

7. On November 11, 2022, Saint Mary's Hospital closed its labor and delivery department, leaving Respondent with only one (1) option for a hospital to deliver a pregnancy, from that point forward, Renown.

8. On November 22, 2022, Respondent lost his hospital privileges at Renown following a voluntary surrender of his clinical privileges while under an investigation relating to his professional competence or his conduct.

9. On or about December 14, 2022, Patient A was contacted by a care manager from her insurance provider about delivery options, where she was informed that Respondent did not have hospital privileges at Renown to deliver her pregnancy. The care manager asked Patient A to reconfirm with Respondent that he would be delivering her pregnancy at Renown.

10. On or about December 16, 2022, at Patient A's appointment with Respondent, Patient A was informed by Respondent that he would not be delivering her pregnancy at Renown, but instead at Northern Nevada Medical Center. Respondent did not hold any hospital privileges at Northern Nevada Medical Center, or any other hospital at the time he made this statement to Patient A.

11. On February 8, 2023, Patient A underwent ultrasound testing at the high-risk pregnancy center which indicated Twin A was growth restricted. Following Twin A's diagnosis of growth restriction, Patient A was recommended to deliver sometime between thirty-six (36) and thirty-seven (37) weeks of gestation by her perinatologist and to continue to receive ultrasound testing every two (2) weeks to monitor her pregnancy.

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12. On March 30, 2023, at thirty-six (36) weeks pregnant, Patient A underwent further ultrasound testing that was performed by the perinatologist which demonstrated little growth of Twin A from the previous ultrasound on March 13, 2023. The perinatologist recommended delivery between thirty-six weeks (36) and thirty-six weeks and three days (36.3).

13. On March 30, 2023, Patient A was seen by Respondent who performed a membrane sweep on Patient A to help induce labor. Respondent informed Patient A that if she wanted to deliver her pregnancy at Renown, because of their neonatal care unit and because her twins may need a higher level of care, she should present to Renown.

14. On March 31, 2023, Patient A was seen by Respondent for a second stripping of her membranes following a bloody show.

15. At no time did Respondent inform Patient A that he did not have hospital privileges at Northern Nevada Medical Center, nor any other area hospital, and thus he could not deliver her pregnancy.

16. Respondent failed to refer Patient A to an appropriate care provider or physician group who could properly induce Patient A for delivery of her pregnancy, despite his knowledge of the perinatologist's delivery recommendation.

17. On April 1, 2023, Patient A had yet to go into labor and presented to Renown for delivery of her pregnancy within the recommended time given to her by the perinatologist. Patient A ultimately delivered her children by cesarean section on April 2, 2023, at Renown performed by another physician.

18. Respondent produced an informed consent form dated November 11, 2022, in response to the IC's Order to Produce Medical Records. This informed consent stated Patient A was aware that Respondent did not have hospital privileges and could not deliver her pregnancy but would merely coordinate her delivery with another provider. The printed section of the form misspelled Patient A's name and contained a signature which also misspelled Patient A's name. Moreover, the signature did not match Patient A's prior signatures on any document or medical record.

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19. Patient A never signed this document nor was she aware that Respondent did not have privileges at any hospital while under his care. Therefore, the document provided to the IC in response to its Order to Produce Medical Records was forged.

COUNT I

NRS 630.301(4) - Malpractice

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

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

22. 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."

23. 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 he rendered medical services to Patient A by failing to make arrangements for Patient A's delivery of her high-risk twin pregnancy following the loss of his hospital privileges on November 22, 2022. Moreover, Respondent committed malpractice by continuing to see Patient A for obstetrical care without having a relationship with any physician or physician group to appropriately deliver Patient A's pregnancy.

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

COUNT II

NRS 630.301(4) - Malpractice

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

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

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27. 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."

28. 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 he rendered medical services to Patient A by lying to and misleading Patient A regarding his hospital privileges and ability to deliver her pregnancy, as well as his falsification of an informed consent form for Patient A.

29. 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 – Failure to Consult

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

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

32. 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."

33. Respondent failed to timely seek consultation with an appropriate care provider in regard to Patient A's medical condition from November 22, 2022, through April 2, 2023, to address the doubtfulness of the diagnosis of Patient A's medical condition, and such a timely consultation would have enhanced the quality of medical care provided to Patient A with regard to the delivery of Patient A's twin pregnancy.

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

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COUNT IV

NRS 630.306(1)(g) - Continual Failure to Exercise Skill or Diligence

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

36. 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).

37. Respondent continually failed to exercise skill or diligence as demonstrated by his continuing prenatal care of Patient A without making arrangements or an appropriate referral for the delivery of Patient A's high-risk pregnancy.

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

COUNT V

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

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

40. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(p).

41. As demonstrated by, but not limited to, the above-outlined facts, Respondent's conduct was unsafe and unprofessional when he lied about his ability to deliver Patient A's pregnancy in an effort to continue to provide obstetrical care to Patient A and by Respondent's failure to make appropriate arrangements with an obstetrical care provider that possessed hospital privileges to deliver Patient A's pregnancy thus exposing Patient A and her unborn children to an unacceptable and high-risk of complications during delivery. Therefore, Respondent's conduct was unsafe and unprofessional.

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

COUNT VI

NRS 630.306(1)(b)(1) – Deceptive Conduct

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

44. NRS 630.306(1)(b)(1) provides that engaging in conduct which is intended to deceive is grounds for initiating disciplinary action or denying licensure.

45. Respondent engaged in deceptive conduct by repeatedly lying to Patient A regarding his hospital privileges and his ability to deliver her pregnancy, and through his forgery of an informed consent form. Respondent subsequently lied to Board investigators by citing to the forged informed consent form and stating that he had informed Patient A of his inability to deliver her pregnancy on November 11, 2022.

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

COUNT VII

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

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

48. 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.

49. As demonstrated by, but not limited to, the above-outlined facts, Respondent violated the trust of a patient and exploited the relationship between the Respondent and Patient A by leading Patient A to believe that he had hospital privileges at Northern Nevada Medical Center to deliver her pregnancy in order to continue to provide obstetrical care to Patient A, despite not having any privileges at any hospital where Patient A could be delivered by Respondent.

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Respondent also presented a falsified informed consent form which misspelled Patient A's name and forged her signature in an attempt to shield himself from professional responsibility regarding his treatment of Patient A.

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

COUNT VIII

NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation – Falsification of Medical Records

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

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

53. NAC 630.230(1)(a) provides that a physician shall not, "falsify records of health care."

54. Respondent falsified Patient A's medical records by presenting a falsified informed consent form which misspelled Patient A's name and forged her signature on the document that detailed Patient A was aware and consented to continued obstetrical care by Respondent, despite not having hospital privileges necessary to deliver her pregnancy.

55. 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;

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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 27th day of March, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________________

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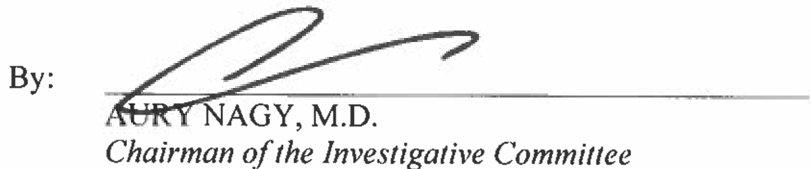
VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Aury Nagy, 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 27th day of March, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

AURY NAGY, M.D.
Chairman of the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 27th day of March, 2024, I served a file-stamped copy of the foregoing **FIRST AMENDED COMPLAINT**, via USPS Certified Mail, postage pre-paid, to the following parties:

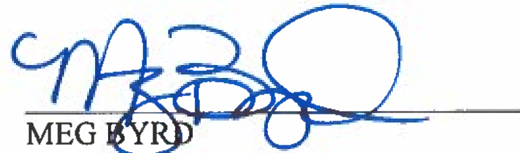
SAMUEL RODOLFO CHACON, M.D.
c/o Eric K. Stryker, Esq.
Wilson Elser Moskowitz Edelman & Dicker LLP
6689 Las Vegas Blvd. South, Suite 200
Las Vegas, NV 89119

Tracking No.: 9171 9690 0935 0241 6248 26

With courtesy copy by email to:

Eric K. Stryker, Esq. at [eric.stryker@wilsonelser.com]
Charles Woodman, Esq. at [hardywoodmanlaw@msn.com]

DATED this 27th day of January, 2024.



MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners