

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint

Case No. 26-46381-1

Against:

FILED

DAVID JOSEPH BENARON, M.D.,

JUN - 4 2026

Respondent.

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
By: [Signature]

COMPLAINT

The Investigative Committee¹ ("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 David Joseph Benaron, 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. 16955). Respondent was originally licensed by the Board on February 17, 2017, and has a specialty in Emergency Medicine.

2. At all times relative to this Complaint, Respondent practiced Emergency Medicine at Renown Regional Medical Center – South Meadows Emergency Department ("Renown").

3. Patient A² was a forty-four (44) year-old male at the time of the events at issue, with a past medical history that included end-stage renal disease on dialysis, insulin-dependent type 2 diabetes mellitus, hypertension, hyperlipidemia, coronary artery disease status post coronary artery bypass grafting with simultaneous mitral valve replacement in July 2020, chronic systolic heart

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 Chowdhury H. Ahsan, M.D., Ph.D., FACC, Ms. Pamela J. Beal, Public Member, and Irwin B. Simon, M.D., FACS.

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 failure, tricuspid regurgitation, and anticoagulation with warfarin. Patient A was also on home
2 dialysis five (5) days per week.

3 4. On October 26, 2022, at approximately 11:50 p.m., Patient A presented to Renown
4 via EMS with a chief complaint of flu-like symptoms for three (3) days, including nasal congestion,
5 intermittent cough, nausea, vomiting, and diarrhea.

6 5. EMS and triage notes documented that Patient A had been found on the bathroom
7 floor by his daughter with an altered level of consciousness, and reported feeling near-syncopal
8 while using the bathroom. Patient A had no recollection of the events leading to being found on the
9 floor and stated only that he was "talking with Logan and the next thing I knew" he was in the
10 hospital.

11 6. Respondent was the attending emergency physician at Renown and was assigned to
12 Patient A at approximately 11:53 p.m.

13 7. Respondent documented a history of syncope but did not obtain or document
14 collateral history from the daughter, who found Patient A on the bathroom floor and in an altered
15 state, nor from Patient A's wife, who was out of town at this time but available by phone. Further,
16 Respondent did not document any inquiry into the timing of Patient A's most recent dialysis session,
17 did not confirm Patient A's anticoagulation status or obtain an International Normalized Ratio
18 ("INR") and did not document any assessment of orientation or mental status beyond noting that
19 Patient A was alert.

20 8. Patient A's initial vital signs were notable for hypertension (BP 183/82), tachycardia
21 (HR 110 bpm), and hypoxia (SpO2 88% on room air). A physical examination documented no signs
22 of trauma and indicated that Patient A was alert and in no distress; however, there was no
23 documentation of a detailed neurologic examination or assessment of orientation. An EKG
24 demonstrated sinus tachycardia without evidence of ischemia or arrhythmia. Laboratory results
25 showed mild leukocytosis (WBC 11.4), mild hyponatremia (134), hyperglycemia (211),
26 BUN/Cr of 74/9.71, and an elevated anion gap of nineteen (19).

27 9. Respondent's medical decision-making documentation indicated a plan to evaluate
28 Patient A for arrhythmia, anemia, and electrolyte derangements.

12. Later that same morning, at approximately 7:49 a.m., Patient A was found unresponsive in his bathroom by his wife. EMS transported him to St. Mary's Regional Medical Center, where a head CT revealed a large acute left subdural hematoma with fifteen (15) mm midline shift. Patient A was intubated, underwent emergent hemicraniectomy and evacuation of the hematoma, and was diagnosed with diabetic ketoacidosis. During his hospitalization, Patient A suffered from a left posterior cerebral artery distribution infarct as well as multiple scattered embolic infarcts.

COUNT I

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

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

16. 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.”

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1 patient presenting with significant structural heart disease, a prosthetic heart valve, anticoagulation,
2 and an unwitnessed syncopal episode without prodrome; (c) failed to obtain a non-contrast head CT
3 on an anticoagulated patient who was found down with amnesia and a possible head strike; and (d)
4 discharged Patient A home without ensuring a safe disposition, failing to account for Patient A's
5 complex medical comorbidities and recent acute illness.

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

8 COUNT II

9 **NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records**

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

12 20. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate
13 and complete medical records relating to the diagnosis, treatment and care of a patient" constitute
14 grounds for initiating discipline against a licensee.

15 21. Respondent failed to maintain complete medical records relating to the diagnosis,
16 treatment, and care of Patient A by failing to correctly document his actions when treating
17 Patient A, including, among other things, not adequately documenting Patient A's neurologic state
18 and orientation, failing to make note that Patient A was taking warfarin, and failing to record an
19 appropriate history of Patient A's dialysis schedule. As a result, Respondent's medical records were
20 not accurate nor complete.

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

23 **WHEREFORE**, the IC prays:

24 1. That the Board give Respondent notice of the charges herein against him and give
25 him notice that he may file an answer to the Complaint herein as set forth in
26 NRS 630.339(2) within twenty (20) days of service of the Complaint;

27 2. That the Board set a time and place for a formal hearing after holding an Early Case
28 Conference pursuant to NRS 630.339(3);

1 3. That the Board determine what sanctions to impose if it determines there has been a
2 violation or violations of the Medical Practice Act committed by Respondent;

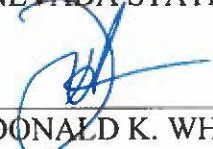
3 4. That the Board award fees and costs for the investigation and prosecution of this case
4 as outlined in NRS 622.400;

5 5. That the Board make, issue and serve on Respondent its findings of fact, conclusions
6 of law and order, in writing, that includes the sanctions imposed; and

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

9 DATED this 4th day of June, 2026.

10 INVESTIGATIVE COMMITTEE OF THE
11 NEVADA STATE BOARD OF MEDICAL EXAMINERS

12 By: 

13 DONALD K. WHITE
14 Senior Deputy General Counsel
15 9600 Gateway Drive
16 Reno, NV 89521
17 Tel: (775) 688-2559
18 Email: dwhite@medboard.nv.gov
19 Attorney for the Investigative Committee

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Chowdhury H. Ahsan, 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 4 day of June, 2026.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:


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