BEFORE THE NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

IN THE MATTER OF THE COMPLAINT AGAINST
J. DANIEL CARPENTER, D.O.
RESPONDENT.

Case No.: PB-04-17-926

Filed: 7-13-04
Executive Director

COMPLAINT

Pursuant to the provisions of Chapter 633 of the Nevada Revised Statutes, and by virtue of the authority vested in it by said chapter, the Investigative Board Member of the Nevada Board of Osteopathic Medicine, having a reasonable basis to believe that J. DANIEL CARPENTER, D.O. hereinafter referred to as "RESPONDENT," has violated the provisions of said chapter, hereby issues its formal Complaint, stating the Investigative Board Member's charges and allegations, as follows:

1. That RESPONDENT is licensed in active status to practice medicine in the state of Nevada, and at all times alleged herein, was so licensed by the Board of Osteopathic Medicine of the State of Nevada pursuant to the provisions of Chapter 633 of the Nevada Revised Statutes.

2. That NRS 633.511(4) provides that gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner, is grounds for disciplinary action.

3. That NRS 633.071 defines "Malpractice" as "the failure on the part of an osteopathic physician to exercise the degree of care, diligence, and skill ordinarily exercised..."
by osteopathic physicians in good standing in the community in which he practices."

4. That NRS 633.041 defines "Gross Malpractice" as follows:

"Gross malpractice" means malpractice where the failure to exercise the requisite degree of care, diligence, or skill consists of:
1. Performing surgery upon or otherwise ministering to a patient while the osteopathic physician is under the influence of alcohol or any controlled substance;
2. Gross negligence;
3. Willful disregard of established medical procedures; or
4. Willful and consistent use of medical procedures, services, or treatment considered by osteopathic physicians in the community to be inappropriate or unnecessary in the cases where used.

5. Unprofessional conduct is grounds for disciplinary action. NRS 633.511(1).

COUNT ONE

(Butler)

6. The allegations set forth in paragraphs 1 through 5 are incorporated herein as if set out in full.

7. That on or about June 7, 2001, Respondent examined and treated Patient Maurice Butler.

8. Mr. Butler sought treatment from Dr. Carpenter on June 7, 2001 for glaucoma.

9. On or about June 7, 2001, Respondent performed a YAG posterior capsulotomy in the Patient's right eye.

10. The medical record for Maurice Butler on the date of the office visit, June 7, 2001, lacks documentation relating to diagnosis, treatment, and care. The patient sought treatment for glaucoma and no intraocular pressure was taken. There is no documentation in the medical record regarding the conditions of the eye warranting a posterior capsulotomy or any diagnosis requiring such treatment.

11. On the first day following surgery, on or about June 8, 2001, the medical records of Maurice Butler lack any documentation regarding the postoperative visual acuity.

12. Respondent failed to generate or create medical records relating to the diagnosis, treatment and care of a patient. Respondent's failure to generate medical records is a failure to exercise the degree of care, diligence, and skill ordinarily exercised by
13. Such conduct is unprofessional conduct pursuant to NRS 633.131(f), and NAC 633.350(5). Such conduct is grounds for disciplinary action pursuant to NRS 633.511(1).

Such conduct also constitutes malpractice.

**COUNT TWO**

(Butler)

14. The allegations set forth in paragraphs 1 through 5 and 6 through 13 are incorporated herein as if set out in full.

15. The medical records of Respondent reflect that on or about June 7, 2001, Respondent performed a YAG posterior capsulotomy on Maurice Butler’s right eye without any history or complaint by Mr. Butler reflected in the record of Respondent regarding visual difficulties in the patient’s right eye.

16. A YAG posterior capsulotomy was performed on Maurice Butler’s right eye without any diagnosis or treatment plan reflected in the patient’s record or any other evidence of need for such a procedure. There is no mention of a posterior capsule opacity in the right eye in the medical records.

17. The visual acuity is recorded as 20/25 taken by automatic refraction dated June 6, 2001. The glare test showed visual acuity at 20/40. This visual acuity does not warrant the procedure performed.

18. Mr. Butler’s purpose in seeking the medical examination as reflected in the medical record was for Respondent to check Mr. Butler’s glaucoma. However, no intraocular pressure was taken of Mr. Butler’s eyes, no optic nerve evaluation or visual field testing was done, yet Respondent was somehow able to conclude that Mr. Butler had “controlled glaucoma.”

19. Despite Mr. Butler’s history of glaucoma, no previous records were requested to determine the amount of damage from the glaucoma. No mention is made in the chart regarding the condition of the retina. The medical record reflects the pupil response as “2/2 brisk” when the patient was diagnosed six months earlier as having “A.P.D.” Afferent Pupillary
Respondent's conduct constitutes a failure to exercise the degree of care, diligence, and skill ordinarily exercised by osteopathic physicians in good standing in the community in which he practices. Such conduct constitutes malpractice. NRS 633.071.

On or about June 13, 2001, Respondent performed cataract surgery on Maurice Butler's left eye, in which Mr. Butler was already blind, and despite the lack of any complaint from the patient regarding his vision.

On December 14, 2000, the cataract in Mr. Butler's left eye was described as nuclear 2+. Six months later, when Respondent examines Mr. Butler he cannot recognize whether the cataract is "+3-4 nuclear cataract" or "solid [white] cataract," as both descriptions of the cataract are set forth in the medical record. Respondent's inability to clearly identify the cataract is further reflected in the operative report which provides a third description of the cataract as one being "2+ -- 3+ nuclear sclerotic cataract." The descriptions of the cataract in the preoperative and operative notes are contradictory. Further, Respondent provides no grading of the cataract.

On or about December 14, 2000, six months before the cataract surgery, Mr. Butler's physician, Dr. Thatcher, diagnosed Mr. Butler's vision in his left eye as "NLP" or "no light perception," meaning the eye is blind. However, using only the automated refraction, Respondent diagnosed Mr. Butler's vision as 20/400. No manual manifest was performed by Respondent. The surgery resulted in no improvement to the patient's vision; the patient was still blind in the left eye. The cataract surgery was conducted without adequate preoperative evaluation and was performed unnecessarily.

Respondent failed to exercise the degree of care, diligence, and skill ordinarily exercised by osteopathic physicians in good standing in the community in which he practices in his preoperative evaluation and examination of his patient, by performing the YAG posterior capsulotomy and by performing the cataract operation on the patient's blind eye. Such conduct constitutes malpractice. NRS 633.071. Respondent engaged in gross or repeated malpractice with regard to his patient, Maurice Butler. Gross or repeated malpractice is
grounds for disciplinary action pursuant to NRS 633.511(4).

COUNT THREE:

(Cabellero)

25. The allegations set forth in paragraphs 1 through 5 are incorporated herein as if set out in full.


27. Ms. Cabellero sought treatment from Dr. Carpenter for intermittent blurred vision and headaches that she was experiencing following her involvement in an auto accident.

28. Ms. Cabellero was charged for and received a bill for Respondent's services including a charge for a consultation requiring medical decision making of high complexity, a sensorimotor examination, and an extended ophthalmoscopy. Such services were charged for but not rendered.

29. Such conduct constitutes obtaining a fee for services not rendered and such conduct constitutes unprofessional conduct pursuant to NRS 633.131(1)(c) and is grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT FOUR

(Cabellero)

30. The allegations set forth in paragraphs 1 through 5 and 25 through 29 are incorporated herein as if set out in full.

31. Respondent implanted punctual plugs in Ms. Cabellero's eyes without obtaining her consent, without testing her for dry eyes and without attempting less intrusive treatment first.

32. The medical record of Ms. Cabellero does not include a history of the patient that includes information as to the frequency, duration, location of the headaches or patient's own treatment of the headaches. The medical record of Ms. Cabellero reflects a diagnosis of dry eyes but Respondent failed to administer any basic and customary tests to diagnose dry eyes. Respondent failed to administer a proper examination of Ms. Cabellero and as a result
a procedure was provided that was not indicated or warranted.

33. Respondent failed to exercise the degree of care, diligence, and skill ordinarily exercised by osteopathic physicians in good standing in the community in which he practices by 1) failing to properly examine the patient, and 2) engaging in intrusive and unnecessary procedures. Such conduct constitutes malpractice. NRS 633.071.

34. Respondent engaged in gross or repeated malpractice with regard to his patient, Vivian Torres Cabellero. Gross or repeated malpractice is grounds for disciplinary action pursuant to NRS 633.511(4).

**COUNT FIVE**

(Cabellero)

35. The allegations set forth in paragraphs 1 through 5 and 25 through 34 are incorporated herein as if set out in full.

36. Respondent billed Vivian Torres Cabellero for procedures and tests that are not supported by any notes in the patient’s medical records.

37. Respondent failed to generate or create medical records relating to the diagnosis, treatment and care of a patient. Such conduct is unethical conduct pursuant to NAC 633.350(5) and constitutes unprofessional conduct, which is grounds for disciplinary action pursuant to NRS 633.511(1).

**COUNT SIX**

(Cabellero)

38. The allegations set forth in paragraphs 1 through 5 and 25 through 37 are incorporated herein as if set out in full.

39. Respondent unbundled charges that were contained in other billing codes so that the patient was billed twice for the same service. Services were billed to Ms. Cabellero that were not performed. Such conduct is fraudulent and the billing statement is a false record.

40. Such conduct is unethical conduct that constitutes unfitness to practice osteopathic medicine pursuant to NAC 633.350(9), NRS 633.131(1)(c) and is grounds for
disciplinary action pursuant to NRS 633.511(1) and the billing statement submitted by
Respondent constitutes a willfully made false file, record, or claim in the licensee’s practice.
Such conduct is unethical conduct pursuant to NAC 633.350(3) and unprofessional conduct.
Such conduct is grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT SEVEN

(Hamel)

41. The allegations set forth in paragraphs 1 through 5 are incorporated herein as if set out in full.
42. That on or about January 12, 2001, Respondent examined and treated Leo
    Hamel.
43. Leo Hamel sought treatment from Dr. Carpenter for “red eye.”
44. Mr. Hamel was diagnosed as having conjunctivitis. Mr. Hamel was billed for
    extended ophthalmoscopy. There is no indication in the record that the test was necessary or
    that it was performed.
45. Mr. Hamel was billed for gonioscopy. There is no evidence in the chart that the
    test was performed and no intraocular pressures were taken.
46. Leo Hamel was charged for services not rendered.
47. Such conduct constitutes obtaining a fee for services not rendered and
    constitutes unprofessional conduct pursuant to NRS 633.131(1)(c) and is grounds for
    disciplinary action pursuant to NRS 633.511(1).

COUNT EIGHT

(Hamel)

48. The allegations set forth in paragraphs 1 through 5 and 41 through 47 are
    incorporated herein as if set out in full.
49. Billing for services not performed or indicated and unnecessary and submitting a
    billing statement to a patient with false information contained thereon is a false record or
    claim.

...
50. Respondent willfully made a false file, record, or claim in the licensee's practice. Such constitutes unprofessional conduct pursuant to NAC 633.350(3) and NRS 633.131(1)(c), and is grounds for disciplinary action.

COUNT NINE

(Kirchhoffer)

51. The allegations set forth in paragraphs 1 through 5 are incorporated herein as if set out in full.

52. That on or about March 26, 2002, Respondent examined and treated Mary Kirchhoffer.

53. Ms. Kirchhoffer sought a routine eye examination from Respondent.

54. Without Ms. Kirchhoffer's consent or knowledge, Respondent placed punctual plugs in the patient's eyes. There is no documentation in the patient's chart that any tests were performed to determine that the patient had dry eyes and/or required punctual plugs.

55. Ms. Kirchhoffer was billed for ophthalmic biometry although there was no indication that the patient needed cataract surgery or there were any plans for cataract surgery. The patient's intraocular pressures were taken but there is no information in the chart regarding cup to disc ratio or visual fields. Gonioscopy was performed and billed when there was no indication it was needed. A sensorimotor examination was performed and billed without any indication it was needed. Ms. Kirchhoffer complained of changing vision. The patient wore contact lenses. Respondent only used auto refraction to determine her visual acuity and prescribed lenses based thereon.

56. Respondent failed to exercise the degree of care, diligence, and skill ordinarily exercised by osteopathic physicians in good standing in the community in which he practices and committed malpractice. NRS 633.071.

57. Such conduct constitutes gross or repeated malpractice and is grounds for disciplinary action pursuant to NRS 633.511(4).
COUNT TEN

(Kirchhoffner)

58. The allegations set forth in paragraphs 1 through 5 and 51 through 57 are incorporated herein as if set out in full.

59. Ms. Kirchhoffner was billed for extended ophthalmoscopy with retinal drawings, interpretation, and report. There is no documentation in the patient’s chart that the test was performed.

60. Patient was billed for refraction and it was not performed.

61. Respondent billed Ms. Kirchhoffner for services not rendered or received.

62. Such conduct constitutes obtaining a fee for services not rendered and constitutes unprofessional conduct pursuant to NRS 633.131(1)(c) and is grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT ELEVEN

(Kirchhoffner)

63. The allegations set forth in paragraphs 1 through 5 and 51 through 62 are incorporated herein as if set out in full.

64. Ms. Kirchhoffner was billed for ophthalmic biometry although there was no indication of the patient’s need for cataract surgery or any plans for cataract surgery. Gonioscopy was performed and billed when there was no indication it was needed. A sensorimotor examination was performed and billed without any indication it was needed.

Respondent billed Ms. Kirchhoffner for sensorimotor examination, which is part of the normal ophthalmic examination that was billed to the patient as a new patient evaluation.

65. Respondent billed Ms. Kirchhoffner twice for the same service or examination and performed tests that were not indicated or necessary. Billing for services not necessary or warranted and double billing a patient is fraud and unethical conduct.

66. Such conduct is unethical conduct that constitutes unfitness to practice osteopathic medicine pursuant to NAC 633.350(9), NRS 633.131(1)(c) and is grounds for
disciplinary action pursuant to NRS 633.511(1).

**COUNT TWELVE**

*(Kirchhoffer)*

67. The allegations set forth in paragraphs 1 through 5 and 51 through 66 are incorporated herein as if set out in full.

68. Ms. Kirchhoffer was billed for services, examinations, and/or procedures that are not documented in Ms. Kirchhoffer’s chart and not indicated or supported in the records.

69. Respondent failed to generate or create medical records relating to the diagnosis, treatment and care of a patient. Such conduct is unethical conduct pursuant to NAC 633.350(3) and (5) and constitutes unprofessional conduct, which is grounds for disciplinary action pursuant to NRS 633.511(1).

**COUNT THIRTEEN**

*(Lepczyski)*

70. The allegations set forth in paragraphs 1 through 5 are incorporated herein as if set out in full.

71. Carol Lepczyski was originally seen by Respondent on or about February 23, 2002, on a hospital consultation for a blowout fracture of the left eye due to a fall or blow to the eye.

72. Ms. Lepczyski was seen by Respondent on April 5, 2002, as a follow-up from her orbital fracture six weeks earlier. There are no documented complaints by the patient of any visual difficulties or blurred vision. In fact, on this visit, the patient’s visual acuity in the left eye was 20/30 and a glare test showed it was 20/50.

73. Ms. Lepczyski was noted as having large cup-to-disc ratios, an indication of glaucoma, but no workup or evaluation of glaucoma was done by Respondent.

74. Despite the lack of complaint by the patient of any visual difficulties, Ms. Lepczyski underwent cataract surgery by Respondent with implant in the left eye on April 29, 2002.

75. Ms. Lepczyski was seen by Respondent on or about April 30, 2002, the first
post-operative day. The records for April 30, 2002 reflect iridodialysis which was not mentioned preoperatively or in the operative notes. On May 10, 2002, the notes in the records reflect iridodialysis with sutures in the wound. This is the first note reflecting suture placement. The operative report states that the wound was closed by hydration not with sutures.

76. On September 27, 2002, Ms. Lepczyski’s visual acuity in the left eye was 20/200.

77. Ms. Lepczyski underwent intraocular lens repositioning on November 4, 2002.

78. On November 12, 2002, the visual acuity in the left eye was 20/300. On December 20, 2002, the visual acuity in the left eye was 20/400. On April 25, 2003, nearly one year after the original surgery, Ms. Lepczyski’s visual acuity in the left eye was 20/400. Ms. Lepczyski’s visual acuity in the left eye went from 20/30 prior to surgery to 20/400 after surgery.

79. On or about November 13, 2003, Ms. Lepczyski underwent suture replacement and wound revision.

80. No preoperative or postoperative diagnosis was noted in the Patient’s chart for the surgery on November 4, 2003 or November 13, 2003. Furthermore, the signed operative report is inconsistent with the postoperative notes and postoperative appearance of the eye.

81. Respondent failed to exercise the degree of care, diligence, and skill ordinarily exercised by osteopathic physicians in good standing in the community in which he practices in his examination and treatment of Ms. Lepczyski and committed malpractice. NRS 633.071.

82. Such conduct constitutes gross or repeated malpractice and is grounds for disciplinary action pursuant to NRS 633.511(4).

**COUNT FOURTEEN**

(Lepperki)

83. The allegations set forth in paragraphs 1 through 5 and 70 through 82 are incorporated herein as if set out in full.

84. Respondent failed to generate or create medical records relating to the
diagnosis, treatment and care of Carol Lepczyski. Such conduct is unethical conduct pursuant to NAC 633.350(3) and (5) and constitutes unprofessional conduct, which is grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT FIFTEEN

(Lepczyski)

85. The allegations set forth in paragraphs 1 through 5 and 70 through 84 are incorporated herein as if set out in full.

86. Carol Lepczyski's chart contains false, inaccurate, and conflicting information. The preoperative report and operative report significantly conflicts with the postoperative appearance of the eye and postoperative notes and constitute false files, records, or claims willfully made in the licensee's practice. Such conduct is unethical conduct pursuant to NAC 633.350(3) and is unprofessional conduct. Such conduct is grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT SIXTEEN

(Lepczyski)

87. The allegations set forth in paragraphs 1 through 5 and 70 through 86 are incorporated herein as if set out in full.

88. Ms. Lepczyski was seen by Respondent on April 5, 2002, as a follow-up from her orbital fracture six weeks earlier. There is no documentation as to the follow-up regarding the blowout fracture.

89. On April 5, 2002, there are no documented complaints by the patient of any visual difficulties or blurred vision. In fact, on this visit, the patient's visual acuity in the left eye was 20/30 and a glare test showed it was 20/50. The patient's condition did not meet Nevada Medicare guidelines for cataract surgery. The patient's visual acuity went from 20/30 to 20/400 due to the surgery.

90. Ms. Lepczyski was noted as having large cup-to-disc ratios, an indication of glaucoma, but no workup or evaluation of glaucoma was done by Respondent.

...
91. Respondent failed to exercise the degree of care, diligence, and skill ordinarily exercised by osteopathic physicians in good standing in the community in which he practices in his examination and treatment of Ms. Lepczyski and committed malpractice. NRS 633.071.

92. Such conduct constitutes gross or repeated malpractice and is grounds for disciplinary action pursuant to NRS 633.511(4).

COUNT SEVENTEEN

(Truman)

93. The allegations set forth in paragraphs 1 through 5 are incorporated herein as if set out in full.

94. Richard Truman had an extensive ocular history with cataract surgery in the late 1960’s and secondary implants in the early 1980’s. Mr. Truman developed glaucoma in the mid-1980’s. When Mr. Truman was first examined by Respondent on March 13, 2003, he had end-stage glaucoma and was taking glaucoma medication.

95. On or about March 25, 2003, Mr. Truman underwent insertion of an Express Glaucoma Mini Shunt to the left eye by Respondent. Due to Mr. Truman’s medical history he was not a good candidate for an Express Mini Shunt.

96. Mr. Truman had his first postoperative visit on March 26, 2003.

97. On March 28, 2003, the Patient underwent wound revision of the left eye and removal and repair of the glaucoma shunt.

98. Mr. Truman saw Respondent postoperatively from March 26, 2003, until on or about April 14, 2003. During this time period, Respondent tried several medications with little or no success in lowering the intraocular pressure of the eye. The pressure remained high for an unacceptable length of time. At no time during the postoperative care did Respondent prescribe any anti-inflammatory medication. Patient had pain in the eye and nausea and vomiting. During Respondent’s postoperative care, he referred the patient to a retina specialist. The patient had glaucoma and needed to be referred to a glaucoma specialist. When the patient finally saw a glaucoma specialist, Dr. Eisenberg, approximately three weeks

...
later on or about April 15, 2003, the doctor found the Express Mini Shunt, inserted to relieve
the pressure in the eye, to be plugged with iris tissue.

99. Respondent's postoperative care was ineffective and inadequate. Due to Mr.
Truman's high intraocular pressure, Mr. Truman lost all the remaining vision in his eye. Due to
the surgery, Mr. Truman also incurred extensive pain.

100. Respondent failed to exercise the degree of care, diligence, and skill ordinarily
exercised by osteopathic physicians in good standing in the community in which he practices
in the post-operative care of his patient and committed malpractice. NRS 633.071.

101. Such conduct constitutes gross or repeated malpractice and is grounds for
disciplinary action pursuant to NRS 633.511(4).

COUNT EIGHTEEN

(Truman)

102. The allegations set forth in paragraphs 1 through 5 and 93 through 101 are
incorporated herein as if set out in full.

103. Mr. Truman was not a good candidate for the Express Mini Shunt due to prior
surgeries and resulting scarring in his eye. The Express Mini Shunt was not a prudent choice
of surgery for an end-stage glaucoma patient.

104. Insertion of the Mini Shunt requires specialized training that Respondent did not
possess.

105. When Mr. Truman's intraocular pressure could not be controlled shortly after
surgery, Respondent should have referred the patient to a glaucoma specialist. Instead,
Respondent referred the patient to a retina specialist who in turn referred the patient to a
glaucoma specialist.

106. Respondent failed to exercise the degree of care, diligence, and skill ordinarily
exercised by osteopathic physicians in good standing in the community in which he practices
in the post-operative care of his patient and committed malpractice. NRS 633.071.

107. Such conduct constitutes gross or repeated malpractice and is grounds for
disciplinary action pursuant to NRS 633.511(4).
COUNT NINETEEN

(Truman)

108. The allegations set forth in paragraphs 1 through 5 and 93 through 107 are incorporated herein as if set out in full.

109. On March 28, 2003, the Patient underwent wound revision of the left eye. No operative report is included in Mr. Truman's chart.

110. Respondent failed to generate or create medical records relating to the diagnosis, treatment and care of Mr. Truman. Such conduct is unethical conduct pursuant to NAC 633.350(3) and (5) and constitutes unprofessional conduct, which is grounds for disciplinary action pursuant to NRS 633.511(1).

COUNT TWENTY

(Laurence Raskin)

111. The allegations set forth in paragraphs 1 through 5 are incorporated herein as if set out in full.

112. On or about May 20, 2002, Laurence Raskin was examined by Respondent.

113. Mr. Raskin was given automated computer refraction without any subjective refraction or examination.

114. An eyeglass prescription was given to Mr. Raskin, which had no add for near vision bifocal, although he had been wearing bifocal eyeglasses for four years. The optometrist at Lenscrafters, Dr. Lochner, III, re-examined Mr. Raskin's eyes and wrote a prescription for an add of +1.50.

115. Mr. Raskin's chart indicated he had cataracts but no intention of cataract surgery was indicated. The chart indicates that an ultrasound biometry was performed. There is no indication in the chart that an ultrasound biometry was necessary. The patient was billed for this unnecessary test.

116. Mr. Raskin's chart indicated that his intraocular pressures were normal, the anterior chamber depth was normal and the cup-to-disc ratio was small. Respondent ...
performed a gonioscopy when there were no indications that such test was necessary. The
patient was billed for this unnecessary test.

117. Respondent failed to exercise the degree of care, diligence, and skill ordinarily
exercised by osteopathic physicians in good standing in the community in which he practices
in his examination of Mr. Raskin's eyes and committed malpractice. NRS 633.071.

118. Such conduct constitutes gross or repeated malpractice and is grounds for
disciplinary action pursuant to NRS 633.511(4).

COUNT TWENTY-ONE

(Robin Raskin)

119. The allegations set forth in paragraphs 1 through are incorporated herein as if
set out in full.

120. On or about May 20, 2002, Robin Raskin sought an annual check-up from
Respondent. Respondent conducted an eye examination of Robin Raskin.

121. Mrs. Raskin was given an automated computer refraction without any subjective
refraction or examination.

122. An eyeglass prescription was given to Mrs. Raskin by Respondent which had an
add of 2.25 for near vision bifocal. Respondent had a subsequent examination by Dr.
Lochner, III, an optometrist, who wrote a prescription for an add of 1.25.

123. Mrs. Raskin was not scheduled for or intended to have cataract surgery.

Furthermore, Mrs. Raskin had normal intraocular pressure and the cup-to-disc ratios were
small. There were no indications of glaucoma. Nonetheless, tests and procedures, including
ultrasound biometry and gonioscopy, were performed on Mrs. Raskin by Respondent that
were not indicated or warranted under the circumstances. The patient was billed for these
unnecessary test.

124. Respondent failed to exercise the degree of care, diligence, and skill ordinarily
exercised by osteopathic physicians in good standing in the community in which he practices
in the examination of Mrs. Raskin and committed malpractice. NRS 633.071.
125. Such conduct constitutes gross or repeated malpractice and is grounds for disciplinary action pursuant to NRS 633.511(4).

COUNT TWENTY-TWO

(Collier)

126. The allegations set forth in paragraphs 1 through 5 are incorporated herein as if set out in full.

127. On or about March 12, 2001, Renee Collier was first examined by Respondent and was scheduled for cataract surgery by Respondent on the next day.

128. The patient had a history of multiple serious medical problems including a kidney transplant. The patient's physicians were not contacted or consulted regarding the patient's medical condition.

129. The chart does not reflect any visual difficulties or complaints by the patient. The only visual acuity noted is from the auto-refractor. A PAM test was not conducted to evaluate the vision potential. The preoperative examination failed to include a manifest refraction and was inadequate and incomplete.

130. Respondent failed to exercise the degree of care, diligence, and skill ordinarily exercised by osteopathic physicians in good standing in the community in which he practices in his examination and treatment of his patient and committed malpractice. NRS 633.071.

131. Such conduct constitutes gross or repeated malpractice and is grounds for disciplinary action pursuant to NRS 633.511(4).

COUNT TWENTY-THREE

(Collier)

132. The allegations set forth in paragraphs 1 through 5 and 126 through 131 are incorporated herein as if set out in full.

133. Respondent examined Renee Collier later the same day of surgery on or about March 13, 2001, and her eye was very inflamed. Respondent did not examine Ms. Collier again until March 19, 2001, six days after the surgery. By March 19, 2001, the eye had deteriorated considerably. The patient's visual acuity prior to surgery was 20/80 and six days
after surgery, it was 20/400. The patient was referred to a specialist by Respondent for persistent inflammation.

134. Respondent noted in the operative report of March 13, 2001 that virtually all the fragments were removed. On March 19, 2001, Dr. Kirmani, the specialist, observed in the patient's left eye inflammation and dislocated lens fragments. On April 6, 2001, Dr. Kirmani states in his operative notes that large fragments of crystalline lens were noted in the posterior pole and extensive lenticular debris. Also noted was a large retinal tear.

135. Respondent failed to exercise the degree of care, diligence, and skill ordinarily exercised by osteopathic physicians in good standing in the community in which he practices by allowing the patient to wait six days after surgery before being examined again. Such conduct constitutes malpractice. NRS 633.071.

136. Such conduct constitutes gross or repeated malpractice and is grounds for disciplinary action pursuant to NRS 633.511(4).

**COUNT TWENTY-FOUR**

**(Fleites)**

137. The allegations set forth in paragraphs 1 through 5 are incorporated herein as if set out in full.

138. Respondent examined Margaret Fleites on or about September 7, 2001. Respondent performed cataract surgery on Margaret Fleites' left eye on or about September 17, 2001.

139. Margaret Fleites had significant diabetic retinopathy, but the preoperative examination did not include a retinal consultation or evaluation and no PAM test to evaluate vision potential.

140. From October 10, 2001 until February 4, 2002, Margaret Fleites was treated by Helga Pizio, M.D. Dr. Pizio observed that considerable damage to the eye and cornea occurred as a result of the cataract surgery on September 17, 2001. Following surgery, Ms. Fleites suffered permanent vision loss.
141. The operative report was not dictated until November 26, 2001, more than two
months after the surgery.

142. Respondent failed to exercise the degree of care, diligence, and skill ordinarily
exercised by osteopathic physicians in good standing in the community in which he practices
in his treatment of Margaret Fleites. Such conduct constitutes malpractice. NRS 633.071.

143. Such conduct constitutes gross or repeated malpractice and is grounds for
disciplinary action pursuant to NRS 633.511(4).

**COUNT TWENTY-FIVE**

**(Fleites)**

144. The allegations set forth in paragraphs 1 through 5 and 137 through 143 are
incorporated herein as if set out in full.

145. Margaret Fleites had cataract surgery on her left eye on or about September 17,
2001. Margaret Fleites was never seen by Respondent following the surgery although Ms.
Fleites did come to Respondent’s office following surgery and waited in Dr. Carpenter’s office
for several hours without ever seeing him due to an alleged emergency by Respondent. Ms.
Fleites’ caregiver attempted to contact Respondent without success regarding Ms. Fleites’
post-operative condition. An “ASAP” request by the nursing home at which Ms. Fleites
resided was never responded to by Respondent. There is no documentation in the patient’s
records which evidence any post-operative care by Respondent.

146. Respondent failed to exercise the degree of care, diligence, and skill ordinarily
exercised by osteopathic physicians in good standing in the community in which he practices
in his post-operative care of Margaret Fleites. Such conduct constitutes malpractice.

147. Repeated malpractice is grounds for disciplinary action pursuant to NRS
633.511(4).

**COUNT TWENTY-SIX**

**(Fleites)**

148. The allegations set forth in paragraphs 1 through 4 and 137 through 147 are
incorporated herein as if set out in full.
149. Respondent failed to provide post-operative care to a patient following cataract surgery and failed to respond to requests for medical treatment by Ms. Fleites or her caregivers.

150. Respondent abandoned his patient. Such conduct is unethical and unprofessional conduct pursuant to NAC 633.350(2) and is grounds for disciplinary action pursuant to NRS 633.511(1).

**COUNT TWENTY-SEVEN**

**(Gross Malpractice)**

151. The allegations set forth in paragraphs 1 through 150 are incorporated herein as if set out in full.

152. Respondent has exhibited a pattern of using medical procedures, services, or treatment, which are inappropriate and unnecessary. Respondent has exhibited a pattern of disregarding established medical procedures in his treatment of patients.

153. Respondent's willful and consistent use of medical procedures, services or treatment considered by osteopathic physicians in the community to be inappropriate or unnecessary in the cases where used constitutes gross malpractice.

154. Respondent's willful disregard of established medical procedures constitutes gross malpractice.

155. Gross malpractice is grounds for disciplinary action pursuant to NRS 633.511(4).

**COUNT TWENTY-EIGHT**

**(Unprofessional Conduct)**

156. The allegations set forth in paragraphs 1 through 155 are incorporated herein as if set out in full.

157. Letterhead used by Respondent as well as the paper used to make notes in his charts, his prescription pad and other papers that make professional use of Respondent's name fail to refer to Respondent as a "D.O." or osteopathic physician or doctor of osteopathy. Respondent has made public reference to himself as "J. Daniel Carpenter M.D." Respondent's filing with the Secretary of State's office reflects that he is an "M.D."
158. Failure of Respondent to designate his school of practice in the professional use
of his name by using the term D.O. or osteopathic physician or doctor of osteopathy is
unprofessional conduct pursuant to NRS 633.131(1)(b). Such a violation is grounds for
disciplinary action pursuant to NRS 633.511(1).

WHEREFORE, THE INVESTIGATIVE MEMBER OF THE BOARD OF OSTEOPATHIC
MEDICINE PRAYS AS FOLLOWS:

1. That the Nevada State Board of Osteopathic Medicine conduct a hearing on this
Complaint as provided by statute;

2. That, pursuant to NRS 633.651, RESPONDENT, J. DANIEL CARPENTER,
D.O., be publicly reprimanded and/or the license of J. DANIEL CARPENTER, D.O., be
revoked, suspended, limited to a specified branch of osteopathic medicine, or placed on
probation with conditions and terms as the Nevada State Board of Osteopathic Medicine may
demn just and proper and which are not inconsistent with law;

3. That RESPONDENT, J. DANIEL CARPENTER, D.O., be ordered to pay
reasonable attorney's fees and costs of the investigation and the administrative and
disciplinary proceedings.

DATED this 11 day of July, 2004.

By:

GARY MONO, D.O.,
Investigating Member of the
Nevada Board of Osteopathic Medicine

Submitted by:
BRIAN SANDOVAL
Attorney General

By:
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