

1 puncture marks were observed on her left knee and had muscle weakness in her left leg, including
2 the inability to move the affected leg on her own.

3 5. Patient A's stay at Humboldt General Hospital totaled close to three (3) hours.
4 During this time, Patient A's heart rate measured from 149 beats per minute to 154 beats per
5 minute, indicating continued tachycardia.

6 6. Respondent documented Patient A's vital signs but did not document Patient A's
7 blood pressure measurements. Respondent's notes during Patient's A presentation did not discuss
8 a recognition of Patient A's continued tachycardia.

9 7. Respondent spoke with the hospitalist at Humboldt General Hospital, who
10 expressed preference to have Patient A transferred to another facility with a higher level of care.

11 8. Respondent then spoke with a physician at Renown Regional Medical Center
12 (Renown) in Reno, Nevada. It was then arranged to have Patient A transferred from Humboldt
13 General Hospital to Renown. Initially, it was decided to transport Patient A via helicopter, but
14 then the decision was made to transport Patient A via ground ambulance.

15 9. Respondent did not document that he spoke with any other physicians regarding
16 Patient A's snake bite.

17 10. During Patient A's entire time at Humboldt General Hospital on May 9, 2020,
18 Respondent elected not to provide an antivenom injection to Patient A, although the appropriate
19 antivenom was available at Humboldt General Hospital on the day of Patient A's arrival.

20 11. The first documented blood pressure measurement on May 9, 2020, was taken by
21 Emergency Medical Services prior to Patient A's departure from Humboldt General Hospital.
22 Patient A's blood pressure reading was 59/40, indicating low blood pressure (hypotension).

23 12. Prior to transferring Patient A by ambulance, Respondent failed to administer the
24 appropriate antivenom, despite clear evidence of Patient A's critical life signs and uncompensated
25 shock.

26 13. Despite clear evidence of Patient A's medical instability, Respondent transferred
27 Patient A from Humboldt General Hospital to Renown via ground ambulance, whereupon
28 Patient A expired on May 13, 2020, as a result of the snake bite.

COUNT I

NRS 630.301(4) - Malpractice

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

15. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating 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.”

17. 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 recognize hypotension and tachycardia in a patient who had been bitten by a snake, and by failing to treat her diminishing condition, failure of which led to Patient A’s expiration.

18. 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

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

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

21. 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.”

22. Respondent failed to timely seek consultation with regard to Patient A’s medical condition on May 9, 2020 and Respondent should have consulted with a medical toxicologist to

1 address the doubtfulness of the diagnosis of Patient A’s medical condition and such a timely
2 consultation would have confirmed or denied such a diagnosis and may have enhanced the quality
3 of medical care provided to Patient A with regard to the need for antivenom and other therapies.

4 23. By reason of the foregoing, Respondent is subject to discipline by the Nevada State
5 Board of Medical Examiners as provided in NRS 630.352.

6 **COUNT III**

7 **NRS 630.3062(1)(a) - Failure to Maintain Appropriate Medical Records**

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

10 25. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate
11 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute
12 grounds for initiating discipline against a licensee.

13 26. Respondent failed to maintain complete and proper medical records relating to the
14 diagnosis, treatment and care of Patient A, by failing to document his actions when he treated
15 Patient A, whose medical records were not timely, legible, accurate, and complete. Respondent’s
16 medical records were not accurate and complete by failing, on May 9, 2020, to note a recognition
17 of Patient A’s elevated heart rate (tachycardia), or a recognition of Patient A’s continued
18 tachycardia, despite treatment with IV fluids, or a recognition of Patient A’s low blood pressure
19 (hypotension).

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

22 **WHEREFORE**, the Investigative Committee prays:

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

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

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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 8th day of March, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 
WILLIAM P. SHOGREN
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Attorney for the Investigative Committee

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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 8th day of March, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:



BRET W. FREY, 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 8th day of March, 2023, I served a file-stamped copy of the foregoing **COMPLAINT and PATIENT DESIGNATION**, with accompanying required fingerprinting materials via U.S. Certified Mail, to the following parties:

JASON HOWARD LASRY, M.D.
216 Piazza Del Verano
Las Vegas, NV 89138
Tracking No.: 9171 9690 0935 0254 7667 97

DATED this 8th day of March, 2023.



MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners