OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 (775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against:

STEPHANIE ANN SHIBATA, PA-C, Respondent.

Case No. 23-41719-1

FILED

NOV 1 5 2023

NEVADA STATE BOARD OF MEDICAL CAMINERS
By:

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Stephanie Ann Shibata, PA-C (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 relevant to this Complaint a physician assistant holding an active license to practice medicine in the State of Nevada (License No. PA1480). Respondent was originally licensed by the Board on December 16, 2013.
 - 2. Patient A² was a twenty-five (25) year-old female at the time of the events at issue.
- 3. Patient A was hospitalized and diagnosed with a shoulder abscess with osteomyelitis, deep vein thrombosis, and sickle cell crisis.
- 4. On January 22, 2019, Patient A was discharged from the hospital with plans to have home healthcare check on Patient A, draw and monitor regular labs, and to assist with administration of antibiotics.

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., Chowdhury H. Ahsan, M.D., Ph.D, FACC, and Col. Eric D. Wade, USAF (Ret.).

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's records from her hospital visit show that her potassium level were 5. within normal range.
- Additionally, as part of Patient A's post-discharge plan, Patient A was to be 6. examined by physicians or physician assistants at the Clinical Infectious Disease Specialists (CIDS) Clinic. At all times relevant to this Complaint, Respondent was employed by CIDS as a physician assistant.
- On February 4, 2019, a visiting nurse drew blood from Patient A at Patient A's 7. home. On February 5, 2019, lab results were obtained and showed that Patient A had critical laboratory levels showing a high potassium level of 7.4 mEq/L, indicating hyperkalemia. The lab results were faxed to CIDS on February 6, 2019.
- Hyperkalemia is defined as an elevated potassium level greater than 5-5.5 mEq/L. 8. Any acute potassium level greater than 6 mEq/L is considered clinically significant.
- On February 11, 2019, Patient A presented to CIDS Clinic and was seen by 9. Respondent. Respondent reviewed the laboratory results from February 5, 2019, with Patient A.
- Respondent's original clinic notes from February 11, 2019, do not mention Patient A's abnormal potassium level nor do they document that Respondent spoke to Patient A about the abnormal potassium level.
- Respondent's medical records from February 11, 2019, do not indicate that 11. Respondent ordered or recommended an electrocardiogram (EKG), to determine any cardiac changes in Patient A as a result of Patient A's acute elevation of potassium.
- Respondent's medical records from February 11, 2019, further do not indicate that 12. Respondent ordered or recommended immediate repeat testing of Patient A's potassium levels, to determine the accuracy of Patient A's labs and to exclude the possibility of pseudohyperkalemia.
- On or about February 11, 2019, a visiting nurse once again drew Patient A's blood. 13. Lab results were obtained from Patient A, showing high potassium levels of greater than 8 mEq/L. CIDS received the lab results on or about February 13, 2019.
- On February 13, 2019, Patient A passed away after suffering cardiopulmonary 14. arrest.

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On February 14, 2019, Respondent attempted to contact Patient A to discuss her 15. laboratory results.

COUNT I

NRS 630.301(4) - Malpractice

- All of the allegations contained in the above paragraphs are hereby incorporated by 16. reference as though fully set forth herein.
- NRS 630.301(4) provides that malpractice of a physician assistant, is grounds for 17. initiating disciplinary action against a licensee.
- NAC 630.040 defines malpractice as "the failure of a physician, in treating a 18. patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."
- 19. 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 promptly act upon Patient A's laboratory results on or before February 11, 2019, including the failure to order or recommend immediate repeat testing of Patient A's potassium levels and the failure to obtain or recommend an EKG for Patient A.
- By reason of the foregoing, Respondent is subject to discipline by the Board as 20. provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) - Failure to Maintain Complete Medical Records

- All of the allegations contained in the above paragraphs are hereby incorporated by 21. reference as though fully set forth herein.
- NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate 22. and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.
- Respondent failed to maintain complete medical records relating to the diagnosis, 23. treatment and care of Patient A, by failing to correctly document her actions when she treated

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Patient A, whose medical records were not timely, legible, accurate, and complete. On February 11, 2019, Respondent did not document Patient A's hyperkalemia, its potentially life-threatening consequences, and Respondent's recommendations in a timely manner. Respondent further did not timely document in the clinic note on February 11, 2019, of the potassium level of 7.4, renal function, or discussion of Patient A's potassium levels and risks Respondent further did not document on February 11, 2019, any associated with it. recommendation for Patient A to immediately go to the emergency room.

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

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

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

DATED this 15th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

WILLIAM P. SHOGREN

Deputy General Counsel 9600 Gateway Drive

Reno, NV 89521 Tel: (775) 688-2559

Email: shogrenw@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL

Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521

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 15th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

. FREY, M.D.

Chairman of the Investigative Committee

CERTIFICATE OF SERVICE I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 15th day of November, 2023, I served a file-stamped copy of the foregoing **COMPLAINT and PATIENT DESIGNATION** via U.S Certified Mail to: STEPHANIE ANN SHIBATA, PA-C c/o Heather Hall, Esq. McBride Hall 8329 W. Sunset Road, Suite 260 Las Vegas, NV 89113 Tracking No.: ____ day of November, 2023.

DATED this

MERCEDES PUENTES

Legal Assistant

Nevada State Board of Medical Examiners

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