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: **LUCAS MICHAL ANDERSON, PA-C** **Respondent.**	**Case No. 24-44161-1**

FILED
JAN 26 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (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 Lucas Michal Anderson, 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 relative to this Complaint a physician assistant holding an active license to practice medicine in the State of Nevada (License No. PA1668). Respondent was originally licensed by the Board on October 16, 2015.

2. Patient A[2] was a thirty-eight (38) year-old male at the time of the events at issue.

3. Patient A presented to the emergency department at Summerlin Hospital on November 12, 2018, at approximately 7:40 a.m., with complaints of low back pain, testicle pain, and dysuria.

4. At the emergency department, Respondent examined Patient A and wrote orders for IV fluids, urinalysis, urine culture, a testicular ultrasound, a complete blood count, basic

[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., Col. Eric D. Wade, USAF (Ret.), and Carl N. Williams, Jr., 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.

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metabolic panel, and a computed tomography (CT) scan of the abdomen and pelvis. Respondent also wrote orders for various analgesics.

5. On November 12, 2018, the urinalysis demonstrated sixteen (16) white blood cells, nineteen (19) red blood cells, and no bacteria. The CT scan demonstrated an obstructing ureteral stone and excessive urine in the ureter and kidney.

6. A white blood cell count over five (5) in urine is typically abnormal and indicative of a possible urinary tract infection. A possible urinary tract infection, combined with an obstructing ureteral stone, typically mandates treatment with antibiotics.

7. Patient A's urinalysis results, and the need for a culture, indicated a possible urinary tract infection.

8. Patient A was discharged on November 12, 2018, at approximately 10:30 a.m., with instructions to follow-up with a urologist.

9. During Patient A's stay at the emergency department on November 12, 2018, Respondent did not document a urinary tract infection or administer or prescribe antibiotics to Patient A.

10. Patient A presented again to the emergency department at Summerlin Hospital on November 14, 2018, and was diagnosed with severe sepsis resulting from a urinary tract infection.

11. Due to the infection, Patient A developed severe medical complications resulting in a lengthy hospitalization.

12. Additionally, the urine culture from November 12, 2018, was reported on November 14, 2018, demonstrating an abnormal amount of Escherichia coli in Patient A's urine.

COUNT I

NRS 630.301(4) - Malpractice

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

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

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15. 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."

16. 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 diagnose and treat Patient A's urinary tract infection in the setting of an obstructed ureteral stone, including by failing to administer or prescribe antibiotics to Patient A.

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

COUNT II

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

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

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

20. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to accurately note Patient A's urinary tract infection on November 12, 2018.

21. 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;

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 26th day of January, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

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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 26th day of January, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee