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: **ANDREW PHILLIPS ROGERS, M.D.,** **Respondent.**	**Case No. 25-53360-1**

FILED
FEB 25 2025
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 its counsel, Alexander J. Hinman, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Andrew Phillips Rogers (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:

Respondent was at all times relative to this Complaint a physician holding an active license to practice medicine in the State of Nevada (License No. 20269). Respondent was originally licensed by the Board on September 1, 2020, with a specialty in surgery.

1. Patient A[2] was a forty-one (41) year-old male at the time of the events at issue.

2. On October 1, 2020, Patient A presented to the Blossom Medical Group, at Warm Springs Surgical Center in Las Vegas, Nevada, seeking care for his morbid obesity and gastroesophageal reflux disease.

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[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. Ashan, M.D., Ph.D., FACC, Ms. Pamela J. Beal, 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.

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3. Patient A was five foot eleven inches (5'11") and had a weight of three hundred and fifty-two pounds (352lbs) with a Body Mass Index (BMI) of forty-nine point one (49.1) at the time of presentation.

4. On October 1, 2020, Patient A underwent a transthoracic echocardiogram revealing a normal left ventricular function, an ejection fraction of sixty to sixty-five percent (60-65%), a normal right atrium and left ventricle, a normal pulmonary artery, and IVC was normal with respiratory variation.

5. On October 2, 2020, an esophagogastroduodenoscopy (EGD) demonstrated a Hill grade 3 hiatal hernia and gastritis. Biopsies of the gastritis were performed and the pathology demonstrated mild chronic superficial gastritis.

6. On October 5, 2020, the Respondent performed a paraesophageal hiatal hernia repair, an EGD, and a sleeve gastrectomy on Patient A.

7. In his surgical notes, Respondent describes a large hiatal hernia repaired with three (3) posterior stitches.

8. Upon completion of the surgery, Patient A was transferred to the recovery room and given IV fluids, anti-emetics, and pain medication.

9. On October 6, 2020, Patient was found to be intolerant of oral intake to the point he could not ingest his own saliva. Respondent elected to take Patient A back to surgery to perform a diagnostic laparoscopy and noted that he discovered the hiatal repair appeared to be too tight.

10. In Respondent's October 6, 2020, operative note, (dated October 5, 2020, in an apparent error as that was the date of the first surgery), he states that he cut and removed the anterior most stich of the hiatal repair, and that the subsequent endoscope passed through the hiatus "more easily". Further, he states that "no fluid, inflammation, purulence, or leakage was seen in any of the previously operated areas."

11. After the diagnostic laparoscopy, Patient A was taken to the recovery room where he appeared to recover uneventfully and was discharged from the facility.

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12. On October 7, 2020, and October 8, 2020, Patient A was seen in follow-up at Blossom Medical Group. Patient A's oral intake was still poor, and he was given IV fluid resuscitation on each visit.

13. On October 8, 2020, Patient A was reported as being very intolerant of oral fluids, getting in zero (0) ounces of water and zero (0) grams of protein. Further, the note from the visit reads, "per Rogers, call ambulance transfer to Henderson hospital."

14. On presentation to the Henderson Hospital on October 8, 2020, Patient A was complaining of left upper quadrant abdominal pain, nausea, and vomiting. His vital signs showed he was tachycardic with a heart rate of 107, and laboratory evaluation revealed an elevated white blood cell count.

15. On October 8, 2020, while at Henderson Hospital, Patient A underwent a CT scan with IV contrast, which revealed that he was developing pneumonia and significant emesis.

16. On October 9, 2020, Patient A was discharged from the hospital with a handwritten discharge summary stating that he was "tolerating [the] diet".

17. On October 10, 2020, Patient A was seen at Blossom Medical Group, and complained of dehydration, stating that he was not tolerating oral vitamin supplements. He was given dietary recommendations and instructed to develop a routine exercise program.

18. On October 11, 2020, Patient A was brought to the Saint Rose Siena emergency department by Emergency Medical Services (EMS). Notes from this incident describe that Patient A was experiencing an acute onset of chest pressure and pleuritic type chest pain and was in severe respiratory distress. The EMS providers reported that his oxygen saturations were low at the time of their arrival, and he was transported to the hospital on a non-rebreather mask.

19. Patient A was tachycardic with a heart rate of 138 and the ER physician moved to intubate him for stabilization. During the intubation, Patient A sustained a cardiac arrest and CPR/ACLS measures were initiated. Patient A returned to spontaneous circulation after approximately twelve (12) minutes of CPR.

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20. Patient A was subsequently placed on a mechanical ventilator for respiratory support and started on vasopressors. The emergency room workup revealed that Patient A had severe mixed acidosis with an elevated creatine level, and he was not producing any urine.

21. An EKG performed at Patient A's bedside showed a strained right ventricle with a McConnell sign (a specific echocardiographic finding that strongly suggests acute pulmonary embolism). He was then given a Tissue Plasminogen Activator and given Heparin (an anticoagulant to prevent blood clots).

22. A CTA of Patient A's chest with IV contrast and a CT of the abdomen and pelvis with IV contrast revealed possible pneumonia, moderate to large pneumoperitoneum, and extensive pneumatosis. Further, he had a six (6) centimeter fluid collection posterior to the gastric sleeve.

23. Under Respondent's directive, Patient A's imaging consisted of a water-soluble contrast of upper GI and a CT scan without oral contrast. Despite Patient A having suspected leaks following sleeve gastrectomy, a CT scan with oral contrast was not ordered which would have allowed for a more comprehensive assessment of the post-surgical anatomy.

24. Patient A was subsequently admitted to the ICU for monitoring. Over the next twenty-four (24) hours, Patient A's urine output and renal function worsened, and a hemodialysis catheter was emergently placed for Renal Replacement Therapy (RRT). Patient A was in severe shock during this time.

25. On October 12, 2020, Patient A became more stable, and another physician took Patient A to the operating room to perform diagnostic laparoscopy, debridement, and drainage of intra-abdominal abscesses with placement of three (3) JP drains.

26. In the surgeon's October 12, 2020, operative report, the surgeon describes "all four quadrants containing enteric looking abscess fluid, about 2 1/2 liters of fluid was removed." He describes, "the remnant of the gastric sleeve to be socked in with fibrinous exudate and states that it was not safe to proceed with further dissection." Thus, a decision was made to leave the three (3) JP drains in place.

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27. Patient A's condition over the ensuing hospitalization did not improve and on the morning of October 16, 2020, a clinical exam was suggestive of brain death. Due to this finding, Patient A was extubated and expired.

COUNT I

NRS 630.301(4) - Malpractice

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

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

30. 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."

31. 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 when he failed to adequately educate, prepare, treat, and engage Patient A perioperatively. Further, Respondent failed to diagnose complications postoperatively, he did not closely follow Patient A with an in-person surgical evaluation, and he failed to treat Patient A in a timely manner.

32. 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 Complete Medical Records

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

34. 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.

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35. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document his actions when he treated Patient A, where, among other things, he failed to document perioperative education to Patient A, and he failed to document proper diagnoses of a stricture and/or leak when Patient A presented with indicia of complications. As a result, Patient A's medical records were not timely, legible, accurate, and complete.

36. 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

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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 25th day of February, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Alexander J. Hinman

ALEXANDER J. HINMAN
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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 25th day of February, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

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

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