BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **RILEY MADISON SWANSON, PA-C,** **Respondent.**	**Case No. 25-53188-1**

FILED

NOV 24 2025

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

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

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Ian J. Cumings, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Riley Madison Swanson, 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. PA2315). Respondent was originally licensed by the Board on August 12, 2020.

2. Patient A[2] was a seventy-two (72) year-old male at the time of the events at issue.

3. Patient A had a relevant medical history of a L3-S1 spinal laminectomy, and an L4-L5 lateral and posterior fusion on December 28, 2021.

4. On February 21, 2023, Patient A presented to Respondent's practice with complaints of lower back pain, and progressive leg pain. An MRI was performed and

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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. Ahsan, M.D., Ph.D., FACC, Ms. Pamela 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.

demonstrated degenerative disc disease, and Patient A was scheduled for an additional spinal surgery.

5. On March 22, 2023, Patient A underwent spinal surgery to include a lateral interbody fusion at the L3-4 and L5-S1 levels by an orthopedic surgeon.

6. Following the procedure on March 31, 2023, Patient A was seen for a post-operative visit and evaluated by a physician assistant working at Respondent's practice who documented pain and swelling in the right knee. Patient A had a normal neurological exam, and the incision site was dry and intact.

7. On April 21, 2023, Patient A was evaluated by Respondent. Patient A continued to have complaints of lower extremity pain, left groin, anterior thigh, and radicular pain down the right leg. Patient A reported to Respondent that his pain level at this visit was 10 out of 10 on a pain scale, and that his wound was worse. Patient A had a normal neurological exam, and Respondent noted that the incision site was dry and intact. Respondent did not document a leg examination during this visit and did not place Patient A on surveillance for possible deep vein thrombosis (DVT) but instead ordered a STAT MRI and a follow-up visit one (1) week later.

8. Patient A's condition continued to deteriorate, and on April 30, 2023, Patient A was evaluated in a satellite emergency room and was found to have multiple blood clots in his right leg. Patient A was transferred via ambulance to a hospital.

9. On May 1, 2023, Patient A underwent emergency surgery to remove several blood clots in his right leg, and vena cava.

10. On May 1, 2023, Respondent filed an addendum of her April 21, 2023, medical record, describing her examination of Patient A's lower extremities, stating that the patient did not display any symmetric swelling of the lower extremities or tenderness.

COUNT I

NRS 630.301(4) - Malpractice

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

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

13. 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."

14. 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 consider or timely rule out a potential DVT during the April 21, 2023, visit..

15. 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

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

17. 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.

18. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document her actions when she treated Patient A, whose medical records were not timely, legible, accurate, and complete by failing to timely document a lower extremity exam for Patient A, and her medical reasoning for sending Patient A for an MRI until after Patient A was discovered to have suffered a DVT.

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

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COUNT III

NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation

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

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

22. 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."

23. Respondent failed to timely seek consultation with regard to Patient A's medical condition on April 21, 2023.Respondent should have consulted with an appropriate care provider to address the doubtfulness of the diagnosis of Patient A's medical condition and such a timely consultation would have confirmed or denied such a diagnosis and may have enhanced the quality of medical care provided to Patient A with regard to ruling out a potential DVT.

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

WHEREFORE, the IC prays:

1. That the Board give Respondent notice of the charges herein against her and give 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;

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 24th day of November, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

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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 24th day of November, 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