BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: DAVID KAYLE McCLEVE, PA-C, Respondent.	Case No. 24-42281-1

FILED

MAR 26 2026

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The above-entitled matter came on regularly for decision before the Nevada State Board of Medical Examiners (Board), on March 6, 2026, at the Board's office located at 325 E. Warm Springs Road, Suite 225, Las Vegas, NV 89119, on the Complaint filed herein. David Kayle McCleve, PA-C, (Respondent), who was duly served with notice of the adjudication, was present and represented by his counsel, Lisa J. Zastrow, Esq., who appeared by telephone. The adjudicating members of the Board participating in these Findings of Fact, Conclusions of Law, and Order (FOFCOL) were Bret W. Frey, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, Ms. Pamela J. Beal, Jospeh Olivarez, P.A.-C, Apeksha Desai, M.D., MBA, and Ms. Kathleen A. Conaboy. Rosalie M. Bordelove, Esq., Chief Deputy Attorney General, served as legal counsel to the Board.

The Board, having received and read the Complaint and exhibits admitted in the matter and filed into the record in this case, the "Findings and Recommendations" prepared by the Hearing Officer, Patricia Halstead, Esq., who presided over the hearing, and the transcript of the hearing, proceeded to make a decision pursuant to the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Nevada Medical Practice Act or NMPA), NRS Chapter 622, NRS Chapter 622A, and NRS Chapter 233B, as applicable.

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

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

The Board, after due consideration of the record, evidence and law, and being fully advised in the premises, makes its FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER in this matter, as follows:

FINDINGS OF FACT

I.

Respondent held a license to practice as a physician assistant in the State of Nevada issued by the Board at all relevant times, and specifically on April 8, 2023, the date of the incident at issue in this case.

II.

On November 22, 2024, the Investigative Committee (IC) of the Board filed its formal Complaint in Case No. 24-42281-1 alleging Respondent violated the NMPA. Respondent was served with the Complaint on or about January 6, 2025, at an address in Las Vegas, Nevada, which was on file with the Board for Respondent, and on December 6, 2024, at an address in Holbrook, Arizona, which was on file with the Board for Respondent. The Complaint alleged four (4) violations of the NMPA, including: one (1) violation of NRS 630.301(4), Malpractice (Count I); one (1) violation of NRS 630.3062(1)(a), Failure to Maintain Appropriate Medical Records (Count II); one (1) violation of NRS 630.306(1)(b)(2), Violation of Standards of Practice Established by Regulation (Count III); and one (1) violation of NRS 630.306(1)(e), Practice Beyond the Scope of License (Count IV). Respondent filed an answer in response to the allegations set forth in the Complaint on January 29, 2025.

III.

An Order was filed on February 5, 2025, scheduling the Early Case Conference (ECC) for the pending matter for February 13, 2025. This Order was served upon Respondent's counsel by email and U.S. Mail. The Early Case Conference (ECC) was held at the scheduled time wherein all parties appeared telephonically. As a result of the ECC, a Scheduling Order was issued and filed February 14, 2025, setting dates for prehearing and hearing. The Prehearing Conference was scheduled for May 9, 2025, and a hearing date was set for July 11, 2025. Respondent's counsel was served a copy of the Scheduling Order by email and U.S. Mail. At the time fixed for the

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

Prehearing Conference, legal counsel for the IC, Deonne E. Contine, General Counsel, and Sarah A. Bradley, Deputy Executive Director, appeared, as well as the Hearing Officer, Patricia Halstead, Esq., and counsel for Respondent, Lisa J. Zastrow, Esq. At the Prehearing Conference, counsel for the IC and Respondent provided the Hearing Officer with the mandated Prehearing Conference Disclosures and had copies of both the Prehearing Conference Statement and the mandated Prehearing Disclosures available for the parties. Respondent was timely and properly served with the Prehearing Conference Statement and the mandated Prehearing Disclosures in accord with NRS and NAC Chapters 630, NRS Chapters 241, 622, 622A and 233B, and the requirements of due process. On July 31, 2025, an Order Rescheduling Evidentiary Hearing was issued and filed, re-setting the dates for hearing to September 17, 2025, September 18, 2025, and September 22, 2025, if necessary.

In an Order filed on September 15, 2025, the Hearing Officer issued an Order Denying Respondent's Motion in Limine seeking to exclude the testimony of the IC's witnesses. Respondents Motion was filed on May 27, 2025, and the IC filed its Opposition on June 5, 2025.

IV.

On September 17, 2025, September 18, 2025, and September 22, 2025, a contested case hearing was held before the Hearing Officer to receive evidence and to hear arguments. The Hearing Officer received the complete Record of Proceedings, including the transcript of the hearing testimony and the exhibits admitted. Upon receipt of the Record of Proceedings, the hearing was closed. The Hearing Officer filed the Findings and Recommendations on November 26, 2025. In her Findings and Recommendations, the Hearing Officer recommended that the Board find that Counts II and IV, as alleged in the Complaint, were proven by a preponderance of evidence. The Hearing Officer's Findings and Recommendations recommended that the Board not find that the IC had met its burden of proof with regard to Counts I and III, as alleged in the Complaint. Respondent was served with the Findings and Recommendations via U.S. Certified Mail, with a copy by email on November 26, 2025.

On December 10, 2025, the IC filed a Motion for Reconsideration, requesting that the Hearing Officer reconsider her Findings and Recommendations with respect to Counts I and III, as

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

contained in the Complaint, and to issue an amended Findings and Recommendations recommending that the Board find that Counts I and III were proven by a preponderance of evidence. The motion was fully briefed, with Respondent filing its opposition on January 16, 2026. After considering all points and authorities, raised by the IC, the Hearing Officer issued an Order Denying Motion for Reconsideration, which was filed on January 29, 2026.

The matter was scheduled for final adjudication on March 6, 2026, at a regularly scheduled Board meeting. The notice of the adjudication was mailed to Respondent on February 3, 2026, via U.S. Certified Mail, with a copy sent by email. Additionally, on February 24, 2026, via Fed Ex Overnight mail, Respondent was provided with a copy of the Investigative Committee's Memorandum of Costs and Disbursements and Attorneys' Fees and a packet of the adjudication materials to be presented at the March 6, 2026 Board meeting.

V.

Pursuant to NRS 622A.300(5)(a), the Board hereby approves the Hearing Officer's Findings and Recommendations with respect to Count II and Count IV, and those Findings and Recommendations are hereby approved by the Board in their entirety and are hereby specifically incorporated and made a part of this Order by reference. *See* **Exhibit 1**.

With regard to the Hearing Officer's Findings and Recommendations concerning Count I and Count III, the Board hereby modifies those Findings and Recommendations and substitutes its own as authorized by NRS 622A.300(5)(a). In reaching this determination, the Board relies on the evidence, including testimony presented at the hearing, and the experience, technical competence and specialized knowledge of the individual Board members when evaluating this evidence. *See* NRS 233B.123(5). The Board does not disagree with the Hearing Officer regarding the credibility of individual witnesses, however, the Board disagrees with the her application of the law to the facts as stated in her Findings and Recommendations with respect to Count I and Count III. The Board hereby determines that the IC proved Count I and Count III by a preponderance of evidence.

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

VI.

The Board cites the following in support of its determination that the IC proved by a preponderance of evidence Count I as alleged in the Complaint.

NAC 630.040, as amended by R171-20 and R069-23, defines malpractice as "the failure of a physician, physician assistant, anesthesiologist assistant, practitioner of respiratory care or perfusionist, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances." NAC 630.040 is an attempt to add a "reasonable provider" standard to determining whether conduct by a named licensee constitutes malpractice. If the Board finds by a preponderance of the evidence that a licensee has committed malpractice that is grounds for disciplinary action against that licensee pursuant to NRS 630.301(4).

In this case, the Board finds that Respondent's injection of botulism type A (Botox) into Patient A in the emergency room during his emergency department shift at North Vista Hospital was not reasonable conduct. This conclusion is supported by testimony from all three health care provider witnesses at the hearing. The IC's witness, Ms. Elmquist, a physician assistant practicing in emergency medicine like the Respondent, indicated that performing an "unauthorized cosmetic procedure in the hospital emergency room," Findings at 3:22–23, was "unreasonable in consideration of the fact that the injections were done in a location where they were not sanctioned and Botox was administered to a patient that was not registered [at the hospital] and no records were made." Findings at 4:20–22. Respondent himself conceded in his testimony that "inviting a patient to a hospital to receive cosmetic injections is 'not normal' and was against hospital policy." Findings at 6:19–20. Respondent further indicated that "medically what he did was fine but ethically it was not." Findings at 9:1. Dr. Sheep, who was Respondent's supervising physician of record,[1] stated "that the location for services [that he previously authorized and supervised] was not North Vista Hospital and that he would never have authorized Respondent to perform a cosmetic procedure there." Findings at 10:24–11:1. Dr. Sheep further testified that

[1] Dr. Sheep was Respondent's supervising physician as shown in the Board's records, but the Board does not find that Dr. Sheep was supervising Respondent with regard to the services provided to Patient A on April 8, 2023, because the Agreement required a practice location wherein Dr. Sheep would be supervising Respondent's provision of medical services. The address provided on this form was not North Vista Hospital. *See* Exhibit 12, NSBME (Reb) at 36. Further, Dr. Sheep's written response to the Board regarding this incident, and Dr. Sheep's testimony at the hearing support that Dr. Sheep had not authorized Respondent to perform these services at this location.

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

"Respondent injecting Botox in a hospital emergency department to a patient that was not registered was not reasonable." Findings at 11:27–12:1. In short, all the health care providers that testified at the hearing, including Respondent, agree that Respondent's injection of Botox into Patient A as alleged in the complaint was not appropriate. Dr. Sheep and Ms. Elmquist both go further stating that Respondent's conduct was not reasonable. Based on the testimony from the three health care provider witnesses at the hearing and the Board's own experience, technical competence, and specialized knowledge, Respondent's conduct in performing a cosmetic procedure by injecting a private pay patient during a break in his hospital shift as an emergency department physician assistant while at the hospital, without registering the patient with the hospital, and without creating medical records of his treatment was not what a provider using reasonable care, skill and knowledge would ordinarily do under similar circumstances. These actions by Respondent constitute malpractice as defined in NAC 630.040. Therefore, the evidence presented at the hearing was sufficient to support the allegations contained in Count I, Malpractice, by a preponderance of the evidence, and, accordingly, the Board finds that Count I has been proven. Consequently, Respondent is subject to disciplinary action pursuant to NRS 630.301(4).

VII.

The Board cites the following in support of its determination that the IC proved by a preponderance of evidence Count III as alleged in the Complaint.

Count III in the IC's Complaint alleges that Respondent violated NAC 630.340(2) by providing medical services to Patient A without having a supervision agreement on file with the Board for such services. Such a violation is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

On April 8, 2023, when Respondent injected Patient A with Botox while on shift at the emergency department at North Vista Hospital, Respondent had an active supervision agreement with Dr. Sheep for cosmetic services on file with the Board. However, Dr. Sheep indicated both

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in a written response to the Board and in his testimony at the hearing, that he was not aware that this agreement was still active after October 1, 2021.[2] Dr. Sheep testified that he was no longer supervising Respondent's provision of cosmetic services after October 1, 2021, when he left MyShape Lipo, Findings at 10:9–11, the incident at issue occurred on April 8, 2023, and Respondent himself indicated, in his testimony, that he had not provided Botox services since 2017, which was prior to the date of the supervision agreement he had on file with Dr. Sheep. Findings at 6:24–25; Exhibit 12, NSBME (Reb) at 36. If Botox was not a service that Respondent had performed since 2017 and the supervision agreement on file between Dr. Sheep and Respondent was dated March 12, 2021[3], Respondent had no basis to reasonably believe that Botox was a service that Dr. Sheep would be supervising him to perform on April 8, 2023.

The hearing testimony supports that Dr. Sheep and Respondent were going to "commence a cosmetic treatment partnership," Findings at 4:6–7,[4] but that had not occurred as of April 8, 2023. The purported reason that Respondent injected Patient A with Botox in the emergency department of Vista Hospital on April 8, 2023, was to impress a medical spa owner that he was ***hoping to do business with***. Findings at 8:13–14 (emphasis added). Respondent testified that it was "his hope to start a business providing services to medical spas as supervises by Dr. Sheep, who had supervised Respondent when he did liposuction with MyShape Lipo." Findings 8:10–12. Logically, if Respondent did not yet have a cosmetic venture in place with Dr. Sheep for the provision of Botox services to medical spa clients, Dr. Sheep could not and was not supervising him during the provision of the service to Patient A on April 8, 2023.

Dr. Sheep testified that "he knew Respondent was working towards establishing a boutique medicine business venture but was unaware that Respondent was going to start or had started providing cosmetic procedures, and the first he learned of it was after the fact in relation to the Botox injections at issue" in this case. Findings at 12:3–6. Dr. Sheep further stated, "the Botox

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[2] Dr. Sheep said that he only learned that the agreement was still active when the Board asked him in June 2023 about the April 8, 2023 incident involving Respondent. Shortly after that conversation, Dr. Sheep terminated the Agreement.

[3] *See* Exhibit 12, NSBME (Reb) at 36.

[4] *See also* Findings at 5:8–11. "Respondent admitted to there being no formal business agreement with Dr. Sheep or a medical spa owner when he was called to provide cosmetic services to a 'VIP' client of a medical spa." The conversations that Dr. Sheep and Respondent were having at this time "were not in a supervisory context" and were "about a venture into boutique medicine" that had not yet occurred. Findings at 11:25–26.

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

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

injections Respondent undertook were not under his supervision and he was not aware that the supervisory agreement was still on file or that Respondent was going to commence undertaking esthetic procedures." Findings at 12:6–9. Dr. Sheep testified that he "was not meeting with Respondent on a regular basis nor in a supervisory capacity, and, to that end, it would not have been reasonable for Respondent to believe that he was still subject to Dr. Sheep's supervision." Findings at 12:9–12. Dr. Sheep further testified that "he was willing to supervise Respondent for esthetic procedures but no formal workings for the business venture contemplated had been finalized." Findings at 12:15–17. In other words, Dr. Sheep contemplated possibly supervising Respondent's provision of cosmetic services at some point in the future, but he was unaware that Respondent was engaging in cosmetic services on April 8, 2023, and he had not authorized Respondent to provide cosmetic services to Patient A on that day.

At the hearing, Respondent indicated that "Dr. Sheep had not authorized him to inject Botox at any specific location," Findings at 7:13, and "Dr. Sheep was not supervising him that day in his capacity working in emergency medicine but was supervising him with respect to carrying out the Botox procedure," Findings at 7:15–17. However, Respondent acknowledged that "Dr. Sheep does not have privileges at North Valley Hospital where Respondent undertook the Botox injections." Findings at 7:18–19.

Based on the testimony of both Dr. Sheep and Respondent, as well as the exhibits admitted into evidence at the hearing, including Respondent's own statement in Exhibit 2,[5] Dr. Sheep's statement in Exhibit 4,[6] and the supervision agreement between Dr. Sheep and Respondent in Exhibit 12,[7] the Board finds that Respondent did not have a supervising physician in place for the services that he provided to Patient A at North Vista Hospital on April 8, 2023. The record is clear that Respondent had a supervising physician in place for his provision of emergency medicine services at North Vista Hospital, as of April 8, 2023, and an old supervision agreement with Dr. Sheep on file as of April 8, 2023. However, Dr. Sheep was not performing the duties required in NAC 630.370 when supervising a physician assistant with regard to Respondent on

[5] Exhibit 2, NSBME at 3–6.
[6] Exhibit 4, NSBME at 9.
[7] Exhibit 12, NSBME (Reb) at 36.

April 8, 2023,[8] Dr. Sheep was not aware that the old supervision agreement was active based on his written statement and testimony, and Dr. Sheep terminated the old supervision agreement on June 14, 2023 after learning that it was still active.[9] Therefore, the two supervision agreements for Respondent that were on file with the Board, as of April 8, 2023, did not cover the services that Respondent provided to Patient A on that day. Respondent even admitted that initially in his response as contained in Exhibit 2.[10] Accordingly, the Board finds by a preponderance of the evidence that Respondent's provision of Botox to Patient A on April 8, 2023, was performed in absence of a supervision agreement for those services in violation of NAC 630.340(2) and that Count III has been proven. Consequently, Respondent is subject to disciplinary action for this violation pursuant to NRS 630.306(1)(b)(2).

VIII.

If any of the foregoing Findings of Fact are more properly deemed a Conclusion of Law, it may be so construed.

CONCLUSIONS OF LAW

I.

The Board has jurisdiction over Respondent and the Complaint, and an adjudication of this matter by the Board members as set forth herein is proper.

II.

Respondent was timely and properly served with the Complaint, and all notices and orders in advance of the hearing and adjudication thereon, in accord with NRS and NAC Chapters 630, NRS Chapters 241, 622A and 233B, and the requirements of due process.

III.

With respect to the allegations of the Complaint, the Board concludes that Respondent has violated NRS 630.301(4), Malpractice (Count I); one (1) violation of NRS 630.3062(1)(a), Failure to Maintain Appropriate Medical Records (Count II); one (1) violation of NRS 630.306(1)(b)(2),

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[8] Dr. Sheep's written statement and testimony at the hearing both indicate that Dr. Sheep had ceased performing supervision duties after October 1, 2021. Findings at 10:9–11; Exhibit 4, NSBME at 9.

[9] *Id.* at 37.

[10] Exhibit 2, NSBME at 4 ("Prior to solidifying a formal written agreement with any med spa owner or Dr. Sheep, . . . I was frantically contacted by a med spa owner and was strongly influence[d] to provide service to one of her 'VIP patients.'").

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

Violation of Standards of Practice Established by Regulation (Count III); and one (1) violation of NRS 630.306(1)(e), Practice Beyond the Scope of License (Count IV). Accordingly, Respondent is subject to discipline pursuant to NRS 630.352.

IV.

The Board finds that, pursuant to NRS 622.400, it may recover from Respondent reasonable and necessary attorneys' fees and costs incurred by the Board as part of its investigative, administrative and disciplinary proceedings against Respondent as it hereby enters this Findings of Fact, Conclusions of Law, and Order finding that Respondent has violated the NMPA, which the Board has the authority to enforce.

V.

The Board has reviewed the Investigative Committee's Memorandum of Costs and Disbursements and Attorneys' Fees, and the Board finds these costs and fees to be necessary and actually incurred by the Board as part of its investigative, administrative and disciplinary proceedings against Respondent. The Board further finds them to be reasonable based on: (1) the abilities, training, education, experience, professional standing and skill demonstrated by Board staff and attorneys; (2) the character of the work done, its difficulty, its intricacy, its importance, the time and skill required, the responsibility imposed and the prominence and character of the parties where, as in this case, they affected the importance of the litigation; (3) the work actually performed by the Board's attorneys and staff, and the skill, time and attention given to that work; and (4) the product of the work and benefits to the Board and the people of Nevada that were derived therefrom.

VI.

If any of the foregoing Conclusions of Law is more properly deemed a Finding of Fact, it may be so construed.

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

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

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, and good cause appearing therefore,

IT IS HEREBY ORDERED that pursuant to NRS 630.352, NRS 622A.410, and NRS 622.400:

1. Respondent's license to practice as a physician assistant shall be revoked and, pursuant to NRS 622A.410, he may not re-apply for licensure until two (2) years after the date of the Board's Order;

2. Pursuant to NRS 622.400, Respondent shall reimburse the Board the reasonable and necessary costs and expenses actually incurred in the investigation and prosecution of this case in the amount of thirty-two thousand one hundred thirty-one dollars and ten cents ($32,131.10) if/when Respondent re-applies for licensure, and these costs and expenses must be paid in full upon submission of Respondent's re-application for licensure;

3. Respondent shall be issued a Public Letter of Reprimand; and

4. Respondent's discipline shall be reported to the appropriate entities, including but not limited to, the National Practitioner Databank (NPDB).

IT IS SO ORDERED.

DATED this 26th day of March, 2026.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

BRET W. FREY, M.D.
Vice President of the Board

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

CERTIFICATION

I certify that the foregoing is the full and true original **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** on file in the office of the Board of Medical Examiners in the matter of David Kayle McCleve, PA-C, Case No. 24-42281-1.

I further certify that Bret W. Frey, M.D., is the Vice President of the Nevada State Board of Medical Examiners and that full force and credit is due to his official acts as such; and that the signature to the foregoing **ORDER** is the signature of said Bret W. Frey, M.D.

IN WITNESS THEREOF, I have hereunto set my hand in my official capacity as Secretary-Treasurer of the Nevada State Board of Medical Examiners.

DATED this 26th day of March, 2026.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

MAGGIE ARIAS-PETREL
Secretary-Treasurer and Public Member of the Board

EXHIBIT 1

EXHIBIT 1

1 BEFORE THE BOARD OF MEDICAL EXAMINERS
2 OF THE STATE OF NEVADA
3 * * * * *

4 In the Matter of Charges and Case No.: 24-42281-1
5 Complaint Against

6 DAVID KAYLE MCCLEVE, PA-C,

7 Respondent.

8

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FILED

NOV 26 2025

NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: ______

10 TO: Sarah Bradley
11 Deputy Executive Director
Nevada State Board of Medical Examiners
12 9600 Gateway Drive
Reno, Nevada 89521
13
David Kayle McCleve, PA-C
14 c/o Lisa Zastrow, Esq.
15 9900 Covington Cross Drive, Ste 210
Las Vegas, NV 89144
16

17 **FINDINGS AND RECOMMENDATIONS**

18 The above-referenced matter came for hearing on September 17, 2025, and was conducted
19 remotely via the Zoom application by consent of the parties. The Investigative Committee of the
20 State of Nevada Board of Medical Examiners was present and represented by Sarah Bradley, Esq.
21 (the "IC"). Also present was David Kayle McCleve, PA-C, referred to throughout the hearing by
22 his legal counsel as "Kayle" ("Respondent"), as was his legal counsel Lisa Zastrow, Esq.
23 The charges at issue are set forth in a Complaint filed on November 22, 2024, and consist
24 of Count I, Malpractice, a violation of NRS 630.301(4), premised upon the allegation that
25 Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar
26 circumstances when on April 8, 2023, he injected a patient with botulism type A (referred to
27 herein as "Botox") sometime during his emergency department shift at North Vista Hospital, did
28 not conduct a medical examination or history, and failed to create any related medical

1 documentation; Count II, Failure to Maintain Complete Medical Records, a violation of NRS
2 630.3062(1)(a), premised upon the allegation that Respondent failed to maintain complete
3 medical records relating to the diagnosis, treatment, and care of a patient in a timely, legible,
4 accurate and complete manner; Count III, Violation of Standard of Practice Established by
5 Regulation, a violation of NRS 630.306(1)(b)(2), premised upon the allegation that Respondent
6 undertook to administer Botox without having a supervisory agreement on file with the Board;
7 and Count IV, Practice Beyond Scope of License, a violation of NRS 630.306(1)(e), premised
8 upon the allegation that Respondent acted outside the scope of his license by injecting Botox
9 without the authorization of his supervising physician. T2 22.

10 The hearing commenced with Respondent requesting reconsideration of the September 12,
11 2025, Order Denying Motion in Limine to Exclude Testimony of Johnna LaRue, Ernesto Diaz,
12 Kory Linn, and Stephanie Elmquist, PA-C. Transcript of Hearing Proceedings, September 17,
13 2025, pp. 7-16 ("TR"). Respondent then sought to preclude IC witness testimony by alleging that
14 the IC failed to summarize witness testimony as established by NAC 630.465 and/or NRS
15 622A.330. That motion was also denied. TR 16-29.

16 Opening statements were then given and the parties moved to testimony commencing with
17 the IC's case. The IC called Ernesto Diaz, the Chief of Investigations of the Nevada State Board
18 of Medical Examiners who addressed his professional experience and his experience with this
19 matter. T 43-48. By and through Mr. Diaz, Exhibits 1-4, 8-9 were admitted. T. 48-62.

20 On cross-examination, Respondent inquired about a peer review report, which is part of
21 the investigative file not relied upon by the IC for the hearing and was addressed in that context
22 and in light of its confidentiality. T. 63-68. Respondent then inquired about the allegation letter,
23 Exhibit 1, the testimony regarding which addressed that the allegation letter did not inquire about
24 Respondent practicing outside the scope of his supervision, nor did the IC take further action to
25 inquire about the specific medical spa Respondent claimed to be working for. T 69-76, 80-81, 91.
26 Exhibit 5 was then admitted. T 79. Timing of the formal complaint was then inquired about, as
27 were allegations in the formal complaint, particularly concerning the allegations of the patient
28 being found unresponsive outside of the hospital shortly after Respondent had administered the

Botox injections, with clarification by counsel that the Patient's subsequent condition was not a result of the actions taken by Respondent. T 82-108. On redirect, the IC addressed the allegation letter and its scope. T 114-119.

The IC next intended to call Johnna LaRue, which prompted the admission of Exhibits 6 - 7 by stipulation. T 122-125. Ms. LaRue was then called by the IC and she testified as to her position with the IC as its Deputy Chief of Investigations, followed by testimony of her professional experience. T 125-127. Ms. LaRue further addressed the allegation letter and its response (Exhibits 1 and 2), followed by testimony regarding Dr. Harris' supervision of Respondent, which was limited to emergency department services that did not encompass Respondent's administration of Botox at the hospital (*see* Exhibit 6). T 128-132.

On cross-examination, Respondent inquired about his supervision agreements (*see* Exhibit 7) and Ms. LaRue' knowledge of another pending matter, discussion of which was limited. T 133-140. On redirect, Ms. LaRue acknowledged that physician assistants can have more than one supervising physician, and that such supervision is subject to an address of the location where the physician's assistant is being supervised. T 142-143. On re-cross, Ms. LaRue was asked about Dr. Sheep failing to contacted the Board about "leaving My Shape Lipo," the location of which is the address provided on Respondent's supervising agreement with Dr. Sheep. T 143-144.

The IC's next witness was Stephanie Elmquist, a licensed physician's assistant who practices in emergency medicine and who testified as to her professional background as reflected in Exhibit 9, which had been admitted. T 148-153. Ms. Elmquist testified that Respondent did not meet the standard of care because he failed to appropriately document the medical treatment of the patient, inclusive of failing to document the patient's history; undertook an unauthorized cosmetic procedure in the hospital emergency room; and performed outside the scope of his emergency room supervisory agreement. T 156-175. As to supervision, Ms. Elmquist testified that, while Respondent had an emergency room supervising physician, the physician that was to be overseeing Respondent for cosmetic procedures had not realized he was still to be supervising Respondent and that performing the cosmetic procedure at the hospital emergency room went beyond the scope of his emergency room duties. T 176-177.

On cross examination, it was established that a physician's assistant is able to perform the work permitted by their supervising physician. T 178-177. Respondent then utilized questioning to contrast emergency room procedures with the comparatively simple task of injecting Botox. T 180-181, 201-202. Questioning was then posed regarding Respondent's supervision agreement with Dr. Sheep, covering the time within which Respondent undertook the Botox injections, which was on April 8, 2021, and related circumstances – that being Respondent's understanding that he and Dr. Sheep would commence a cosmetic treatment partnership. T182-184, 195-196. With respect to the Botox treatment in particular, Ms. Elmquist testified that it was impossible to know whether its administration fell below the applicable standard of care because no records were made in relation thereto, although Respondent attempted to paint his report to the emergency room physician given after the patient was found in the hospital parking lot unresponsive as a medical report. T 185-194, 197-201, 205-209, 242-244. Ms. Elmquist further testified she was not aware that Respondent was supervised by a Doctor of Osteopathy, had not reviewed any records in relation thereto, and that she was not testifying that the patient suffered any adverse reaction from the Botox. T 212-218.[1]

On redirect, Ms. Elmquist reiterated that without records to review, proper treatment of the patient cannot be determined, so one could not say how the patient was treated, which falls below the standard of care. T 239-240. In that same vein, Ms. Elmquist further testified that she could not emphatically state that the situation constitutes malpractice because she cannot definitively determine what happened but that such actions were unreasonable in consideration of the fact that the injections were done in a location where they were not sanctioned and Botox was administered to a patient that was not registered and no records were made, which could be deemed malpractice, and which was reframed on re-cross to be a conclusion of malpractice based

[1] Paragraph 7 of the formal Complaint, filed on November 22, 2024, provides, "Records show that on April 8, 2023, less than one (1) hour after the procedure, Patient A was found unresponsive in the North Vista Hospital parking lot. Patient A was wheeled into the emergency room in an altered mental state, intubated for airway protection, and transferred by ambulance to Sunrise Hospital for a higher level of care." Despite the implication of the paragraph, Patient A's condition was not attributed to Respondent or the Botox he administered (*see* Exhibit 8). T 103-108, 219. Questions were also posed regarding Respondent being supervised by a Doctor of Osteopathy but no evidence regarding any such supervision was presented and questions of counsel are not evidence. T 233-37

1 upon a lack of record keeping. T 248-256. It was further confirmed on re-cross that Ms. Elmquist
2 does not have training in cosmetic procedures. T 256-260.
3 Testimony recommenced the following day, at which time the IC called Respondent to
4 testify. Trial Transcript, September 18, 2025 ("T2"). Respondent testified that he has been
5 licensed as a physician's assistant in Nevada since 2014, and was licensed in Arizona prior. T2 9.
6 Respondent testified that his licensing with the Board of Osteopathic Medicine expired on
7 December 31, 2022. T2 10. Respondent testified to the accuracy of his representations in his
8 response to the Board's allegation letter as provided at Exhibit 2. T2 10. Respondent admitted to
9 there being no formal business agreement with Dr. Sheep or a medical spa owner when he was
10 called to provide cosmetic services to a "VIP" client of a medical spa that was not identified in his
11 response letter. T2 9-10. In addressing his ability to do so, Respondent testified that Dr. Sheep
12 had already signed a supervising agreement that was on file with the Board. T2 11. Respondent
13 also suggested he has medical notes about the procedure in the medical spa's EMR system and
14 had notes and photographs in his phone, which included pictures of the vial, the lot number, his
15 "mental notes of what actually transpired," and how he administered the Botox. T2 11, 13.
16 Notably, no such records were ever formally produced, and Respondent says he never offered
17 them even though they were requested in the allegation letter, which Respondent submitted
18 without formal counsel (although two attorneys, including Respondent's current legal counsel,
19 were carbon copied on the email). T2 11-13, 15-16, 72-73, 75.
20 At the time at issue, Respondent had supervising agreements on file with Dr. Sheep and
21 Dr. Harris, who supervised Respondent in the emergency room of North Vista Hospital. T2 16-
22 17, 21, 23, 155, 164. Respondent was aware of an address for services on his supervisory
23 agreements but attempted to justify working outside the identified address by testifying that he
24 was working on a new business venture with Dr. Sheep and a new address had not yet been
25 established. T2 18, 184.
26 Respondent sought to clarify that Dr. Sheep was not his supervisor at North Vista Hospital
27 where he administered the Botox to the patient, but that Dr. Sheep had authorized Respondent to
28 act under Dr. Sheep's license and supervision at any medical spa at any location based upon them

developing a "non-traditional business model" where they go into medical spas to provide cosmetic care. T2 19-20, 22, 29. To that end, it was Respondent's testimony that he undertook the Botox procedure at issue at North Vista Hospital in accordance with the supervisory agreement with Dr. Sheep. T2 25-26.

As to monthly meeting requirements for physician supervision as provided for by NAC 630.370, Respondent testified that he satisfied the requirement of meeting with Dr. Sheep once a month by and through their ongoing communication but did not satisfy the select chart review requirement because the patient at issue was their first, although the requirement had been satisfied prior with respect to other work at My Shape Lipo. T2 32-34, 84-87.

Respondent testified that Dr. Sheep, who is board certified in emergency medicine and has a certification with respect to tumescent liposuction, was aware that Respondent was providing the services at issue based upon their longstanding agreement that Respondent could provide cosmetic services under Dr. Sheep's supervision. T2 35-36.

With respect to Respondent's background, in addition to his training that he testified to at T2 38-39, Respondent testified that he had worked in emergency medicine, dermatology, liposuction, and currently works in orthopedic spine surgery and pain management. T2 39. Respondent also testified that he has several current certifications (T 39-40), and that he has trained with a cosmetic surgeon and other doctors that provide cosmetic services. T2 41-42.

Respondent concedes that inviting a patient to a hospital to receive cosmetic injections is "not normal" and was against hospital policy but states that the care provided was reasonable under the circumstances, testifying that there was no meaningful distinction between the hospital and a medical spa in terms of location. T2 54-58, 64. Respondent confirmed that he is trained to administer Botox and testified that when he was working in dermatology he administered Botox daily and has done so throughout his career intermittently but had not done Botox procedures since 2017. T2 58, 60-61.

Respondent maintains that the notes he put in his phone, which were never formally produced and admitted, are applicable records but testified that he is unsure if they meet the appropriate record keeping standard even though he deems them complete. T2 66-68.

Respondent articulated the requirements for complete records, which expanded well beyond the information he stated he entered on his phone and indicated that the "appropriate disclosures" had been handed by the medical spa owner who referred the patient. T2 69-71, 207-209. Respondent also emphasized that he gave pertinent related information to Dr. Clark when the patient was admitted after having been found unresponsive in the parking lot. T2 72-73.

The IC questioned Respondent regarding Exhibit 10, which was admitted and was an email between Respondent and the IC, dated March 17, 2023, that addressed the sharing of vials of Botox, which Respondent says he sent the Board prior to the incident at issue in an effort to seek clarification. T2 78-83. The IC also asked Respondent if he had submitted any documentation evidencing his qualifications to administer Botox, to which Respondent stated the IC has his CV from another case. T2 83-85. Respondent further testified that he had discussed the patient at issue with Dr. Sheep "within a couple of days," and clarified that Dr. Sheep had not authorized him to inject Botox at any specific location as opposed to authorizing him to inject Botox in medical offices, presumably medical spas that Respondent was in talks with. T2 88-89. As to supervision for injecting Botox on the occasion at issue, Respondent testified that Dr. Sheep was not supervising him that day in his capacity working in emergency medicine but was supervising him with respect to carrying out the Botox procedure. T2 89-90. In response to follow up by the IC, Respondent acknowledged that Dr. Sheep does not have privileges at North Valley Hospital where Respondent undertook the Botox injections but maintained that, nonetheless, he was being supervised by Dr. Sheep and reference was made by the IC to Exhibit 7, which demonstrates dates of association with supervising doctors. T2 88-93.

On cross-examination, Respondent inferred that Exhibit 10, the March 17, 2023 email with the Board regarding the sharing of a Botox vial, should have demonstrated to the Board that Respondent was performing or was going to be performing cosmetic procedures and that the Board should have let him know if that was problematic. T2 96-97. Respondent then explained that he is frustrated with the IC because he admitted to and had been punished for violating hospital policy for injecting the patient with Botox during his emergency room shift at the hospital. Respondent also testified that he acknowledged poor record keeping (admitting to it at

T2 131-132) and, therefore, does not believe the other counts alleged are warranted given the care he delivered "was on point." T2 97-109.

With respect to his experience "administer[ing] paralytics," Respondent testified he had undertaken injections prior to this incident "hundreds, maybe thousands of times" and that he is "well-versed with Botox." T2 109-110, 126-127. Respondent then turned his attention to Exhibit 4, which is a letter by Dr. Sheep by which Dr. Sheep wrote that he had not supervised Respondent since October 1, 2021. According to Respondent, Dr. Sheep's statements made therein are inaccurate, although specific statements were not addressed. T2 110-112.

Respondent then addressed Exhibit 2, which was his response to the IC's allegation letter, testifying that it was his intent to be fully transparent, and it was his hope to start a business providing services to medical spas as supervised by Dr. Sheep, who had supervised Respondent when he did liposuction with My Shape Lipo. T2 112-113. According to Respondent, what prompted him to inject Patient A with Botox was a call from a medical spa owner whom he was hoping to forge a relationship with and who had asked Respondent to assist with the Botox injections on an urgent basis. Unable to access the medical spa, Respondent went to his shift in the emergency department at North Vista Hospital, after which the patient called him and asked if Respondent could inject the Botox in the parking lot, upon which Respondent directed the patient to come to the hospital where Respondent took him into the emergency room and administered the Botox. Although the patient offered to pay Respondent $2,000, Respondent states he did not accept. T2 123.

Approximately forty-five minutes later, the patient had "a reaction" and went back into the hospital where the patient was treated by Dr. Clark, whom Respondent then reported to about the Botox injections. T2 116-118. Respondent indicates that he went through "an entire medical encounter" and asked the patient "all of the screening questions necessary" prior to administering the Botox. T2 118. According to Respondent, he injected the patient with 50 units and kept a picture of the vial. T2 119-120.

For having performed the Botox procedure on the patient at the hospital, Respondent lost his job, the basis for which was violating hospital policy. T2 123. Respondent maintained that

medically what he did was fine but ethically it was not. T2 125. To reiterate, the Board should understand that the patient is not believed to have suffered an adverse reaction because of the Botox. T2 126, 129-130, 160-61 (*see* ftn 1).

Respondent again testified that he injected the patient with Botox pursuant to his supervision agreement with Dr. Sheep. T2 141-142. As far as Dr. Sheep's qualifications to supervise him for the Botox administration, Respondent testified that Dr. Sheep had indicated that he was proficient in the procedures that were intended to be performed under the umbrella of "boutique medicine." T2 145-146. Respondent also testified that Dr. Harris knew he worked outside the emergency department under the supervision of another physician as acknowledged in Exhibit 5. T2 156-157. Further, according to Respondent, he did not need Dr. Sheep's permission to administer the Botox to the patient. T2 166-167, 183.

On redirect, Respondent testified that the patient's recreational drug use, which the patient had admitted to prior to the Botox administration, had no bearing on whether it was appropriate to administer Botox to the patient. T2 188-191, 203, 211.

The IC's next witness was Kory Linn, the Chief of Licensing for the Board who testified as to the supervisory agreement form. T2 213-218. Ms. Linn then addressed Dr. Sheep's supervisory agreement, Exhibit 7, testifying that it has an association date of March 16, 2021, and a disassociation date of June 27, 2023. The blank supervisory form with cited statutory authority that had been used for reference was then admitted as Exhibit 11. T2 218-221.

On cross-examination, Ms. Linn testified that the supervisory form is what is required for a physician's assistant to be linked to a physician in the Board's system (T2 226); that the form does not indicate the scope of services being supervised (T2 228); that Respondent was licensed (T2 229); that the scope under which a physician's assistant works is determined by the physician (T2 230-232); and that Respondent had a supervision agreement at the time at issue with both Dr. Harris and Dr. Sheep (T2 232). On redirect, testimony was elicited regarding the location of services as indicated on the supervisory form. T2 233-234.

The last witness called was Dr. Andrew Sheep who was called by the IC in rebuttal to Respondent's testimony. T2 235-244. Dr. Sheep testified that he is employed by Team Health,

has been licensed in Nevada since 2019, and that he practices in emergency medicine. T 244-245. Dr. Sheep identified Respondent as a friend and someone who he had worked with and spoke with about doing esthetic procedures together. T2 245. Dr. Sheep also testified that he had never supervised Respondent with respect to emergency medicine. T2 245.

As for the supervisory form, Dr. Sheep testified that for other physician assistants he supervises, he would usually list Sunrise Hospital and Medical Center for the location of services but could not recall the location he had listed for Respondent, although he did recall that the location as not North Vista Hospital. T2 248-249.

The IC next inquired of Dr. Sheep regarding Exhibit 4, which Dr. Sheep testified was accurate, and that any services performed by Respondent after October 1, 2021, would not have been authorized under Dr. Sheep's supervision. T2 250, 256. Per Dr. Sheep he spoke with Respondent after October 1, 2021, but not in a "professional manner," so he was not meeting with him to review charts and had not spoken with him about the incident at issue until after it took place. T2 249-250, 252. Although the supervisory agreement between Dr. Sheep and Respondent was still on file and had not been terminated as of the date at issue, Dr. Sheep testified that it was his understanding that after October 1, 2021, Dr. Roberts would be supervising Respondent and that he had not met with Respondent thereafter in a supervisory capacity.[2] T2 252-253. The supervisory location for Respondent per Dr. Sheep was at My Shape Lipo and possibly some other medical spas but that would have been prior to October 1, 2021, and only the My Shape Lipo address is listed – *see* Exhibit 12. T2 253-255. Dr. Sheep's supervision was limited to what was provided for "on the credential list" but no "credential list" was made part of the record. T2 255.

Exhibit 12, which was Dr. Sheep's supervisory agreement for Respondent was marked and admitted, with respect to which Dr. Sheep testified that the location for services was not North Vista Hospital and that he would have never authorized Respondent to perform a cosmetic

[2] In Exhibit 4, Dr. Sheep writes that he was unaware as of October 1, 2021, that a physician's assistant could have more than one supervising physician and, therefore, assumed that when Dr. Roberts began to supervise Respondent, Dr. Sheep's supervisory agreement would no longer be effective.

procedure there. T2 258-263. Dr. Sheep also testified that the address on the supervisory agreement was neither of the medical spas where he had supervised Respondent prior (although that does not appear to be accurate because the address on the supervisory agreement is for My Shape Lipo, a medical spa that Dr. Sheep had testified just prior was a location where he supervised Respondent), and that he formally terminated the supervisory agreement on June 14, 2023, when he learned that he was still listed as a supervising physician. T2 264. Dr. Sheep further testified that he did not recall if he had a conversation with Respondent about terminating the supervisory agreement as opposed to merely discussing the fact that he was leaving My Shape Lipo. T2 265-267, 280.

On cross-examination, Dr. Sheep acknowledged that he was required to give notice to the Board of when he was no longer supervising Respondent. T2 274-275. Dr. Sheep acknowledged discussing doing esthetic procedures with Respondent and had previously worked with Respondent at multiple locations. T2 275-279, 280-281. Dr. Sheep reiterated that he did not know he still had a supervisory agreement for Respondent on file and repeatedly stated he did not recall reminding Respondent that the supervisory agreement was still on file when they were discussing working together to do esthetic procedures, with respect to which they had also met with some medical spa owners. Despite denying having spoken about the supervisory agreement with Respondent, Dr. Sheep nonetheless testified that he would have no reason to disagree with Respondent if Respondent had believed the supervisory agreement to have still been on file at the time at issue. T2 279-284.

Dr. Sheep acknowledged that a physician's assistant could act as authorized by a physician and was not subject to constant supervision. T2 285-286. According to Dr. Sheep, Respondent is an excellent physician's assistant, as a result of which Dr. Sheep assisted Respondent to obtain work and he believed Respondent to be trained in neurotoxins. T2 287-288.

On redirect, Dr. Sheep testified that he had been talking with Respondent about a venture into boutique medicine but such conversations were not in a supervisory context, and that Respondent injecting Botox in a hospital emergency department to a patient that was not

registered was not reasonable. T2 289-292. On re-cross, Dr. Sheep acknowledged he was not asked to consider the standard of care in terms of the actual treatment. T2 293-297.

In responding to questioning by the undersigned, Dr. Sheep testified that he knew Respondent was working towards establishing a boutique medicine business venture but was unaware that Respondent was going to start or had started providing cosmetic procedures, and the first he learned of it was after the fact in relation to the Botox injections at issue. T2 295-299. Per Dr. Sheep, the Botox injections Respondent undertook were not under his supervision and he was not aware that the supervisory agreement was still on file or that Respondent was going to commence undertaking esthetic procedures. T2 299. Lending to Dr. Sheep's understanding was the fact that Dr. Sheep was not meeting with Respondent on a regular basis nor in a supervisory capacity and, to that end, it would not have been reasonable for Respondent to believe he was still subject to Dr. Sheep's supervision. T2 302, 311-313. However, upon further questioning by Respondent, Dr. Sheep stated that it was possible that Respondent believed Dr. Sheep was still his supervising physician even though Dr. Sheep himself did not believe so. T2 304-306, 310. Upon final questioning from the IC, Dr. Sheep testified that he was willing to supervise Respondent for esthetic procedures but no formal workings for the business venture contemplated had been finalized. T2 311.

With the consent of the IC, Respondent once more testified, stating that in the spring of 2023, he and Dr. Sheep agreed to move forward with a "boutique thing" with Dr. Sheep supervising him to be able to administer Botox. T2 317. According to Respondent, it was Dr. Sheep who stated that it would work out to move forward given that the supervisory agreement with Dr. Sheep was still in effect, and the lack of chart review was attributable to the fact that the patient at issue was the first patient Respondent undertook to inject with Botox under the contemplated business agreement and that Respondent did so in an attempt to establish good will with the medical spa owner who referred the patient. T2 317-320. According to Respondent, Dr. Sheep was aware that he was Respondent's supervising physician for the Botox injections based upon their business plan and prior discussions, and that Dr. Sheep's cooperation with the IC is premised upon Dr. Sheep himself being subject to a Board investigation. T2 320-321.

Closing statements were given remotely on Monday, September 22, 2025, and were likewise transcribed. In summary, the IC argued that the business venture discussed between Dr. Sheep and Respondent had not been formalized and, therefore, putting aside the problems with injecting the patient with Botox at North Vista Hospital while on an emergency room shift, it was unreasonable to perceive the supervisory agreement as being applicable, particularly when Dr. Sheep was not aware that Respondent had commenced to provide esthetic services. The IC argued that no medical records as required to be maintained had been created, and that Respondent's judgement was so bad as to constitute medical malpractice in having undertaken the Botox injections at the hospital, the location of which was not listed in the supervisory agreement, and having failed to create required documentation in relation thereto. As for Count IV, practicing beyond the scope of a license, the IC argued that the premise of the count was that the Botox injections were not authorized by Dr. Sheep, having acknowledged that Respondent had performed such procedures in the past and "so maybe there's not concerns like his competence or how he might perform them." T3 24.

Respondent, in closing, took issue with the IC's motivation and the manner in which the case was pleaded, and argued that Respondent had conceded the records violation although some records had been made and pertinent information had been provided by Respondent when the patient was formally admitted to the emergency room for reasons unrelated to the Botox injections. Respondent takes issue with the malpractice count, arguing that it applies to a physician and not a physician's assistant but that, regardless, the actual administration of the Botox was not below the standard of care. Respondent addressed the supervisory agreement and how it was in place with Dr. Sheep for supervision of cosmetic procedures, having originally been for liposuction and was believed to be still in effect by Respondent, and Respondent emphasized his ability to perform Botox injections. Respondent further argued that the IC is commingling allegations to bolster counts that are not supported by the legal standards that apply to them and takes issue with disciplinary options that the IC deems to be applicable.

The crux of this matter is that Respondent, on his own accord and without the knowledge of his purported supervising physician, administered Botox to a patient at a location that he should

1 not have and, in relation thereto, failed to create relevant medical records. The dispute as to the
2 charges by the IC in relation thereto rests with how such action falls within the counts pleaded by
3 the IC.

4 Count II, Failure to Maintain Complete Medical Records, a violation of NRS
5 630.3062(1)(a) is undisputed and supported by the lack of medical records created. *See, e.g.* T3 p.
6 40 (Respondent's counsel: "Mr. McCleve admitted to the records violations . . ."). Given the
7 admission of the violation of Count II, Respondent should be held accountable for the same and
8 undersigned will address the remaining counts, commencing with Count I, Malpractice, a
9 violation of NRS 630.301(4).

10 As an initial matter, NRS 630.301(4) provides that malpractice of a physician's assistant is
11 grounds for initiating disciplinary action. It is the definition of malpractice at NAC 630.040 with
12 which Respondent takes issue given that the definition as of April 8, 2023, when the action at
13 issue was taken by Respondent, refers to a physician in particular. That said, NAC 630.040 was
14 amended as reflected by LCB File No. R171-20, filed on June 2, 2023, to specifically include a
15 physician's assistant in the definition of "malpractice." To the extent that definition was amended
16 after the incident at issue to include all regulated health care providers including, but not limited
17 to a physician's assistant, the applicable definition of malpractice itself was nonetheless
18 unchanged and remained the failure in treating a patient to use reasonable care, skill, or
19 knowledge ordinarily used under similar circumstances. *See also* NRS 41A.015, which defines
20 "professional negligence" as the failure of a health care provider, in rendering services, to use the
21 reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly
22 trained and experienced providers of health care.

23 With that, the inquiry rests upon the *treatment* of Patient A. As testified to by Ms.
24 Elmquist, she was unable to address malpractice as to Respondent's actual treatment because of
25 his lack of record keeping. However, evidence of malpractice does not always rest in records but
26 is also evidenced in subsequent adverse reactions or harm suffered by a patient. Here, the adverse
27 condition of Patient A was not related to the Botox injections administered by Respondent as was
28

addressed on the record and reflected in Exhibit 8. Thus, there was no evidence to demonstrate that the harm suffered by Patient A derived from Respondent's treatment.

Perhaps to overcome this, the IC's pleading of the malpractice count focused on the setting where the Botox was administered, the allegation that Respondent did not conduct a medical examination or history, and the fact that Respondent failed to document his treatment by creating related medical records. While the location where the Botox was administered could go to treatment, NRS 629.086 permits the administration of Botox at a "medical facility," and NRS 449.0151 specifically includes a hospital in the definition of a "medical facility." As such, a finding of malpractice cannot appropriately rest on Respondent having administered the Botox at the hospital. That is not to say that it was appropriate for Respondent to do so. To the contrary, it was completely inappropriate for all the reasons argued by the IC and Respondent was fittingly fired for it. However, it remains that the hospital is a medical facility and Respondent indicated that he "prepared a location within the hospital" to administer the Botox and, as such, the location itself does not properly subject Respondent to a finding of malpractice. *See* Exhibit 2.

With respect to the IC's allegation that Respondent failed to conduct a medical examination or history, Respondent testified and indicated in Exhibit 2 that he undertook a proper medical screening. T2 118, 189; Exhibit 2. While his statements as to such could be deemed self-serving, there is no evidence to contradict his testimony and there is no reason to believe that he did not actually do so, particularly given the specifics described by Respondent as to what was divulged by the patient as to prior drug use. Such information was reflected in Exhibit 8 and would necessarily have been conveyed by Respondent given that Patient A was unresponsive and the urine drug screen result was normal and negative for illicit drug use.

The last basis the IC pleads in support of its malpractice claim is that Respondent failed to create any medical documentation related to his treatment of Patient A. While that is true, that does not go to Respondent's actual treatment and is encompassed within Count II, which Respondent has admitted to. Thus, based upon the foregoing considerations, I cannot recommend a finding of malpractice; although, at first blush, to paint Respondent's actions as such is seemingly appropriate.

1 Count III is for the alleged violation of a standard of practice established by regulation and
2 is premised upon Respondent not having a supervision agreement on file that would allow him to
3 undertake the Botox injections he administered to Patient A. Unfortunately, this issue is murky
4 and Dr. Sheep failed to shed much light on it. Whether that was by design on Dr. Sheep's part
5 given concern about his own licensing, loyalty to Respondent whom he considered a friend once
6 faced by Respondent during his testimony, or for any other number of possible reasons, it remains
7 that Dr. Sheep's testimony was not entirely consistent with his statements in Exhibit 4 nor
8 definitive as to he and Respondent's contemplated boutique medical endeavor.
9 Although Dr. Sheep was clear that he did not lead Respondent to believe that he was to
10 supervise Respondent with respect to cosmetic procedures, Dr. Sheep vouched for Respondent's
11 credibility and said he could not refute Respondent's understanding to the contrary. Dr. Sheep
12 also substantiated Respondent's ability to administer Botox. It also makes little sense that the two
13 would be in discussions to pursue a cosmetic practice partnership if Dr. Sheep would not be
14 Respondent's supervising physician in relation thereto. That said, there was no formal business
15 plan or agreement between the two, and Dr. Sheep was unaware that Respondent had commenced
16 cosmetic procedures.
17 With little definitive testimony, what is irrefutable is that there was a supervisory
18 agreement on file between Dr. Sheep and Respondent effective April 8, 2023, when Respondent
19 administered the Botox to Patient A, and there was no basis established from which to conclude
20 that a prior address listed on the form was fatal to its purpose. Given the complaint pleads the
21 count on the premise that no such supervision agreement was on file, and in consideration of the
22 ambiguous testimony that precludes a finding by a preponderance of the evidence, undersigned
23 cannot recommend a finding that Respondent violated Count III.
24 Count IV, practice beyond the scope of license, is premised upon Respondent not being
25 authorized by Dr. Sheep to administer Botox to Patient A. It is evident that Respondent and Dr.
26 Sheep had contemplated a business arrangement that would encompass the treatment Respondent
27 provided to Patient A; however, Dr. Sheep made it clear that he was unaware that Respondent had
28 any intention to commence actually undertaking cosmetic procedures as of April 8, 2023, and

Respondent himself acknowledged that he administered the Botox at the behest of a third party or parties and only in anticipation of a formal business agreement eventually being undertaken. In addition, Respondent only informed Dr. Sheep of the treatment after it was undertaken. As the IC argued, Respondent "jumped the gun." Having a supervisory agreement on file is one thing, but presuming to perform a service thereunder that one has not performed in approximately six years without the knowledge and prior approval of a supervising physician is another.

The IC premised the allegation on a violation of NRS 630.306(1)(e), which supports disciplinary action for "[p]racticing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform or which are beyond the scope of his or her training." Given there was no evidence refuting Respondent's training and ability to administer the Botox injections, what is left is the scope of his actions as permitted by law.

NAC 630.360 provides that the medical services a physician's assistant is authorized to provide must be commensurate with the education, training, experience and level of competence of the physician's assistant and within the scope of practice of the supervising physician of the physician's assistant. At the time the Botox injections were administered by Respondent, Dr. Sheep's scope of practice was emergency medicine. By all accounts, no foray into a boutique cosmetic practice had yet been established.

With that, it is evident that Dr. Sheep had not authorized Respondent to recommence cosmetic services and, therefore, Respondent practiced beyond the scope permitted by law in that Dr. Sheep's scope of practice, without having made any shift back to cosmetic medicine, was limited at the time to emergency medicine.[3] As such, it would be appropriate to hold Respondent accountable for practicing outside the scope of his license.

BASED UPON THE FOREGOING, it is recommended that the Board find Respondent David Kayle McCleve, P.A.-C in violation of NRS 630.3062(1)(a), Failure to Maintain Complete Medical Records, as alleged in Count II of the Complaint field on November 22, 2024; and NRS

[3] Whether Dr. Sheep was qualified to supervise the cosmetic procedure that Respondent performed is a question undersigned does not reach.

630.306(1)(e), Practice Beyond Scope of License, as alleged in Count IV of the Complaint. Undersigned defers to the Board as to determining appropriate sanctions.

DATED this 25th day of November, 2025.

By:

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

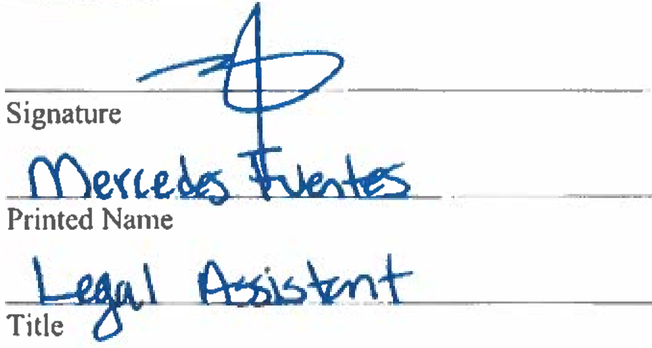
1 **CERTIFICATE OF SERVICE**

2 I certify that on this day, I served by personally delivering or mailing, postage pre-paid, a
3 true and correct file-stamped copy of the foregoing **FINDINGS AND RECOMMENDATIONS**
4 to the following parties:

5 Deonne E. Contine
General Counsel
6 Sarah A. Bradley
Deputy Executive Director
7 Nevada State Board of Medical Examiners
9600 Gateway Drive
8 Reno, NV 89521

9 David Kayle McCleve, PA-C
C/o Lisa Zastrow, Esq.
10 9900 Covington Cross Drive, Ste. 210
Las Vegas, NV 89144
11
Certified Mail No.: 9489 0178 9820 3045 5236 76
12
13 DATED this 26th day of November, 2025.

14



15 Signature

16 Mercedes Fuentes
17 Printed Name

18 Legal Assistant
19 Title

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