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 MATTHEW OBIM OKEKE, M.D., Respondent.	**Case No. 19-22461-1**

FILED
MAY 30 2019
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), hereby issues this formal Complaint (Complaint) against Matthew Obim Okeke, M.D. (Respondent), a physician licensed in Nevada. After investigating this matter, the IC has a reasonable basis to believe that Respondent has violated provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act). The IC alleges the following facts:

1. Respondent was licensed (License No. 14957) in Nevada by the Board on September 6, 2013, with a scope of practice in psychiatry.

TREATMENT OF PATIENT A

2. Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

3. Respondent provided medical services and care to Patient A from August 9, 2015, through January 30, 2018.

4. On August 9, 2015, Patient A presented to Respondent for an initial psychiatric evaluation. Based upon his initial evaluation, Respondent indicated the following diagnoses: Bipolar I Disorder, Most Recent Episode Depressed," "Post-traumatic Stress Disorder," and "Generalized

[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 Wayne Hardwick, M.D., Chairman, Mr. M. Neil Duxbury, and Aury Nagy, M.D.

Anxiety Disorder." Respondent prescribed the following treatment medications: Geodon, Effexor XR, and Proprandolol.

5. On October 7, 2015, Respondent did not document any assessment or treatment plan within Patient A's medical record.

6. On October 19, 2015, Respondent documents a follow-up encounter with Patient A and the medical record documentation is verbatim compared to the October 7, 2015 medical record, despite this encounter lasting for 30 minutes.

7. On December 8, 2015, Respondent noted a pertinent and original subjective report of Patient A; however, there was no assessment or clinical rationale for treatment, but for a configuration of copied and pasted generic phrases substituted for a unique and pertinent medical record. Respondent prescribed a benzodiazepine (Xanax 0.5mg PO BID), which was the activitating antidepressant and a beta-blocker. Here, the primary diagnosis of Patient A, as indicated in the medical records, was Bipolar I Disorder, and such a treatment plan of prescribing Xanax is not within the standard of care.

8. On February 24, 2016, Respondent documented a relevant subjective section, but there is no specific or original documentation in the Assessment or Plan sections; there is no clinical reasoning or decision-making and, as previous medical records maintained by the Respondent, this encounter with Patient A is documented with a vast majority of copy and paste phrases from previous medical records. The Nevada Prescription Monitoring Program (PMP) report of Patient A indicates a controlled substance prescription for benzodiazepine medication alprazolam (Xanax) in the amount of 60 (quantity) 0.5 milligram tablets, as prescribed by the Respondent.

9. On March 21, 2016, Respondent's medical record for this encounter of Patient A is verbatim compared to the previous 2/24/2016 encounter, including an identical subjective section. The PMP report of Patient A indicates a controlled substance prescription for benzodiazepine medication alprazolam (Xanax) in the amount of 60 (quantity) 2.0 milligram tablets (four times the previous prescription amount). Respondent failed to document the medical justification for this substantial and significant increase in this controlled substance for Patient A's treatment plan.

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10. On April 18, 2016, Respondent's medical record for the encounter is verbatim when compared to the two previous medical records (2/24/16 and 3/21/16), including the same subjective section. Here, Respondent changed the Xanax prescription dosage from 0.5 mg PO BID (as documented on 2/24/2016) to a 2.0 mg PO BID. Respondent failed to document any clinical rationale given for such an increase in dosage and there was no formulation or specific treatment plan documented. Patient A's dosage of Xanax increased by four (4) times from 0.5 mg to 2.0 mg.

11. On May 17, 2016, Respondent's medical record is verbatim when compred to the medical records from 2/24/2016, 3/21/2016, and 4/18/2016. There is no new or specific original documentation pertaining to this specific encounter between Patient A and Respondent.

12. On June 14, 2016, Respondent's medical record of this follow-up encounter contains specific and pertinent information in the subjective section; the remainder of this encounter was copied and pasted from prior encounters.

13. From July 7, 2016 through January 30, 2018, all of the documented encounters between Respondent and Patient A are essentially verbatim when compared to the June 14, 2016 medical record, and contain no original documentation to theses specific patient encounter dates, but for the exception of the start/stop times and Patient A's blood pressure. Specifically, the dates for these verbatim medical records are as follows: 7/12/2016, 8/9/2016, 9/7/2016, 10/5/2016, 11/2/2016, 11/28/2016, 12/28/2016, 1/25/2017, 2/23/2017, 3/22/2017, 4/19/2017, 5/17/2017, 7/12/2017, 8/9/2017, 9/7/2017, 10/5/2017, 11/2/2017, 11/30/2017, 12/28/2017 [this note indicates that Xanax (2 mg PO BID) was the only medication prescribed], and the last encounter between Patient A and Respondent was on 1/30/2018 [this note indicates that the following were prescribed: Xanax (0.5 mg), Effexor XR, Proprandolol].

14. On December 28, 2017, Patient A, without Respondent's consent, video recorded her patient encounter with the Respondent by placing her smart phone video camera upon Respondent's desk. This video shows the physical proximity between Respondent and Patient A, who can be clearly seen rubbing Respondent's arm, then later rubbing his back, and, eventually attempting to touch Respondent's groin area. At no time during this interaction did the Respondent re-direct Patient A away from his personal and physical space. There was no therapeutic interpretation or confrontation

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by the Respondent regarding Patient A's comments or behavior[2] during this patient encounter.

AGREEMENT WITH PATIENT A

15. On May 5, 2018, Patient A and Respondent entered into an agreement (Agreement). This Agreement appears to be a legal document, drafted by a Nevada licensed attorney, signed by Patient A and Respondent, and involves having Patient A refrain from filing, or assisting any other individual from filing, lawsuits, administrative actions or complaints against the Respondent in return for Patient A receiving monetary payments of $25,000 (paid in 2/2018), $3,000 (in April of 2018), and $1500 (paid on 5/8/2018).

TREATMENT OF PATIENT B

16. Patient B'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.

17. Respondent provided medical services and care to Patient B, who was a 10-year-old male, from 9/9/2015 to 1/30/2018.

18. On September 9, 2015, Respondent provided an initial evaluation during the timeframe from 9:25 am to 10:30 am, which is essentially the same time period of Respondent's encounter with Patient A. Respondent noted the following diagnoses: "ADHD," "Autistic Disorder," and "Intermittent Explosive Disorder," and then prescribed Nuedexta and Clonidine in furtherance of Patient B's treatment plan.

19. On or about April of 2019, the IC reviewed the findings from an Independent Medical Expert (IME), who reviewed the medical records and additional relevant documentation, and, consequently, this IME opined that Respondent, via his acts and/or omissions, violated the Medical Practice Act when rendering medical care and treatment to Patient A and Patient B.

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[2] As opined by the IC's Independent Medical Expert (IME), who interviewed and evaluated Respondent, and reviewed the medical records and additional relevant documentation, including, but not limited to, Patient A's video tape, Respondent's written responses to the IC and other relevant information.

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Count I

NRS 630.301(4) (Malpractice)

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

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

22. 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.

23. 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 he provided medical care to Patient A.

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

Count II

NRS 630.3062(1)(a) (Failure to Maintain Proper Medical Records)

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

26. 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 is grounds for initiating discipline against a licensee.

27. Respondent failed to maintain timely, legible, accurate, and complete medical records for Patient A.

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

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Count III

NRS 630.306(1)(g) (Continual Failure to Exercise the Skill or Diligence or Use the Methods Ordinarily Exercised Under the Same Circumstances by Physicians in Good Standing Practicing in the Same Speciality or Field)

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

30. NRS 630.306(1) provides that the following acts, among others, constitute grounds for initiating disciplinary action: ... (g) continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.

31. Respondent from August 9, 2015, through January 30, 2018, failed to exercise the skill, diligence, and methods ordinarily used when treating Patient A.

Count IV

NRS 630.301(4) (Malpractice)

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

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

34. 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.

35. 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 he provided medical care to Patient B.

36. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in NRS 630.352.

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Count V

NRS 630.3062(1)(a) (Failure to Maintain Proper Medical Records)

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

38. 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 is grounds for initiating discipline against a licensee.

39. Respondent failed to maintain timely, legible, accurate, and complete medical records for Patient B.

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

Count VI

NRS 630.306(1)(g) (Continual Failure to Exercise the Skill or Diligence or Use the Methods Ordinarily Exercised Under the Same Circumstances by Physicians in Good Standing Practicing in the Same Speciality or Field)

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

42. NRS 630.306(1) provides that the following acts, among others, constitute grounds for initiating disciplinary action: ... (g) continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.

43. Respondent from 9/9/2015 to 1/30/2018, failed to exercise the skill, diligence, and methods ordinarily used when treating Patient B.

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

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WHEREFORE, the IC 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 finds and concludes that there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, to include sanctions to be imposed; and

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

DATED this 30 day of May, 2019.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

Robert Kilroy, Esq.
General Counsel
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Wayne Hardwick, 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 30th day of May, 2019.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Wayne Hardwick
Wayne Hardwick, M.D., Chairman

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CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 30th day of May, 2019, I served a filed copy of the COMPLAINT, via USPS e-certified return receipt mail to the following:

Matthew Obim Okeke, M.D.
c/o L. Kristopher Rath, Esq.
Hutchison & Steffen, LLC
Peccole Professional Park
10080 W. Alta Drive, Suite 200
Las Vegas, NV 89145

Dated this 30th day of May, 2019.

Sheri L. Quigley
Legal Assistant

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