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. 21-22461-1**

FILED
OCT 26 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, Esq., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Matthew Obim Okeke, M.D. (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 Medical Doctor holding an active-probation license to practice medicine in the State of Nevada (License No. 14957). Respondent was originally licensed by the Board on September 6, 2013. On September 6, 2019, Respondent's license was placed upon probationary conditions (female supervision for all female patient encounters and maintain a formal monitoring agreement) for two (2) years from the aforementioned date or otherwise ordered by the Board. An Amended Settlement Agreement was approved March 6, 2020 by the Board and filed March 9, 2020 which did not change the above-outlined terms of the agreement.

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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 Mr. M. Neil Duxbury, Aury Nagy, M.D., Michael C. Edwards, M.D., FACS

2. On December 3, 2013, Patient A[2] was diagnosed by Respondent with bipolar disorder from a psychiatric evaluation based upon Patient A's most recent severe manic episode. Respondent notes such diagnosis of Bipolar disorder in the "chief complaint" section of Patient A's medical record. Respondent did not discuss or document any medication adjustments to address Patient A's "severe" symptoms. Respondent documented "continue present management." Less than thirty (30) days later, Patient A was hospitalized in an acute psychiatric setting for suicidal ideation and paranoia.

3. On September 11, 2014, Patient A requested and Respondent granted an increase in her drug medications, Strattera, Topamax, and Trazodone. Patient A stated her request was based upon her poor sleep and increased drug cravings. The Stattera was increased and another drug was added, Trazodone (a nightly dosage of 300mg). No medical justification or rationale was documented by Respondent into Patient A's medical record for the increased dosage or the added medication. Patient A's medical history and diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) was not documented by Respondent into Patient A's medical record. Respondent did not check Patient A's Prescription Monitoring Program Report (PMP) from the Nevada State Board of Pharmacy to ensure another medical provider had not already prescribed this type of medication to Patient A.

4. On January 20, 2015, Patient A started taking Lithium Carbonate (Lithium) in addition to the Depakote previously prescribed by Respondent. Again, Respondent did not properly monitor or document his monitoring, nor provide medical justification of these aforementioned medications given their respective therapeutic windows and a possibility of drug toxicity due to potential, unintended, side-effects with regard to the Lithium. Respondent did not check Patient A's PMP to ascertain if she was subject to any other prescriptions by other medical providers.

5. On April 13, 2015 and on April 22, 2015, Respondent documented another drastic change in Patient A's "treatment medications" without any indication of a discussion regarding the following: 1) Patient A's non-compliance with Respondent's treatment plan; 2) any possible,

[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 and filed under seal.

unintended side-effects of Patient's change in medications; nor, 3) any medical justifications for the medication changes. Respondent did not check Patient A's PMP.

6. On June 27, 2016, Respondent ordered a drug screen for Patient A. The results demonstrated that Patient A was compliant with Respondent's medication regime, but for the positive test results for opiates, which were not indicated or documented in Patient A's medical records. Respondent failed to address the opiate test results with Patient A. Respondent did not check Patient A's PMP.

7. On March 27, 2017, Patient A presented to Respondent and mentioned her having a "schizophrenic episode." Respondent did not document in Patient A's medical record any symptoms she experienced, and if there was any resolution, or a return to the baseline functioning for Patient. Similarly, on September 17, 2018, Patient A presented to Respondent following her most recent acute hospitalization where she suffered seizures and was eventually released on an antiepileptic medication. Here, Respondent did not update Patient A's medical record's sections of "medical history" and "review of systems" to reflect the recent seizures. Respondent did not query or investigate whether Patient A's seizures were potentially medication-withdrawal related. Respondent did not check Patient A's PMP.

8. On January 1, 2018, Respondent failed to review Patient A's PMP prior to his prescribing controlled substances to Patient A. Respondent should have ordered random drug screen tests due to Patient A's medical history of substance and alcohol use. No such tests were ordered and no review of Patient A's current medication (PMP) was documented. Respondent did not check Patient A's PMP.

9. On January 16, 2018, Patient A's complaint of hallucinations was documented in the "chief complaint" section but was not included in the section of the mental status examination. Additionally, Respondent prescribed Adderall (20mg/morning) without any medical justification or rationale documented into Patient A's medical record although Patient A stated her anxiety had worsened and she suffered from psychotic symptoms, both of which could be further exacerbated by a stimulant medication (Adderall). Respondent did not check Patient A's PMP.

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10. On January 25, 2019, Respondent documented Patient A's "treatment medications" were listed as "Fanapt (8mg/night) and Belsoma (20mg/night)." Respondent did not check Patient A's PMP.

11 On February 4, 2019, Patient A stopped taking the aforementioned (Fanapt Belsoma) medications; Respondent updated "treatment medications" and listed "Zoloft (100mg/daily); Geodon (160mg/nightly); Gabapentin (600mg/3x daily)" On February 11, 2019, Patient A stated that she restarted taking Valium (5mg/2x daily) and Belsomra as documented by Respondent in the "treatment medications" of the medical record. Respondent did not either address these recent medications and/or he did not document his medical rationales or justifications for Patient A to continue to take these medications (Valium & Belsomra) in her medical record. Again, Respondent did not check Patient A's PMP. Diazepam (5mg/2x) was the last prescription Respondent wrote for Patient A.

13. On April 24, 2019, Respondent documented "bipolar disorder, current episode manic without psychotic features" and "bipolar disorder, current episode depressed, severe, without psychotic features" in the section label "diagnosis." Here, the entries are inconsistent with each other, e.g., "manic" and "depressed" are the opposite sides of this medical condition. This medical record is inaccurate as to what was the correct type of episode Patient A suffered on this date.

14. On August 22, 2019, Patient A committed suicide at the age of thirty-nine (39) years old. The cause of death was determined by the Clark County Coroner who stated that the manner of death was multiple drug intoxication (bupropion, gabapentin, and diphenhydramine). The autopsy report stated that Patient A had a history of chronic obstructive pulmonary disease; multiple mental illnesses, including bipolar disorder, anxiety and depression; she suffered from addiction since the age of fifteen (15) (chronic alcohol, methamphetamine, and prescription drug abuse). The report further indicated that Patient A's prescription medications were inventoried and too many pills remained in their containers. Thus, indicating non-compliance with taking her prescriptions as ordered.

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COUNT I

NRS 630.301(4) (Malpractice)

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

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

17. 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.

18. As demonstrated by, but not limited to, the above-outlined factual allegations, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he provided medical services to Patient A. Respondent's specific acts of malpractice are as follows, but not limited to: 1) failing to justify the use, increase and decrease, and then subsequent increases in dosages of Patient A's medication; 2) prescribing a combination of controlled substances without documenting the medical justification or rationale; 3) failing to review the PMP report prior to, during, and after the encounters with Patient A; 4) failing to assess Patient A's concurrent medication interactions; 5) failing to assess Patient A for possible drug abuse, drug diversion or any other non-medical related activity; 6) failing to assess Patient A for possible drug screens on a consistent basis; and, 7) failing to diligently monitor potential medication interactions in Patient A's changing treatment plans.

19. 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 Proper Medical Records)

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

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21. 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 disciplinary action against a licensee.

22. As demonstrated by, but not limited to, the above-outlined factual allegations, Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A. The medical records for Patient A were inaccurate and incomplete due to his lack of diligence in documenting the medical justifications and rationales for all of his prescribing of various different medications for Patient A. As well as, the lack of documenting his request and receipt of the PMP reports for Patient A from the Nevada Board of Pharmacy. Further, Respondent failed to document important details regarding Patient A's medication changes, symptomatology, psychiatric history, and medical history.

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

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this matter as outlined in NRS 622.400.

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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

DATED this 26th day of October, 2021.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 26th day of October, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

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