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

* * * * *

In the Matter of Charges and Complaint Against: **MATTHEW OBIM OKEKE, M.D.** **Respondent.**	**Case Nos. 24-22461-1** **24-22461-2** **24-22461-3** **24-22461-4**

FILED

JUN 13 2025

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The above-entitled matter came on regularly for adjudication and decision before the Nevada State Board of Medical Examiners (Board), during a regularly scheduled Board meeting on June 6, 2025, at the Board's office located at 9600 Gateway Drive, Reno, NV 89521 (video-conferenced to 325 E. Warm Springs Road, Suite 225, Las Vegas, NV 89119), on the Complaints filed herein. Matthew Obim Okeke, M.D., (Respondent), who was duly served with notice of the adjudication, was present and represented by his counsel, Liborius Agwara, Esq. The adjudicating members of the Board participating in these Findings of Fact, Conclusions of Law, and Order (FOFCOL) were, Nick M. Spirtos, M.D., F.A.C.O.G., Ms. Maggie Arias-Petrel, Ms. Pamela Beal, Irwin B. Simon, M.D., FACS, Joseph Olivarez, P.A.-C, and Jason B. Farnsworth, RRT, MBA. Henna Rasul, Senior Deputy Attorney General, served as legal counsel to the Board.

The Board, having received and read the Complaints 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 Medical Practice Act), NRS Chapter 622A, and NRS Chapter 233B, as applicable.

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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 medicine in the State of Nevada issued by the Board at all relevant times.

A. Case Nos. 24-22461-1, 24-22461-2, and 24-22461-3

1. On February 21, 2024, the Investigative Committee filed its formal Complaint in Case No. 24-22461-1, alleging Respondent violated the Medical Practice Act. Respondent was personally served with the Complaint on or about February 27, 2024. A First-Amended Complaint was filed October 29, 2024, and a copy was served upon Respondent November 4, 2024. The First-Amended Complaint alleged two hundred eleven (211) violations of the Nevada Medical Practice Acts, including: sixty-six (66) violations of NRS 630.301(4), Malpractice (Counts I-LXVI), thirteen (13) violations of NRS 630.3062(1)(a), Failure to Maintain Complete Medical Records (Counts LXVII-LXXIX), fifty-seven (57) violations of NRS 630.306(1)(b)(3), Violation of Statutes and Regulations of the Nevada State Board of Pharmacy (Counts LXXX-CXXXVI), sixty-one (61) violations of NRS 630.3062(1)(h), Fraudulent, Illegal, Unauthorized, or Otherwise Inappropriate Prescribing of Controlled Substances Listed in Schedule II, III, or IV (Counts CXXXVII-CXCVII), seven (7) violations of NRS 630.306(2)(b)(1), Engaging in Conduct Which is Intended to Deceive (Counts CXCVIII-CCIV), and seven (7) violations of NRS 630.305(1)(d), Charging for Services Not Rendered (Counts CCV-CCXI). Respondent did not file an answer in response to the allegations set forth in the Complaint or the First-Amended Complaint.

2. On February 21, 2024, the Investigative Committee filed its formal Complaint in Case No. 24-22461-2, alleging Respondent violated the Medical Practice Act. Respondent was personally served with the Complaint on or about February 27, 2024. A First-Amended Complaint was filed June 27, 2024, and a copy was served upon Respondent via email and U.S.

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mail. The First-Amended Complaint alleged twenty-four (24) violations of the Nevada Medical Practice Acts, including: five (5) violations of NRS 630.301(4), Malpractice (Counts I-V), five (5) violations of NRS 630.3062(1)(a), Failure to Maintain Complete Medical Records (Counts VI-X), six (6) violations of NRS 630.306(1)(b)(3), Violation of Statutes and Regulations of the Nevada State Board of Pharmacy (Counts XI-XVI), four (4) violations of NRS 630.3062(1)(h), Fraudulent, Illegal, Unauthorized, or Otherwise Inappropriate Prescribing of Controlled Substances Listed in Schedule II, III, or IV (Counts XVII-XX), and four (4) violations of NRS 630.306(2)(b)(1), Engaging in Conduct Which is Intended to Deceive (Counts XXI-XXIV). Respondent did not file an answer in response to the allegations set forth in the Complaint or the First-Amended Complaint.

3. On February 23, 2024, the Investigative Committee filed its formal Complaint in Case No. 24-22461-3, alleging Respondent violated the Medical Practice Act. Respondent was personally served with the Complaint on or about February 29, 2024. A First-Amended Complaint was filed October 29, 2024, and a copy was served upon Respondent via U.S. Mail and email on or about October 29, 2024. The First-Amended Complaint alleged seven (7) violations of the Nevada Medical Practice Acts, including: one (1) violation of NRS 630.301(4), Malpractice (Count I), one (1) violation of NRS 630.3062(1)(a), Failure to Maintain Complete Medical Records (Count II), one (1) violation of NRS 630.306(1)(b)(3), Violation of Statutes and Regulations of the Nevada State Board of Pharmacy (Count III), one (1) violation of NRS 630.306(1)(p), Unsafe or Unprofessional Conduct (Count IV), one (1) violation of NRS 630.301(9), Disreputable Conduct (Count V), one (1) violation of NRS 630.301(7), Violation of Patient Trust and Exploitation of Physician and Patient Relationship for Financial or Personal Gain (Count VI), and one (1) violation of NRS 630.3062(1)(h), Fraudulent, Illegal, Unauthorized, or Otherwise Inappropriate Prescribing of Controlled Substances Listed in Schedule II, III, or IV (Count VII). Respondent did not file an answer in response to the allegations set forth in the Complaint or the First-Amended Complaint.

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4. An Order was filed on March 26, 2024, scheduling the Early Case Conference (ECC) for the pending matters in Case Nos. 24-22461-1, 24-22461-2, and 24-22461-3. This Order was served upon Respondent's counsel by U.S. Mail and email.

5. On April 26, 2024, an Order Staying Proceedings was filed in Case Nos. 24-22461-1, 24-22461-2, and 24-22461-3, staying the proceedings pending confirmation of a potential settlement agreement. This Order was served upon Respondent's counsel by U.S. Mail and email.

6. On May 22, 2024, an Order Scheduling Status Conference was filed in Case Nos. 24-22461-1, 24-22461-2, and 24-22461-3, setting a status conference for May 23, 2024, at 2:00 p.m. This Order was served upon Respondent's counsel by U.S. Mail and email. On May 23, 2024, as noticed by the Order, a status conference commenced whereby the parties appeared. The pending matters were placed back on calendar and dates for Prehearing and Hearing were agreed to and as a result, a Scheduling Order was issued on May 24, 2024, setting the Prehearing Conference for June 27, 2024, at 10:00 a.m., and a Hearing date was set for September 9-11, 2024, in Case No. 24-22461-1, September 16-17, 2024, in Case No. 24-22461-2, and October 21-22, 2024, in Case No. 24-22461-3.

B. Case No. 24-22461-4

7. On May 17, 2024, the Investigative Committee filed its formal Complaint in Case No. 24-22461-4, alleging Respondent violated the Medical Practice Act. Respondent was personally served with the Complaint on or about May 20, 2024. The Complaint alleged seven (7) violations of the Nevada Medical Practice Acts, including: one (1) violation of NRS 630.301(4), Malpractice (Count I), one (1) violation of NRS 630.3062(1)(a), Failure to Maintain Complete Medical Records (Count II), one (1) violation of NRS 630.306(2)(b)(1), Engaging in Conduct Which is Intended to Deceive (Count III), one (1) violation of NRS 630.254(3), Failure to Notify the Board Regarding Office Closure and Location of Patient Records (Count IV), one (1) violation of NRS 630.254(1), Failure to Notify the Board Regarding Change of Mailing Address (Count V), one (1) violation of NAC 630.230(2), Failure to Provide Patient Records to Patient Upon Request (Count VI), and one (1) violation of NRS 630.3065(2)(c), Knowing or Willful Failure to Comply

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with a Provision in NRS Chapter 630 (Count VII). Respondent did not file an answer in response to the allegations set forth in the Complaint.

8. An Order was filed June 12, 2024, scheduling the ECC for the pending matter in Case No. 24-22461-4. This Order was served upon Respondent's counsel by U.S. Mail and email. The ECC was held at the scheduled time wherein all parties appeared telephonically. As a result of the ECC, the pending matters in Case Nos. 24-22461-1, 24-22461-2, 24-22461-3 and 24-22461-4 were consolidated and new dates for Prehearing and Hearing were set.

9. An Amended Scheduling Order was filed on June 28, 2024, scheduling the Prehearing Conference for the pending matters for August 21, 2024. This Order was served upon Respondent's counsel by email and certified U.S. Mail. A hearing date was set for October 21, 2024, through October 24, 2024. At the time fixed for the Prehearing Conference, legal counsel for the Investigative Committee, Sarah A. Bradley, Deputy Executive Director, appeared, as well as the Hearing Officer, Patricia Halstead, Esq., and counsel for Respondent, Liborius Agwara, Esq. At the Prehearing Conference, counsel for the Investigative Committee 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, 622A, and 233B, and the requirements of due process.

10. On October 21, 2024, through October 24, 2024, hearings were held before the Hearing Officer to receive evidence and to hear arguments on each of the four (4) cases. The Hearing Officer received the complete Record of Proceedings, including the transcript of the testimony received and the exhibits admitted. Upon receipt of the Record of Proceedings, the hearings were closed. The Hearing Officer filed the Findings and Recommendations on May 19, 2025. The matters were scheduled for final adjudication on June 6, 2025, at a regularly scheduled Board meeting. The notice of the adjudication was mailed to Respondent on May 7, 2025, via U.S. Certified Mail, with a copy by email as well. On May 19, 2025, Respondent was sent a copy of the Hearing Officer's Findings and Recommendations via U.S.

Certified Mail, with a copy by email. Additionally, on May 29, 2025, via Fed Ex 2-Day mail, Respondent was given a copy of the Investigative Committee's Memorandum of Costs and Disbursements and Attorneys' Fees and a packet of the materials to be presented at the scheduled Board meeting.

II.

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

III.

In accord with the Findings and Recommendations, the Board hereby finds that the following counts, as recapitulated above, have been established by a preponderance of the evidence:

1. In Case No. 24-22461-1, Counts I-LXVI, sixty-six (66) violations of NRS 630.301(4); Counts LXXVII-LXXIX, thirteen (13) violations of NRS 630.3062(1)(a); Counts LXXX-CXXXVI, fifty-seven (57) violations of NRS 630.306(1)(b)(3); Counts CXCVIII-CCIV, seven (7) violations of NRS 630.306(1)(b)(1); and Counts CCV-CCXI, seven (7) violations of NRS 630.305(1)(d) were proven.

2. In Case No. 24-22461-2, Count I, one (1) violation of NRS 630.301(4); Counts VI-VII, two (2) violations of NRS 630.3062(1)(a); and Counts XI-XII, two (2) violations of NRS 630.306(1)(b)(3) were proven.

3. In Case No. 24-22461-3, the Board found all seven (7) Counts set forth in the First-Amended Complaint were proven.

4. In Case No. 24-22461-4, Count II, one (1) violation of NRS 630.3062(1)(a); Count IV, one (1) violation of NRS 630.254(3); Count V, one (1) violation of NRS 630.254(1); and Count VI, one (1) violation of NAC 630.230(2) were proven.

IV.

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

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CONCLUSIONS OF LAW

I.

The Board has jurisdiction over Respondent and the Complaints, 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 Complaints, 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 Complaints, the Board concludes that Respondent has violated sixty-eight (68) violations of NRS 630.301(4), seventeen (17) violations of NRS 630.3062(1)(a), sixty (60) violations of NRS 630.306(1)(b)(3), seven (7) violations of NRS 630.306(2)(b)(1), seven (7) violations of NRS 630.305(1)(d), one (1) violation of NRS 630.306(1)(p), one (1) violation of NRS 630.301(9), one (1) violation of NRS 630.301(7), one (1) violation of NRS 630.3062(1)(h), one (1) violation of NRS 630.254(3), one (1) violation of NRS 630.254(1), and one (1) violation of NAC 630.230(2). 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 Medical Practice Act, 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 them to be the actual fees and costs incurred by the Board as part of its investigative, administrative and disciplinary proceedings against Respondent, and 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.

ORDER

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

IT IS HEREBY ORDERED that:

1. Pursuant to NRS 630.352(4)(e) and NRS 622A.410(1), respectively, Respondent's license to practice medicine, License No. 14957, is immediately revoked and Respondent may not apply for licensure in the State of Nevada for a period of seven (7) years from the service of this Order;

2. Respondent shall reimburse the Board the reasonable costs and expenses actually incurred in the investigation and prosecution of this case in the amount of fifty-nine thousand five hundred thirty-eight dollars and seventy-seven cents ($59,538.77), which amount shall be stayed, and which will become immediately due and payable upon Respondent's application for licensure in the State of Nevada;

3. Case No. 21-22461-1 is hereby closed, and if and when, Respondent reapplies for licensure, the Board may reinstate the monitoring requirements from this matter that have not been completed, as well as any other new requirements it deems necessary to ensure Respondent's competency and the safety of the public;

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

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5. This Order shall be reported to the appropriate entities, including the National Practitioner Databank (NPDB).

IT IS SO ORDERED.

DATED this 13th day of June, 2025.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

NICK M. SPIRTOS, M.D., F.A.C.O.G.
President of the Board

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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 Matthew Obim Okeke, M.D., Case Nos. 24-22461-1, 24-22461-2, 24-22461-3, and 24-22461-4.

I further certify that Nick M. Spirtos, M.D., F.A.C.O.G., is the 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 Nick M. Spirtos, M.D., F.A.C.O.G.

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 13th day of June, 2025.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Maggie Arias-Petrel

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

EXHIBIT 1

EXHIBIT 1

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against MATTHEW OBIM OKEKE, M.D., Respondent.	Case No.s: 24-22461-1 24-22461-2 24-22461-3 24-22461-4 24-22461-5

FINDINGS AND RECOMMENDATIONS

FILED

MAY 19 2025

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

TO: Sarah A. Bradley
Deputy Executive Director
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Matthew Obim Okeke, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste. 280
Henderson, NV 89121

The above-referenced matters came for hearing on October 21, 2024 through October 24, 2024. The hearings were held by video conferencing between the State of Nevada Board of Medical Examiners' Reno and Las Vegas offices, with counsel for the Investigative Committee of the State of Nevada Board of Medical Examiners (the "IC"), Sarah A. Bradley, and the undersigned hearing officer appearing in Reno, and Respondent Dr. Matthew Obim Okeke ("Respondent") appearing from Las Vegas along with his counsel Liborius Agwara, Esq. The matters were presented out of sequence commencing with Matter 4. For purposes of ease for drafting this Findings and Recommendations, the matters will be addressed in the same order.

Matter 4

Matter 4 is premised upon a Complaint for seven claims for relief. Count I is Malpractice, a violation of NRS 630.301(4), premised upon the allegation, in summary, that is was improper for Respondent to prescribe a benzodiazepine (specifically alprazolam, the brand name of which

is Xanax) when he knew or should have known that the patient was also taking opioids; and/or that Respondent failed to consider outside medical records regarding the patient's use of opioids; and/or by failing to properly document the patient's treatment.

Count II alleges a violation of NRS 630.3062(1)(a), Failure to Maintain Complete Medical Records, and is premised upon the allegations that the patent records at issue were copied and pasted with data from other patients; and/or backdated; and/or failed to document review or discussion of the patient's Prescription Monitoring Program ("PMP") report; and/or failed to ensure the patient medications were updated and accurate each visit; and/or failed to document any attempt to obtain outside medical records related to the patient's use of opioids as prescribed be any other provider.

Count III is a charge of Engaging in Conduct that is Intended to Deceive, a violation of NRS 630.306(2)(b)(1), and is premised upon the allegation that Respondent was not forthright when representing to the Investigative Committee of the Nevada Board of Medical Examiners (the "IC") that he had only seen the subject patient twice.

Count IV alleges a violation of NRS 630.254(3), Failure to Notify the Board Regarding Office Closure and Location of Patient Records as related to Respondent's closing of his office referred to as "Grand Desert."

Count V, Failure to Notify the Board Regarding Change of Mailing Address, a violation of NRS 630.254(1), is self-explanatory and relates to the closing of Respondent's office.

Count VI is for Failure to Provide Patient Records to Patient Upon Request, a violation of NAC 630.230(2), and is premised upon the allegation that requested patient records had not been timely provided and that the location of the records remains unknown.

The final charge, Count VII, is for Knowing or Willful Failure to Comply with a Provision of NRS Chapter 630, a violation of NRS 630.3065(2)(c), and is premised upon Respondent's alleged knowingly and willful failure to have provided contact information upon the closure of his office and his failure to disclose the location of the patient records that are the subject of Count VI.

Throughout the course of the hearing, IC Exhibits 1 through 10 were admitted.

The IC's first witness was the IC's Chief Investigator Ernesto Diaz, who authenticated exhibits and through whom Exhibits 1-5 were admitted. Mr. Diaz also supported Count III, Engaging in Conduct that is Intended to Deceive, a violation of NRS 630.306(2)(b)(1), by testifying that medical records contradict Respondent's response to IC inquiries regarding having only seen Patient A twice.

The IC's next witness was Bryan Czerniski, M.D., a licensed Nevada psychiatrist, who testified to his credentials (*see* Exhibits 9-10, which were admitted), and opined that Respondent fell below the standard of care by prescribing a benzodiazepine, specifically alprazolam, to a patient who was on opioids and by further failing to document related risk factors. Transcript pp. 47-50 (abbreviated hereafter as "T" with page numbers following). According to Dr. Czerniski, Respondent should have checked the patient's PMP report before prescribing any controlled substance. T 50. Dr. Czerniski further testified that the combination of a benzodiazepine with an opioid can lead to respiratory distress and increase the chances of "mortality by tenfold," (T 53-54), and that alprazolam (a benzodiazepine) should not be utilized long-term for someone with anxiety due to the state of withdrawal causing more anxiety, especially if there is a history of alcohol use disorder because the withdrawal can induce alcohol cravings. T 56-57, 63-65, 86. Dr. Czerniski expressed concern about the alprazolam prescription due to a history of seizures and the withdrawal increasing the chance of seizures. T 57-58. Based upon these risks, Dr. Czerniski testified that the alprazolam should have been tapered off. T 59.

According to Dr. Czerniski, Respondent's records indicate that after Respondent checked the PMP report, he did decrease the alprazolam dosage but did so too abruptly without proper titration and then inexplicably bumped the dosage back up. T 60-61, 107. Dr. Czerniski further testified that there is no indication that Respondent collaborated to establish a shared treatment program with the patient's other provider(s) in light of the alprazolam he had prescribed and opioid prescription another provider had prescribed, nor did Respondent document the basis for his alprazolam prescription and dosage changes. T 62, 99.

As to Respondent's medical records, Dr. Czerniski noted concerns about notations being cloned, meaning copied and pasted from other records. T 66, 71-3. He also expressed that the medication list was unclear due to duplication and dosages, and that date entries were either auto-populated after the visit or subject to having been changed, which is contrary to records being required to be maintained as they were made after they are finalized. T 67-68, 71.

Adverse reactions as a result of the benzodiazepine prescription of alprazolam with the opioids as specific to Patient A was brought out in cross-examination, as to which Dr. Czerniski testified that the adverse reactions resulted in twelve emergency department visits, with ten of those during times the PMP report was kept, and eight of those having followed within two days of the Xanax prescription (alprazolam, which again, is a benzodiazepine). T 78-79. Notes related thereto provide "[p]rofound sedation due to medication of substances" but there is no way of knowing if the patient was compliant with medication instructions; although, the description is consistent with an overdose of alprazolam or a mixture of alprazolam and opiates, which Dr. Czerniski opined was the cause. T 79-83.

It was established on cross-examination that the patient had already been prescribed benzodiazepines by another provider, Dr. Kroegel, in 2019, and that when Respondent saw the patient three years later in September 2021 and October 2021, according to Dr. Czerniski, Respondent should have taken the patient off the alprazolam in consultation with the patient's other providers by tapering the patient off in consideration of the patient's seizure disorder and "rebound anxiety." T 89-96, 99-100.

The IC's next witness was Darla Zarley who is the Prescription Monitoring Program Administrator for the Nevada State Board of Pharmacy. T 120. Relevant to the charges, Ms. Zarley testified that the PMP records indicate that Respondent first ran a PMP inquiry for the patient on September 16, 2021, at which time Respondent prescribed the patient alprazolam (a benzodiazepine) despite the patient already being prescribed oxycodone (an opioid). T 123.

The next to testify was Johnna LaRue, the Deputy Chief of Investigations and Compliance Officer for the Nevada State Board of Medical Examiners. T 131. Ms. LaRue testified that Respondent's license was moved from active to inactive on June 9, 2023 in accordance with

admitted Exhibit 6, which is an email from Respondent's counsel requesting that Respondent's license be moved to inactive. Exhibit 7, which is an allegation letter regarding Respondent's failure to provide Patient B his or her records, was also admitted through Ms. LaRue. T 136-38. Exhibit 8, which is an envelope marked undeliverable to Respondent's address on file with the Board was also admitted. T 138-39. Ms. LaRue further testified that Patient B's records were never provided despite having been requested. T 140. On cross-examination, Ms. LaRue indicated that she did not follow up on the returned mail with Respondent by calling him but that she had tried to email him with no response. T 142-43.

Respondent for his case presented only his testimony, by which he testified that it is not his practice to prescribe benzodiazepines but will continue such prescriptions for existing users (T 146); Respondent lowered the patient's benzodiazepine prescription because he was not comfortable with the amount currently prescribed (T 148-49); the patient was not prescribed the benzodiazepine by him originally (T 149); that the reduction he gave was drastic so he increased it again to help the patient cope (T 150); and that he still maintains the address where his practice was located and that the Board has on file but there was no one there to sign for the mail the Board sent that was returned (T 150).

On cross-examination, Respondent acknowledged that he did not note any reasoning for the changes to the benzodiazepine prescription dosages. T 151. Then on re-direct, Respondent testified that the two times he saw the patient in 2021 and 2022 he was just covering and, therefore, did not want to make drastic changes to the patient's prescriptions. T 153.

Counts I and II

As to whether Respondent committed malpractice by prescribing benzodiazepines while he knew or should have known that the patient was taking opioids, the rub is that the patient was already prescribed benzodiazepines when the patient was seen by Respondent, who testified he was covering for another provider. Per the IC's expert, although it was inappropriate to allow the benzodiazepine prescription to continue, that being Xanax in particular, it also was not appropriate to cease the prescription altogether. Given the foregoing, I cannot recommend a finding that Respondent committed malpractice by continuing to prescribe the benzodiazepine.

However, it remains that Respondent's records are not appropriately reflective of the basis for his actions with respect to the continuing prescription, its increase and decrease, and there is no indication that he took care to address the problems that arise with the prescription in consideration of concurrent opioid use. The records also have cloned entries. The manner by which the records tracked prescriptions is also problematic in that, as testified to by Dr. Czerniski, the medication list was unclear due to duplication and dosages, and that date entries were either auto-populated after the visit or subject to having been changed, which is contrary to records being required to be maintained as they were made after they are finalized. T 6-68, 71. The failure to make and maintain appropriate medical records is pleaded as the basis for malpractice claim as well as the failure to maintain complete medical records claim. Given the duplicity, I recommend finding a violation on Count II.

Count III

Count III is engaging in conduct that is meant to deceive and is premised upon Respondent's written response to the IC's investigation whereby Respondent indicates that he only saw the patient at issue twice, which was not accurate. Respondent actually saw the patient eight times - twice in 2021 and six times in 2018. T 102; Exhibit 3.

The letter upon which Count II is based was written by Respondent's counsel but was adopted by Respondent and his signature appears on it. *See* Exhibit 2. The letter from the IC that the Respondent was answering referenced treatment of the patient "for years" and was focused on the prescription of narcotics to the identified patient. *See* Exhibit 1. The times that Respondent saw the patient and prescribed narcotics were the two visits in 2021.

In reviewing the statute, NRS 630.306, it is focused on actions that are the basis for initiating an investigation and, if warranted, disciplinary proceedings, and is not tailored to responding to the IC once an investigation is underway; but, even assuming the statute could be applied in such an instance, given the context of the inquiry and the timeframe Respondent could assume was at issue, I cannot find that Respondent referencing the two recent visits rises to the level of an intentional deception, particularly when Respondent provided all the records that included the visits from 2018. T 37-38.

Counts IV, V, and VI

Counts IV, V, and VI are for failure to notify the Board about the office closure and location of records; failure to notify the Board regarding a change of address; and failure to provide patient records to a patient upon request. Respondent did not defend his failure to provide patient records. As to the office closure and change of address, Respondent testified that he maintains that address although he closed his practice.

Given Respondent closed his practice, mail sent by the Board was returned, and the patient records remain unaccounted for, I submit that Respondent should be held accountable for each of these three counts. If a practitioner closes an office and cannot be reached by the Board by certified mailing, that is a problem and is the exact problem the mandates outlined in the counts are meant to address. It is particularly unacceptable that the patient records at issue in Count VI remain unaccounted for.

Matter 1

Matter 1 commenced upon the amendment of the Complaint as provided for on the record. A true and correct copy of the Complaint as amended was filed on October 29, 2024. The exhibits were also addressed and updated on the record. The parties stipulated that Respondent was out of the country from February 26, 2017 through March 11, 2017; September 27, 2017 through October 2, 2017; and June 30, 2018 through July 7, 2018; and November 9, 2018 through November 23, 2018, as stated in paragraph two of the Complaint as amended.

Counts 1-66 are for malpractice, a violation of NRS 630.301(4), as alleged with regard to patients A through NNN, and is premised upon the allegation that Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when rendering medical services because he billed for services not rendered, prescribed controlled substances via paper prescriptions when he was out of the country, failed to check the PMP as required by Nevada law, and failed to examine patients prior to writing prescriptions for controlled substances.

Counts 67 through 79 relate to patients A through M and are for failure to maintain complete medical records, a violation of NRS 630.3062(1)(a), premised upon Respondent's

alleged failure to completely and correctly document medical care and treatment and/or by over-reliance on templated material in the records, causing the same to be untimely, illegible, inaccurate, and incomplete.

Counts 80 through 136 relate to patients C, E, and J through NNN excluding L and M, and are premised upon alleged violations of statutes and regulations of the Nevada State Board of Pharmacy, a violation of NRS 630.306(1)(b)(3), specifically Respondent's alleged failure to run PMP reports as required to prescribe controlled substances.

Counts 137 through counts 197 plead violations of NRS 630.3062(1)(b)(3), Fraudulent, Illegal, Unauthorized, or Otherwise Inappropriate Prescribing of Controlled Substances Listed in Schedule II, III, or IV, in relation to patients C, E, G, and I through NNN, alleging that Respondent pre-signed prescription pads for his staff or other practitioners to utilize while he was out of the country.

Counts 198 to 204 are premised upon alleged violations of Engaging in Conduct that is Intended to Deceive, a violation of NRS 630.306(2)(b)(1), in relation to patients A, B, D, E, F, G, and H based upon providing services under his name and NPI number that he did not provide, which is deceptive.

Counts 205 through 211, relate to alleged violations of NRS 630.305(1)(d), Charging for Services Not Rendered, for allegedly charging patients A, B, D, E, F, G, and H for services that were not rendered.

The parties stipulated to numerous exhibits as identified on the record and removed others based upon Respondent's stipulation to not running PMP's for 57 patients as is relevant to Counts 80-136.

The IC's first witness was Ernesto Diaz, the Board's Chief Investigator, who testified as to Respondent's National Provider Identification number and to patient visit records of November 12-14, 2018 and November 20-21, 2018 – dates Respondent was out of the country. Transcript of October 22, 2024, pp. 50-56. The same testimony was given for the dates of February 28, 2017; September 27, 2017; November 24, 2018; November 9-10, 2018; November 16-19, 2018, in

addition to some overlap of prior dates. T 57-59. On cross-examination, Respondent implied the visits were by "telemed." T 60-62.

The IC then called Dr. Jayleen Chen, a psychiatrist, who testified as to her qualifications and that Respondent did not meet the standard of care by failing to have established a "bona fide patient/prescriber relationship" when having purportedly seen patients and prescribing controlled substances while out of the country, as well as failing to write progress notes to support the prescriptions. T 62, 67-71.

Per Dr. Chen, billing records indicate that the visits were office visits, that being that the place of service was the office; and, if the visits were by telehealth, that should have been noted. T 75-79. Dr. Chen also testified that electronic prescriptions, versus paper, are now the norm for prescribing controlled substances but, in relation to this matter, Respondent purported to have issued paper prescriptions while out of the country. T 80. It was surmised by Dr. Chen that the paper prescriptions were dated in such a manner as to be issued while Respondent was out of the country (T 81-86) as opposed to being filled out with "do not fill" until a certain date, which is the proper manner to issue future prescriptions. T 83. Dr. Chen also testified that it is not allowed for someone other than Respondent to have given the paper prescriptions to the patients. T 87. Dr. Chen further testified that Respondent's records contained copying and pasting and duplicate medication listings with differing dosages. T 89-91, 107. Dr. Chen also confirmed that a check of the PMP database was not undertaken when it should have been. T 93. On cross-examination, Dr. Chen was questioned about other care workers who are part of a treatment team billing under Respondent's Medicare billing code, which was referenced as "14." T 102-103. On redirect Dr. Chen testified that compromised prescribing credentials must be reported. T 110.

Respondent testified and addressed his experience (T 118-19); that he did not run the required PMP inquiries based upon his electronic medical record program giving the same information (T 119-21, 123-26, 138); and that, at the time at issue, it was acceptable to "postdate" written prescriptions (that being to write a future date), which is what Respondent did so that his patients would not run out of their prescriptions and face withdrawal symptoms (T 121, 126, 140-42). Respondent also testified that he was on the telephone with the provider seeing his patients

on unidentified occasions when the provider treating the patient had questions (T 122-23), and that other levels of providers would bill Medicaid under a general billing number that was also reflective of the number he used and, therefore, the usage of that number was not necessarily identifying as to him (T 126-131). On cross-examination, Respondent testified that a billing code "20" as opposed to a "14" would be the other psychiatrist affiliated with the office or the nurse practitioner but likely the nurse practitioner because the other psychiatrist would have put their name (T 136-37).

After Respondent's testimony, Darla Zarley of the Nevada State Board of Pharmacy was recalled as a witness by the IC, and testified that Respondent's EMR system was not integrated with the PMP system until July of 2020 (T of October 23, 2024, pp. 6-7) and reiterated that a PMP report was required to be run as of January 1, 2018. T 9.

Counts I – LXVI

Counts I-LXVI are for malpractice, defined by NAC 630.040 as "the failure of a physician . . . in treating a patient to use reasonable care, skill, or knowledge ordinarily used for similar circumstances," and are premised upon billing for services not rendered, prescribing controlled substances via paper prescriptions while out of the country, failing to run PMP reports as required by law, and failing to examine patients prior to writing prescriptions for controlled substances.

Respondent stipulated to being out of the country for the dates at issue and, therefore, did not examine the patients (and only conferring by phone with providers who did see them on occasion per his own testimony); admitted to not running the PMP reports as required by law; postdated prescriptions without complying with NAC 453.450(4), which applies to Schedule II substances, and otherwise postdated written prescriptions for controlled substances outside of Schedule II substances; and billed for treatment of the identified patients as demonstrated by billing records that, regardless of the PT code (which Respondent referred to as a Medicaid code that could apply to other levels of providers), reference Respondent as the provider by and

through his name, electronic signature, and NPI Code. As such, I recommend finding against Respondent for these counts.[1]

Counts LXVII - LXXIX

These counts allege that Respondent failed to maintain timely, eligible, accurate and complete medical records relating to the diagnosis, treatment and care of the identified patients by failing to completely and correctly document his care and treatment for each of the patients at issue and/or over-relying on templated material. The only direct testimony regarding the same came from Dr. Chen who substantiated the allegations and, therefore, I suggest finding against Respondent on these counts.

Counts LXXX – CXXXVI

These counts are for violation of statutes and regulations of the Nevada State Board of Pharmacy and is premised upon failure to run the PMP reports as addressed in counts I – LXVI. Based upon Respondent's admission to failing to run the PMP reports, Respondent should be found to have violated these counts.

Counts CXXXVII – CXCVII

These counts are for fraudulent, illegal, unauthorized, or otherwise inappropriate prescribing of controlled substances listed in Schedule II, III, or IV and are based upon the postdating of the prescriptions as was addressed in counts I – LXVI; however, the premise is that Respondent postdated the prescriptions and then provided them to office staff or other practitioners to hand out while he was out of the office. There is no testimony that was proffered to substantiate that and, contrary thereto, Respondent indicates that he postdated the prescriptions and himself provided them during previous appointments. October 22, 2024 T 139-40. This was not refuted by the IC and, therefore, I cannot recommend that Respondent be held in violation of these counts as pleaded.

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[1] There are numerous patients at issue and, given the parties treated them as a block to which all allegations and defenses apply, the undersigned hearing officer likewise did so and, therefore, did not address each patient individually in making the above findings. This applies to all of the counts addressed with respect to Matter 1.

Counts CXCVIII – CCIV and Counts CCV - CCXI

These counts are in relation to seven identified patients who Respondent purported to provide services to while he was out of the country and are premised upon engaging in conduct intended to deceive and charging for services not rendered.[2] As set forth herein, I find that services were purportedly rendered and billed for that did not take place. To the extent that is deceptive, I recommend a finding that Respondent violated these counts.

Matter 2

This matter is similar to Matter 1 in that it alleges malpractice based upon prescribing an identified patent benzodiazepines when the patient was taking opioids and also prescribing five patients controlled substances by paper prescription when he was out of the country; failing to run each patient's PMP report; and failing to examine the patients prior to writing the prescriptions. The complaint also alleges counts for failure to maintain complete medical records in the same manner as addressed in Matter 1, that being over reliance upon templated material and/or cutting and pasting; counts premised upon violation of statutes and regulations of the Nevada State Board of Pharmacy for the failure to run the PMP reports; counts for fraudulent, illegal, unauthorized, or otherwise inappropriate prescribing of controlled substances listed in Schedule II, III, or IV by pre-signing paper prescriptions and providing them to staff and/or other practitioners to provide to patients while he was out of the country; and counsel for engaging in conduct that is intended to deceive by making misleading statements in response to the IC investigation. Matter 2 was heard on October 23, 2024 and continued through October 24, 2024 and is summarized as follows.

The IC's first witness was its Chief Investigator Ernesto Diaz who authenticated records and addressed Respondent's response to the IC investigation letter whereby Respondent indicated that he never authorized Dr. Victor Bruce to write any prescriptions. October 23, 2024 Transcript, pp. 20-41. Mr. Diaz also testified that as of his time at the IC, since March 2020, he had not received any information about Respondent's prescribing credentials being compromised. T 43.

[2] The IC's statutory citation at to counts CXCVIII - CCIV is "NRS 630.306(2)(b)(1)" but is apparently meant to be NRS 630.306(1)(b)(1).

On cross-examination Mr. Diaz was asked about the scope of any investigation he personally performed. T 46-49.

The IC next called Darla Zarley, the Prescription Monitoring Program Administrator with the Nevada State Board of Pharmacy who testified that the PMP reports run for the patients at issue were not run within the time period at issue as required by law. T 51-54. Ms. Zarley also testified that she was not notified of Respondent's prescribing credentials having become compromised. T 55. On cross-examination, Ms. Zarley testified that the PMP report showed that Respondent prescribed controlled substances to the patients subject to the complaint (T 57), and that the prescription should have been called in by the prescriber who saw the patient (T 59). As to Exhibit 20 in particular, Ms. Zarley testified that it looked like a person named "Mary" called the prescription in on behalf of Respondent. T 59-60. In response to questioning from the undersigned hearing officer, Ms. Zarley further testified that the prescribing credentials would come from whoever called in the prescription and, as to Exhibit 20, the number given was not Respondent's but could have been written down wrong. T 61-64. Respondent's prescribing credentials were then identified for the record. T 64-65. It was then established that a prescriber would not necessarily know if his or her credentials were being improperly used, which is why prescribers are required to run their related reports every six months to ensure their credentials are related solely to prescriptions they have issued. T 65-66. In follow up it was established that Exhibit 17 contains Respondent's credentials, as is the case for Exhibit 25, and a query for Respondent attributes Exhibit 20 to him. T 67-70. As for each of the prescriptions in Exhibits 17, 20, and 25, they were called in and would have been written down by the pharmacist. T 71.

The IC's next witness was Jayleen Chen, M.D., a psychiatrist who testified to her credentials and experience. Dr. Chen then testified that she opined that Respondent fell below the standard of care by prescribing benzodiazepines to Patient A who has been receiving opioids from another provider as well as having failed to run the PMP and took issue with the clarity and accuracy, by way of copying and pasting, of Patient A's records. T 79-91, 97-98, 101, 109-10, 126-27. Dr. Chen then addressed Respondent prescribing a controlled substance to Patient B on a date Respondent should have seen the patient to properly do so but was out of the country and for

which no PMP inquiry was made. T 113-15. Moving to Patient C, Dr. Chen testified that Patient C was prescribed a controlled substance on a date when Respondent was out of the country and, therefore, undertook the prescription without having seen the patient and for which no PMP report was run. T 115-18. The same testimony was also given for Patient D and Patient E, each action testified to by Dr. Chen having been deemed by her to fall below the appropriate standard of care. T 118-23. Dr. Chen then expressed ongoing concern about the clarity of the records and cutting and pasting versus providing tailored notations for different visits. T 124-26.

On cross-examination, Respondent represented that Sana Behavior Health is a treatment facility or hospital of which he was the medical director and, therefore, his role was to oversee treatment of all patients. T 130-31, 134. It was also established that three of the five patients at issue were Respondent's patients. T 132-33; October 24, 2024 T 5. As to Patient D in particular, by reference to Exhibit 21, Dr. Chen testified that she attributed that patient's care to Respondent because Respondent was listed as the psychiatrist on the record and a prescription was written under Respondent's name (which patients were Respondent's was never sorted on the record). T 133-36. Dr. Chen testified that when the prescription for Patient D that is part of the record as Exhibit 20 was written, Respondent was out of the country and, therefore, someone else wrote the prescription and Dr. Chen assumes it was authorized by Respondent; however, under questioning she acknowledged that the pharmacist writes the physician's name and could have put the primary doctor as opposed to the physician that ordered the prescription. T 138-41. Dr. Chen then testified that she was assuming Respondent was the attending physician for Patient D and that if that was not the case and was the medical director then she "could see that being ok," referring to Respondent not being present to provide care given his role of overseeing patient care. October 24, 2024 T 6. With Respondent not having left to go out of the country until the evening of November 8, 2019, Dr. Chen also testified that the prescription for Patient B could have been issued by Respondent that day (T 7-8), and that her main concern with Patient A was Respondent's failure to run a PMP report and lack of appropriate record documentation but agreed that it was not appropriate for Respondent to run a PMP for a patient that was not his (T 9-10).

On redirect, Dr. Chen reiterated that to prescribe a controlled substance, a PMP report must be run by the prescriber and that the prescriber must see the patient. T 12-13. As to Patient B, looking at Exhibit 14, the attending physician for October 10, 2019 was Respondent and for November 8, 2019 was Debra Perkins and it was surmised that Respondent provided the prescription dated for November 8, 2019 on October 10, 2019, which is inconsistent with Respondent's statement in Exhibit 4 that he did not postdate the November 8, 2019 prescription. T 13-15.

On recross, Respondent established that Exhibit 17 was a written prescription that was undertaken while Respondent was out of the country and, therefore "had nothing to do with [Respondent]" and that Dr. Chen did not "have a problem with whatever role, if any, that [Respondent] played with respect to these exhibits [17, 20, and 25]," which Dr. Chen agreed with. T 17-18.

On final redirect, Dr. Chen reiterated the requirement for post-dating prescriptions at the time, that being that they had to have the date of the day they were undertaken and had to provide "do no fill" until a certain date with no more than three prescriptions from the same issuing date. T 19-20.

When the undersigned hearing officer attempted to clarify Dr. Chen's testimony with respect to whether it was appropriate that the called in prescriptions were attributed to Respondent even though he was out of the country when they were issued, Dr. Chen stated that it was appropriate because Respondent was the medical director. T 20-22.

Counts I-V

These are malpractice claims based upon several allegations, the first of which is that Respondent prescribed Patient A benzodiazepines while she was taking opioids. This was attributed to Respondent having failed, admittedly, to run a PMP report.

Exhibit 7 contains Patient A's medical records and Respondent is consistently listed as her attending physician from 2013 to 2019. As such, Patient A does not present a scenario where Respondent was covering for another provider or was unfamiliar with her prescription history. Thus, to the extent it was not refuted that Patient A should not have been prescribed

benzodiazepines while taking opioids, I recommend that Respondent be held accountable for this portion of this count.

The remaining basis of the malpractice claim is that Respondent prescribed controlled substances to Patients A through E while he was out of the country, without checking a PMP report, and without conducting corresponding examinations. As to Patient A, the record does not reflect, so far as undersigned has been able to determine, that Patient A was prescribed any controlled substances while Respondent was out of the country and without conducting corresponding examinations, although he did not run PMP reports in conjunction with prescribing controlled substances for other dates and should be held accountable for that reason. With respect to Patient B, it was determined that Respondent could have personally seen that patient to facilitate the prescription but, again, did not run the PMP report, for which he should be held accountable. As to Patients C, D, and E, those were Sana Behavioral Health patients and, per testimony, their prescriptions could have been appropriately linked to Respondent as the Medical Director and not necessarily as the attending physician, which Dr. Chen testified was not problematic.[3] The fact that the burden was not met as to those patients as to each of the counts (not just the malpractice counts) was somewhat conceded by the IC on the record. T 31-32. To the extent that what remains of this count is duplicative of what remains of counts XI-XVI as to Patients A and B, undersigned recommends that these violations be accounted for in the latter counts and not encompassed in allegations of malpractice.

Counts VI-X

These counts relate to patients A through E and are premised upon Respondent's failure to maintain complete medical records in that such records were lacking in relevant notations, reflected copying and pasting, etc. This was a consistent concern throughout each of the hearings and the state of the records was no different in relation to this matter. As such, Respondent should

[3] Undersigned was surprised to hear Dr. Chen testify, and even clarify when queried by undersigned, that prescriptions could be called in under Respondent's name as the facility Medical Director when he was not the physician who saw the patient or directed the prescription. I do not believe this to actually be accurate but that is what the record bore out and I have rendered this recommendation in accordance with the record and the testimony provided.

be held accountable for these counts in relation to Patients A and B (with the counts as to Patients C, D, and E being excluded for the reasons set forth above).

Counts XI-XVI

These counts are for violation of pharmacy regulations related to Respondent's admitted failure to run PMP reports in relation to Patients A through E. To the extent Respondent is responsible therefore in relation to Patients A and B, Respondent should be held accountable.

Counts XVII-XX

These counts are for fraudulent, illegal, unauthorized, or otherwise inappropriate prescribing of controlled substances for allegedly pre-signing prescriptions and would be relevant as to Patients C, D, and E. For the reasons set forth above, the burden of proof for these counts have not been satisfied.

Counts XXI-XXIV

These counts are based upon Respondent's statements in response to investigative inquires by the IC that he checks "the PMP regularly" and in relation to what he guessed may have taken place with regard to Patients C, D, and E. As noted elsewhere herein, undersigned does not interpret the conduct complained of as a violation of NRS 630.306(1)(b)(3), but which is presumably meant to refer to NRS 630.306(1)(b)(1), because undersigned does not interpret the statute to include conduct or statements made in response to an already pending IC investigation. The statute states that deceitful conduct "constitutes grounds for initiating disciplinary action." Given disciplinary action had already commenced by way of an opened investigation, I do not find that this conduct is actionable as pleaded. How I interpret that statute is that deceitful conduct can be the basis to open an investigation and subject a physician to subsequent consequences. That being said, there is no doubt that such misrepresentations support a lack of credibility and support related culpability.

Matter 3

This matter involves a patient with whom Respondent admittedly had a personal/sexual relationship and entails counts for malpractice; failure to maintain complete medical records; violation of statutes and regulations regarding the Nevada State Board of Pharmacy; unsafe or

unprofessional conduct; disreputable conduct; violation of a patient's trust and exploitation of physician/patient relationship for financial or personal gain; and fraudulent, illegal, unauthorized, or otherwise inappropriate prescribing of controlled substances.

The parties stipulated to the admission of exhibits 1-6, 10, and 11.

The IC's first witness was Ernesto Diaz, the Chief of Investigations for the IC who testified to having reviewed text messages between Respondent and the Patient dated February 2021 through June 2021.

The IC next called Darla Zarley, the administrator of the Prescription Monitoring Program, who testified that a prescribing physician is required to run a PMP report each time a controlled substance is prescribed and every 90 days thereafter. October 24, 2024 transcript, p. 29. Ms. Zarley also testified to Exhibits 4 and 5, which demonstrated that Respondent ran two PMP reports in relation to the Patient on March 18, 2022 as reflected in Exhibit 4 despite having prescribed controlled substances to her on several other occasions (Exhibit 5). T 27-29.

The IC then called Jayleen Chen, M.D., a psychiatrist who testified to her credentials and who further testified to the impropriety of having a romantic relationship with a patient. T 32-37. Dr. Chen expressed concern regarding medications being prescribed with no premise therefore being documented, high dosages, and failure to run PMP reports, as well as concern about Respondent's romantic relationship with the patient and incomplete records that were, at times, hard to follow and included inapplicable diagnosis and cutting and pasting. T 38-48.

Respondent testified that he was already dating the Patient when he began to treat her and admitted it was wrong for him to do so, indicating that the Patient then began to threaten and extort him, including threatening to report him to the Nevada States Board of Medical Examiners, and that he had been negatively financially impacted as a result of his relationship and the Patient's demands upon him. T 53-57.

Count I

This is a count for malpractice, a violation of NRS 630.301(4) and is based upon Respondent having treated the Patient while having a personal relationship with her; prescribing controlled substances without running corresponding PMP reports; and failing to justify in his

medical records a prescription for Ambien and a prescription for Adderall, which was overprescribed. These allegations have been substantiated and Respondent should be held accountable.

Count II

This count is premised upon failure to maintain accurate and complete medical records, a violation of NRS 630.3062(1)(a). Dr. Chen's testimony was that the records kept were insufficient and her testimony was not disputed. Respondent should be held accountable for such.

Count III

Count III is for violation of statutes and regulations of the Nevada State Pharmacy Board, a violation of NRS 630.306(1)(b)(3), and is premised upon Respondent's failure to run PMP reports, which was established and for which Respondent should be held accountable.

Count IV

This count is for unsafe or unprofessional conduct, a violation of NRS 630.306(1)(p), and is based upon the overprescribing of Adderall and engaging in a personal relationship with the Patient and/or prescribing her controlled substances. This conduct was established and unrefuted. Respondent should be held accountable accordingly.

Count V

Disreputable conduct as set forth in NRS 630.301(9) is conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a code of ethics adopted by the Board by regulation based on a national code of ethics. Having a sexual relationship with a patient is patently unethical and is a violation of the same statute, subsection (5), "engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner." While not charged under section 5, which is exactly on point, it remains that the same conduct brings the medical profession into disrepute and is a violation for which Respondent should be held accountable.

Count VI

Count VI is for violation of patient trust and exploitation of the physician and patient relationship for financial or personal gain, a violation of NRS 630.301(7). Respondent's position

was that he was the victim of exploitation at the hands of the Patient in that the Patient utilized their relationship to exploit Respondent for financial gain; however, it cannot be overlooked that it was Respondent that put himself into that position for personal gain – that being the benefits of an ongoing personal/sexual relationship. Regardless of the fact that Respondent may have already been dating the Patient when he started treating her, her reliance upon him for medications and/or treatment that then becomes tied to an ongoing sexual relationship is exploitive, cannot be condoned, and was unequivocally a breach of trust regardless of any unfavorable actions the Patient may have responded with.

Count VII

The final count is for the fraudulent, illegal, unauthorized or otherwise inappropriate prescribing of controlled substances, a violation of NRS 630.3062(1)(h). Prescribing controlled substances to a patient without whom Respondent was personally involved was inappropriate and Respondent should be held accountable accordingly.

Matter 5

Matter 5 was dismissed by and through an Order for Dismissal With Prejudice, filed on October 29, 2024, and signed by Brett W. Frey, M.D., Chair of the IC.

BASED UPON THE FOREGOING, in summary, it is recommended that Respondent be held accountable for the following:

Matter 1:	Counts I-LXVI;
	Counts LXVII-LXXIX;
	Counts LXXX-CXXXVI;
	Counts CXCVIII-CCIV; and
	Counts CCV-CCXI
Matter 2:	One count of Counts I-V for prescribing benzodiazepines to Patient A while she was prescribed opioids;
	Two counts of Counts VI-X for the medical records related to Patients A and B;

Two counts of Counts XI-XVI for failing to run PMP reports as to Patients A and B;

Matter 3: All Counts

Matter 4: Counts II, IV, V, and VI;

Matter 5: Dismissed

RESPECTFULLY SUBMITTED this 19th day of May 2025.

Patricia Halstead, Esq.,
Hearing Officer
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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 19th day of May, 2025, I served a file-stamped copy of the foregoing **FINDINGS AND RECOMMENDATIONS**, via USPS Certified Mail, postage pre-paid, to the following parties:

MATTHEW OBIM OKEKE, M.D.
c/o Liborius Agwara
LAW OFFICES of LIBO AGWARA, LTD
2785 E. Desert Inn Rd., Ste 270
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With courtesy copy by email to:

Liborius Agwara, Esq., at libolaw@yahoo.com

DATED this 19th day of May, 2025.

Valerie Jenkins

VALERIE JENKINS
Legal Assistant
Nevada State Board of Medical Examiners