OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
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Reno, Nevada 89521
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# 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. 24-22461-4** |

FILED
MAY 17 2024
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 Sarah A. Bradley, J.D., MBA, Deputy Executive Director 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 license to practice medicine in the State of Nevada (License No. 14957). Respondent was originally licensed by the Board on October 8, 2003.[2]

### Respondent's Treatment of Patient A

2. Patient A[3] was a thirty-seven (37) year-old male at the time of the events at issue.

3. Beginning on January 1, 2018, prescribing practitioners in Nevada are required to obtain a patient utilization report (Patient Report) regarding the patient from the Prescription Monitoring Program (PMP) before issuing an initial prescription for controlled substances listed

[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 Bret W. Frey, M.D., Chowdhury H. Ahsan, M.D., PhD., FACC, and Col. Eric D. Wade, USAF (Ret.) (Public Member).

[2] Respondent's original license number issued on October 8, 2003, was 10668. Respondent was issued license number 14957 on September 6, 2013. As of the date of this Complaint, Respondent's license is in an inactive-probation status.

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

in Schedules II, III, or IV, or an opioid that is a controlled substance listed in Schedule V, and at least once every ninety (90) days thereafter for the duration of the course of treatment of using the controlled substance.

4. Respondent began providing treatment to Patient A on August 16, 2018, and saw Patient A thereafter on August 30, 2018, September 13, 2018, October 31, 2018, November 26, 2018, December 21, 2018, September 16, 2021, and October 15, 2021, according to the medical records provided to the Board in connection with this matter's corresponding investigation.

5. In a letter from Respondent to the Board, dated June 24, 2022, Respondent indicated that he "saw this patient only twice, first on 9/16/2021 and again on 10/15/21."

6. Respondent obtained a Patient Report from the PMP for Patient A on September 16, 2021.[4]

7. At the time that Respondent obtained Patient A's Patient Report, it would have shown that Patient A had received a prescription for "oxycodone-acetaminophen 7.5-325" written on August 16, 2021, from another health care provider, that was filled on August 29, 2021.

8. This prescription was for thirty (30) days and totaled one hundred and twenty (120) pills, meaning that Patient A would be taking four (4) oxycodone-acetaminophen 7.5-3.25 pills per day.

9. On September 16, 2021, Respondent prescribed thirty (30) alprazolam 1 mg tablets to Patient A, for thirty (30) days.

10. This means that, if Patient A was taking his medications as prescribed, he would have been taking (1) alprazolam pill per day prescribed by Respondent at the same time that he was taking four (4) oxycodone-acetaminophen pills per day.

11. The standard of care for prescribing controlled substances is to avoid the use of benzodiazepines (such as alprazolam) with opioids (such as oxycodone-acetaminophen).

12. There is an increased potential for respiratory depression with the use of opioids and benzodiazepines at the same time.

[4] It is unknown whether Respondent obtained Patient Reports for Patient A during his care of Patient A in 2018 because those PMP records were not available to Board staff at the time of this investigation.

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13. Respondent prescribed Patient A benzodiazepines on September 16, 2021, when Respondent knew, or should have known, from Patient A's Patient Report that Patient A was being prescribed opioids by another prescribing provider at that same time.

14. It is unknown whether Respondent actually reviewed Patient A's Patient Report obtained by Respondent on September 16, 2021, because Respondent made no notes about it or otherwise referred to it in Patient A's medical records.

15. Patient A's medical records do not show that Respondent discussed Patient A's use of opioids and benzodiazepines at the same time with Patient A.

16. Patient A's medical records do not show that Respondent suggested other medication options for Patient A in order to avoid Patient A from taking both opioids and benzodiazepines at the same time.

17. Patient A's use of both opioids and benzodiazepines at the same time put Patient A at great risk.

18. Respondent should have talked to Patient A about this risk and documented that discussion in Patient A's medical records.

19. Patient A's medical records do not reflect that Respondent discussed this with him.

20. The standard of care in a situation like this is to convert the patient's short-acting benzodiazepine (alprazolam) to a long-acting version, such as diazepam or clonazepam, and then taper off the use of the benzodiazepine at a rate of no more than 25% each week.

21. The standard of care would also include obtaining and/or attempting to obtain outside medical records for the patient regarding the patient's use of the other medications listed in the patient's Patient Report from the PMP.

22. Obtaining or attempting to obtain outside medical records for a patient would be documented in the patient's medical records.

23. Patient A's medical records do not show that Respondent obtained or attempted to obtain outside medical records for Patient A.

24. Respondent's notes in Patient A's medical records for September 16, 2021, and October 15, 2021, are identical in the subjective section and mental status examination section,

except for the start/stop times and the note for September 16, 2021, that Patient A was being seen by telemedicine.[5]

25. Upon information and belief, this is evidence that Respondent simply copied verbiage from previous notes in Patient A's medical records instead of recording what Patient A said during that visit in the subjective section and actually completing and/or recording the results of Patient A's mental status examination during that visit.

26. Upon information and belief, Respondent copied and pasted progress notes from visit to visit for Patient A, which led to a failure to maintain clear, legible, accurate, and complete medical records for Patient A.

27. Patient A's medical records for September 16, 2021, and October 15, 2021, include information for vital signs taken from future dates, December 14, 2021, and January 11, 2022.

28. Specifically, for both September 16, 2021, and October 15, 2021, Patient A's medical records state "Blood pressure check – Unable to Obtain" on both December 14, 2021, and January 11, 2022.

29. Upon information and belief, the information in ¶ 27–28 indicates that Patient A's medical records for September 16, 2021, and October 15, 2021, were actually created in the future and then back-dated.

30. It is not appropriate under the standard of care to back-date patient medical records.

31. Back-dated patient records may be deemed as falsified records.

32. Patient A's medical records for August 16, 2018, include information for vital signs (blood pressure check) taken from future dates in 2018 (6 future visits documented), 2019 (13 future visits documented), 2020 (4 future visits documented), 2021 (2 future visits documented), and 2022 (1 future visit documented).

33. Similarly, Patient A's medical records for August 16, 2018, include "Weight Control Review" information, including Patient A's weight in pounds, for future dates in 2018 and 2019.

[5] On September 16, 2021, after "Chief Complaint", Patient A's medical record says "Today, patient evaluated via telemedicine/Telehealth." On October 15, 2021, after "Chief Complaint", Patient As' medical records says "Patient is doing telemed appointment today."

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34. Specifically, there is no "Weight Control Review" information listed for that appointment date, August 16, 2018, but there is information listed for future appointment dates August 30, 2018, September 13, 2018, October 4, 2018, October 31, 2018, November 26, 2018, December 21, 2018, March 14, 2019, May 10, 2019, June 5, 2019, July 3, 2019, and August 28, 2019.

35. Upon information and belief, the information in ¶ 32–34 indicate that Patient A's medical records for August 16, 2018, were actually created in the future and then back-dated.

36. Patient A's medical records for August 30, 2018, includes information for vital signs (blood pressure check) taken from future dates in 2018 (5 future visits documented), 2019 (13 future visits documented), 2020 (4 future visits documented), 2021 (2 future visits documented), and 2022 (1 future visit documented).

37. Similarly, "Weight Control Review" information is included in Patient A's medical records on August 30, 2018, for ten (10) future dates in 2018 and 2019.

38. Upon information and belief, the information in ¶ 36–37 indicate that Patient A's medical records for August 30, 2018, were actually created in the future and then back-dated.

39. Patient A's medical records for September 13, 2018, include information for vital signs (blood pressure check) taken from future dates in 2018 (4 future visits documented), 2019 (13 future visits documented), 2020 (4 future visits documented), 2021 (2 future visits documented), and 2022 (1 future visit documented).

40. Similarly, "Weight Control Review" information is included in Patient A's medical records on September 13, 2018, for nine (9) future dates in 2018 and 2019.

41. Upon information and belief, the information in ¶ 39–40 indicate that Patient A's medical records for September 13, 2018, were actually created in the future and then back-dated.

42. Patient A's medical records for October 31, 2018, include information for vital signs (blood pressure check) taken from future dates in 2018 (2 future visits documented), 2019 (13 future visits documented), 2020 (4 future visits documented), 2021 (2 future visits documented), and 2022 (1 future visit documented).

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43. Similarly, "Weight Control Review" information is included in Patient A's medical records on October 31, 2018, for seven (7) future dates in 2018 and 2019.

44. Upon information and belief, the information in ¶ 42–43 indicate that Patient A's medical records for October 31, 2018, were actually created in the future and then back-dated.

45. Patient A's medical records for November 26, 2018, include information for vital signs (blood pressure check) taken from future dates in 2018 (1 future visit documented), 2019 (13 future visits documented), 2020 (4 future visits documented), 2021 (2 future visits documented), and 2022 (1 future visit documented).

46. Similarly, "Weight Control Review" information is included in Patient A's medical records on November 26, 2018, for six (6) future dates in 2018 and 2019.

47. Upon information and belief, the information in ¶ 45–46 indicate that Patient A's medical records for November 26, 2018, were actually created in the future and then back-dated.

48. Patient A's medical records for December 21, 2018, include information for vital signs (blood pressure check) taken from future dates in 2019 (13 future visits documented), 2020 (4 future visits documented), 2021 (2 future visits documented), and 2022 (1 future visit documented).

49. Similarly, "Weight Control Review" information is included in Patient A's medical records on December 21, 2018, for five (5) future dates in 2019.

50. Upon information and belief, the information in ¶ 48–49 indicate that Patient A's medical records for December 21, 2018, were actually created in the future and then back-dated.

51. It is not appropriate under the standard of care to back-date patient medical records.

52. Back-dated patient records may be deemed as falsified records.

53. Upon information and belief, Respondent's care of Patient A showed a lack of diligence in both documentation, review, and management of Patient A's medications which fell below the standard of care.

54. It is unethical to pre-date or back-date a patient's medical record.

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55. Alternatively, if Patient A's medical records were not backdated by Respondent, they were not saved in a format that could not be altered in the future which would also fall below the standard of care for maintaining proper medical records.

56. Respondent also failed to ensure that Patient A's current medications were correctly documented in Patient A's medical records.

57. For this reason, it is difficult to ascertain what medications Patient A was taking from visit-to-visit and/or what medications were a part of Patient A's current treatment plan.

58. For example, Patient A's medical records dated August 18, 2018, list both alprazolam 2 mg (quantity 60) and 1 mg (quantity 90) as current medications for Patient A.

59. Similarly, Patient A's medical records dated August 16, 2018, list two strengths and quantities of doxepin (25 mg and 75 mg) for Patient A as well as three strengths of lamotrigine (25 mg, 100 mg, and 150 mg) three strengths and quantities of quetiapine (50 mg, 200 mg, and 100 mg), and two strengths of venlafaxine (75 mg and 150 mg).

60. Some of the medications shown in Patient A's current medication list also treat the same conditions, such as Pristiq and venlafaxine, among others, and it is unclear which of these medications Patient A is actually taking and/or whether or not the overlap of medications is intentional.[6]

61. The same concerns noted above in ¶ 56–60 regarding Patient A's medical records dated August 16, 2018, are also evident in all of the other records for Patient A provided to the Board's investigator in connection with this investigation.

62. Specifically, those medical records are dated August 30, 2018, September 13, 2018, October 31, 2018, November 26, 2018, December 21, 2018, September 16, 2021, and October 15, 2021, and show similar confusion and/or lack of clarity regarding Patient A's current medications with regard to both different strengths and quantities as well as possible overlap due to treating the same conditions with more than one medication.

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[6] Multiple medications shown in Patient A's medical records as "current medications" treat both anxiety and depression, among other conditions. It is unclear what medications are truly current medications and what medications are no longer being used by Patient A.

63. For controlled substances, another practitioner could use Patient A's Patient Report from the PMP to determine what controlled substances Patient A is taking by reviewing his refill history.

64. However, for non-scheduled medications, another practitioner would likely need to rely on Patient A's medical records maintained by Respondent which do not clearly and accurately lay out his current medications.

**Investigation No. 22-21354 Regarding Respondent**

63. On April 4, 2022, a Board investigator sent an allegation letter to Respondent along with an IC Order to Produce Healthcare Records, requesting that Respondent reply to the inquiry and provide Patient A's records within thirty (30) calendar days (May 4, 2022).

64. No response was received from Respondent.

65. On April 11, 2022, a Board investigator sent an allegation letter to Respondent along with an IC Order to Produce Healthcare Records, requesting that Respondent reply to the inquiry and provide Patient A's records within thirty (30) calendar days (May 11, 2022).

66. No response was received from Respondent.

67. On May 12, 2022, a Board investigator sent a second request for a response to the allegations and an IC Order to produce Patient A's records to Respondent, requesting that Respondent reply to the inquiry and provide Patient A's records within fifteen (15) calendar days (May 27, 2022).

68. No response was received from Respondent.

69. On May 27, 2022, a Board investigator sent a final request for a response to the allegations and an IC Order to produce Patient A's records to Respondent, requesting that Respondent reply to the inquiry and provide Patient A's records within ten (10) calendar days (June 6, 2022).

70. Respondent did not send a response to the Board investigator until June 24, 2022.

71. Therefore, based on the allegations contained in ¶ 63–70 Respondent did not timely respond to the Board in Investigation No. 22-21354.

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**Respondent's Closure of Grand Desert Psychiatry**

72. Patient B was a patient at Respondent's practice, Grand Desert Psychiatry, located at 2021 S. Jones Blvd., Las Vegas, NV 89146 (Grand Desert) from 2017–2022.

73. On June 14, 2023, Respondent requested to the Board that his license to practice medicine be placed on inactive status due to his inability to comply with the monitoring term contained in the Board's Order dated December 8, 2022, in Legal Case No. 21-22461-1.

74. Upon information and belief, Respondent closed Grand Desert on or about that same time (June 14, 2023).

75. Respondent did not notify the Board in writing within fourteen (14) days after the closure of Grand Desert that he had closed his practice, and he did not provide the location of the medical records for his patients to the Board.

76. In addition, Respondent did not notify the Board that there was a change to his mailing address.

77. As of the date of this Complaint, the only address that Respondent has provided to the Board is the street address for Grand Desert. This address is listed as his public address in his licensing profile.

78. As of the date of this Complaint, Respondent provided the same address to the Board for his mailing address and that address remains in his licensing profile.

**Respondent's Medical Records for Patient B**

79. Patient B was a twenty-nine (29) year-old female at the time of the events at issue.[7]

80. Patient B filed a complaint with the Board in February 2024 due to her inability to obtain her medical records from Respondent.

81. On March 5, 2024, an investigator for the Board sent an allegation letter to Respondent, at his address of record, regarding Patient B's complaint, containing an IC Order to produce Patient B's medical records, requesting a response within thirty (30) days (April 4, 2024).

82. This letter and the IC Order were returned to the Board by the U.S. Post Office as "undeliverable return to sender" because Grand Desert is closed.

[7] Patient B'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.

83. The Board has no other mailing address for Respondent in its records.

84. As of the date of this Complaint, Respondent has not informed the Board regarding the location of all of his patient records, including records for Patient B, and Respondent has failed to provide Patient B's records, as ordered by the IC.

**COUNT I**

**NRS 630.301(4) - Malpractice**

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

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

87. 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."

88. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A when he prescribed benzodiazepines to Patient A while he knew, or should have known, that Patient A was taking opioids at the same time and/or when Respondent failed to recognize, address, and document any discussion with Patient A about his use of opioids and benzodiazepines at the same time. Further, Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he failed to maintain proper medical records for Patient A when he failed to request and/or document his attempt to obtain outside medical records regarding Patient A's use of opioids prescribed by another provider and/or when he failed to document his care and treatment for Patient A in Patient A's medical records, such as ensuring the subjective section and mental status section of Patient A's medical records were accurate and updated for the current visit and/or when he back-dated Patient A's medical records and/or did not save Patient A's medical records in a manner that did not allow them to be edited in the future.

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

**COUNT II**

**NRS 630.3062(1)(a) - Failure to Maintain Complete Medical Records**

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

91. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.

92. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to ensure that Patient A's medical records were clear, legible, accurate, and complete.

93. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by 1) failing to completely and correctly document his medical care and treatment for Patient A with over-reliance on templated material in the medical records for Patient A and/or over-reliance on copy and pasting data from other patient visits; 2) back-dating Patient A's medical records or otherwise allowing information from future visits to be included in Patient A's medical records on a specific date; 3) not documenting his review and/or discussion of Patient A's Patient Report from the PMP in Patient A's medical records; 4) failing to ensure that Patient A's current medication list and treatment plan was updated and accurate at each visit; and/or 5) failing to document any attempt to obtain outside medical records for Patient A related to Patient A's use of opioids prescribed by another provider.

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

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## COUNT III

**NRS 630.306(2)(b)(1) - Engaging in Conduct Which is Intended to Deceive**

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

96. When Respondent stated, regarding Patient A, that he "saw this patient only twice" in a written letter to the Board, but records provided to the Board in connection with this matter's investigation show otherwise, Respondent engaged in deceptive conduct toward the Board and/or the IC.

97. This conduct violates NRS 630.3062(1)(h).

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

## COUNT IV

**NRS 630.254(3) – Failure to Notify the Board Regarding Office Closure and Location of Patient Records**

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

100. Respondent failed to timely inform the Board regarding the closure of Grand Desert as required by NRS 630.254(3)(a).

101. Respondent further failed to keep the Board apprised in writing regarding the location of his patients' medical records after the closure of Grand Desert as required by NRS 630.254(3)(b).

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

## COUNT V

**NRS 630.254(1) – Failure to Notify the Board Regarding Change of Mailing Address**

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

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104. Respondent failed to timely notify the Board of the change in his permanent mailing address within thirty (30) days of the change.

105. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352 and/or NRS 630.254(1).

**COUNT VI**

**NAC 630.230(2) – Failure to Provide Patient Records to Patient Upon Request**

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

107. NRS 629.061(2) requires that medical records maintained within Nevada be available for inspection upon request by the patient or his or her appropriate representative within ten (10) working days after the request.

108. NRS 629.061(2) requires that medical records maintained outside of Nevada be available for inspection upon request by the patient or his or her appropriate representative within twenty (20) working days after the request.

109. To date, Patient B has not received her patient records, and the location of Respondent's patient records remains unknown.

110. Similarly, Respondent also failed to respond to the Board regarding Patient B's records, and it has been more than twenty (20) working days since the Board attempted to contact Respondent regarding Patient B's records.[8]

111. Accordingly, Respondent failed to timely provide patient records to Patient B upon request in violation of NRS 629.061(2), which violates NAC 630.230(2), as amended by LCB File No. R002-23, and which is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

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

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[8] NRS 629.061(1)(g) includes the Board as an authorized requester of patient records and NRS 629.061(2) provides the same time for Respondent to comply with a request for records from the Board as the time allowed for Respondent to respond to requests from patients.

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**COUNT VII**

**NRS 630.3065(2)(c) – Knowing or Willful Failure to Comply with a Provision in NRS Chapter 630**

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

114. Respondent failed to respond to the IC's Order to Produce Patient B's records in Investigation No. 24-23855.

115. Respondent failed to update both his permanent and mailing addresses on file with the Board as required by NRS 630.254.

116. Respondent also failed to inform the Board regarding the location of his patients' records as required by NRS 630.254.

117. Respondent, as a highly educated person and a holder of a privileged license issued by the Board, knew or should have known that he must update his permanent and mailing addresses with the Board.

118. Respondent, as a highly educated person and a holder of a privileged license issued by the Board, knew or should have known that the location of his patients' records is important to his patients, and therefore, to the Board, in order to protect the public.[9]

119. It is not reasonable for Respondent, as a highly education person and a holder of a privileged license issued by the Board, to close his practice without ensuring that his patients have the ability to access their medical records.

120. Accordingly, Respondent's actions with regard to the location of his patients' records, his patients' access to their records, and providing information to the Board regarding the closure of his practice and the location of his patients' records may be deemed knowing and willful.

121. Accordingly, Respondent knowingly and/or willfully failed to comply with NRS 630.254, which is grounds for disciplinary action pursuant to NRS 630.3065(2)(c).

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[9] The Board has statutory authority to take possession of patient medical records if a physician is unable to keep his or her office open due to death, disability, incarceration or any other incapacitation in order to ensure that patients are able to have access to their medical records. NRS 630.139. The Board has a duty to protect the public in all of its actions. *See* NRS 630.003.

122. 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 case as outlined in NRS 622.400;

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

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

DATED this 17th day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
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*Attorney for the Investigative Committee*

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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 17th day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
*Chairman of the Investigative Committee*

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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 17th day of May, 2024, I served a file-stamped copy of the foregoing **COMPLAINT** and **PATIENT DESIGNATION** via USPS Certified Mail, postage pre-paid, to the following parties:

MATTHEW OBIM OKEKE, M.D.
c/o Liborius Agwara, Esq.
Law Offices of Libo Agwara, Ltd.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121

*Tracking No.:* 9171 9690 0935 0241 6277 42

DATED this 17th day of May, 2024.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners