BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **ORLANDO LAMAR WELLS, M.D., Respondent.**	**Case No. 23-28073-1**

FILED
NOV 16 2023
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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Orlandis Lamar Wells, 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. 10558). Respondent was originally licensed by the Board on July 7, 2003.

2. Patients A-I[2] were all patients of Respondent at various times while Respondent held an active license to practice medicine in the State of Nevada.

3. Patient A was a twenty-five (25) year-old female at the time of the events at issue and was a patient of Respondent from on or about October 6, 2015, to on or about October 6, 2016.

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[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Rachakonda D. Prabhu, M.D., Ms. Sandy Peltyn and Victor M. Muro, M.D.

[2] Patient A's through Patient I's true identities are not disclosed herein to protect their privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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4. Patient B was a thirty-eight (38) year-old male at the time of the events at issue and was a patient of Respondent from on or about June 2, 2016, to on or about October 6, 2016.

5. Patient C was a twenty-eight (28) year-old female at the time of the events at issue and was a patient of Respondent from on or about June 2, 2016, to on or about October 20, 2016.

6. Patient D was a thirty (30) year-old male at the time of the events at issue and was a patient of Respondent from on or about May 26, 2016, to on or about September 19, 2016.

7. Patient E was a thirty (30) year-old female at the time of the events at issue and was a patient of Respondent from on or about June 17, 2016, to on or about October 3, 2016.

8. Patient F was a forty (40) year-old male at the time of the events at issue and was a patient of Respondent from on or about June 16, 2016, to on or about October 3, 2016.

9. Patient G was a thirty-five (35) year-old female at the time of the events at issue and was a patient of Respondent from on or about June 2, 2016, to on or about October 6, 2016.

10. Patient H was a twenty-nine (29) year-old male at the time of the events at issue and was a patient of Respondent from on or about March 8, 2016, to on or about May 5, 2016.

11. Patient I was a forty-one (41) year-old female at the time of the events at issue and was a patient of Respondent from on or about May 25, 2016, to on or about October 17, 2016.

12. Eight (8) of the nine (9) patients' records were nearly identical with regards to the physical exam and plan sections (demonstrating a lack of individual care for each of the nine (9) patients); Respondent occasionally prescribed methadone for all patients except Patient I as needed for pain and oxycodone for all patients as needed for pain, which is extremely dangerous and also demonstrates a failure to maintain proper medical records, as medical records when compared to prescriptions show these incongruencies; there is no indication that Respondent utilized urine drug screening to ensure compliance with the patients' pain medications; except for Patient H[3], and Respondent documented that the other eight (8) patients had nearly identical physical exams and diagnoses, resulting from the same straight leg tests and the FABER tests.

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[3] Upon information and belief, Respondent did not have access to Patient H's medical records and therefore he did not provide them.

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COUNTS I – IX (Patients A – I)

NRS 630.301(4) - Malpractice

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

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

15. 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."

16. 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 Patients A-I, when he failed to comply with the *Guidelines for the Chronic Use of Opioid Analgesics*, the vast majority of his documentation was copied and pasted for nearly all patients except Patient H, Respondent failed to give these nine (9) patients individualized care (the plan in his medical records for all patients were identical), and at times he prescribed methadone as needed for pain and oxycodone as needed for pain, which is extremely dangerous due to elevated risk of overdose.

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

COUNTS X – XVII (Patients A – G and I)

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

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

19. 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.

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20. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patients A – G and I, when he copied and pasted the medical records of these patients, resulting in nearly identical records for all nine (9) patients.

21. Respondent occasionally prescribed methadone for all patients except Patient I as needed for pain and oxycodone as needed for pain for all patients, which is extremely dangerous and also demonstrates a failure to maintain proper medical records, as medical records when compared to prescriptions show these incongruencies.

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

COUNTS XVIII – XXVI (Patients A – I)

NRS 630.306(1)(b)(2) - Violation of Standards of Practice

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

24. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

25. The Board adopted by reference the Model Policy in NAC 630.187.

26. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of writing prescriptions for controlled substances to treat acute pain or chronic pain in a manner that deviates from the standards set forth in the Model Policy.

27. As demonstrated by, but not limited to, the above-outlined facts, Respondent wrote prescriptions to Patients A - I for opioid analgesics to treat chronic pain in a manner that deviated from the Model Policy when he did not provide individualized care to each of the nine (9) patients, prescribed methadone and oxycodone to be taken as needed which is extremely dangerous, failed to obtain informed consent from some patients, and inappropriately continued these nine (9) patients on relatively high doses of opioids with little or no justification in the medical records, which were copied and pasted resulting in nearly identical diagnoses and treatment plans.

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

COUNTS XXVII – XXXV (Patients A – I)

NRS 630.306(1)(g) - Continual Failure to Exercise Skill or Diligence

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

30. Continual failure by the Respondent to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(g)

31. Respondent continually failed to exercise skill or diligence when he failed to comply with the *Guidelines for the Chronic Use of Opioid Analgesics*, the vast majority of his documentation was copied and pasted for all patients, Respondent failed to give these nine (9) patients individualized care (the plan in his medical records for all patients were identical), at times he prescribed methadone as needed, which is extremely dangerous due to elevated risk of overdose, failed to obtain informed consent from some patients, and inappropriately continued these nine (9) patients on relatively high doses of opioids with little or no justification in the medical records, which were copied and pasted resulting in nearly identical diagnoses and treatment plans.

32. 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);

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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 16th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Chowdhury H. Ahsan, M.D., Ph.D., FACC, 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 16th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
CHOWDHURY H. AHSAN, M.D., PhD., FACC
Chairman of the Investigative Committee

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