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KS State Board of Healing Arts

**BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS**

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| In the Matter of |) | |
| |) | KSBHA Docket No. 12-HA00016 |
| Jack S. Bell, P.A. |) | |
| Kansas License No. 15-00239 |) | OAH Docket No. 12HA0005 |

CONSENT ORDER FOR SURRENDER

COMES NOW, the Kansas State Board of Healing Arts, ("Board"), by and through Stacy R. Bond, Associate Litigation Counsel ("Petitioner"), and Jack S. Bell, P.A. ("Licensee"), by and through his counsel, Glenn E. Casebeer, II, and move the Board for approval of a Consent Order affecting Licensee's license to practice as a physician assistant in the State of Kansas. The Parties stipulate and agree to the following:

1. Licensee's last known mailing address to the Board is: **Confidential**
Coffeyville, Kansas 67337.
2. Licensee is or has been entitled to engage in the practice as a physician assistant in the State of Kansas, having been issued License No. 15-00239 on approximately March 7, 1986. Licensee's license is currently active, having last been renewed on approximately January 1, 2012.
3. The Board is the sole and exclusive administrative agency in the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice as a physician assistant. K.S.A. 65-28a01 *et seq.* and K.S.A. 65-28a02.
4. This Consent Order and the filing of such document are in accordance with applicable law and the Board has jurisdiction to enter into the Consent Order as

Consent Order for Surrender

In the Matter of Jack S. Bell, P.A.; KSBHA Docket No. 12-HA00016

provided by K.S.A. 77-505 and 65-28a12. Upon approval, these stipulations shall constitute the findings of the Board, and this Consent Order shall constitute the Board's Final Order.

5. The Kansas Physician Assistant Licensure Act is constitutional on its face and as applied in this case. Licensee agrees that, in considering this matter, the Board is not acting beyond its jurisdiction as provided by law.
6. Licensee voluntarily and knowingly waives his right to a hearing. Licensee voluntarily and knowingly waives his right to present a defense by oral testimony and documentary evidence, to submit rebuttal evidence, and to conduct cross-examination of witnesses. Licensee voluntarily and knowingly agrees to waive all possible substantive and procedural motions and defenses that could be raised if an administrative hearing were held.
7. The terms and conditions of the Consent Order are entered into between the undersigned parties and are submitted for the purpose of allowing these terms and conditions to become an Order of the Board. This Consent Order shall not be binding on the Board until an authorized signature is affixed at the end of this document. Licensee specifically acknowledges that counsel for the Board is not authorized to sign this Consent Order on behalf of the Board.
8. The Board has received information and investigated the same, and has reason to believe there are grounds pursuant to K.S.A. 65-28a05, to take action with respect to Licensee's license under the Kansas Physician Assistant Licensure Act, K.S.A. 65-28a01, *et seq.*

9. On July 29, 2011, a Petition was filed against Licensee alleging multiple violations of the Kansas Physician Assistant Licensure Act.
10. This Consent Order is hereby entered into with respect to Counts 1, 4, 8, 10, 11, and 13 of the Petition filed on July 29, 2011. Counts 2, 3, 5, 6, 7, 9, and 12 of such Petition are hereby dismissed with prejudice.
11. The Petition as amended is hereby incorporated by reference as if fully restated herein.
12. Licensee acknowledges that if formal hearing proceedings were conducted and Licensee presented no exhibits, witnesses, or other evidence, the Board has sufficient evidence to prove that Licensee has violated the Kansas Physician Assistant Licensure Act with respect to the above allegations.
13. Pursuant to K.S.A. 65-28a05, the Board may revoke Licensee's license; alternatively, Licensee may surrender his license while under investigation.
14. According to K.S.A. 65-28a12 and K.S.A. 77-505, the Board has authority to enter into this Consent Order without the necessity of proceeding to a formal hearing.
15. All pending investigation materials in KSBHA Investigation number 08-00094, 09-00014, 09-00017, 09-00138, 09-00261, 09-00616, 10-00166, 10-00198, and 10-00365, regarding Licensee, were fully reviewed and considered by the Board members who serve on the Board's Disciplinary Panel. Disciplinary Panel No. 23 authorized and directed Board counsel to seek settlement of this matter with the provisions contained in this Consent Order.

16. Nothing in this Consent Order shall be construed to deny the Board jurisdiction to investigate alleged violations of the Kansas Physician Assistant Licensure Act, or to investigate complaints received under the Risk Management Law, K.S.A. 65-4921 *et seq.*, that are known or unknown and are not covered under this Consent Order, or to initiate formal proceedings based upon known or unknown allegations of violations of the Kansas Physician Assistant Licensure Act.
17. Licensee hereby releases the Board, its individual members (in their official and personal capacity), attorneys, employees and agents, hereinafter collectively referred to as "Releasees", from any and all claims, including but not limited to those alleged damages, actions, liabilities, both administrative and civil, including the Kansas Judicial Review Act, K.S.A. 77-601 *et seq.* arising out of the investigation and acts leading to the execution of this Consent Order. This release shall forever discharge the Releasees of any and all claims or demands of every kind and nature that Licensee has claimed to have had at the time of this release or might have had, either known or unknown, suspected or unsuspected, and Licensee shall not commence to prosecute, cause or permit to be prosecuted, any action or proceeding of any description against the Releasees.
18. Licensee further understands and agrees that upon signature by Licensee, this document shall be deemed a public record and shall be reported to any entities authorized to receive disclosure of this Consent Order.
19. This Consent Order, when signed by both parties, constitutes the entire agreement between the parties and may only be modified or amended by a subsequent document executed in the same manner by the parties.

20. Licensee agrees that all information maintained by the Board pertaining to the nature and result of any complaint and/or investigation may be fully disclosed to and considered by the Board in conjunction with the presentation of any offer of settlement, even if Licensee is not present. Licensee further acknowledges that the Board may conduct further inquiry as it deems necessary before the complete or partial acceptance or rejection of any offer of settlement.
21. Licensee, by signature to this document, waives any objection to the participation of the Board members, including the Disciplinary Panel and General Counsel, in the consideration of this offer of settlement and agrees not to seek the disqualification or recusal of any Board member or General Counsel in any future proceedings on the basis that the Board member or General Counsel has received investigative information from any source which otherwise may not be admissible or admitted as evidence.
22. Licensee acknowledges that he has read this Consent Order and fully understands the contents.
23. Licensee acknowledges that this Consent Order has been entered into freely and voluntarily.
24. Upon execution of this Consent Order by affixing a Board authorized signature below, the provisions of this Consent Order shall become a Final Order under K.S.A. 77-526. This Consent Order shall constitute the Board's Final Order when filed with the office of the Executive Director for the Board and no further Order is required.
25. This Consent Order constitutes disciplinary action.

26. The Board may consider all aspects of this Consent Order in any future matter regarding Licensee.
27. In lieu of conducting a formal proceeding, Licensee, by signature affixed to this Consent Order, hereby voluntarily agrees to the following disciplinary action against his license to engage in the practice as a physician assistant:

SURRENDER

28. Licensee hereby surrenders his license to practice as a physician assistant, effective upon filing of this Consent Order with the Board. Such surrender shall be treated as a revocation for all purposes including reporting.
29. Licensee agrees that if he applies for reinstatement of his license, such application will be considered by the Board in accordance with the provisions of K.S.A. 65-2844. Further, Licensee's application will be governed by *Vakas v. The Kansas Board of Healing Arts*, 248 Kan. 589 (Kan. 1991), and all applicable statutes, law, rules and regulations regarding qualifications for licensure and reinstatement.
30. Licensee shall be required to pay the fee for reinstatement of a revoked license with any application for reinstatement.
31. Licensee agrees that in the event he applies for reinstatement of his license, the allegations contained in the Petition and this Consent Order will be considered as findings of fact and conclusions of law.
32. Licensee shall place his patients' records in the custody of his responsible physician. Licensee shall notify the Board on or before November 30, 2012, of the specific measures taken and the appropriate contact information so that the

Board can respond to questions from patients about the location of their medical records and how they can obtain them.

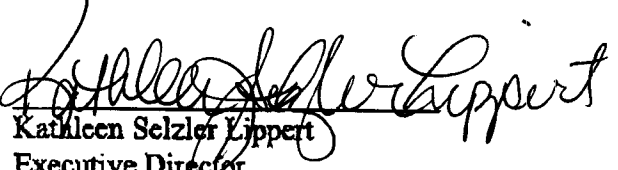
COSTS

33. Licensee is hereby ordered to pay the Board's incurred COSTS in conducting these proceedings under the Kansas Administrative Procedure Act in the amount of \$7767.60. The total amount of \$7767.60 shall be due on or before March 30, 2013.
34. In the alternative, Licensee may make monthly payments to be applied to the balance of the Licensee's aforementioned assessed COSTS. If so chosen, Licensee shall make a payment of \$323.65 for twenty-three (23) months with a twenty-four (24th) and final monthly payment of \$323.65 for a total of \$7767.60 to be paid over twenty-four (24) months. The initial payment is due on or before March 15, 2013, with the remainder of the monthly payments due on or before the fifteenth (15th) day of each month thereafter.
35. Licensee shall make all payments payable to the Kansas State Board of Healing Arts and send all payments to the attention of: Compliance Coordinator, Kansas State Board of Healing Arts, 800 SW Jackson, Lower Level-Suite A, Topeka, Kansas 66612.
36. In the event that the Board does not receive a payment due and owing, the total amount of costs still due shall become immediately due and payable in full upon written notice by the Board to Licensee stating that payment has not been received.

IT IS THEREFORE ORDERED that the Consent Order and agreement of the parties contained herein is adopted by the Board as findings of fact, conclusions of law, and as a Final Order of the Board.

IT IS SO ORDERED on this 19 day of Feb, 2013.

FOR THE KANSAS STATE
BOARD OF HEALING ARTS:

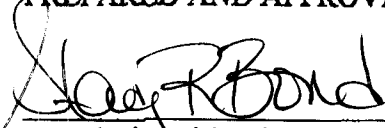

Kathleen Selzler Lippert
Executive Director

2/19/13
Date


Jack S. Bell, P.A.
Licensee

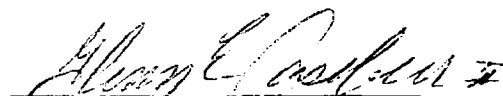
2/11/13
Date

PREPARED AND APPROVED BY:



Stacy R. Bond #17673
Associate Litigation Counsel
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612
785-296-3268

APPROVED AS TO FORM BY:



Glenn E. Casebeer, II
Attorney for Licensee
1505 W. 4th
Coffeyville, Kansas 67337

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the Consent Order for Surrender by United States mail, postage prepaid, on this 19th day of February, 2013, to the following:

Jack S. Bell, P.A.
Confidential
Coffeyville, Kansas 67337

Glenn E. Casebeer, II
Attorney for Licensee
1505 W. 4th
Coffeyville, Kansas 67337

And the original was hand-filed with:

Kathleen Selzler Lippert
Executive Director
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

And a copy was hand-delivered to:

Stacy R. Bond
Associate Litigation Counsel
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

Melissa Massey
Compliance Coordinator
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

Katy Lenahan
Licensing Administrator
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

Cathy A. Brown

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of)

Jack S. Bell, P.A.)

Kansas License No. 15-00239)

Docket No.: 12-HA 00016

PETITION

COMES NOW the Kansas State Board of Healing Arts ("Board"), by and through Associate Litigation Counsel Lori D. Dougherty ("Petitioner"), and initiates these proceedings pursuant to the provisions of K.S.A. 65-28a05, K.S.A. 65-2851a, and K.S.A. 77-501 *et seq.* For its cause of action, Petitioner alleges and states:

1. Jack S. Bell, P.A.'s ("Licensee") last known mailing address to the Board is: 306 Southern Hill, Coffeyville, Kansas 67337.
2. Licensee is or has been entitled to engage in practice as a physician assistant in the State of Kansas, having been issued License No. 15-00239 on approximately March 07, 1986 and having last renewed such license on approximately December 6, 2010.
3. At all times relevant to the allegations set forth in the Petition, Licensee has held a current and active license to engage in practice as a physician assistant in the State of Kansas.
4. Since issuance of license, and while engaged in a regulated profession as a physician assistant in the State of Kansas, pursuant to K.S.A. 65-28a01 *et seq.*, Licensee did commit the following act(s):

COUNT I

5. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
6. From January 2003 through July 2007, Patient 1, a female born on December 9, 1955, was treated by Licensee for hypertension and chronic arthritis problems.
7. Licensee prescribed Hydrocodone 10/500 and Lorazepam to Patient 1 in increasingly larger dosages during this timeframe.
8. Licensee authorized additional quantities and early refills of the prescriptions for Patient 1.
9. Licensee called Patient 1's prescriptions into multiple pharmacies, including Walgreens in Tulsa, Oklahoma; Wal-Mart in Tulsa, Oklahoma, and Coffeyville, Kansas; and Drug Warehouse in Tulsa, Oklahoma, and Broken Arrow, Oklahoma.
10. Patient 1 alleges she repeatedly asked to be tapered off of the medications, but states Licensee's typical response was that Patient 1 "needed to be on these medications and needed to be at the prescribed dosage levels."
11. Patient 1 alleges she was only able to taper off the medications with the help of her pharmacist.
12. On March 17, 2007, Licensee documented he spoke with Patient 1 regarding taking too many narcotics and needing therapy; however, Licensee continued to prescribe greater amounts to Patient 1.
13. Licensee failed to maintain adequate medical record documentation for Patient 1.
14. Licensee failed to conduct adequate physical examinations of Patient 1.

15. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary and/or gross negligence which is believed and alleged and will be disclosed upon proper discovery in the course of these proceedings.
16. Licensee's acts and conduct during the course of treating Patient 1 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
 - a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(i): prescribing, selling, administering, distributing, or giving a controlled substance to any person for other than a medically accepted or lawful purpose;
 - ii. K.A.R. 100-28a-8(j): prescribing, selling, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper, or inappropriate manner or quantity, or not in the course of licensee's professional practice; and
 - iii. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.
 - b. K.S.A. 65-28a05, as further defined in K.A.R. 100-28a-7(a) in that Licensee failed to adhere to the applicable standards of care to a degree which constitutes gross negligence by inappropriately prescribing addictive narcotic medication and failing to maintain proper medical records.
 - c. K.S.A. 65-28a05, as further defined in K.A.R. 100-28a-7(b) in that Licensee failed to adhere to the applicable standards of care to a degree which

constitutes ordinary negligence by inappropriately prescribing addictive narcotic medication and failing to maintain proper medical records.

17. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, or limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT II

18. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
19. From October 2002 through April 2008, Patient 2, a female born February 20, 1980, was seen by Licensee for stress, anxiety, depression, and bipolar disorder.
20. Licensee diagnosed Patient 2 with fatigue, bipolar, gastritis, nausea and vomiting, panic attacks, back pain, tooth pain, depression, and allergies.
21. Licensee prescribed to Patient 2 Hydrocodone, Prilosec, Xanax, Gabatril, Abilify, Lortab, Celexa, Loratidine, and Bentyl.
22. Licensee failed to document reasons for prescribing Patient 2 Hydrocodone 10mg.
23. Licensee failed to document reasons for prescribing Patient 2 Glipizido ER 2.5mg, when Patient 2's chart never indicated any abnormal blood sugars.
24. Licensee states he refilled medications authorized by Four County Medical Health because Patient 2 was unable to be seen on a timely schedule when she failed to keep her appointments there.
25. Licensee's medical records do not appropriately state an overall evaluation, including the basis for his continued prescribing of medications originally authorized by other health care providers.

26. On April 23, 2008, Patient 2 arrived at the Coffeyville Regional Medical Center (CRMC) Emergency Department unresponsive. Patient 2's neighbor found her with multiple pills in a cereal bowl, eating the pills with a spoon. The pills identified in the bowl include: Gabatril, Abilify, Celexa, Xanax, and Hydrocodone.
27. Licensee failed to ensure that Patient 2 received psychiatric care after prescribing Patient 2 psychotropic medication for an extended period of time.
28. Licensee's acts and conduct during the course of treating Patient 2 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
 - a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(i): prescribing, selling, administering, distributing, or giving a controlled substance to any person for other than a medically accepted or lawful purpose;
 - ii. K.A.R. 100-28a-8(j): prescribing, selling, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper, or inappropriate manner or quantity, or not in the course of licensee's professional practice; and
 - iii. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.
29. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT III

30. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
31. From March 2004 through December 2007, Patient 3, a female born on October 30, 1958, was treated by Licensee for migraines, back pain, and anxiety.
32. Licensee failed to perform or document a complete physical examination for Patient 3.
33. On November 29, 2007, Patient 3 was brought in to Coffeyville Regional Medical Center ("CRMC") Emergency Department by her husband because she was cyanotic and unresponsive. Her Glasgow coma scale was three (3), and her respirations were diminished so she was given one hundred (100) percent nonrebreather.
34. Patient 3's triage drug screen was positive for opiates and benzodiazepines when she arrived at CRMC.
35. Licensee prescribed to Patient 3 Soma, Hydrocodone, Medrol, Allegra, Naproxen, and Ativan without documenting reasons for the prescriptions in Patient 3's patient record.
36. On June 15, 2006, Licensee increased the dosage of Lortab to 10mg without documenting his reason for the increase. Licensee notes to "watch" pain medications.
37. On October 30, 2007, Licensee prescribed Lortab 7.5mg #30, along with Tramadol 50mg #10. Licensee did not document any changes in Patient 3's physical examination to justify prescribing two pain medications.

38. Licensee inappropriately prescribed medications to Patient 3.
39. Licensee failed to maintain adequate documentation for Patient 3.
40. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence which is believed and alleged and will be disclosed upon proper discovery in the course of these proceedings.
41. Licensee's acts and conduct during the course of treating Patient 3 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
 - a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(i): prescribing, selling, administering, distributing, or giving a controlled substance to any person for other than a medically accepted or lawful purpose;
 - ii. K.A.R. 100-28a-8(j): prescribing, selling, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper, or inappropriate manner or quantity, or not in the course of licensee's professional practice; and
 - iii. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.
 - b. K.S.A. 65-28a05, as further defined in K.A.R. 100-28a-7(b) in that Licensee failed to adhere to the applicable standards of care to a degree which constitutes ordinary negligence by inappropriately prescribing addictive narcotic medication and failing to maintain proper medical records.

42. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT IV

43. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
44. From September 2004 through September 2008, Patient 4, a male born on March 2, 1959, was treated by Licensee for back pain.
45. Licensee prescribed Patient 4 large quantities of multiple narcotics and multiple sleeping pills without documenting pain levels or reasons for choosing this method of pain management.
46. Licensee documentation only includes a vague patient history and physical examination. The physical examination does not support the prescriptions written by the Licensee.
47. On November 14, 2007, Licensee prescribed Patient 4 Fentanyl 50mcg #10, despite prescribing Lortab 10mg #90 on November 13, 2007, and again November 26, 2007. Licensee had noted in Patient 4's chart to decrease Lortab, but did not do so.
48. On July 10, 2008, Licensee prescribed Patient 4 Methadone 5mg #60, Alprazolam 1mg #90, Lortab 10mg #90, and Temazepam 30mg #30, without documenting in the chart why this amount of medication was prescribed in one visit.

49. On August 9, 2008, Patient 4 arrived at CRMC Emergency Department via ambulance due to a change in level of consciousness over a period of time. Patient 4 arrived unresponsive.
50. Patient 4 had a total of thirty-one (31) medications listed in the medication history.
51. Patient 4's chart documents overdose with multiple medications including per patient's statement. Over a six (6) hour period, Patient 4 ingested three (3) tablets of 60mg Avinza and unknown quantities of Lortab, Alprazolam, and Temazepam.
52. Licensee inappropriately prescribed multiple pain medications.
53. Licensee failed to maintain adequate documentation for Patient 4.
54. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence which is believed and alleged and will be disclosed upon proper discovery in the course of these proceedings.
55. Licensee's acts and conduct during the course of treating Patient 4 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
 - a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(i): prescribing, selling, administering, distributing, or giving a controlled substance to any person for other than a medically accepted or lawful purpose;
 - ii. K.A.R. 100-28a-8(j): prescribing, selling, administering, distributing a prescription drug or substance, including a controlled substance, in an

excessive, improper, or inappropriate manner or quantity, or not in the course of licensee's professional practice; and

iii. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.

b. K.S.A. 65-28a05, as further defined in K.A.R. 100-28a-7(b) in that Licensee failed to adhere to the applicable standards of care to a degree which constitutes ordinary negligence.

56. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine, or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT V

57. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.

58. On April 8, 2008, Licensee wrote a letter to Adult Protective Services regarding Patient 5, a male born on October 15, 1954.

59. Licensee's letter claimed Patient 5 could no longer be adequately cared for at home by his wife, even though there was documentation from Hospice, Coffeyville Regional Medical Center, and home health services that Patient 5 was receiving good care at home.

60. Licensee's acts and conduct during the course of treating Patient 5 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:

a. K.S.A. 65-28a05(a), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:

- i. K.A.R. 100-28a-8(v): using false, fraudulent, or deceptive statement in any document connected with the practice of the healing arts, including the intentional falsifying or fraudulent altering of a patient or medical care facility record.
- 61. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT VI

- 62. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
- 63. From March 2005 to November 2005, Patient 6, a female born on January 1, 1962, was treated by Licensee for diabetes, hypertension, bipolar disorder, and anxiety.
- 64. Patient 6 died on November 30, 2005, from asphyxiation.
- 65. Licensee failed to maintain adequate documentation as to why Patient 6 was prescribed Lortab, Alprazolam, and Fioricet.
- 66. Lortab and Alprazolam have individual depressive effects on the central nervous system that, in aggregate, potentiates negative effects on the coordination of the muscles involved in swallowing.
- 67. Licensee's acts and conduct during the course of treating Patient 6 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
 - a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:

- i. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.
68. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT VII

69. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
70. From February 2005 to February 2009, Patient 7, a female born on March 18, 1964, was treated by Licensee.
71. Licensee failed to complete or adequately document Patient 7's physical examination.
72. Licensee did not see Patient 7 from October 5, 2005, until August 2, 2006, but continued to prescribe Lortab and Alprazolam.
73. On February 22, 2009, Patient 7 was admitted into the Coffeyville Regional Medical Center ("CRMC") Emergency Department with poly-drug overdose and respiratory distress. Patient 7 arrived with an allergic reaction and angioedema.
74. Patient 7 was prescribed both Xanax and Lortab by Licensee. The Alprazolam was filled on February 16, 2009, with one hundred (100) pills and only six (6) were remaining when she was admitted to CRMC emergency department. Lortab 10/325 was prescribed February 4, 2009, with one hundred (100) pills and only six (6) tablets remained when she was admitted to CRMC emergency department.

75. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence which is believed and alleged and will be disclosed upon proper discovery in the course of these proceedings.
76. Licensee's acts and conduct during the course of treating Patient 7 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
- a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(i): prescribing, selling, administering, distributing, or giving a controlled substance to any person for other than a medically accepted or lawful purpose;
 - ii. K.A.R. 100-28a-8(j): prescribing, selling, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper, or inappropriate manner or quantity, or not in the course of licensee's professional practice; and
 - iii. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.
 - b. K.S.A. 65-28a05, as further defined in K.A.R. 100-28a-7(b) in that Licensee failed to adhere to the applicable standards of care to a degree which constitutes ordinary negligence.
77. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT VIII

78. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
79. From April 2005 to October 2009, Patient 8, a male born on November 2, 1950, was treated by Licensee for obesity.
80. Licensee failed to maintain an adequate record for Patient 8, including not documenting his height. A February 24, 2009, hospital admission note documented his height as six (6) feet.
81. Patient 8 was not obese, but Licensee prescribed Phentermine from April 29, 2005 to October 02, 2009. Phentermine is not indicated for long term use.
82. Licensee refilled Phentermine for Patient 8 without seeing Patient 8 in the office in order to obtain height and weight. Licensee did not weigh Patient 8 on a monthly basis.
83. Patient 8 had a documented history of alcohol abuse. Phentermine is contraindicated for alcoholics.
84. Licensee regularly prescribed narcotic medications to Patient 8 without adequate documentation.
85. In 2007, Licensee began refilling prescriptions more frequently without adequate documentation.
86. On February 20, 2009, Patient 8 was seen in the Coffeyville Regional Medical Center ("CRMC") emergency department for an unintentional drug overdose. The patient was taking three (3) to four (4) Lortab every two (2) to three (3) hours for pain. Patient 8 states that he was told by Licensee to take the medication "as

needed.” Patient 8 filled a prescription for sixty (60) pills on February 17, 2009, and had only two (2) tablets remaining when he arrived at the emergency department.

87. On February 22, 2009, Patient 8 was seen in the CRMC emergency department again with the same diagnosis.
88. On February 25, 2009, Patient 8 came to the CRMC emergency department, for a third time, requesting pain medications.
89. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence which is believed and alleged and will be disclosed upon proper discovery in the course of these proceedings.
90. Licensee’s acts and conduct during the course of treating Patient 8 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
 - a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(i): prescribing, selling, administering, distributing, or giving a controlled substance to any person for other than a medically accepted or lawful purpose;
 - ii. K.A.R. 100-28a-8(j): prescribing, selling, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper, or inappropriate manner or quantity, or not in the course of licensee’s professional practice; and
 - iii. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.

- b. K.S.A. 65-28a05, as further defined in K.A.R. 100-28a-7(b) in that Licensee failed to adhere to the applicable standards of care to a degree which constitutes ordinary negligence.
91. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT IX

92. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
93. From April 2003 to September 2009, Patient 9, a female born on July 28, 1977, was treated by Licensee for chronic pain.
94. Licensee failed to maintain adequate documentation for Patient 9, including failing to document what medications he prescribed to Patient 9 and the reasons for the prescriptions.
95. Licensee did not document why he prescribed narcotics for Patient 9's chronic pain. Patient 9's prescriptions stayed the same throughout the time Patient 9 was under the Licensee's care.
96. Licensee documented Patient 9 had a history of drug abuse.
97. Patient 9 did not receive proper medical management of chronic pain. Patient 9 was on multiple medications and had a complicated medical history.
98. On August 1, 2009, Patient 9 was admitted to the ER for a poly-drug overdose. Patient 9 was being prescribed Alprazolam, Hydrocodone, Amitriptyline, Gabapentin, Dilantin, Cymbalta, Lyrica, and Fentanyl patches by Licensee.

99. The emergency department physician documented a list of the medications Patient 9 reported she was taking:
- a. Duragesic seventy five (75) micrograms every three (3) days
 - b. Kelantan one hundred (100) milligrams three (3) in the morning and two (2) at night
 - c. Depakote two hundred fifty (250) milligrams in the morning and five hundred (500) milligrams in the evening
 - d. Lyrica one hundred fifty (150) milligrams two (2) times a day
 - e. Alprazolam one (1) milligram three (3) times a day, but sometimes she takes more
 - f. Lortab 10/500 milligrams one (1) pill, four (4) or five (5) times a day
 - g. Amitriptyline twenty five (25) milligrams three (3) or four (4) times a day
 - h. Elavil twenty five (25) milligrams three (3) or four (4) times a day
 - i. Prozac forty (40) milligrams daily
 - j. Cymbalta sixty (60) milligrams daily
 - k. Temazepam thirty (30) milligrams at night
100. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence which is believed and alleged and will be disclosed upon proper discovery in the course of these proceedings.
101. Licensee's acts and conduct during the course of treating Patient 9 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
- a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(i): prescribing, selling, administering, distributing, or giving a controlled substance to any person for other than a medically accepted or lawful purpose;
 - ii. K.A.R. 100-28a-8(j): prescribing, selling, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper, or inappropriate manner or quantity, or not in the course of licensee's professional practice; and

- iii. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.
 - b. K.S.A. 65-28a05, as further defined in K.A.R. 100-28a-7(b) in that Licensee failed to adhere to the applicable standards of care to a degree which constitutes ordinary negligence.
102. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine, or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT X

103. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
104. From July 2002 to December 2009, Patient 10 a female, born on October 12, 1982, was treated by Licensee.
105. Licensee did not see Patient 10 for seven (7) months, yet continued to prescribe medications for Patient 10.
106. Licensee failed to maintain adequate patient record and did not document reasons for prescribing Patient 10 Lortab, Methadone, Tramadol, and Valium.
107. Patient 10 has been admitted to Coffeyville Regional Medical Center ("CRMC") on January 18, 2009, March 21, 2009, and July 13, 2009, for complications of overdose.
108. On March 20, 2008, Licensee received a letter from John D. Hastings, M.D., advising that Patient 10 should avoid narcotics or other habit forming medications

as much as possible. Dr. Hastings recommended non-narcotic medications such as Gabapentin, Lyrica, and amitriptyline for her nerve pain.

109. On April 8, 2009, Licensee increased Patient 10's dosage of Methadone without documenting in her patient record the reason for the increase.
110. On April 11, 2009, Licensee increased Patient 10's Lortab, but did not document the reason for the increase.
111. The Coffeyville Regional Medical Center emergency department admission note documents medications Patient 10 was taking at the time of admission:
 - a. Tandem plus one (1) tablet daily
 - b. Potassium Chloride ten (10) milliequivalent daily
 - c. Lisinopril forty (40) milligrams two (2) times a day
 - d. Hydrochlorothiazide twenty five (25) milligrams daily
 - e. Gabapentin two hundred (200) milligrams three (3) times a day plus two (2) one hundred (100) milligram tablets two (2) times a day
 - f. Ketoprofen seventy five (75) milligrams daily
 - g. Tramadol fifty (50) milligrams three (3) times a day
 - h. Fexofenadine one hundred eighty (180) milligrams daily
 - i. Folic acid one (1) milligram daily
 - j. Methadone ten (10) milligrams half (1/2) tablet three (3) times a day and then ten (10) milligrams two (2) times a day as needed
 - k. Hydrocodone ten (10) milligrams every six (6) hours
 - l. Prednisone twenty (20) milligrams daily
 - m. Diazepam ten (10) milligrams two (2) times a day
 - n. Carisoprodol three hundred fifty (350) milligrams daily
 - o. Pravastatin forty (40) milligrams daily
 - p. Singulair ten (10) milligrams daily
 - q. Tylenol five hundred (500) milligrams plus diphenhydramine twenty five (25) milligrams
 - r. Advair Diskus
112. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence which is believed and alleged and will be disclosed upon proper discovery in the course of these proceedings.

113. Licensee's acts and conduct during the course of treating Patient 10 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
- a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(i): prescribing, selling, administering, distributing, or giving a controlled substance to any person for other than a medically accepted or lawful purpose;
 - ii. K.A.R. 100-28a-8(j): prescribing, selling, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper, or inappropriate manner or quantity, or not in the course of licensee's professional practice; and
 - iii. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.
 - b. K.S.A. 65-28a05, as further defined in K.A.R. 100-28a-7(b) in that Licensee failed to adhere to the applicable standards of care to a degree which constitutes ordinary negligence.
114. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine, or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT XI

115. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.

116. From March 2005 to August 2009, Patient 11, a male born on June 11, 1958, was treated by Licensee.
117. Licensee failed to document in the patient chart the reason he chose to prescribe narcotic medications to Patient 11.
118. On May 26, 2009, Patient 11 reported to the Licensee that his pain medication had been stolen but no police report was ever filed. Licensee refilled Patient 11's medications.
119. On June 23, 2009, Licensee saw Patient 11 and noted in his chart, "Will try to watch pain meds."
120. On June 24, 2009, Patient 11 presented to Coffeyville Regional Medical Center ("CRMC") emergency department with overdose of narcotic medications. Patient 11 stated that he took fourteen (14) Xanax in two (2) days. While at the emergency department, Patient 11 attempted to ingest thirty three (33) blue oval pills that he was keeping in his pocket. Patient 11 was placed in protective custody.
121. Licensee continued to prescribe the same medications to Patient 11 even after he presented to CRMC on June 24, 2009.
122. Licensee was aware that Patient 11 had a history of abusing ethyl alcohol, but continued to prescribed narcotics without documentation or justification.
123. Licensee routinely prescribed medications to Patient 11 without documenting the need for the medications in the patient record.

124. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence which is believed and alleged and will be disclosed upon proper discovery in the course of these proceedings.
125. Licensee's acts and conduct during the course of treating Patient 11 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
- a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(i): prescribing, selling, administering, distributing, or giving a controlled substance to any person for other than a medically accepted or lawful purpose;
 - ii. K.A.R. 100-28a-8(j): prescribing, selling, administering, distributing a prescription drug or substance, including a controlled substance, in an excessive, improper, or inappropriate manner or quantity, or not in the course of licensee's professional practice; and
 - iii. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.
 - b. K.S.A. 65-28a05, as further defined in K.A.R. 100-28a-7(b) in that Licensee failed to adhere to the applicable standards of care to a degree which constitutes ordinary negligence.
126. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

COUNT XII

127. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
128. From February 2005 to August 2009, Patient 12, a male born on July 5, 1967, was treated by Licensee.
129. Licensee failed to document reasons why he prescribed Patient 12 morphine.
130. On September 1, 2009, Patient 12 was seen at Coffeyville Regional Medical Center (“CRMC”) emergency department for an overdose.
131. Patient 12 continued to receive narcotic pain medication from Licensee after September 1, 2009.
132. On September 09, 2009, Patient 12 returned to the ER with acute renal failure. His condition required him to be transferred to a tertiary care center.
133. Licensee’s acts and conduct during the course of treating Patient 12 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
 - a. K.S.A. 65-28a05(a), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.
134. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee’s license for violation of the Kansas Physician Assistant Licensure Act.

COUNT XIII

135. Petitioner incorporates by reference the above-preceding paragraphs as if fully restated and realleged herein.
136. From approximately 1990, Patient 13, a male born on March 15, 1953, was a patient of Licensee's. Licensee treated Patient 13 for obesity, stomach problems, and depression.
137. Licensee inappropriately prescribed medication to Patient 13. Licensee prescribed to Patient 13 on November 02, 2009:
- a. Fexofenadine one hundred eighty (180) MG Tab
 - b. Flomax 0.4 MB Capsule
 - c. Etodolac ER six hundred (600) MG Tab
 - d. Potassium CL ten (10) MEQ Tab
 - e. Singulair ten (10) MG Tab
 - f. Avodart 0.5 MG Cap
 - g. Penicillin VK five hundred (500) MG Cap
 - h. Ciprofloxacin five hundred (500) MG
 - i. Aciphex twenty (20) MG Tab
 - j. Metoclopramide ten (10) MG Tab
 - k. Hydrocodone/APAP 10-500 Tab
 - l. Alprazolam one (1) MG Tab
 - m. Gabapentin three hundred (300) MG Cap
 - n. Morphine Sul thirty (30) MG Tab
138. Licensee did not document the reason for Patient 13 to be prescribed antibiotics on November 2, 2009.
139. On November 18, 2009, Patient 13 presented to the Coffeyville Regional Medical Center ("CRMC") emergency department with a complaint of epigastric pain. An emergency department nurse noticed Patient 13 had numerous antibiotics prescribed to him by Licensee on the same day, November 2, 2009. Patient 13 reported that he was "stockpiling these medications so that he did not have to pay for his medications at the beginning of the year."

140. Licensee did not document in Patient 13's chart reoccurring infections that would require "stockpiling" of antibiotics.
141. CRMC providers diagnosed Patient 13 with nonsteroidal anti-inflammatory medication-induced gastritis based on Patient 13's history.
142. On March 2, 2010, Licensee stated, "[Patient 13] keeps two antibiotics around for his leg, his back, and any type of upper respiratory infections he may have. He does not take these antibiotics at the same time and only when needed, which is rarely." Licensee mentions "recurring pneumonias" but this is not in the chart as a diagnosis for Patient 13.
143. Licensee maintained inadequate documentation for Patient 13. Licensee's notes in Patient 13's medical chart are not entirely legible.
144. Licensee failed to adhere to the applicable standard of care to a degree constituting ordinary negligence which is believed and alleged and will be disclosed upon proper discovery in the course of these proceedings.
145. Licensee's acts and conduct during the course of treating Patient 13 constitutes acts in violation of the Kansas Physician Assistant Licensure Act as follows:
 - a. K.S.A. 65-28a05(c), in that Licensee committed an act of unprofessional conduct as defined by the rules and regulations adopted by the board, to wit:
 - i. K.A.R. 100-28a-8(i): prescribing, selling, administering, distributing, or giving a controlled substance to any person for other than a medically accepted or lawful purpose;
 - ii. K.A.R. 100-28a-8(j): prescribing, selling, administering, distributing a prescription drug or substance, including a controlled substance, in an

excessive, improper, or inappropriate manner or quantity, or not in the course of licensee's professional practice; and

iii. K.A.R. 100-28a-8(u): failing to keep written medical records that accurately describe the services rendered to the patient.

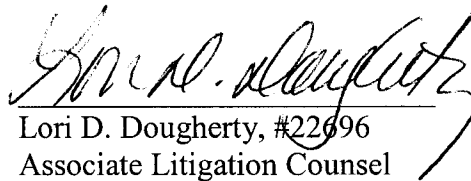
b. K.S.A. 65-28a05, as further defined in K.A.R. 100-28a-7(b) in that Licensee failed to adhere to the applicable standards of care to a degree which constitutes ordinary negligence.

146. Pursuant to K.S.A. 65-28a05, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Physician Assistant Licensure Act.

WHEREFORE, Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Kansas Physician Assistant Licensure Act, that Licensee's license to practice as a physician assistant in the State of Kansas be revoked, suspended, censured, fined, or otherwise limited, and that the Board assess such administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

WHEREFORE, Petitioner further requests this matter be set for a conference hearing pursuant to K.S.A. 77-533. It would be appropriate to set this matter for hearing at the next regularly scheduled Board meeting scheduled for October 21, 2011.

Respectfully submitted,


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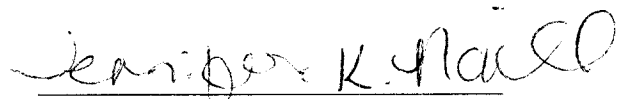
CERTIFICATION OF SERVICE

I, Jennifer Naill, hereby certify that I served a true and correct copy of the Petition by United States mail, postage prepaid, on this 29th day of July 2011, to the following:

Jack S. Bell, P.A.
Licensee
Confidential
Coffeyville, Kansas 67337

And the original was hand-delivered for filing with:

Kathleen Selzler Lippert
Executive Director
Kansas Board of Healing Arts
800 SW Jackson Street
Lower Level Suite A
Topeka, Kansas 66612


Jennifer Naill