BEFORE THE BOARD OF CHIROPRACTIC EXAMINERS
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., OKLAHOMA BOARD OF CHIROPRACTIC EXAMINERS	)	
	)	**Complaint No. 010-2019**
	)	**(failure to provide medical records)**
IN THE MATTER OF THE COMPLAINT AGAINST:	)	
	)	**Complaint No. 016-2019**
	)	**(no response to complaint 010-2019)**
LENNON KIRKENDALL, D.C. LICENSE NO. 3872	)	**Complaint No. 020-2019**
	)	**(no cooperation in 010-2019)**
	)	**Complaint No. 001-2020**
	)	**(no subpoena response in 010-2019)**
	)	**Complaint No. 017-2019**
Respondent.	)	**(failure to provide medical records)**

FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER

This matter came on for hearing before the Oklahoma Board of Chiropractic Examiners (the "Board") on **August 27, 2020**, regarding the STATEMENT OF COMPLAINT and Request for Suspension of Respondent's License filed against Respondent LENNON KIRKENDALL, D.C., in Complaints Numbered 010-2019, 016-2019, 020-2019, 001-2020 and 017-2019. Respondent LENNON KIRKENDALL, D.C., appeared in person and was represented by attorney Walter D. Haskins. The prosecution appeared by and through Assistant Attorney General Martha R. Kulmacz. The Board advisor was Chief Assistant Attorney General John Settle. A quorum of Board members heard the case. After hearing the testimony of witnesses SHERIDAN MILLER, BRIAN

CARTER, BETH KIDD and LENNON KIRKENDALL, taking official and/or judicial notice of the Board's administrative record as reflected in the administrative record documents identified on the attached Prosecution Exhibit List, and reviewing the Exhibits listed on the **attached Prosecution Exhibit List** that had been admitted into evidence, and Respondent's Exhibits, if any, that had been introduced into evidence, hearing the argument of counsel, and entering into and exiting from Executive Session, if any, the Board makes the following findings, conclusions and orders:

FINDINGS OF FACT
which the Board finds have been established by clear and convincing evidence

1. Respondent LENNON KIRKENDALL, D.C., ("Dr. Kirkendall" or "Respondent"), is a licensed chiropractic physician with License Number 3872, and was at all times relevant engaged in practice at a clinic at 131 Blue Starr Drive, Claremore, OK 74104.

2. The Board exercises jurisdiction over the Respondent pursuant to 59 O.S. Section 161.1 et seq.

3. At all relevant times Sheridan Miller was a resident of Rogers County, Oklahoma. On or about August 13, 2017, Ms. Miller as a passenger in a motor vehicle collision suffered physical injuries. From August 14, 2017 to May 14, 2018, Respondent on approximately forty-nine (49) occasions provided Ms. Miller with chiropractic treatment for those injuries and billed Ms. Miller in the amount of $2,536.00 for those treatments.

4. Regarding her injury claim, Ms. Miller was represented by attorneys BRIAN D. CARTER ("Complainant") and James M. Wirth and the Wirth Law Office, located in Tulsa, Oklahoma. On October 12, 2018, Ms. Miller executed Authorizations to

Release Medical Records authorizing the Respondent to release both her medical records and medical bills to the Wirth Law Office where Complainant CARTER is employed.

5. On or about July 1, 2019, Complainant CARTER on behalf of the Wirth Law Office sent to Respondent's chiropractic office a fax cover sheet to which was attached CARTER's letter dated July 1, 2019, designated as "FORTH REQUEST", together with the Authorization for Release of Records, requesting **"all medical history and physicals, doctor's and/or nurse's notes, admission summaries, consultation reports, x-ray reports (including CT scan, MRI's, etc.), discharge summaries, and medical bills"**. The letter requested to be advised if prepayment of the copying cost was required.

6. In response to the July 1, 2019 records request, on or about July 30, 2019, Respondent faxed to the Wirth Law Office only seven (7) pages of documents. The documents included Respondent's fax cover sheet and letter dated July 26, 2019, the Wirth fax cover sheet and letter dated July 1, 2019, and the Respondent's 2-page invoice for treatment services rendered in the amount of $2,536.00 which document was titled "Patient Receipt".

7. The Respondent's July 26, 2019 letter acknowledged receipt of the records request for Sheridan Miller's records and informed the Wirth Law Office that it was not the Respondent's policy to reduce the fees for treatment rendered. No other documents, such as Respondent's treatment notes, were produced. No other documents and records requested by the Wirth Law Office on July 1, 2019 have ever been produced by the Respondent to the Complainant.

8. On or about August 16, 2019, the Respondent produced a few other documents and records to Sheridan Miller and her father, but those documents and records

did not include any of the Respondent's treatment notes for any of the 49 treatments other than the initial treatment on August 14, 2017. [The Wirth Law Office Second Request was made on January 28, 2019, and a further request was also made on November 15, 2019, to which requests Respondent did not produce any treatment notes or other records, per Exhibit 42, including pages A.061 and A.067–A.069.]

9. On or about August 26, 2019, Complainant filed investigative Complaint No. 010-2019 with the Oklahoma Board of Chiropractic Examiners regarding the failure of Respondent to comply with the request for documents and records.

10. On or about September 11, 2019, Board staff by letter dated September 10, 2019, sent by certified mail a letter of notification to Respondent regarding investigative Complaint No. 010-2019, notifying Respondent of the complaint, of Respondent's duty under OAC 140: 3-3-2(g) to submit a written response to the complaint within thirty (30) days of its mailing, and Respondent's duty under OAC 140:15-7-5(3)(D) to cooperate with the Board's investigation. Respondent received the certified mail notification on September 16, 2019.

11. As part of the investigation of Complaint No. 010-2019, on or about September 17, 2019, the Board's investigator traveled to Respondent's clinic in Claremore, Oklahoma, and met in person with the Respondent and requested the Sheridan Miller medical records and documents which had been requested but not received by the Complainant.

12. During the Respondent's meeting with the Board's investigator on September 17, 2019, Respondent stated words to the effect that she was not able at that moment to produce the Sheridan Miller medical documents and records and that she would

fax them to the investigator. No such fax, or mail, or email was ever received by the Board, and Respondent has produced no fax cover sheet or other documentation that substantiates that the requested medical records were sent, by any method. The failure to provide the requested records to the investigator is a failure to cooperate in the investigation of investigative Complaint No. 010-2019.

13. On or about October 31, 2019, the Board's Executive Director in investigative Complaint No. 010-2019 issued a Subpoena for Production of Documents directed to the Respondent requesting "[a]ll documents, records, billing statements, and notes of any nature" regarding "patient Sheridan Miller from August 13, 2017 through and including the present." This Subpoena was served on Respondent by certified mail on November 6, 2019, and it directed the Respondent to within 20 days provide copies of the requested documents to the Board's investigator. Respondent did not produce to the Board any documents or records in response to the Subpoena for Production of Documents issued October 31, 2019.

Complaint # 010-2019
(failure to comply with Wirth/Carter records request)

14. The facts alleged in paragraphs 1 through 13 above are adopted herein.

15. Regarding the Wirth Law Firm request dated July 1, 2010, designated as "Forth Request", the Second Request dated January 28, 2019, and the subsequent request dated November 15, 2019, the prosecution has established by clear and convincing evidence that on three (3) occasions the Respondent failed to within 21 calendar days of the receipt of Sheridan Miller's authorization, or ever, provide to Complainant copies of all of the records and treatment notes Sheridan Miller had authorized to be produced. OAC 140:15-7-5(3)

16. On July 29, 2020 and August 13, 2020 Respondent produced to the Board

records reflecting that Respondent had treated Sheridan Miller on at least 45 different dates, but produced treatment notes for only three (3) of those days. There is clear and convincing evidence that Respondent failed on forty-two (42) occasions to maintain patient records for Sheridan Miller, a patient under Respondent's care, and failed to maintain the highest standards of professional and personal conduct. OAC 140:15-7-5(3)(B); OAC 140:15-7-5(5)

Complaint No. 016-2019
(failure to respond to Complaint No. 010-2019)

17. The facts alleged in paragraphs 1 through 16 above are adopted herein.

18. On or about October 30, 2019, Board staff filed investigative Complaint No. 016-2019 against the Respondent regarding Respondent's failure to file a response to investigative Complaint No. 010-2019. The letter of notification dated October 31, 2019 sent to Respondent together with investigative Complaint No. 016-2019 again notified Respondent that OAC 140:3-3-2(g) required that Respondent provide the Board with a written response to investigative Complaint No. 016-2019 within 30 days of the date of mailing.

19. Investigative Complaint No. 016-2019 and the notification letter dated October 31, 2019 were received by Respondent by certified mail on November 4, 2019. No response to investigative Complaint No. 016-2019 has ever been received from the Respondent.

20. The prosecution has established by clear and convincing evidence that Respondent failed to within 30 days of the day that investigative Complaint No. 010-2019 was mailed to her, or from the date received by her, to file a response to the investigative complaint. OAC 140:3-3-2(g).

Complaint No. 020-2019
(failure to cooperate in investigation of Complaint No. 010-2019)

21. The facts alleged in paragraphs 1 through 12 above are adopted herein.

22. On or about December 2, 2019, Board staff filed Complaint No. 020-2019 against the Respondent regarding Respondent's failure to cooperate in the investigation of investigative Complaint No. 010-2019. The letter of notification dated December 9, 2019, sent to Respondent together with investigative Complaint No. 020-2019 again notified Respondent that OAC 140:3-3-2(g) required that Respondent provide the Board with a written response to investigative Complaint No. 020-2019 within 30 days of the date of mailing.

23. Investigative Complaint No. 020-2019 and the notification letter dated December 9, 2019 were received by Respondent by certified mail on December 12, 2019. No response to investigative Complaint No. 020-2019 has ever been received from the Respondent.

24. The prosecution has established by clear and convincing evidence that by failing to provide the Board's investigator with the requested Sheridan Miller records, the Respondent failed to make all Sheridan Miller records available for inspection and copying by the Board's investigator during normal business hours, failed to provide the Board's investigator with information lawfully requested, and failed to cooperate in the lawful investigation of investigative Complaint No. 010-2019. OAC:15-7-5(3)(A); OAC 140:15-7-5(3)(D)

25. As stated in paragraph 16 above, on July 29, 2020 and August 13, 2020 Respondent produced to the Board records reflecting that Respondent had treated Sheridan Miller on at least 45 different dates, but produced treatment notes for only three (3) of those

days. It has been established by clear and convincing evidence that Respondent failed to on forty-two (42) occasions maintain patient records for Sheridan Miller, a patient under Respondent's care, and failed to maintain the highest standards of professional and personal conduct. OAC 140:15-7-5(3)(B); OAC 140:15-7-5(5)

Complaint No. 001-2020 (failure to produce documents in response to Complaint No. 010-2019 Subpoena for Production of Documents)

26. The facts alleged in paragraphs 1 through 13 above are adopted herein.

27. On or about February 10, 2020, Board staff filed investigative Complaint No. 001-2020 against the Respondent regarding Respondent's failure to comply with the Subpoena For Production of Documents which had been issued and served on her in investigative Complaint No. 010-2019. The letter of notification dated February 10, 2020 sent to the Respondent together with investigative Complaint No. 001-2020 again notified Respondent that OAC 140:3-3-2(g) required that Respondent provide the Board with a written response to investigative Complaint No. 001-2020 within 30 days of the date of mailing.

28. Investigative Complaint No. 001-2020 and the notification letter dated February 10, 2020 were received by Respondent by certified mail on February 18, 2020. No response to investigative Complaint No. 001-2020 has ever been received from the Respondent.

29. The prosecution has established by clear and convincing evidence that the Respondent failed to ever produce any documents responsive to the investigative Subpoena for Production of Documents issued and served on Respondent in investigative Complaint No. 010-2019 and thus failed to comply with a lawfully issued subpoena of the Board. OAC 140:15-7-5(14)

30. As stated in paragraphs 16 and 25 above, on July 29, 2020 and August 13, 2020 Respondent produced to the Board records reflecting that Respondent had treated Sheridan Miller on at least 45 different dates, but produced treatment notes for only three (3) of those days. It has been established by clear and convincing evidence that Respondent failed on forty-two (42) occasions to maintain patient records for Sheridan Miller, a patient under Respondent's care, and failed to maintain the highest standards of professional and personal conduct. OAC 140:15-7-5(3)(B); OAC 140:15-7-5(5)

Complaint No. 017-2019
(failure to comply with Bates records request)

31. On or about February 25, 2019, Complainant Londa Bates was injured in an automobile accident and sought and received chiropractic treatment from Respondent. On April 12, 2019, Londa Bates in writing authorized the Respondent to release to Bates' attorney Jeffrey Martin, and his agents and employees, all of her medical and billing records and itemized billing statement.

32. On August 1, 2019, after Respondent released Ms. Bates from treatment, Ms. Bates' attorney with the Jeff Martin Law Office requested Respondent to provide them with Ms. Bates' medical records and bill. No records or bill were provided by Respondent in response to that request. [Exhibit 27, Exhibit 43, p. B.025, Exhibit 39]

33. On or about August 21, 2019, a second Bates request for medical records and bill was submitted to Respondent. No records or bill were provided by the Respondent in response to that request. [Exhibit 27, Exhibit 39]

34. On or about September 6, 2019, a third Bates request for medical records and bill was submitted to Respondent. Claimant contends that no records or bill were provided by the Respondent in response to that request. However, on July 29, 2020,

Respondent in her Response to the charging Complaint contended that she faxed 25 pages of records on September 20, 2019, but Respondent submitted no mechanical facsimile transmittal verification to support such transmittal and it is uncontroverted that no treatment notes were sent. Per Exhibit 45, other than the treatment notes for March 6 & 7, 2019, it is impossible that any other treatment notes provided to claimant since the treatment notes were not printed until August 12, 2020.

35. On or about October 2, 2019, a fourth Bates request for medical records and bill was submitted to Respondent, followed by a facsimile request on October 3, 2019 reciting the history of all of the requests that had been previously made.

36. On October 23, 2019 Respondent faxed to the Jeffrey Martin Law Office the following Bates records and no others: intake paperwork that included police report, diagnostic imaging report, and the paperwork completed in Ms. Bates' handwriting at her first appointment. No billing statement or treatment notes or any other documents or records were received.

37. On or about November 4, 2019, Londa Bates filed investigative Complaint No. 017-2019 with the Oklahoma Board of Chiropractic Examiners. The letter of notification dated November 5, 2019, sent to the Respondent together with investigative Complaint No. 017-2019, notified Respondent that OAC 140:3-3-2(g) required that Respondent provide the Board with a written response to investigative Complaint No. 001-2020 within 30 days of the date of mailing.

38. Investigative Complaint No. 017-2019 and the notification letter dated November 5, 2019 were received by Respondent by certified mail on November 7, 2019. No response to investigative Complaint No. 017-2019 has ever been received from the

Respondent.

39. Regarding the August 1, 2019, August 21, 2019, September 6, 2019 and October 2, 2019 Bates' requests, the prosecution established by clear and convincing evidence that the Respondent failed on four (4) occasions to within 21 calendar days of the receipt of Londa Bates' authorization, or ever, provide to Ms. Bates' attorney copies of all of the records and treatment notes that Londa Bates had authorized to be produced. OAC 140:15-7-5(3)

40. On July 29, 2020, and August 13, 2020, Respondent produced to the Board records reflecting that Respondent had treated Londa Bates on at least 29 different dates, but produced treatment notes for only twenty-four (24) of those days. It has been established by clear and convincing evidence that Respondent failed on five (5) occasions to maintain patient records for Londa Bates, a patient under Respondent's care, and failed to maintain the highest standards of professional and personal conduct. OAC 140:15-7-5(3)(B); OAC 140:15-7-5(5)

41. At the conclusion of its investigation of each of the above investigative Complaints, the Advisory Committee submitted to the Board its report recommending that probable cause be found regarding each of the above complaints, that charging complaints be filed, and that a hearing be scheduled. This report was considered and the recommendations were adopted by the Board at its May 28, 2020 Board Meeting, and the above charging Complaints and a Subpoena for Production of Documents were filed and served on Respondent on June 17, 2020.

42. The charging Complaints and the Subpoena for Production of Documents requested responses within twenty (20) days, which would make the responses due no later

than July 6, 2020. Respondent was notified in the charging Complaints that the hearing was scheduled for July 23, 2020.

43. On July 15, 2020 Respondent filed Motions seeking additional time to respond to the Complaint and Subpoena, which requests the Board granted on July 23, 2020 extending the response deadlines to July 29, 2020 and the hearing to August 27, 2020.

44. On July 29, 2020 the Respondent filed a Response to the charging Complaints admitting most of the allegations. She also filed a Response to the Subpoena for Production of Documents and produced some documents that had not previously been produced, but very few daily treatment notes for either the Miller or Bates patients.

45. On August 13, 2020, Respondent again produced medical charts for Miller and Bates, but this production regarding Miller did not contain any documents not previously produced and was at a minimum missing at least 42 days' worth of daily treatment notes for Miller and missing at least five (5) days' worth of daily treatment notes for Bates.

46. It has been established by clear and convincing evidence that: Respondent failed to timely, or ever, produce all of the Sheridan Miller medical records requested by her attorney on three (3) occasions regarding Complaint 010-2019; failed to submit a response to investigative Complaint No. 010-2019 as alleged in Complaint No. 016-2019; failed to cooperate in the investigative Complaint No. 010-2019 investigation as alleged in Complaint No. 020-2019; failed to produce the documents subpoenaed in the investigative Complaint No. 010-2019 Subpoena for Production of Documents; and failed in Complaint No. 017-2017 to on four (4) occasions to timely, or ever, produce all of the Londa Bates medical records requested by her attorney as alleged in Complaint No. 017-2017; failed on

forty-two (42) occasions to maintain Sheridan Miller patient record, and failed on five (5) occasions to maintain Londa Bates patient record.

47. The evidence or testimony, if any, presented regarding Respondent's personal familial and/or health issues does not constitute a defense to the violations alleged, but have been considered by the Board in determining the appropriate penalty to assess.

48. The evidence or testimony, if any, presented regarding the difficulties incurred by Sheridan Miller, Londa Bates and/or their attorneys as a result of Respondent's violations have not been considered by the Board as an element of the violations alleged, but have been considered in determining the penalty assessed.

CONCLUSIONS OF LAW

1. The Board has jurisdiction of this matter under 59 O.S. § 161.1 et seq.

2. Applicable Oklahoma statutes include but are not limited to the following:

59 O.S. Section 161.12 - Grounds for Imposing Penalties.

> B. The following acts or occurrences by a chiropractic physician shall constitute grounds for which the penalties specified in subsection A of this section may be imposed by order of the Board:
>
> 12. Violating any provision of the Oklahoma Chiropractic Practice Act; or
>
> 13. Violating any of the rules of the Board.

3. Applicable Oklahoma Board of Chiropractic Examiners' rules, with emphasis added, with which chiropractic physicians must comply include but are not limited to the following:

OAC 140:3-3-2(g)

> (g) **The investigator shall provide the chiropractic physician named in the complaint with a notice of the complaint and shall require said**

chiropractic physician to provide a written response to the complaint within thirty (30) calendar days of mailing of a copy of the notice to said chiropractic physician. The failure of a chiropractic physician to respond to such a request of the Advisory Committee or investigator shall be grounds for disciplinary action by the Board. In addition, the chiropractic physician named in the complaint shall not contact, attempt to contact or allow anyone else to contact the person(s) who filed the complaint or the person(s) who the chiropractic physician named in the complaint believes may have filed the complaint.

OAC 140:15-7-5. Code of Ethics

There is hereby created the "Oklahoma Chiropractic Code of Ethics". This Code of Ethics is based upon the fundamental principle that the ultimate end and objective of the chiropractic physician's professional services and effort should be: "The greatest good for the patient."

(3) **Chiropractic physicians shall comply within twenty-one (21) calendar days of a patient's authorization certification to provide records, or copies of such records, to those persons whom the patient designates as authorized to inspect or receive all or part of such records.** A reasonable charge may be made for the cost of copying records. Unpaid charges incurred by the patient are not grounds for refusal to release records.

(A) **After receipt of complaint, all records shall be available for inspection and copying by investigators of the Board during normal business hours.**

(B) **A patient record shall be maintained for every patient under the care of the chiropractic physician** and such records shall be kept confidential. Only authorized personnel shall have access to the records.

(C) Records generally shall not be removed from the control of the chiropractic physician except upon court order or as authorized by law. **Board staff shall be authorized to obtain copies or review any records to assure compliance with these rules or other parts of the Act.**

(D) **Chiropractic physicians shall furnish the Board, its investigators or representatives, information lawfully requested by the Board and shall cooperate with a lawful investigation conducted by the Board.**

(5) **Chiropractic physicians shall maintain the highest standards of professional and personal conduct. Chiropractic physicians shall**

refrain from all illegal or morally reprehensible conduct;

(7) **Chiropractic physicians shall observe the appropriate laws, decisions and rules of state** and federal **governmental agencies** of the United States and the State of Oklahoma **and cooperate with the pertinent activities.**

(14) **Chiropractic physicians shall not** violate any lawful order of the Board previously entered in a disciplinary hearing or **fail to comply with a lawfully issued subpoena of the Board.**

Complaint # 010-2019
(failure to comply with Wirth/Carter records request)

4. As set forth in the facts alleged in Statement of Facts paragraphs 1 through 16 and 41-46 above, it has been established by clear and convincing evidence that the Respondent failed on three (3) occasions to within 21 calendar days of the receipt of Sheridan Miller's authorization provide to Complainant copies of all of the records Sheridan Miller had authorized to be produced which constitutes a violation of 59 O.S. Section 161.12(B)(13) and OAC 140:15-7-5(3).

5. Respondent's failure to prepare daily treatment notes for at least 42 of Sheridan Miller's treatment dates constitutes clear and convincing evidence that Respondent failed on forty-two (42) occasions to maintain a patient record for Sheridan Miller, a patient under Respondent's care, and failed to maintain the highest standards of professional and personal conduct which constitute violations of 59 O.S. Section 161.12(B)(13), OAC 140:15-7-5(3)(B) and OAC 140:15-7-5(5).

Complaint No. 016-2019
(failure to respond to Complaint No. 010-2019)

6. As set forth in the facts alleged in Statement of Facts paragraphs 1 through 20 and 41-46 above it has been established by clear and convincing evidence that Respondent failed to within 30 days of the day that investigative Complaint No. 010-2019

was mailed to her, or the date received by her, to file a response to investigative Complaint No. 010-2019, which constitutes a violation of 59 O.S. Section 161.12(B)(13) and OAC 140:3-3-2(g).

Complaint No. 020-2019
(failure to cooperate in investigation of Complaint No. 010-2019)

7. As set forth in the facts alleged in Statement of Facts paragraphs 1 through 12, 21-25 and 41-46 above it was established by clear and convincing evidence that by failing to provide the Board's investigator with the requested Sheridan Miller records, the Respondent failed to make all Sheridan Miller records available for inspection and copying by the Board's investigator during normal business hours, failed to provide the Board's investigator with information lawfully requested, and failed to cooperate in the lawful investigation of investigative Complaint No. 010-2019, which constitute violations of 59 O.S. Section 161.12(B)(13), OAC:15-7-5(3)(A) and OAC 140:15-7-5(3)(D)

8. Respondent's failure to prepare daily treatment notes for at least 42 of Sheridan Miller's treatment dates constitutes clear and convincing evidence that Respondent failed on forty-two (42) occasions to maintain a patient record for Sheridan Miller, a patient under Respondent's care, and failed to maintain the highest standards of professional and personal conduct which constitute violations of 59 O.S. Section 161.12(B)(13), OAC 140:15-7-5(3)(B) and OAC 140:15-7-5(5).

Complaint No. 001-2020 (failure to produce documents in response to Complaint No. 010-2019 Subpoena for Production of Documents)

9. As set forth in the facts alleged in Statement of Facts paragraphs 1 through 13, 26-30 and 41-46 above it has been established by clear and convincing evidence that the Respondent failed to produce any documents responsive to the investigative Subpoena

for Production of Documents issued and served on Respondent in investigative Complaint No. 010-2019 and thus failed to comply with a lawfully issued subpoena of the Board, which constitutes a violation of 59 O.S. Section 161.12(B)(13), and OAC 140:15-7-5(14).

10. Respondent's failure to prepare daily treatment notes for at least 42 of Sheridan Miller's treatment dates constitutes clear and convincing evidence that Respondent failed on forty-two (42) occasions to maintain a patient record for Sheridan Miller, a patient under Respondent's care, and failed to maintain the highest standards of professional and personal conduct which constitutes violations of 59 O.S. Section 161.12(B)(13), OAC 140:15-7-5(3)(B) and OAC 140:15-7-5(5).

Complaint No. 017-2019
(failure to comply with Bates records request)

11. As set forth in facts alleged in Statement of Facts paragraphs 31 through 46 above, it has been established by clear and convincing evidence that the Respondent failed on four (4) occasions to within 21 calendar days of the receipt of Londa Bates' authorization provide to Ms. Bates' attorney copies of all of the records and treatment notes that Londa Bates had authorized to be produced, which constitute violations of 59 O.S. Section 161.12(B)(13) and OAC 140:15-7-5(3).

12. Respondent's failure to prepare daily treatment notes for at least five (5) of Londa Bates' treatment dates constitutes clear and convincing evidence that Respondent failed on five (5) occasions to maintain a patient record for Londa Bates, a patient under Respondent's care, and failed to maintain the highest standards of professional and personal conduct which constitutes a violation of 59 O.S. Section 161.12(B)(13), OAC 140:15-7-5(3)(B) and OAC 140:15-7-5(5).

POTENTIAL PENALTIES

13. Title 59 O.S.§ 161.12(A) provides the penalties which may be imposed by the Board, which penalties are as follows:

> A. The Board of Chiropractic Examiners is authorized, after notice and an opportunity for a hearing pursuant to Article II of the Administrative Procedures Act, to issue an order imposing one or more of the following penalties whenever the Board finds, by clear and convincing evidence, that a chiropractic physician has committed any of the acts or occurrences set forth in subsection B of this section:
>
> 1. Disapproval of an application for a renewal license;
>
> 2. Revocation or suspension of an original license or renewal license, or both;
>
> 3. Restriction of the practice of a chiropractic physician under such terms and conditions as deemed appropriate by the Board;
>
> 4. An administrative fine not to exceed One Thousand Dollars ($1,000.00) for each count or separate violation;
>
> 5. A censure or reprimand; and
>
> 6. Placement of a chiropractic physician on probation for a period of time and under such terms and conditions as the Board may specify, including requiring the chiropractic physician to submit to treatment, to attend continuing education courses, to submit to reexamination, or to work under the supervision of another chiropractic physician.
>
> 7. The assessment of costs expended by the Board in investigating and prosecuting a violation. The costs may include, but are not limited to, staff time, salary and travel expenses, witness fees and attorney fees, and shall be considered part of the order of the Board..

14. Regarding past disciplinary proceedings, if any, OAC 140:3-3-4 (k) provides that:

> The board shall consider past disciplinary action taken against any accused found guilty in any present proceeding. Such past conduct shall not be evidence of guilty in the present proceeding but will be considered only in determining appropriate sanctions to be imposed by the Board in the present proceeding.

15. In considering what penalty should be imposed, OAC 140:3-3-5 provides the following considerations:

> Whenever the Board finds a chiropractic physician guilty of a violation in an individual proceeding, the Board may consider the following factors in its determination of a penalty to be imposed against said chiropractic physician:
>
> > (1) **Consequences to the public.** If potential or actual damage to the health, safety or welfare of the general public is more likely than not to occur as a result of acts or omissions by the licensee, the Board may impose a more severe punishment than if such damage is less likely to occur.
> >
> > (2) **Consequences to the patient.** If potential or actual damage to the health, safety, or welfare of the patient on whose behalf the complaint is brought is more likely than not to occur as a result of acts or omissions by the licensee, the Board may impose a more severe punishment than if such damage is less likely to occur.
> >
> > (3) **Intent.** If it is evident from the facts presented that the violation committed by the licensee was intentional, the Board may impose a more severe punishment than if it is not so evident; provided that such violation may be deemed by the Board to be intentional on the part of the licensee if the violation:
> >
> > > (A) occurred as the result of negligence on the part of the licensee; or
> > >
> > > (B) was part of a pattern of extreme or ongoing carelessness as to be without regard for the health, safety or welfare of the general public or a patient; or
> > >
> > > (C) violated the principles of the Chiropractic Code of Ethics.
> >
> > (4) **Negligence.** If the violation committed by the licensee resulted from negligence on the part of licensee, but was not so gross, or was not the result of such carelessness, as to meet the test of (3) of this subsection, the Board may impose a less severe punishment than would be the case if the negligence met such a test.

HISTORY OF PRIOR DISCIPLINE

Respondent has no history of prior discipline with this Board.

FINAL ORDER

IT IS THEREFORE ORDERED by the Oklahoma Board of Chiropractic Examiners as follows regarding **Complaints numbered 010-2019, 016-2019, 020-2019, 001-2020 and 017-2019**:

1. The Respondent is assessed an Administrative Penalty/Fine of $500.00 per violation for each of 15 violations, as follows:

   Complaint 010-2019; 5 violations; Penalty assessed is $2,500.00;
   Complaint 016-2019; 1 violation; Penalty assessed is $500.00;
   Complaint 020-2019; 2 violations; Penalty assesses is $1,000.00;
   Complaint 001-2020; 1violation; Penalty assessed is $500.00; and
   Complaint 017-2019; 6 violations; Penalty assessed is $3,000.00.

   Total Administrative Penalty/Fine assessed is $7,500.00 to be paid to the Oklahoma Board of Chiropractic Examiners at the rate of $250.00 per month commencing on **January 15, 2021**, with a similar amount due on the 15th day of each month thereafter until paid in full, and should any payment not be timely received at the Board office the Respondent's chiropractic license **shall without further action by the Board be SUSPENDED at 12:01a.m. of the 16th day of the month** in which the payment is not received by the Board and shall remain suspended until the entire balance due on legal fees is paid in full, and the Board reserves jurisdiction to assess further costs if Respondent does not comply with the terms of this Agreed Order and further proceedings are required.

2. The Respondent's license to practice chiropractic is **SUSPENDED** until such time as the Board has determined that the supervision referenced in paragraph 4 below is in place and the initial reports referenced in paragraphs 6 and 7 below have been received by the Board and the Board has determined that Respondent is being adequately supervised and that Respondent is fit to practice chiropractic and capable of complying with Respondent's medical record keeping and/or production responsibilities.

3. Respondent **LENNON KIRKENDALL, License No. 3872,** is placed on **THREE (3) YEARS PROBATION** commencing with the ending date of the SUSPENSION of Respondent's license, with Twenty-Four (24) months of that probation to be SUPERVISED at Respondent's expense by **Affiliated Monitors, Inc., or by a similar entity approved in advance by the Board's Executive Director.** The purpose of the supervision is to monitor the Respondent's medical record keeping, and her compliance with requests for medical records, with the

monitor reporting directly to the Board whether Respondent is timely complying with her medical record keeping and production requirements. Said reports must be submitted directly to the Board by the monitor no less than monthly and within 10 days should Respondent's medical record keeping and/or production be deemed at any time to be insufficient by the monitor. Respondent shall promptly execute whatever waivers may be required in order for the monitor to be able to provide the Executive Director with the monitor's reports. The Respondent agrees that all expenses associated with the monitoring shall be paid by Respondent, and that the monitor's written reports may be admitted into evidence during hearings before the Board, if any. **Respondent must ensure that there is in place no later than September 23, 2020, a monitoring arrangement approved in advance in writing by the Board's Executive Director.** The supervised portion of the Probation shall commence on the first day that the monitoring commences. **The status of the monitoring agreement is set for review on the Board's September 24, 2020 Agenda, at which time the Respondent must appear in person.**

4. During the 24-month supervised period of probation, the Board will review the monitor's reports at each regularly scheduled Board meeting. However, should the Board's Executive Director receive a report from the monitor reflecting that Respondent's record keeping at any time after September 24, 2020 is deficient, then Respondent's chiropractic license shall immediately without further action by the Board become SUSPENDED and remain suspended until further action by the Board.

5. Respondent shall immediately provide her treating therapist with a copy of this Agreed Order and shall at Respondent's expense and no later than **September 15, 2020** have her treating therapist submit a confidential report directly to the Board's Executive Director addressing whether Respondent's mental health status is such that Respondent is fit to practice chiropractic, and in particular address whether Respondent's mental health adversely impacts Respondent's ability to comply with Respondent's medical record keeping and/or production responsibilities. The report must also address the frequency of therapy sessions recommended by the therapist and whether the Respondent is complying with those recommendations. This report must be submitted by Respondent's therapist directly to the Board's Executive Director, and Respondent shall promptly execute any waivers necessary in order to accomplish transmittal of the reports referenced in this paragraph. Similar confidential reports must be submitted by the treating therapist directly to the Board's Executive Director no later than December 31, 2020, March 30, 2021, June 30, 2021 and September 30, 2021. All reports shall be at Respondent's expense. Should any report be received by the Board indicating that Respondent is not fit to practice chiropractic, is not fit to comply with Respondent's medical record keeping and/or production responsibilities, and/or is not complying with the therapist's recommended treatment schedule, then Respondent's license to practice chiropractic shall immediately without further action by the Board become suspended and remain suspended until further action by the Board.

6. No later than **September 30, 2020** and, unless in advance waived in writing by the Board, once per year thereafter during Respondent's probation, Respondent shall at Respondent's expense submit herself to a psychological examination or confirmation of an appointment to occur before October 15, 2020, for such an examination by a licensed psychologist or psychiatrist selected and approved in advance by the Board's Executive Director, with the purpose of the examination being for that professional to make a determination as to whether Respondent is fit to practice chiropractic and fit to comply with Respondent's medical record keeping and/or production responsibilities. The confidential report shall be submitted directly by the health care provider to the Board's Executive Director, and Respondent shall promptly execute any waivers needed in order for that report to be transmitted. Should Respondent not submit herself for evaluation, or should any report be received by the Board indicating that Respondent is not fit to practice chiropractic and/or is not fit to comply with Respondent's medical record keeping and/or production responsibilities, then Respondent's license to practice chiropractic shall immediately without further action by the Board become suspended and remain suspended until further action by the Board.

7. Respondent shall, at her own expense, on or before **December 1, 2020,** successfully complete the Professional Standards section of the EBAS Exam and shall submit to Board staff satisfactory verification of Respondent's successful completion of the exam.

8. Respondent shall pay to the Oklahoma Board of Chiropractic Examiners the sum of **Nine Thousand Three Hundred and Twenty-eight and 75/100 Dollars (9,328.75.75)** towards legal fees incurred by the Board, with said amount to be paid at the rate of $250.00 per month commencing on the **January 15, 2021** with a similar amount due on the 15th day of each month thereafter until paid in full, and should any payment not be timely received at the Board office the Respondent's chiropractic license **shall without further action by the Board be SUSPENDED at 12:01a.m. of the 16th day of the month** in which the payment is not received by the Board and shall remain suspended until the entire balance due on legal fees is paid in full, and the Board reserves jurisdiction to assess further costs if Respondent does not comply with the terms of this Agreed Order and further proceedings are required.

9. The Board is required to report this adverse action to the Federation of Chiropractic Licensing Boards which in turn reports it to the National Practitioner Data Bank.

10. Failure of the Respondent to comply with any of the terms of this Final Order could result in further disciplinary action as allowed by any applicable law or the Board's rules.

11. The Board retains jurisdiction over this case until all matters are finally resolved as set forth in the Final Order.

12. The Board reserves the right to initiate, continue with, and/or pursue disciplinary action against the Respondent for acts, if any, which were not part of the specific acts and patients giving rise to this individual proceeding as referenced herein.

IT IS SO ORDERED, ADJUDGED, AND DECREED

On **August 27, 2020**, subject to Attorney General review, if any, pursuant to Executive Order 2019-17, the Board in open session approved the above *Agreed Order*.

M. Ker, D.C.
Presiding Board Member

CERTIFICATE OF SERVICE

On the 2nd day of November, 2020, I mailed a true and correct copy of the forgoing *Agreed Order* in the U.S. Mails, by certified mail, return receipt requested, to the following Respondent using the last known address as on file with the Oklahoma Board of Chiropractic Examiners, and to others by email, as follows:

By Certified Mail

Lennon Kirkendall, D.C.
131 Blue Starr Drive
Claremore, OK 74017

By Certified and Email

Walter D. Haskins
Atkinson, Haskins, Nellis, Brittingham,
Gladd & Fiasco
525 South Main, Suite 1500
Tulsa, OK 74103
Email: whaskins@ahn-law.com
Attorney for Respondent

By Email

Martha R. Kulmacz
Assistant Attorney General
Email: Martha.Kulmacz@oag.ok.gov
Attorney for the Oklahoma Board of Chiropractic Examiners

Beth Kidd, Executive Director