State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

December 11, 2024

Case number: 24-CRF-0211

Jonathan Chadwick Cole, D.O.
20242 Augusta Dr
Lawrenceburg, IN 47025-7370
jonathanccole24@gmail.com

Dear Doctor Cole:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) During the time period from in or around September 2015 to in or around June 2022, you provided care and treatment in the routine course of your practice to eight patients as identified in the attached Patient Key. (Patient Key is confidential and to be withheld from public disclosure). From on or about January 1, 2016, to at least in or around June 2022, you inappropriately treated and/or failed to appropriately treat and/or failed to appropriately document your treatment of these patients, which included:

- Inappropriately prescribing, and failing to appropriately monitor the patients' medications;
- A failure to provide appropriate care, and failing to appropriately manage the patients' conditions; and
- Inadequate and/or incomplete documentation.

(2) Examples of such conduct and care to the eight patients include, but are not limited to, the following:

(a) You treated Patient 1 from in or around December 2015 to at least in or around December 2021. While you diagnosed Patient 1 with Bipolar II Disorder, Bipolar I Disorder, Posttraumatic Stress Disorder, Generalized Anxiety Disorder and Insomnia, those diagnoses were not substantiated using DSM5 criteria. Throughout the course of your treatment, you prescribed a number of medications, including Adderall, Valium, Zoloft, Tegretol, lithium, Lunesta, Latuda, Inderal and Cogentin. The diagnosis of Attention Deficit Hyperactivity Disorder was not substantiated, and Adderall was not prescribed for an appropriate condition. In addition, you failed to

document an appropriate purpose for utilizing Valium and Adderall at high dosages and for extended periods. You further failed to conduct blood testing at appropriate intervals. Adjustments of antidepressant medication dosages, or trials of different antidepressants, were not conducted to address ongoing symptoms. You also failed to appropriately document, and/or address, and/or monitor the potential for drug dependency regarding Valium, Adderall and Lunesta. In addition, informed consent for the medications was not appropriately addressed. Further, OARRS reports were not always obtained in a timely manner, and the results were not incorporated into the medical record and treatment plan. At the time of the last visit for the records provided, you were prescribing Adderall 30 mg three times a day, and Valium 10 mg four times a day.

(b) You treated Patient 2 from in or around July 2016 to at least in or around January 2022. While you diagnosed Patient 2 with Major Depressive Disorder, recurrent, Generalized Anxiety Disorder and Attention Deficit Hyperactivity Disorder, those diagnoses were not substantiated using DSM5 criteria. Throughout the course of your treatment, you prescribed a number of medications, including Wellbutrin, Ritalin, Klonopin and Adderall. Despite prescribing Klonopin for an extended period, you failed to appropriately address and/or monitor the potential for drug dependency or abuse; you failed to obtain informed consent addressing the risks and benefits of prolonged Klonopin use; and you failed to appropriately document an effort to titrate down or discontinue Klonopin. Despite an ongoing diagnosis of Major Depressive Disorder, recurrent, mild, you discontinued the antidepressant medication (Wellbutrin), and no antidepressant medication was prescribed to replace the Wellbutrin; instead Klonopin was continued. In addition, you failed to incorporate the OARRS results into the medical record and treatment plan. At the time of the last visit for the records provided, you were prescribing Klonopin 0.5 mg three times daily as needed for anxiety, and Adderall 20 mg twice daily.

(c) You treated Patient 3 from in or around April 2018 to at least in or around July 2021. While you diagnosed Patient 3 with Major Depressive Disorder, recurrent, and Generalized Anxiety Disorder, those diagnoses were not substantiated using DSM5 criteria. Throughout the course of your treatment, you prescribed a number of medications, including Xanax. Ambien, Klonopin, Seroquel, Wellbutrin, and Dalmane. You prescribed Xanax at high doses for an extended period, and at times, multiple benzodiazepines were prescribed concurrently. At the time you last saw Patient 3 in July 2021, you were prescribing 1.5 mg Xanax to be taken every six hours as needed, for panic disorder; however, panic disorder was not among the patient's disorders. The patient exhibited multiple red flags regarding medication misuse or abuse, including early refills of Xanax, and drug testing positive for amphetamines and Subutex. In addition, the patient had visits to the emergency department for altered mental status, and the patient also was assessed with benzodiazepine overdose. You failed to appropriately document, and/or address, and/or monitor the potential for drug dependency or abuse regarding benzodiazepine utilization; you failed to obtain informed consent for the risks and benefits of prolonged Xanax use, and you failed to document an appropriate effort to titrate down the Xanax dosage. In addition, you prescribed antipsychotic medications without a documented indication. You further failed to incorporate the OARRS results into the medical record and treatment plan.

(d) You treated Patient 4 from in or around March 2018 to at least in or around November 2018. While you diagnosed Patient 4 with Attention Deficit Hyperactivity Disorder, that diagnosis was not substantiated using DSM5 criteria, rating scales, collateral informants, or a review of past records. The patient reported to you that he had received Vyvanse 140 mg daily from a prior provider, and you prescribed that dosage without corroboration. You failed to obtain informed consent for the risks and benefits of high-dose Vyvanse, and there were no documented attempts to titrate down the Vyvanse dose. In addition, you failed to appropriately obtain, or document obtaining, an OARRS report when you initially prescribed Vyvanse, and you further failed to incorporate OARRS results into the patient record and treatment plan. At the time of the last visit in the patient chart, the patient was being prescribed Vyvanse 140 mg daily.

(e) You treated Patient 5 from in or around September 2015 to at least in or around October 2019. While you diagnosed Patient 5 with Posttraumatic Stress Disorder, Panic Disorder without Agoraphobia, and Sedative/Hypnotic/Anxiolytic Disorder, those diagnoses were not substantiated using DSM5 criteria. Throughout the course of your treatment, you prescribed a number of medications, including Xanax, Ambien, Celexa, Seroquel, Wellbutrin, and Benadryl. In addition, other providers were prescribing opiates and muscle relaxers to the patient. You prescribed Xanax at high doses for an extended period, and the dosage was increased between visits without a documented rationale. The patient exhibited some red flags, such as indicating that her medication was lost when it was spilled down the drain. You failed to appropriately address and/or monitor the potential for drug dependency or abuse regarding benzodiazepine utilization; you failed to obtain informed consent for the risks and benefits of prolonged Xanax use; and you failed to document an appropriate effort to titrate down the Xanax dosage. While you documented discussing the tapering of the Xanax dosage with the patient, you further documented that the patient refused and you continued to prescribe Xanax 8 mg daily. The patient was concurrently being prescribed Xanax and Ambien, and those medications also were being prescribed concurrently with Norco and Zanaflex. In addition, your documentation was unclear at times regarding the initiation, continued prescribing, change in dosing, and/or apparent discontinuation of some medications. Further, OARRS reports were not always obtained in a timely manner, and the results were not incorporated into the medical record and treatment plan. At the time of the last visit in the patient chart, the patient's medications included Xanax 2mg four times daily as needed for anxiety, Celexa 40 mg daily, Ambien 10 mg at bedtime, and Benadryl 50 mg at bedtime for insomnia.

(f) You treated Patient 6 from in or around September 2016 to at least in or around July 2021. While you diagnosed Patient 6 with Bipolar I Disorder, ADHD and Generalized Anxiety Disorder, those diagnoses were not substantiated using DSM5 criteria. Toward the end of your treatment, Generalized Anxiety Disorder and ADHD were no longer listed as diagnoses, but no rationale was documented in the chart. Throughout the course of your treatment, you prescribed a number of medications, including Vyvanse, Valium, Risperdal, lithium and Wellbutrin. You prescribed Valium at the initial appointment and throughout your treatment as a first-line agent for anxiety without first attempting to use non-controlled medications. The Vyvanse dose was twice the recommended dose for the first five sessions, and then reduced to the recommended maximum dose. You failed to appropriately

address and/or monitor the potential for drug dependency or abuse regarding Valium and Vyvanse; you failed to obtain informed consent for the risks and benefits of the medications prescribed; and you failed to document an appropriate effort to titrate down the Valium dosage. In addition, OARRS reports were not always obtained in a timely manner, and the results were not incorporated into the medical record and treatment plan. At the time of the last visit in the patient chart, the patient's medications included Risperdal 2 mg twice daily, lithium 600 mg twice daily, and Valium 5mg as needed (dose not documented).

(g) You treated Patient 7 from in or around April 2017 to at least in or around September 2019. While the diagnoses listed in the patient chart included Obsessive Compulsive Disorder, Depressive Disorder unspecified, Anxiety Disorder unspecified and rule out ADHD, those diagnoses were not substantiated using DSM5 criteria. Throughout the course of your treatment, you prescribed a number of medications, including Xanax, Ambien, Adderall, Abilify, Effexor, Viibryd and Buspar. You prescribed Xanax at moderately high doses for an extended time, and concurrently with Ambien. In addition, you prescribed Adderall at high doses for an extended period, and no diagnosis of Attention Deficit Hyperactivity Disorder was substantiated. You failed to appropriately address and/or monitor the potential for drug dependency or abuse regarding Xanax, Ambien and Adderall; you failed to obtain informed consent for the risks and benefits of the medications you prescribed; and you failed to document an appropriate effort to titrate down the Xanax and Adderall dosages. In addition, you failed to appropriately address red flags, such as the patient being required to attend drug classes. In addition OARRS reports were not always obtained in a timely manner, and the results were not incorporated into the medical record and treatment plan. At the time of the last visit in the patient chart, the patient's medications included Abilify 10 mg daily and Effexor 375 mg daily.

(h) You treated Patient 8 on an outpatient basis from in or around January 2019 to at least in or around June 2022. While the diagnoses listed in the chart included Major Depressive Disorder (recurrent, severe) and Generalized Anxiety Disorder, those diagnoses were not substantiated using DSM5 criteria. Throughout the course of your treatment, you prescribed a number of medications, including Cymbalta, Desyrel, selegiline, phenelzine, Neurontin, Vistaril, Benadryl, Dalmane, Ativan, Lunesta, Halcion and Xanax. At times, two or more sedatives were prescribed concurrently. In addition, sedatives were prescribed at the same time Patient 8 was receiving opiate analgesics and muscle relaxers. Benzodiazepines also were prescribed for an extended period, and at various time, multiple benzodiazepines were prescribed concurrently. You failed to appropriately address and/or monitor the potential for drug dependency or abuse regarding benzodiazepine utilization; you failed to obtain informed consent for the risks and benefits of prolonged benzodiazepine use; and you failed to document an appropriate effort to titrate down or discontinue the benzodiazepine. In addition, your documentation was, at times, unclear regarding the initiation and prescribing of some of the medications you prescribed. OARRS reports were not always obtained in a timely manner, and the results were not incorporated into the medical record and treatment plan. At the time of the last visit in the patient chart for the records provided, the patient's medications included Xanax 2mg as needed for insomnia, Ativan

2mg twice daily as needed for anxiety, Prozac 40 mg daily, and Neurontin 400 mg three times daily.

(3) On or about January 4, 2024, you discussed with a representative of the Board some matters relating to your patient care, prescribing of medications and documentation. You indicated that in or around 2021 and 2022, you were informed of concerns by your employer that you were not seeing patients, to whom you were prescribing medications, on a frequent enough basis. You indicated that there were approximately five patients to whom you were prescribing medications, including controlled substances, that you had not seen, either in-person or virtually, for more than one year.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a) through 2((h) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a) through 2(h) above, individually and/or collectively, constitute a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after December 31, 2015, until August 30, 2017, as alleged in paragraphs (1) and (2)(a), 2(b), 2(e), 2(f) and 2(g), individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: General Provisions, Rule 4731-11-02, Ohio Administrative Code, as in effect at that time. Pursuant to Rule 4731-11-02(E), Ohio Administrative Code, as in effect at that time, a violation of Rule 4731-11-02, Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(2), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred on or after August 31, 2017, until December 22, 2018, as alleged in paragraphs (1), (2)(a) through 2(g), and (3) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: General Provisions, Rule 4731-11-02, Ohio Administrative Code, as in effect at that time. Pursuant to Rule 4731-11-02(E), Ohio Administrative Code, as in effect at that time, a violation of Rule 4731-11-02, Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(2), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1), (2)(a) through (2)(h), and (3) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: General Provisions, Rule 4731-11-02, Ohio Administrative Code, as currently in effect. Pursuant to Rule 4731-11-02(E), Ohio

Administrative Code, as currently in effect, a violation of Rule 4731-11-02, Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(2), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a),(2)(b), (2)(d), (2)(f), and (2)(g) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Utilization of schedule II controlled substance stimulants, Rule 4731-11-03, Ohio Administrative Code, as in effect from December 31, 2015 until February 27, 2023. Pursuant to Rule 4731-11-03(C), Ohio Administrative Code, as in effect at that time, a violation of Rule 4731-11-03, Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(2), Ohio Revised Code, Section 4731.22(B)(3), Ohio Revised Code, and Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions that occurred from December 31, 2015 to at least September 29, 2021 as alleged in paragraphs (1) and (2)(a) through (2)(h) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Standards and Procedures for Review of "Ohio Automated Rx Reporting System" (OARRS), Rule 4731-11-11, Ohio Administrative Code, as in effect from December 31, 2015 through September 29, 2021.

Further, your acts, conduct, and/or omissions that occurred from September 30, 2021 to the present as alleged in paragraphs (1) and (2)(a) through (2)(h) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Standards and Procedures for Review of "Ohio Automated Rx Reporting System" (OARRS), Rule 4731-11-11, Ohio Administrative Code, as in effect from September 30, 2021 through the present.

Furthermore, for any violations that occurred on or after September 29, 2015, the Board may impose a civil penalty in an amount that shall not exceed twenty thousand dollars, pursuant to Section 4731.225, Ohio Revised Code. The civil penalty may be in addition to any other action the Board may take under section 4731.22, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of service of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of service of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate."

Copies of the applicable sections are enclosed for your information.

THE STATE MEDICAL BOARD OF OHIO

Kim G. Rothermel, M.D.
Secretary

KGR/MRB/lv
Enclosures

Via Email: jonathanccole24@gmail.com

IN THE MATTER OF JONATHAN CHADWICK COLE, D.O.

24-CRF-0211

DECEMBER 11, 2024, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY