

BEFORE THE MINNESOTA

BOARD OF DENTISTRY

In the Matter of
Bruce D. Larson, D.D.S.
License No. D7686

**STIPULATION AND
ORDER FOR VOLUNTARY
SURRENDER OF LICENSE**

The Minnesota Board of Dentistry ("Board") is authorized pursuant to Minn. Stat. ch. 150A, §§ 214.10 and 214.103, to license and regulate dentists, to refer complaints against dentists to the Attorney General for investigation, and to take disciplinary action when appropriate.

The Board received a complaint(s) against Bruce D. Larson, D.D.S. ("Licensee"). The Board's Complaint Committee ("Committee") reviewed the complaint(s) and referred it to the Attorney General for investigation. Following the investigation, the Committee held a disciplinary conference with Licensee which resulted in a Stipulation and Order for Limited and Conditional License. Licensee is currently subject to the Stipulation and Order for Limited and Conditional License.

Subsequently, the Board received another complaint against Licensee which it forwarded to the Committee. In addition, the Board's representative conducted a compliance inspection of Licensee's office pursuant to his current Stipulation and Order for Limited and Conditional License. Thereafter, the Committee met with Licensee to discuss the compliance report and the new complaint and as a result have agreed that the matter may now be resolved by this Stipulation and Order for Voluntary Surrender.

STIPULATION

IT IS HEREBY STIPULATED AND AGREED by and between Licensee and the Committee as follows:

A. Jurisdiction. Licensee holds a license to practice dentistry in the State of Minnesota from the Board and is subject to the jurisdiction of the Board with respect to the matters referred to in this stipulation. Licensee states that he does not hold a license to practice dentistry in any other jurisdiction and does not hold any other professional or occupational licenses.

B. Facts. This stipulation is based upon the following facts:

Background

1. On September 19, 2003, the Board adopted a Stipulation and Order for Limited and Conditional License ("2003 Order") which placed a limitation and conditions on the dental license of Licensee. The 2003 Order was based on allegations and evidence of inadequate infection control, substandard diagnostic/operative care, substandard endodontic care, substandard prosthodontic care, substandard periodontal care, substandard recordkeeping, and unprofessional conduct. Pursuant to paragraphs 7, 8 and 9 of Licensee's 2003 Order, Licensee shall be subject to the language stated within relative to fines, additional discipline, and other procedures for resolution as determined by the Board's Committee.

2. On November 4, 2003, Licensee submitted his report indicating completion of a hands-on endodontic course and petitioned for the removal of the endodontic limitation in his 2003 Order. On November 25, 2003, the Committee agreed to lift the limitation prohibiting endodontic care in paragraph D.1. of Licensee's 2003 Order. Nevertheless, Licensee is currently subject to the 2003 Order.

3. Pursuant to paragraph 2 of Licensee's 2003 Order, Licensee has also completed the following required courses and examinations: conferred with an infection control consultant in August 2003; the Jurisprudence Examination in October 2003; a Special Course on

Treatment Planning in May 2004; a risk management course in May 2004; and a nonsurgical hands-on periodontics course in June 2004.

4. In April 2004, the Board received a complaint against Licensee alleging inadequate infection control and radiology practices and forwarded it to the Committee. Licensee was notified of the complaint and submitted his response to the allegations to the Committee.

5. On November 30, 2004, the Board's representative conducted an infection control and recordkeeping compliance inspection (to review recordkeeping, radiographic technique, and patient care) at Licensee's dental office pursuant to paragraphs D.3.b. and D.3.c. of his 2003 Order. The Board's representative submitted a compliance report of the findings to the Committee which revealed concerns with Licensee's patient care, infection control/radiation safety, billing, and recordkeeping.

6. On March 31, 2005, the Committee held a disciplinary conference with Licensee to discuss the compliance report and new complaint. From the conference, the Committee determined the following violations which warranted further disciplinary action against Licensee.

Substandard Infection Control / Radiation Safety

7. Licensee failed to maintain adequate safety and sanitary conditions for a dental office. Licensee also failed to comply with the most current infection control recommendations and guidelines of the Centers for Disease Control (CDC), as described below:

a. Licensee failed to appropriately change his lab coat on a routine basis or when it became soiled or dirty from the treatment of patients.

- b. Licensee and his staff failed to consistently wash their hands prior to putting on gloves when treating patients.
- c. Licensee failed to place protective barriers on the following: the seating area of the patient chair with duct tape; the exposure button, controls, and head of the x-ray machine; handpiece; air/water syringe; high volume suction; and saliva ejector in his office.
- d. Licensee failed to properly bag and sterilize all instruments (i.e. handpiece, matrix bands/holders, wire cutter, scissors, pliers) found in operatory drawers.
- e. Licensee failed to wear heavy-duty, puncture resistant utility gloves when processing dental instruments.
- f. Licensee failed to perform proper procedures for processing and sterilizing a contaminated dental handpiece.
- g. Licensee failed to properly maintain the dental equipment in his office; the light shield was corroded and electrical wires underneath the bracket table were exposed and frayed.
- h. Licensee failed to properly maintain housekeeping surfaces in his dental office such as the dirty stains on the carpeted floor and dust on a heating vent.
- i. Licensee failed to designate well-defined areas for instrument processing. For instance, Licensee had a bagged instrument next to the ultrasonic cleaner and stored completed prosthodontic items by the cold sterilization container.
- j. Licensee failed to follow certain radiation safety guidelines while taking dental radiographs as follows: failed to provide patients with the option of having a lead apron draped over them; failed to exit the operatory room with the patient's preschool child; and failed to properly store and maintain his lead apron.

Substandard Diagnostic/Operative Care and Recordkeeping

8. Licensee failed to adequately document pertinent information and/or provide appropriate diagnostic and operative treatment when providing diagnostic/operative care to one or more of his patients. Examples include the following:

a. For patient 1 in December 2003, Licensee performed an examination and obtained radiographs, but failed to document and/or provide a diagnosis or operative treatment to the radiolucent areas of decay on six teeth. Furthermore, Licensee failed to document and/or diagnose that two teeth were impacted and document his diagnosis to extract one tooth.

b. For patient 2, Licensee failed to document and/or provide a comprehensive diagnosis and treatment plan that addressed all existing overhanging restorations and open contacts on certain teeth.

c. For patient 3 in October 2004, Licensee performed an examination and obtained radiographs, but failed to document and/or provide a diagnosis or operative treatment to the radiolucent areas of decay on three teeth. Furthermore, Licensee failed to document and/or provide a diagnosis for prosthodontic treatment to replace four extracted teeth.

d. For patient 4 in November 2004, Licensee failed to document and/or provide a diagnosis or operative treatment to the radiolucent areas of decay on one tooth. Furthermore, Licensee failed to note and remove the overhanging restoration on another tooth.

e. For patient 5 in May 2004, Licensee performed an examination and obtained radiographs, but failed to document and/or provide a diagnosis or operative treatment to the radiolucent areas of decay on ten teeth. Furthermore, Licensee failed to

document and/or provide a comprehensive diagnosis and treatment plan for patient 5 that addressed all existing overhanging restorations and management of the patient's rampant decay.

f. For patient 6 in June 2004, Licensee performed an examination and obtained radiographs, but failed to document and/or provide a diagnosis or operative treatment to the radiolucent areas of decay on nine teeth. Licensee also failed to document and/or diagnose that one tooth was impacted. Furthermore, Licensee failed to document and/or provide a comprehensive diagnosis and treatment plan for patient 6 that addressed all existing overhanging restorations and management of the patient's rampant decay.

Substandard Endodontic Care and Recordkeeping

9. Licensee failed to adequately document pertinent information and/or provide appropriate endodontic treatment when providing endodontic care to one or more of his patients. Examples include the following:

a. In 2003, Licensee took a radiograph on patient 1, but failed to endodontically treat the apical lesion on tooth #4. Instead, Licensee placed an amalgam restoration and later performed endodontic treatment on tooth #4 in 2004. Moreover, Licensee failed to properly obturate the canals of tooth #4 for patient 1, the obturation is overextended.

b. In providing endodontic treatment to patient 4, Licensee failed to properly obturate the canals of tooth #14, the obturation is short. Moreover, the lingual canal of tooth #14 has a broken endodontic file within it.

c. For patient 5, Licensee failed to properly obturate the canal of tooth #27 when providing endodontic treatment, the obturation is overextended. Later, Licensee extracted tooth #27 on patient 5 without documenting his rationale for doing so.

d. In 2004, Licensee took radiographs on patient 6, but failed to diagnose and endodontically treat the apical lesion on tooth #13; instead, he placed an amalgam restoration. Furthermore, Licensee had attempted to perform endodontic treatment on tooth #14 without documentation of this or rationale for doing so. Licensee later extracted tooth #14.

Substandard Periodontal Care and Recordkeeping

10. Licensee failed to adequately document pertinent information and/or provide appropriate periodontal treatment when providing periodontal care for one or more of his patients. Examples include the following:

a. For patients 1, 2, 3, 5, and 6, Licensee failed to document and/or provide adequate periodontal care that includes the following: a prophylaxis; a full mouth periodontal probing; periodontal charting and/or further assessment of the status of the patient's periodontal health; and full mouth radiographs for periodontal diagnosis. For patient 5, the radiographs reveal significant bone loss and heavy calculus around numerous teeth whereby Licensee failed to refer this patient to a periodontist.

b. For patients 4, Licensee failed to document and/or provide adequate periodontal care as described in paragraph 10.a. above, except for the prophylaxis. In addition, Licensee failed to document that the patient was being treated by a periodontist. The radiographs taken on patient 4 reveal severe posterior bone loss around numerous teeth.

Improper Billing

11. Licensee has improperly billed the patient, third-party payor, and/or others relating to the practice of dentistry when he billed different fee amounts for the same dental services rendered. For example for patients 2 and 4, Licensee billed the patients' insurance company higher fee amounts for dental services rendered in 2004, as seen on his insurance

claims. Comparatively, Licensee indicated lower fee amounts for the same dental services on the same dates in the patients' progress notes.

Additional Substandard Recordkeeping

12. Licensee has failed to make or maintain adequate records for one or more of his patients. Examples include the following:

- a. Licensee failed to consistently and thoroughly document his review of medical/dental information provided by patients 1 through 6.
- b. Licensee failed to document a complete record of the patient's existing oral health status including but not limited to dental caries, missing or unerupted teeth, restorations, and periodontal conditions/charting for patients 1 through 6.
- c. Licensee failed to obtain adequate clinical examination records to include full mouth radiographs or any other diagnostic aids for patients 1 through 6. The majority of the radiographs taken by Licensee were insufficient for diagnostic purposes due to cone cuts or improper radiation exposure.
- d. Licensee failed to adequately document his diagnosis and treatment plan prior to performing dental treatment for patients 1 through 6.
- e. Licensee failed to obtain the patient's informed consent prior to providing dental treatment to the patient as observed by the Board's representative.
- f. When documenting the treatment provided to patients 1 through 6, Licensee failed to indicate that he was the dental provider by noting his name or initials in the patient's treatment record.
- g. Licensee failed to make corrections properly in patient records for patients 1 through 3, 5, and 6 by writing over existing documentation.

h. Licensee failed to properly indicate the tooth number when completing laboratory slips relative to prosthodontic treatment for patients 2 and 4.

C. Violations. The Committee finds that the conduct specified above constitutes violations of the Minn. Dental Practice Act, 150A.08 et seq., the Minn. R. 3100.6200 et seq., and the 2003 Stipulation and Order, and are sufficient grounds for the disciplinary action specified below.

D. Disciplinary Action. Licensee and the Committee recommend that the Board issue an order **RESCINDING** the 2003 Stipulation and Order and accepting the **VOLUNTARY SURRENDER** of Licensee's license to practice dentistry in the State of Minnesota in accordance with the following terms:

1. Surrender. Effective July 1, 2005, Licensee's license to practice dentistry in the State of Minnesota is terminated. By July 11, 2005, Licensee shall surrender to the Board Licensee's original license and current renewal certificate by delivering them personally or by first-class mail to Marshall Shragg, Executive Director, Minnesota Board of Dentistry, 2829 University Avenue S.E., Suite 450, Minneapolis, Minnesota 55414.

2. Prohibitions. After July 1, 2005, Licensee shall not engage in any act which constitutes the practice of dentistry as defined in Minn. Stat. § 150A.05 and shall not imply to former patients or other persons by words or conduct that Licensee is licensed to practice dentistry.

3. Transfer of Patient Records. No later than August 1, 2005, Licensee shall notify his patients that he has closed his practice and that they may request that their patient records be provided to them or their new treating dentists. Licensee shall comply with record requests within 15 days of receipt. By August 1, 2005, Licensee shall provide the Board with written verification that he has complied with this paragraph.

E. Application for Relicensure. Licensee may apply to the Board for relicensure at any regularly scheduled Board meeting no earlier than one year after the effective date of the Board's order. Licensee must comply fully with the applicable statutes and rules in effect at the time of Licensee's application, including the payment of all fees relating to relicensure. Minnesota Rule 3100.1850 does not apply to an application for relicensure following the issuance of a stipulation and order for voluntary surrender of license.

In addition, if Licensee is out of practice for more than two (2) years after the effective date of this stipulation and order, he shall attain a passing score on the regional clinical examination. Licensee's compliance with the above-referenced requirements shall not create a presumption that he should be granted a license to practice dentistry in the State of Minnesota.

Upon Licensee's application for relicensure, the burden of proof shall be upon him to demonstrate to the Board by clear and convincing evidence that he is capable of conducting himself in a qualified and competent manner, is able to perform the duties of a dentist with reasonable skill and safety, and has complied fully with the terms of the Board's order.

F. Meeting with a Complaint Committee. Licensee shall meet with a complaint committee of the Board at least 30 days prior to the Board meeting to consider Licensee's application for relicensure. The complaint committee shall review and discuss Licensee's

application and fitness to resume the practice of dentistry. After meeting with Licensee, the complaint committee shall forward a report containing its recommendations to the Board.

G. Board Action. At any regularly scheduled Board meeting following Licensee's application for relicensure and meeting with a complaint committee, the Board may take any of the following actions:

1. Reissue a license to Licensee;
2. Reissue a license to Licensee with limitations and/or conditions placed upon the scope of Licensee's practice; or
3. Deny the application for relicensure upon Licensee's failure to meet the burden of proof.

H. Judicial Relief. If Licensee violates paragraph D above, a district court of this state may, upon application of the Committee, enter an order enjoining Licensee from such practice and grant the Board costs, reasonable attorney fees, and other appropriate relief.

I. Attendance at Conference. Licensee attended a conference with the Committee on March 31, 2005. The following Committee members attended the conference: Linda Boyum, R.D.A.; John Bengtson, D.D.S.; and Mark Harris, D.D.S. The Committee was represented by Tamar N. Gronvall, Assistant Attorney General. Although Licensee was informed in the notice of conference that he could be represented by legal counsel, Licensee has knowingly and voluntarily waived that opportunity.

J. Waiver of Licensee's Rights. For the purpose of this stipulation, Licensee waives all procedures and proceedings before the Board to which Licensee may be entitled under the Minnesota and United States constitutions, statutes, or the rules of the Board, including the right to dispute the facts contained in this stipulation and order and to dispute the appropriateness of

discipline in a contested proceeding pursuant to Minn. Stat. ch. 14. Licensee agrees that upon the application of the Committee without notice to or an appearance by Licensee, the Board may issue an order imposing the discipline specified herein. The Committee may participate in Board deliberations and voting concerning the stipulation. Licensee waives the right to any judicial review of the order by appeal, writ of certiorari, or otherwise.

K. Board Rejection of Stipulation and Order. In the event the Board, in its discretion, does not approve this stipulation or a lesser remedy than specified herein, this stipulation and order shall be null and void and shall not be used for any purpose by either party hereto. If this stipulation is not approved and a contested case proceeding is initiated pursuant to Minn. Stat. ch. 14 and § 150A.08, Licensee agrees not to object to the Board's initiation of the proceeding and hearing the case on the basis that the Board has become disqualified due to its review and consideration of this stipulation and the record.

L. Record. This stipulation, related investigative reports, and other documents shall constitute the entire record of the proceedings herein upon which the order is based. The investigative reports, other documents, or summaries thereof may be filed with the Board with this stipulation. Any reports or other material related to this matter which are received after the date the Board approves the stipulation and order shall become a part of the record and may be considered by the Board in future aspects of this proceeding.

M. Data Classification. Under the Minnesota Data Practices Act, this stipulation and order is classified as public data. Minn. Stat. § 13.41, subd. 5. All documents in the record shall maintain the data classification to which they are entitled under the Minnesota Government Data Practices Act, Minn. Stat. ch. 13. They shall not, to the extent they are not already public documents, become public merely because they are referenced herein. Pursuant to federal rule

(45 C.F.R. parts 60 and 61), the Board must report the disciplinary action contained in this stipulation and order to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

N. Entire Agreement. Licensee has read, understood, and agreed to this stipulation and is freely and voluntarily signing it. This stipulation contains the entire agreement between the parties hereto. Licensee is not relying on any other agreement or representations of any kind, verbal or otherwise.

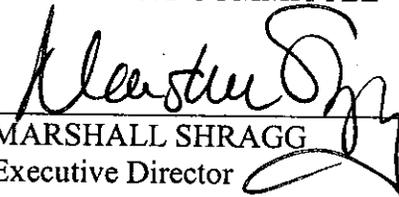
O. Service and Effective Date. If approved by the Board, a copy of this stipulation and order shall be served personally or by first-class mail on Licensee. The order shall be effective and deemed issued when it is signed by the President or Vice-President of the Board.

LICENSEE



BRUCE D. LARSON, D.D.S.

COMPLAINT COMMITTEE

By: 

MARSHALL SHRAGG
Executive Director

Dated: 5-31-, 2005

Dated: JUNE 2ND, 2005

ORDER

Upon consideration of the foregoing stipulation and based upon all the files, records and proceedings herein, the Board **RESCINDS** the September 19, 2003, Stipulation and Order, approves and adopts the terms of the stipulation, orders the recommended action set forth in the stipulation, and accepts the **VOLUNTARY SURRENDER** of Licensee's license to practice dentistry in the State of Minnesota effective this 17th day of June, 2005.

MINNESOTA BOARD
OF DENTISTRY

By: Linda R. Boyum
LINDA BOYUM, R.D.A.
President