BEFORE THE MINNESOTA

BOARD OF DENTISTRY

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

STIPULATION AND ORDER FOR LIMITED AND CONDITIONAL 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 the matter to the Attorney General's Office for investigation. Following the investigation, the Committee held a conference with Licensee. The Committee and Licensee have agreed that the matter may now be resolved by this stipulation and order.

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:

Substandard Infection Control

1. Licensee failed to maintain adequate safety and sanitary conditions for a dental office. He 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 and his employee failed to perform biological monitoring of his autoclave on a weekly basis. In a letter dated May 28, 2003, Licensee enclosed an invoice from a dental supply company which shows that he ordered a biological monitoring system for his office on May 23, 2003.

b. Licensee failed to flush the handpieces and air/water syringes at the beginning and end of each day and between patients. In addition Licensee failed to place anti-retraction valves in the water line in his dental operatory. In his May 12, 2003 response to the Board's Notice of Conference ("response") and during his May 22, 2003 conference with the Complaint Committee ("conference"), Licensee told the Committee he now flushes handpieces and air/water syringes at the beginning and end of each day and between patients. In addition, he has had an anti-retraction valve installed in the water line of his dental operatory.

c. Licensee failed to have a written protocol in his office addressing instrument processing, operatory clean-up, management of injuries or exposure incidents, dental healthcare worker orientation, continuing education or blood spill procedures. In his response and at his conference, Licensee stated that he has implemented a written protocol for each of these procedures and has taken a continuing education program on effective infection control for dental offices.

d. Licensee failed to obtain a new pair of gloves when he returned to the operatory during treatment of a patient; he inverted his gloves and reused them. In his

response and at his conference, Licensee told the Committee he now uses a new pair of gloves if he must leave the operatory and returns to the patient. He uses a new pair of gloves for every patient.

e. Licensee and his employee failed to wear adequate personal protection when providing care to patients. In his response and at his conference, Licensee told the Committee that he and his employee now wear appropriate personal protection, including safety glasses with side shield and lab coats, while providing treatment to patients.

f. Neither Licensee nor his employee has been immunized for Hepatitis B. In his response, Licensee submitted copies of certifications of immunization for himself and his employee.

g. Licensee failed to install an eyewash station for flushing eyes in an emergency. In his response and at his conference, Licensee stated that he has obtained and installed an eyewash station in his office.

h. Licensee and his employee have failed to consistently use proper cold sterilization procedures for contaminated instruments. In his response and at the conference, Licensee explained that he now uses proper cold sterilization procedures.

i. Licensee failed to properly bag and sterilize all instruments in operatory drawers. In his response and during his conference, Licensee explained that he is now properly bagging and sterilizing all instruments in operatory drawers.

j. Licensee failed to wear heavy duty nitrile gloves when processing contaminated dental instruments. In his response and at his conference, Licensee stated that he has obtained heavy duty nitrile gloves for processing contaminated dental instruments.

k. Licensee and his employee failed to perform proper procedures for processing and sterilizing contaminated dental instruments. In his response and during his conference, Licensee stated that he has implemented proper procedures for processing and sterilizing contaminated instruments. He stated that his procedures now include initially scrubbing instruments with a brush in soapy water while wearing heavy duty nitrile gloves, bagging the instruments and placing them in an autoclave and keeping them bagged in autoclave sterilization pouches until they are used.

l. Licensee failed to maintain a first aid kit and emergency resuscitation equipment in this office. In his response and at his conference, Licensee told the Committee he now has a fully maintained first aid kit and emergency resuscitation equipment in his office.

Substandard Diagnostic/Operative Care/Recordkeeping

2. Licensee failed to adequately document pertinent information and/or provide adequate diagnostic/operative treatment when providing diagnostic/operative care to one or more of his patients as described below:

a. On August 25, 1999 and June 24, 2002, Licensee performed an examination and obtained bitewing radiographs for patient 2 that revealed tooth #J with the eruption of tooth #13 resorbing only the mesial half of #J. Licensee failed to provide adequate treatment for patient 2 by not extracting tooth #J. At his conference, Licensee stated that under ideal conditions the tooth should have been extracted and orthodontic treatment provided. However, this patient has medical assistance which no orthodontists in Licensee's area accept.

b. Licensee failed to note and remove overhanging restorations which were observed on bitewing radiographs for patients 3, 6, 8, and 9. At the conference, Licensee stated that all overhangs are clinically unacceptable and will remove them in the future.

c. After taking bitewing radiographs which revealed decay on teeth #12 and 31 of patient 4; tooth #11 of patient 8; teeth #14, 3, and 18 of patient 9; and teeth #4, 5, 13, 15, 18, 19, 20, 28, 29, and 30 of patient 10, Licensee failed to provide operative treatment to those teeth. At the conference and in his written response, Licensee stated that he performed a root canal on tooth #12 of patient 4 on June 5, 2002 and recommended that tooth #31 be extracted, but the patient would not agree. For patient 8, License stated that he continually examined tooth #11 with an explorer and found no evidence of a lesion. Regarding patient 9, Licensee explained that the delay in treatment was due to the patient's not scheduling treatment. Finally, Licensee stated that teeth #20 and 29 of patient 10 did not have lesions and he observes etchings on teeth until the decay compromises the enamel of teeth.

d. At the conference Licensee told the Committee that he had not had his eyes examined recently. He did so on May 23, 2003 and purchased new eyeglasses.

Substandard Endodontic Care/Recordkeeping

3. Licensee failed to adequately document pertinent information and/or provide adequate endodontic treatment when providing care to one or more of his patients. At his conference, Licensee told the Committee he has enrolled in an independent study course offered by the University of Minnesota to show his commitment to providing the best endodontic care for his patients and to improve his skills.

a. On April 11, 2002, Licensee obtained two bitewing radiographs on patient 1, but failed to take a periapical readiograph of tooth #30 which had deep decay.

Licensee stated that he recognized the decay on #30 during a routine examination, and planned to schedule another appointment to treat it and would have taken a radiograph at that time.

b. Licensee provided endodontic treatment to tooth #13 of patient 3 and tooth #12 of patient 4 without taking pre-operative radiographs of these teeth.

c. Licensee failed to document in patient 7's progress notes the endodontic treatment he provided to tooth #11 as evident on a periapical (working length) radiograph dated June 19, 2002. In addition, he failed to obtain a post-operative radiograph of the tooth.

d. Licensee failed to obtain pre- and post-operative radiographs for patient 8's endodontic treatment on May 3, 2001 for tooth #5 and on March 27, 2002 for tooth #13. He also failed to document three periapical radiographs taken on September 5, 2002 of teeth #5 and 13 which reveal improper obturation of canals (short) and only one canal obturated on tooth #5 instead of two canals.

e. Licensee provided endodontic treatment to patient 9 on April 2, 1998 without obtaining pre-and post-operative radiographs of tooth #20, and on October 4, 2002 without a post-operative radiograph of tooth #14. In addition, the working length radiographs failed to show the apexes of teeth #20 and 14.

Substandard Prosthodontic Care/Recordkeeping

4. Licensee failed to adequately document pertinent information and/or provide adequate prosthodontic treatment when providing prosthodontic care to one or more of his patients.

a. On June 5, 2002, Licensee provided a crown on tooth #8 of patient 4 without obtaining pre- and post-operative radiographs and failed to document his diagnosis.

b. On July 9, 2002 Licensee provided patient 7 with a bridge from tooth #11 to tooth #15 with inadequate pre-operative radiographs. On May 28, 2002, Licensee obtained two periapical radiographs that failed to show the apex of the root and/or coronal portion of teeth #11 and 15. Licensee failed to document his diagnosis regarding the bridge placement and the materials used in cementing the bridge. In addition, he failed to obtain diagnostic study models on patient 7 before proceeding with the bridge and failed to provide a post and core on tooth #11 after endodontic treatment.

Substandard Periodontal Care/Recordkeeping

5. Licensee failed to document pertinent information and/or provide adequate periodontal treatment for one or more of his patients.

a. Licensee failed to document and/or provide adequate periodontal care to patients 1, 2, 4, 5, 7 and 8; their charts show no indication that he completed a prophylaxis, full mouth periodontal probing, periodontal charting and/or further assessment of the status of the patients' periodontal health, or obtained full mouth radiographs for a periodontal diagnosis. For patient 4, the bitewing radiographs dated April 15, 2002 reveal significant posterior bone loss around numerous teeth. In his response and at the conference, Licensee stated that he recognized the bone loss in patient 4 and recommended that the patient see a specialist, although he did not document his recommended treatment plan. He also stated that few of his patients make appointments for regular, preventive care.

b. For patients 3, 6, and 9, Licensee failed to document and/or provide adequate periodontal care that includes 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. In addition, Licensee provided only four prophylaxes

from 1972 to 2002 for patient 6. Licensee failed to document in patient 9's progress notes a referral to a periodontist.

Unprofessional Conduct

6. Licensee engaged in conduct unbecoming a person licensed to practice dentistry when he treated patient 11. On December 7, 2002, Licensee provided operative treatment to patient 11, a child. The patient started to cry, kick his feet, and told Licensee that "It hurts." Licensee failed to acknowledge patient 11's discomfort and told him to "shut up". In his response and at his conference, Licensee explained that he was faced with a child who was having a temper tantrum.

Substandard Recordkeeping

7. Licensee failed to make or maintain adequate patient records. Examples include the following:

a. Licensee failed to provide a diagnosis, a treatment plan, treatment options or informed consent to patients 1-10 and 12-14.

b. Licensee failed to identify himself as the provider of dental care, and failed to identify the types or amounts of materials used or anesthesia administered to patients 1-10 and 12-14.

c. Licensee failed to take comprehensive radiographs of patients 3-10 and 12-14.

d. Licensee failed to consistently document the reason for the visits of patients 1-7.

e. Licensee failed to update the medical histories of patients 1, 4, 7, 8, 10, 12, 13 and 14; Licensee failed to document any medical history for patients 1 and 9.

f. Licensee failed to document any periodontal measurements for patients 5, 6, 7, 8, 9, 10 and 12.

C. Violations. Licensee admits that the facts and conduct specified above constitute violations of Minn. Stat. § 150A.08, subd. 1(10), and Minn. R. 3100.6200 K and 3100.6300 (failure to maintain adequate safety and sanitary conditions for a dental office); Minn. Stat. §150A.08, subd. 1(6) and Minn. R. 3100.6200 A (personal conduct which brings discredit to the profession of dentistry); Minn. Stat. §150A.08, subd. 1(6) and Minn. R. 3100.6200 B (repeated performance of dental treatment which falls below accepted standard); and Minn. R. 3100.9600 (failure to make or maintain adequate dental records on each patient) and are sufficient grounds for the disciplinary action specified below.

D. Disciplinary Action. Licensee and the Committee recommend that the Board issue an order which places a LIMITATION and CONDITIONS on Licensee's license to practice dentistry in the State of Minnesota as follows:

LIMITATION

1. Licensee is prohibited from providing endodontic care to any patient except in emergency situations until he successfully completes the endodontic course described below and report. At that time, he may petition the Committee for removal of the limitation.

CONDITIONS

2. Coursework. Licensee shall successfully complete the coursework described below. All coursework must be approved in advance by the Committee. Licensee is responsible for locating, registering for, and paying for all coursework taken pursuant to this

stipulation and order. If Licensee attends an undergraduate or graduate dental school course, Licensee must provide each instructor with a copy of this stipulation and order prior to commencing a course. Licensee shall pass all courses with a grade of 70 percent or a letter grade "C" or better. Licensee's signature on this stipulation and order constitutes authorization for the course instructor(s) to provide the Committee with a copy of the final examination and answers for any course Licensee takes. Licensee's signature also authorizes the Committee to communicate with the instructor(s) before, during, and after Licensee takes the course about Licensee's needs, performance and progress. None of the coursework taken pursuant to this stipulation and order may be used by Licensee to satisfy any of the continuing dental education requirements of Minn. R. 3100.4100, subps. 1 and 2. The coursework is as follows:

a. Within one year of the effective date of this order, Licensee shall complete a minimum of 10 hours of instruction in endodontics which includes a hands-on component at the University of Minnesota or an equivalent course.

b. Within one year of the effective date of this order, Licensee shall complete a minimum of 22 hours of instruction in nonsurgical periodontics which includes a hands-on component at the University of Minnesota (Periodontal Therapies I) or an equivalent course.

c. Within one year of the effective date of this order, Licensee shall complete the Special Course on Treatment Planning (a minimum of 30 hours of individualized instruction) offered by the University of Minnesota or an equivalent course.

d. Within six months of this order, Licensee shall complete 4 hours of instruction on risk management and recordkeeping.

e. Within three months of the effective date of this order, Licensee shall confer with a consultant who has expertise in the training of infection control procedures for the dental office.

3. Written Reports and Information. Licensee shall submit or cause to be submitted to the Board the reports and/or information described below. All reports and information are subject to approval by the Committee:

a. Within 30 days of completing any coursework or the consultation taken pursuant to paragraph 2 above, Licensee shall submit to the Board (a) a transcript or other documentation verifying that Licensee has successfully completed the course, if the course is a graduate or undergraduate dental school course, (b) a copy of all materials used and/or distributed in the course, and (c) a written report summarizing what Licensee learned in the course and how Licensee has implemented this knowledge into his practice. Licensee's report shall be typewritten in Licensee's own words, double—spaced, at least two pages and no more than three pages in length, and shall list references used to prepare the report. The report for recordkeeping classes shall include sample recordkeeping forms that Licensee has begun to use in his practice.

b. Records Inspection. Within three months of Licensee's successful completion of all coursework described above, Licensee shall cooperate with an unannounced office visit during normal office hours by a representative of the Board. The representative shall randomly select, remove, and make copies of original patient records, including radiographs, to provide to the Committee for its review of Licensee's record keeping. radiographic technique and patient care.

c. Office Inspection. After completing the infection control consultation and the report on what he as learned and changed after the consultation, Licensee shall fully cooperate with an unannounced inspection of his office by a representative of the Board for the purpose of reviewing Licensee's safety and sanitary conditions. The Board's representative shall conduct the inspection during normal business hours.

4. Jurisprudence Examination. Within 90 days of the effective date of this stipulation and order, Licensee shall take and pass the Minnesota jurisprudence examination with a score of at least 90 percent. Licensee may take the jurisprudence examination within the 90-day period as many times as necessary to attain a score of 90 percent, however, Licensee may take the examination only once each day. Within 10 days of each date Licensee takes the jurisprudence examination, Board staff will notify Licensee in writing of the score attained.

5. Other Conditions.

a. Licensee shall comply with the laws or rules of the Board of Dentistry. Licensee agrees that failure to comply with the Board's laws or rules shall be a violation of this stipulation and order.

b. Licensee shall fully and promptly cooperate with the Board's reasonable requests concerning compliance with this stipulation and order, including requests for explanations, documents, office inspections, and/or appearances at conferences. Minn. R. 3100.6350 shall be applicable to such requests.

c. If the Board receives a complaint alleging additional misconduct or deems it necessary to evaluate Licensee's compliance with this stipulation and order, the Board's authorized representatives shall have the right to inspect Licensee's dental office(s) during normal office hours without prior notification and to select and temporarily remove original

patient records for duplication. Licensee shall fully and timely cooperate with such inspections of Licensee's office and patient records.

d. In the event Licensee should leave Minnesota to reside or practice outside the state, Licensee shall notify the Board in writing of the new location within five days. Periods of residency or practice outside of Minnesota will not apply to the reduction of any period of Licensee's discipline in Minnesota unless Licensee demonstrates that practice in another state conforms completely to this stipulation and order.

6. Removal of Limitation and Conditions. Licensee may petition to have the conditions removed from Licensee's license at any regularly scheduled Board meeting no sooner than one year after the effective date of this order provided that Licensee's petition is received by the Board at least 30 days prior to the Board meeting. He may petition to have the limitation removed from his license at any regularly scheduled Board meeting following committee approval of his report on his infection control consultation provided that his petition is received by the Board at least prior to the Board meeting. Licensee shall have the burden of proving that Licensee has complied with the limitation and conditions and that Licensee is qualified to practice dentistry without limitations and conditions. Licensee's compliance with the foregoing requirements shall not create a presumption that the limitations should be removed. Upon consideration of the evidence submitted by Licensee or obtained through Board investigation, the Board may remove, amend, or continue the limitations and conditions imposed by this order.

7. Fine for Violation of Order. If information or a report required by this stipulation and order is not submitted to the Board by the due date, or if Licensee otherwise violates this stipulation and order, the Committee may fine Licensee $100 per late report or other violation. Licensee shall pay the fine and correct the violation within five days after service on

Licensee of a demand for payment and correction. If Licensee fails to do so, the Committee may impose additional fines not to exceed $500 per violation. The total of all fines may not exceed $5,000. Licensee waives the right to seek review of the imposition of these fines under the Administrative Procedure Act, by writ of certiorari under Minn. Stat. § 480A.06, by application to the Board, or otherwise. Neither the imposition of fines nor correction of the violation will deprive the Board of the right to impose additional discipline based on the violation.

8. Additional Discipline for Violation of Order. If Licensee violates this stipulation and order, Minn. Stat. ch. 150A, or Minn. R. ch. 3100, the Board may impose additional discipline pursuant to the following procedure:

a. The Committee shall schedule a hearing before the Board. At least ten days prior to the hearing, the Committee shall mail Licensee a notice of the violation alleged by the Committee and of the time and place of the hearing. Within seven days after the notice is mailed, Licensee shall submit a response to the allegations. If Licensee does not submit a timely response to the Board, the allegations may be deemed admitted.

b. At the hearing before the Board, the Committee and Licensee may submit affidavits made on personal knowledge and argument based on the record in support of their positions. The evidentiary record before the Board shall be limited to such affidavits and this stipulation and order. Licensee waives a hearing before an administrative law judge and waives discovery, cross-examination of adverse witnesses, and other procedures governing administrative hearings or civil trials.

c. At the hearing, the Board will determine whether to impose additional disciplinary action, including additional conditions or limitations on Licensee's practice, or suspension or revocation of Licensee's license.

9. Other Procedures for Resolution of Alleged Violations. Violation of this stipulation and order shall be considered a violation of Minn. Stat. § 150A.08, subd. 1(13). The Committee shall have the right to attempt to resolve an alleged violation of the stipulation and order through the procedures of Minn. Stat. § 214.103, subd. 6. Nothing herein shall limit (1) the Committee's right to initiate a proceeding against Licensee pursuant to Minn. Stat. ch. 14, or (2) the Committee's and the Board's right to temporarily suspend Licensee pursuant to Minn. Stat. § 150A.08, subd. 8, based on a violation of this stipulation and order or based on conduct of Licensee before or after the date of this stipulation which is not specifically referred to in paragraph B. above.

10. Attendance at Conference. Licensee attended a conference with the Committee on May 22, 2003. The following Committee members attended the conference: : Susan Gross, D.D.S., Annie Stone Thelen, D.D.S., and Linda Boyum, R.D.A. Assistant Attorney General Rosellen Condon represented the Committee at the conference. Licensee is represented by Tiffany A. Blofield and Julie M. Engbloom in this matter, who have advised Licensee regarding this stipulation and order.

11. 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 adequateness 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.

12. 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 section 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.

13. 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.

14. Data Classification. Under the Minnesota Data Practices Act, this stipulation and order is classified as public data. Minn. Stat. § 13.41, subd. 4. 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. part 60), the Board must report the disciplinary action contained in this stipulation and order to the National Practitioner Data Bank.

15. 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.

16. 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's legal counsel. 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
BRUCE D. LARSON, D.D.S.

Dated: 8-8, 2003

By:

COMPLAINT COMMITTEE

MARSHALL SHRAGG
Executive Director

Dated: August 14th, 2003

ORDER

Upon consideration of the foregoing stipulation and based upon all the files, records, and proceedings herein,

The terms of the stipulation are approved and adopted, the recommended disciplinary action set forth in the stipulation is hereby issued as an order of this Board placing a LIMITATION and CONDITIONS on it effective this 19th day of September, 2003.

MINNESOTA BOARD
OF DENTISTRY

By: Freeman N. Rosenblum DDS
FREEMAN ROSENBLUM, D.D.S.

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