BEFORE THE MINNESOTA

BOARD OF DENTISTRY

In the Matter of
Michael Mattingly, D.D.S.
License No. D9998

FINDINGS OF FACT, CONCLUSIONS, AND FINAL ORDER

The above-entitled matter came on for hearing at a special meeting of the Minnesota Board of Dentistry ("Board") on February 27, 2012, convened at 2829 University Avenue S.E., Suite 450, Minneapolis, Minnesota 55414. The Board conducted a hearing pursuant to the procedure set forth in paragraph H. of the Stipulation and Order issued by the Board to Michael Mattingly, D.D.S. ("Respondent"), on September 24, 2010 ("2010 Order"). At the hearing, the Board Complaint Committee presented by affidavit evidence of Respondent's violations of the 2010 Order. Geoffrey S. Karls, Assistant Attorney General, appeared and presented oral argument on behalf of the Board Complaint Committee. Respondent did not appear. Board members Candace Mensing, D.D.S., Nancy Kearn, D.H., and Neal Benjamin, D.D.S., did not participate in deliberations and did not vote in the matter. Karen B. Andrews, Assistant Attorney General, was present as legal advisor to the Board.

FINDINGS OF FACT

The Board has reviewed the record of this proceeding and hereby issues the following Findings of Fact:

1. The Board is authorized pursuant to Minnesota Statutes chapter 150A to license, regulate, and discipline persons who apply for, petition, or hold licenses as dentists and is further authorized pursuant to Minnesota Statutes sections 214.10 and 214.103 to review complaints

against dentists, to refer such complaints to the Attorney General's Office, and to initiate appropriate disciplinary action.

2. Respondent agreed to and signed the 2010 Order issued by the Board on September 24, 2010. In paragraph H. of the 2010 Order, Respondent expressly acknowledged and agreed to several procedures the Board Complaint Committee may use to resolve alleged noncompliance with or violation of the 2010 Order, Minnesota Statutes chapter 150A, or Minnesota Rules chapter 3100. The 2010 Order remained in full force and effect at the time the conduct described in paragraph 5 below occurred.

3. Respondent expressly acknowledged and agreed in paragraph H. of the 2010 Order that if Respondent violates the 2010 Order, the Board Complaint Committee may seek additional disciplinary action.

4. Respondent expressly acknowledged and agreed in paragraph H. of the 2010 Order that in the event the Board received evidence Respondent violated the terms of the 2010 Order, Minnesota Statutes chapter 150A, or Minnesota Rules chapter 3100, he would be notified of such allegations in writing and, following the opportunity to contest the allegations, the Board may impose additional disciplinary action against Respondent's license.

5. The Board received information Respondent violated the terms of the 2010 Order and engaged in acts or omissions which would be a violation of Minnesota Statutes section 150A.08 as follows:

a. Paragraph E.5. of the 2010 Order required that a Board representative conduct an unannounced visit at Respondent's dental office for a recordkeeping inspection. On December 19, 2011, a Board compliance officer, Deborah A. Endly, arrived at Respondent's office to conduct the recordkeeping inspection. After entering Respondent's office, Endly

observed that the office failed to comply with the most current infection control requirements, in violation of paragraph E.6.c. of the 2010 Order. Endly proceeded to conduct inspections for both recordkeeping and infection control at Respondent's office, which revealed the following:

1) Respondent failed to properly perform weekly biological (spore) testing of the autoclave at his dental office. In general, Respondent's biological (spore) testing information revealed the following: in 2011, testing was performed on 13 occasions out of 52 weeks; in 2010, testing was performed on two occasions out of about 13 weeks of practicing dentistry after having his license reinstated by the Board; and in 2009, testing was performed on four occasions out of about 37 weeks of practicing dentistry before his license was terminated by the Board.

2) Surfaces, such as floors, walls, windowsills, sinks, and ceiling lights, were visibly dusty or soiled with dirt, debris, insects, or pet hair.

3) An inappropriate amount of clutter was present on working surfaces, in cupboards, and on the floor, including dead flowers, boxes, a paint tray, a brass pot, cups, supplies, and an exercise mat. Underwear and other laundry were also found strewn on work surfaces and the floor.

4) A drawer in the sterilization area was broken and taped together, and a wall in the second operatory had a hole exposing electrical/plumbing.

5) Respondent failed to properly dispose of two used facemasks located on a shelf. He also failed to adequately clean and disinfect the clinical contact surface of his operatory chair, where debris was visible near the footrest.

6) Respondent failed to properly bag or re-bag and sterilize all dental instruments and items, including two handpieces, three contra-angles, x-ray film holders, metal

impression trays, two dental scissors, and acrylic burs, which were found in operatory drawers or the laboratory.

7) Respondent failed to wear heavy-duty nitrile gloves when processing contaminated dental instruments. The nitrile gloves present at Respondent's office were located toward the back of the cabinet under the sink and were stuck together, indicating that they were not being used.

8) No protective barriers were found on various objects and surfaces in Respondent's operatory rooms, such as on the bracket tray, handpiece unit, air/water syringe, high/low volume suctions, overhead light handles, curing light handle, chair headrest, or x-ray head and control.

9) Respondent had an expired bottle of Gingi-Pak, demonstrating he failed to properly maintain his inventory of dental products used during treatment procedures on patients.

10) Respondent's lab coat and cloth towels were dirty and stained, indicating he failed to adequately launder or replace these items on a routine basis.

11) Respondent failed to adequately maintain the radiology processing area in his office. This area was unclean and disorganized having several unidentified developed radiographs on the counter and on hangers.

12) Respondent failed to properly clean and disinfect the dental lathe, including the rag wheel, in his laboratory.

13) Respondent failed to comply with work-practice controls for the sharps container by overfilling the container past the manufacturer's designated "full" line on the container.

14) Respondent failed to properly place contaminated waste, such as extracted teeth, into a puncture-resistant, leakproof container set aside for contaminated waste; instead, teeth were found in laboratory drawers.

15) Respondent failed to have an adequate medical emergency kit and access to emergency resuscitation equipment in his office. Respondent only had a pocket mask present in his office. Respondent's kit did not contain any medical emergency items such as an epinephrine, histamine blocker (diphenhydramine), nitroglycerin, ammonia inhalant, glucose source, and asthma inhaler (bronchodilator). Additionally, Respondent failed to have a current healthcare provider CPR card. Instead, Respondent presented a healthcare provider CPR card from the American Heart Association with a recommended renewal date of January 2011.

16) While conducting the inspection, Endly observed that Respondent had been viewing a pornographic website on his personal laptop computer in the front desk area, found a business card revealing a sexually graphic design on the desk next to his computer, and found a packaged condom in one of the laboratory drawers.

17) During the inspection, Endly took a photograph of Respondent sitting in the reception area showing his unprofessional appearance. It is unknown if Respondent saw any patients that particular day or not.

b. On December 21, 2011, Endly submitted an infection control inspection report, including photographs, to the Complaint Committee. After reviewing the report, the Complaint Committee found that Respondent has been non-compliant with the infection control condition of his 2010 Order by failing to maintain adequate safety and sanitary conditions for a dental office and failing to comply with the most current infection control recommendations and guidelines of the Centers for Disease Control ("CDC").

6. On February 13, 2012, Respondent was served with a Notice of Hearing for Alleged Noncompliance With Stipulation and Order by first-class mail. The Notice informed Respondent of the alleged violations and of the date, time, and place of the hearing. The Notice also informed Respondent he was required to submit a response to the allegations in the Notice within seven days after the Notice was mailed.

7. Respondent failed to respond to the Notice.

8. After submission of all written and oral argument, the Board finds that the Committee's allegations are supported by the record.

CONCLUSIONS

Based upon the foregoing Findings of Fact, the Board makes the following Conclusions:

1. The Board has jurisdiction in this matter pursuant to Minnesota Statutes chapter 150A and Minnesota Statutes sections 150A.08, subdivision 1, 214.10, and 214.103.

2. The Board Complaint Committee gave proper notice of the alleged violations to Respondent, pursuant to paragraph H. of the 2010 Order.

3. Under paragraph H. of the 2010 Order, the allegations contained in the Notice are deemed admitted because of Respondent's failure to submit a written response.

4. The Board Complaint Committee has the burden of establishing the statutory violations charged by a preponderance of the evidence.

5. The Board Complaint Committee has proved by a preponderance of the evidence that Respondent has violated Minnesota Statutes section 150A.08, subdivision 1(1), (6), and (13); Minnesota Rules 3100.6200 B., 3100.6200 I., 3100.6200 J., 3100.6350, and 3100.9600; and the 2010 Order.

6. As a result of the violations set forth above and pursuant to the terms of the 2010 Order, the Board has the authority to impose additional disciplinary action against Respondent's license to practice dentistry.

ORDER

Based on the foregoing Findings of Fact and Conclusions, the Board issues the following Order:

1. NOW, THEREFORE, IT IS HEREBY ORDERED that the 2010 Order issued to Respondent on September 24, 2010, is hereby **RESCINDED** and shall have no future force or effect.

2. IT IS FURTHER ORDERED that the license of Respondent to practice dentistry in the State of Minnesota is **SUSPENDED** immediately for an indefinite period of time.

3. IT IS FURTHER ORDERED that during the period of suspension Respondent shall not engage in any conduct that constitutes the practice of dentistry as defined in Minnesota Statutes section 150A.05 and shall not imply to any person by words or conduct that Respondent is authorized to practice dentistry in the State of Minnesota.

4. IT IS FURTHER ORDERED that Respondent surrender to the Board his original dental license and current renewal certificate. Respondent shall personally deliver or mail his license and certificate to the Minnesota Board of Dentistry, c/o Marshall Shragg, Executive Director, Suite 450, 2829 University Avenue S.E., Minneapolis, Minnesota 55414, within ten days of the date of this Order.

5. IT IS FURTHER ORDERED that Respondent may petition the Board to have the suspended status removed from his license at such time as he is willing to respond to the Findings of Fact set forth above and no earlier than five (5) years from the date of this Order.

Respondent's license may be reissued, if at all, as the evidence dictates and based upon the need to protect the public. The burden of proof is on Respondent to demonstrate by a preponderance of the evidence that he is capable of conducting himself in a fit and competent manner in the practice of dentistry. At the time of Respondent's petition, Respondent must meet with a Complaint Committee to review his response to the Findings of Fact. In petitioning for removal of the suspension, Respondent must comply with or provide the Board with, at a minimum, the following:

a. A response to each separate fact contained in the Findings of Fact;

b. Evidence of compliance with the provisions of this Order;

c. Evidence that he is capable of practicing dentistry to the minimum standards of accepted and prevailing practices; and

d. Any additional information relevant to Respondent's petition reasonably requested by the Committee.

6. IT IS FURTHER ORDERED that if Respondent petitions to have the suspended status removed from his license, he will be required to attain a passing score on a Board-approved regional clinical examination. Respondent's compliance with this requirement will not create a presumption that he should be granted a license to practice dentistry in the State of Minnesota.

7. IT IS FURTHER ORDERED that Respondent must meet all reinstatement requirements in effect at the time of his petition, including but not limited to completing the appropriate application, paying the requisite fees, and completing any necessary professional development requirements.

8. IT IS FURTHER ORDERED that Respondent's violation of this Order will constitute violation of a Board order for purposes of Minnesota Statutes section 150A.08, subdivision 1(13), and provide grounds for further disciplinary action.

9. IT IS FURTHER ORDERED that the Board may, at any regularly scheduled meeting following Respondent's petition for removal of the suspension of his license and his meeting with a Complaint Committee, take any of the following actions:

a. Reissue to Respondent his license to practice dentistry;

b. Reissue a license to Respondent with limitations placed upon the scope of Respondent's practice and/or conditional upon further reports to the Board; or

c. Continue the suspension of Respondent's license based upon his failure to meet the burden of proof.

10. This Order constitutes disciplinary action against Respondent.

11. This Order is a public document and will be forwarded to all appropriate databanks as required by law.

Dated: Sept. 18, 2012

MINNESOTA BOARD
OF DENTISTRY

David A. Linde DDS

DAVID A. LINDE, D.D.S.
President

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