

BEFORE THE MINNESOTA

BOARD OF DENTISTRY

In the Matter of
John A. Muller, D.D.S.
License No. 7235

**STIPULATION AND ORDER
FOR CONDITIONAL LICENSE
AND REMOVAL OF AUTHORIZATION
TO ADMINISTER CONSCIOUS SEDATION**

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 John A. Muller, D.D.S. ("Licensee"). The Board's Complaint Committee ("Committee") reviewed the complaint(s) and referred it to the Attorney General for investigation. Subsequently, the Board received additional complaint(s) against Licensee which it forwarded to the Committee for review and the Committee referred it to the Attorney General for investigation. Thereafter, Licensee and his attorney met with the Complaint Committee for a disciplinary conference on September 23, 2005. Thus, 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:

Background

History of Past Disciplinary Actions

On November 22, 1980, and November 26, 1980, respectively, the Board adopted a Settlement Stipulation for Conditional License and an Order for Suspended and Conditional License Order ("1980 Orders"), which placed limitations and conditions on the dental license of the Licensee. The 1980 Orders were issued based on findings of auxiliary misuse.

On June 30, 1989, the Board adopted a Notice and Order of Temporary Suspension and Order for Psychiatric Examination based on findings of Licensee's mental disability and unprofessional conduct. On September 26, 1989, Licensee entered into a Stipulation and Order ("1989 Order") for a conditional license based on impairment due to Licensee's mental health condition and unprofessional conduct. The conditions of the 1989 Order related to the monitoring of Licensee's mental health condition. The Order also required Licensee to provide to the Board information regarding the financing options offered to his patients.

From 1989 to 1992, the Board received complaint(s) alleging various violations and reports of Licensee's non-compliance with the 1989 Order, which led to mediation at the Office of Administrative Hearings. On September 24, 1993, an Amended Stipulation and Order ("1993 Amended Order") was issued based on findings of unprofessional conduct, substandard care,

failure to maintain safety conditions, misleading advertising, impairment due to a mental health condition, substandard recordkeeping (including failures to record administration of local anesthetic and nitrous oxide analgesia), excessive administration of local anesthetic, and improper prescribing of controlled substances. Substandard care violations cited in the 1993 Amended Order included numerous findings of inadequate medical history reviews, substandard diagnoses (including poor radiographic quality, inadequate periodontal, endodontic and oral surgery diagnoses), substandard dental treatments (including endodontic, restorative and oral surgery), and failure to document pertinent information relating to diagnoses and treatments.

The 1993 Amended Order required Licensee to work with a supervising dentist and included a five-year suspension that was stayed upon Licensee's compliance with his 1993 Amended Order. The conditions of the 1993 Order included monitoring of Licensee's mental health condition. The Order also required the Licensee to surrender his Drug Enforcement Agency (DEA) certificate until his successful completion of a pharmacology course. The Order also required Licensee to take coursework in the following areas: endodontics, periodontics, recordkeeping, diagnosis and treatment planning and radiographic diagnoses and interpretation.

The 1993 Order also required Licensee to provide to the Board information relating to various business procedures in his practice. Licensee was also required to submit evidence of corrections made to the nitrous oxide administration equipment in his practice. Licensee was also required to develop and submit for Board approval, an office protocol to ensure quality of panoramic x-rays. Licensee also was required to complete the jurisprudence examination and to pay a fine of \$3,000.

On April 11, 1995, the Board issued an Order of Suspension based on Licensee's violation of conditions of his 1993 Amended Order. Licensee had failed to timely complete the

pharmacology course and had failed to timely enter into an Agreement to Supervise when there was a change in supervising dentists. After complying with the conditions stated within the Order of Suspension, the Board issued an Order of Reinstatement to Licensee on May 3, 1995.

From 1993 to 1997, the Board received complaint(s) alleging substandard care and failure to comply with the 1993 Amended Order. This resulted in a Second Amended Stipulation and Order for Limited and Conditional License ("1997 Second Amended Order") issued on September 29, 1997. This Order was based on findings of substandard oral surgery, excessive use of local anesthetic, improper prescribing, substandard recordkeeping, and unsatisfactory reports from supervising dentists. Supervising dentist reports included information relating to the various deficiencies in Licensee's practice of dentistry. The 1997 Second Amended Order required Licensee to continue working with a supervising dentist. The Order also required continued monitoring of Licensee's mental health condition.

From 1998 to 2000, the Board received complaint(s), which led to a Third Amended Stipulation and Order for Limited and Conditional License ("2001 Third Amended Order") issued on September 21, 2001. This Order was based on findings of improper administration of nitrous oxide, inadequate safety/sanitary conditions, and substandard recordkeeping.

The 2001 Third Amended Order required Licensee to complete coursework and/or independent study in the following subject areas: infection control, recordkeeping, nitrous oxide administration and ethics. Licensee was required to follow up on the remedial education by submitting to the Board reports of what he learned and how he is applying the information to his current practice. Licensee complied with the requirements and on September 19, 2003, Licensee was granted an unconditional license.

Background for Current Violations

From January to May 2004, the Board of Dentistry received complaint(s) against Licensee alleging impairment due to a mental health condition (licensee provided information to the Committee which indicated his mental health condition was under control), unprofessional conduct, inadequate infection control, substandard care (diagnostic and restorative), auxiliary misuse, fraud, and misleading advertising. Following the Attorney General's Office investigation of the complaints, the Committee became concerned about Licensee's ability to practice safely.

Subsequently, the Committee received additional complaints from February to April 2005 against Licensee alleging substandard care, including that Licensee over-sedated patients and did not properly monitor patients during conscious sedation procedures. The Committee referred the matter to the Attorney General's Office for investigation including obtaining and reviewing the patient records of several patients whom Licensee had treated with conscious sedation.

In May and June 2005, a local, credentialed oral surgery and conscious sedation expert ("expert") reviewed the records of at least 13 patients whom Licensee recently treated with conscious sedation throughout 2004 and 2005. On June 1, 2005, the expert issued a report. The expert concluded that Licensee's conscious sedation procedures and techniques deviated from the minimal and accepted standards of conscious sedation practices. Specifically, the report indicated that among other things, the Licensee repeatedly administered overdoses of sedation medication and failed to adequately monitor patients during sedation. The expert also observed that Licensee failed to consider and evaluate the medical histories and health conditions of many patients, including several elderly patients, before deciding to administer conscious sedation. In

doing so, Licensee failed to ensure the safety of these patients. The expert concluded that Licensee's conscious sedation treatment demonstrated gross ignorance or incompetence and put many of these patients at imminent risk of harm.

On June 17, 2005, the Board adopted a Stipulation and Order to Cease Using Conscious Sedation ("2005 Order to Cease") which placed limitations on Licensee's license as follows: Licensee was (a) prohibited from performing any conscious sedation procedures or administering any conscious sedation medications; (b) prohibited from supervising, advising, or managing any conscious sedation procedures performed by his staff or associates; and (c) prohibited from advertising himself as being eligible to perform conscious sedation procedures or administer conscious sedation medications. Licensee's 2005 Order to Cease was based on findings of improper prescribing and administration of conscious sedation medication. The 2005 Order to Cease was also based on findings of improper and inadequate monitoring and evaluation of patients before, during and after conscious sedation procedures.

In June and July 2005, the Committee received additional complaint(s) against Licensee alleging that Licensee had violated the limitations indicated within his 2005 Order to Cease relating to conscious sedation and advertising. Upon review of the complaints, the Committee referred the matter for an Attorney General's Office inspection of Licensee's office pursuant to paragraph D.2.d. of his 2005 Order to Cease.

Violation of 2005 Order to Cease Using Conscious Sedation

C. Licensee has violated his 2005 Order to Cease Using Conscious Sedation. On June 17, 2005, the Board adopted a Stipulation and Order to Cease Using Conscious Sedation which placed limitations on Licensee's license regarding conscious sedation and advertising. Examples of violations of these limitations include the following:

1. Licensee has violated the limitation prohibiting him from performing any conscious sedation procedures or administering any conscious sedation medications, including but not limited to Triazolam, Midazolam, and Romazicon pursuant to paragraph D.1. of his 2005 Order to Cease. Licensee is also prohibited from supervising, advising, or managing any conscious sedation procedures. On July 15, 2005, the Attorney General's investigators conducted an inspection of Licensee's office retrieving ten patient records pursuant to paragraph D.2.d. of his 2005 Order to Cease. After reviewing the patient records, the investigator submitted a report to the Committee. Upon reviewing the report, the Committee has determined that Licensee has violated his 2005 Order to Cease, as follows:

a. Subsequent to the effective date, June 17, 2005, of Licensee's 2005 Order to Cease, Licensee provided dental treatment to ten known patients who were administered conscious sedation medications. According to the records of patients 18 through 27, the patients received medications such as Triazolam, Midazolam (Versed), Romazicon, and Ketorolac (Toradol). The patients' billing histories indicate that Licensee performed the dental treatment and his associate dentist ("associate") administered the conscious sedation to the patients. Upon reviewing the appointment schedule for both Licensee and his associate, it shows that Licensee's associate was scheduled with conscious sedation patients at the same time that Licensee treated patients 18 through 27. Conclusively, Licensee's associate would have been unable to monitor Licensee's patients and his own patients concurrently. Thus, Licensee was left to monitor and evaluate his own conscious sedation patients, which was prohibited by his 2005 Order to Cease. Alternatively, if Licensee did not monitor or evaluate his own patients, the patients were also not continuously being monitored or evaluated by Licensee. At the conference with the Complaint Committee, Licensee admitted that subsequent to the June 2005 Order, his dental assistant and an

associate dentist in his practice, monitored and assessed patients in conscious sedation procedures in which Licensee performed the dental procedures. And Licensee's associate signed off on whether it was acceptable to administer sedation.

Substandard Care/Substandard Conscious Sedation

D: Licensee failed to appropriately evaluate patients' medical histories and conditions to determine if patients were eligible for conscious sedation procedures. Licensee also failed to properly administer the appropriate dosage of sedation medications, namely Triazolam, Midazolam, and Romazicon during conscious sedation procedures. Licensee failed to adequately monitor the vital signs of patients during conscious sedation and failed to properly document his monitoring of patients. Additionally, Licensee failed to report serious or unusual outcomes of several conscious sedation procedures to the Board as required by the Board of Dentistry's Rules. Examples are outlined in subparagraphs 1 - 16 below.

Licensee admitted that he did not always indicate in the patient charts the American Society of Anesthesiologists' Physical Status ("ASA") Classifications of the patients. And Licensee admitted that his office did not always gather additional information from a patient's physician as to their pre-existing medical conditions or suitability for conscious sedation procedures.

Licensee stated that he always works on patients with the pulse oximeter in place from the beginning of sedation, when a baseline reading is obtained. But Licensee additionally admitted that pulse oximeter readings in the patient records showed discrepancies as a result of not having programmed the clock of the pulse oximeters with the actual time of day. Additionally, in some cases, tapes from the pulse oximeter may have been lost.

Licensee explained that such isolated aberrant readings may be the result of interferences, positional changes in the dental chair, placement of the recording sensor or a fear-based response by the patient. However, Licensee provided no proof to explain such readings. Licensee admitted that he did not follow up on aberrant readings after receiving them.

In regard to the NPO (“nothing by mouth”) restrictions of twelve (12) to fourteen (14) hours, Licensee explained that this was his protocol prior to April 2005.

1. On October 27, 2004, Licensee gave patient 1 at least two administrations of Triazolam, resulting in a total dose of 0.5 mg over a five-minute period. Patient 1 is 80 years old and indicated a significant medical history, including asthma, diabetes, significant hypertension, kidney diseases and potential congestive heart failure. Licensee failed to properly evaluate whether this dose of sedation medication was appropriate for the patient. Licensee failed to monitor patient 1’s blood pressure, pulse or hemoglobin oxygen saturation even though patient 1’s vital signs taken one day before sedation indicated significant hypertension and oxygen saturation of 91%. Licensee also failed to assess the patient’s blood glucose level at any time. Moreover, Licensee failed to ensure that the patient’s escort (or wife who is about the same age) would be able to adequately assist the patient upon returning home after the sedation procedure. The escort was unable to wake the patient after returning home which resulted in the patient remaining asleep in their car.

Licensee administered four carpules of local anesthetic with epinephrine in concentration 1:100,000 cc which resulted in a total dose of 0.072 mg. of epinephrine (dose should not exceed 0.060 mg.). As a result, the health of patient 1 was compromised because of his cardiovascular disease. At the conference, Licensee stated that he was not aware of a maximum dose for epinephrine.

2. On December 14, 2004, and January 11, 2005, Licensee sedated patient 2. In the December 14, 2004 sedation, Licensee gave patient 2 four administrations of Triazolam in one hour and 25 minutes, for a total dose of 2 mg, with 1 mg given during the first 17 minutes. Licensee failed to evaluate patient 2's weight, ASA status, baseline vital signs or oxygen saturation. Licensee failed to monitor patient 2's sedation until more than 20 minutes after he administered the last dose of Triazolam. Licensee failed to ensure patient 2's safety when the patient experienced a period of hemoglobin desaturation (92%) and hypotension (100/78).

a. In the January 11, 2005 sedation of patient 2, Licensee gave the patient at least two administrations of Triazolam over a 32 minute period, for a total dose of 1 mg, with 0.5 mg being given initially. Licensee failed to monitor patient 2 or document patient's vital signs until at least 1.5 hours after he sedated patient 2. Licensee failed to ensure the patient's safety when Licensee documented that patient 2 had a hypertension emergency, resulting in a blood pressure reading of 231/189. Licensee also failed to indicate the etiology of this occurrence and how Licensee treated it. Licensee failed to include an informed consent form for the patient, which would have included preoperative sedation instructions, and failed to document NPO or "nothing by mouth" instructions or status. Licensee explained that informed consent for the January 11, 2005 sedation procedure was obtained at the prior appointment (on December 2, 2004). Licensee stated that he was not aware that informed consent needs to be obtained for each sedation episode.

3. On October 19, 2004, Licensee sedated patient 3, a young female, with at least seven administrations of Triazolam over a period of five hours and 40 minutes, for a total dose of 2.5 mg with 0.5 mg given in the first administration and 2 mg in the second administration, 25 minutes later. Patient 3 indicated she was taking pre-natal vitamins, but

Licensee failed to confirm that patient 3 was not pregnant or inform her of the possible role of Triazolam and birth defects. Licensee also administered 18.5 carpules of a local anesthetic with vasoconstrictor, but failed to document when this was administered. At the conference, Licensee demonstrated that he was not knowledgeable of maximum dosages and interactions of different types of local anesthetic. Licensee failed to monitor patient 3's vital signs and oxygenation for about 45 minutes during the sedation. Licensee instructed patient 3 to have no beverages for 12-14 hours before the procedure, and with no oral intake during the more than 7-hour procedure. Patient 3 was dehydrated during the procedure.

a. Immediately after the October 19, 2004 sedation appointment, it was alleged that Licensee instructed one of his staff members to drive patient 3 to a nearby motel, since the patient did not have a ride home. Prior to leaving Licensee's office, patient 3 allegedly vomited at the practice. Once at the motel, patient 3 allegedly vomited in the lobby and she was left unattended in a room at the motel. There is no documentation in patient 3's chart about becoming ill or being driven to a motel by a staff member.

The Licensee explained that patient 3 was transported to a motel by one of Licensee's staff members, subsequent to her appointment, as a result of not knowing about the lack of companion before the sedation medication was administered. Licensee now ensures that all sedated patients are accompanied by a companion. In regard to not recording information relating to the patient having vomited, Licensee explained that typically, the fact that a patient vomited is not recorded in his patients' records.

4. On August 24, 2004 and October 25, 2004, Licensee sedated patient 4. Patient 4 is a 52-year-old with a medical history of smoking. Licensee failed to evaluate and/or failed to document the pulmonary and cardiac status of patient 4 to determine whether conscious

sedation was appropriate for a smoker over the age of 50. Licensee also failed to evaluate patient 4's vital signs, which revealed a borderline hypertensive blood pressure of 147/87, to determine whether conscious sedation was appropriate for patient 4.

a. At the August 24, 2004 sedation, Licensee gave patient 4 three administrations of Triazolam, for a total dose of 1.25 mg in 90 minutes, with the first administration of 0.5 mg. Licensee failed to monitor patient 4 until 6 to 7.5 hours after administering the sedation medication.

b. During the October 25, 2004 sedation, Licensee administered three doses of Triazolam, for a total dose of 0.75 mg in 60 minutes, but Licensee failed to monitor patient 4 until one hour and 18 minutes later.

5. On December 13, 23, and 30, 2004, and January 13, 2005, Licensee sedated patient 5. Licensee failed to evaluate and/or document patient 5's weight, or any of the patient's baseline vital signs, including blood pressure or hemoglobin oxygen saturation percentages before Licensee began the sedation on each occasion.

a. At the December 13, 2004 sedation, Licensee administered both Triazolam and Midazolam to patient 5. Licensee first sedated the patient at 7:25 a.m., with 0.5 mg of Triazolam. Licensee failed to document how he administered the 20 administrations of Midazolam, 56 mg total, to the patient over a 6 hour and 30 minute period. At 2:30 p.m., Licensee administered 10 mg of Midazolam to patient 5. Five minutes later, Licensee administered 8 mg of Romazicon (Flumazenil), a benzodiazepine receptor antagonist, to reverse the sedation effects of Triazolam and Midazolam. Licensee failed to indicate how or why he administered the flumanzenil dosage, which was more than double the standard dosage. Licensee also failed to evaluate whether it was appropriate to administer this dosage to patient 5

where the risk of adverse reactions include convulsions, increased muscle tone, and hyperesthesia.

b. On December 23, 2004, Licensee sedated patient 5 for a second time and gave patient 5 at least three administrations of Triazolam for a total dose of 1.5 mg over a 45-minute period. Then Licensee gave the patient five administrations of Midazolam for a total dose of 12 mg over a 30 minute period. Licensee also failed to monitor the patient until eight minutes prior to the last administration of Midazolam. Licensee also failed to properly ensure the safety of the patient during this procedure when there was an oxygen saturation reading of 91%, indicative of hypoxia, approximately one hour after the last drug administration.

c. On December 30, 2004, Licensee sedated patient 5 for a third time and gave patient 5 0.5 mg of Triazolam followed 35 minutes later by seven administrations of Midazolam for a total of 15 mg of Midazolam in 1 hour and 45 minutes. Licensee failed to monitor/document the patient until two hours after the last administration of Midazolam.

d. On January 13, 2005, Licensee sedated patient 5 for a fourth time and gave the patient two administrations of Triazolam for a total dose of 0.75 mg over a 30-minute period. Licensee then gave the patient three administrations of Midazolam, for a total dose of 5 mg in 28 minutes. Licensee failed to monitor/document patient 5 until 20 minutes after the last dose of sedative.

Licensee explained that patient 5 had an unusual, though not uncommon, paradoxical reaction to Midazolam. Licensee also stated that the Flumazenil dosage was inadvertently recorded in milligrams instead of milliliters. At the conference, Licensee stated he did not recall learning from his training the cause of paradoxical reactions.

6. On December 20, 2004, January 10 and 25, 2005, Licensee sedated patient 6 to provide dental treatment. Patient 6, a 63-year-old, indicated several medical conditions, including diabetes, a history of steroid therapy, signs of congestive heart failure (including the swelling of feet, ankles), and a significant medication history, which the patient indicated on a health history form. Licensee failed to assess whether conscious sedation was appropriate for patient 6 given the patient's age and medical conditions. Licensee also failed to evaluate/document the patient's weight and patient's baseline vital signs or ASA assessment.

a. On December 20, 2004, Licensee sedated patient 6 with three administrations of Triazolam, with the first dose of 0.5 mg, for a total dose of 1 mg over two hours and seven minutes. Licensee failed to consistently monitor the patient's oxygen saturation. Licensee also failed to properly ensure the patient's safety, as there is evidence of mild systolic hypertension.

b. On January 10, 2005, Licensee sedated patient 6 for a second time with three administrations of Triazolam, each being 0.5 mg, for a total dose of 1.5 mg over 30 minutes. Licensee failed to monitor/document the patient's vital signs until about two hours after the last dose of sedation medication.

c. On January 25, 2005, Licensee sedated patient 6 for a third time with three administrations of Triazolam for a total dose of 1.25 mg over 45 minutes, with an additional dose of 0.5 mg and 0.5 mg 25 minutes later. Licensee failed to monitor/document the patient's vital signs until one and a half hours after the last administration of sedation medication.

7. On December 28 and 29 2004, and January 25, 2005, Licensee sedated patient 7. Patient 7, who was 69 years old, reported a history of hypertension and was on

medication to control it. Patient 7 also reported a compromised pulmonary function and took albuterol (beta 2 agonist for bronchial dilation) to control that condition. Licensee failed to evaluate whether conscious sedation was an appropriate procedure for this patient.

a. On December 28, 2004, at the first sedation, Licensee gave patient 7 two administrations of Triazolam, of 0.5 mg each, for a total dose of 1 mg over a 39-minute interval. Five minutes after the last administration of Triazolam, Licensee gave patient 7 two administrations of Midazolam, for a total dose of 5 mg over a five-minute interval. Licensee failed to monitor/document the patient's vital signs until more than one hour after the last administration of the sedation medications. Licensee also failed to consistently monitor and or document the patient's oxygen saturation levels.

b. On December 29, 2004, Licensee sedated patient 7 for the second time with four administrations of Triazolam, for a total dose of 1 mg over a two hour and five minute interval that included an initial dose of 0.25 mg and 0.25 mg 15 minutes later. Licensee failed to monitor/document the patient's vital signs until about one hour after the first dose of sedative. Licensee also failed to consistently monitor/document the patient's vitals for at least a one-hour period.

c. On January 25, 2004, Licensee sedated patient 7 for the third time with two administrations of Triazolam, for a total dose of 1 mg over a 45 minute period. Licensee failed to monitor/document the patient until 90 minutes after the last dose of sedative. The Licensee also failed to ensure the patient's safety when the patient sustained an episode of hypertension of 198/101.

d. During one of the aforementioned sedation appointments, it was alleged that patient 7's wife informed Licensee's staff that her husband had consumed alcohol

the day of his appointment. In turn, the staff informed Licensee about patient 7's alcohol consumption; however, Licensee still administered conscious sedation to patient 7.

8. On August 2, 2004, Licensee sedated patient 8 to provide dental treatment. Patient 8, a 69-year-old, indicated a history of high blood pressure and arthritis. Licensee failed to evaluate whether conscious sedation was an appropriate procedure for an elderly patient with significant medical history. Licensee gave patient 8 at least six administrations of Triazolam, with a total dose of 1.5 mg over four hours, with 0.75 mg being administered within the first 32 minutes of sedation. Licensee failed to monitor/document patient 8 after he administered the last dose of sedation. Licensee failed to properly ensure the patient's safety when patient experienced hypertension of 174/94, with many readings of systolic measurements greater than 140 mm hg.

9. On March 15, 2005, Licensee sedated patient 9 to provide dental treatment. Patient 9 reported a history of smoking, a swelling of the feet and ankles and presented with a baseline blood pressure of 144/106 indicating hypertension. Licensee failed to evaluate whether conscious sedation was an appropriate procedure for this patient with this medical history. Licensee gave patient 9 at least four administrations of Triazolam, for a total dose of 1.75 mg over four hours and 48 minutes, with 1.5 mg being administered in the first 55 minutes of sedation. Licensee also administered 3.5 mg of Romazicon about three hours into the sedation, which was an excessive dose. Moreover, Licensee failed to document the rate of dosage or the reason the Romazicon was administered. Two hours after administration of the Romazicon to patient 9, Licensee administered additional Triazolam. Licensee failed to monitor patient 9's vital signs during the sedation. Licensee failed to report adverse reactions to the

Board. Finally, Licensee admitted that he lost the monitoring record and that he did not document the rationale for following the Midazolam with the Flumazenil (Romazicon).

10. On March 24, 2005, Licensee gave patient 10 six administrations of Triazolam, resulting in a total dose of 1.5 mg over a four-hour period. Patient 10 presented with a medical history of diabetes and indicated that the patient was taking hypertension medication. Licensee failed to evaluate the patient's medical history to determine whether patient 10 was an appropriate candidate for conscious sedation. Licensee also failed to ensure the patient's safety when the patient experienced hypoxia, oxygen saturation readings of 81%-92%, throughout the procedure.

a. Immediately after the March 24, 2005 sedation appointment, it was alleged that Licensee instructed one of his staff members to drive patient 10 to her home, since the patient did not have a ride home. Once at home, patient 10 was allegedly left unattended with no one else at home to look after the patient. There is no documentation in patient 10's chart indicating that the patient was driven home by a staff member and being left unattended at the home.

Licensee explained that he was not aware that patient 10 did not have a companion to take her home before sedation was administered. Additionally, Licensee explained that Patient 10 was accompanied by a staff member to her home, and the staff member was instructed not to leave the patient alone.

11. On March 8, 2005, Licensee treated patient 11 by administering conscious sedation, performing extractions and preparing teeth for crowns. Patient 11 indicated that he was taking high blood pressure medication, but Licensee noted in the patient record that it was "under control." When patient 11 presented for treatment, the patient's blood pressure was 193/110.

Licensee failed to properly evaluate whether patient 11 was an appropriate candidate for conscious sedation. At the beginning of the sedation, Licensee gave the patient one administration of 0.5 mg Triazolam and then administered a total of 8.5 mg of Midazolam over approximately two hours. One minute after administering 0.5 mg Triazolam, patient 11's blood pressure rose to 209/110. Licensee also failed to properly monitor and ensure the patient's safety when he continued to administer sedation medication when the patient experienced markedly high blood pressure. Licensee explained that he did not initiate treatment for patient 11 until after the systolic blood pressure reading was less than 200.

a. While administering local anesthetic to patient 11 by means of a right mandibular block, Licensee broke the anesthetic needle, lodging it in the patient's mandible. Licensee admitted he did not tell the patient or the patient's escort at that time about the broken needle. But Licensee arranged for the patient to visit an oral surgeon that day and Licensee told the patient about it later. The oral surgeon was unable to remove the needle. Licensee also failed to report this adverse reaction or event to the Board as required by the Board's rules.

12. On December 29, 2004, Licensee sedated patient 12, a 50-year-old, to provide dental treatment. Licensee gave patient 12 at least four administrations of Triazolam for a total dose of 1.5 mg over 2 hours 30 minutes, with 1.0 mg being administered within the first 25 minutes of sedation. Licensee also failed to properly ensure the patient's safety when the patient experienced four hypertension readings with systolic measurements greater than 140 mm hg. Licensee instructed patient 12 to have no beverages for 12-14 hours before the procedure, and with no oral intake during the more than 5-hour procedure. Patient 12 was dehydrated during the procedure.

13. On November 2, 2004, Licensee sedated patient 13, a 59-year-old, to provide dental treatment. Patient 13 indicated a significant medical history including back problems, a heart murmur, and mild depression. The pre-operative blood pressure readings of 179/109 and 168/100 indicated hypertension. Medications listed include Fosinopril for a heart murmur and Cymbalta for depression. Licensee failed to evaluate and/or failed to adequately document the health status of patient 13 to determine whether conscious sedation was appropriate considering the medical history information. Licensee gave patient 13 at least six administrations of Triazolam for a total dose of 3.0 mg over 3 hours and 25 minutes, with 1.5 mg being administered within the first 60 minutes of sedation.

14. On March 24 and 31, 2005, Licensee sedated patient 14 to provide dental treatment. Patient 14, a 39-year-old, indicated a medical history of thyroid disease and asthma. Licensee failed to evaluate/document the patient's weight and patient's baseline vital signs or ASA assessment on each occasion.

a. At the March 14, 2005 sedation, Licensee gave patient 14 at least seven administrations of Triazolam for a total dose of 2.25 mg over 4 hours and 22 minutes, with 0.75 mg being administered within the first 10 minutes of sedation

b. On March 31, 2005, Licensee sedated patient 14 for a second time. Licensee gave patient 14 at least three administrations of Triazolam for a total dose of 1.5 mg over 64 minutes. Within 20 minutes after the last dose of Triazolam, Licensee administered Midazolam for a total dose of 9 mg over 3 hours and 20 minutes.

15. On December 27, 2004, Licensee treated patient 16, a seven-year-old child, by administering nitrous oxide inhalation analgesia and extracting two deciduous teeth. According to patient 16's progress notes, Licensee administered levels of 5.5 liter/min. for

nitrous oxide and 2.5 liter/min. for oxygen which are considered abnormally high levels for conscious sedation on a child. However, Licensee failed to obtain the parent's or guardian's informed consent prior to providing conscious sedation to patient 16. Licensee also failed to properly monitor and document patient 16's vital signs and oxygen saturation levels during the sedation.

Licensee explained that he would not administer 5.5 liter/min. of nitrous oxide to a child patient. Licensee also explained that for a child undergoing two extractions under local anesthesia, this level may be warranted to diminish apprehension and fear. Licensee further explained that patient 16 was not given nitrous oxide for ten minutes as written in the chart. Licensee also explained that the appropriate informed consent forms were signed by the patient's parent, but it appears to have been lost from the file.

16. On July 29, 2004, Licensee sedated patient 17 to provide dental treatment. Licensee gave patient 17 at least five administrations of Triazolam for a total dose of 1.5 mg over 3 hours and 12 minutes, with 0.75 mg being administered within the first 20 minutes of sedation.

a. At a subsequent appointment on August 12, 2004, patient 17 informed Licensee of her request for no sedation at future appointments due to experiencing a migraine headache after receiving sedation at her previous appointment.

Licensee explained that he does not recall patient 17 mentioning the headache issue with patient 17 at her follow up appointment. Licensee further explained that headaches are a relatively common albeit undesirable side effect of Triazolam use.

Substandard Endodontic Care / Recordkeeping

E. Licensee failed to adequately document pertinent information and/or provide appropriate endodontic treatment when providing endodontic care to one or more of his patients.

Licensee admits that he does not properly chart his endodontic care. Examples include the following:

1. Licensee failed to perform appropriate diagnostic evaluations of the pulpal and periradicular status of teeth and/or document the pulpal and periradicular diagnosis before providing endodontic treatment to his patients. For example:

a. For patient 5, Licensee failed to perform adequate pulp testings and document a diagnosis for the endodontic treatment on teeth #6, 13, and 20 on December 13, 2004.

b. For patient 10, Licensee failed to perform adequate pulp testings and document a diagnosis for the endodontic treatment on tooth #30 on March 24, 2004.

c. For patient 12, Licensee failed to perform adequate pulp testings and document a diagnosis for the attempted endodontic treatment on tooth #5 on January 3, 2005. On this same date, Licensee extracted tooth #5 after he had broken an endodontic file in the canal of the tooth.

d. For patient 13, Licensee failed to perform adequate pulp testings and document a diagnosis for the endodontic treatment on tooth #2 on November 2, 2004.

e. For patient 14, Licensee failed to perform adequate pulp testings and document a diagnosis for the endodontic treatment on tooth #14 on March 24, 2005.

f. For patient 17, Licensee failed to perform adequate pulp testings and document a diagnosis for the endodontic treatment on tooth #29 on July 29, 2004.

2. Licensee failed to obtain diagnostic pre-operative and/or post-operative periapical radiographs when providing endodontic treatment to his patients, as follows:

a. For patient 13, Licensee failed to maintain a pre-operative periapical radiograph for the endodontic treatment of tooth #2 on November 2, 2004.

b. For patient 14, Licensee did obtain a post-operative periapical radiograph for the endodontic treatment of tooth #14 on March 24, 2005; however, the radiograph is of poor quality due to improper cone placement.

3. For patient 12, Licensee failed to clearly document an adequate treatment plan and/or other treatment options that properly address the issue of the broken endodontic file in the canal of tooth #5 that occurred when attempting to provide endodontic treatment to this tooth.

4. Licensee failed to utilize rubber dam isolation when providing endodontic treatment to patients, as evidenced by Licensee's failure to document rubber dam use in the patient's progress notes, as follows:

a. Patient 3 on October 19, 2004 for teeth #6, 7, 9, 11, 21, and 27.

b. Patient 5 on December 13, 2004 for teeth #6, 13, and 20.

c. Patient 10 on March 24, 2004 for tooth #30.

d. Patient 13 on November 2, 2004 for tooth #2.

e. Patient 14 on March 24, 2005 for tooth #14.

f. Patient 17 on July 29, 2004 for tooth #29.

5. When providing endodontic treatment to his patients, Licensee failed to properly obturate the canals of the teeth as evidenced on post-operative periapical radiographs for these patients, as follows:

a. For patient 5, the obturation in the canal of tooth #6 is substandard due to the presence of a void, as seen on the December 13, 2004 periapical radiograph.

b. For patient 17, the obturation in the canals of tooth #29 is overextended, as seen on the July 29, 2004 periapical radiograph.

Substandard Periodontal / Prosthodontic Care / Recordkeeping

F. Licensee failed to adequately document pertinent information and/or provide appropriate periodontal treatment prior to providing prosthodontic treatment to one or more of his patients. Examples include the following:

1. For patient 5, Licensee failed to properly prioritize and sequence the patient's periodontal treatment prior to placing a six-unit bridge on the patient's teeth, as follows:

a. On December 9, 2004, Licensee performed a comprehensive examination and a chart of periodontal probing for patient 5. Nothing was documented regarding patient 5's tissue condition. The results of the probing indicated that patient 5 had pocket depths of 5mm on tooth #6 and 6mm on tooth #11.

b. On December 13, 2004, Licensee provided a debridement treatment using Pro-select with irrigation for patient 5. On this same date, Licensee prepped teeth #6 and #11 for a six-unit bridge.

c. On December 30, 2004, Licensee indicated in patient 5's progress notes that he gave him a "Perio-med." However, Licensee failed to note the rationale for the type of periodontal medication given and the reason for waiting two weeks after the debridement treatment before it was provided to patient 5.

d. On January 13, 2005, Licensee cemented a prosthodontic bridge involving teeth #6-11 for patient 5, only one month after providing periodontal treatment. Relative to treatment, Licensee failed to indicate patient 5's tissue response to the Pro-select and

the Perio-med. Licensee stated he prioritized treatment in this way because the patient traveled a long distance (120 miles) to seek treatment.

2. For patient 9, Licensee failed to consider the patient's periodontal conditions before proceeding with a crown, as follows:

a. On March 3, 2005, Licensee performed a comprehensive examination and a chart of periodontal probing for patient 9. Nothing was documented regarding patient 9's tissue health. The results of the probing indicated that patient 9 had a pocket depth of 6mm on tooth #11.

b. However on March 15, 2005, Licensee prepared tooth #11 for a crown for patient 9. Licensee failed to provide appropriate periodontal and prosthodontic treatment by placing a crown on a compromised tooth for patient 9.

Licensee explained that for patient 9, the depth of 6mm on tooth #11 did not interfere with the treatment because a porcelain crown was placed on the tooth. Additionally, instrumentation around the teeth was done in an appointment prior to placement of the crown. Licensee also explained that the failure to document tissue health was a charting error.

3. For patient 12, Licensee failed to provide appropriate periodontal treatment before proceeding with a three-unit bridge, as follows:

a. Licensee failed to document and/or provide adequate periodontal care for patient 12 including: a full mouth chart of periodontal probing; further assessment of the status of the patient's periodontal health; and full mouth radiographs for periodontal diagnosis.

b. Despite his lack of periodontal information, Licensee proceeded with cementing a new prosthodontic bridge involving teeth #4-6 for patient 12 on January 28, 2005. Licensee admitted that he failed to adequately chart his periodontal care for patient 12.

4. For patient 14, Licensee failed to provide appropriate periodontal treatment before proceeding with two three-unit bridges, as follows:

a. On March 14, 2005, Licensee performed a comprehensive examination and indicated in patient 14's progress notes that a full mouth probing was done. However, Licensee failed to document and/or provide adequate periodontal care for patient 14 including: a full mouth chart of periodontal probing; and further assessment of the status of the patient's periodontal health.

b. On March 24, 2005, Licensee prepared teeth #12 and #14 for a three-unit bridge for patient 14. On this same date, Licensee performed a periodontal root planing and scaling in all four quadrants for the patient.

c. On March 31, 2005, Licensee prepared teeth #3 and #5 for a three-unit bridge for patient 14. Nonetheless, Licensee proceeded with prosthodontic treatment without any further information regarding patient 14's periodontal conditions. Conclusively, Licensee has failed to properly prioritize and sequence patient 14's periodontal treatment and conditions in conjunction with providing extensive dental treatment to the patient.

Licensee explained that patient 14 requested of Licensee to not use the periodontal probe because it was painful for her. However, Licensee failed to document the patient's request.

5. For patient 17, Licensee failed to provide appropriate periodontal treatment before proceeding with a three-unit bridge, as follows:

a. On June 29, 2004, Licensee failed to document and/or provide adequate periodontal care for patient 17 including: a full mouth chart of periodontal probing; further assessment of the status of the patient's periodontal health; and full mouth radiographs

for periodontal diagnosis. Licensee only indicated a few pocket depths and “lots of recession” on patient 17’s Periodontal Screening Examination form.

b. Despite his lack of periodontal information, Licensee proceeded with cementing a new prosthodontic bridge involving teeth #29-31 for patient 17 on August 12, 2004.

Licensee explained that the x-rays indicated no periodontal contraindication to seating the bridge.

Substandard Diagnostic Care / Treatment Planning / Recordkeeping

G. Licensee failed to adequately document pertinent information and/or provide an appropriate diagnosis and treatment plan when providing diagnostic care to one or more of his patients. Examples are as follows:

1. For patient 3, Licensee performed a comprehensive examination and developed a treatment plan on October 14, 2004 for extensive dental treatment including extractions, operative restorations, crowns, and bridges. However, Licensee failed to document and/or provide a diagnosis for the treatment indicated for each tooth as to the rationale for doing the treatment and other treatment options.

2. For patient 5, Licensee performed a comprehensive examination and developed a treatment plan on December 9, 2004 for extensive dental treatment including extractions, operative restorations, build-ups, and a bridge. However, Licensee failed to document and/or provide a diagnosis for the treatment indicated for each tooth as to the rationale for doing the treatment and other treatment options.

3. For patient 8, Licensee performed a new patient examination and developed a treatment plan on July 27, 2004 which included his recommendation for a

nightguard for the patient. However, Licensee failed to document and/or provide a diagnosis for the nightguard as to the rationale for doing so.

4. For patient 9, Licensee performed a comprehensive examination and developed a treatment plan on March 3, 2005 for extensive dental treatment including extractions, operative restorations, five crowns, and three bridges. However, Licensee failed to document and/or provide a diagnosis for the treatment indicated for each tooth as to the rationale for doing the treatment and other treatment options.

5. For patient 10, Licensee performed a new patient examination and developed two treatment plans on March 16, 2004 and January 25, 2005, as follows:

a. The March 16, 2004 treatment plan for patient 10 included, but was not limited to, dental treatment for tooth #20, a prophylaxis, and root planing and scaling in four quadrants. However, Licensee failed to document and/or provide a diagnosis for the treatment indicated for tooth #20 as to the rationale for doing the treatment and other treatment options. In addition, Licensee failed to document and/or provide a diagnosis for the root planing and scaling as to the rationale or basis for doing so. Patient 10's periodontal charting indicated pocket depths of 4mm or less and a prophylaxis was performed on the same day as the root planing and scaling.

b. The January 25, 2005 treatment plan for patient 10 included, but was not limited to, a build-up and crown for tooth #12. However, Licensee failed to document and/or provide a diagnosis for the treatment indicated for tooth #12 as to the rationale for doing the treatment and other treatment options, as seen on the March 16, 2004 bitewing radiographs.

6. For patient 11, Licensee performed a comprehensive examination and developed a treatment plan on February 28, 2005 which included, but was not limited to,

extracting seven lower teeth and four lower crowns. However, Licensee failed to document and/or provide a diagnosis for the treatment indicated for each tooth as to the rationale for doing the treatment and other treatment options. Licensee does indicate his general diagnosis for extracting seven lower teeth on the form entitled "Consent For Extraction(s)"; however, he failed to indicate a detailed diagnosis for each tooth in the patient's progress notes and/or treatment plan.

7. For patient 13, Licensee performed a comprehensive examination and a chart of periodontal probing which indicated pocket depths of 2-4mm for the upper teeth and 2-5mm for the lower teeth on November 1, 2004. On November 2, 2004, Licensee performed a periodontal root planing and scaling in all four quadrants for patient 13. However, Licensee failed to document and/or provide a diagnosis for the root planing and scaling as to the rationale for doing so with the indicated pocket depths.

8. For patient 13, Licensee also extracted teeth #1 and #16 on November 2, 2004. Licensee does indicate his general diagnosis for extracting these teeth on the form entitled "Consent For Extraction(s)"; however, he failed to indicate a detailed diagnosis for each tooth in the patient's progress notes and/or treatment plan.

9. For patient 14, Licensee performed a comprehensive examination and developed a treatment plan on March 14, 2005 for extensive dental treatment including extractions, operative restorations, build-ups, crowns, two bridges, and root planing and scaling in four quadrants. However, Licensee failed to document and/or provide a diagnosis for the treatment indicated for each tooth as to the rationale for doing the treatment and other treatment options. In addition, Licensee failed to document and/or provide a diagnosis for the root planing

and scaling as to the rationale or basis for doing so since no periodontal information was obtained for patient 14.

10. For patient 17, Licensee performed a new patient examination and developed a treatment plan on June 29, 2004 which included, but was not limited to, root planing and scaling in four quadrants. However, Licensee failed to document and/or provide a diagnosis for the root planing and scaling as to the rationale or basis for doing so. Licensee's periodontal charting for patient 17 was inconclusive in that it only indicated a few pocket depths and "lots of recession."

Substandard Operative Care / Recordkeeping

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

1. For patients 13 and 14, it was alleged that Licensee improperly provided operative treatment when he used a high speed handpiece without water and burned the patient's teeth. When it was brought to Licensee's attention that the water was not on, Licensee responded by saying that the tooth he was working on was non-vital.

Licensee stated that if a tooth is non-vital, there are no nerves and so there is no pain and further, a lack of water cannot harm a non-vital tooth.

2. For patient 17, Licensee failed to provide adequate operative treatment to carious lesions on teeth #15 and #17, as follows:

a. On June 29, 2004, Licensee performed an examination and obtained bitewing radiographs that revealed radiolucent areas of decay on the mesial and distal aspects of tooth #15 and the mesial aspect of tooth #17 for patient 17.

b. On July 29, 2004, Licensee placed a MO (mesio-occlusal) composite restoration in tooth #17 for patient 17. Licensee also placed a MOD (mesio-occlusal-distal) composite restoration in tooth #15 on August 12, 2004 for patient 17.

c. On February 28, 2005 (about 7-months later), patient 17 saw a subsequent treating dentist who performed an examination and obtained bitewing radiographs that revealed radiolucent areas of decay on the mesial aspect of tooth #15 and the mesial aspect of tooth #17. Conclusively, Licensee failed to properly remove all of the decay in teeth #15 and #17 when providing operative treatment for patient 17 in July and August 2004.

Licensee explained that he removed the decay and that it is impossible to determine whether the decay was removed merely from a bitewing radiograph taken six months later.

Unprofessional Conduct

I. Licensee engaged in conduct unbecoming a person licensed to practice dentistry when treating one or more of his patients. Examples include the following:

1. It was alleged that Licensee pressured patients into dental treatment and/or conscious sedation, as follows:

a. Licensee encourages most of his patients to have conscious sedation administered for their dental treatment.

b. Licensee fails to adequately respond to and/or has spoken over patients when they question him about proposed treatments.

Licensee explained that he does not pressure patients into having dental treatment or to having conscious sedation administered, and that he presents them with a recommendation and alternative treatment options.

2. Licensee prepared letters with inappropriate content that he sent to a terminated employee and to the boyfriend of a terminated employee.

3. It was alleged that Licensee failed to maintain patient confidentiality/privacy, as follows:

a. Licensee has previously instructed patients who have taken oral conscious sedation medications to wait unmonitored in the office reception area and has also instructed them to return to the reception area after treatment. Other patients have witnessed drowsy patients being escorted by Licensee and/or his staff in the reception area. After consulting with a registered nurse regarding proper conscious sedation administration procedures, Licensee has discontinued having patients in the reception area.

b. Licensee has allowed other individuals to observe his sedated patients without that sedated patients' knowledge or consent as alleged by three individuals.

Licensee explained that this is a false statement as he does not allow other individuals to observe sedated patients.

c. Licensee has discussed another patient's treatment with other patients as alleged by three individuals.

Licensee explained that he does not recall revealing the names of patients to any other patients, and it is not his practice to do so.

d. After being informed by the patient's wife, Licensee's staff informed Licensee about patient 7's alcohol consumption on the day of his scheduled sedation/treatment appointment. Subsequently, Licensee went out to the reception area, approached another individual other than patient 7, and asked that individual if he had been drinking.

Licensee explained that his approaching another patient was a result of an unfortunate miscommunication between him and a staff member.

4. It was alleged that Licensee failed to provide pertinent information to a patient in a timely manner by failing to promptly inform patient 11 about the occurrence of the needle breaking and remaining lodged within the patient's mandibular area when he was administering local anesthesia to the patient. Instead, Licensee completed patient 11's dental treatment which involved extracting seven teeth and preparing four teeth for crowns. Then, Licensee dismissed patient 11 without informing the patient or the patient's escort of the broken needle. Later, Licensee called patient 11 telling him of the broken needle and referring the patient to an oral surgeon.

Licensee explained that he did not discuss the broken needle matter with patient 11 or his escort while they were at the office because he wanted to first arrange for follow up care by a local oral surgeon before informing the patient or his escort.

5. It was alleged that Licensee intentionally altered or supplemented documentation within certain patient records prior to submitting these same patient records to the Board in 2004.

Licensee admitted that he and his staff made minor changes to the records before submitting records in to the Board in 2004.

Enabling Unauthorized Practice of Dentistry

J. On one or more occasions, Licensee has employed, assisted, or enabled his associate and auxiliary staff to practice dentistry in that Licensee has inappropriately authorized and permitted the dentist associate, registered dental assistants or unregistered dental assistants to perform tasks which exceeded their legal scope of practice. Examples include the following:

1. On one or more occasions, Licensee has authorized and permitted the dentist associate employed in his office to provide dental treatment to, and thereby monitor, patients that had been induced into conscious sedation by Licensee, prior to the dentist associate becoming certified with the Minnesota Board of Dentistry for administration of conscious sedation on April 19, 2005.

2. On one or more occasions, Licensee has authorized and permitted registered dental assistant/s employed in his office to perform the following tasks:

a. Monitor patients who have been administered medication for conscious sedation. Licensee stated that he is not familiar with the name of supervision classification when asked by the Complaint Committee at the conference about the level of supervision required for the registered dental assistant.

Licensee admitted that the registered dental assistants have been responsible for monitoring patients under conscious sedation, but that Licensee is always no more than five seconds away from the patient and/or left the room after conscious sedation was initiated.

b. Administer nitrous oxide inhalation analgesia to patients without obtaining the required training to perform this procedure; and

3. On one or more occasions, Licensee has authorized and permitted unregistered dental assistants employed in his office to perform the task of administering Triazolam to sedation patients when they arrived at the office for dental treatment.

Licensee explained that this practice no longer occurs as preoperative doses of Triazolam are no longer provided to patients in his practice.

Substandard Infection Control

K. 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 alleged by five out of eight individuals interviewed as part of Board's investigation, as described below:

1. Licensee failed to remove his contaminated disposable gloves and mask before leaving an operatory and has subsequently worn them while walking throughout the office. In addition, Licensee failed to remove his contaminated disposable gloves or properly wash his hands before handling patient charts and radiographs.

2. Licensee failed to wear appropriate personal protection equipment such as a laboratory coat or gown when providing treatment to patients.

3. Licensee failed to wear sterile surgical gloves and use sterile irrigating water when performing oral surgery procedures on patients.

4. Licensee failed to apply appropriate sterile techniques when retrieving an intravenous anesthetic (Versed) from a multiuse vial. On one or more occasions, Licensee used a contaminated needle from the same patient or a previous patient to puncture through the rubber membrane on the vial.

Licensee explained that his protocol related to using a multiuse vial for Midazolam has improved in that he now uses a new, sterile needle every time he retrieves Midazolam from the multiuse vial, even if it is for the same patient.

5. Licensee failed to properly sterilize his oral surgery instruments, namely an instrument known as a rongeur, between providing oral surgery on patients.

6. Licensee failed to properly dispose of single-use tubing which he utilized during endodontic procedures on patients. Instead, Licensee directed his staff to place the tubing into a cold sterilization solution and re-use the tubing on patients.

7. Licensee failed to properly clean his magnifying glasses which are attached to his prescription glasses when they became splattered with blood from providing dental treatment to patients.

8. Licensee failed to wear latex disposable gloves when performing clinical examinations on patients.

9. Licensee failed to accept multiple reminders from staff about concerns they observed with his infection control protocols / procedures.

Improper Billing

L. Licensee improperly billed patients, third-party payors, and/or others relating to the practice of dentistry when he billed for different dental services than those actually rendered, and/or when he followed other improper billing procedures, as outlined below.

At the conference, Licensee explained that he has instructed staff to be cognizant that claims may only be submitted after the entire treatment has been completed.

1. Licensee improperly billed patient 6's insurance company for three crowns prior to seating the crowns. On December 20, 2004, Licensee prepared teeth #8, #9, and

#22 for crowns for patient 6. Licensee seated the crowns on January 10, 2005. However, Licensee submitted a claim form which claimed the completed date of service was December 20, 2004.

2. Licensee improperly billed patient 13's insurance company for a crown prior to seating the crown. On November 2, 2004, Licensee prepared tooth #2 for a crown for patient 13. Licensee seated the crown on November 30, 2004. However, Licensee submitted a claim form which claimed the completed date of service was November 2, 2004.

3 Licensee also improperly billed patient 13's insurance company using an oral surgery procedure code that was upcoded from the actual surgical services rendered. On November 2, 2004, Licensee billed for the extractions of teeth #1 and #16 using the procedure code "7210," the surgical removal of an erupted tooth. However, after reviewing the November 1, 2004 panorex radiograph, the Committee determined that the proper procedure code for these teeth should have been "7140" due to the teeth being over-erupted.

4. Licensee improperly billed patient 17's insurance company for a three-unit bridge prior to seating the bridge. On July 29, 2004, Licensee prepared teeth #29 and #31 for a three-unit bridge for patient 17. Licensee seated the bridge on August 12, 2004. However, Licensee submitted a claim form which claimed the completed date of service was July 29, 2004.

Misleading Advertising

M. Licensee has used a form of public communication containing a false, fraudulent, misleading, or deceptive statement of claim. For example:

1. On or about January 7, 2004 in two local newspapers, Licensee has falsely stated within a public advertisement regarding the use of conscious sedation in his practice the following statement to include, but not limited to, "...this office is one of two North of the Twin

cities, offering this service.” In January 2004, a staff member of the Board reviewed data of other licensees who were certified in the administration of conscious sedation and practiced north of the Twin Cities. The Board’s staff member discontinued reviewing the data at the point of finding at least five other licensees who fit the same criteria. From this information, the Committee found Licensee’s advertising statement to be in violation of the Board’s rules.

Licensee explained that he had no intention of misleading anyone and as soon as the information was brought to his attention in May 2004, he immediately discontinued the advertisement.

Additional Substandard Recordkeeping

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

1. For patients 1, 2, 3, 6, 9, 11, and 14, Licensee failed to document the tooth number in the patient’s progress notes that is associated with each periapical radiograph taken on the patient.
2. For patients 7 and 16, Licensee failed to obtain personal patient data such as the name and phone of emergency contact person for the patient.
3. For patient 3, Licensee failed to document in the patient’s progress notes that he had prepared teeth #23 through #26 for crown and bridge restorations. Licensee only indicated that he had cemented crowns #23-26 for patient 3.

Licensee explained that he continued to work on his charting skills and has taken steps that will help with administration of charts.

O. Violations. Licensee acknowledges and the Committee has found that the facts and conduct specified above constitute violations of Minn. Stat. § 150A.08, subd. 1 (5, 6, 10, 11,

13); 150A.11, subd. 1; Minn. Stat. §§ 151 or 152, Minn. R. 3100.3600, subp. 3 and 5; Minn. R. 3100.6200 A, B, I, K; Minn. 3100.6300; Minn. 3100.6500; and, Minn. R. 3100.9600
However, Licensee does not make any admission regarding the above allegations to the extent they may be used in a forum other than a proceeding or action before or by the Committee or the Board.

P. Disciplinary Action. Licensee and the Committee recommend that the Board issue an order as follows: The Committee RESCINDS the 2005 Order to Cease and replaces it with an order which places CONDITIONS on Licensee's license to practice dentistry in the State of Minnesota and REMOVES Licensee's authorization to administer conscious sedation, as follows:

**REMOVAL OF AUTHORIZATION
TO ADMINISTER CONSCIOUS SEDATION**

1. No Performance of Conscious Sedation Procedures or Administration of Conscious Sedation Medications.

Licensee shall continue to be prohibited from performing conscious sedation procedures or administering conscious sedation medication. Licensee's involvement in any conscious sedation procedures is limited exclusively to performing dental procedures on sedated patients that are being continuously assessed and monitored by another qualified professional such as a dentist, nurse anesthetist, or physician anesthesiologist, as outlined in par. P. 2. below.

2. Performance of Dental Procedures on Sedated Patients only under Personal and Direct Supervision of a Qualified Provider.

Licensee may perform dental procedures on sedated patients if and only if the sedated patient undergoes a pre-operative assessment by and is constantly monitored and assessed by a dentist, nurse anesthetist, or physician anesthesiologist who is qualified to administer conscious

sedation medication and to monitor conscious sedation patients (hereinafter, “qualified provider”). The qualified provider shall monitor and assess the conscious sedation patient until the patient is fully responsive. Before employing such a qualified provider, Licensee must provide the qualified provider’s qualifications and protocol to the Board for approval. Licensee is responsible for notifying the Board of any change in the qualified provider’s qualifications or protocol. This provision does not release Licensee from practicing in accordance with all the applicable sections of the Minnesota Dental Practice Act and the applicable standard of care.

If the qualified provider is a dentist, the qualified provider dentist may not provide dental treatment on another patient in the office at the same time the qualified provider dentist is providing sedation procedures.

Any qualified provider and Licensee must ensure that in the event a patient experiences an adverse reaction while under the influence of sedation medications, an adverse reaction report is provided to their respective Minnesota Health Licensing Board(s), as required.

3. No Advertising of Involvement in Conscious Sedation Procedures.

Licensee is prohibited from advertising himself as being eligible to perform conscious sedation procedures or administering conscious sedation medications. Specifically Licensee is prohibited from advertising through any means or media, that he is involved, in any manner, in the administration of conscious sedation.

CONDITIONS

4. Coursework. Licensee shall successfully complete the coursework described below. All coursework must be approved in advance by the Committee. None of the coursework may be home study. 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/professional development requirements of Minn. R. 3100.5100, subpart 2. The coursework is as follows:

a. Patient Management. Within nine months of the effective date of this order, Licensee shall complete the treatment planning / recordkeeping course entitled “Dental Patient Management: Dental Records and Treatment Planning Fundamentals” offered by the University of Minnesota. The instruction for Licensee shall emphasize coordinating proposed periodontal assessments, diagnoses, and treatments with proposed prosthodontic assessments, diagnoses, and treatments.

b. Ethics. Within one year of the effective date of this order, Licensee shall complete an individually designed course in ethics offered by Dr. Muriel Bebeau at the University of Minnesota Dental School. Licensee’s signature on this stipulation and order is authorization for Dr. Bebeau and the Committee to communicate regarding Licensee’s needs, performance and progress before, during, and after Licensee takes the course.

c. Infection Control. Within six months of the effective date of this order, Licensee shall successfully complete a minimum of six hours of instruction in infection control based on the 2003 Guidelines for Infection Control in Dental Health-Care Settings.

d. Recordkeeping and Risk Management Coursework. Within one year of the effective date of this order, Licensee shall complete a minimum of 6 hours of instruction on recordkeeping and risk management.

e. One-On-One Instruction in Administration of Nitrous Oxide Analgesia and Administration of Local Anesthesia. Within six months of the effective date of this order, Licensee shall successfully complete one-on-one instruction in the administration of nitrous oxide analgesia and administration of local anesthesia. Licensee must provide the instructor(s) with a copy of this stipulation and order prior to commencing instruction. The instructor(s), the curriculum and the coursework must be approved in advance by the Committee. The curriculum and coursework must address indications and contraindications for the medications as they relate to patients' health conditions; minimum and maximum dosages of the medications; and proper documentation of administration of the medications.

5. Records Inspection. After completing the coursework described above, Licensee shall submit, under Board staff direction, five to ten duplicated patient records, for Committee review of Licensee's recordkeeping practices. Licensee shall fully and timely cooperate with the inspection of Licensee's patient records.

6. Infection Control Inspection. Licensee shall cooperate with at least one unannounced office visit at each of his dental offices during normal office hours by a representative of the Board. The representative shall conduct an inspection at each of Licensees'

offices for the purpose of reviewing safety and sanitary conditions. Additional office visits shall be at the discretion of the Committee.

7. Reimbursement of Costs. Licensee shall pay the Board the sum of \$45,000 as partial reimbursement for the Board's costs in this matter. Payments shall be made by certified check, cashier's check, or money order made payable to the Minnesota Board of Dentistry in two installments as follows: \$15,000 within six months of the effective date of this order, \$15,000 within one year, and the balance of \$15,000 within one eighteen months, or by the time Licensee petitions to have the conditions removed from Licensee's license, whichever occurs first.

8. Review of Stipulation and Order. Within 30 days of the effective date of this stipulation and order, Licensee shall submit to the Board a signed, written statement from all individuals at Licensee's practice involved in patient care and administrative staff in support of patient care that they have received and reviewed a copy of this stipulation and order. Within 10 days of hire, new association, contractor or partnership, Licensee shall inform the Board in writing of the hire, new association, contractor or partnership. Within 30 days he shall submit to the Board a signed written statement from the new partner, associate, contractor or employer verifying that he/she has received and reviewed a copy of this stipulation and order.

9. 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. In Licensee's practice of dentistry, Licensee shall comply with the most current infection control requirements of Minn. R. 3100.6300 and 6950.1000 through 6950.1080, and with Centers for Disease Control and Prevention, Public Health Service, United States Department of Health and Human Services, *Guidelines for Infection Control in Dental Health-Care Settings - 2003*, Morbidity and Mortality Weekly Report, December 19, 2003 at 1.

d. 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.

e. 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.

Q. Removal of Conditions. Licensee may petition to have the conditions removed from Licensee's license at any regularly scheduled Board meeting provided that Licensee's petition is received by the Board at least 30 days prior to the Board meeting. Licensee shall have the burden of proving that Licensee has complied with the conditions and that Licensee is qualified to practice dentistry without conditions. Licensee's compliance with the foregoing

requirements shall not create a presumption that the conditions should be removed. Upon consideration of the evidence submitted by Licensee or obtained through Board investigation, the Board may remove, amend, or continue the conditions imposed by this order.

R. 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.

S. Summary Suspension for Violating Order. In addition to or in lieu of the procedures described in paragraphs I. and J. below, the Committee may, if it concludes that Licensee has failed to observe the removal of authorization to administer conscious sedation and/or meet the conditions of this Order, immediately and summarily suspend Licensee's license to practice dentistry. The Committee's Order for Summary Suspension shall constitute a final order of the Board. The suspension is effective upon written notice by the Committee to Licensee and Licensee's attorney. Service of notice on Licensee is complete upon mailing the notice to Licensee and his attorney. Such suspension shall remain in full force and effect until Licensee meets with the Committee to discuss the bases for the summary suspension and a new Order is issued by the Board.

T. 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:

1. 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.

2. 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.

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

U. 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.

V. Attendance at Conference. Licensee and his counsel Tiffany A. Blofield and Julie M. Engbloom, attended a conference with the Committee on September 23, 2005. The following Committee members attended the conference: Freeman Rosenblum, D.D.S., Ronald King, D.D.S. and Nadene Bunge, D.H. Assistant Attorney General Tamar N. Gronvall, Assistant Attorney General, represented the Committee at the conference.

W. 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.

X. 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.

Y. 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.

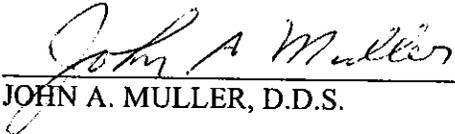
Z. Data Classification. Under the Minnesota Data Practices Act, this stipulation and order is classified as public data. Minn. Stat. § 13.41, subd. 4. All documents in the record shall maintain the data classification to which they are entitled under the Minnesota Government Data Practices Act, Minn. 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.

AA. 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.

BB. 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

COMPLAINT COMMITTEE



JOHN A. MULLER, D.D.S.

By:



MARSHALL SHRAGG
Executive Director

Dated: 2/28/06

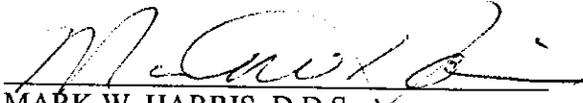
Dated: MARCH 2nd, 2006

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 CONDITIONS on Licensee's license effective this 7th day of March, 2006.

MINNESOTA BOARD
OF DENTISTRY

By:  P.D.S.

MARK W. HARRIS, D.D.S.
President