BEFORE THE MINNESOTA

BOARD OF DENTISTRY

In the Matter of
Jane Odgers, D.D.S.
License No. D9999

STIPULATION AND ORDER FOR CONDITIONAL LICENSE

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

BACKGROUND

On April 4, 1997, the Board adopted a Stipulation and Order for Conditional License (1997 Order) which placed conditions on the dental license of Jane Odgers, D.D.S. ("Licensee"). The 1997 Order provided that if the Board received another complaint alleging additional misconduct by Licensee, she would be required to cooperate with an office inspection and the temporary removal for duplication of patient records.

In September 1998, the Board received a complaint against Licensee alleging inadequate infection control practices and forwarded it to the Board's Complaint Committee ("Committee"). The Board's compliance officer conducted an office inspection on November 2, 1998, and the report following the inspection concluded that Licensee had violated the 1997 Order by failing to maintain safety and sanitary conditions for a dental office.

On February 3, 1999, the Committee served a Notice of Conference ("Notice") on Licensee, which asked her to provide the Committee with a written response to the allegations referenced in the Notice and required her to meet with the Committee to discuss them on

March 11, 1999. The Committee reviewed Licensee's written response and, after she agreed to submit to another inspection, canceled the conference.

On June 10, 1999, the Board's compliance officer conducted another inspection of Licensee's office. After reviewing the inspection report, the Committee informed Licensee by letter that it had found insufficient evidence to support additional disciplinary action at that time.

In addition, the Committee reminded Licensee that should the Board receive additional complaints of a similar nature in the future, the Committee could reopen the matter.

In February 2000, the Board received additional complaints against Licensee, which the Committee referred to the Office of the Attorney General ("AGO") for investigation. Following the investigation, the Committee held conferences with Licensee on September 11 and October 26, 2000. Licensee, who had been informed by the Board on September 11, 2000 that she had the right to counsel, was not represented by legal counsel. At that conference, the Committee discussed allegations of unprofessional conduct towards patients and employees as outlined in the Committee's Notice of Conference dated September 1, 2000. Licensee stated she was unable to adequately respond to the allegations and told the Committee she had not read the Notice of Conference. As a result of the discussion at the conference, on October 4, 2000, the Committee served Licensee with an Order for Mental and Physical Examination ("2000 Order"). Licensee agreed to comply with the 2000 Order and scheduled an evaluation at the Rush Behavioral Health Center ("Rush") in Chicago, Illinois on November 1. Prior to the evaluation, however, the Committee met with Licensee on October 26, 2000, to discuss inadequate infection control and substandard care allegations detailed in the Committee's second Notice of Conference dated September 27, 2000. Licensee was represented by Gregory W. Deckert at the October conference.

Licensee was evaluated at Rush November 1-3. In a report dated November 27, 2000 ("Rush Report"), Rush provided the Committee with an opinion on Licensee's mental health and made a set of recommendations to address the Committee's concerns about her ability to practice dentistry with reasonable skill and safety. The clinicians at Rush concluded that Licensee did not have a mental disability.

Following the Rush Report, the Board received more complaints about Licensee, which it referred to the AGO for investigation. Following review of the investigative report, the Committee sent Licensee a Notice of Allegations and Opportunity to Respond on April 24, 2002. She responded in writing on May 15, 2002. On November 16, 2002, the Committee asked Licensee to submit six patient records involving recent prosthodontic treatment she had provided. The Committee met with Licensee and her attorney, Gregory W. Deckert, on January 23, 2003 to discuss the records.

Based on the discussions at the September 11, 2000, October 26, 2000 and January 23, 2003 conferences and her response to the Committee's April 24, 2002 Notice, 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 she does not hold a license to practice dentistry in any other jurisdiction and does not hold any other professional or occupational licenses.

B. Facts. Licensee agrees that the Board may consider the following facts to be true, but only for the purposes of this Stipulation and any further proceedings before the Board, and not for any other purposes, including but not limited to any civil litigation.

Inadequate Safety and Sanitary Conditions

1. Pursuant to a request from the Committee, on May 4, 2000, the AGO investigator conducted an inspection of Licensee's dental office. On separate occasions in April and May 2000, the investigator interviewed some of Licensee's current and former employees. Based on the inspection and those interviews, the Board finds that Licensee failed to maintain adequate safety and sanitary conditions for a dental office and failed to comply with the most current infection control guidelines of the Centers for Disease Control ("CDC"), as described below:

a. Former employees stated that Licensee allowed pet hair to remain on her scrub uniforms when treating patients.

b. Licensee failed to consistently require her employees to place their soiled lab coats and/or scrub uniforms in a designated area for storage, washing, decontamination, or disposal before leaving the work area. Licensee told the investigator that laundry service had been and was available to her employees. During their interviews, several employees denied this.

c. Several of Licensee's former employees reported that Licensee failed to change gloves before leaving and re-entering the operatory where a patient was being treated and frequently interrupted a patient's treatment to write in the patient's chart, and then resumed treatment without changing her gloves.

d. Licensee failed to consistently conduct weekly spore tests of the autoclave in her office. Licensee said she spore tested her autoclave by sending an autoclaved spore strip to the University of Minnesota each month and by placing an autoclaved spore ampule in an incubator in the office's basement each week. When asked whether she kept a record of the spore ampule test results, Licensee explained she would keep a log if there were any positive results, but there had not been any. In contrast, Licensee's staff told the investigator that the office didn't have an incubator and, instead, Licensee placed the autoclaved ampules in a box in the basement.

e. Former employees also told the investigator:

1) Licensee failed to change cloth towels between patients or to use single-use towels when drying her hands.

2) Licensee and her employees failed to change their face masks on a daily basis.

3) Licensee failed to consistently use a needle recapping device or a single-handed method for recapping used needles.

4) Licensee and her staff failed to consistently flush operatory waterlines at the beginning of the day and between patient appointments.

5) Licensee failed to consistently wear gloves when placing exposed radiographs in the developer.

6) Licensee and her staff failed to maintain the sterility of autoclaved instruments by storing them unbagged in operatory drawers.

7) Licensee and her staff failed to disinfect patient impressions before sending them to the dental laboratory.

8) During the employee interviews, the investigator learned that several of the employees were unaware that Licensee's office maintained an infection control protocol or manual.

At her October conference, Licensee told the Committee that she denies many of these allegations and has corrected past violations of the Board's infection control rules.

Substandard Operative and Prosthodontic, Endodontic Treatment

2. The Board finds Licensee failed to provide appropriate operative and/or prosthodontic treatment to one or more of her patients. Examples include the following:

a. The Board finds Licensee failed to provide appropriate treatment to tooth #14 of patient 1, as described below:

1) Patient 1 first saw Licensee on April 24, 1995. On January 22, 1995 [1996], Licensee noted patient 1 had called to report he was experiencing pain. The following day, Licensee saw patient 1 and noted that tooth #14 was cracked and she placed a lingual amalgam restoration in the tooth.

2) On April 1, 1996, Licensee again saw patient 1 who reported biting pain and some hot and cold sensitivity in tooth #14. Licensee prescribed Ampicillin and referred the patient to another dentist for "intraoral crack.shot, Endo[dontic] Ass[essment]."

3) On April 19, 1996, Licensee prepared tooth #14 for a full gold crown. On May 6, 1996, Licensee noted, "Crown did not seat—new impression occlusal trays." About two weeks later, Licensee seated a full gold crown on tooth #14 and noted, "Wait 3 weeks w/crown on to see if pain improves."

4) Licensee saw patient 1 on June 13, 1996 and April 4, 1997 for dental care but did not treat tooth #14.

5) On January 6, 1998, patient 1 saw a subsequent treating dentist who took bitewing radiographs and a periapical radiograph of the area around teeth #13-14. He noted the presence of an open margin on the distal aspect of tooth #14. Approximately two weeks later, he sent patient 1 with recent radiographs back to Licensee to check the fit of the crown on tooth #14.

6) On January 23, 1998, Licensee replaced the lingual amalgam she had placed in tooth #14 on January 23, 1996. Patient 1 continued treatment with the subsequent treating dentist through 1999. On December 8, 1999, that dentist took a periapical radiograph of tooth #14 which showed that the open margin on the tooth had not been corrected.

b. The Board finds Licensee failed to provide adequate treatment to teeth #3, 4, and 29 of patient 3, as described below:

1) On June 22, 1992, Licensee placed a disto-occlusal (DO) amalgam restoration in tooth #4 of patient 3.

2) On April 13, 1993, Licensee saw patient 3 for an emergency examination of tooth #4 and noted he reported having discomfort in the area of that tooth for quite a while. Licensee took a periapical radiograph which showed the amalgam restoration was close to the pulp of the tooth. She removed the restoration and provided palliative treatment.

3) On May 27, 1993, Licensee saw patient 3 for another emergency examination of tooth #4, took another periapical radiograph, and noted, "Has had

tenderness, abcessing [sic] feeling — PA reveals tract draining — access." Licensee then initiated root canal therapy on the tooth.

4) On June 21, 1993, Licensee continued the root canal treatment on tooth #4 and noted a plan to place a DO amalgam restoration in the tooth at the patient's next visit. It was placed on April 22, 1999.

5) On June 20, 1994, Licensee placed an O amalgam in tooth #3.

6) On October 6, 1995, Licensee saw patient 3 for an emergency examination of tooth #3, took a periapical radiograph, and noted the patient had temperature-sensitive pain. She also noted a radiolucency on the radiograph, provided palliative treatment, and referred the patient to an endodontist.

7) On February 15, 1996, Licensee saw patient 3 for an emergency examination and noted that tooth #3 had broken down after endodontic treatment. Licensee built-up and placed a pin in the tooth and noted, "N.V. [Next Visit] crown length & impression full gold crown." Four days later, Licensee noted she accomplished "crown lengthening" of tooth #3 by performing "electrosurgery" on the gingiva around the tooth and took an impression. She seated the crown on tooth #3 on March 7, 1996.

8) On April 22, 1999, Licensee placed a DO amalgam restoration in tooth #4 and performed a build-up with two pins on tooth #29. Licensee failed to note the rationale for this. Approximately three weeks later, Licensee prepared teeth #4 and 29 for porcelain fused to metal crowns (PFM), again failing to note the reason for the treatment. Six days later she re-impressioned both teeth, and on July 9, 1999, she seated crowns on teeth #4 and #29 .

9) On October 29, 1999, Licensee saw patient 3 for an emergency examination, took a periapical radiograph of tooth #29 and noted the patient's gingiva was swollen on the facial aspect of the tooth. Licensee accessed the tooth's nerve, provided palliative care, prescribed Ampicillin, and referred the patient to an endodontist.

10) On November 22, 1999, Licensee placed a post and core and performed a build-up on tooth #29 of patient 3. Two days later, Licensee re-cemented the post and core and crown in tooth #29. On December 6, 1999, she placed a new post and core in tooth #29 and re-prepared the tooth for a crown. On March 9, 2000, Licensee removed the remainder of the post in tooth #29 which had fractured, and placed a "Flexiflange" post and a core, performed a build-up, and re-cemented the crown on tooth #29. On April 7, 2000, patient 3 was seen for an examination, prophylaxis and bitewing radiographs. One of Licensee's employees noted that the crown on tooth #29 had come off again, but did not record whether Licensee re-cemented the crown at this appointment.

11) On April 17, 2000, patient 3 returned for the placement of a mesio-occlusal (MO) amalgam on tooth #3, a lingual amalgam on tooth #14, and a buccal amalgam restoration on tooth #30. Licensee failed to note whether she re-cemented the crown on tooth #29 which had fallen off on or before April 7, or whether she provided any other treatment to the tooth at this appointment. In addition, although Licensee placed an MO amalgam on tooth #3, she again noted that the patient needed a crown on the tooth.

c. Licensee failed to document her rationale for placing veneers on teeth #7 and 10 of patient 4 and was unable to maintain the veneer on tooth #10, as described below:

1) On October 13, 1997, patient 4 was seen for an initial examination, bitewing radiographs, and a prophylaxis. The patient wanted Licensee to place a veneer or crown on tooth #10 and bleach all his teeth. Licensee failed to describe the physical state of teeth #7 and 10 or the reason for placing veneers on the teeth.

2) On April 2, 1998, Licensee prepared teeth #7 and 10 for porcelain veneers. Five days later, the patient telephoned Licensee to report that one of his temporary veneers had fallen off. On April 18, 1998, Licensee re-prepared teeth #7 and 10 for empress veneers.

3) On May 1, 1998, Licensee seated veneers on teeth #7 and 10 with empress. However, on May 9, 1998, patient 4 was seen for a prophylaxis and Licensee noted again, "[Teeth #]7 and 10 seated veneers w/ Empress" and added "(1997) base." Licensee failed to note why it was necessary to re-seat the veneers on teeth #7 and 10. On May 13, 1998, Licensee noted the veneer on tooth #10 was broken, but failed to document a plan to repair the tooth. Eight days later, Licensee seated a veneer with empress on tooth #10.

4) On May 28, 1998, Licensee repaired a chip on the disto-incisal (DI) edge of tooth #10 of patient 4. On July 24, 1998, she again repaired tooth #10 of patient 4, but did not indicate where or how the tooth had been damaged. Patient 4 was not seen again until December 22, 1998 when License prepared tooth #10 for an empress crown. She did not document the reason for replacing the veneer on tooth #10 with a crown, which was seated on January 14, 1999. On March 4, 1999, patient 4 was seen for an emergency examination of tooth #10. Licensee took a periapical radiograph, noted "Painful to percussion only. PA reveals diffuse radiolucency, "blue" tissue, perio[dontal] abscess," and prescribed 500 mg. of Ampicillin.

5) In an undated note found in the patient's chart, one of Licensee's employees wrote that patient 4 was dissatisfied with Licensee's work, had had to miss two photography shoots because he was missing a tooth, and disputed his bill.

6) In a letter dated July 14, 1999, Licensee wrote the following to patient 4:

> Dear [patient 4],
>
> I'm so sorry I won't be able to continue to treat you. You seem a nice young man. Enclosed find a refund for the veneer.
>
> I have lost my shirt financially and emotionally on this case and can no longer continue to do so.
>
> I hope you can find someone who you have confidence in so you'll be able to sit perfectly still. I would recommend [a dentist's name and business location]. He does very good work.

d. The Board finds Licensee failed to provide appropriate treatment to tooth #12 of patient 5, as follows:

1) On April 3, 1997, Licensee placed a mesio-occluso-distal (MOD) composite restoration in tooth #12 of patient 5. On September 23, 1997, she placed a facial (Fa) composite restoration in the tooth and noted a plan to place a crown at the next visit. On October 17, 1997, Licensee placed two pins and a MOD composite restoration in tooth #12.

2) On January 27, 1998, Licensee prepared tooth #12 for a PFM crown, which she seated on February 17, 1998. On March 2, 1998, Licensee saw patient 5 and noted that tooth #12 had fractured off completely. Licensee built-up and placed three pins in tooth #12. A month later, Licensee took a new impression for a crown on tooth #12 and used the crown which had fractured off as a temporary. The new crown was seated on April 27, 1998.

e. The Board finds Licensee failed to provide appropriate treatment to teeth #13 and 10 of patient 6, as follows:

1) On January 15, 1992, Licensee saw patient 6 and smoothed the buccal surface of tooth #13 where the cusp had chipped off. On January 4, 1993, Licensee placed an MO amalgam restoration in tooth #13.

2) On March 24, 1994, Licensee placed a DO amalgam restoration with a pin in tooth #13. On August 21, 1995, Licensee replaced the MO amalgam restoration in tooth #13. On July 22, 1997, Licensee replaced the MO amalgam in tooth #13 with a MO composite restoration. On September 30, 1997, Licensee prepared tooth #13 for a PFM crown, built-up the tooth, and took an impression for the crown which was seated on October 14, 1997.

3) On December 23, 1997, Licensee saw patient 6 who had fractured off the crown and build-up placed in tooth #10 by Licensee in 1992. Licensee built up the tooth with herculite and placed a pin in it. Licensee noted a plan to crown the tooth at the next visit. On January 21, 1998, Licensee prepared tooth #10 for an empress crown which she seated on February 12, 1998.

4) On March 12, 1998, Licensee saw patient 6 and noted that the facial aspect of the crown on tooth #10 had sheared off, but the interproximal and lingual aspects were still intact. To describe her repair of the tooth, Licensee wrote only, "Optibond repair, C3, herculite."

5) On April 27, 1998, Licensee saw patient 6 and noted, "Recement crown with Panavia." without describing whether all or part of tooth #10 had fractured off again or whether the crown had fallen off.

6) On May 4, 1998, Licensee saw patient 6 and noted, "Repair to crown Chrisma C4" without providing details as to the nature and extent of the break on

tooth #10 and its repair. On June 5, 1998, Licensee prepared tooth #11 for a PFM crown and rebuilt tooth #10, and noted her intent to fuse the two teeth together.

7) On June 18, 1998, Licensee noted that patient 6 had swallowed the crowns on teeth #10 and 11 as she removed them to make adjustments. Licensee failed to note whether the patient swallowed the temporary or permanent crowns and what action she took to address this incident.

f. The Board finds Licensee failed to provide appropriate care to patient 7 (YOB: 1994) as described below.

1) On November 5, 1999, Licensee saw patient 7 for an initial examination, prophylaxis, fluoride treatment, and took two bitewing radiographs. Licensee noted the patient had interproximal decay and planned to place two surface restorations in teeth #A, B, J, K, S, T, and possibly L; sealants on teeth #3, 14, and 19 and to perform a pulpotomy on tooth I.

2) On November 11, 1999, Licensee placed sealants on teeth #14 and 19, and placed a mesial composite restoration in tooth# A, a DO composite in tooth# B, and a mesial composite restoration in tooth #J. Regarding tooth #I, Licensee noted, "B & T temp[orary] filling-refer." On December 2, 1999, an employee noted that the office had received an insurance payment on patient 7's account, the patient had been referred to a specified pediatric dentist, and a radiograph had been sent to the pediatric dentist's office that day.

3) On January 3, 2000, patient 7 saw a subsequent treating dentist for an initial examination, prophylaxis, and two bitewing radiographs. In the patient's progress notes one of the treatment providers wrote, "Mom mentioned she cannot floss on the UR [Upper Right] quadrant [of the patient's mouth] where composites are placed. Clinical exam

revealed multiple dental caries and secondary caries underneath composite restorations already placed."

4) On January 11, 2000, the subsequent treating dentist placed a sealant on tooth #14 of patient 7, where, on November 11, 1999, Licensee had placed a sealant; an MO amalgam on tooth# J, where on November 11, 1999 Licensee had placed a mesial composite; and a stainless steel crown on tooth #I, where on November 11, 1999 Licensee had placed a temporary restoration.

5) On February 16, 2000, the subsequent treating dentist placed a buccal restoration and a sealant on tooth #19 of patient 7, where on November 11 , 1999, Licensee had placed a sealant. In addition, the dentist placed a stainless steel crown on tooth #L, a tooth which Licensee had examined on November 5, 1999 and noted, "L-DO?"

6) At the initial examination, the subsequent treating dentist also noted a plan to place an MO in tooth # A and a DO in tooth #B. On November 11, 1999, Licensee had placed mesial and DO composite restorations in these teeth.

g. The Board finds Licensee failed to provide appropriate treatment to tooth #8 of patient 8, as described below:

1) On March 9, 1998, Licensee placed a DI composite restoration in tooth#8 of patient 8.

2) On April 6, 1999, Licensee placed a distal composite restoration in tooth #8 and noted, "Old restoration lost."

3) On April 26, 1999, Licensee placed another distal composite restoration in tooth #8 without noting the reason for replacing the restoration she placed on April 6, 1999.

4) On October 8, 1999, Licensee prepared tooth #8 for an all-ceramic crown without noting the rationale for replacing the restoration she placed on April 26, 1999.

5) On November 1, 1999, Licensee noted concerning tooth #8, "Crown fractured as cementing into."

6) On November 10, 1999, Licensee re-cemented the temporary crown on tooth #8.

7) On November 22, 1999, Licensee noted she cemented an empress crown, but added the following entry on the same date, "[Tooth #]8 Fractured empress crown-recement temp w/temp cem[ent]."

8) On December 6, 1999, Licensee seated a new temporary crown on tooth #8 using luxatemp and temporary cement.

9) On December 20, 1999, Licensee seated a porcelain fused to gold crown on tooth #8 of patient 8.

h. The Board finds Licensee failed to provide appropriate treatment to teeth #3 and 20 of patient 9, as described below:

1) On January 3, 1996 [1997], Licensee prepared tooth #3 for a PFM crown which was seated on January 20, 1996 [1997].

2) On September 11, 1997, Licensee placed a DO composite restoration in tooth #20. On January 23, 1998, Licensee noted that the composite restoration in tooth #20 had come out and replaced it with herculite and a pin. Licensee also prepared the tooth for a crown, which she seated on March 16, 1998, when she noted the entire buccal cusp of the tooth had fractured off.

3) On January 11, 1999, Licensee re-cemented the PFM crown on tooth #3 and added, "[Tooth #3] may need [a] post and core, new crown fractured off some build-up."

4) On July 1, 1999, Licensee noted, "[Tooth #3] Crown off--decay on margins--placed post-cosmo, post cemented with panavia. Post and core build-up. Recemented crown with panavia."

5) On July 16, 1999, Licensee noted, "[Tooth #3] Post broken off w/crown [frowning face drawn here] Non-restorable-refer to O.S. [oral surgeon] for extraction. Placed composite."

6) On January 17, 2000, Licensee placed a buccal amalgam in tooth #20, a tooth on which she had placed a PFM crown on March 16, 1998.

i. The Board finds Licensee failed to provide appropriate treatment to tooth #F of patient 10 (YOB: 1994) as described below:

1) On September 22, 1998, Licensee saw patient 10 for an initial examination, prophylaxis, and fluoride treatment and took two bitewing radiographs. On the Treatment Schedule sheet in the patient's chart, Licensee noted a plan to place a DO restoration in tooth #L and distal restorations in teeth # E and F. Licensee noted, "N.V. extract or pulptecomy [sic]." Licensee failed to indicate which tooth she might extract or provide with a pulpectomy.

2) About November 10, 1998, Licensee placed a distal restoration in tooth #E, a mesial and a distal composite restoration in tooth # F, a facial composite in tooth #C, and a distal-occlusal composite restoration in tooth #L.

3) On December 21, 1998, Licensee noted the patient had an abscess on the facial of tooth #F. Licensee further noted, "Tooth mobile—PA reveals entire root still present. Access endo for pulptecomy [sic] Fl [formacresol] cotton—N.V. extract or complete pulptecomy [sic]." Licensee also replaced the facial composite restoration in tooth #C.

4) On December 31, 1998, Licensee completed the pulpotomy on tooth #F and wrote, "B & T. Canal was total necrositic [sic]. 'Boil' on tissue. Patient did not complain of pain when asked. Dyract on mesial. Tooth may be cracked below gum line."

5) On January 21, 1999, Licensee took a periapical radiograph of tooth #F and placed a mesial composite restoration on it. Licensee noted, "Boil is slowly healing."

6) On February 19, 1999, Licensee took a periapical radiograph of tooth #F and wrote, "Mother presents with patient concerned about abscessing above central—no boil today, healing okay but may need complete endo/extract."

7) On March 30, 1999, Licensee replaced the mesial composite on tooth #F and wrote a confusing note, "For photo today office call gave referral slip to pedo[dontist]. Tooth is mobile."

8) On April 14, 1999, patient 10 saw a pediatric dentist for an initial examination, prophylaxis, and fluoride, and two bitewing radiographs were taken. The pediatric dentist noted a plan to extract tooth #F and prescribed Amoxicillin to the patient.

9) On April 21, 1999, the pediatric dentist extracted tooth #F. She noted that due to the presence of decay in tooth #L, she placed a stainless steel crown on the tooth. Licensee had placed a DO composite restoration in tooth #L on November 10, 1998.

j. The Board finds Licensee failed to provide appropriate endodontic treatment to tooth #29, failed to provide appropriate prosthodontic treatment to tooth #15, and failed to detect decay, inadequate margins, and overhanging margins on the bridge from teeth #29-31 of patient 11, as described below:

1) On August 19, 1996, Licensee saw patient 11 for an initial examination, prophylaxis, and took four bitewing radiographs. Licensee noted that teeth #14, 29, and 31 would require two-surface restorations.

2) On September 10, 1996, Licensee saw patient 11, took a periapical radiograph of the bridge and the area around teeth #29 and 31. Licensee noted the presence of decay under tooth #31 and placed a distal amalgam in the tooth. Licensee also initiated endodontic treatment to tooth #29.

3) On September 20, 1996, Licensee continued to provide root canal therapy to tooth #29 and noted the gingiva in that area was very swollen.

4) On September 27, 1996, Licensee continued providing endodontic treatment to tooth #29. She failed to treat a lesion in the area of a perforation of the distal aspect of tooth #29's root as seen on an undated periapical radiograph found in the patient's chart.

5) On October 8, 1996, Licensee continued to provide endodontic treatment to tooth #29 and noted, "Gutta percha & tubliseal to obturate, miracle mix buildup. — Wait three weeks check bridge stability."

6) On November 4, 1996 and April 8, 1997, Licensee saw patient 11 for treatment but failed to note she assessed the stability of the bridge on teeth #29-31.

7) On May 13, 1997, Licensee placed a facial composite restoration in tooth #29, but failed to note that she assessed the stability of the bridge for which the tooth was an abutment.

8) On October 20, 1997, patient 11 was seen for an examination and a prophylaxis. Four bitewing radiographs were taken, but Licensee failed to note that she had assessed the stability of the bridge on teeth #29-31.

9) On November 6, 1997, Licensee saw patient 11 and noted, "[Tooth #29] cast post & core duralay pattern (removed old bridge 29-30-31). Licensee noted she prepared teeth #28 and 31 for PFM bridge abutments, but failed to note the rationale for replacing the bridge on teeth #29-31.

10) On November 13, 1997, Licensee noted, "[Tooth #29] seated cast post & core w/panavia. [Teeth #28 and 31] refined preps for PFM bridge. [Tooth #30] pontic, hemodent retraction, perform impression, seated bridge—temporary w/provinlah."

11) On December 15, 1997, Licensee seated the bridge on teeth #28—31 of patient 11.

12) On December 23, 1997, Licensee saw patient 11 for a complaint related to tooth #13 and took a periapical radiograph of the tooth. Licensee also noted, "Bridge doing well." Radiographs taken after the placement of the bridge show decay and overhanging margins along the bridge. In addition, at the patient's next prophylaxis appointment on May 19, 1998, one of Licensee's employees noted that the patient was having trouble with food impaction between teeth #30 and 31.

13) On August 2, 1999, Licensee saw patient 11 for treatment of swelling around teeth #14 and 15. Licensee took a periapical radiograph of that area and also of tooth #29, but failed to note the concern reported with tooth #29. Licensee indicated she provided palliative care to tooth #14 and referred the patient to an endodontist.

14) On September 16, 1999, Licensee placed a DO composite restoration in tooth #14 and prepared tooth #15 for a full gold crown. Licensee also noted, "removed old gold crown. Future post?"

15) On October 4, 1999, Licensee noted that the crown the lab prepared for tooth #15 was too short on the lingual aspect and that she pulled out and replaced the buildup and placed a pin in the tooth's mesio-buccal root. Licensee also noted that she replaced a loose DO composite restoration in tooth #14 which she had placed on September 16, 1999.

16) On November 11, 1999, Licensee saw patient 11 and noted, "swallowed crown—recement temp w/temp cem." Licensee failed to note whether the patient swallowed the crown while in the dental chair or whether she had provided any follow-up to ensure that the crown had not been aspirated into the patient's lungs.

17) On November 15, 1999, Licensee re-cemented the temporary crown on tooth #15.

18) On December 13, 1999, Licensee noted she took a new impression for a full gold crown for tooth #15 and re-cemented the temporary crown.

19) On December 16, 1999, Licensee noted the temporary crown on tooth #15 had fallen off and that she added "isotemp" to the temporary and re-

cemented it. Licensee also noted a plan to place a new temporary crown on the tooth if this temporary came off again.

20) On December 20, 1999, Licensee noted she re-cemented the temporary on tooth #15. Contrary to her plan at the last appointment, she did not make a new temporary crown for the tooth.

21) On December 27, 1999, Licensee seated a full gold crown on tooth #15 of patient 11.

k. The Board finds Licensee failed to provide appropriate treatment to pediatric patient 12 (YOB: 1993), as described below:

1) On June 17, 1996, Licensee saw patient 12, a two and one-half-year -old female, for an initial examination and noted the parents' primary concern was the presence of decay on their daughter's anterior teeth. Licensee noted that at the patient's next appointment she planned to take bitewing radiographs and place amalgam restorations in the patient's teeth.

2) On July 12, 1996, Licensee placed occlusal amalgam restorations in teeth #B, K, and J without first taking the bitewing radiographs that she had planned to take to determine the extent of the patient's decay. Although Licensee had placed a restoration in tooth #K, she indicated she intended to place restorations in teeth #K and S at the patient's next visit.

3) On June 6, 1997, Licensee placed a facial composite restoration in tooth #E of patient 12 and noted that the patient's next appointment would include a prophylaxis, fluoride treatment, bitewing radiographs and treatment to teeth #S, L, and G.

4) On June 24, 1997, Licensee placed a facial composite in tooth #G, an MO composite in tooth #S, and replaced the occlusal amalgam restoration she had placed in tooth #K on July 12, 1996 with an occlusal composite restoration. Licensee repeated her plan for the patient to receive a prophylaxis, fluoride treatment, and bitewing radiographs at the patient's next visit.

5) On July 22, 1997, Licensee placed a crown on tooth #G and wrote, "Pedo crown white brite luxatemp variolink. Resin crown."

6) On July 24, 1997, Licensee placed resin crowns on teeth #E and F of patient 12.

7) On September 18, 1997, Licensee placed a crown on tooth #D of patient 12.

8) On September 19, 1997, Licensee treated tooth #D of patient 12 and noted, "Shell off, but luxatemp remained, polished."

9) On October 9, 1997, Licensee placed a new crown on tooth #D and noted that she intended to place dyract restorations in teeth #B and K.

10) On October 21, 1997, Licensee placed occlusal dyract restorations in teeth #B and T and noted she administered local anesthetic to the patient.

11) On June 5, 1998, Licensee saw patient 12 and noted, "Chip off of facial of crown, some mobility." Licensee also examined all the patient's teeth, took a periapical radiograph, and noted the presence of decay on the patient's posterior teeth without specifying which teeth were affected. Licensee failed to note a plan to treat tooth #E or the rest of the patient's teeth. Licensee failed to take any bitewing radiographs or to provide the patient with a prophylaxis. This was the patient's final appointment with Licensee.

12) One of Licensee's employees left an undated note to Licensee in the patient's file saying that patient 12's mother did not want to pay the balance of her bill because she was dissatisfied with the treatment her daughter had received. She had recently taken her child to a pediatric dentist who told her that patient 12 needed substantial work ($2,000) on her posterior teeth.

13) During the time that Licensee treated patient 12, she took only two periapical radiographs of the patient's teeth. Only one of these is listed in the patient's chart. In addition, these were periapical radiographs of the patient's anterior teeth rather than bitewing radiographs of the patient's posterior teeth where Licensee subsequently provided extensive restorative treatment. Licensee failed to indicate a diagnosis as to the nature and the cause of the extensive decay present in this patient's teeth and failed to develop an adequate or effective treatment plan for them.

l. The Board finds Licensee failed to provide appropriate treatment to patient 13, as described below:

1) On November 5, 1999, Licensee saw patient 13 for treatment of a broken mesio-lingual cusp on tooth #31 and placed a mesio-lingual amalgam restoration on the tooth. On a separate sheet, she noted a plan to place PFM crowns on teeth #18, 19, 30, and 31. Licensee also noted the presence of decay on the distal surface of tooth #23.

2) On November 23, 1999, Licensee saw patient 13 for a complete examination, prophylaxis, and a full mouth series of radiographs. In her notes, Licensee indicated a plan to perform an oral cancer screen at the patient's next visit. Although she saw patient 13 at nine subsequent appointments, including the patient's last appointment on February 15, 2000, Licensee failed to note that the screen was ever completed. Although

Licensee noted she intended to place a crown on tooth #18, she failed to note the presence of decay on the mesial aspect of the tooth as shown in radiographs taken on this date.

3) On December 9, 1999, Licensee prepared teeth #30 and 31 for PFM crowns. In a separate entry with the same date, Licensee noted she re-made and re-cemented the temporary crown for tooth #30.

4) On December 11, 1999, Licensee made a new temporary crown for tooth #30.

5) On December 14, 1999, Licensee re-cemented the temporary crown on tooth #30 and also indicated she placed a composite on the facial surface of the tooth.

6) On December 16, 1999, Licensee placed a new temporary crown on tooth #30 and added to the tooth structure using isotemp material.

7) On December 21, 1999, Licensee put a new temporary crown on tooth #30 and reduced the tooth's central pit.

8) On December 28, 1999, Licensee prepared tooth #30 for a PFM crown and performed additional occlusal reduction on the tooth.

9) On January 13, 2000, Licensee seated the crowns on teeth #30 and 31.

10) On February 15, 2000, Licensee noted she performed follow-up on teeth #30 and 31, indicating only that she adjusted the occlusion on the opposing teeth. This was the patient's last appointment with Licensee. Licensee failed to complete her treatment plan for teeth #18, 19, and 23, and left decay on the mesial surface of tooth #18 and the distal surface of tooth #23.

m. The Board finds Licensee failed to provide appropriate treatment to patient 14, as described below:

1) On March 28, 1994, Licensee saw patient 14 for an initial examination, a partial prophylaxis, and took four bitewing radiographs.

2) On April 15, 1994, Licensee placed an MOD amalgam with a pin in the mesial root of tooth #13 and a restoration in tooth #15. Licensee noted that tooth #13 needed a crown.

3) On June 23, 1994, Licensee noted that the buccal cusp of tooth #13 had broken off and the tooth would need a crown.

4) On March 10, 1997, after the patient had been away from the practice for almost three years, Licensee saw patient 14 for an examination, prophylaxis, and took four bitewing radiographs. Licensee indicated that at the patient's next visit, she intended to place a crown on tooth #13 and DO restorations in teeth #18, and 29.

5) On April 24, 1997, Licensee placed MOD amalgam restorations in teeth #14 and 29. Licensee noted her plan to place a crown on tooth #13 and a DO restoration in tooth #18 at the patient's next visit. Licensee indicated she had removed the overhanging margin on the mesial aspect of tooth #15. However, the overhanging margin on the mesial surface of tooth #15 is visible on a radiograph dated September 17, 1998.

6) On August 20, 1998, Licensee saw patient 14 because the buccal cusp of tooth #13 had fractured off again. Licensee placed an MO amalgam restoration in tooth #2, but failed to note that she provided any type of palliative or other treatment to tooth #13 or to note the reason for failing to do so.

7) On September 17, 1998, patient #14 was seen for prophylaxis and a full mouth series of radiographs. This series of radiographs failed to include the periapicals of the patient's maxillary posterior teeth. Licensee noted that she planned to place crowns on teeth #2, 13, and 18, and a DO restoration in tooth #29. She failed to note the presence of deep recurrent decay in tooth #29 visible on the radiographs taken that day.

8) On October 16, 1998, Licensee placed a DO amalgam restoration in tooth #29 and noted, "very sore, pain in mandible in area of mental foramen, has had cortizone shots for [unintelligible] arthristitis [sic], constant pain. No pain on occlusion or hot or cold. Heavy bleeding."

9) On October 27, 1998, Licensee adjusted the occlusion on tooth #29 of patient 14 and noted the patient reported the pain was much improved.

10) On December 2, 1999, Licensee prepared tooth #14 for a PFM crown.

11) On December 20, 1999, Licensee seated the crown on tooth #14 and placed bucco-occlusal composite restorations in teeth #13 and 18.

12) On January 6, 2000, Licensee adjusted the occlusion on tooth #14 of patient 14.

13) On January 28, 2000, Licensee saw patient 14 and noted the patient reported the area between teeth #12-14 was very painful and there was swelling into the buccal vestible. Though Licensee failed to note that she took a periapical radiograph of the tooth, she did note that a radiograph showed a radiolucency on tooth #13. She initiated root canal therapy and provided palliative treatment to tooth #13 before referring the patient to an endodontist. The periapical radiograph of tooth #13 also reveals a second pin in tooth #13.

Licensee documented that she had placed a pin in tooth #13 on April 15, 1994; there is no documentation that she had placed a second pin in the tooth at another time.

14) In a letter dated February 17, 2000, the subsequent treating endodontist informed Licensee that her diagnosis of tooth #13 was necrosis and chronic apical periodontitis and that the prognosis for the tooth was questionable due to the crown-root ratio.

15) On May 2, 2000, following endodontic treatment to tooth #13, Licensee placed an occlusal composite restoration in the tooth. Licensee noted that patient reported pain in tooth #29. Physical and radiographic examination revealed a fistula tract in the tooth. Licensee referred the patient back to the endodontist for treatment of tooth #29. Licensee failed to note that she discussed the poor prognosis for tooth #13 with the patient or that any alternative treatments were offered.

16) During the time that Licensee provided treatment to patient 14, she failed to perform any periodontal probing of the patient's teeth or to provide any periodontal diagnosis or treatment.

n. The Board finds Licensee failed to diagnose decay on the mesial aspect of tooth #12, an abutment tooth in the bridge from teeth #12-14 of patient 15, as described below:

1) On March 18, 1992, Licensee saw patient 15 for an examination and prophylaxis and noted that she intended to place a restoration in the lingual surface of tooth #12.

2) On March 20, 1992, Licensee saw patient 15 and noted, "L (lingual) - decay. Has had sensitivity in bridge. Difficulty to point (to)." Licensee failed to note whether she placed a restoration in the lingual surface of tooth #12.

3) On March 30, 1992, Licensee saw patient 15 and noted, "Patient has still had problems with tooth [#12]. Facial tissue is very swollen. PA reveals slight radiolucency at apex. Hot and cold sensitive." Licensee prescribed penicillin for the patient, but did not refer her to an endodontist.

4) On April 8, 1992, Licensee saw patient 15 and noted, "Fistulus tract feeling w/out appearance. I & D. Refer to endo if not improved."

5) On July 20, 1992, Licensee took a periapical radiograph of tooth #12 and noted, "Pain & swelling over tooth, PA reveals radiolucency at apex. Refer to Endo Associates for endo." Licensee failed to note the presence of decay on mesial surface of tooth #12 visible on the periapical radiograph taken on this date.

o. Patient 17 had her initial appointment with Licensee on October 27, 1998; her last appointment with Licensee was on January 11, 2000. During that 15-month period, Licensee placed amalgam restorations on teeth #30 MO, #5 DO, #3 O, 2 (sealant), #12 DO, #14 MODL, #15 DO, #18 O, #19 MB, #20 DO, #4 DO, #31 MO, and #29 DO. The Board finds Licensee used inadequate radiographs in making her diagnoses and failed to recognize and diagnose multiple caries when she placed the restoration.

p. On August 13, 2001, Licensee placed a restoration on tooth #9D for patient 19. It had unfinished margins and stained the tooth. The restoration was redone by another dentist on September 25, 2001.

q. In response to the Board's November 13, 2002 letter requesting additional patient records for prosthodontic cases, Licensee provided records identified as patients 1 through 6. During her January 23, 2003 meeting with the Committee, Licensee described the following treatment she provided to patient 2, who was fourteen years old when

she began treating him in 1999. Initially, Licensee referred patient 2 to an orthodontist for his orthodontic treatment. When orthodontic treatment was completed on March 6, 2002, Licensee referred the patient to an oral maxillofacial surgeon for implant placement. On March 22, 2002, the oral surgeon surgically placed implants to replace teeth #7 and #10 on patient 2. Licensee indicated that she did not have complete control over patient 2's treatment. The Board finds that Licensee failed to adequately coordinate patient 2's entire dental treatment with other specialists. The Board finds that Licensee should have mounted patient 2's case on an articulator and determined whether the patient was still growing prior to referring patient 2 to an oral surgeon for implants. Licensee disagrees that she needed to use an articulator to mount the case or to determine if growth had stopped.

r. Licensee states that she no longer provides endodontic treatment and will not do so in the future.

Substandard Periodontal Treatment

3. The Board finds Licensee failed to appropriately assess and document patients' periodontal status, diagnose and treat periodontal disease, and refer patients for periodontal treatment. Examples include the following:

a. Licensee failed to follow up and treat patient 6's periodontal disease. On October 3, 1996, patient 6 was seen for an examination, prophylaxis, and four bitewing radiographs. The sextant readings of 3 in one sextant and 4 in the other five sextants of the patient's mouth may have indicated the presence of periodontal disease. Licensee failed to follow up on this information by performing a full mouth periodontal probing. On October 26, 1998, patient 6 was seen for an examination, prophylaxis, and four bitewing and three periapical radiographs were taken. The progress notes indicate the presence of 5 mm

pockets on the lingual aspect between teeth #2-3 and on the facial aspect of teeth #13-14. In addition, radiographs taken on this date show evidence of bone loss. No further periodontal charting, comprehensive treatment plans or periodontal referrals were provided to the patient at either of these appointments.

b. Licensee failed to follow up and treat patient 9's periodontal disease. On April 16, 1996 and August 25, 1997, patient 9 was seen for an examination and prophylaxis and four bitewing radiographs were taken at each appointment. At the appointment in 1996, sextant readings of 3 were noted in the patient's maxillary right and left posterior teeth. At the appointment in 1997, sextant readings of 3 were noted in all the patient's posterior teeth. Licensee failed to follow up on these readings by performing a full mouth periodontal probing and failed to provide the patient with a comprehensive treatment plan or a referral to a periodontist.

c. Licensee failed to follow up and treat patient 13's periodontal disease. On November 23, 1999, Licensee performed a complete examination of patient 13 and noted sextant readings of 3 in five of six sextants and a reading of 4 in the patient's maxillary right posterior teeth. Licensee failed to follow up on these readings by performing a full mouth periodontal probing, or by further assessing the patient's periodontal health.

d. Licensee failed to follow up and treat patient 15's periodontal disease. On March 14, 1994, patient 15 was seen for an examination and prophylaxis and four bitewing radiographs were taken. Licensee's dental hygienist noted the presence of gingivitis and moderate bleeding throughout the patient's mouth and indicated she had stressed more frequent recall appointments. Licensee failed to perform a full mouth periodontal probing and/or periodontal charting and failed to refer the patient to a periodontist. On December 29,

1994, nine months later, patient 15 was seen for a recall examination appointment and it was noted that the patient had a 10 mm pocket on the buccal surface of tooth #18. Following both appointments, Licensee failed to request a full mouth probing, periodontal charting, and/or further assessment of the status of the patient's periodontal health.

e. Licensee failed to make any periodontal charting for patients 4, 5, 8, and 11.

Substandard Radiographic Diagnosis and Recordkeeping

4. The Board finds Licensee took an insufficient number of radiographs to assess patients' dental health. Examples include the following:

a. From March 3, 1997 until February 4, 1999, Licensee provided extensive restorative treatment to patient 5, including placing pins and crowns in tooth #12. However, the patient's file contains only four bitewing radiographs.

b. From November 25, 1991 until December 1, 1999, Licensee provided extensive treatment to patient 6, including placing a crown on tooth #10 and extracting tooth #31. However, until January 30, 1997 and October 26, 1998, when she took three periapical radiographs of the patient's teeth, Licensee had taken only periodic bitewing radiographs of the patient's teeth.

c. Licensee provided extensive restorative treatment to patient 12 without first taking adequate diagnostic radiographs.

d. On March 2, 1999, Licensee provided extensive restorative treatment to 15 of patient 16's teeth although she had taken only four bitewing radiographs at the patient's initial appointment.

e. Of the 13 adult patient records reviewed in this case, only three contained a full mouth series of radiographs. In addition, the full mouth series of radiographs dated September 17, 1998, taken for patient 14 failed to include the maxillary anterior periapicals.

5. Licensee failed to take appropriately diagnostic radiographs in that the 17 patient charts reviewed in this case contained dark, non-diagnostic radiographs and cone-cut radiographs that Licensee failed to have retaken.

6. Licensee failed to make or maintain adequate radiographic records for her patients in that the radiographic record of patient 9 contained three undated bitewing and one undated periapical radiographs, and the radiographic record of patient 11 contained four undated periapical radiographs of tooth #29 and one undated periapical of tooth #15.

Unprofessional Conduct/Failure to Respond to Patients' Requests for Records

7. The Board finds Licensee has engaged in unprofessional conduct and failed to respond promptly to patients' requests for their records.

a. Between January 12, 1999 and November 29, 1999, Licensee provided dental treatment to patient 16 (the father of patients 17 and 18). On or about July 24, 2001, patient 16 came to Licensee's office, seeking another copy of his record and a first copy of his daughter's (patient 17) chart. Patient 16 stated that one of Licensee's staff members refused to release the paper portions of the chart, claiming it was illegal to do so.

b. On at least one occasion, when Licensee planned to be away from her office, she instructed her staff to refer patients with emergencies to three other dentists. Licensee had not discussed this referral plan with the three dentists.

C. Violations. Licensee admits that the facts and conduct specified above constitute violations of Minn. Stat. § 150A.08, subd. 1(6), (8), (10), and (13), and Minn. R. 3100.6200A, B, D, E, and K, 3100.6300, and 3100.9600 and are sufficient grounds for the disciplinary action specified below.

D. Disciplinary Action. Licensee and the Committee recommend that the Board supercede its April 4, 1997 Stipulation and Order for Conditional License and issue an order which places CONDITIONS on Licensee's license to practice dentistry in the State of Minnesota as follows:

CONDITIONS

1. Licensee's license shall be subject to the following conditions:

a. Licensee shall discuss her next four cases involving implants with a prosthodontist approved by the Committee. The prosthodontist may have a professional relationship with Licensee. The discussions will take place at two stages of treatment: (1) following Licensee's diagnosis of the patient's needs and development of a treatment plan and following Licensee's consultations with the laboratory she uses and the oral/periodontal surgeon who will perform the surgery; and (2) following completion of implant treatment. Licensee shall cause the consulting prosthodontist to submit reports to the Committee within 30 days of completion of each patient's implant treatment. These reports shall address the reasonableness of Licensee's treatment decisions and adequacy of the treatment she provides.

b. Course Work. Licensee shall successfully complete the coursework described below within three years of the effective date of this stipulation and order. **All coursework must be approved in advance by the Committee.** Licensee is responsible for locating, registering for, and paying for all coursework taken pursuant to this stipulation and

order. None of the coursework taken pursuant to this stipulation and order may be used by Licensee to satisfy any of the continuing dental education requirements of Minn. R. 3100.4100, subps. 1 and 2. The Committee will not accept any home study coursework, except for the required infection control course. Licensee shall pass the examination 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 Licensee's final examination and answers, and for the Committee and the instructor(s) to communicate before, during, and after Licensee takes the course about Licensee's needs, performance, and progress. The coursework is as follows:

1) Treatment Planning. Licensee shall successfully complete an individually-designed course on treatment planning. The course shall include individualized assessment of Licensee by the course instructor(s) before Licensee begins the course and shall consist of a minimum of 30 hours of class and examination time, exclusive of study time.

2) Endodontics. Licensee must successfully complete an undergraduate dental school or continuing education course in endodontics, including diagnosis, treatment of pulp and periapically involved teeth. The class must include a clinical portion. The course must consist of a minimum of 20 hours of instruction.

3) Periodontics. Licensee must successfully complete an undergraduate or continuing education course in periodontics, including, patient risk assessment and charting, advanced instrumentation and instrumentation techniques, and soft tissue management. The course must consist of a minimum of 16 hours including a hands-on, clinical component.

4) Radiographic Technique and Interpretation. Licensee must successfully complete an undergraduate or continuing education course on radiographic technique and radiograph interpretation. The course must consist of a minimum of six hours on radiographic technique and six hours of radiograph interpretation. Within 30 days after successful completion of the course, Licensee shall submit to the Committee a copy of her office radiation control protocol, including radiographic need indications, quality control, and radiation safety for the patient and the operator.

5) Restorative Dentistry. Licensee must complete an undergraduate or continuing education course on restorative dentistry. The course must consist of a minimum of 85 hours, including 30 hours of hands-on experience. The course must address dental materials, anterior and posterior composites, occlusion, anterior and posterior ceramics, fixed and removable prosthetics.

6) Infection Control. Within 6 months of the effective date of this order, Licensee shall complete a minimum of 8 hours of instruction in infection control. Licensee shall pass the examination with a letter grade "B" or better, or its equivalent.

7) Recordkeeping. Within 12 months of the date of this order Licensee shall successfully complete eight hours of instruction in recordkeeping and professional risk management. The courses may be developed by a malpractice insurance carrier, and must emphasize accurate and complete recordkeeping.

b. Written Reports and Information. Licensee shall submit or cause to be submitted to the Board the reports and/or information described below. All reports and information are subject to approval by the Committee. Within 30 days of completing any

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

c. Office Visit. After successfully completing all coursework described above, Licensee shall submit to an office visit to review Licensee's record-keeping practices. Respondent shall be given at least twenty-four (24) hours' notice of this office visit and review. The visit shall be conducted by a representative of the Board. The representative shall conduct the office visit during normal business hours and shall randomly choose and temporarily remove five to ten original patient records for duplication and review by the Committee. Licensee shall, also, submit to an unannounced office visit to inspect the safety and sanitary conditions of her office. The visit shall be conducted by a representative of the Board. The representative shall conduct the office visit during normal business hours. Licensee shall fully and timely cooperate with such inspections of Licensee's office and patient records.

d. Staff Review of Amended Stipulation and Order. Within 30 days of the effective date of this amended stipulation and order, Licensee shall submit to the Board a signed, written statement from each current partner and associate in Licensee's practice, verifying that the partner or associate has received and reviewed a copy of this amended

stipulation and order. Within 10 days of new partnership or association, Licensee shall inform the Board in writing of the new partnership or association and within 30 days she shall submit to the Board a signed written statement from the new partner or associate verifying that the partner or associate has received and reviewed a copy of this amended stipulation and order.

e. Self-reports. Licensee shall submit quarterly self-reports to the Board with the first report due within 60 days of the effective date of this order. Each report shall address and/or provide:

1) The status of Licensee's practice, including information about the possibility of Licensee's joining a group practice or hiring an associate dentist, her therapy, and coursework required by this amended stipulation and order;

2) Information relating how Licensee has handled any patient complaints; and

3) Any other information Licensee deems relevant.

f. Reimbursement of Costs. Licensee shall pay the Board the sum of $1,500 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: $750 within six months of the effective date of this order and $750 by the time Licensee petitions to have the conditions removed from Licensee's license.

8. 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 amended stipulation and order.

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

c. In Licensee's practice of dentistry, Licensee shall comply with the most current infection control recommendations, guidelines, precautions, procedures, practices, strategies, and techniques. Currently, those guidelines are presented in Centers for Disease Control and Prevention, Public Health Service, United States Department of Health and Human Services, Recommended Infection-Control Practices for Dentistry, 1993, Morbidity and Mortality Weekly Report, December 19, 2003, Vol. 52, No. RR-17.

d. If the Board receives a complaint alleging additional misconduct or deems it necessary to evaluate Licensee's compliance with this amended 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 inspect 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 with this amended stipulation and order.

E. Removal of Conditions. Licensee may petition to have the conditions removed from Licensee's license at any regularly scheduled Board meeting after meeting the conditions of

this order 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.

F. Fine for Violation of Order. If information or a report required by this amended stipulation and order is not submitted to the Board by the due date, or if Licensee otherwise violates this amended 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.

G. Summary Suspension For Violating Order. In addition to or in lieu of the procedures described in paragraphs H. and I. below, the Committee may, if it concludes that Licensee has failed to 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 her 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.

H. Additional Discipline for Violation of Order. If Licensee violates this amended 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 amended 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 on Licensee's practice, or suspension or revocation of Licensee's license.

I. Other Procedures for Resolution of Alleged Violations. Violation of this amended 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 amended 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 amended 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.

J. Attendance at Conferences. Licensee was unrepresented when she attended a conference with the Committee on September 11, 2000. At her second conference with the Committee on October 26, 2000, Licensee was represented by attorney Gregory W. Deckert, Vest & Deckert, 6160 Summit Drive, Suite 360, Brooklyn Center, Minnesota 55430. Committee member Susan Gross, D.D.S. attended both conferences: Annie Stone Thelen, D.D.S. attended the second conference. Assistant Attorney General Rosellen Condon represented the Committee. Licensee continues to be represented by Gregory W. Deckert, who has advised Licensee regarding this amended stipulation and order.

K. 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 amended stipulation and order and to dispute the appropriateness of discipline in a contested proceeding pursuant to Minn. Stat. ch. 14. Licensee agrees that upon the application of the Committee without notice to or an appearance by Licensee, the Board may issue an order imposing the discipline specified herein. The Committee

may participate in the 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.

L. 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 amended 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.

M. 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 amended stipulation and order shall become a part of the record and may be considered by the Board in future aspects of this proceeding.

N. Data Classification. Under the Minnesota Data Practices Act, this amended stipulation and order is classified as public data. Minn. Stat. § 13.41, subd. 4 (1998). 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 disciplinary action contained in this amended stipulation and order must be reported to the National Practitioner Data Bank.

O. 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.

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

LICENSEE

JANE ODGERS, D.D.S.

Dated: Dec. 15th, 2004

By:

COMPLAINT COMMITTEE

MARSHALL SHRAGG
Executive Director

Dated: January 10th, 2004

ORDER

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

The Board's Order dated April 4, 1997, is superseded by this Stipulation and Order, the terms of this Stipulation and Order 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 28th day ~~of~~ January, 2005.

MINNESOTA BOARD
OF DENTISTRY

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

AG: #1323381-v1