

**BEFORE THE MINNESOTA
BOARD OF DENTISTRY**

In the Matter of
Paul S. Petrungaro, D.D.S.
License No. D11084

**STIPULATION AND ORDER
FOR CONDITIONAL LICENSE**

STIPULATION

Paul S. Petrungaro, D.D.S. ("Licensee") and the Minnesota Board of Dentistry's Complaint Committee ("Committee") agree the above-referenced matter may be resolved without trial of any issue or fact as follows:

I.

JURISDICTION

1. The Minnesota Board of Dentistry ("Board") is authorized pursuant to Minnesota Statutes chapter 150A, section 214.10, and section 214.103 to license and regulate dentists and to take disciplinary action when appropriate.

2. Licensee holds a license from the Board to practice dentistry in the State of Minnesota and is subject to the jurisdiction of the Board with respect to the matters referred to in this Stipulation and Order.

II.

CONFERENCE

3. On September 27, 2012, Licensee and his attorney, Anthony J. Novak, appeared before the Committee, composed of Board members Joan Sheppard, D.D.S., Teri Youngdahl, L.D.A., and Paul Walker, D.D.S., to discuss allegations made in a Notice of Conference dated June 13, 2012. Geoffrey S. Karls, Assistant Attorney General, represented the Committee at the

conference. In January 2013, the Committee received a subsequent complaint against Licensee that was referred to the Minnesota Attorney General's Office for investigation. After reviewing the investigative report, the Committee included additional information regarding patient 5 into this Stipulation and Order.

4. Licensee was advised by Committee representatives that he may choose to be represented by legal counsel in this matter. Licensee retained Anthony J. Novak, Esq., of Larson & King, LLP, 30 East Seventh Street, Suite 2800, St. Paul, Minnesota.

III.

FACTS

5. The parties agree this Stipulation and Order is based upon the following facts:

Substandard Diagnostic, Periodontal, Prosthodontic, and Oral Surgery Care

a. Licensee failed to provide appropriate diagnostic, periodontal, prosthodontic, and oral surgery care to more than one of his patients. Examples include the following:

1) Patient 1

a) In July 2009, Licensee failed to personally obtain sufficient clinical examination records from patient 1 for the assessment and diagnosis necessary to provide extensive prosthodontic treatment, including: a comprehensive medical history addressing the "sinus disease" condition identified by the patient; a complete head and neck examination; and a complete periodontal assessment of the patient's periodontal conditions.

b) In July 2009, Licensee failed to provide an appropriate diagnosis and comprehensive treatment plan for patient 1 that addressed the following:

(1) The patient's periodontal conditions prior to providing any prosthodontic treatment.

(2) The rationale for his proposed dental treatment, including tooth extractions, bilateral sinus lifts, and implants.

(3) The treatment needed on the lower teeth including addressing carious lesions and replacing missing teeth, as seen on the July 20, 2009, computerized tomography scan.

c) In 2009 and 2010, Licensee exposed patient 1 to unnecessary radiation from taking five computerized tomography scans on July 20, August 21, September 2, October 21, 2009, and January 20, 2010. Additionally, Licensee failed to document the diagnostic interpretation of the four latter scans and the name of the person interpreting each scan in patient 1's progress notes. Licensee also failed to take full mouth radiographs on patient 1 prior to treatment.

d) Prior to surgery on August 11, 2009, Licensee overprescribed two antibiotic medications, Augmentin and Levoquin, for patient 1 when a staff member incorrectly mailed both prescriptions to the patient. Patient 1's pharmacist contacted Licensee's office about the two antibiotic medications, and only filled the Augmentin for the patient, which failed to be documented in patient 1's record. Furthermore, Licensee failed to document his rationale for instructing patient 1 to take an antibiotic, calcium, and magnesium prior to her surgery.

e) The following occurred when Licensee provided surgical treatment to patient 1 on August 21, 2009:

(1) Licensee administered 12 carpules (800 mg) of 4% articaine with 1:100,000 epinephrine and two carpules (34 mg) of 2% lidocaine with 1:50,000 epinephrine to patient 1, prior to performing any surgical procedures. Licensee's administration of these local anesthetics exceeded the maximum allowable dosage.

(2) Licensee placed the implants and performed the bilateral sinus lifts for patient 1 on the same date. However, patient 1's maxillary arch does not appear to have sufficient bone to provide initial stabilization of the implants, as seen on the July 20, 2009, computerized tomography scan. At the conference, Licensee stated that patient 1 had 2mm of bone present in the area, which confirmed that the bone depth was insufficient.

f) On September 10 and October 9, 2009, Licensee failed to personally examine patient 1 at her general dentist's practice when the patient was experiencing swelling, soreness, and drainage in her maxillary arch. At the first appointment, patient 1 was examined by her general dentist, who failed to document a diagnosis or render treatment that addressed the patient's symptoms. At the latter appointment, patient 1 saw an associate dentist of the practice who prescribed penicillin for her.

g) Licensee examined patient 1 on October 21, 2009. Patient 1 was experiencing seepage in her nose when gargling, and a bad taste and loose particles in her mouth. Licensee performed an examination, took a computerized tomography scan, and removed the implant at the site of tooth #14 due to non-integration. However, Licensee failed to document the presence of sinus disease in patient 1's progress notes, as seen on the October 21, 2009, computerized tomography scan. In addition, Licensee failed to properly examine and diagnose the site of the removed implant for an oroantral communication.

h) On October 28, 2009, Licensee failed to personally examine patient 1 and remove the implant at the site of tooth #15. Instead, patient 1's implant was removed by her general dentist who failed to properly examine the site of the removed implant for an oroantral communication.

i) On December 14, 2009, the following occurred:

(1) Licensee examined patient 1 and removed the implants at the sites of teeth #3 and #4 due to non-integration. When Licensee was removing the implants, patient 1 claimed that one of the implants was accidentally drilled into her sinus and then retrieved by him. However, Licensee failed to document this event in patient 1's progress notes.

(2) In patient 1's progress notes, Licensee indicated that he observed the presence of purulence from the patient's right sinus. However, Licensee failed to document how he would treat this sinus symptom for patient 1.

(3) Licensee claimed that he conducted a bacteriologic test on the purulence from patient 1's right sinus. However, Licensee failed to document the results of the test in patient 1's record.

j) On May 27, 2010, patient 1 saw a subsequent dental provider who diagnosed a sinus infection and oroantral fistula on the left side of the patient's maxillary arch. The subsequent dental provider has since resolved the sinus infection and closed the fistula for patient 1.

2) Patient 2

a) In 2003, Licensee failed to obtain sufficient clinical examination records from patient 2 for the assessment and diagnosis necessary to provide

extensive prosthodontic treatment, including: a complete head and neck examination; and a complete periodontal assessment of the patient's periodontal conditions.

b) In 2003, Licensee failed to provide an appropriate diagnosis and comprehensive treatment plan for patient 2 addressing the following: the rationale for his proposed dental treatment for teeth #7, #8, #9, #10, #11, and #12; and the patient's periodontal conditions prior to providing any prosthodontic treatment.

c) In 2003, Licensee failed to obtain an adequate informed consent from patient 2 prior to extracting teeth and placing implants in the patient's maxillary arch. Licensee's informed consent for patient 2 lacked teeth numbers and signatures.

d) In 2003 and 2004, Licensee's progress notes for patient 2 failed to contain documentation about each of the eight post-operative clinical examinations when providing dental treatment to teeth #7, #8, #9, #10, #11, and #12.

e) In 2003 and 2004, Licensee failed to refer patient 2 to another dental specialist in a timely manner when she had been experiencing pain in tooth #9 for seven months. Due to Licensee's delay, patient 2 suffered additional destruction of the tissues surrounding tooth #9.

3) Patient 3

a) In May 2005, Licensee failed to obtain sufficient clinical examination records from patient 3 for the assessment and diagnosis necessary to provide extensive prosthodontic and periodontal treatment, including: a complete head and neck examination; a complete periodontal assessment of the patient's periodontal conditions; and his diagnostic interpretation of the panorex radiograph taken on May 2, 2005.

b) On October 13, 2005, Licensee removed patient 3's existing implant at the site of tooth #9, placed bone graft and platelet rich plasma ("PRP") into the tooth site, and took two periapical radiographs. However, Licensee failed to document his diagnostic interpretation of the two radiographs taken on this date.

c) On October 24, 2005, when examined by her general dentist on behalf of Licensee, patient 3 complained that the sutures were "feeling really tight." However, patient 3's progress notes failed to contain documentation about the dentist clinically examining the patient's symptom, and whether Peridex was used or prescribed at this appointment.

d) On November 3, 2005, Licensee examined patient 3, who complained of "some shooting pain" in the area of tooth #10. However, Licensee failed to clinically examine patient 3's teeth, take a radiograph, perform any endodontic assessments, or provide his diagnosis of tooth #10.

e) On January 12, 2006, Licensee placed an implant at the site of tooth #9 and performed crown lengthening on teeth #3 to #14 for patient 3. However, Licensee perforated the floor of patient 3's nose with the apical portion of the implant for tooth #9, as seen on the January 23, 2006, panorex radiograph. Moreover, Licensee failed to diagnose that the implant perforated the floor of patient 3's nose after reviewing the radiograph, and failed to inform patient 3 of the perforation. At the conference, after reviewing a computerized tomography scan dated May 31, 2007, Licensee admitted that the implant extended 1.5mm into patient 3's sinus floor.

f) On May 6, 2010, four years later, Licensee examined patient 3 and observed that the implant for tooth #9 had moved apically in the patient's mouth.

However, Licensee failed to take any radiographs and perform a clinical examination of patient 3's tooth, including assessing the soft tissues, mobility, and periodontal probing depths. Instead, Licensee recommended taking a computerized tomography scan, removing the implant, and placing a special bone graft into the site.

g) On August 30, 2010, patient 3 saw a subsequent dental provider, who determined that the implant for tooth #9 had perforated the patient's nasal floor, and that the bone surrounding the implant had low density, as seen on the August 16, 2010, computerized tomography scan.

4) Patient 5

a) On January 21, 2011, Licensee failed to personally obtain sufficient clinical examination records from patient 5 for the assessment and diagnosis necessary to provide extensive oral surgery and prosthodontic treatment, including a medical history and a complete head and neck examination. Following this extensive treatment, Licensee failed to perform a post-operative clinical examination until six months later.

Unprofessional Conduct

b. Licensee engaged in conduct unbecoming a person licensed to practice dentistry. Examples include the following:

1) Licensee's conduct was unprofessional while providing dental treatment to patient 1, as follows:

a) On December 14, 2009, Licensee became very angry while treating patient 1, jumped up from his chair with a loud outburst of words, and began pacing in and out of the room. Licensee's inappropriate behavior startled patient 1, creating a scene wherein she felt embarrassed and blamed for the negative outcome of her implant procedure.

b) On March 2, 2010, patient 1 claimed that Licensee's behavior was again unprofessional toward her as he leaned in close to her face and asked her to kiss him on the cheek. Patient 1 turned her face away from Licensee, but he continued asking for kisses, stating that he would not place the implants unless patient 1 kissed him first. Patient 1 felt insulted and appalled by Licensee's unprofessional behavior.

2) Licensee's conduct was unprofessional when he violated patient 3's confidentiality and invaded her privacy by using photographic images taken of her in his case study presentations without her written consent.

3) Licensee's conduct was unprofessional when he prescribed triazolam, Atarax, and Augmentin for patient 4 prior to her appointment on November 30, 2011. At the conference, Licensee stated that he intended to achieve "light sedation" with these medications. However, Licensee does not hold a sedation certificate from the Board. Additionally, Licensee failed to properly document in patient 4's progress notes the prescriptions for these medications, such as the amount, dosage strength, and the directions for use. Alternatively, Licensee did not retain a copy of the prescriptions in patient 4's record.

4) Licensee's conduct was unprofessional while providing dental treatment to patient 5. Licensee administered intramuscular moderate sedation to patient 5 at her appointment on January 21, 2011. However, Licensee does not hold a sedation certificate from the Board. Additionally, Licensee failed to properly document in patient 5's record that he provided a thorough pre-operative assessment and adequate monitoring when sedating the patient.

Substandard Recordkeeping

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

1) Licensee failed to consistently document a complete record of the patient's existing oral health status, including dental caries, missing or unerupted (impacted) teeth, restorations, oral cancer evaluation, hard/soft tissue examination, and periodontal conditions for patients 1, 2, and 3.

2) Licensee failed to consistently document his diagnoses for dental treatment for patients 1, 2, and 3.

3) Licensee failed to consistently document appropriate treatment plans for providing dental treatment to patients 1, 2, 3, and 5.

4) When documenting the treatment provided to patients 1, 2, and 3, Licensee failed to consistently indicate he was the dental provider by noting his name or initials in the patient's treatment record.

5) Licensee improperly documented the chronology of dental treatment provided or other visits in the patient's progress notes for patient 2.

6) Licensee failed to make corrections properly in the patient's record for patients 1 and 2.

IV.

LAWS

6. Licensee acknowledges the conduct described in section III. above constitutes a violation of Minn. Stat. §150A.08, subd. 1(6) and (13), Minn. R. 3100.6200 A, 3100.6200 B, and 3100.9600, and justifies the disciplinary action described in section V. below.

V.

DISCIPLINARY ACTION

The parties agree the Board may take the following disciplinary action and require compliance with the following terms:

CONDITIONS

7. The Board places the following **CONDITIONS** on Licensee's license:

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

1) Local Anesthesia. Within six months of the effective date of this Order, Licensee shall personally attend and successfully complete one full-day course of instruction in comprehensive local anesthesia relating to the practice of dentistry and administering local anesthesia to patients, including maximum dosages of local anesthetic.

2) Professional Boundaries. Within six months of the effective date of this Order, Licensee shall arrange to enroll in an individualized professional boundaries training course taught by John Hung, Ph.D., L.P. in Edina, Minnesota, or another equivalent course approved in advance by the Committee. The professional boundaries course shall address proper patient communication. Licensee's signature on this Order is authorization for the Committee to communicate with the instructor/practitioner before, during, and after Licensee takes the course about his needs, performance, and progress. Licensee's signature also

constitutes authorization for the instructor/practitioner to provide the Committee with copies of all written evaluation reports. Successful completion of the boundaries course shall be determined by the Committee based on input from Dr. Hung, or the instructor/practitioner of an equivalent course.

3) Dental Implants. Within nine months of the effective date of this Order, Licensee shall personally attend and successfully complete a minimum of 20 hours of instruction in dental implants through the University of Minnesota School of Dentistry, or another accredited dental institution. The dental implant course(s) must have a hands-on component and focus on diagnosis, treatment planning, informed consent, status of periodontal conditions, and proper implant placement.

4) Treatment Planning / Recordkeeping. Within one year of the effective date of this Order, Licensee shall personally attend and successfully complete the treatment planning / recordkeeping course entitled “Dental Patient Management: Dental Records and Treatment Planning Fundamentals” offered at the University of Minnesota School of Dentistry, or a course deemed equivalent by the Committee.

b. Coursework Reports. Within 30 days after completing each of the courses listed above, Licensee shall submit to the Committee:

- 1) proof of Licensee’s attendance and completion of the course;
- 2) copies of all materials used and/or distributed in the courses; and
- 3) a summary report of what Licensee learned in the course and specific information addressing how Licensee will incorporate this recently gained knowledge into Licensee’s practice.

4) Licensee's reports shall be typewritten in Licensee's own words, double-spaced, at least two pages in length but no more than three pages, and shall list references used to prepare the report.

5) All coursework reports submitted by Licensee are subject to review and approval by the Committee.

c. Patient Records Review. At a later date, the Board's representative shall instruct Licensee to submit to the Committee copies of original records of five (5) randomly selected patients, including radiographs, which illustrate what Licensee has learned in the treatment planning/recordkeeping course. The Committee shall review the patient records focusing on Licensee's recordkeeping practices. Additional requests for patient records shall be at the discretion of the Committee.

Removal of Conditions

8. Licensee may petition to have the conditions removed from Licensee's license at any regularly scheduled Board meeting no sooner than one year after the effective date of this Stipulation and 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 Stipulation and Order.

VI.

CONSEQUENCES FOR NONCOMPLIANCE OR ADDITIONAL VIOLATIONS

9. 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.

10. In Licensee's practice of dentistry, Licensee shall comply with the most current infection control requirements of Minnesota Rules parts 3100.6300 and 6950.1000 to 6950.1080, and with the Centers for Disease Control and Prevention, Public Health Service, and the United States Department of Health and Human Services.

11. 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, or appearances at conferences. Minnesota Rules part 3100.6350 shall be applicable to such requests.

12. It is Licensee's responsibility to ensure all payments, reports, evaluations, and documentation required to be filed with the Board pursuant to this Stipulation and Order are timely filed by those preparing the payment, report, evaluation, or documentation. Failure to file payments, reports, evaluations, and documentation on or before their due date is a violation of this Stipulation and Order.

Imposition of Fine

13. 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 Minnesota Statutes section 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.

Noncompliance or Violation With Stipulation and Order

14. If Licensee fails to comply with or violates this Stipulation and Order or it is determined Licensee has further violated Minnesota Statutes chapter 150A or Minnesota Rules chapter 3100, the Committee may, in its discretion, seek additional discipline either by initiating a contested case proceeding pursuant to Minnesota Statutes chapter 14 or by bringing the matter directly to the Board pursuant to the following procedure:

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

b. The Committee, in its discretion, may schedule a conference with the Licensee prior to the hearing before the Board to discuss the allegations and to attempt to resolve the allegations through the procedures of Minnesota Statutes Section 214.103, subdivision 6.

c. Prior to the hearing before the Board, the Committee and Licensee may submit affidavits and written argument in support of their positions. At the hearing, the

Committee and Licensee may present oral argument. Argument shall not refer to matters outside the record. The evidentiary record shall be limited to the affidavits submitted prior to the hearing and this Stipulation and Order. The Committee shall have the burden of proving by a preponderance of the evidence that a violation has occurred. If Licensee has failed to submit a timely response to the allegations, Licensee may not contest the allegations, but may present argument concerning the appropriateness of additional discipline. Licensee waives a hearing before an administrative law judge, discovery, cross-examination of adverse witnesses, and other procedures governing hearings pursuant to Minnesota Statutes chapter 14.

d. Licensee's correction of a violation prior to the conference, hearing or meeting of the Board may be taken into account by the Board but shall not limit the Board's authority to impose discipline for the violation. A decision by the Committee not to seek discipline when it first learns of a violation will not waive the Committee's right to later seek discipline for that violation, either alone or in combination with other violations, at any time while this order is in effect.

e. Following the hearing, the Board will deliberate confidentially. If the allegations are not proved, the Board will dismiss the allegations. If a violation is proved, the Board may impose additional discipline, including additional conditions or limitations on Licensee's practice, suspension, or revocation of Licensee's license.

f. Nothing herein shall limit the Committee's or the Board's right to temporarily suspend Licensee's license pursuant to Minnesota Statutes section 150A.08, subdivision 8, based on a violation of this Stipulation and Order or based on conduct of Licensee not specifically referred to herein.

VII.

ADDITIONAL INFORMATION

15. Within ten days of execution of this Stipulation and Order, Licensee shall provide the Board with the names of all states in which Licensee is licensed to practice as a dental professional or holds any other professional or occupational license or registration.

16. If while residing or practicing in Minnesota, Licensee should become employed at any other dental clinic or facility or move, Licensee shall notify the Board in writing of the new address and telephone number within ten days.

17. In the event Licensee should leave Minnesota to reside or to practice outside of the state, Licensee shall notify the Board in writing of the new address and telephone number within ten 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. If Licensee leaves the state, the terms of this order continue to apply unless waived in writing.

18. Licensee waives the contested case hearing and all other procedures before the Board to which Licensee may be entitled under the Minnesota and United States constitutions, statutes, or rules.

19. Licensee waives any claims against the Board, the Minnesota Attorney General, the State of Minnesota, and their agents, employees, and representatives related to the investigation of the conduct herein, or the negotiation or execution of this Stipulation and Order, which may otherwise be available to Licensee.

20. This Stipulation and Order, the files, records, and proceedings associated with this matter shall constitute the entire record and may be reviewed by the Board in its consideration of this matter.

21. Either party may seek enforcement of this Stipulation and Order in any appropriate civil court.

22. Licensee has read, understands, and agrees to this Stipulation and Order and has voluntarily signed this Stipulation and Order. Licensee is aware this Stipulation and Order must be approved by the Board before it goes into effect. The Board may approve the Stipulation and Order as proposed, approve it subject to specified change, or reject it. If the changes are acceptable to Licensee, the Stipulation and Order will take effect and the order as modified will be issued. If the changes are unacceptable to Licensee or the Board rejects the Stipulation and Order, it will be of no effect except as specified in the following paragraph.

23. Licensee agrees that if the Board rejects this Stipulation and Order or a lesser remedy than indicated in this settlement, and this case comes again before the Board, Licensee will assert no claim that the Board was prejudiced by its review and discussion of this Stipulation and Order or of any records relating to it.

24. This Stipulation and Order shall not limit the Board's authority to proceed against Licensee by initiating a contested case hearing or by other appropriate means on the basis of any act, conduct, or admission of Licensee which constitutes grounds for disciplinary action and which is not directly related to the specific facts and circumstances set forth in this document.

VIII.

DATA PRACTICES NOTICES

25. This Stipulation and Order constitutes disciplinary action by the Board and is classified as public data pursuant to Minnesota Statutes section 13.41, subdivision 5. Data regarding this action will be provided to data banks as required by Federal law or consistent with Board policy. While this Stipulation and Order is in effect, information obtained by the Board pursuant to this Order is considered active investigative data on a licensed health professional, and as such, is classified as confidential data pursuant to Minnesota Statutes section 13.41, subdivision 4.

26. This Stipulation contains the entire agreement between the parties, there being no other agreement of any kind, verbal or otherwise, which varies this Stipulation.

LICENSEE

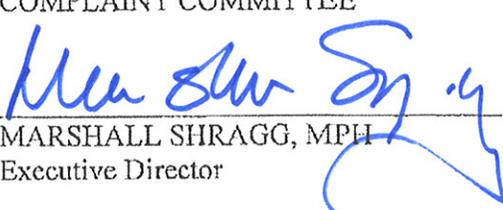


PAUL S. PETRUNGARO, D.D.S.

Dated: 11/19/13, 20

COMPLAINT COMMITTEE

By:



MARSHALL SHRAGG, MPH
Executive Director

Dated: November 19th, 2013

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, and the recommended disciplinary action set forth in the Stipulation is hereby issued as an Order of this Board effective this 22 day of NOVEMBER, 2013.

MINNESOTA BOARD
OF DENTISTRY

By: Nancy Kearns D.H.
NANCY KEARN, D.H.
President