

**BEFORE THE MINNESOTA  
BOARD OF DENTISTRY**

In the Matter of  
Richard Riemenschneider, D.D.S.  
License No. D 7348

**STIPULATION AND ORDER FOR  
LIMITED AND  
CONDITIONAL LICENSE**

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

The Board received complaints against Richard Riemenschneider, D.D.S. ("Licensee"). The Board's Complaint Committee ("Committee") reviewed the complaints and referred them to the Attorney General's Office for investigation. Following the investigation, the Committee held a conference with Licensee. The Committee and Licensee have agreed that the matter may now be resolved by this Stipulation and Order.

**STIPULATION**

IT IS HEREBY STIPULATED AND AGREED by and between Licensee and the Committee as follows:

A. Jurisdiction. Licensee holds a license to practice dentistry in the State of Minnesota from the Board and is subject to the jurisdiction of the Board with respect to the matters referred to in this stipulation. Licensee states that Licensee does not hold a license to practice dentistry in any other jurisdiction and does not hold any other professional or occupational licenses.

## Background

Licensee was subject to a Stipulation and Order for Conditional License between June 7, 1991 and September 9, 1994 because of inadequate infection control. In 1992, the Board received information that violations continued to exist in Licensee's practice. The new allegations were investigated and a conference was held in May 1994. The new matters were resolved through an Agreement for Corrective Action dated August 2, 1994. Dr. Riemenschneider completed the requirements of the Agreement and was granted an unconditional license on May 9, 1995.

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.

### Substandard Periodontal Diagnosis and Treatment

1. The Board finds that Licensee failed to provide or document appropriate periodontal treatment to patients 2, 3, 5, 6, 7, 8, 9, 12, and 13.

a. Patient 2 has Down's Syndrome. She first saw Licensee in 1980. Licensee saw her approximately every eight to ten months for an examination and a prophylaxis. He never took a full mouth series of x-rays ("FMX") or a periapical radiograph ("PA") of patient 2; bitewing x-rays ("BWs") were taken only on December 20, 1995 and September 14, 2000. Licensee failed to document any periodontal examination or full mouth probing.

b. Patient 3 saw Licensee from 1984 to February 10, 2000. Patient 3 saw Licensee approximately once a year for cleanings and examinations. On several occasions, she presented with gingival bleeding, complaining that her mouth was sore and tender. Licensee never took a FMX or a Panorex of patient 3; he did take PAs March 5, July 18 and 24, 1996,

which indicate posterior horizontal bone loss. Licensee did not provide treatment at that time or refer patient 3 to a periodontist.

On July 21, 1998, Licensee saw patient 3, who presented with gums and mouth very tender and sore. Licensee checked her mouth and told patient 3 that her gums and mouth looked very clean and healthy. He recommended that she rinse more often and massage her gums. She was seen again in January and September 1999 and placed on a six month recall schedule.

On February 7, 2000, patient 3, complaining of a tender mouth, saw Licensee. Licensee referred her to an oral surgeon who diagnosed her with periodontal disease and recommended that four teeth be extracted. Patient 3 saw another dentist for a second opinion. This dentist confirmed the oral surgeon's diagnosis and referred patient 3 to a periodontist. Ultimately, patient 3 had five teeth extracted, four quadrants of scaling and root planing, three quadrants of osseous surgery (including guided tissue regeneration and a bone graft), a root canal, two bridges and four composite fillings. On May 2, 2001, at the North Oaks office of oral surgeon LeRoy Albjerg, D.D.S., M.S.D., patient 3's attorney, Licensee's attorney, Licensee, and Dr. Albjerg met. Licensee stated that patient 3 had no pockets and that her gingiva was receding along with the bone loss. He stated that he hadn't been treating the problem since it wasn't necessary.

c. Patient 5 saw Licensee from September 1985 to June 15, 2000. Licensee did not take a FMX or Panorex of this patient. He took other x-rays, however, the patient declined x-rays on various occasions. There is no periodontal probing documented, although the patient's chart indicates gingivitis and subgingival calculus as early as 1988. An entry dated November 4, 1996 states, "#3 perio (?) no pocket." On February 23, 2001, patient 5

saw another dentist who took a FMX and charted periodontal probings, including readings of 6-7 mm pockets between teeth #2 and #3. The radiographs also showed the lower anterior teeth, especially #25, with bone loss and a large radiolucent area; tooth #24 with a splint or restorative material; and bone loss in the posterior area. The subsequent treating dentist's periodontal charting shows significant bone loss in all four quadrants, especially the upper molars and tooth #25. Ultimately, the patient had two quadrants of scaling and root planing done by the subsequent treating dentist on March 5 and 12, 2001.

d. Patient 7 saw Licensee for dental care from May 1976 to July 27, 2000. Licensee did not record any periodontal charting, diagnoses or classification. There are only two notations in patient 7's records referring to periodontal condition. This patient's first periodontal charting was done by a subsequent treating dentist on February 22, 2001. It shows moderate bone loss in all four quadrants in the posterior area with measurements ranging from 4-6 mm.

e. Licensee provided dental services to patient 8 from March 1969 to July 18, 2000. This patient came for cleanings irregularly; patient 8 requested yearly recall visits in February 1997. Licensee made few notes regarding patient 8's periodontal condition and recorded no periodontal probings. Patient 8 was seen by a subsequent treating dentist on April 24, 2001. Periodontal charting on that date indicates moderate periodontal disease and a FMX taken on that date shows moderate horizontal and vertical bone loss. The hygienist noted moderate calculus, heavy bleeding, Type III perio, 6 mm pockets on every molar and 4 mm pockets on all the other teeth.

f. Patient 9 was treated by Licensee from March 1971 to October 5, 2000. Although Licensee failed to document any periodontal probing, this patient had several

appointments for scaling and root planing. Licensee would note "perio scale" or "root plane," but did not state which teeth or quadrants were treated. Examples of this are found in chart entries dated: January 1, 1984; June 17, 1985; July 22, 1987; June 22 and October 26, 1988; and April 18 and November 22, 1989. On August 4, 1994, Licensee wrote "measure pkts!" but did not record pocket depths in the record at this or future appointments.

A subsequent treating dentist saw patient 9 on February 21, 2001 and noted that the crown on tooth #8 had class III mobility. On March 28, 2001, her hygienist noted advanced periodontal disease and generalized pockets up to 9 mm. Patient 9 was referred to a periodontist.

g. Licensee provided dental care to patient 12 from September 1972 to April 6, 2000. Licensee did not document any periodontal probing for this patient, although there are many chart entries by a dental hygienist indicating periodontal concerns. Notes from cleaning appointments on July 9, 1987; March 17, 1988; October 20 [1988?]; June 5, 1989; and February 26, 1992 indicate significant calculus, gingivitis, Class II, and generalized subgingival calculus. Progress notes from February 28, 1995 indicate tooth #3 had a 5 mm mesial pocket and tooth #15 had a 4 mm mesial pocket. Films taken February 19, 1997 indicate that the patient had generalized horizontal and vertical bone loss on tooth #3. "[S]ome RP [root planing]" was noted on June 30, 1999.

On April 17 2001, patient 12 saw a subsequent treating dentist who did a full-mouth periodontal probing and charting. Generalized pockets of 4-9 mm were found throughout the patient's mouth. The subsequent treating dentist diagnosed Type IV advanced periodontal disease with heavy calculus and heavy bleeding.

h. Patient 13 received dental care from Licensee from November 1973 to October 23, 2000. Radiographs taken February 18, 1993 and March 9, 1998 show horizontal and furcation bone loss. Licensee tried to manage patient 13's periodontal disease by scaling and root planing (March 15, 1984, February 18, 1993, March 9, 1998, June 16, 1999, and August 31, 1999). No periodontal probing is recorded in patient 13's chart. Licensee contends that periodontal probing was done on a separate treatment form but that the treatment form is missing from the records. Patient 13 was seen by a subsequent treating dentist on April 25, 2001 and referred to a periodontist.

#### Substandard Endodontic Diagnosis and Treatment

2. The Board finds that Licensee failed to provide appropriate endodontic treatment to patients 1, 2, 6, and 13.

a. Patient 1 received dental treatment from Licensee for almost 30 years. On February 16, 1993, Licensee placed an ML amalgam on tooth #14; on October 30, 1994, he placed a composite on tooth #14B. On September 11, 1996, Licensee took one PA film and started root canal treatment (RCT) on tooth #14. Licensee's progress notes state that he couldn't enter both buccal canals and could enter the Li canal only 3 mm. He completed the RCT on May 12, 1998, noting ". . . only chg pt 1 canal couldn't fill B and DB." Patient 1 returned to Licensee on December 17, 1998 and May 17 and 31, 2000 because she had developed pain and a bad taste with tooth #14. Licensee told her nothing was wrong with tooth #14, but the tooth next to it was the problem. Licensee did a root canal on tooth #13 on January 12, 1999. Licensee took several radiographs, but told patient 1 he saw nothing unusual. In 1999, patient 1 noticed a lump near tooth #14. When she mentioned it to Licensee on May 17, 2000, he prescribed Cleocin and told her he didn't know what it was and it didn't appear on a radiograph.

Patient 1 saw another dentist who referred her to an endodontist to re-treat tooth #14. Eventually, the tooth was extracted. Radiographs dated June 14, 2000 show a periapical radiolucency in the area of tooth #6 which had previously had endodontic treatment. The record indicates the Licensee restored #6-MLi on January 12, 1999, without having taken any x-rays prior to treatment. Patient 1 is currently receiving dental care from the University of Minnesota Dental School. She needs two more root canals and a bridge on her lower right. In addition, two crowns on her front teeth need to be redone.

b. Patient 2 saw Licensee on November 15, 1999 suffering from tooth pain. The written record states that Licensee performed a root canal on tooth #26, however, periapical radiographs in the record dated November 15, 1999 show tooth #28 being treated. A few months later, patient 2 developed tooth pain while in Florida. She saw a dentist there who told her father that the root canal had been done on tooth #28, rather than tooth #26. He further found that the endodontic fill was poor and the seal inadequate. This second dentist referred patient 2 to an endodontist who retreated the tooth. On April 10, 2000, tooth #28 was extracted by an oral surgeon in Minnesota.

c. Patient 13 was treated by Licensee from November 1973 through October 12, 2000. On March 15, 1984, Licensee performed RCTs on teeth #23 and 24. These teeth had been injured in an accident in the spring of 1979. Licensee also placed a splint on teeth #22-27. Composites were placed on these teeth on March 2, 1998 and September 21, 1999. PAs taken February 13, 1993 and April 25, 2001 show radiolucencies at the apices of teeth #23 and 24 and widened periodontal ligaments on teeth #25 and 26. Licensee failed to diagnose, treat or record observations of this deterioration in the patient record. A subsequent treating dentist saw

the patient on April 25, 2001 because the splint on teeth #23-25 was loose. This dentist recommended that teeth #23-25 be removed and replaced with a partial denture.

During his interview with the investigator from the AGO, Licensee said his radiographs show severe periodontal bone loss in the lower anterior teeth. He said that he had recently re-splinted these teeth and recommended that the patient consider extracting the teeth and placing a bridge.

### Substandard Restorative Diagnosis and Treatment

3. The Board finds that Licensee failed to provide appropriate restorative treatment to patients 2, 4, 5, 6, 7, 8, 10, 12, and 14.

a. At her December 20, 1995 dental appointment, Licensee took two BWs of patient 2. They show radiolucencies of the mesial and distal surfaces of tooth #2. Licensee failed to diagnose decay.

b. Patient 4 received dental care from Licensee from 1981 until September 14, 2000. Licensee took PAs of tooth #29 on May 9, 1996, January 12, 1999, February 24 and August 22, 2000; all indicate radiolucency associated with recurrent caries, but nothing is noted in the patient's record. On September 14, 2000, patient 4 saw Licensee for hot and cold sensitivity on tooth #29. Licensee told her that she had swollen gums, but did not diagnose any other problem. Licensee did not take a PA of tooth #29.

Patient 4 continued to have symptoms and saw another dentist who gave her antibiotics and pain medication. The next day, patient 4 was seen at St. John's Hospital where she was diagnosed with a masticator space infection and put on IV antibiotics and pain medication. Eventually, the second dentist performed RCT on tooth #29. Between February 1,

2001 and June 15, 2001, she also performed root canals on teeth #18 and 21 and replaced the bridge from teeth #18-21 due to recurrent decay.

c. Patient 5 saw Licensee from September 1985 to June 15, 2000 and at the most recent appointment placed a composite restoration on tooth #2-mesial. On February 23, 2001, patient 5 saw another dentist who took a full mouth series of radiographs which showed tooth #2 with a large area of caries on the mesial aspect.

d. Patient 6 was treated by Licensee from October 1979 until March 6, 2000. Licensee initially treated tooth #13 on November 1, 1979 with a DLI amalgam and subsequently provided multiple restorative treatments to the same tooth from September 1994 through 1995. On June 13, 1995, Licensee noted tooth #13 was loose and, approximately a month later, placed a #13 composite build-up and bonded teeth #13 and 14 together for extra support. There is no notation in the record regarding other treatment options for this tooth.

Licensee placed a DO amalgam on tooth #21 of patient 6 on August 27, 1992. He replaced this filling on June 20, 1996, noting that the patient requested no x-rays. Progress notes from the same day state that tooth #21 had a buccal fracture and the DO amalgam was loose. On January 30, 1997, Licensee re-cemented the bond on tooth #21 and placed an MI resin filling. On February 14, 1997, patient 6 presented with pain. Another dentist started RCT, which Licensee finished on March 3, 1997. Licensee placed a post on April 13, 1998 and on May 5, 1998, did a crown prep and build-up. There is no indication in his notes that the crown was cemented.

Patient 6 was seen by a subsequent treating dentist on November 6, 2000. She took a FMX, which showed caries on teeth #5, 6, 8, 9, 11, 22, 23, 26, and 27. She also noted

that tooth #13 had a cracked temporary crown; tooth #20 had periapical pathology; and the crown on tooth #21 was not attached to the root. The subsequent treating dentist referred the patient to an oral surgeon who extracted teeth #13 and 20 on January 22, 2001. Licensee placed a post on tooth #21 on April 13 1998 and on May 5, 1998 did crown buildup. There is no indication in his notes that the crown was cemented.

e. Patient 7 received dental care from Licensee from May 1976 through July 27, 2000. Licensee placed posts in tooth #3 on March 12, 1998; in tooth #7 on July 12, 1985; and in tooth #18 on February 3, 1994. There is no documentation of Licensee placing a post in tooth #20, although radiographs dated February 6, 1997 and following show a post in place. When patient 7 was seen by a subsequent treating dentist on February 22, 2001, she took a FMX which shows posts perforating the roots of teeth #3, 7 and 20.

f. Licensee treated patient 8 from March 1969 through July 18, 2000. Licensee placed a crown on tooth #21. The record does not indicate the date of the original placement, but BWs taken February 18, 1997 show a crown in place and indicate a radiolucency underneath it. There is no mention of this in patient 8's chart. A crown build-up and re-cementation was done on October 1, 1998. The crown was re-cemented on December 12, 1998 and February 8, 1999. Patient 8 was seen by a subsequent treating dentist who took a FMX on April 4, 2001. These films show a radiolucency under the crown on tooth #21 which was not documented by Licensee.

Extensive decay in tooth #32 is evident in a radiograph dated February 18, 1997. Although Licensee noted a referral for extraction of the tooth, there is no follow-up documentation.

g. Licensee provided dental care to patient #10 from February 3, 1999 to April 19, 2000. When he first saw Licensee, patient 10 hadn't seen a dentist in 15 years. At his initial appointment, Licensee did an examination and took four BWs and two PAs. The films show tooth #3 missing most of the clinical crown, having a short mesiobuccal root with a periapical radiolucency and a possible root fracture. Licensee did not treat this tooth until April 5, 2000 when he did a crown prep and build-up. The crown was cemented on April 19, 2000. A subsequent treating dentist saw patient 10 on March 7, 2001 and claimed to have found caries under the crown.

h. Patient 12 saw Licensee from September 1972 through April 6, 2000. On February 18, 1997, Licensee took 4 BWs and 2 PAs for patient 12. Two BWs and one PA show evidence of decay on teeth #14 and 15. Licensee told the Committee they were restored the same day, but he failed to note this. On November 24, 1997, he noted "no problems" at a recall appointment. BWs taken April 6, 2000 indicate decay progressing on these teeth. Again, progress notes do not indicate that Licensee observed these areas of decay. Patient 12 saw a subsequent treating dentist on April 17, 2001 who took a FMX. This shows a radiolucency on tooth #15 and another on the distal border of the amalgam on tooth #14.

i. Patient 14 received dental care from Licensee from January 1972 through April 26, 2000. Licensee took two BWs on April 14, 1998, which indicate decay on tooth #19D. This is not reflected in the patient's chart. Patient 14 saw a subsequent treating dentist on April 23, 2001. She took a FMX which shows the decay progressing on this tooth.

Licensee performed a RCT on tooth #31 in June 1997. Periapical (PA) radiographs dated June 25, 1997, April 14, 1998 and January 5, 1999 show Class II furcation involvement of the tooth, but there is no documentation in the record. Licensee placed a post

build-up and crown on the tooth on April 30, 1998. On May 5, 1999, patient 14 returned to Licensee complaining of tenderness and an abscess on the lower right of his mouth. Licensee treated this by root planing tooth #31; he noted that he gave the patient a periodontal probe to clean around teeth #30 and 31 and adjusted the patient's bite. On April 11, 2000, patient 14 had a "post 31" done. Licensee failed to document why this treatment was necessary. A radiograph taken January 5, 1999 shows a post in place on tooth #31. The FMX taken by the subsequent treating dentist shows the post in the mesial root of tooth #31 perforating the root. It also shows extensive decay on the mesial of this tooth.

#### Substandard Recordkeeping

4. The Board finds that Licensee failed to make or maintain adequate patient records. Examples include the following:
  - a. Licensee failed to document a diagnosis, a treatment plan, treatment options or informed consent to patients 1-10 and 12-14.
  - b. Licensee failed to identify himself as the provider of dental care, and failed identify the types or amounts materials used or anesthesia administered to patients 1-10 and 12-14.
  - c. Licensee failed to take comprehensive radiographs of patients 3-10 and 12-14.
  - d. Licensee failed to consistently document the reason for the visits of patients 1-7.
  - e. Licensee failed to update the medical histories of patients 1, 4, 7, 8, 10, 12, 13 and 14; Licensee failed to document any medical history for patients 1 and 9.

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

At his conference with the Committee on January 17, 2003, Licensee said after his 1994 Agreement for Corrective Action with the Committee, he did at least one periodontic examination per year per patient. He also stated that he did not document that he had done these examinations. He explained that he now works in a group setting and his recordkeeping meets the Board's standards.

#### July 17, 2003 Incident

5. On September 3, 2003, the Complaint Committee received a Death or Serious Injury Report from the Department of Human Services describing an incident where a patient stopped breathing while being treated by Licensee. The patient was admitted to the hospital having suffered an anoxic brain injury and died a few days later.

a. On July 17, 2003, Licensee provided dental treatment to patient 15, a 71-year old severely retarded man.

b. A few minutes into treatment, the patient lost consciousness. Licensee said that the patient fell asleep. He also said that he continued treatment after checking vital signs and they were normal but they were not documented.

c. A few minutes later the patient's respirations were fewer and shallower. Licensee said the patient's pulse was normal, but not documented. Licensee continued treatment.

d. Approximately a minute and a half later, the patient stopped breathing. Emergency procedures were initiated. The patient was taken to the hospital with a brain injury and died a few days later.

e. The patient's vital signs were not documented during his dental treatment.

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

D. The Committee's Order for Temporary Suspension and Notice of Hearing dated September 25, 2003 is hereby rescinded.

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

#### **LIMITATION**

1. Licensee is prohibited from providing dental care to any patient in an independent practice or non-group practice setting unless this has been approved by the Board.

2. Licensee is prohibited from providing dental care to any patient in a clinic or group practice unless another dentist is present.

3. Licensee is required to employ a pulse oximeter when treating any patient who has been premedicated for the purpose of receiving dental care or who is under the influence of nitrous oxide during dental treatment.

#### **CONDITIONS**

4. Coursework. Within eighteen months of the effective date of this order Licensee shall successfully complete the coursework described below. All coursework must be approved in advance by the Committee. Licensee is responsible for locating, registering for, and paying for all coursework taken pursuant to this stipulation and order. If Licensee attends an

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

- a. Licensee shall complete a minimum of 22 hours instruction in non-surgical periodontology, including a hands-on component, at the University of Minnesota or an equivalent course.
- b. Licensee shall complete a minimum of 18 hours of instruction in endodontics, including a hands-on component.
- c. Licensee shall complete the Special Course on Treatment Planning (a minimum of 40 hours of individualized instruction) offered by the University of Minnesota in the summer or an equivalent course.
- d. Licensee shall complete a minimum of 20 hours of instruction in restorative dentistry, focusing on current techniques and treatment modalities.
- e. Licensee shall complete a 6 hour course in radiographic techniques.

f. Licensee shall complete 8 hours of instruction on risk management and recordkeeping.

g. Within 3 months, the Licensee shall satisfactorily complete 12 hours of instruction on medical history evaluation and management of medical emergencies in dentistry. The Committee has approved in advance, the independent study course offered through the University of Minnesota Continuing Dental Education department.

h. Within 6 months, the Licensee shall satisfactorily complete a 6 hour lecture / participation course on managing dental patients with medical problems. The Committee has approved in advance, the course offered on October 17, 2003 through the University of Minnesota Continuing Dental Education department.

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

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

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

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

7. Review of Stipulation and Order. Within 30 days of the effective date of this stipulation and order, Licensee shall submit to the Board a signed, written statement from each Licensee's current partners, associates, or employers in Licensee's practice verifying that the partner, associate, or employer has received and reviewed a copy of this stipulation and order. Within 10 days of hire, new association or partnership, Licensee shall inform the Board in writing of the hire, new association or partnership within 30 days he shall submit to the Board a signed written statement from the new partner, associate, or employer verifying that he/she has received and reviewed a copy of this stipulation and order.

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 stipulation and order.

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

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

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

9. Removal of Limitation and Conditions. Licensee may petition to have the limitation and conditions removed from Licensee's license at any regularly scheduled Board meeting no sooner than one year after the effective date of this order provided that Licensee's petition is received by the Board at least 30 days prior to the Board meeting. Licensee shall have the burden of proving that Licensee has complied with the limitation and conditions and that Licensee is qualified to practice dentistry without limitations and conditions. Licensee's compliance with the foregoing requirements shall not create a presumption that the limitations should be removed. Upon consideration of the evidence submitted by Licensee or obtained

through Board investigation, the Board may remove, amend, or continue the limitations and conditions imposed by this order.

10. Fine for Violation of Order. If information or a report required by this stipulation and order is not submitted to the Board by the due date, or if Licensee otherwise violates this stipulation and order, the Committee may fine Licensee \$100 per late report or other violation. Licensee shall pay the fine and correct the violation within five days after service on Licensee of a demand for payment and correction. If Licensee fails to do so, the Committee may impose additional fines not to exceed \$500 per violation. The total of all fines may not exceed \$5,000. Licensee waives the right to seek review of the imposition of these fines under the Administrative Procedure Act, by writ of certiorari under Minn. Stat. § 480A.06, by application to the Board, or otherwise. Neither the imposition of fines nor correction of the violation will deprive the Board of the right to impose additional discipline based on the violation.

11. Summary Suspension for Violating Order. In addition to or in lieu of the procedures described in paragraphs 13 and 14 below, the Committee may, if it concludes that Licensee has failed to observe the limitation and meet the conditions of this Order, immediately and summarily suspend Licensee's license to practice dentistry. The Committee's Order for Summary Suspension shall constitute a final order of the Board. The suspension is effective upon written notice by the Committee to Licensee and Licensee's attorney. Service of notice on Licensee is complete upon mailing the notice to Licensee and his attorney. Such suspension shall remain in full force and effect until Licensee meets with the Committee to discuss the bases for the summary suspension and a new Order is issued by the Board.

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

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

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

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

13. Other Procedures for Resolution of Alleged Violations. Violation of this stipulation and order shall be considered a violation of Minn. Stat. § 150A.08, subd. 1(13). The Committee shall have the right to attempt to resolve an alleged violation of the stipulation and order through the procedures of Minn. Stat. § 214.103, subd. 6. Nothing herein shall limit (1) the Committee's right to initiate a proceeding against Licensee pursuant to Minn. Stat. ch. 14, or (2) the Committee's and the Board's right to temporarily suspend Licensee pursuant to Minn.

Stat. § 150A.08, subd. 8, based on a violation of this stipulation and order or based on conduct of Licensee before or after the date of this stipulation which is not specifically referred to in paragraph B. above.

14. Attendance at Conference. Licensee attended a conference with the Committee on January 17, 2003. The following Committee members attended the conference: Freeman Rosenblum, D.D.S., Ronald King, D.D.S., and Lewis Pierce, D.D.S. Assistant Attorney General Rosellen Condon represented the Committee at the conference. Although Licensee was informed in the notice of conference that Licensee could be represented by legal counsel, Licensee has voluntarily and knowingly waived legal representation at the conference. Licensee is currently represented by Gregory W. Deckert, Vest & Deckert, 6160 Summit Drive, Suite 360, Brooklyn Center, MN 55430.

15. Waiver of Licensee's Rights. For the purpose of this stipulation, Licensee waives all procedures and proceedings before the Board to which Licensee may be entitled under the Minnesota and United States constitutions, statutes, or the rules of the Board, including the right to dispute the facts contained in this stipulation and order and to dispute the 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 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.

16. Board Rejection of Stipulation and Order. In the event the Board in its discretion does not approve this stipulation or a lesser remedy than specified herein, this stipulation and order shall be null and void and shall not be used for any purpose by either party

hereto. If this stipulation is not approved and a contested case proceeding is initiated pursuant to Minn. Stat. ch. 14 and section 150A.08, Licensee agrees not to object to the Board's initiation of the proceeding and hearing the case on the basis that the Board has become disqualified due to its review and consideration of this stipulation and the record.

17. Record. This stipulation, related investigative reports and other documents shall constitute the entire record of the proceedings herein upon which the order is based. The investigative reports, other documents, or summaries thereof may be filed with the Board with this stipulation. Any reports or other material related to this matter which are received after the date the Board approves the stipulation and order shall become a part of the record and may be considered by the Board in future aspects of this proceeding.

18. Data Classification. Under the Minnesota Data Practices Act, this stipulation and order is classified as public data. Minn. Stat. § 13.41, subd. 4. All documents in the record shall maintain the data classification to which they are entitled under the Minnesota Government Data Practices Act, Minn. Stat. ch. 13. They shall not, to the extent they are not already public documents, become public merely because they are referenced herein. Pursuant to federal rule (45 C.F.R. part 60), the Board must report the disciplinary action contained in this stipulation and order to the National Practitioner Data Bank.

19. 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.

20. Service and Effective Date. If approved by the Board, a copy of this stipulation and order shall be served personally or by first class mail on Licensee's legal counsel.

The order shall be effective and deemed issued when it is signed by the President or Vice-President of the Board.

LICENSEE

COMPLAINT COMMITTEE

Richard Riemschneider By:  
RICHARD RIEMENSCHNEIDER, D.D.S.

Marshall Shragg  
MARSHALL SHRAGG  
Executive Director

Dated: Oct 3, 2003

Dated: October 3<sup>rd</sup>, 2003

**ORDER**

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

The Board hereby rescinds its September 25, 2003 Order for Temporary Suspension.

The terms of the stipulation are approved and adopted, the recommended disciplinary action set forth in the stipulation is hereby issued as an order of this Board placing a LIMITATION and CONDITIONS on Licensee's license to practice dentistry in Minnesota effective this 3 day of October, 2003.

MINNESOTA BOARD  
OF DENTISTRY

By: Freeman Rosenblum, D.D.S. Pres.  
FREEMAN ROSENBLUM, D.D.S.  
President