BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

IN THE MATTER OF:	)	
	)	
	)	**FINAL AGENCY DECISION**
Andrew W. Kelly, D.D.S.	)	
(License No. 7350; Permit No.0348)	)	
	)	

THIS MATTER was heard before the North Carolina State Board of Dental Examiners ("Board") on January 25-27, 2024, pursuant to N.C. General Statute §§ 90-41.1 and 150B-38 and 21 NCAC 16N .0504 of the Board's Rules. The Board's Hearing Panel consisted of Board members Dr. Mark W. Johnson, presiding; Dr. Karen E. Lanier; Dr. William M. Litaker, Jr.; Dr. Edward J. Clemons, Jr.; and W. Stan Hardesty. Board member Dr. Catherine A. Watkins served as the Investigative Panel's Case Officer. Dr. Watkins and Board members, Ms. Lori Gordon Hendrick and Mr. Dominic Totman, were present for the hearing but did not participate in the deliberation or decision of this matter. Joshua H. Bennett, Savannah Williamson, and Dudley Witt represented Respondent, Dr. Andrew W. Kelly ("Respondent"). Douglas J. Brocker and Crystal S. Carlisle represented the Investigative Panel, and Fred Morelock represented the Hearing Panel.

Based upon the stipulations of the parties and the evidence introduced at the hearing, the Board Hearing Panel makes the following:

FINDINGS OF FACT

1. The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding pursuant to the authority granted to it in Chapter 90 of the North Carolina General Statutes, including the Dental Practice Act in Article 2 and the Rules and Regulations of the Board set forth in 21 North Carolina Administrative Code Chapter 16.

2. Respondent was licensed to practice dentistry by credentialing on July 17, 2001 and has held license number 7350 at all times relevant hereto.

3. Respondent was first issued Moderate Conscious Sedation Permit ("Permit") number 0348 on November 28, 2006.

4. Respondent is subject to the Dental Practice Act and the rules promulgated thereunder.

5. At all times relevant hereto, Respondent worked as a general dentist in North Carolina, including performing dental surgery, placing dental implants, and administering sedation.

Respondent's Treatment of Ralph H.

6. On October 4, 2018, Patient Ralph H. presented to Respondent for an implant consultation. Patient Ralph H. specifically sought out treatment from Respondent due to a Groupon issued by Respondent.

7. During the consultation, Patient Ralph H. discussed an interest in an implant at tooth #30 and crowns at teeth #s 8 and 9.

8. Respondent's treatment notes for Patient Ralph H. contain incomplete, contradictory, and confusing entries and fail to include an adequate description of the treatment rendered, including when and by whom.

9. For example, Respondent's treatment notes state that he performed a comprehensive examination. However, Respondent later stated that he did not perform a comprehensive examination of Patient Ralph H.

10. Even though Respondent later stated that he did not perform a comprehensive examination, Respondent recommended an extensive treatment plan to Patient Ralph H., including an extraction, implant, and bone graft at tooth #5; crowns on teeth #s 6-13 and 20-22; an implant, abutment, and crown on tooth #30; impressions for study models; and lab-fabricated temporaries.

11. In the patient treatment records for the initial visit on October 4, 2018, Respondent did not include any information regarding Patient Ralph H.'s periodontal presentation or whether his periodontal condition was discussed with him prior to his decision to proceed with implants.

12. Patient Ralph H. elected to have tooth #5 extracted and impressions taken for study models at the October 4, 2018 appointment.

13. On October 4, 2018, Respondent's treatment notes indicate that he performed a "simple extraction" of tooth #5, but he billed the patient for a surgical extraction.

14. The panoramic image Respondent took on that date demonstrates an infection and significant bone loss around tooth #5.

15. The treatment notes indicate Respondent prescribed Keflex, Motrin, and Peridex to Patient Ralph H. at the October 4, 2018 visit.

16. Respondent later stated at a pre-hearing conference that he also performed a bone graft for ridge preservation with osteogenic plugs after extracting tooth #5, but this procedure is not included or described in his treatment note for October 4, 2018 and not billed to the patient at that visit.

17. Patient Ralph H. presented to Respondent's office for placement of the implant at tooth site #5 on November 29, 2018.

18. Even though his treatment note from the October 4, 2018 procedure states that Respondent did a simple extraction of tooth #5, Respondent's subsequent treatment notes for November 29, 2018, describe the surgical extraction of tooth #5 as: "[u]sed highspeed to cut tooth in 4s. Used peritomes w/mallet and elevator as well as forceps."

19. Respondent later stated at a pre-hearing conference that the November 29, 2018 note was an error because tooth #5 was removed by simple extraction on October 4, 2018.

20. The bone graft procedure that Respondent contends was performed on October 4, 2018 was not billed to the patient until November 29, 2018, at the same appointment during which Respondent placed the implant at tooth site #5.

21. Respondent's treatment notes, including those for the October 4, 2018 and the November 29, 2018 procedures, do not contain a description of any technique used to perform a ridge preservation graft for Patient Ralph H.'s complex ridge defect, which Respondent contends that he performed.

22. Respondent's records do not contain a CT scan or radiograph of the tooth #5 area prior to placing the implant. A radiograph taken after the implant was placed

demonstrates that the site did not have sufficient bone to place an implant and that Respondent placed the implant improperly with only the 1/3 apical portion of the implant placed in bone.

23. Respondent's notes for November 29, 2018, indicate he used an implant kit to make an osteotomy for the implant at tooth site #5; placed the implant; covered the area with a healing abutment, triple antibiotic, and heliostat; and closed the area using perycryl. However, one set of the notes for the implant procedure for the November 29, 2018 visit is date-stamped as being entered on March 28, 2019, months after Respondent dismissed Patient Ralph H as a patient.

24. Respondent's treatment notes for the procedure are inadequate in part because they do not include the following necessary information:

a. Whether a flap was made and, if so, the type and size of the incision and whether any releases were necessary;
b. A description of the bone at the implant site;
c. The size, lot number, expiration date, or platform size of the implant placed;
d. Whether any bone graft material was used;
e. The torque value of the implant; and
f. The type of suturing technique used.

25. Periapical images taken on November 29, 2018 and included in Respondent's record indicate that they are for tooth #11. At a pre-hearing conference, Respondent stated that is an error and the images were actually taken of tooth site #5.

26. The periapical images taken of tooth site #5 on November 29, 2018 show a clear bony defect in the area with only soft tissue on the mesial side and no bone engaging the threads of the top half of the implant on the distal side.

27. Patient Ralph H. returned to Respondent's office for a post-operative appointment two weeks later on December 13, 2018. Respondent took a periapical image of tooth site #5, and his treatment notes indicate Patient Ralph H. had no pain and was healing well.

28. In Respondent's record, the periapical image taken on December 13, 2018 also indicates that it is for tooth #11. Respondent stated at a pre-hearing conference that

also is an error and the image was actually taken of the implant at tooth site #5. The image that Respondent took at this subsequent appointment again shows that the implant was placed in insufficient bone and was starting to fail.

29. Despite his notes indicating that the area was healing well, Respondent noted there was "still" infection around the apex of the implant and prescribed Clindamycin to attempt to clear the infection. Respondent advised Patient Ralph H. to return for a follow-up appointment in 7-10 days.

30. On December 20, 2018, Patient Ralph H. returned to Respondent's office and informed him that the implant at tooth site #5 had fallen out since his last visit a week earlier.

31. At the December 20 appointment, Respondent again prescribed Clindamycin for Patient Ralph H. and advised him to return in a few weeks to have the implant replaced. The initial note for that appointment contains no mention of a bone graft.

32. The radiographic image from earlier that month demonstrates that the failed implant site still had a huge bony defect and would not be an appropriate site to place a new implant in a few weeks and needed significant bone grafting for ridge preservation.

33. According to his treatment records, Respondent dismissed Patient Ralph H. from his practice on January 25, 2019 due to "derogatory emails and threats from patient."

34. An additional note indicating the area at tooth site #5 was grafted at the December 20, 2018 appointment is date-stamped as being entered on March 27, 2019, which was more than two months after Respondent dismissed Patient Ralph H. as a patient.

35. Respondent's additional treatment note for the last December 20, 2018 appointment, date stamped as March 27, 2019, was not made contemporaneously with the visit, does not accurately reflect what occurred on that date, and was not credible.

Applicable Standard of Care for Patient Ralph H.

36. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Patient Ralph H. required that dentists performing extractions and implant surgery:

a. Assess patients to determine if they are appropriate candidates for implants, including assessing and ensuring treatment of periodontal disease and determining whether adequate bone exists at the planned site prior to placing implants;
b. Take appropriate diagnostic radiographs both pre- and post- treatment;
c. Maintain adequate patient records, including accurately documenting the diagnosis and treatment rendered, such as teeth extractions and implant surgical techniques and the dates they were performed;
d. Utilize appropriate implant surgical techniques, including proper staging and sequence of treatment if necessary;
e. Use adequate procedures to eliminate infection prior to placing implants; and
f. Adequately manage complications from treatment.

37. In his assessment and treatment of Patient Ralph H., Respondent violated the standard of care by failing to:

a. Adequately assess Patient Ralph H.'s periodontal condition and bone loss to determine if he was an appropriate candidate for implant treatment;
b. Take diagnostic radiographs to assess Patient Ralph H.'s condition both pre- and post-treatment;
c. Maintain adequate patient records which accurately documented the diagnosis and treatment performed for Patient Ralph H., including teeth extractions and implant surgical techniques and the dates they were actually performed;
d. Stage and sequence treatment appropriately for Patient Ralph H. and use appropriate implant surgical techniques;

e. Use adequate procedures to eliminate any infection Patient Ralph H. had prior to placing implants; and

f. Manage Patient Ralph H.'s complications.

Expert Witness Testimony and Evidence Concerning Patient Ralph H.

38. The Investigative Panel presented the expert testimony of David Earle Sullivan, D.D.S., and his related written report concerning Respondent's treatment of Patient Ralph H.

39. Dr. Sullivan testified, or presented evidence through his report, that:

a. Respondent's treatment of Patient Ralph H. violated the standard of care in numerous respects including:

i. Respondent's records for Patient Ralph H. included conflicting and contradictory information regarding the treatment provided;

ii. After Patient Ralph H. initially presented with a periapical infection and extensive bone loss around the apex of tooth #5, Respondent placed an implant approximately two months later at the next office visit without taking an image to determine if the area had healed and the bone was ready for placement of an implant;

iii. The implant at tooth #5 was improperly placed where there was still a bony defect and only the apical third of the implant engaged bone;

iv. The implant at tooth #5 began to fail and became infected but Respondent did not inform Patient Ralph H. that the implant should be removed; and

v. The implant ultimately failed and Respondent advised Patient Ralph H. that he could come back to his office in a few weeks to have the implant replaced.

40. Dr. Sullivan's testimony regarding these issues was credible and compliant with Rule 702.

41. Dr. Sullivan presented written learned articles relied upon by others in the fields of general dentistry and implantology which supported his testimony and opinions.

42. Respondent did not offer expert testimony or other evidence concerning his treatment and care of Patient Ralph H.

43. Respondent's violations of the standard of care caused harm or injury to Patient Ralph H.

Respondent's Treatment of Patient Theresa E.

44. On November 23, 2020, Patient Theresa E. presented to Respondent's office for an implant consultation. Respondent developed a treatment plan which included extracting her remaining teeth, placing implants, and performing a sinus lift of the upper right and upper left.

45. Patient Theresa E. presented for a pre-operative appointment on May 19, 2021. Respondent prescribed antibiotics and Patient Theresa E. signed the necessary consent forms, but Respondent did not make a conventional denture to assist him in determining where to place the implants.

46. Patient Theresa E.'s health history indicated that she had "allergies," including a penicillin allergy, and "sinus problems," but Respondent either failed to ask necessary follow-up questions on these issues or to record her responses in the treatment notes.

47. On June 7, 2021, Patient Theresa E. presented to Respondent's office to have the procedures described in the treatment plan.

48. Respondent's treatment notes for June 7, 2021 indicate the following teeth were extracted and implants were placed in those areas: 3, 6, 11, 14, 19, 22, 27, and 30. Respondent's treatment notes also indicate he performed a sinus lift of the upper right and upper left and "[p]laced one graft and heliotape and (2) bone plugs."

49. Respondent's clinical notes state that the local anesthetic used in the procedure included twelve (12) carpules of Septocaine at 1:200,000 4% epinephrine and two (2) carpules of marcaine w/0.5% epinephrine.

50. Respondent indicated the area was "[c]overed with healing screw with triple antibiotic and heliostat" and "[c]losed with 3.0 chromic gut sutures." A final CT was taken after the procedures. Respondent noted that there were no complications, and he prescribed pain medication for Patient Theresa E.

51. Respondent's treatment notes for Patient Theresa E. contain incomplete, contradictory, and confusing entries and fail to include an adequate description of the treatment rendered, when, and by whom.

52. For example, Respondent's treatment notes from June 7, 2021 state, "patient presents for ext and implants." However, another dentist extracted Patient Theresa E.'s teeth after the November 23, 2020 consultation and prior to her pre-operative appointment on May 19, 2021 with Respondent.

53. The local anesthetic recorded in the treatment note contradicts his sedation record. The clinical treatment note indicates that Respondent administered 12 carpules of Septocaine 1:200,000 4% epinephrine. However, the sedation record indicates that Respondent administered 14 carpules of Septocaine. Neither record indicates if Respondent administered the local anesthetic drug at the same time or over a period of time.

54. In the treatment note, Respondent does not adequately describe the surgical procedure he performed on Patient Theresa E. on June 7, 2021 and does not include the following necessary information:

a. Type of sinus lift performed;
b. Method for lifting sinus membrane;
c. Perforations or complications;
d. Type, amount, and where graft material was used;
e. Use of membranes;
f. Residual bone height to stabilize the implant; and
g. Method of placing implants, including type of incision and sutures, bone quality and any reduction of bone, and use of surgical guide.

55. Respondent stated in the treatment notes that Patient Theresa E.'s post-operative CT scan showed no complications. However, the CT scan demonstrates that the implants were placed incorrectly.

56. Respondent also did not stage the procedure by performing a sinus lift followed by a period of healing before placing the implants. Respondent failed to place any of the implants in the correct position, including by placing the implants: (a) into inadequate residual bone height, (b) at an inadequate depth relative to surrounding bone and soft

tissue, (c) in the bone too close to the buccal plate, (d) at an improper angulation for placement of a denture or other restoration, and (e) into the sinus cavity resulting in a perforation.

57. Patient Theresa E. returned to Respondent's practice on June 16, 2021 for a post-operative appointment. Respondent took another CT scan and stated the implants were doing great and requested that Patient Theresa E. return in one month.

58. Contrary to what Respondent stated in the treatment notes, the CT scan shows inflammation of the sinus with extrusion of graft material into the sinus and substandard placement of implants.

59. On July 14, 2021, Patient Theresa E. presented for a soft reline. She stated the temporary dentures were horrible and she had not been able to eat at all. She reported that her maxillary area hurt and the mandibular posterior area rocked when she bit down.

60. At this visit, Respondent attempted to trim off the excess and adjust the dentures to make them comfortable but was not able to do so. Respondent added a permanent reline to Patient Theresa E.'s treatment plan.

61. From August 23, 2021 through March 2, 2022, Respondent and the dental lab worked with Patient Theresa E. to attempt to fabricate dentures that would correctly seat with the implants Respondent placed improperly but were unable to do so.

62. On March 2, 2022, Patient Theresa E. had a discussion with Respondent regarding her options. Respondent advised Patient Theresa E. that her implants should be removed and they should start over with a hybrid denture. Though the appointment was on March 2, 2022, the notes concerning removing the implants and starting over with a hybrid denture are date-stamped as being entered on September 13, 2022, which is after Patient Theresa E. left Respondent's practice as a patient and another dentist requested her records from Respondent.

63. On March 15, 2022, Patient Theresa E. reported that she had a sore implant. Respondent took a CT scan to check the area. She returned on March 29, 2022 for a wax try-in and signed for the dentures which were scheduled to be delivered at the next appointment. The dentures were not delivered at the next appointment because Patient Theresa E. wanted to be sedated for the procedure.

64. Patient Theresa E. presented to Respondent's office again on May 10, 2022. Respondent's treatment notes state that he sedated Patient Theresa E. and removed the closure caps for all implants.

65. On the same date, Respondent documented that "#14 perforated the sinus," the implant was removed, and "a bone graft/lateral sinus lift was done and the area repaired." Respondent noted he placed collagen in the area and used vicryl sutures to close.

66. Respondent then placed locator abutments on all remaining implants, except for #6, and "upper and lower snap in was picked up and adjusted as needed."

67. The treatment notes for this procedure fail to include an adequate description of the treatment rendered and Patient Theresa E.'s dental condition. For example, there is no description of how the surgery was performed or of the bone loss that is noticeable on the CT scans.

68. Respondent prescribed amoxicillin 875 mg potassium clavulanate 125 mg tablets to Patient Theresa E. on May 11, 2022, despite her prior reports of a penicillin allergy.

69. According to Patient Theresa E., her pharmacist noticed that Respondent prescribed an antibiotic to which Patient Theresa E. was allergic before it was filled.

70. Respondent did not prescribe a replacement antibiotic until five (5) days later on May 16, 2022.

71. During the period from May to July of 2022, Patient Theresa E. returned to Respondent's office for impressions, try-ins, and attempted delivery of her dentures.

72. On August 9, 2022, Patient Theresa E. presented to Respondent's office for what turned out to be the final attempted try-in of her dentures.

73. Though the appointment was on August 9, 2022, the only notes for that last visit are date-stamped as being entered on March 21, 2023, which is months after Patient Theresa E. left Respondent's practice but only shortly after the Board notified Respondent that she had filed a complaint against him.

74. In this note entered on March 21, 2023, Respondent:

a. Documented marked recession around multiple implants;

b. Acknowledged in his treatment record for the first and only time the bone loss that could be seen on the prior CT scans;
c. Stated that the patient purportedly advised him she was smoking during the treatment process;
d. Claimed that he advised Patient Theresa E. that she should have a medical evaluation and then he would make an upper and lower hybrid denture for her at a reduced cost or refund her money so she could seek care somewhere else; and
e. Wrote that due to her "high esthetic demands," she would need to have a fixed full arch prosthesis similar to what was offered to her on her initial visit.

75. Respondent's treatment note for the last August 9, 2022 appointment date-stamped on March 21, 2023 was not made contemporaneously with the visit, does not accurately reflect what occurred on that date, and was not credible.

76. Respondent never provided a refund to Patient Theresa E. of the substantial funds paid to his office for her treatment.

77. Patient Theresa E. subsequently presented to general dentist, Dr. Jeffrey Leal, for evaluation and treatment.

78. The Investigative Panel presented the testimony of Dr. Leal and his treatment records concerning Patient Theresa E.

79. On September 1, 2022, Patient Theresa E. presented to Dr. Leal's office for evaluation. She stated the implant at #3 was painful and radiated throughout the right temporalis area. Dr. Leal noted 5–6 millimeter pockets around all of her implants and supragingival calculus on tooth #26. He also noted that several of the implants were buccally placed, superimposed over the vestibular spaces, and were difficult to utilize to place dentures.

80. Dr. Leal repeatedly attempted, without success, to get Patient Theresa E.'s complete records from Respondent's office beginning on the first appointment on September 1, 2022.

81. On September 13, 2022, he received only seven (7) panoramic images via email. On September 15, 2022, Dr. Leal noted that he received a disc from Respondent's office, but it was blank and the records had to be requested again.

82. As of October 31, 2022, Dr. Leal still did not have Patient Theresa E.'s records he requested from Respondent's office. Dr. Leal eventually received some images from Respondent's office but never received Patient Theresa E.'s implant information from Respondent's office, which delayed and negatively impacted his ability to move forward with her treatment.

83. Dr. Leal referred Patient Theresa E. to an oral surgeon, Dr. Jason Ringeman, for evaluation. She presented to Dr. Ringeman's office on October 25, 2022. According to records received by Dr. Leal and utilized by him for planning Patient Theresa E.'s treatment, Dr. Ringeman measured bone loss around each of the implants and performed a CBCT scan. The CBCT scan revealed that the implant at #3 was in the maxillary sinus.

84. Dr. Leal concurred with Dr. Ringeman's evaluation that Patient Theresa E.'s existing implants placed by Respondent could not be used as part of a permanent solution and ultimately would need to be removed and replaced with properly positioned implants. Dr. Leal further concurred with Dr. Ringeman's evaluation and recommended using the existing restorations with a removable prosthesis in the interim.

85. On March 1, 2023, Patient Theresa E. presented to a periodontist, Dr. Hunter Dawson, for a consultation at Dr. Leal's recommendation.

86. The Investigative Panel presented the testimony of Dr. Dawson and his treatment records concerning Patient Theresa E.

87. At the March 1, 2023 appointment, Dr. Dawson recommended that Patient Theresa E. return for a comprehensive examination and 3D simulation of her current implants to determine if they were placed in a restorable position.

88. Patient Theresa E. returned to Dr. Dawson's office on May 8, 2023 for a comprehensive examination and diagnostic records appointment. After completing the examination, Dr. Dawson determined that the implants were not in a proper position and completed wax try-in and double scan procedures before developing a treatment plan for Patient Theresa E., which included developing pre-surgical dentures.

89. Over the course of the next four (4) appointments, Patient Theresa E. returned to Dr. Dawson's office for pre-surgical wax try-ins of the dentures.

90. On August 15, 2023, Dr. Dawson used a double scan, CBCT technique to capture the current position and ideal position of implants and determined the following for the implants in the maxillary arch:

a. The implant at approximate site #4 appeared to be into or close to the maxillary sinus;
b. The implant at site #6 had an extreme angle, minimal restorative space, and little to no bone on the buccal surface of the first 50-60% of the implant; and
c. The implant at site #11 had an extreme angle and little to no bone on the first 50-60% of the buccal and 5-6 mm of the palatal, and the apex of the implant was in very close proximity to the left maxillary sinus.

91. Using the same technique, Dr. Dawson determined the following for implants in the mandibular arch:

a. Uniform loss of the buccal bone for the first 50-60% of the implants; and
b. The angulations and inadequate restorative space were problematic for a snap-in locator overdenture.

92. Given the advanced bone loss around the implants, the inadequate restorative space, and the angulation issues, Dr. Dawson recommended removal and replacement of the implants for the appropriate aesthetic Patient Theresa E. desired in the future.

93. Dr. Dawson referred Patient Theresa E. to oral surgeon, Dr. Richard Kapitan, to have the implants removed. Dr. Kapitan removed the implants on November 28, 2023.

94. Because she had already spent a large amount of funds having the implants placed by Respondent, none of which was refunded, Patient Theresa E. has not been able to have the implants replaced to date and currently wears interim dentures.

Applicable Standard of Care for Patient Theresa E.

95. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Patient Theresa E. required that dentists performing implant surgery and sinus lift procedures properly:

a. Assess patients to determine if they are appropriate candidates for such procedures, including obtaining a detailed medical history;
b. Perform appropriate presurgical planning, including taking diagnostic radiographs prior to treatment;
c. Maintain adequate patient records, including accurately documenting the diagnosis, dental condition, treatment rendered, and surgical techniques;
d. Utilize appropriate surgical techniques, including proper staging and sequence of treatment if necessary;
e. Use an appropriate surgical guide when clinically necessary to place implants in a proper position; and
f. Communicate all complications to patients.

96. In his assessment and treatment of Patient Theresa E., Respondent failed to:

a. Properly assess Patient Theresa E. to determine whether she was an appropriate candidate for implants and snap-in dentures and did not obtain a detailed history, particularly concerning her allergy to penicillin;
b. Perform appropriate treatment and pre-surgical planning, including taking diagnostic radiographs and fabricating a proper overdenture to use as a surgical guide for the appropriate placement of implants;
c. Maintain adequate patient records, including accurately documenting Patient Theresa E.'s diagnosis, dental condition, treatment rendered, and surgical techniques;
d. Utilize proper surgical techniques in determining where implants should be placed and stage the sinus lift and implant procedures; and
e. Communicate all complications to Patient Theresa E.

Expert Witness Testimony and Evidence Concerning Patient Theresa E.

97. The Investigative Panel presented the expert testimony of David Earle Sullivan, D.D.S., and his related written report concerning Respondent's treatment of Patient Theresa E.

98. Dr. Sullivan testified, or presented evidence through his report, that:

a. Respondent's treatment of Patient Theresa E. violated the standard of care in numerous respects including:

i. Respondent's records did not accurately document Patient Theresa E.'s diagnosis, dental condition, treatment rendered, and surgical techniques, and failed to indicate a clear restorative plan;

ii. Respondent poorly planned Patient Theresa E.'s treatment;

iii. Respondent did not perform a prosthetic work-up prior to the implant surgery on June 7, 2021 and did not use an appropriate surgical guide for the surgery;

iv. The post-operative CT scan taken on June 7, 2021, the same day the implants were placed, showed that none of the implants were placed in an acceptable position;

v. Implant placed at tooth #3 perforated the sinus membrane with extrusion of material into the sinus;

vi. Performing a lateral window sinus lift while also attempting to stabilize implants at teeth #s 3 and 14 was risky and aggressive and should have been a staged procedure;

vii. Implants placed at teeth #s 3 and 14 were placed in a very small amount of residual bone height and did not have primary stability;

viii. Implant at tooth #6 was angled too far to the buccal preventing the fabrication of a denture flange that fit correctly in the maxilla;

ix. Implant at tooth #11 was angled too far to the buccal and was sticking into the sinus with no associated graft;

x. No bone was reduced prior to placing lower implants;

xi. Lower implants were placed with a significant portion of the buccal aspect of the implant entirely outside of the bony housing, were not

placed deep enough, and impeded the ability to place a denture due to lack of restorative space; and

xii. Respondent did not inform Patient Theresa E. of complications as they arose during treatment.

99. Dr. Sullivan's testimony regarding these issues was credible and compliant with Rule 702.

100. Dr. Sullivan presented written learned articles relied upon by others in the fields of general dentistry and implantology which supported his testimony and opinions.

101. Respondent did not offer expert testimony or other evidence concerning his treatment and care of Patient Theresa E.

102. Respondent's violations of the standard of care caused harm or injury to Patient Theresa E.

Respondent's Treatment of Patient Larry J.

103. On March 15, 2021, Patient Larry J. presented to Respondent's office for an implant consultation. Patient Larry J. stated he did not want removable dentures.

104. Respondent took a CT scan at the initial consultation and created a treatment plan consisting of placing six (6) implants and an upper anterior hybrid.

105. On May 6, 2021, Patient Larry J. presented for extraction of his remaining upper teeth and placement of six implants and a hybrid prosthetic in the maxillary with IV sedation.

106. Respondent's treatment notes for the procedure are inadequate in part because they do not include the following necessary information:

a. The type and size of the incision and whether any releases were necessary;

b. Whether any bone graft material was used;

c. The torque values of the implants; and

d. The type of suturing technique used.

107. Patient Larry J. returned to Respondent's office for a post-surgical follow-up appointment on May 12, 2021. Respondent took a CT scan and noted that the implant was "doing great." Respondent did not indicate a reason for taking the scan. Despite

taking the scan, Respondent either did not recognize or did not notify Patient Larry J. that a root fragment of tooth #13 remained, and the implant was placed up against the remaining infected root fragment from his prior extraction on May 6.

108. On May 17, 2021, Patient Larry J. presented to Respondent's office because the temporary prosthetic hybrid had broken from teeth #s 12-15. Respondent advised Patient Larry J. that he would leave the broken part off and smoothed the edges where the hybrid had broken.

109. Respondent took another CT scan at a follow-up appointment on June 1, 2021 and prescribed Augmentin to Patient Larry J. Respondent did not indicate a reason for taking the scan or for prescribing Augmentin in his treatment notes. Respondent informed Patient Larry J. that the hybrid was "doing great," but again either failed to recognize or inform Patient Larry J. of the retained root fragment at tooth #13.

110. At the same appointment, Patient Larry J. complained of discomfort in his lip and tongue due to rough edges and food becoming stuck in the hybrid prosthetic. Respondent adjusted the hybrid prosthetic with a handpiece.

111. On June 16, 2021, Patient Larry J. returned to Respondent's office for a follow-up appointment. Respondent again took a CT scan and did not indicate a reason for taking the scan in his treatment notes. Respondent again either failed to recognize or inform Patient Larry J. of the retained root fragment at tooth #13.

112. After Respondent took impressions and performed a final try-in, the final upper hybrid prosthetic was delivered to Patient Larry J. on December 21, 2021.

113. Respondent's treatment notes concerning the delivery of the final upper hybrid prosthetic do not include the following necessary information:

a. The material of the hybrid;
b. The occlusion and whether any adjustments were necessary;
c. The torque applied to the abutment screws;
d. Whether the multi-unit abutments were re-torqued to ensure implant integration;
e. Whether radiographs were taken to ensure the prosthetic was fully seated;

f. Whether instructions were provided to the patient regarding how to clean and care for the hybrid; and

g. Whether the patient was provided with a recall schedule concerning when to return for follow-up care.

114. In January and February of 2022, Patient Larry J. complained of his bite being "off." Respondent sent the hybrid to the lab for repair. According to Patient Larry J., the bite was never correct on the hybrid prosthetic, even after Respondent attempted repairs.

115. A year later, Patient Larry J. returned to Respondent's office in January and February 2023 because the anterior of the hybrid had chipped and broken but was unable to be seen by Respondent.

116. On March 21, 2023, Patient Larry J. presented to Dr. Jeffrey Duffy's office for a second opinion regarding the broken hybrid.

117. The Investigative Panel presented the testimony of Dr. Duffy and his treatment records concerning Patient Larry J. Dr. Duffy had treated Patient Larry J. previously for unrelated issues since 2014.

118. At the March 21, 2023 visit, Dr. Duffy took intraoral photographs of the hybrid, which showed broken anterior teeth on the prosthesis, and also took PAs of the implants. His office requested implant information from Respondent and was informed they would charge Patient Larry J. $8,000 to replace the broken prosthesis.

119. On April 6, 2023, during a return visit, Dr. Duffy took PAs with the prosthesis in place and after he removed the prosthesis. Patient Larry J. experienced significant pain on the most upper left implant while the hybrid was being unscrewed and reported that implant had always been painful when the prosthesis was attached or removed.

120. The implant at tooth #13 was noted to be mobile with necrotic looking bone on the mesial. Dr. Duffy took a PA of the area.

121. At that same visit, Dr. Duffy then removed the loose necrotic piece which was touching the implant, and that piece was a tooth root. Dr. Duffy photographed the tooth root. He then reattached the prosthesis to give the area time to heal.

122. On April 24, 2023, Dr. Duffy removed the prosthesis and the implant at tooth #13 had not improved, was still painful, and had not osseointegrated so he removed the implant at #13. Dr. Duffy re-attached the prosthesis.

123. Dr. Duffy conducted an analysis which demonstrated that the prosthesis placed by Respondent was not correct for Patient Larry J.'s bite, including at the locations where it had broken, which is why Dr. Duffy determined it should be replaced rather than repaired.

124. Patient Larry J. elected to proceed with a new prosthesis by Dr. Duffy on the remaining implants, which were noted to be stable.

125. On August 25, 2023, Dr. Duffy delivered a new upper prosthesis to Patient Larry J. and there have been no issues with the new prosthesis breaking or chipping.

Applicable Standard of Care for Patient Larry J.

126. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Patient Larry J. required that dentists performing implant surgery and placing prostheses:

a. Maintain adequate patient records, including accurately documenting surgical techniques, the treatment rendered, and the materials used;
b. Refrain from taking an excessive number of images, including CT scans, without documenting appropriate reasons for doing so, to ensure radiation is as low as reasonably achievable; and
c. Recognize and communicate all complications to patients, including failing to remove a root tip that is or becomes infected.

127. In his assessment and treatment of Patient Larry J., Respondent:

a. Failed to accurately document and list the materials used in the surgical techniques and treatment rendered to Patient Larry J.;
b. Took an excessive number of unnecessary images during Patient Larry J.'s treatment; and
c. Failed to recognize or communicate complications to Patient Larry J., specifically that a tooth root was left behind after a tooth was extracted,

was adjacent to implant #13, was infected, and could be causing pain and other complications that Patient Larry J. experienced.

Expert Witness Testimony and Evidence Concerning Patient Larry J.

128. The Investigative Panel presented the expert testimony of David Earle Sullivan, D.D.S., and his related written report concerning Respondent's treatment of Patient Larry J.

129. Dr. Sullivan testified, or presented evidence through his report, that:

a. Respondent violated the standard of care in numerous respects including:

i. Failing to recognize and diagnose an infected root tip that was left behind at the area of tooth #13, near an implant;

ii. Failing to inform Patient Larry J. that an infected root tip was left behind at the area of tooth #13; and

iii. Taking multiple CT scans without justification subjecting Patient Larry J. to unnecessary radiation.

130. Dr. Sullivan's testimony regarding these issues was credible and compliant with Rule 702.

131. Dr. Sullivan presented written learned articles relied upon by others in the fields of general dentistry and implantology which supported his testimony and opinions.

132. Respondent did not offer expert testimony or other evidence concerning his treatment and care of Patient Larry J.

133. Respondent's violations of the standard of care caused harm or injury to Patient Larry J.

Failure to Timely Produce Complete Patient Records

134. During the Board's investigations of the complaints by Patients Ralph H., Theresa E., and Larry J. from 2021 through 2023, Respondent repeatedly failed to respond and provide complete treatment and other records, including radiographic images, in a timely manner and in response to the Board's multiple requests, despite submitting verifications that he had provided complete records.

135. For example, the Board initially requested Respondent's treatment records and a response to the complaint filed by Patient Ralph H. on January 17, 2021.

136. Respondent provided a response and a signed verification dated March 8, 2021, attesting that he had provided all documentation requested by the Board, which he had not done.

137. Despite the Board's multiple requests, Respondent failed to produce portions of the treatment record for Patient Ralph H. up through at least December 2022.

138. Additionally, the Board initially requested Respondent's treatment records and a response to the complaint filed by Patient Theresa E. on March 16, 2023.

139. Respondent provided an initial response and records on April 10, 2023 and a signed verification dated April 25, 2023, attesting that he had provided all documentation requested by the Board, which he had not done.

140. Thereafter, despite multiple Board requests, Respondent failed to provide multiple missing CT scans of Patient Theresa E. until May 11, 2023.

141. The Board initially requested Respondent's treatment records and a response to the complaint filed by Patient Larry J. on May 8, 2023.

142. Respondent provided a response and a signed verification dated June 22, 2023, attesting that he had provided all documentation to the Board, which he had not done.

143. Thereafter, despite multiple Board requests, Respondent failed to provide multiple CT scans of Patient Larry J. until August 1, 2023 and additional scans were produced in December 2023.

144. Respondent's failure to respond timely and provide complete treatment and other records in a timely manner on multiple occasions delayed the Board's investigation of these complaints and thereby the issuance of the Notice of Hearing.

False Statements and Evidence About Expiration of Permit

145. Respondent was first issued a moderate conscious sedation permit on November 28, 2006.

146. Pursuant to 21 NCAC 16Q .0301(a) and .0305(a), Respondent is required to renew his Permit on an annual basis.

147. The Board sends emails, postcards, and letters to dentists reminding them that the renewal date is approaching each year.

148. In order to avoid a late fee, the application and renewal payment of $100 for Respondent's Permit was due by January 31, 2021 for the 2021 year. If the renewal application and payment, including $50 late fee, were not submitted prior to March 31, 2021, his Permit would expire.

149. Dentists may renew their permit online by electronically submitting their application and payment.

150. Once renewed, dentists are required to print their renewal permit, which must be displayed in their office along with their dental license.

151. The Board did not receive Respondent's renewal application and payment by March 31, 2021, and his Permit expired on that date.

152. On or about April 8, 2021, Board staff sent a certified letter to Respondent informing him that his Permit had expired for nonpayment and failure to renew for 2021. The letter stated that an application for reinstatement along with a check for $150 must be submitted to apply for reinstatement.

153. On April 29, 2021, in response to the Board's letter, Respondent emailed Board staff stating, "...I am certain that I paid my sedation renewal at the same time that I paid for my dental license renewal. As a matter of fact, I made a copy of the check before I mailed it."

154. Respondent sent a second email on April 29, 2021, attaching a copy of check number 2019 which was dated January 22, 2021. Respondent represented that it was a copy of the check he had sent to the Board for renewal in January.

155. The check was written for $150, which was not the correct amount due at the time the check was allegedly dated.

156. Respondent renewed his dental license on December 21, 2020 and did not renew his Permit at the same time as he stated in his April 29, 2021 email to the Board.

157. Respondent historically renewed his Permit online rather than sending a check, including for the previous ten years since 2011.

158. Respondent's bank statements indicate check 2019 was not in sequence with other checks written in January 2021 but was in sequence with checks written in April and May 2021.

159. Respondent subsequently submitted an application and payment to reinstate his Permit, which was received by the Board on May 3, 2021. Respondent's Permit was reinstated on May 4, 2021.

160. Respondent did not issue or sign check number 2019 at the same time he paid for his dental license renewal, and he did not issue or sign check number 2019 on or about January 22, 2021. Instead, Respondent fabricated check number 2019 after he got the Board's notice in an effort to conceal that he had failed to renew his permit before it expired. Therefore, Respondent's statement to the Board on April 29, 2021 that he had done so was a false and material misrepresentation.

Administration of Sedation to Patients While Permit Expired

161. Respondent administered moderate conscious sedation to numerous patients between April 1, 2021 and May 3, 2021 when he did not have a Permit, including to the following patients on the dates specified:

a. Illora C. – 4/28/21
b. Joshuandy S. – 4/6/21
c. Kelsi M. – 4/13/21
d. Melissa T. – 4/26/21
e. Savannah W. – 4/12/21
f. Thelma W. – 4/21/21 and 4/28/21
g. Tricia B. – 4/20/21
h. Rebecca W. – 4/12/21
i. Constance K. – 4/7/21

162. Because he did not renew it before March 31, 2021, Respondent's Permit was expired between April 1 and May 3.

163. Respondent knew or should have known his Permit was expired when he administered the above sedations in April 2021, in part because he had not renewed it

before March 31, 2021, and he was unable to print the renewal certificate for 2021 as required.

Inspection and Fabricated Drug Logs

164. After Respondent applied to have his Permit reinstated, a Board Investigator inspected his office on June 20, 2022, pursuant to 21 N.C.A.C. 16Q .0305(b).

165. Respondent provided the Board Investigator with sedation drug logs. When he presented the sedation logs to the Board, Respondent failed to disclose or inform the Board that they: (i) had not been maintained contemporaneously, (ii) had been created after getting notice of the upcoming inspection, and (iii) were not an accurate representation of the drugs Respondent or others working in his office administered to patients.

166. Both of the random sedation records selected by the Board Investigator failed to appear in the sedation drug logs, including for patients Joshuandy S. (4/6/21) and Savannah W. (4/12/21).

167. Respondent later admitted the following about the drug logs provided to the Board at the June 20, 2022 inspection:

a. They were not maintained contemporaneously;
b. He had staff members create the drug logs prior to and in anticipation of the Board inspection;
c. He did not see the drug logs until the date of the Board inspection; and
d. The drug logs are inaccurate and do not reflect the type and amounts of controlled substances administered to patients.

168. Respondent failed to maintain accurate drug logs for controlled substances required by the U.S. Drug Enforcement Administration pursuant to 21 C.F.R. Part 1304.

169. Board Rule 21 NCAC 16V .0101 (28) defines unprofessional conduct as "committing any act that violates State or federal statutes or regulations governing controlled substances."

170. At the time of the inspection when the drug logs were presented, Respondent failed to advise the Board staff of the material information in Paragraph 165.

171. Respondent's production of the drug logs at the June 20, 2022 inspection that he had created after-the-fact and which did not accurately represent the controlled

substances administered to patients constituted presenting a false or misleading record or omission.

172. Board Rule 21 NCAC 16V .0101 (2) defines unprofessional conduct as "presenting false or misleading testimony, statements, omissions or records in any communication to the Board or the Board's investigators, employees, or agents regarding any matter subject to the provision of the Dental Practice Act or the Dental Hygiene Act."

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and over the subject matter of this case.

2. Respondent violated the applicable standard of care for dentists practicing in North Carolina in his assessment and treatment of Patient Ralph H.

3. Respondent violated the applicable standard of care for dentists practicing in North Carolina in maintaining inadequate patient treatment records for Patient Ralph H.

4. Respondent was negligent in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(12), committed acts constituting malpractice in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(19), and engaged in acts violating Article 2 of Chapter 90 of the North Carolina General Statutes in violation of N.C. Gen. Stat. § 90-41(a)(6) and 21 NCAC 16T .0101 in his treatment and care of Patient Ralph H., as set forth in Conclusions of Law 2 and 3 and Findings of Fact 6-43.

5. Respondent violated the applicable standard of care for dentists practicing in North Carolina in his assessment and treatment of Patient Theresa E.

6. Respondent violated the applicable standard of care for dentists practicing in North Carolina in maintaining inadequate patient treatment records and failing to promptly provide or transfer records for Patient Theresa E.

7. Respondent was negligent in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(12), committed acts constituting malpractice in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(19), and engaged in acts violating Article 2 of Chapter 90 of the North Carolina General Statutes in violation of N.C. Gen.

Stat. § 90-41(a)(6) and 21 NCAC 16T .0101 and .0102 in his treatment and care of Patient Theresa E., as set forth in Conclusions of Law 5 and 6 and Findings of Fact 44-102.

8. Respondent violated the applicable standard of care for dentists practicing in North Carolina in his assessment and treatment of Patient Larry J.

9. Respondent violated the applicable standard of care for dentists practicing in North Carolina in maintaining inadequate patient treatment records for Patient Larry J.

10. Respondent was negligent in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(12), committed acts constituting malpractice in the practice of dentistry in violation of N.C. Gen. Stat. § 90-41(a)(19), and engaged in acts violating Article 2 of Chapter 90 of the North Carolina General Statutes in violation of N.C. Gen. Stat. § 90-41(a)(6) and 21 NCAC 16T .0101 in his treatment and care of Patient Larry J., as set forth in Conclusions of Law 8 and 9 and Findings of Fact 103-133.

11. Respondent committed unprofessional conduct in violation of N.C. Gen. Stat. § 90-41(a)(26) and 21 NCAC 16V .0101(2), (14), and (17) by repeatedly failing to respond and provide complete treatment and other records in a timely manner and by verifying that he had provided all records when he had not done so, as set forth in Findings of Fact 134-144.

12. Respondent violated N.C. Gen. Stat. § 90-41(a)(26) by presenting false or misleading statements or records when communicating with the Board or its agents, pursuant to 21 NCAC 16V .0101(2), as set forth in Findings of Fact 145-160.

13. Respondent violated the Board regulations in violation of N.C. Gen. Stat. § 90-41(a)(6) and 21 N.C.A.C. 16Q .0301(a) and .0305(a) by administering moderate conscious sedation when he did not have a Permit, as set forth in Findings of Fact 161-163.

14. Violations of 21 N.C.A.C. 16Q .0301(a) and .0305(a) may result in suspension or revocation of Respondent's Permit or license to practice dentistry in accordance with N.C. Gen. Stat. § 90-41 and 21 NCAC 16Q .0701.

15. Respondent violated N.C. Gen. Stat. § 90-41(a)(6) and (26) and 21 NCAC 16V .0101 (28) by committing an act that violated state or federal statutes or regulations governing controlled substances, as set forth in Finding of Fact 168-169.

16. Respondent violated N.C. Gen. Stat. § 90-41(a)(6) and (26) and 21 NCAC 16V .0101 (2) by providing inaccurate drug logs that he had fabricated prior to the Board inspection, as set forth in Findings of Fact 164-172.

17. Respondent violated N.C. Gen. Stat. § 90-41(a)(6), by violating the Rules and Statues set forth in Conclusions of Law 1-16 and Findings of Fact 6-172 above.

In addition to the foregoing Findings of Fact and Conclusions of Law, and based on the evidence presented in the record, the Hearing Panel makes the following findings and conclusions regarding mitigating and aggravating factors relevant to the appropriate discipline to impose for the violations found and to protect the public:

ADDITIONAL FINDINGS AND CONCLUSIONS REGARDING DISCIPLINE

In addition to the foregoing Findings of Fact and Conclusions of Law, and based on the evidence presented in the record, the Hearing Panel makes the following findings and conclusions regarding the factors set forth in 21 NCAC 16N .0607(1)(c); (2)(c)-(f), (h), (l); (3)(a)-(f), (h), (j)-(m), (o), (s), and (t) that are relevant to the appropriate discipline to impose for the violations found and to protect the public, including:

1. Respondent committed multiple instances of negligence or malpractice in treating Patients Ralph H., Theresa E., and Larry J. (21 NCAC 16N .0607(2)(h))

2. Respondent intended to treat Patients Ralph H. and Theresa E. in a manner where the potential harm was foreseeable. (21 NCAC 16 N. .0607(2)(f))

3. Respondent's violations resulted in harm to Patients Ralph E., Theresa E., Larry J., and potentially serious or catastrophic harm to the patients sedated while Respondent's Permit was expired. Respondent's violations also resulted in harm to the dental profession. (21 NCAC 16N .0607(2)(d))

4. Respondent's violations adversely affected Patients Ralph H., Theresa E., and Larry J. because they received negligent treatment and suffered resulting harm. As a result of Respondent's negligent treatment of them, Patients Theresa E. and Larry J. were required to have additional treatment at their own expense. (21 NCAC 16N .0607(3)(a))

5. Respondent's actions have had a negative impact on Patients Larry J.'s and Theresa E.'s perception of the dental profession. (21 NCAC 16N 0607(3)(l))

6. Respondent did not make restitution to Patients Ralph H., Theresa E., or Larry J. for Respondent's negligent dental treatment or attempt to rectify the consequences of his negligent treatment of them. (21 NCAC 16N .0607(3)(m))

7. Respondent elevated his interest above that of his patients or the public and demonstrated a selfish motive by negligently performing dental services and failing to refund fees for services he performed in a negligent manner. (21 NCAC 16N .0607(3)(b))

8. Respondent failed to respond or provide responsive documents or information upon request and in a timely manner during the Board's investigation of his treatment of Patients Ralph H., Theresa E., and Larry J. (21 NCAC 16N .0607(3)(h))

9. Respondent demonstrated a dishonest motive by providing false information to the Board regarding the purported renewal of his sedation permit for 2021. (21 NCAC 16N .0607(3)(d))

10. Respondent submitted false evidence, statements, or engaged in other deceptive practices during the Board's investigation or disciplinary proceedings, including:

a. Creating false verifications stating he had submitted all treatment records for Patients Ralph H., Theresa E., and Larry J. when he had not done so;

b. Fabricating or creating after-the-fact controlled substance drug logs prior to the Board inspection; and

c. Submitting false or inaccurate drug logs at the inspection and failing to disclose or inform Board Investigators that the drug logs he presented to them were not maintained contemporaneously. (21 NCAC 16N .0607(3)(j))

11. Respondent engaged in fraud, dishonesty, misrepresentation, deceit, or fabrication related to the practice of dentistry, including by:

a. Making false statements regarding the purported renewal of his Permit for 2021;

b. Fabricating or creating after-the-fact controlled substance drug logs prior to the Board inspection; and

c. Fabricating or creating after-the-fact false or inaccurate and self-serving entries in his patient treatment record that did not accurately describe what occurred and doing so after he was no longer treating the patient and, in at least one instance, after he was notified that the patient had filed a complaint with the Board. (21 NCAC 16N .0607(1)(c), (2)(l))

12. Respondent's violations, including the false statements and other misconduct indicated in Nos. 9-11 above, demonstrate a lack of honesty, trustworthiness, or integrity. (21 NCAC 16N .0607(2)(f))

13. On August 18, 2011, Respondent voluntarily signed a Consent Order with the Board ("2011 CO"). The 2011 CO found that Respondent violated the standard of care in his treatment of three (3) patients in several respects spanning from 2005-2009, including:

a. Perforating a patient's tooth and failing to inform the patient;

b. Failing to manage a patient's sequence of treatment; and

c. Failing to provide a patient with a proper denture and obtain adequate informed consent before placing implants.

14. On April 9, 2013, Respondent was issued a Reprimand for causing a left lingual nerve injury during the extraction of a patient's tooth and then failing to refer the patient to a specialist to address her resulting paresthesia in 2010-11 ("2013 Reprimand").

15. On December 11, 2015, Respondent voluntarily entered into a Consent Order with the Board ("2015 CO"). The 2015 CO found that Respondent violated the 2011 CO and violated the standard of care in his treatment of three (3) patients in several respects spanning from 2009-12, including by failing to:

a. Appropriately select patients for sedation and implants;

b. Obtain informed patient consent for sedation and placement of implants;

c. Administer the appropriate dosage of sedation medication to patients;

d. Perform appropriate pre-operative planning and proper monitoring and airway management of patients during procedures;
e. Maintain proper recordkeeping during procedures;
f. Promptly recognize when a patient is in distress or danger and take appropriate action, including involving emergency services; and
g. Select appropriate abutments with which to restore implants.

16. The 2015 CO also found violations of the standard of care for an additional nine (9) patients up through 2015, including that Respondent:

a. Repeatedly used an anesthesia medication, propofol, that is contraindicated and unsafe for general practitioners with a moderate conscious sedation permit, risking unanticipated deep sedation, general anesthesia, and significant respiratory depression;
b. Administered propofol to patients while also performing procedures on those patients;
c. Administered excessive amounts of local anesthetics;
d. Sedated patients to a level of deep sedation or general anesthesia resulting in apnea or significant respiratory depression and hypoxemia;
e. Used a monitor on sedation patients that was subject to interference by his electrical handpiece;
f. Failed to recognize and adequately treat patients for hyper- and hypotension and respiratory depression when immediate treatment was indicated;
g. Failed to properly select and evaluate patients to undergo sedation procedures;
h. Failed to evaluate the airway prior to sedation procedures;
i. Failed to obtain a comprehensive medical history for patients;
j. Failed to consult with patients' treating physicians when indicated by their disclosed medical histories; and
k. Failed to maintain adequate recordkeeping.

17. Over the past at least 18 years since 2005, Respondent has provided negligent dental care in the following clinical practice areas:

a. Pre-operative planning;
b. Pre-sedation patient assessment, evaluation, and selection;
c. Informed consent;
d. Sequence of treatment, addressing periodontal disease;
e. Dentures, partials, and other restorations, including a tooth perforation not disclosed to the patient;
f. Extractions resulting in nerve injury and paresthesia;
g. Referral to specialists when clinically necessary;
h. Placement of implants on numerous occasions;
i. Administering and monitoring sedation on numerous occasions;
j. Recognizing and treating clinical emergencies; and
k. Sedation and treatment records.

18. Respondent has been repeatedly negligent, committed malpractice, violated the standard of care, and committed numerous other violations in the past as set forth in the 2011 CO, 2013 Reprimand, and 2015 CO. (21 NCAC 16N .0607(3)(c))

19. Respondent engaged in a lengthy and extensive pattern of violations, as demonstrated by the standard of care violations in this matter and the prior disciplinary actions issued by the Board in the 2011 CO, 2013 Reprimand, and 2015 CO. (21 NCAC 16N .0607(3) (e))

20. Respondent's violations in his prior discipline through the current matter span from 2005 through 2023 and are not remote in time. (21 NCAC 16N .0607(3)(s))

21. The probationary period in Respondent's 2015 CO was still in effect when he began treating Patient Ralph H and committed negligence. The 2015 CO prohibited Respondent from violating any of the Board's statutes or rules for a five-year probationary term. Respondent failed to comply with the 2015 CO in his negligent treatment of Patient Ralph H. from October 4, 2018 through December 20, 2018. (21 NCAC 16N .0607(2)(e))

22. When combined with the numerous violations in this matter, the extensive pattern of providing negligent care and committing malpractice for numerous patients over the past 18 years in a wide range of practice areas spanning most aspects of dental care with failed attempts at remediation demonstrates that Respondent is incompetent in the practice of dentistry. (21 NCAC 16N .0607(2)(c))

23. Respondent has refused to acknowledge the wrongful nature of any of the violations included in the Notice of Hearing and found in this matter. (21 NCAC 16N .0607(3)(k))

24. Respondent has practiced dentistry in North Carolina for more than twenty (20) years and numerous attempts to rehabilitate Respondent through remediation measures contained in prior discipline have been ineffective because the same or similar pattern of violations or misconduct has continued to recur. (21 NCAC 16N .0607(3)(o),(t))

25. The Hearing Panel individually considered all remaining factors set forth in 21 NCAC 16N .0607 and determined that the following factors are not applicable or relevant to the discipline in this case: 1(a), (b), 2(a), (b), (g), (i)-(k), and (3)(g), (i), (n) (p)-(r), (u), and (v).

26. The conclusion that Respondent is incompetent in the practice of dentistry noted above independently and separately warrants revocation his dental license and Permit to protect the public, even without any evidence, findings, and conclusions on unrelated issues set forth in the Final Agency Decision and in this section, including Paragraphs 27 and 28. (21 NCAC 16N .0607(2)(c) and (h))

27. Respondent's compounded acts of dishonesty and misrepresentation demonstrating a lack of honesty, trustworthiness or integrity warrant revocation of his dental license and Permit to protect the public, even without any evidence, findings, and conclusions on unrelated issues set forth in the Final Agency Decision and in this section, including Paragraphs 26 and 28. (21 NCAC 16N .0607(1)(c) and (2)(f))

28. Respondent's conduct and violations for administering sedation to patients without a valid Permit, combined with his extensive and significant past violations involving sedation established in the 2015 Consent Order, and the serious potential harm to patients and others, independently warrants revocation of Respondent's dental license and Permit to protect the public, even without any evidence, findings, and conclusions on unrelated issues set forth in the Final Agency Decision and in this section, including Paragraphs 26 and 27. (21 NCAC 16N .0607(2)(d) and 21 NCAC 16Q .0701)

29. The Board has attempted without success to address Respondent's lengthy history of prior violations through the other disciplinary options available to it under N.C. Gen. Stat. § 90-41(a). Attempts at remediating past violations while under probation, and

even an active suspension, were unsuccessful in preventing further violations and thereby failed to adequately protect the public.

30. Respondent's numerous, compounded acts of negligence, malpractice, and other violations cannot be adequately remediated as prior attempts at remediation ordered by the Board were unsuccessful.

31. Respondent's numerous, compounded violations and other conduct demonstrate that if Respondent is permitted to continue practicing dentistry, there is a substantial risk that he will engage in further misconduct and violations and pose a significant risk to the public safety and well-being.

32. All lesser discipline and other options authorized by N.C. Gen. Stat. § 90-41(a) were considered but all are insufficient to protect the public pursuant to 21 NCAC 16N .0607.

33. Respondent's misconduct and violations, along with his lengthy and extensive disciplinary history involve such serious, numerous violations of the Dental Practice Act that revocation of his dental license and Permit is the only discipline or disciplinary measure sufficient to protect the public.

Based on the foregoing Findings of Fact, Conclusions of Law, and Additional Findings and Conclusions Regarding Discipline, the Hearing Panel enters the following:

ORDER OF DISCIPLINE

Respondent's license to practice dentistry in North Carolina is REVOKED. Respondent's sedation permit also is REVOKED. The revocation of Respondent's license to practice dentistry and of his sedation permit are both effective on May 1, 2024, or upon service of this Final Agency Decision, whichever is later ("Effective Date"). The purpose of the delayed Effective Date is to allow Petitioner a brief wind down period to complete patients in mid-treatment and refer all existing patients to another provider to ensure continuity of dental care. Respondent shall not accept any new patients or begin new treatment on existing patients during this wind down period. On or before the Effective Date, Petitioner shall: (i) notify all current patients of how the patient or a subsequent provider may obtain the patient's record from his office and refer all existing patients to

another provider if feasible to ensure continuity of dental care, and (ii) surrender his dental license and current renewal certificate to the Dental Board.

This the 22nd day of April 2024.

Mark W. Johnson, DDS

Dr. Mark W. Johnson, Presiding Officer
on behalf of the Hearing Panel
The N.C. State Board of Dental Examiners