IN THE MATTER OF	*	BEFORE THE MARYLAND
DEVINDER K. GUPTA, D.D.S.	*	STATE BOARD OF
Respondent	*	DENTAL EXAMINERS
License Number: 6657	*	Case Numbers: 2016-082 & 233

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CONSENT ORDER

On April 4, 2018, the Maryland State Board of Dental Examiners (the "Board") charged **DEVINDER K. GUPTA, D.D.S.,** (the "Respondent"), License Number 6657, with violating the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol.).

The Board charged the Respondent with violating certain provisions of the Act and COMAR 10.44 *et seq.*, including:

Health Occ. I § 4-315. Denials, reprimands, probations, suspensions, and revocations -- Grounds.

(a) *License to practice dentistry.* -- Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry, a limited license to practice dentistry, or a teacher's license to practice dentistry to any applicant, reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the applicant or licensee:

(6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;

(16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; [and]

(20) Violates any rule or regulation adopted by the Board[.]

COMAR 10.44.23.01 Unprofessional or Dishonorable Conduct

B. A dentist . . . may not engage in unprofessional or dishonorable conduct.

C. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry . . .:

(2) Engaging in conduct which is unbecoming a member of the dental profession; [and]

(8) Committing any other unprofessional or dishonorable act or omission in the practice of dentistry . . .[.]

COMAR 10.44.30.02 General Provisions for Handwritten, Typed and Electronic Health Records.

I. A dental record shall contain:

(7) Medical and dental histories which shall be updated at each visit[.]

K. Dental records shall:

(1) Accurate;

(2) Be detailed; [and]

(5) Document all data in the dentist's possession pertaining to the patient's dental health status[.]

U. Dentists are responsible for the content of the dental records.

COMAR 10.44.30.03 Clinical Charts.

A. Each patient's clinical chart shall include at a minimum the following:

(2) Reasons for the patient's visit;

(3) Treatment plans that are signed and dated by both the treating dentist and the patient;

(4) Patient's complaints;

(5) Diagnosis and treatment notes;

(7) Post operative instructions;

(10) Identification of medications prescribed, administered, dispensed, quantity, and direction for use;

(11) Clinical details with regard to the administration of:

(a) Nitrous oxide;

(b) Anxiolytics;

(c) Sedation; and

(d) General anesthesia.

(12) Radiographs of diagnostic quality;

(13) Periodontal charting;

(14) Laboratory work authorization forms and correspondence to and from laboratories;

(15) Informed consent;

(18) Details regarding referrals and consultations; [and]

(20) Noncompliance and missed appointment notes[.]

On July 18, 2018, a Case Resolution Conference ("CRC") was held before a committee of the Board. During the settlement conference, the CRC committee took into consideration the Respondent's cooperation with the Board investigation and his refutation of the fraud allegations in the charges and agreed not to make any findings of fraud in this Consent Order. As a resolution of this matter, the Respondent agreed to

enter this public Consent Order consisting of Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

I. BACKGROUND

1. At all times relevant, the Respondent was and is licensed to practice dentistry in the State of Maryland. The Respondent was originally licensed to practice dentistry in Maryland on October 23, 1997, under License Number 6657. The Respondent's dental license is scheduled for renewal on or before June 30, 2019.

2. At all times relevant, the Respondent maintained an office for the practice of dentistry in Baltimore, Maryland.

II. COMPLAINTS

3. On or about November 19, 2015, the Board received a complaint from a patient ("Patient A")[1] who alleged that the Respondent failed to diagnose dental decays over a prolonged period, resulting in Patient A needing more extensive treatment later. Patient A further stated that during two visits in late 2015 the Respondent acted unprofessionally when he made racially insensitive comments to Patient A.

4. After receiving Patient A's complaint, the Board initiated an investigation of the Respondent's dental practices under Case Number 2016-082.

[1] To ensure confidentiality and privacy, the names of individuals, hospitals and healthcare facilities involved in this case are not disclosed in this document.

5. While investigating Patient A's complaint, the Board, on or about May 5, 2016, received a second complaint from another patient ("Patient F") who alleged that the Respondent's substandard care caused him "sore throat, a headache and a mouth full of ulcers." Patient F alleged that the Respondent provided him a lower partial denture that had protruding wires, which caused discomfort and later fractured a temporary crown.

6. After receiving Patient F's complaint, the Board initiated a second investigation of the Respondent's dental practices under Case Number 2016-233.

III. INVESTIGATION

7. As part of its investigation, the Board subpoenaed 17 patient charts from the Respondent and forwarded them to a general dentist (the "Expert") licensed in Maryland for an expert review. Based on his review, the Expert found that the Respondent's care and treatment of the 17 patients under review demonstrated a pattern of substandard care.

IV. SUMMARY OF DEFICIENCIES

8. The Respondent's care and treatment of 17 patients (Patients A through Q) constituted: practicing dentistry in an incompetent manner; behaving dishonorably or unprofessionally; and violating regulations adopted by the Board, for reasons including, but not limited to:

a. Failing to perform and document complete clinical examinations including, but not limited to, head and neck examination, oral cancer screening, periodontal examination, intraoral hard and soft tissue examination and caries assessment;

b. Failing to document existing restorations, missing teeth, caries, teeth to be extracted, temporomandibular joint examinations, and occlusion classification;

c. Failing to perform prophylaxis cleaning and provide oral hygiene instructions;

d. Failing to formulate formal treatment plans, which resulted in non-diagnosed caries, periodontal diseases and eventual tooth loss;

e. Failing to perform medical history review and updates;

f. Performing procedures without a diagnosis or updated radiographs;

g. Treating patients with misdiagnoses;

h. Failing to document prescription dosage, quantity and dental necessity;

i. Failing to document type and dosage of local anesthesia used;

j. Performing unnecessary surgical extractions and failing to document the location, quantity and removal of sutures;

k. Failing to document the sizes and types of post and core;

l. Treating patients with crown preparation and impression prior to root canal completion; and

m. Failing to keep adequate dental records in accordance with the Board's regulations.

V. PATIENT-SPECIFIC SUMMARIES

PATIENT A

9. Patient A, a male born in the 1960s, initially saw the Respondent on or about June 12, 2013. The Respondent performed a limited evaluation, took six periapical and two bitewing radiographs, and performed crown preparation for Teeth #7 and #8. The Respondent failed to perform and/or document a review of medical history, dental charting or periodontal examination. The Respondent noted a large buccal decay on Tooth #8 and mesial/distal decay on Tooth #7 but failed to document a proper diagnosis and alternative treatments. With respect to this visit, the Respondent also failed to document Patient A's complaint or reason for the visit, the justification for core build-up and the type and amount of anesthesia used.

10. On or about August 1, 2013, the Respondent documented performing an evaluation of Patient A with full mouth debridement, prophylaxis and fluoride. The Respondent failed to perform and/or document an examination and charting of Patient A's present dental condition, a medical history review, a head and neck examination, an oral cancer screening, an intraoral oral hard and soft tissue examination and a periodontal examination. The Respondent also failed to document his findings from the evaluation.

11. Patient A returned on or about August 23, 2013, for a restorative appointment. The Respondent failed to perform and/or document a medical history review. The Respondent also failed to document the type of restorative material and local anesthetic used.

12. On or about September 19, 2013, Patient A saw the Respondent for restorative treatment on Teeth #3 and #4. The Respondent failed to perform and/or

document a medical history review, periodontal examination, or oral cancer screening. The Respondent also failed to document the type and dosage of anesthesia used.

13. On or about November 7, 2013, the Respondent documented "Evaluation with full mouth debridement/prophylaxis/fluoride." The Respondent failed to perform and/or document a medical history review, head and neck examinations, intraoral hard and soft tissue examination, periodontal examination, carries assessment, or oral cancer screening.

14. Patient A returned on or about September 3, 2014, where the Respondent documented "Evaluation, prophylaxis, composite bonding teeth #10 and #11." The Respondent failed to perform and/or document a medical history review, head and neck examinations, oral cancer screening and intraoral hard and soft tissue examination. The Respondent failed to document the dental necessity for bonding Teeth #10 and 11, as well as the material used and surfaces bonded.

15. On or about May 25, 2015, the Respondent saw Patient A and documented "Evaluation, prophylaxis, fluoride." The Respondent failed to perform and/or document a medical history review, head and neck examinations, oral cancer screening, intraoral hard and soft tissue examinations, periodontal examination and carries assessment. The Respondent further noted "Next visit #3, 4, 10 mesial, facial, distal, incisal (MFDI)." The Respondent failed to document the treatment necessity, such as radiographic findings, and treatment plan for Teeth #3 and #4. Patient A had not had radiographs taken since his first visit on June 12, 2013.

16. On or about June 25, 2015, the Respondent performed restorations on Teeth #10 and #11. The Respondent failed to perform and/or document a medical history review, periodontal examination, carries assessment and failed to document the type of anesthesia used. The Respondent also failed develop and/or document a diagnosis and the dental necessity for restorations on Teeth #10 and #11, as they were restored less than a year ago.

17. Patient A saw the Respondent on or about August 27, 2015, for crown preparation for Teeth #2, #3, #4, #30 and #31. The Respondent documented that all the mentioned teeth had wrap around decay and the old fillings that had recurrent decay. Despite having evaluated Patient A's teeth on numerous occasions since June 2013, the Respondent had never documented any decay to Teeth #2, #30 and #31. The Respondent performed core build-up on Teeth #2, #4, #30 and #31. Finally, the Respondent failed to document the type of anesthetic used for this visit.

18. On or about October 3, 2015, the Respondent cemented crowns to Teeth #2, #4, #30 and #31, and referred Tooth #3 for root canal therapy ("RCT"). The Respondent failed to determine the prognosis for Tooth #3 prior to cementing crowns on Teeth #2 and #4. Radiographs from a subsequent provider showed open margins on Teeth #2 and #4.

PATIENT B

19. Patient B, a female born in the 1950s, initially saw the Respondent on or about December 1, 2012, for a limited evaluation, prophylaxis, fluoride treatment and restorations on Teeth #4, #6 and #11. The Respondent failed to perform and/or document

a medical history review, head and neck examinations, intraoral hard and soft tissue examination, dental charting of existing restorations or missing teeth and periodontal examination. The Respondent performed restorations on Teeth #4, #6 and #11 without developing and/or documenting a diagnosis to support the dental necessity for the restorations. The Respondent further failed to document the type of anesthetic used.

20. On or about August 8, 2013, and May 21, 2014, Patient B returned for "Exam, scaling, prophylaxis, fluoride treatment." During those visits, the Respondent failed to perform and/or document medical history reviews, head and neck examinations, oral cancer examinations, intraoral hard and soft tissue examinations, carries assessments and periodontal examinations. A review of the radiographs showed generalized periodontal disease, which the Respondent failed to document, diagnose and treat.

21. On or about May 29,2014, the Respondent noted bone loss to Tooth #12 and splinted Tooth #12 to #11. The Respondent failed to perform and/or document periodontal probing or mobility evaluation of Tooth #12 to determine the extent and type of bone loss to Tooth #12. The Respondent also failed to document the dental necessity for the splinting. The Respondent failed to treat the bone loss, or at least refer Patient B to a periodontist.

22. On or about July 9, 2014, despite Patient B previously listing Penicillin allergy on her medical history form, the Respondent called in a prescription for Amoxicillin 500 mg (#28) for Patient B, which he failed to document in Patient B's chart.

23. Patient B returned on or about July 12, 2014, for an "impression for new partial; treatment plans for extraction of #4, 12." The Respondent failed to develop

and/or document a diagnosis for Teeth #4 and #12. Despite prior radiographic evidence of generalized periodontal disease, the Respondent failed to perform and/or document a periodontal examination, or a periodontal referral. The Respondent's failure to evaluate and treat Patient B's periodontal disease early on eventually led to Patient B's tooth loss.

24. On or about August 12, 2014, the Respondent extracted Teeth #4 and #12. The Respondent failed to perform and/or document a medical history review and failed to document the type of anesthesia used. The Respondent also failed to schedule a follow-up visit and document post-operative instructions.

25. On or about September 17, 2014, the Respondent performed restorations on Teeth #27, #28, #29 and #30. The Respondent failed to perform and/or document a medical history review and periodontal examination. The Respondent also failed to develop and/or document a diagnosis to support treatment of those teeth, and failed to document the type of dental material and anesthetic used.

26. On or about March 21, 2015, and September 3, 2015, the Respondent conducted examinations, scaling, prophylaxis and fluoride treatments. The Respondent failed to perform and/or document medical history reviews, head and neck examinations, oral cancer examinations, intraoral examinations of hard and soft tissues, and periodontal examinations. The Respondent still had not treated Patient B's generalized periodontitis, or refer Patient B to a periodontist.

27. Patient B saw the Respondent on or about November 18, 2015, for restorations on Teeth #6, #20, #21 and #22. The Respondent failed to document the type of dental material and anesthetic used.

28. On or about April 20, 2016, the Respondent performed oral evaluation, scaling, prophylaxis and fluoride treatment. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, intraoral examination of hard and soft tissues and periodontal examination. Patient B had generalized periodontitis, which the Respondent still had not treated or refer to a periodontist. The last radiographs taken of Patient B was approximately two years ago in May 2014.

PATIENT C

29. Patient C, a female born in the 1970s, saw the Respondent once on or about October 10, 2015. The Respondent performed an examination, took a full mouth series radiograph and diagnosed Patient C with periapical pathosis. The Respondent recommended RCT on Tooth #12, despite not having performed and/or document diagnostic testing, such as vitality testing, percussion, mobility, swelling and probing. The Respondent also failed to document a medical history review. Patient C's radiograph failed to show that she had periapical pathosis, although the Respondent documented that she had periapical pathosis.

PATIENT D

30. Patient D, a male born in the 1970s, initially saw the Respondent on or about January 16, 2016, for a limited examination. The Respondent took six periapical and four bitewing radiographs, and diagnosed Patient D with periapical pathosis on Tooth #15. The Respondent recommended RCT on Tooth #15 and extraction of Tooth #16. The Respondent failed to perform and/or document diagnostic testing, such as vitality,

percussion, periodontal probing, mobility and swelling, to support his diagnosis and treatment recommendation. A review of the radiographs failed to show evidence of periapical pathosis on Tooth #15.

31. Patient D's only other visit occurred on or about January 11, 2016, during which the Respondent performed a pulpotomy and crown preparation on Tooth #15. The Respondent failed to document the dental necessity for a pulpotomy and crown on Tooth #15. Patient D's bitewing radiographs indicated decay isolated to the mesial segment, which should be treated with excavation and restorative filling.

PATIENT E

32. Patient E, a male born in the 1970s, initially saw the Respondent on or about June 14, 2013, for an oral examination. The Respondent took six periapical radiographs and recommended RCT consultation for Tooth #31, crowns for Teeth #24, #25 and #26, and a bridge for Teeth #27 to #31. The review of Patient E's radiographs failed to show that crowns for Teeth #24, #25 and #26 were indicated. The Respondent failed to perform and/or document a periodontal examination, including probing and mobility testing of abutment teeth to Teeth #27 to #31, to ensure that those teeth can support a bridge.

33. Patient E returned on or about June 28, 2013. The Respondent noted the use of 3 carpules of anesthetic for treatment on Teeth #24, 25 and 26, and a bridge on

Teeth #27 to #31. The Respondent ordered a return visit for metal try-in. The Respondent also failed to document the type of local anesthesia used.

34. On or about July 31, 2013, the Respondent took a periapical radiograph of Tooth #29 but failed to document his findings.

35. On or about October 11, 2013, the Respondent inserted crowns on Teeth #24, #25 and #26, and inserted a bridge on Teeth #27 to #31. The Respondent, however, failed to take and/or document periapical radiographs to confirm margins.

36. On or about November 11, 2013, Patient E returned for crown preparation on Teeth #7, #8 and #9. The Respondent previously noted that Patient E's Tooth #8 came loose and his prior dentist had to recement it several times. The Respondent failed to perform and/or document a periodontal examination and failed to document the anesthesia used.

37. Patient E returned on or about December 9, 2013, for a final impression of with local anesthetic. The Respondent failed to document the type and quantity of anesthesia used.

38. On or about December 17, 2013, the Respondent noted inserted the crowns on Teeth #7, #8 and #9 but failed to verify and/or document the margins and occlusion contacts.

39. Patient E saw the Respondent twice in 2014. On or about June 21, 2015, Patient E returned for an examination, scaling, prophylaxis and a full mouth series radiograph. The Respondent noted that Tooth #17 appeared to be fractured. He took an impression for a laboratory fabricated temporary teeth and referred Patient E to an

endodontist. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, intraoral examination and periodontal examination. The Respondent also failed to document the extent of the fracture to Tooth #17 and the reason for the referral to an endodontist as well as which teeth the laboratory temporaries were for.

40. On or about February 1, 2016, the Respondent discussed treatment plan with Patient E for crowns on Teeth #3, #4, #5 and #6. The Respondent failed to develop and/or document a diagnosis for Teeth #3, #4, #5 and #6, and failed to document the dental necessity for recommending crowns on those teeth. The Respondent also failed to consider and/or document alternative treatment options, such as fillings.

41. On or about February 22, 2016, the Respondent performed crown build-up and preparation for Teeth #3, #4, #5 and #6, and inserted the crowns at a subsequent undocumented date. The Respondent still had no documented a diagnosis for those teeth. He also failed to perform and document a periodontal examination and the type and dosage of anesthesia used. On or about February 24, 2014, the Respondent issued a laboratory prescription which did not include support for an upgraded porcelain.

PATIENT F

42. Patient F, a female born in the 1960s, initially saw the Respondent on or about May 22, 2003, for an emergency examination for fractured teeth. The Respondent noted that Tooth #18 cracked halfway and Tooth #19 had a crack line and MDO decay. The Respondent further noted that Patient F wanted extraction to avoid extrusion of Tooth #15. The Respondent failed to perform and/or document a medical history review

and periodontal examination. The radiographs taken were not of diagnostic quality. The Respondent extracted Tooth #18 and used Tooth #19 as an abutment for a cantilever bridge but failed to consider an implant as part of treatment plan. The Respondent failed to document clinical details of the extraction, anesthesia used, suture placement and post-operative instructions. The Respondent also failed to obtain and/or document informed consent for the extraction.

43. On or about July 24, 2003, Patient F returned because the cantilever bridge broke. The Respondent inserted a crown on Tooth #19 with a mesial restoration. The Respondent should have redone the bridge since Patient F specifically wanted to avoid extrusion to Tooth #15.

44. On or about October 8, 2003, the Respondent performed restoration on Tooth #20 and buildup and crown insertions on Teeth #21 and #22. The Respondent failed to perform and/or document a medical history review and periodontal examination. The Respondent also failed to document the dental material and the anesthesia used for Tooth #20.

45. On or about August 12, 2004, Patient F saw the Respondent with complaints of pain to the upper right quadrant. The Respondent performed a limited evaluation and took one periapical radiograph. The Respondent noted there was no decay to Tooth #3 but possible periapical pathosis. The Respondent prescribed Penicillin VK 500 mg. The Respondent failed to perform and/or document endodontic testing on Tooth #3 and/or refer Patient F to an endodontist. He also failed to document his clinical findings to support prescribing Penicillin VK 500 mg. Patient F returned on or about

November 17, 2004, and the Respondent noted that she had no pain and proceeded with crown preparation for Tooth #3. The Respondent failed to determine whether Tooth #3 was endodontically involved prior to performing crown preparation.

46. For the next two years, Patient F had no contact with the Respondent other than a telephone call complaining of pain to the upper right quadrant on or about May 25, 2005. Patient F returned to see the Respondent on or about May 31, 2007. The Respondent performed an examination, and took one periapical and one bitewing radiograph. The Respondent noted Tooth #4 appeared to be endodontically involved. The Respondent failed to perform and/or document a periodontal examination, and failed to document a clinical examination. The Respondent also failed to render treatment or recommend follow up treatment for Tooth #4. A review of the radiograph showed no evidence of periapical pathosis associated with Tooth #4.

47. On or about April 4, 2008, Patient F saw the Respondent with complaints of toothache. The Respondent took a periapical radiograph and noted that Tooth #4 appeared to have recurrent decay. The Respondent noted a referral to an endodontist. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, caries assessment and periodontal examination. The Respondent to perform and/or document a clinical examination on Tooth #4, including but not limited to hot/cold testing, percussion testing and periodontal examination. Despite noting deep decay on Tooth #4, the Respondent failed to provide and/or document any treatment recommendations.

48. Patient F returned approximately a year later, on or about April 23, 2009, for a limited evaluation and a referral to an endodontist. The Respondent failed to document his clinical findings from the limited evaluation and schedule a follow up visit.

49. Patient F saw the Respondent on or about May 23, 2009, for another limited evaluation and a gold crown on Tooth #30. The Respondent failed to perform and/or document a medical history review and a periodontal examination. The Respondent also failed to develop and/or document a diagnosis for Tooth #30 to support a crown placement. The Respondent also failed to document the anesthetic used and any follow up on Tooth #4.

50. On or about June 11, 2009, the Respondent inserted a crown on Tooth #30 and performed prophylaxis and scaling. The Respondent failed to perform and/or document a head and neck examination, oral cancer screening, a periodontal examination, caries assessment and treatment planning.

51. Patient F returned on or about October 22, 2009, for a limited evaluation during which the Respondent took a periapical radiograph and noted fracture to Tooth #4. The Respondent performed a pulpotomy and crown preparation on Tooth #4. The Respondent's failure to follow up on Tooth #4 resulted in the fracture and endodontic involvement. The Respondent failed to perform and/or document a periodontal examination and failed to document the anesthetic used. The Respondent failed to perform a post and core fabrication prior to the crown preparation.

52. On or about January 20, 2010, the Respondent noted placement of post and core, and insertion of a crown on Tooth #4. The Respondent failed to document the post

size, the core material used, the anesthetic used and verification of margins. The Respondent also failed to schedule a return visit for prophylaxis and radiographs.

53. For approximately two years and nine months, Patient F did not see the Respondent. On or about November 8, 2012, Patient F returned for a limited evaluation. The Respondent took two bitewing radiographs and determined that Tooth #2 was fractured. He performed a crown buildup and preparation on Tooth #2 and referred Patient F to a periodontist for Teeth #4 and #5. Although the Respondent noted a "medical history update," there was no medical history update in Patient F's chart. Despite a near three-year hiatus, the Respondent failed to perform and/or document a head and neck examination, oral cancer screening, periodontal examination and caries assessment. The Respondent also failed to document the dental reasons for referral to a periodontist, and his referral form failed to mention Teeth #4 and #5.

54. Patient F returned on or about January 23, 2013, for insertion of a crown on Tooth #2. The Respondent noted two bitewing radiographs and a periodontal evaluation. The Respondent failed to perform and/or document a head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, caries assessment and charting. Despite noting a periodontal evaluation, the Respondent failed to document the findings from his evaluation. He also failed to retain the two bitewing radiographs he took. The Respondent also failed to follow up with Patient F regarding the previous referral to a periodontist.

55. Patient F's file contained two bitewing radiographs dated November 6, 2013, which the Respondent failed to document in Patient F's chart. A review of the

radiographs revealed evident decay to Tooth #30, which the Respondent failed to diagnose and treat.

56. On or about November 7, 2013, the Respondent performed an examination, prophylaxis and fluoride treatment. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, periodontal examination, caries assessment, charting and treatment planning.

57. Patient F returned approximately two years later, on or about November 12, 2015, with complaints of pain to the lower right quadrant. The Respondent performed a crown buildup and preparation on Tooth #30, took an impression and placed a temporary crown. The Respondent failed to document taking a periapical radiograph of Tooth #30, which showed progressive decay compared to the radiograph from November 7, 2013, that the Respondent failed to diagnose and treat. Moreover, the periapical radiograph of Tooth #30 this time showed no evidence of pulp involvement, which would indicate direct restoration rather than crown placement. The Respondent inserted the crown on Tooth #30 on or about December 14, 2015.

58. On or about February 1, 2016, the Respondent performed an oral evaluation and took two periapical and one bitewing radiographs. The Respondent failed to document the reason for Patient F's visit and retain her radiographs in the file.

59. Patient F returned on or about March 9, 2016. The Respondent noted an evaluation, full mouth series radiographs, scaling, prophylaxis and fluoride treatment. The Respondent failed to document his findings from the evaluation. He also failed to

perform and/or document a medical history review, head and neck examination, periodontal examination, intraoral hard and soft tissue examination and caries assessment.

PATIENT G

60. Patient G, a male born in the 1930s, initially saw the Respondent on or about May 20, 215, with complaints of a fractured tooth and a broken partial denture. The Respondent noted multiple compromised teeth, including a fracture on Tooth #3, and an ill-fitting mandibular partial denture. Patient G refused any tooth extraction or RCT. The Respondent: splinted Teeth #3 and #14 with temporary crowns; took an impression for mandibular lower partial denture; performed a pulpotomy and crown preparation for Tooth #30; and referred Patient G for RCT for Teeth #4, #30, #21 and #12. The Respondent noted debridement and periodontal consultation for Patient G's next visit. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, intraoral hard and soft tissue examination and a periodontal examination. The Respondent also failed to retain the full mouth series radiographs in Patient G's file.

61. Patient G returned on or about July 1, 2015, for a try-in of the partial denture. The Respondent noted Patient G refused RCT on Tooth #30 but would wait to change the temporary crowns to permanent crowns. On or about July 16, 2015, the Respondent inserted the partial denture. During those visits, the Respondent failed to perform and/or document head and neck examination, oral cancer screening, periodontal examination and charting of teeth. The Respondent also failed to discuss and/or

document following up with Patient G regarding debridement and periodontal consultation, which he previously treatment planned.

62. On or about April 14, 2016, Patient G returned with complaints that the temporary crowns were broken. The Respondent remade the temporary crowns but failed to schedule Patient G for a complete examination and prophylaxis.

PATIENT H

63. Patient H, a female born in the 1970s, initially saw the Respondent on or about April 9, 2008, with complaints of tooth abscess. The Respondent performed an examination and diagnosed Tooth #14 with periapical pathosis. The Respondent prescribed Amoxicillin 500 mg and referred Patient H to an endodontist. The Respondent failed to document clinical details regarding the condition of Tooth #14.

64. On or about July 1, 2009, Patient H returned with complaints of pain to the lower left quadrant. The Respondent noted Patient H had RCT in May 2008. The Respondent failed to develop and/or document a diagnosis or treatment plan. The Respondent also failed to document clinical details regarding his findings or the extent of Patient H's pain.

65. On or about October 14, 2009, the Respondent performed a limited evaluation, took a periapical radiograph and surgically extracted Tooth #4. The Respondent failed to develop and/or document a diagnosis to support the extraction of Tooth #4. He failed to document: any alternative treatment options; details regarding the sutures; the type of anesthetic used; post-operative instructions; issuance of a prescription for antibiotics; and scheduling of return visit. Patient H signed a blank "Oral Surgical

Consent Form," which failed to describe the type of procedure to be performed and the tooth involved.

66. Patient H returned on or about December 5, 2009. The Respondent performed a limited evaluation, took a periapical radiograph and referred Patient H to an oral surgeon for extraction of Teeth #14 and #6. The Respondent failed to document his clinical findings from the radiograph and the referral to an oral surgeon.

67. On or about June 26, 2010, Patient H saw the Respondent with complaints of pain. The Respondent performed a pulpotomy on Tooth #13. The Respondent failed to develop and/or document a diagnosis to justify the procedure performed. He also failed to document his clinical findings and the type of anesthetic used.

68. The next day on or about June 27, 2010, the Respondent performed a limited evaluation and referred Patient H to an oral surgeon for evaluation on Teeth #13 and #18 for possible periapical pathosis. The Respondent failed to perform and/or document a periodontal examination and a treatment plan. Patient H had been seeing the Respondent for more than two years and the Respondent still had not performed and/or document a comprehensive examination and prophylaxis.

69. Patient H's next visit was on or about April 20, 2011. The Respondent took four periapical radiographs and noted large/deep decay on Teeth #2, #3 and #31. He also found fractured buccal on Teeth #29. The Respondent performed bridge preparation for Teeth #3, #4 and #5, and Teeth #29, #30 and #31. He also performed crown preparation for Tooth #2 and placed a temporary crown on Tooth #31. The Respondent prescribed Amoxicillin and Lortab to Patient H. The Respondent failed to perform and/or document

a complete examination, including head and neck examination, oral cancer screening, intraoral hard and soft tissue examination and periodontal examination. The Respondent also failed to formulate and/or document a treatment plan. Patient H had been seeing the Respondent since 2008, during which the Respondent never diagnosed decay to Teeth #2, #3 and #31. The Respondent initiated bridge preparation without a periodontal evaluation or a referral to an endodontist. The Respondent prescribed Amoxicillin and Lortab to Patient H without documenting the dosage and quantity prescribed.

70. On or about July 25, 2011, the Respondent referred Patient H to an endodontist but failed to retain the referral form in Patient H's chart. The Respondent noted a return visit for post/core and final impression.

71. Patient H did not return until approximately nine months later, on or about April 20, 2012, during which the Respondent never tried to contact her. During this visit, the Respondent noted that Patient H's temporary crowns had cracked/lost and he remade seven units of temporary crowns. The Respondent referred Patient H to an endodontist for an evaluation on Tooth #3 but failed to retain the referral form in Patient H's chart.

72. Patient H did not return until more than a year later, on or about July 8, 2013, with complaints of a fractured tooth. The Respondent took two periapical radiographs and noted that Patient H had buccal abscess. The Respondent removed the roots, performed an alveoplasty and sutured with silk. The Respondent failed to follow up on bridge preparations he made three years prior, including examining the condition of the abutments. The Respondent also failed to perform and/or document a periodontal examination. The Respondent removed the sutures on or about July 15, 2013, but failed

to perform and/or document a periodontal examination, head and neck examination, oral cancer screening, a medical history review and caries assessment.

73. On or about February 17, 2014, Patient H saw the Respondent for an oral evaluation. The Respondent took two periapical radiographs and prescribed Amoxicillin and Lortab to Patient H. The Respondent noted that Patient H had had temporary crowns for years and referred her to an endodontist for Tooth #31. The Respondent failed to document his findings from his evaluation, the dosages and quantity of medications prescribed and that he advised Patient H to have RCT done as soon as possible. He also failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, periodontal examination and caries assessment.

74. Patient H returned on or about July 18, 2014, with complaints of pain to the lower left quadrant. The Respondent took four periapical radiographs and noted buccal abscess on Tooth #31. The Respondent prescribed Amoxicillin and Lortab to Patient H. In his written response to the Board, the Respondent stated that he told Patient H see an endodontist as soon as possible to save those teeth. The Respondent, however, failed to document those instruction in the patient chart. The Respondent also failed to document his findings from his evaluation, including clinical details regarding Patient H's pain. The Respondent failed to order a return visit for a complete examination, prophylaxis and treatment planning.

75. On or about March 4, 2015, the Respondent documented RCT on Teeth #18 and #20, and bridge preparation. The Respondent noted that Patient H had had temporaries in the upper and lower left quadrants for three to four years. The Respondent

failed to perform and/or document a head and neck examination, oral cancer screening, teeth charting, caries assessment, periodontal examination and prophylaxis. The Respondent failed to address the issue of Patient H using temporary abutments for years and insisted treatment for another bridge.

76. On or about March 18, 2015, the Respondent inserted a bridge on Teeth #18 to #20, and prescribed Amoxicillin for periapical pathosis on Tooth #31. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, periodontal examination, verification of margins and caries assessment. The Respondent also failed to document the dosages and quantity of medication prescribed and failed to address upper right/lower right bridged which he started four years prior.

77. On or about October 28, 2015, Patient H saw the Respondent with complaints of pain. The Respondent took two periapical radiographs and recommended extraction of Teeth #2, #3 and #5, and an impression for an upper partial denture. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, periodontal examination and caries assessment. In his written response to the Board, the Respondent stated that extractions were necessary due to large carious lesions, which he failed to document in the patient chart. Patient H had those carious lesions because the Respondent had consistently failed to perform caries assessment on Patient H. The Respondent failed to insert permanent restoration for over four years, which failed to protect Patient H's teeth.

78. On or about November 2, 2015, the Respondent surgically extracted Teeth #2, #3 and #5, sutured with silk and prescribed Amoxicillin and Lortab. The Respondent noted the extractions were difficult and a distal root tip was left close to the sinus. The Respondent failed to perform and/or document a medical history review prior to the surgery. He also failed to document the type of anesthesia used, the dosages and quantity of medications prescribed, the number and location of sutures and post-operative instructions. The Respondent failed to have Patient H initial various aspects of the informed consent form and failed to sign the form himself. The Respondent further failed to refer Patient H to an oral surgeon for evaluation of the root tip.

79. Patient H returned on or about November 4, 2015, with complaints of pain. The Respondent took an impression for a partial and advised Patient H to return as needed. The Respondent failed to perform and/or document an examination with his findings. He also failed to perform caries assessment for the lower right quadrant and follow up on bridge placement, similar to the failures to the upper right quadrant.

80. On or about November 11, 2015, the Respondent took a periapical radiograph and noted fracture to Tooth #12. The Respondent performed a post/core on Tooth #29, restored Tooth #11 and performed a pulpotomy on Tooth #12. The Respondent failed to perform and/or document a medical history review. He performed a pulpotomy on Tooth #12 without documenting a diagnosis or clinical findings. He performed a post/core on Tooth #29 without an assessment of the tooth. He failed to recommend a treatment for Tooth #12 and complete the bridge on Teeth #29 to #31.

81. On or about January 18, 2016, the Respondent performed a limited examination, took two periapical radiographs and inserted a bridge. The Respondent failed to document his findings from the limited examination. He inserted a bridge without assessing the clinical condition of teeth, including caries assessment. Those teeth underwent bridge preparation five years ago, and Tooth #29 recently underwent a post/core. The Respondent also failed to follow up on Tooth #12 and reevaluate the root tip from previous surgery.

PATIENT I

82. Patient I, a female born in the 1950s, initially saw the Respondent on or about February 18, 2004. The Respondent performed an examination, took full mouth series radiographs and took an impression for a mandibular partial. He planned to extract Teeth #23, #24, #25 and #26 at the next visit. The Respondent failed to perform and/or document a medical history review, head and neck examination, intraoral examination, oral cancer screening, periodontal examination and caries assessment. The Respondent failed to develop and/or document a diagnosis for extraction of Teeth #23, #24, #25 and #26. He also failed to retain the full mouth series radiographs in the patient file.

83. Patient I returned on or about April 15, 2004, for extraction of Teeth #23, #24, #25 and #26. The Respondent noted that he inserted the mandibular partial and prescribed Penicillin VK 500 mg. The Respondent prescribe Penicillin to Patient I despite her file indicating that she was allergic to Penicillin. The Respondent failed to document clinical details regarding the surgery, sutures, and anesthesia used. The Respondent also failed to obtain and/or document informed consent. The Respondent

failed to document support for a surgical extraction, as opposed to a forceps extraction, and post-operative instructions.

84. On or about June 29, 2006, Patient I saw the Respondent for an emergency visit with complaints of Tooth #13 being loose. The Respondent took a periapical radiograph and an impression for an immediate partial. The Respondent failed to perform and/or document a periodontal examination of Tooth #13, including probing, mobility and bleeding. He also failed to document a periodontal referral and laboratory authorization for a maxillary partial with upgrade. The Respondent failed to retain the periapical radiograph in the patient file.

85. On or about August 3, 2006, the Respondent extracted Tooth #13 and inserted the maxillary partial. The Respondent failed to obtain and/or document written informed consent for the extraction. He failed to document clinical details regarding the extraction and post-operative instructions. He failed to schedule a return visit for a comprehensive examination, prophylaxis and periodontal examination.

86. Patient I returned on or about October 21, 2006, for an emergency visit concerning a fractured tooth. The Respondent took a periapical radiograph and noted that Teeth #30 and #31 were fractured. He performed restorations on those teeth and recommended RCT and crowns. The Respondent failed to perform and/or document a medical history review, head and neck examination, intraoral hard and soft tissue examination, oral cancer screening and periodontal examination. The Respondent failed to document the restorative material and anesthesia used. Patient I file did not contain a referral to a periodontist on this date.

87. Patient I did not return until approximately three years and four months later, on or about February 24, 2010. The Respondent performed a limited evaluation and took a periapical radiograph. The Respondent noted that Tooth #31 was cracked. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening and periodontal examination. A review of the radiograph showed severe periodontal involvement and decay on Teeth #30 and #31.

88. On or about March 7, 2010, the Respondent noted possible extraction of Tooth #30, crown preparation for Tooth #31, impression for maxillary immediate and future extraction of Teeth #4 to #10, despite not documenting a diagnosis. The Respondent failed to perform and/or document a medical history review, head and neck examination and oral cancer screening. The Respondent failed to perform and/or document a periodontal or endodontic evaluation of Teeth #30 and #31, which had severe decay and periodontal disease, or refer Patient I for consultation. At no time has there been a comprehensive evaluation, caries assessment or periodontal examination.

89. Patient I returned on or about March 20, 20110, for insertion of crown on Tooth #31. The Respondent failed to document the type of cement used and verify the margins. He also failed to schedule Patient I for a return visit for prophylaxis, comprehensive examination, periodontal examination and referral.

90. On or about June 2, 2010, Patient I complained about severe pain with swelling. The Respondent failed to provide any details with respect to the swelling and/or treatment recommendations. The Respondent called in a prescription for Clindamycin. The Respondent failed to follow up on Patient I's complaint.

91. Patient I returned approximately a year later, on or about May 25, 2011. The Respondent too seven periapical radiographs, extracted Teeth #5, #12, #22 and #27, and took impression for partial denture. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, periodontal examination, teeth charting and caries assessment. The Respondent failed to document obtaining informed consent, type of anesthesia used and post-operative instructions. The Respondent failed to retain record of impression taken and the radiograph for Tooth #12.

92. Patient I did not see the Respondent again until approximately two and one-half years later, on or about October 10, 2013, complaining about her immediate complete denture. The Respondent took three periapical radiographs, performed an alveoplasty of the upper anterior quadrant, extracted Teeth #6, #7, #8, #9, #10 and #11., and inserted a complete denture. The Respondent failed to perform and/or document a medical history review, head and neck examination and periodontal examination. The Respondent failed to document the anesthesia used, clinical details regarding the alveoplasty and post-operative instructions. He also failed to develop and/or document a diagnosis to justify the treatment rendered.

93. Patient I returned on or about October 16, 2013, for a limited evaluation. The Respondent took a periapical radiograph and recommended RCT for Tooth #30. The Respondent noted Patient I refused RCT and wanted the tooth filled. The Respondent performed restoration on Tooth #30 and prescribed Motrin 800 mg. The Respondent failed to perform and/or document a medical history review, oral cancer screening, head

and neck examination, intraoral hard and soft tissue examination and periodontal examination. He also failed to document the type of anesthesia used. The Respondent failed to refer Patient I to a periodontist.

94. On or about October 24, 2013, the Respondent noted "office visit" without providing further details regarding the visit.

95. On or about January 10, 2015, the Respondent took four periapical radiographs, recommended extraction of Teeth #20, #21, #28, #29 and #30, and took an impression for a lower partial denture. The Respondent failed to perform and/or document a medical history review, oral cancer screening, head and neck examination, periodontal examination and caries assessment. The Respondent failed to develop and/or document a diagnosis to justify the treatment rendered. The Respondent failed to refer Patient I to a periodontist.

96. Patient I returned on or about February 5, 2015, for extraction of Teeth #20, #21, #22, #28, #29 and #30. The Respondent failed to perform and/or document a medical history review prior to the extractions. The Respondent failed to document clinical details regarding the extractions, the type of anesthesia used, details regarding the sutures and post-operative instructions.

97. On or about February 19, 2015, the Respondent performed an evaluation but failed document his findings. The Respondent further failed to document removal of sutures on this visit.

98. Patient I had a try-in on or about May 21, 2015, and on or about June 25, 2015, the Respondent extracted Teeth #19 and #30, inserted the lower denture and

prescribed Amoxicillin and Lortab. The Respondent failed to perform and/or document a medical history review prior to surgery. He also failed to document clinical details regarding the surgical extractions, the type of anesthesia used, details regarding the sutures placed and post-operative instructions.

PATIENT J

99. Patient J, a female born in the 1970s, initially saw the Respondent on or about March 19, 2015, for an evaluation of the lower right quadrant. The Respondent took a periapical radiograph. He noted cellulitis and Teeth #27 and #28 being broken, and prescribed Clindamycin and Lortab. The Respondent failed to document clinical details regarding the cellulitis and the type of anesthesia used.

100. On or about March 21, 2015, the Respondent extracted Teeth #27 and #28, and prescribed Lortab to Patient J. The Respondent failed to document clinical details regarding the surgical extraction, the type of anesthesia used, details regarding the sutures placed and post-operative instructions. Patient I signed an informed consent form that were not initialed, failed to include the specific teeth to be extracted and did not contain the Respondent 's signature.

101. On or about April 24, 2015, the Respondent surgically extracted Teeth #20, #19, #18 and #17, and performed restoration on Tooth #21 (MFD). The Respondent failed to document a treatment plan for those extractions, obtaining and/or document informed consent and providing post-operative instruction. The Respondent also failed to document removal of sutures from the previous extractions. The Respondent also failed

to perform and/or document head and neck examination, teeth charting, oral cancer screening, intraoral hard and soft tissue examination and periodontal examination.

102. On or about May 6, 2015, the Respondent surgically extracted Teeth #2, #4 and #5, performed bridge preparation and temporary crown placement on Teeth #3, #4, #5 and #6, and took an impression of lower partial denture. The Respondent failed to document a treatment plan for the treatment rendered, the type of anesthesia used and post-operative instructions. He failed to examine and document the periodontal status of abutment Teeth #3 and #6. He failed to provide Patient J alternative an alternative treatment plan such as implants on Teeth #4 and #5. The Respondent took an impression on the same day as extractions, which is contraindicated. The patient chart contained an informed consent form that did not have Patient J's signature.

103. On or about June 13, 2015, the Respondent noted "Try-in bridge and new impression for lower partial." The Respondent failed document removal of sutures from the previous surgical extractions. He failed to take a radiograph to confirm the margins of the bridge try-in. Since he started treating Patient J, the Respondent still had not perform and/or document a complete examination, including but not limited to head and neck examination, oral cancer screening and periodontal examination.

104. Patient J returned on or about July 1, 2015, for insertion of bridge, extraction of Teeth #13 and #15 and bridge preparation for Teeth #11 to #14. The Respondent failed to document a treatment plan for Teeth #11 to #14, or provide alternative treatment such as implants or partial upper. The Respondent failed to obtain

and/or document informed consent for extraction of Teeth #13 and #15, and failed to ascertain the periodontal status of Abutment #11 or #14.

105. The Respondent noted "Evaluation" on or about July 25, 2015, but failed to document any details regarding the evaluation. The Respondent also failed to document insertion of the bridge on Teeth #11 to #14.

106. Patient J returned on or about January 28, 2016, for crown preparation on Teeth #8 and #9, final impression and insertion of lower partial. The Respondent failed to document the dental necessity crowns on Teeth #8 and #9. Prior radiographs did not the necessity for crowns on those teeth. The Respondent also failed to perform and/or document a periodontal examination of those teeth.

107. On or about February 11, 2016, the Respondent inserted crowns on Teeth #8 and #9. The Respondent failed to perform and/or document head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, teeth charting and periodontal examination.

PATIENT K

108. Patient K, a male born in the 1940s, initially saw the Respondent on or about August 10, 2015, for a limited evaluation. The Respondent took two periapical radiographs and noted cellulitis to the upper left quadrant and periapical pathosis on Teeth #10 to #12. The Respondent prescribed Amoxicillin and Lortab to Patient K. The Respondent failed to perform and/or document a head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, teeth charting, periodontal examination, and the status of abutments associated with the bridge, and caries

assessment. The Respondent also failed to document clinical details regarding the cellulitis and type and dosages of medication prescribed. The Respondent failed to refer Patient K to an oral surgeon for an evaluation of the cellulitis.

109. Patient K returned on or about August 14, 2015, during which the Respondent took a full mouth series radiograph. The Respondent noted decay to Teeth #13 and #14. He performed an incision and drainage and crown/bridge preparation for Teeth #3 and #10 to #14. The Respondent referred Patient K to an endodontist for Teeth #13 and #14. The Respondent failed to perform and/or document periodontal examination those teeth and endodontic testing of Teeth #13 and #14. The Respondent also failed to document clinical details regarding the incision and drainage, and the type of anesthetic used. A review of the radiographs showed no definitive decay to Tooth #14 as well as no periapical pathosis.

110. The Respondent failed to retain Patient K's financial records in the patient file.

PATIENT L

111. Patient L, a male born in the 1970s, initially saw the Respondent on or about July 31, 2015, with complaints of pain to teeth and jaw. The Respondent took two periapical radiographs and noted periapical pathosis to Tooth #19 and unknow diagnosis to Tooth #14. The Respondent prescribe Clindamycin and Lortab to Patient L. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, periodontal examination and an examination of Patient L's jaw, which was the chief complaint. The Respondent in his written response

to the Board stated that Patient L had deep caries on Tooth #14, which he failed to document. A review of the radiographs failed to show significant decay to Tooth #14 or periapical pathosis on Tooth #19.

112. Patient L returned on or about August 3, 2015, for pulpotomy and crown preparation on Tooth #19 and crown preparation on Tooth #14. The Respondent placed temporary crowns to Teeth #14 and #19. The Respondent failed to perform and/or document periodontal examination. He also failed to develop and/or document a diagnosis for Tooth #14 and dental justification for pulpotomy on Tooth #19.

113. On or about August 26, 2015, the Respondent performed a post/core on Tooth #19 and took a final impression of Teeth #14 and #19. On or about September 25, 2015, the Respondent inserted crowns on Teeth #14 and #19, and scheduled a return visit for prophylaxis. The Respondent failed to take a radiograph after the insertion to confirm and verify margins.

PATIENT M

114. Patient M, a male born in the 1960s, initially saw the Respondent on or about April 24, 2013, for an oral examination. The Respondent noted taking eight periapical radiographs, surgically extracted Teeth #11, #12 and #14 and prescribed Amoxicillin 500 mg. The Respondent failed to perform and/or document a medical history review prior to surgical extraction and periodontal examination. The Respondent failed to develop and/or document a diagnosis to support extraction of those teeth. The Respondent failed to document clinical details regarding the surgical extraction and post-

operative instructions. The Respondent failed to obtain and/or document informed consent.

115. Patient M returned approximately one year and ten months later, on or about February 18, 2015. The Respondent noted extraction of Teeth #7, #8, #9, #10, #24, #25 and #27. The Respondent failed to perform and/or document a medical history review, periodontal examination and caries assessment. The Respondent failed to develop and/or document a diagnosis to support the extractions. The Respondent failed document clinical details regarding the extractions and suture placement and post-operative instructions. The Respondent failed to obtain informed consent prior to the extractions.

116. The Respondent removed Patient M's sutures on or about February 25, 2015, but failed to document it.

117. On or about November 11, 2015, the Respondent noted "Set up for c/c (denture); bite registration." In his written response to the Board, the Respondent stated that he advised Patient M to return to his office to extract the remaining teeth and deliver denture. The Respondent failed to perform and/or document a medical history review, head and neck examination, oral cancer screening, intraoral examination, periodontal examination and caries assessment. The Respondent failed to develop and/or document a diagnosis for teeth extraction. He failed to order radiographs and failed to document taking an impression.

118. On or about December 9, 2015, Patient M returned for teeth extraction and denture delivery. The Respondent's written response to the Board stated that he extracted

Teeth #20, #22 and #28. Patient M's informed consent form indicated consent for extraction of Tooth #3, #5, #20 and root tip of #6. Patient M's progress notes showed extraction for Tooth #20, #22, root of #6 and an indecipherable number. The Respondent failed to develop and/or document a diagnosis for the extractions. The Respondent failed to document clinical details regarding the extractions, including the specific teeth extracted. The Respondent failed to document post-operative instruction and failed to obtain new radiographs prior to the extractions and instead used old radiographs.

PATIENT N

119. Patient N, a female born in the 1970s, initially saw the Respondent on or about October 21, 2015, for an oral examination. The Respondent noted carious exposure on Tooth #14 and prescribe Amoxicillin and Lortab. On or about October 23, 2015, the Respondent performed a pulpotomy on Tooth #14 and inserted a temporary crown. The Respondent adjusted bite on or about October 31, 2015, and performed a post/core and crown insertion on or about December 15, 2015. During those visits, the Respondent failed to perform and/or document head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, periodontal examination and caries assessment. The Respondent failed to document type of anesthesia used and failed to verify margins.

PATIENT O

120. Patient O, a male born in the 1930s, initially saw the Respondent on or about April 4, 2015, for an oral examination. The Respondent took six periapical and

four bitewing radiographs and noted that Patient O had previous RCT on Tooth #13 and cantilever bridge on Teeth #14 and #15 was loose. The Respondent performed a three-unit bridge preparation, took impressions and inserted temporaries. The Respondent failed to perform and/or document a head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, periodontal examination and caries assessment. The Respondent failed document the use and type of anesthesia. The Respondent fraudulently charged the periapical radiographs separately instead of a full mouth series. The radiograph were of poor quality.

121. On or about May 2, 2015, the Respondent inserted the bridge. The Respondent failed to order radiographs to confirm the margins and failed to perform and/or document periodontal examination and caries assessment. The Respondent also failed to schedule Patient O for a return visit for prophylaxis.

122. On or about October 18, 2015, the Respondent noted an examination, impression for laboratory temporaries and upper/lower arch. The Respondent failed to document the purpose of the laboratory temporaries, the teeth involved and the periodontal status of the teeth. Patient O's chart indicated that he paid for the laboratory temporaries prior to signing the informed consent. The Respondent also failed to perform and/or document head and neck examination, oral cancer screening, periodontal examination, caries assessment and a treatment plan.

PATIENT P

123. Patient P, a female born in the 1960s, initially saw the Respondent on or about February 29, 2012, with complaints of broken teeth. The Respondent performed a

limited evaluation and took a periapical radiograph. The Respondent noted that Tooth #8 was fractured and performed a composite restoration. The Respondent failed to perform and/or document a head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, periodontal examination and caries assessment. The Respondent failed to document the anesthesia and restorative material used. Patient P's radiograph showed possible periapical radiolucency, which the Respondent failed to document. The Respondent also failed to have Patient P sign her medical history form.

124. Patient P did not return until nearly three years later, on or about January 26, 2015, for an evaluation. The Respondent noted that Tooth #8 was again fractured and required a crown. The Respondent failed to order a radiograph and failed to document clinical findings from his evaluation. The Respondent also failed to perform and/or document a head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, periodontal examination and caries assessment.

PATIENT Q

125. Patient Q, a male born in the 1970s, initially saw the Respondent on or about June 19, 2014, for an oral examination. The Respondent took six periapical and four bitewing radiographs and scheduled a return visit to address missing Teeth #3, #14, #19 and #30. The Respondent's written response to the Board stated that Patient Q complained of pain to the lower right area, which he failed to document. The Respondent failed to perform and/or document a head and neck examination, oral cancer screening, caries assessment and periodontal examination. The Respondent also failed to have Patient Q signed his medical history form.

126. Patient Q returned several months later, on or about November 24, 2014, with complaints of pain. The Respondent took four periapical radiographs and noted Patient Q had pain on Tooth #18 on pressure. The Respondent failed to document clinical details regarding findings from his evaluation. The Respondent written response to the Board stated that Tooth #18 had infectious lesion. A review of Patient Q's radiographs failed to show infectious lesion on Tooth #18. The Respondent prescribed Amoxicillin to Patient Q without documented support such as swelling.

127. Patient Q returned on or about December 4, 2014, for a limited evaluation and two periapical radiographs. The Respondent noted pressure pain to Tooth #18 and performed a pulpotomy. He also performed bridge preparation for Teeth #12 to #14 and Teeth #18 to #20, and referred Patient Q to an endodontist. In his written response to the Board, the Respondent stated that Tooth #18 had deep decay, which was not evident on the radiograph. Although the Respondent documented performing a pulpotomy on Tooth #18, radiographs from Patient Q's endodontist failed to show a pulpotomy had been performed. The Respondent made bridge preparations but failed document a periodontal examination or alternative treatment options such as implants.

128. On or about December 17, 2014, the Respondent inserted a bridge on Teeth #18 to #20 and performed a post/core on Tooth #18. The Respondent failed to perform and/or document a head and neck examination, oral cancer screening, intraoral hard and soft tissue examination, a medical history review and periodontal examination. The Respondent also failed to order a radiograph to confirm the margins of the bridge.

129. On or about January 8, 2015, the Respondent performed bridge preparation for Teeth #2 to #4 and Teeth #29 to #31. The Respondent failed perform and/or document a periodontal examination. The Respondent failed to document offering Patient Q alternative treatment such as implant. The Respondent failed to document the type and dosage of anesthesia used.

130. Patient Q returned on or about January 22, 2015, for bridge insertion. The Respondent failed to order radiographs to verify the margins.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's care and treatment of Patients A through Q, as set forth in detail above, constitute: practicing dentistry in a professionally incompetent manner or in a grossly incompetent manner, in violation of Health Occ. § 4-315(a)(6); behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. § 4-315(a)(16); and violating any rule or regulation adopted by the Board, i.e. COMAR 10.44.23.01, COMAR 10.44.30.02 and COMAR 10.44.30.03, in violation of Health Occ. § 4-315(a)(20)..

ORDER

It is, on the affirmative vote of a majority of the Board, hereby:

ORDERED that the Respondent is placed on **PROBATION** for a minimum of period of **THREE (3) YEARS** subject to the following probationary terms and conditions:

I. During the probationary period, the Respondent shall practice dentistry under the **SUPERVISION** of a Board-approved supervisor.

A. Within 15 days from the date of this Consent Order, the Respondent shall submit the name and professional credentials of a dentist licensed in Maryland for Board approval to serve as Supervisor for his practice of dentistry. The Supervisor shall not be associated with the Respondent through any current or past personal, collegial, professional or academic affiliation. The Respondent shall provide the Supervisor with a copy of the charging document, Consent Order, and any other document the Board deems relevant to his case. The Respondent understands and agrees that the Board may terminate any Supervisor and require that another Supervisor be designated.

B. The Respondent shall ensure that the Supervisor notifies the Board, in writing, within ten (10) days of the Board's approval of his/her acceptance of the supervisory role.

C. The Supervisor shall meet with the Respondent in person at least once a month for random chart review and discussion. At these meetings, the Supervisor shall choose a random sample of dental charts of at least ten (10) active cases to review. The Supervisor shall review the charts to determine the Respondent's compliance with quality of care, ethical standards and record keeping standards. In addition, the Supervisor shall discuss the cases with the Respondent to evaluate the Respondent's understanding of the conditions he is treating and his compliance with standards of care, ethical standards and record keeping standards.

D. The Supervisor shall submit quarterly written reports to the Board, which shall include but not be limited to the number and type of cases reviewed, dental issues discussed and his/her assessment of the Respondent's understanding of the conditions he is treating and his compliance with standards of care, ethical standards and record keeping standards.

E. The Respondent is solely responsible for ensuring that the Supervisor submits the required quarterly reports to the Board in a timely manner.

F. The Board has sole authority to implement any changes in the supervision and retains all authority to approve any changes in the supervision.

G. In the event that the Supervisor discontinues supervising the Respondent for any reason, the Respondent shall immediately notify the Board and submit a replacement candidate to serve as his Supervisor under the terms specified above.

H. The Respondent shall comply with the Maryland Dentistry Act and all laws, statutes and regulations pertaining to the practice of dentistry.

I. The Respondent may file a petition to waive the condition of supervision after two (2) years from the date of this Consent Order. After consideration of the petition, the Board, or a designated committee of the Board, may grant or deny such petition at its sole discretion.

II. Within thirty (30) days of the date of this Consent Order, the Respondent shall pay a fine of **$2,500** to the Maryland Board of Dental Examiners in certified bank check or money order.

III. Within sixty (60) days of the date of this Consent Order, the Respondent shall submit a course syllabus for in-person tutorial courses on the following topics: eight (8) credit hours on dental recordkeeping; and four (4) credit hours on professional ethics, for Board approval. Within four (4) months of the date of this Consent Order, the Respondent shall enroll in and successfully complete the Board-approved courses in dental recordkeeping and professional ethics. The Respondent is solely responsible for promptly providing to the Board verification of his successful completion of the courses upon their completion. These mandated courses under this provision may not be applied toward his license renewal.

IV. The Respondent is subject chart reviews by the Board. The Board, at its discretion, may conduct office visits for the purpose of chart review to ensure that the Respondent is in compliance with the Maryland Dentistry Act and all laws, statutes and regulations pertaining to the practice of dentistry.

V. The Respondent shall comply with the Maryland Dentistry Act and all laws, statutes and regulations pertaining to the practice of dentistry.

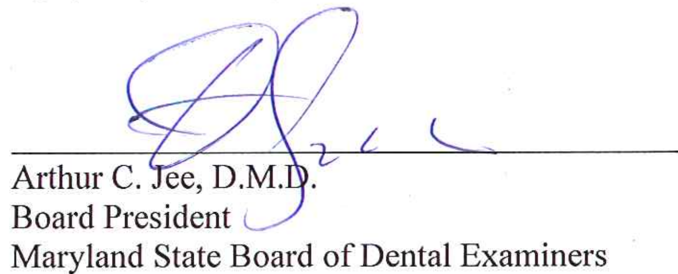
AND IT IS FURTHER ORDERED that at the conclusion of the **THREE (3) YEAR** probationary period, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board. The Respondent may be required to appear before the Board or a committee of the Board to discuss his petition for termination. The Board will grant the petition to terminate the probation if the Respondent has complied with all the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that if the Board determines, after notice and an opportunity for an evidentiary hearing before the Board if there is a genuine dispute as to a material fact or a show cause hearing before the Board if there is no genuine dispute as to a material fact, that the Respondent has failed to comply with any terms or condition of probation or this Consent Order, the Board may reprimand the Respondent, place the Respondent on probation with appropriate terms and conditions, impose a civil monetary fine upon the Respondent, or suspend or revoke the Respondent's license to practice dentistry in Maryland; and it is further

ORDERED that the Respondent is responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that, unless stated otherwise in the order, any time period prescribed in this order begins when the Consent Order goes into effect. The Consent Order goes into effect upon the signature of the Board Chair; and is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions §§ 4-101 *et seq.* (2014).



11/9/18
Date

Arthur C. Jee, D.M.D.
Board President
Maryland State Board of Dental Examiners

CONSENT

I, Devinder K. Gupta, D.D.S., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

8/18/18
Date

Devinder K. Gupta, D.D.S.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Carroll

I HEREBY CERTIFY that on this 18th day of August ______, 2018, before me, a Notary Public of the foregoing State and City/County personally appear Devinder K. Gupta, D.D.S., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Notary Public

My commission expires: 12-19-2020