UNAPPROVED

BOARD OF DENTISTRY

MINUTES
SPECIAL CONFERENCE COMMITTEE "B"

TIME AND PLACE:	Special Conference Committee "B" convened on August 8, 2014 at 9:08 a.m., at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.
FIRST CONFERENCE:	9:08 a.m.
PRESIDING:	Charles E. Gaskins, III, D.D.S.
MEMBERS PRESENT:	John Alexander, D.D.S. Surya P. Dhakar, D.D.S.
MEMBERS ABSENT:	A. Rizkalla, D.D.S.
STAFF PRESENT:	Kelley W. Palmatier, Deputy Executive Director Donna Lee, Discipline Case Manager Tiffany Laney, Adjudication Specialist
QUORUM:	With three members present a quorum was established.
Howard Mendelsohn, D.D.S. **Case No.: 148648**	Dr. Mendelsohn appeared with counsel, W. Benjamin Pace, to discuss the allegations set forth in a Notice of the Board dated December 12, 2013. Also present on behalf of Dr. Mendelsohn was Susan Sanderson, his dental assistant. The Committee received statements from Dr. Mendelsohn, Ms. Sanderson, and Mr. Pace and discussed the allegations with them.
Closed Meeting:	Dr. Alexander moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Howard Mendelsohn. Additionally, Dr. Alexander moved that Ms. Palmatier, Ms. Lee, and Ms. Laney attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.
Reconvene:	Dr. Alexander moved that the Committee certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was

convened. The motion was seconded and passed.

DECISION:
Case No.: 148648

Ms. Laney reported that the Committee found that Dr. Mendelsohn authorized/allowed/directed his dental assistants to independently perform services in violation of Virginia law. Dr. Mendelsohn allowed Individual A, a dental assistant I, to use a slow speed hand piece drill to complete the removal of decay on Patient K's tooth #K prior to placing a filling in that tooth; render a final diagnosis and treatment plan for Patient K, her son, by determining that tooth #K required patching with a resin composite restoration; take a radiograph of Patient K's tooth; use topical anesthetic near tooth #8; and extract tooth #D.

The Committee found that Dr. Mendelsohn permitted a dental assistant I to administer nitrous oxide to patients, a duty that is only delegable to a qualified licensed dental hygienist; and also allowed a dental assistant I to bond and place a retraction cord.

The Committee also found that radiographs showed that Dr. Mendelsohn failed to obturate and seal canals on Patient B's tooth #30; failed to obturate the canals to the apex of Patient F's tooth #30; failed to completely obturate and fill the canal to the apex of Patient G's tooth #22; filled the canal short of the apex on Patient H's tooth #20; perforated the root of Patient J's tooth #24; and he failed to diagnose decay on Patient A's teeth #3, 4, 14, 19 and 20.

Dr. Mendelsohn charged Patient F's account for a two surface resin composite restoration on tooth #21, despite the fact that treatment records do not reflect that this treatment was performed and radiographs do not show that a restoration was placed on Patient F's tooth #21.

Dr. Mendelsohn charged Patient G's account for a resin composite restoration on four surfaces of tooth #18 and a three surface resin on tooth #20, despite the fact that a post-operative radiograph showed that only two surfaces were restored on each tooth. Dr. Mendelsohn charged Patient G's account for a three surface resin composite restoration on tooth #2 and teeth #29 and 31, despite the fact that post-operative radiographs showed that only two surfaces were restored on each tooth.

Dr. Mendelsohn failed to keep controlled substances maintained in his office stored in a securely locked, substantially constructed cabinet; failed to take an inventory of controlled substances that documented the dates the drugs were purchased; failed to take a

biennial inventory of his stock of controlled substances; and failed to maintain records of receipt and distribution of such drugs. Dr. Mendelsohn maintained Valium in his briefcase.

Dr. Mendelsohn failed to maintain Patient G's records and Patient I's records for three years from the most recent date of service, despite the fact that billing ledgers indicated that treatment was provided to both patients in the year 2012.

Dr. Mendelsohn failed to list Patient A's name and Patient E's name on their treatment records for several years. Dr. Mendelsohn failed to obtain an updated health history for Patient A, Patient H, and Patient J, who were seen in his practice on multiple occasions for more than one year.

Dr. Mendelsohn failed to document a diagnosis in the treatment records for Patients A, B, and E that explained the need for the treatment provided to each patient. Dr. Mendelsohn also failed to document in the treatment records for Patients A, B, D, F, G, H, and J the various treatments that he rendered to each patient. Dr. Mendelsohn failed to document the list of drugs prescribed, administered or dispensed and the quantity in treatment records for Patients B, D, E and H. Dr. Mendelsohn failed to maintain duplicate lab work orders for Patients A, C, D, E, I, and J. Dr. Mendelsohn failed to identify himself as the treating provider and, in the notes written by his dental assistant, he failed to review and approve progress notes during various treatment dates in the year 2011 for Patients A, B, C, D, E, H, I, and J.

The sanctions reported by Ms. Laney were that Dr. Mendelsohn shall be issued a reprimand; pay a $5,000.00 monetary penalty; and that within 6 months from the date of entry of the Order he shall successfully complete a 4 hour continuing education course in caries detection; a 7 hour continuing education course in endodontics; and a 7 hour continuing education course in recordkeeping and risk management.

Dr. Dhakar moved to adopt the decision of the Committee. The motion was seconded and passed.

SECOND CONFERENCE: 2:27 p.m.

PRESIDING: Charles E. Gaskins, III, D.D.S.

MEMBERS PRESENT: John Alexander, D.D.S.
Surya P. Dhakar, D.D.S.

MEMBERS ABSENT: A. Rizkalla, D.D.S.

STAFF PRESENT: Kelley W. Palmatier, Deputy Executive Director
Donna Lee, Discipline Case Manager
Corie Wolf, Assistant Attorney General
Gerald Milsky, Adjudication Specialist

QUORUM: With three members present a quorum was established.

William Allen, Jr., D.D.S.
Case No.: 153446

Dr. Allen appeared without counsel to discuss the allegations set forth in a Notice of the Board dated April 28, 2014. Patrice Wunsch, D.D.S., appeared as an expert witness on behalf of the Board. The Committee received additional evidence and statements from Dr. Allen and Dr. Wunsch and discussed the allegations with them.

Closed Meeting:

Dr. Alexander moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of William Allen. Additionally, Dr. Alexander moved that Ms. Palmatier, Ms. Lee, and Mr. Milsky attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene:

Dr. Alexander moved that the Committee certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

DECISION:
Case No.: 153446

Mr. Milsky reported that the Committee found that Dr. Allen administered 136mg of Septocaine (articaine HCL 4% with epinephrine 1:100,000) to Patient A, a child aged three years and nine months, without obtaining an accurate weight so as to assure proper dosing. Based on Patient A's weight of approximately 15.5kg, as determined by the patient's pediatrician the following day, 136 mg of Septocaine was an excessive dose, as Patient A should have received no more than 108.5 mg of Septocaine; the maximum dose as set forth by the Federal Drug Administration, the manufacturer, and the American Academy of Pediatric Dentistry. Immediately following administration of the Septocaine, Patient A experienced a seizure, and Dr. Allen instructed his staff to call 911 and requested emergency medical

services at his office.

The Committee also found that Dr. Allen endangered the well-being of Patient A by his failure or refusal to permit emergency medical personnel responding to the 911 call to examine the patient, and interfered with the emergency medical personnel in their attempts to assess and transport the patient to the local emergency department.

Dr. Allen administered Septocaine to Patient B, a seven year old, on two separate occasions, and failed to document the patient's current weight on each occasion in order to properly calculate the dosage to be administered.

Dr. Allen failed to document or failed to record accurately in treatment records the amount of local anesthetic he administered to Patients A and B.

Dr. Allen failed to have a signed consent for passive/active restraint in place, as provided in the American Academ of Pediatric Dentistry's "Guideline on Protective Stabilization for Pediatric Dental Patients," prior to beginning the procedures for Patients A and B, in which he utilized a PediWrap for "protective stabilization." Dr. Allen's treatment records for Patients A and B include no documentation that he discussed the use of the PediWrap or that he obtained informed consent from Patient A's mother and Patient's B guardian, as required by guidelines.

Dr. Allen's treatment records for Patients A and B failed to contain an updated health history, the name of the dentist, dental hygienist, or dental assistant II providing services; failed to include an accurate record of the actual amount of local anesthetic administered; and failed to document a discussion with the parent or guardian regarding active/passive restraint and an executed consent form.

The Committee further found that Dr. Allen failed to comply with a term of the Board's Order of Summary Restriction entered April 28, 2014, that required him to accurately determine and record the patient's weight and to record the manner in which he utilized this information in computing the maximum safe and appropriate dosage of local anesthetic for each patient.

The sanctions reported by Mr. Milsky were that Dr. Allen shall be issued a reprimand; pay a $5,000.00 monetary penalty; and that his license shall be placed on probation for a period of not

less than 12 months, subject to certain terms and conditions.

Dr. Allen is prohibited from administering or causing to be administered Septocaine to any patient in the Commonwealth of Virginia. Prior to the administration of local anesthetic, Dr. Allen shall be required to accurately determine and record the patient's weight and to record the manner in which he utilized this information in computing the maximum safe and appropriate dosage of local anesthetic for each patient.

Within 6 weeks from the date of entry of the Order, Dr. Allen shall develop and submit to the Board his written emergency medical protocol.

Within 6 months from the date of entry of the Order, Dr. Allen shall complete the Pediatric Advanced Life Support course for healthcare providers; complete 3 hours of continuing education in the subject of dental recordkeeping; complete the Comprehensive Review Course offered by the American Academy of Pediatric Dentistry; and complete the Healthcare Provider CPR course offered by the Virginia Dental Association.

Dr. Allen's dental office shall be the subject of an unannounced inspection, which shall include obtaining a random sample of 5 patient records for review.

Dr. Alexander moved to adopt the decision of the Committee. The motion was seconded and passed.

Approval of Minutes: Upon a motion by Dr. Alexander, the minutes from the Informal Conference conducted on June 20, 2014 were approved.

ADJOURNMENT: With all business concluded, the Committee adjourned at 5:04 p.m.

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Charles E. Gaskins, III, D.D.S., Chair

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Sandra K. Reen, Executive Director

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Date

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Date