

APPROVED

BOARD OF DENTISTRY

MINUTES

SPECIAL CONFERENCE COMMITTEE "C" MEETING

TIME AND PLACE: Special Conference Committee "C" convened on November 17, 2006, at 9:03 a.m. at the Department of Health Professions, 6603 W. Broad Street, Richmond, Virginia.

APPROVAL OF MINUTES: On a properly seconded motion by Dr. Pirok, the Committee approved the Minutes of the Special Conference Committee "C" meeting held on September 29, 2006.

FIRST CONFERENCE: 9:03 a.m.

PRESIDING: James D. Watkins, D.D.S.

MEMBERS PRESENT: Meera A. Gokli, D.D.S.
Darryl J. Pirok, D.D.S.

MEMBERS ABSENT: Misty L. Sissom, R.D.H.

STAFF PRESENT: Patricia L. Larimer, Deputy Executive Director
Cheri Emma-Leigh, Operations Manager
Leigh C. Kiczales, Adjudication Specialist

QUORUM: Three members of the Committee were present.

**William B. Pruden, III,
D.M.D.
Case Nos. 90850, 92769,
102600, 102627, and
104663**

William B. Pruden, III, D.M.D., appeared with counsel, Jeffrey A. Sachs, Esq., to discuss allegations that he may have:

1. violated § 54.1-2706(5) and (11) of the Code, in that, on May 27, 2003, during the course of his treatment of Patient A, he failed to properly treat a distal crack on tooth #18, which required extraction by a subsequent dentist, approximately eight (8) days later;
2. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(3) of the Regulations of the Board of Dentistry, in that, he maintained inadequate records in that dental records for Patient A failed to denote his observation of a distal crack on tooth #18, and are deficient in describing the actual treatment rendered to tooth #18;
3. violated § 54.1-2706(5) and (11) of the Code, and 18 VAC 60-20-15(5) of the Regulations of the Board of Dentistry, in that, he failed to diagnose six (6) teeth that needed replacement fillings and one (1) tooth that needed an occlusal composite during treatment of Patient B on or

- about September 28, 2003, and failed to retain copies of the September 28, 2003, radiographs;
4. violated § 54.1-2706(7) and (9) of the Code, and 18 VAC 60-20-180.F(1) of the Regulations of the Board of Dentistry, in that, his coupon which advertises a "\$59 Dental Check-Up" omits the fact that the discount is not applicable to emergency visits;
 5. violated § 54.1-2706(5) of the Code, in that, he failed to perform an adequate dental examination of Patient C, and did not obtain x-rays of diagnostic quality, on or about June 11, 2004, and as a result, he failed to diagnose an occlusal lingual cavity on tooth #15;
 6. violated § 54.1-2706(5) and (9) of the Code, and 18 VAC 60-20-15.A(2), (3) and (5) of the Regulations of the Board of Dentistry, in that dental records for Patient C did not include an initial health history or a description of the diagnosis and treatment rendered, and failed to maintain the original and/or a copy of Patient C's bitewing films taken on June 11, 2004;
 7. violated § 54.1-2706(5) of the Code, in that, he failed to deliver a properly fitting crown to tooth #14, during treatment of Patient D on or about January 10, 2005;
 8. violation of § 54.1-2706(5) and (9) of the Code, and 18 VAC 60-20-15.A(2) and (3) of the Regulations of the Board of Dentistry, in that dental records for Patient D did not include a health history or a description of the diagnoses;
 9. violated § 54.1-2706(5) and (11) of the Code, in that, on or about July 25, 2005, Patient E presented to his office on an emergency basis, at which time he diagnosed a large area of decay on the distal occlusal side of tooth #31 and recommended the placement of a porcelain/ceramic onlay, which was completed that day. On or about July 28, 2005, Patient E returned to his office, complaining of continued pain in tooth #31, at which time he performed an occlusal adjustment of the tooth. During Patient E's follow-up visit to his office on August 10, 2005, she complained of continued pain in tooth #31; however, he failed to discern that tooth #31 was infected, and proposed that root canal therapy be started that day. On August 11, 2005, Patient E sought the opinion of another dentist, who noted that tooth #31 was "very infected" and had been "drilled so far down that it was close to the pulp." He prescribed an antibiotic and pain

medication for Patient E, and recommended root canal therapy at a later date. By Dr. Pruden's own admission, his initial treatment of tooth #31 "was probably too much for the nerve."

10. violated § 54.1-2706(5) and (11) of the Code, in that on or about January 18, 2005, during the course of treatment of Patient F, he delivered a crown to tooth #29 without first identifying that there was insufficient tooth structure to ensure a successful result. Further the crown on tooth #29 had to be re-seated on May 12, 2005, due to Dr. Pruden's failure to remove an oil layer which is present on new, Cerec crowns;
11. violated § 54.1-2706(9) of the Code and 18 VAC 60-2015 of the Regulations of the Board of Dentistry, in that the dental records for Patient F do not reflect an accurate diagnosis and/or treatment rendered, and there is no entry regarding the delivery of a crown to tooth #29 and there is no entry for the list of drugs administered, dispensed or the quantity used in the treatment of tooth #29;
12. violated § 54.1-2706(5) and (11) of the Code, in that on or about November 29, 2005, during the course of his treatment of Patient G, he failed to identify that tooth #3 had previous root canal treatment, a fractured post, a fractured lingual aspect, and did not have sufficient structure to hold a crown, prior to the delivery of a crown to tooth #3; and
13. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(2) and (4) of the Regulations of the Board of Dentistry, in that the dental records for Patient G do not include an initial health history or a list of drugs administered, dispensed and the quantity used,

Dr. Watkins stated that he knew Dr. Pruden from his association with the Old Dominion Dental Society and he felt he could render an unbiased decision in this case. Dr. Watkins asked Mr. Sachs and Dr. Pruden if they had any objections to him hearing this case. Both Mr. Sachs and Dr. Pruden stated they had no objections.

The Committee received Dr. Pruden's statements and discussed the evidence in the case with him.

The Committee received statements from Patient E.

Closed Meeting:

Dr. Pirok moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of William B. Pruden, III, D.D.S. Additionally, Dr. Pirok moved that Board staff, Patricia Larimer, Cheri Emma-Leigh, and Administrative Proceedings Division staff, Leigh Kiczales, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene:

Dr. Pirok moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision:

Ms. Kiczales reported the Findings of Fact and Conclusions of Law adopted by the Committee. A summary of the Findings of Fact and Conclusions of Law are as follows:

1. Dr. Pruden holds a current Virginia dental license;
2. Adopted as Findings of Fact and Conclusions of Law, allegations #1 and #2 as outlined in the Notice of Informal Conference;
3. Amended and adopted as Finding of Fact and Conclusions of Law, allegation #3 as outlined in the Notice of Informal Conference, as follows: Dr. Pruden violated § 54.1-2706(5) and (11) of the Code and 18 VAC 60-20-15(5) of the Regulations of the Board, in that, on or about September 28, 2003, during his treatment of Patient B, he failed to perform a comprehensive oral evaluation and to diagnose six (6) teeth that needed replacement fillings and that one (1) tooth needed an occlusal composite, subsequently discovered by another dentist through examination and x-ray in October, 2003. Further Dr. Pruden failed to retain copies of the September 28, 2003 radiographs for Patient B;

4. Allegation #4 as outlined in the Notice of Informal Conference was dismissed;
5. Adopted as Finding of Fact and Conclusions of Law, allegations #5 as outlined in the Notice of Informal Conference with the deletion of "perform an adequate dental examination of Patient C, and did not obtain x-rays of diagnostic quality. As a result you failed;"
6. Adopted as Finding of Fact and Conclusions of Law, allegation #6 as outlined in the Notice of Informal Conference with the deletion of § 54.1-2706(5) of the Code, and the deletion of "dental records for Patient C did not include an initial health history of a description of the diagnosis and treatment rendered. Further;"
7. Adopted as Finding of Fact and Conclusions of Law, allegation #7, as outlined in the Notice of Informal Conference;
8. Allegation #8 as outlined in the Notice of Informal Conference was dismissed;
9. Amended and adopted as Finding of Fact and Conclusions of Law, allegation #9 as outlined in the Notice of Informal Conference, as follows: Dr. Pruden violated § 54.1-2706(5) and (11) of the Code, in that on or about July 25, 2005, Patient E presented to his office on an emergency basis, at which time he diagnosed a large area of decay on the distal occlusal side of tooth #31 and recommended the placement of a porcelain/ceramic onlay, when a root canal or extraction was warranted;
10. Adopted as Finding of Fact and Conclusions of Law, allegation #10 as outlined in the Notice of Informal Conference; and
11. Allegations #11, #12, and #13 as outlined in the Notice of Informal Conference were dismissed.

The sanctions reported by Ms. Kiczales were that Dr. Pruden be assessed an \$8,000.00 monetary penalty, be required to complete seven (7) continuing education hours in diagnosis and treatment planning and four (4) continuing education hours in recordkeeping, and be subjected to two unannounced inspections.

Dr. Pirok moved that the Committee adopt the Findings of Fact

and Conclusions of Law, and the sanctions as reported by Ms. Kiczales. The motion was seconded and passed.

As provided by law, this decision shall become a Final Order thirty days after service of such on Dr. Pruden unless a written request to the Board for a formal hearing on the allegations made against him is received from Dr. Pruden. If service of the order is made by mail, three additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of this conference committee shall be vacated.

SECOND CONFERENCE: 1:19 p.m.

PRESIDING: James D. Watkins, D.D.S.

MEMBERS PRESENT: Meera A. Gokli, D.D.S.
Darryl J. Pirok, D.D.S.

MEMBERS ABSENT: Misty L. Sissom, R.D.H.

STAFF PRESENT: Patricia L. Larimer, Deputy Executive Director
Cheri Emma-Leigh, Operations Manager
Cynthia E. Gaines, Adjudication Specialist

QUORUM: Three members of the Committee were present.

**Laura Y. Ki, D.D.S.
Case No. 102941**

Laura Y. Ki, D.D.S., appeared with counsel, Marc A. Brown, Esq., to discuss allegations that she may have:

1. violated § 54.1-2706(5) and (11) of the Code, in that, she failed to properly prepare and seat Patient A's crowns on teeth #7, #8 and #22 in June and July 2003,
2. violated § 54.1-2706(4) of the Code, and 18 VAC 60-20-170(6) of the Regulations of the Board of Dentistry, in that, she charged Patient A's insurance company for the crowns on teeth #7 and #8 on or about June 24, 2003, and by her own admission, the permanent crowns for teeth #7 and #8 were never seated; and
3. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(2) of the Regulations of the Board of Dentistry, in that, she maintained inadequate records, in that she failed to document Patient A's health history in her

dental records.

The Committee received Dr. Ki's statements and discussed the evidence in the case with her.

The Committee received Evelyn Sy's statements on behalf of Dr. Ki.

Closed Meeting:

Dr. Pirok moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Laura Y. Ki, D.D.S. Additionally, Dr. Pirok moved that Board staff, Patricia Larimer, Cheri Emma-Leigh, and Administrative Proceedings Division staff, Cynthia Gaines, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene:

Dr. Pirok moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision:

Ms. Gaines reported the Findings of Fact and Conclusions of Law adopted by the Committee. A summary of the Findings of Fact and Conclusions of Law are as follows:

1. Dr. Ki holds a current Virginia dental license;
2. Allegation #1 as outlined in the Notice of Informal Conference was dismissed;
3. Adopted as Finding of Fact and Conclusions of Law, allegation #2 as outlined in the Notice of Informal Conference; and
4. Adopted as Finding of Fact and Conclusions of Law, allegation #3 as outlined in the Notice of Informal Conference with the addition of the word "updated" inserted in front of health history.

The sanction reported by Ms. Gaines is that Dr. Ki be assessed a monetary penalty of \$1,000.00.

Dr. Pirok moved that the Committee adopt the Findings of Fact and Conclusions of Law, and that no sanctions be imposed as reported by Ms. Gaines. The motion was seconded and passed.

As provided by law, this decision shall become a Final Order thirty days after service of such on Dr. Ki unless a written request to the Board for a formal hearing on the allegations made against her is received from Dr. Ki. If service of the order is made by mail, three additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of this conference committee shall be vacated.

THIRD CONFERENCE:

2: 41 p.m.

PRESIDING:

James D. Watkins, D.D.S.

MEMBERS PRESENT:

Meera A. Gokli, D.D.S.
Darryl J. Pirok, D.D.S.

MEMBERS ABSENT:

Misty L. Sissom, R.D.H.

STAFF PRESENT:

Patricia L. Larimer, Deputy Executive Director
Cheri Emma-Leigh, Operations Manager
Cynthia E. Gaines, Adjudication Specialist

QUORUM:

Three members of the Committee were present.

**Zachary Leiner, D.D.S.
Case Nos. 98768, 98769,
and 98770**

Zachary Leiner, D.D.S., appeared with counsel, Kenneth Hirtz, Esq. to discuss allegations that he may have:

1. violated § 54.1-2706(5), in that, on or about March 22, 2003, he re-cemented a crown onto tooth #20 for Patient A with the knowledge that the condition of the tooth was poor, and his failure to adequately treat tooth #20 at that time caused the adjacent denture to lose the support provided by tooth #20, and the fit of the partial denture to change;

2. violated § 54.1-2706(5) of the Code, in that, by his own admission, his July 19, 2001, and December 19, 2002 radiographs for Patient A were of poor quality and should not be relied upon for making a diagnosis;
3. violated § 54.1-2706(5) of the Code, in that, by his own admission, his May 19, 2003, radiographs for Patient B were of poor quality and should not be relied upon for making a diagnosis;
4. maintained inadequate records, in that, records for Patient A reflect that he may have:
 - a. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(2) of the Regulations of the Board of Dentistry, in that, he failed to maintain an updated health history;
 - b. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(3) of the Regulations of the Board of Dentistry, in that, he failed to adequately document his diagnoses and treatment rendered;
 - c. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(4) of the Regulations of the Board of Dentistry, in that, he failed to maintain an adequate record of controlled substances prescribed, administered, dispensed, and the quantities of such controlled substances;
 - d. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(5) of the Regulations of the Board of Dentistry, in that, he failed to provide evidence to the Board that he maintained radiographs for at least three years;
 - e. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(6) of the Regulations of the Board of Dentistry, in that, he failed to maintain complete financial records;
 - f. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(7) of the Regulations of the Board of Dentistry, in that, he failed to indicate the dentist or dental hygienist providing services for several entries in the patient's chart; and
 - g. violated § 54.1-2706(9) and § 54.1-2719 of the Code, and 18 VAC 60-20-15(8) of the Regulations of the Board of Dentistry, in that, he failed to maintain copies of the laboratory work

- orders for at least three years.
5. maintained inadequate records, in that, records for Patient B reflect that, he may have:
 - a. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(4) of the Regulations of the Board of Dentistry, in that, he failed to maintain an adequate record of controlled substances prescribed, administered, dispensed, and the quantities of such controlled substances;
 - b. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(3) of the Regulations of the Board of Dentistry, in that, he failed to adequately document his diagnoses and treatment rendered;
 - c. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(5) of the Regulations of the Board, in that, he failed to provide evidence to the Board that he maintained radiographs for at least three years;
 - d. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(6) of the Regulations of the Board of Dentistry, in that, he failed to maintain complete financial records;
 - e. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(7) of the Regulations of the Board of Dentistry, in that, he failed to indicate the dentist or dental hygienist providing services for several entries in the patient's chart; and
 - f. violated § 54.1-2706(9) and § 54.1-2719 of the Code, and 18 VAC 60-20-15(8) of the Regulations of the Board of Dentistry, in that, he failed to maintain copies of the laboratory work orders for at least three years.
 6. maintained inadequate records, in that, records for Patient C reflect that he may have:
 - a. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(2) of the Regulations of the Board of Dentistry, in that, he failed to maintain an updated health history;
 - b. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(3) of the Regulations of the Board of Dentistry, in that, he failed to adequately document his diagnoses and treatment rendered;

- c. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(4) of the Regulations of the Board, in that, he failed to maintain an adequate record of controlled substances prescribed, administered, dispensed, and the quantities of such controlled substances;
- d. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(6) of the Regulations of the Board of Dentistry, in that, he failed to maintain complete financial records;
- e. violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-15(7) of the Regulations of the Board of Dentistry, in that, he failed to indicate the dentist or dental hygienist providing services for several entries in the patient's chart; and
- f. violated § 54.1-2706(9) and § 54.1-2719 of the Code, and 18 VAC 60-20-15(8) of the Regulations of the Board of Dentistry, in that, he failed to maintain copies of the laboratory work orders for at least three years;

The Committee received Dr. Leiner's statements and discussed the evidence in the case with him.

Closed Meeting:

Dr. Pirok moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Zachary Leiner, D.D.S. Additionally, Dr. Pirok moved that Board staff, Patricia Larimer, Cheri Emma-Leigh, and Administrative Proceedings Division staff, Cynthia Gaines, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene:

Dr. Pirok moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-

3712(D) of the Code.

Decision:

Ms. Gaines reported the Findings of Fact and Conclusions of Law adopted by the Committee. A summary of the Findings of Fact and Conclusions of Law are as follows:

1. Dr. Leiner holds a current Virginia dental license;
2. Allegations #1, #2, #3, #4a, #4b, and #4c as outlined in the Notice of Informal Conference were dismissed;
3. Adopted as Finding of Fact and Conclusions of Law, allegation #4d as outlined in the Notice of Informal Conference;
4. Allegation #4e as outlined in the Notice of Informal Conference was dismissed;
5. Adopted as Findings of Fact and Conclusions of Law, allegations #4f and 4g as outlined in the Notice of Informal Conference;
6. Allegations #5a, and 5b as outlined in the Notice of Informal Conference were dismissed;
7. Adopted as Finding of Fact and Conclusions of Law, allegation #5c as outlined in the Notice of Informal Conference;
8. Allegation #5d as outlined in the Notice of Informal Conference was dismissed;
9. Adopted as Findings of Fact and Conclusions of Law, allegations #5e and 5f as outlined in the Notice of Informal Conference;
10. Allegations #6a, #6b, #6c, and #6d as outlined in the Notice of Informal Conference were dismissed; and
11. Adopted as Findings of Fact and Conclusions of Law, allegations #6e and #6f as outlined in the Notice of Informal Conference.

The sanctions reported by Ms. Gaines were that Dr. Leiner be required to complete four (4) continuing education hours in recordkeeping and three (3) continuing education hours in risk management, and be subjected to one unannounced records inspection.

Dr. Pirok moved that the Committee adopt the Findings of Fact and Conclusions of Law, and the sanctions as reported by Ms. Gaines. The motion was seconded and passed.

As provided by law, this decision shall become a Final Order thirty days after service of such on Dr. Leiner unless a written request to the Board for a formal hearing on the allegations made against him is received from Dr. Leiner. If service of the order is made by mail, three additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of this conference committee shall be vacated.

ADJOURNMENT:

With all business concluded, the Committee adjourned at 4:04 p.m.

James D. Watkins, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date