SETTLEMENT AGREEMENT BETWEEN MISSOURI DENTAL BOARD AND RUTH C. GOMES, D.M.D.

Come now Ruth C. Gomes, D.M.D. ("Licensee") and the Missouri Dental Board ("Board") and enter into this settlement agreement for the purpose of resolving the question of whether Licensee's license as a dentist will be subject to discipline.

Pursuant to the terms of § 536.060, RSMo[1], the parties hereto waive the right to a hearing by the Administrative Hearing Commission of the State of Missouri ("AHC") regarding cause to discipline the Licensee's license, and, additionally, the right to a disciplinary hearing before the Board under § 621.110, RSMo.

Licensee acknowledges that she understands the various rights and privileges afforded her by law, including the right to a hearing of the charges against her; the right to appear and be represented by legal counsel; the right to have all charges against her proven upon the record by competent and substantial evidence; the right to cross-examine any witnesses appearing at the hearing against her; the right to present evidence on her own behalf at the hearing; the right to a decision upon the record by a fair and impartial administrative hearing commissioner concerning the charges pending against her and, subsequently, the right to a disciplinary hearing before the Board at which time she may present evidence in mitigation of discipline; and the right to recover attorney's fees incurred in defending this action against his license. Being aware of these rights provided her by operation of law, Licensee knowingly and voluntarily waives each and every one of these rights and freely enters into this settlement agreement and agrees to abide by the terms of this document, as they pertain to her.

Licensee acknowledges that she has received a copy of the investigative report and other documents relied upon by the Board in determining there was cause to discipline her license, along with citations to law and/or regulations the Board believes was violated.

For the purpose of settling this dispute, Licensee stipulates that the factual allegations contained in this settlement agreement are true and stipulates with the Board that Licensee's license, numbered 2005038976 is subject to disciplinary action by the Board in accordance with the provisions of Chapters 621 and 332, RSMo.

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[1] All statutory references are to Missouri Revised Statutes 2000, as amended, unless otherwise indicated.

Joint Stipulation of Fact and Conclusions of Law

1. The Missouri Dental Board ("Board") is an agency of the State of Missouri created and established pursuant to § 332.021, RSMo, for the purpose of executing and enforcing the provisions of Chapter 332.

2. Licensee Ruth C. Gomes, D.M.D. ("Licensee") is licensed by the Board as a dentist, License No. 2005038976. Licensee's Missouri license was at all times relevant herein, and is now, current and active.

3. On or about April 2, 2009, the Board received a complaint regarding Licensee from C.B., a former patient of Licensee. C.B.'s complaint contained several allegations against Licensee:

a. The treatment received from Licensee and her staff was "unprofessional and traumatizing."

b. When she had sedation dentistry, Licensee "did not have her license for this."

c. Licensee cut her lip during treatment, "which still has not healed."

d. "She did not return phone calls for several days after C.B.'s procedure."

e. Licensee prescribed Motrin and Tylenol, four every four hours, which "caused me severe stomach problems." I "have a healing ulcer as well as a hiatus hernia."

f. C.B. has seen several specialists and "this has been so stressful for me."

g. C.B. developed "TMD" as a result of her not doing the proper mouth adjustment and occlusion for me. "C.B. had to find a new dentist and pay him to fix her occlusion and other problems."

h. "Licensee charged her for two teeth that were not worked on with the veneers and stated she had done extra work on other teeth so there would be no refund. C.B. had three cavities and a root canal while putting on the veneers. She stated in her complaint the root canal was unexpected and believes it was because of the veneers."

i. When C.B. asked for her records, Licensee stated she would "get back to her but at the time of the complaint, she had not received her records. She obtained some x-rays and patient visit information."

j. C.B. asked for a $12,000 refund for the pain and suffering which Licensee did not respond to.

4. With her complaint, C.B. included copies of letters she wrote to Licensee on July 15, 2008 and November 13, 2008 regarding the care she received. The letters detail all the complaints listed above in paragraph 3 and request a response from Licensee. The documents contain no response.

5. C.B. requested a peer review of Licensee from the Missouri Dental Association (MDA) on December 29, 2008. The request details the complaints listed in paragraph 3 above. The MDA sent Licensee a letter dated February 17, 2009. The letter included a copy of the request for peer reviewed and a release of confidential information. The letter stated that the peer review process was voluntary and the matter would be reviewed only if Licensee agreed to participate. Licensee sent the MDA a letter dated March 10, 2009 declining to participate in peer review. The MDA sent C.B. a letter dated March 16, 2009 stating that Licensee declined to participate and informing her of her right to file a complaint with the Board.

6. On or about November 12, 2009, the Board received a complaint from Dr. Ronald W. Antoine, DDS regarding Licensee. Dr. Antoine's complaint alleged that Licensee's website for her practice, Viva Smiles, was not in compliance with the advertising regulation by advertising cosmetic dentistry, specialty and non-specialty interest areas without the proper disclaimer and by using the word "advanced." Dr. Antoine also states that the website does not contain the name of the licensed dentist, only the telephone number.

7. On or about December 10, 2009, the Board received a complaint from Dr. Robert Waxler, DMD regarding Licensee. Dr. Waxler's complaint alleged that Licensee's advertisement in the yellow pages for herself and Dr. Michael O'Brien was not in compliance with the advertising regulations because it was under the heading "dentist orthodontist" and neither Licensee nor Dr. O'Brien are orthodontists. Additionally, when reviewing the complaint, the Board noted that the advertisement also was non-compliant in that it was advertising cosmetic dentistry, specialty and non-specialty interest areas without the proper disclaimer and by using the word "advanced."

8. The Board conducted an investigation of each of the three complaints from C.B., Antoine and Waxler, against Licensee. The Board's investigation revealed:

a. Board Investigator Joseph Sears (Sears) conducted a sweep of local pharmacies to collect controlled substance profiles on Licensee for all controlled substances authorized from June 1, 2007 through June 16, 2009. Licensee wrote prescriptions for APAP/Codeine, Diazepam, Hydroco/APAP, Oxycod/APAP and Triazolam.

b. On July 21, 2009, Investigator Sears visited Licensee's practice location. Investigator Sears met with Licensee and her office manager, her husband Armando Gomes. Licensee stated the practice consisted of one other dentist who is employed by Licensee, two hygienists and three

dental assistants. Licensee stated that none of the dental assistants are Dental Assistant National Board (DANB) certified or Expanded Function Dental Assistants (EFDA).

c. With regard to C.B.'s complaint, Licensee stated that her case was "weird from the beginning." Licensee stated she was not aware of the billing complaint but understood a man who accompanied her to the appointments was paying for the services. She stated that she did cut her lip because C.B. "has a small mouth." She stated she instructed her staff to go to a neighboring plastic surgery office and request materials to correct the injury. She stated that the material she used "worked so well that there is no visible scar as a result."

d. Licensee stated she did send a complete copy of C.B.'s records to her upon her request.

e. Licensee stated that as to the dosage of Tylenol or Motrin, she "believes that her receptionist" may have given the dosage recommendation and that C.B. may have misunderstood what the receptionist told her. Licensee stated the receptionist was dismissed related to other work issues.

f. Investigator Sears asked Licensee about a particular prescription from Walgreens for twenty .25 mg tablets of Triazolam to L.M. on June 12, 2008. Licensee stated L.M. is an administrative employee and that L.M., in an attempt to save Licensee money, convinced her to write her the Triazolam prescription with which Licensee could supply her controlled substance stock. Licensee stated she was reluctant to do so but was eventually persuaded. She stated she has not done so since that time. Licensee also confirmed that she did not document the Triazolam script to L.M. in L.M.'s patient records or any other record.

g. Licensee stated that she does currently store controlled substances in the office. Licensee gave Investigator Sears permission to conduct a controlled substance audit. Investigator Sears requested all controlled substance records as required by the Missouri Department of Health and Senior Services' Missouri Bureau of Narcotics and Dangerous Drugs (BNDD) and the Drug Enforcement Administration (DEA). Licensee was only able to provide her administration log. She stated she was unaware of the annual and initial inventory requirements. Investigator Sears instructed Licensee to provide the additional records by the end of the week. Licensee showed Investigator Sears the safe where she maintained the controlled substances. The safe

was in her administrator's office, under a desk and directly on the floor. Investigator Sears was easily able to pull the safe from its location into the middle of the room. Licensee opened the safe and allowed Investigator Sears to inventory the controlled substances. In her stock, Licensee had eighty-two .125 mg tablets of Triazolam and eighty-one and one-half .25 mg tablets of Triazolam. Also in the safe was an empty prescription bottle which had contained the prescription L.M. obtained. Licensee stated she had administered all of those tablets.

h. On July 28, 2009, the Board received Licensee's additional records including her annual inventory and patient records. A review of the records revealed:

   i. The only transfer record Licensee provided was a shipping invoice and box content list from Henry Schein for Triazolam in June 2008. The record did not contain the dates the controlled substances were transferred, the name, address and registration number for Henry Schein and the name, address and registration number for Licensee. The record, if correct, did state that Licensee received one hundred .125 mg tablets of Triazolam and one hundred .25 mg tablets of Triazolam. Including the twenty .25 mg. tablets of Triazolam from L.M., Licensee had a total of two hundred twenty tablets of Triazolam in June 2008.

   ii. Licensee did not provide an initial inventory of controlled substances.

   iii. During Investigator Sears' visit, Licensee provided what she stated was her administration log. The document was titled "Prescriptions Report" and contained a list of the controlled substances she administered. The report listed medications administered as dispensed but Licensee confirmed she only administers the medications she has stocked. The administration log does not contain the address of the patient who received the controlled substance or the dosage for of the controlled substance. Additionally, the log indicates that only fifty and one half .25 mg tablets of Triazolam were administered. It does not indicate that any of the .125 mg tablets of Triazolam were administered. However, in comparing that with her shipping invoice and Investigator Sears' inventory, the administration log fails to account for eighteen .125 mg tablets of Triazolam.

iv. On July 27, 2009, Licensee provided two annual inventories for controlled substances. Licensee completed both inventories on July 22, 2009. The first annual inventory listed controlled substances kept in the office on June 18, 2008. The second indicated the amount of controlled substances stocked on July 22, 2009. The second inventory matched Investigator Sears' audit he completed during his visit. In the second inventory, Licensee stated that the total quantity of controlled substances in the practice on June 18, 2008 was 220 tablets of Triazolam. Licensee did not complete the first annual inventory within one year of the previous inventory.

v. Licensee provided five patient records to the Board. Patient 1's record for her May 15, 2008 and May 16, 2008 prescriptions from Licensee for Valium did not contain the strength and dosage form for the Valium. Patient 2's record for her February 3, 2009, February 23, 2009 and March 13, 2009 prescriptions from Licensee for Vicodin did not contain the strength and dosage form for the Vicodin. Patient 3's record for his January 22, 2009 prescription from Licensee for Vicodin did not contain the strength and dosage form for the Vicodin. Patient 3's record for his December 29, 2008, January 26, 2009 and January 29, 2009 prescriptions did not contain the dosage strength for the Vicodin. Patient 4's record did not reference any controlled substance prescriptions but it did reference two tablets of Triazolam Licensee administered. However, Patient 4 filled a prescription from Licensee for 30 7.5-750 mg tablets of Hydroco/APAP on August 8, 2008 and again on August 15, 2008 at Walgreens. Neither prescription was listed in her records. Patient 5's record for her March 9, 2009 prescription from Licensee for 30 tablets of Vicodin did not contain the strength or dosage form for the Vicodin. According to the controlled substance profile collected from Walgreen's, Patient 5's prescription was filled for 60 tablets, not 30 tablets.

i. Based on all of Licensee's records and Investigator Sears' inventory during his visit to Licensee, as of June 18, 2008, Licensee stocked one hundred .125 mg and one hundred twenty .25 mg tablets of Triazolam, totaling two hundred twenty tablets. According to Investigator Sears' audit and Licensee's inventory, which match, Licensee's stock at the time of the investigation was

eighty-two .125 mg and eighty one and one half .25 mg tablets of Triazolam, totaling one hundred sixty three and one half tablets. According to Licensee's administration log, however, Licensee administered fifty and one half .25 mg tablets of Triazolam and no .125 mg tablets. Therefore, Licensee should have sixty nine and one half .25 mg tablets and one hundred .125 mg tablets. However, Licensee has eighty one and one half .25 mg tablets, thirty one more than her administration record. Licensee has eighty two .125 mg tablets, eighteen fewer than her administration log.

j. Neither Licensee nor her employee, Dr. O'Brien have a Conscious Sedation Permit or a Deep Sedation/General Anesthesia Permit. Licensee stated she hopes to provide conscious sedation in the future.

k. On July 27 and 28, 2009, Investigator Sears confirmed that Licensee was not registered with BNDD for her current practice location until February 3, 2009, eight months after she began stocking and administering controlled substances.

l. Licensee has business cards, pamphlets and a website that advertise her business.

    i. Licensee's pamphlet states "Neuromuscular dentist can realign your bite and resolve your TMJ problems."

    ii. Licensee's website states "Vivasmiles is one of the few offices in the St. Louis area with the training to perform the gentle, freeing procedures of neuromuscular dentistry that can help you say goodbye to headache and jaw pain forever!"

    iii. Licensee's business cards, pamphlets and website all state "Advanced Dentistry to Change Your Life," which Licensee stated she copied from the Las Vegas Institute for Advanced Dental Studies.

    iv. Licensee's business cards state "State-of-the Art Dental Center."

    v. Licensee's pamphlets state "State of the Art Dental Center provides you with the utmost in comfort, coupled with the latest advancements in dentistry," "[w]e utilize the latest technologies for a dental experience that is pain-free and delivers optimal results quickly," "[w]e combine state-of-the art technology and artistry in a spa-like setting."

    vi. Licensee's website states:

1. "We focus on providing comprehensive care in a friendly, ultra-modern and comfortable environment truly featuring all the latest technologies in dentistry."
2. "We combine state-of-the-art technology and artistry in a spa-like setting."
3. "Our team is highly trained with many years of experience and is dedicated and passionate about dentistry."
4. "Our ultra-modern newly renovated facilities truly have all the best that modern dentistry has to offer."
5. "VivaSmiles offers a comforting atmosphere of relaxation with beautifully modern treatment rooms, with many VIP amenities so you relax while we rejuvenate your smile."
6. "Advances in technology, materials and techniques have revolutionized dental diagnostics and treatment. We are proud to feature in our state-of-the-art dental center the latest technologies that dentistry has to offer to maintain the best possible oral health for our patients."
7. "Treatment is then carried out using the latest techniques and technology available. Your comfort is of paramount importance to us and we provide many spa amenities. We work hard to make every treatment pain free, and we have methods and technology to ease discomfort."
8. "Dr. Gomes continues to undergo specialized training to provide VivaSmiles patients with the latest techniques which can legitimately make a claim to be pain free, with proven, dramatic results."
9. "VivaSmiles is equipped to handle most of your dental needs, from routine cleanings and fillings to the most advanced treatments in modern dentistry including dental implants, orthodontics, smile makeovers, and headache/jaw pain treatments."

vii. According to Board records, neither Licensee nor any other dentists in her practice at the time of this investigation were specialists. However, Licensee's pamphlets state that Licensee "holds a doctor of DDS and an international degree in Ortho."

Additionally, the website states that "VivaSmiles isn't just your regular orthodontist," and Licensee "holds a Doctor of Dental Surgery (D.D.S) degree and an international specialization degree in Orthodontics." Licensee's website does contain the disclaimer: "Dr. Gomes practices General Dentistry and is not an Orthodontist, although she has an international Orthodontics degree (two year full-time program.)"

viii. Licensee's business cards state "General & Aesthetic Dentistry" but contain no disclaimer. Licensee's website states "pain-free dentistry" with no disclaimer. Licensee's pamphlets state, with regard to her employee dentist "restorative dentistry" but contain no disclaimer. The business cards, pamphlets and website contain no disclaimer about specialties not recognized by the ADA.

ix. Neither Licensee nor her employee dentist possesses a deep sedation/general anesthesia permit or a conscious sedation permit. However, Licensee's website states: "methods and technology to ease your pain: sleep or oral sedation: You simply take a pill just prior to your appointment. You're still awake, but in a blissful and deeply relax state throughout," and "It's easy to turn any dental appointment into a pleasant dream – almost! We now have the ability to help you deeply relax during your dental appointment. If you're especially fearful, have a strong gag reflex or a low pain threshold, talk to us! With oral sedation, you simply take a pill just prior to your appointment. You will still be awake, but in a blissful state. Keep in mind; you will need someone to drive you to and from our office."

x. Licensee's website and pamphlet both state "[w]e look beyond just the teeth and gums, treating the whole patient, comprehensively."

m. Licensee confirmed that the practice does provide nitrous oxide. She confirmed that she will allow her dental assistants to watch patients receiving nitrous oxide while she steps out of the room for various reasons but is otherwise in the room. She stated her dental assistants did not have nitrous oxide permits.

n. In further reviewing Patient 4's records, Patient 4's record indicates, in several places, that Patient 4 was either alone during the administration of nitrous oxide, or just with a member of Licensee's staff. The following notations were made in Patient 4's chart:

   i. Referring to Licensee in the third person, "Joanna and I set it up for her."

   ii. "She was talking with the friend, the Hyg had come up to the front desk."

   iii. Hygienist Joanna Heinemann wrote that she left Patient 4 to retrieve Patient 4's boyfriend. She then wrote that she left Patient 4 and her boyfriend while Patient 4 was receiving nitrous oxide. She wrote that she returned to tell Patient 4 not to talk because that would waste the gas. Finally, she stated that "Linda" (a member of the staff) went to Patient 4 and also told her not to talk because it wasted the gas.

   iv. Heinemann wrote "Tried 3 times to numb, kept saying she wasn't ready. Finally Licensee was able to annex pt w/nitrous oxide."

   v. Heinemann wrote she asked "Tom", Licensee's assistant whether she could remove TENS system connected to Patient 4 or whether Licensee needed to remove it. According to her note, "Tom" told Heinemann that she could remove it herself. The note does not reflect whether either "Tom" or Heinemann consulted Licensee.

o. During his visit to Licensee's practice, Investigator Sears determined that neither Licensee's, nor Dr. O'Brien's, nor the hygienists' licenses were displayed in the office. Licensee's staff stated it was because the licenses were not aesthetically pleasing.

p. Licensee did complete her required 50 hours of continuing education for the period December 1, 2006 through November 30, 2008. However, Licensee did not complete the correct basic life support (BLS) or advanced cardiac life support (ACLS) certification course. Licensee stated she was aware she did not complete the correct course and would correct that as soon as possible. As of August 19, 2009, Licensee had not provided a new BLS or ALCS certification record. On Licensee's 2008-2010 renewal application, Licensee attested that she had current certification in either BLS or ACLS.

9. On October 29, 2009, Investigator Sears again visited Licensee's practice. Licensee informed Investigator Sears that neither of the hygienists were in the office that day. Additionally, she stated one, Lori Coates, was no longer employed by the practice.

10. On November 3, 2009, Investigator Sears spoke with Lori Coats, RDH, by telephone. She stated she had been a hygienist for Licensee for one to two months prior to when she quit in August 2009. She stated she stopped working for her due to personality conflicts with other staff members, but not Licensee. She stated she works for another licensed dentist at this time. She stated she currently holds permits in both local anesthesia and nitrous oxide. She stated when she worked for Licensee, she did basic hygiene work including repertories, adult prophys, root planning, scaling, applied local anesthesia, x-rays, oral hygiene instructions and applied fluoride. She stated she did not take impressions, chair side assist, apply sealants, call in prescriptions, assist with the administration of nitrous oxide, administer sedation medications, review x-rays with patients, diagnose, or work with orthodontia patients. She stated she would only see patients when Licensee was in the office and after Licensee had seen them.

11. On November 4, 2009, Investigator Sears spoke with Joanna Heinemann, RDH by telephone. She stated she is currently Licensee's hygienist and has been since September 2008. She stated she holds an Illinois hygiene license and planned to complete a Missouri course on nitrous oxide administration in November 2009. Ms. Heinemann stated that her job duties include taking x-rays, child and adult prophys, perio root planning, taking impressions for bleaching trays, providing oral hygiene instructions, oral health screenings and applying fluoride. She stated she will review x-rays with patients and point out areas of concern to discuss with Licensee. She stated she does not chair side assist, apply dental sealants, call in prescriptions, administer medications, diagnose or assist with orthodontia work. She stated that regarding Licensee's use of nitrous oxide, Licensee does provide nitrous oxide and can receive it when they meet with the hygienist. She stated that they can receive it during scaling and root planning. She said either she or one of the assistant will set up the nitrous equipment in the room, the patient is seated and Licensee will begin administering the nitrous. She stated that she completes her work on the patient without Licensee in the room and it can be several minutes before Licensee returns to the room. She confirmed it could be just her and the patient during nitrous administration. She stated that she will see all of Licensee's new patients first. She stated she will chart their medical history, make patient notes and conduct prophys if she feels she can proceed. She stated that after

she is finished, Licensee will see the patient. She stated she will see a patient of record if Licensee is not in the office but only do prophys.

12. On July 22, 2010, Licensee attended the Board's scheduled meeting regarding the three complaints and investigation. During her appearance, Licensee stated:

a. As to C.B.'s complaint, Licensee stated that the allegations were "completely unfounded." She stated she was aware she could perform minimal sedation in Missouri and that is what she used with C.B., .25 or .50 [mg] of Triazolam. As to the charges, Licensee stated that she did not overcharge. She wrote off nearly $8,000 in charges. She stated as to cutting C.B.'s lip, it was "an accident" when C.B. closed her mouth unexpectedly. She stated it was a small cut on the inside of her lip. She stated "since we have a very high quality, nice practice" Licensee had her treatment coordinator speak with a plastic surgeon whose practice was in the same building. He provided glue to fix the cut. Licensee stated she informed C.B. after she was not under anesthesia of the cut.

b. With regard to C.B.'s treatment history, Licensee stated that she talked with C.B. about her medical history and C.B. did not disclose the ulcers she referenced in her complaint. Licensee stated that her medical history was "within normal."

c. With regard to her standard sedation treatment, Licensee stated that she gives a single dose, "most of the time Triazolam, .25 or .50, depends on the weight of the patient. Just one time. This is just to calm them down. They will be aware of everything. I give them the day before diazepam ... five to ten milligrams." Licensee stated she uses a pulse oximeter and an automatic blood pressure machine. She stated the blood pressure is taken constantly during the procedure.

d. She stated that she treats TMJ but that C.B. never complained of any symptoms of TMJ prior to treatment. She stated C.B. did complain some about discomfort and then inquired of prescription pain killers including Vicodin. She stated she advised Motrin or Tylenol. C.B. wanted to have work done on the lowers despite the discomfort of the uppers. She stated she informed her she would not do the lowers at the time and placed her in a splint. She stated she

advised treating the TMJ before completing the lowers. She stated C.B. went to another dentist after that.

e. She stated her then office manager L.M. ordered Triazolam for her, as a favor, and paid for the drugs herself. She stated that she placed the drugs in the safe with all the other drugs. She stated she did so because she was familiar with the practice. She stated she was not reimbursed for the prescriptions though she informed Ms. Moore not to make the purchase again.

f. With regard to the missing 18 tablets of Triazolam, Licensee stated she was not in a position to state Investigator Sears' count of the drugs was wrong but she was not present when he counted. She stated there are differences in the bookkeeping since his initial count and she "would not think that that thing could happen again."

g. With regard to administration of nitrous oxide, Licensee stated an assistant and hygienist "they were trained with nitrous oxide, they have a lot of experience." Licensee stated that she allowed them to administer nitrous oxide before they had a permit in Missouri. She stated she was present the whole time when it was being administered. She stated when she learned they needed to have a permit, she required them to do so.

h. Licensee denied that a hygienist would perform services on a new patient prior to her seeing the patient. She stated she was unaware of it if it occurred.

i. She admitted that the complaints regarding her advertising had merit and that her advertising was in error. She stated she would make all changes to her advertising that the Board suggested. She stated she is an orthodontist in Brazil and did more than 2,500 hours of orthodontics. She stated she is also a member of the International Orthodontist Association.

j. Counsel for Licensee stated many of the changes in the advertising had already taken place.

k. Licensee stated she is obtaining her sedation permit to help better serve her patients.

l. Licensee was unaware the Board had another complaint against her. She stated "maybe because we are growing too fast."

m. She stated that "I always start the nitrous" and stated that she is always in the practice when it is being used.

n. She stated she does not probe every patient during an examination and only records the probe if she finds more than three pockets.

o. She stated that "I don't want to – to break any rules. I want to comply with anything that the board asks me to do. And if I did, I immediately change. I'm willing to change whatever I'm not doing right. And I mean, I don't have any problem. I – I – I don't want to break any rules. If I can, I did my best to fix them and I'm – I will try my best to comply with all the regulations."

13. On or about December 10, 2010, the Board received a complaint regarding Licensee from F.R. F.R. stated that Licensee's advertisement and resume led her to believe that Licensee was a specialist in orthodontics. F.R. obtained a brochure from Licensee's office entitled "Why Neuromuscular Orthodontics?" and read on a brochure that Licensee "holds a Doctor of Dental Surgery Degree and an international specialization in orthodontics." F.R. stated that had she known Licensee was not a specialist, she never would have gone to her. F.R. alleged that during her consultation at Licensee's dental practice, a staff member, "Nikki" recommended to her that she get an orthotic which cost $5,200 and later when Licensee came in and examined her teeth, Licensee stated that F.R. definitely had TMJ. F.R. also alleged that while another staff member, "Joanna" was cleaning her teeth, she showed F.R. a television screen and told her that she had five leaking cavities that needed to be redone. F.R. stated that another staff person, "Amber" worked on her orthotic because it was cutting her cheek but that on that visit she did not get to see Licensee. F.R. stated that she was told prior to agreeing to do the orthotic procedure that if she quit before the procedure was completed, she would get her money back. Nikki told her she could get money back but it would be prorated. After F.R. stopped the procedure, she received only $576 back. F.R. also paid Licensee $636.10 for the replacement fillings. With regard to the cavities that Licensee's staff stated needed to be replaced, F.R.'s subsequent treating dentist stated that they did not need to be replaced.

14. The Board conducted an investigation into F.R.'s complaint. On February 17, 2012, Board Investigator Kevin Davidson visited Licensee's practice location at 141 North Meramec, Suite 217. Licensee stated that she owned the dental practice but the office was managed by her estranged husband Armando. She stated she employed two dental assistants, both of whom were expanded function dental assistants in prosthodontics and orthodontics. She stated they were not employed at the time of the complaints. She stated she had one dental hygienist, Joanna Probst, who was not employed at the time of the complaints either. She

stated there were two other dentists employed at the practice, Dr. Dennis O'Brien and Dr. Genevieve Lange. She stated there were six operatories at the practice, two of which she used. She stated there was a separate room for TMJ patients and one hygiene room. She stated Drs. O'Brien and Lange were only at the practice once a week and they used the other operatories based on scheduled. She stated her husband was the office manager and IT person so he handled all the computer "stuff." She stated that as a result of her husband handling the computer, there were complaints about her advertising and information on the website which, she said, should have been corrected. Licensee's attorney stated that the website had been taken down and since that time Armando was not involved in the business. With regard to F.R.'s complaint, Licensee stated that when F.R. came to the practice, Armando was still handling the website. She stated that she remembered that F.R. needed treatment for TMJ and recommended an orthotic. She stated that Nikki only relayed Licensee's recommendation, Nikki did not make it. Licensee stated that Nikki was Nicole Bean, one of her treatment coordinators. She stated a treatment coordinator was a person who is assigned to a patient and knows all about them. She stated that the person is present at appointments and takes notes about treatment. She stated the person also helps the patient with financing and follows up with the patient after treatment because the treatment coordinator has all the information about the patients. Investigator Davidson asked Licensee why F.R. would state that she had never seen Licensee, only Nikki who had presented the idea of the orthotic to her. Licensee stated she would have had to examine the patient prior to making any recommendation. She stated the treatment coordinator was not allowed to diagnose patients and if Nikki told F.R. anything otherwise, Licensee was not aware. Licensee stated that F.R. agreed to the treatment with the orthotic. Licensee stated that she normally gave her TMJ patients muscle relaxers before the placement of the orthotic because "they are usually grinders and clinchers." She stated that the orthotic was made on April 20, 2010. Licensee stated that F.R. began complaining about the orthotic immediately. Licensee stated that she again informed F.R. that it was a fixed orthotic and went over her teeth so it wasn't going to be like there was nothing in her mouth. Licensee stated she told F.R. that it would be noticeable. Licensee also stated she had told F.R. all that prior to fitting the orthotic. Licensee stated that F.R. called the office the next day and stated that the orthotic made her bit her right cheek and it was difficult to chew without biting her jaw. Licensee stated that expanded function dental assistant Amber Reichling saw F.R. and made adjustments to the orthotic with a low-speed hand piece to smooth the edges. Licensee stated she did not see F.R. that day. Licensee stated that on F.R.'s next

appointment, F.R. decided to stop treatment because of how the orthotic made her look and how difficult it was to eat. Licensee stated it did not take 4-5 hours to remove the orthotic as F.R. stated in her complaint. Licensee stated she did not see F.R. as a patient after that. Licensee stated that while she did not refer to herself as an orthodontist, there were things on the website at that time that "could be construed that way." Licensee and her attorney stated it had been remedied. Licensee stated that treatment coordinator Nikki told F.R. that Licensee was an orthodontist "in her country" and an "international orthodontist" but did not state she was a Missouri board certified orthodontist.

15. On or about November 10, 2010, the Board received a complaint regarding Licensee from C.L., a former employee of Licensee. C.L. alleged that between October 4-6, 2010, Licensee did not come into the office and requested that her patients for October 4 and 5 be cancelled but for October 6, she informed treatment manager Damien Parks not to cancel the consults but for him to see those patients. C.L. stated that Parks is not a dentist or dental hygienist but did see the patients and provided prices and what treatment would entail without Licensee being present. C.L. stated that Parks saw two patients on that day, S.F. and T.H. C.L. stated that if Parks entered any treatment on their patient records, it was later deleted and the notes just show that Parks spoke with them. The only dentist present at the time was Dr. O'Brien who had no experience with TMJ or smile makeovers.

16. As a result of C.L.'s complaint, the Board conducted an investigation into the complaint. Investigator Davidson also spoke with Licensee about C.L.'s complaint when he visited Licensee's practice on February 17, 2012. With regard to C.L.'s complaint, Licensee stated that C.L. was employed by her practice as a dental assistant and mainly worked for Dr. O'Brien. Licensee stated she also worked for her estranged husband Armando ordering supplies. Licensee stated she thought C.L. only worked there for about five months. Licensee stated C.L. was terminated because she "didn't want to do anything." Licensee stated that C.L. was lazy and the other dental assistants complaint about her because they had to do her work. Licensee stated that because she did not work with C.L. much, she did not know her that well. Licensee stated that Armando terminated her. Licensee stated that she did not recall the day of the allegations in the complaint. Licensee stated she was going through marital problems about that time and she had closed the office for several days when Armando "cleaned out the bank account and she didn't have any money to operate or pay staff." She stated that because Armando took care of the computer system, she did not have access to records. Licensee

stated that Damien Parks was a treatment coordinator. She stated that he would not have been able to give a patient information because he "could not have accessed their files." Licensee stated she would provide a copy of the patient schedule for October 6. Licensee did not provide the schedule to the Board.

17. On or about October 26, 2011, the Board received a complaint regarding Licensee from L.M. L.M. stated that he and his attorney had made several requests for a copy of his complete patient record but Licensee only released "a few documents."

18. As a result of L.M.'s complaint, the Board conducted an investigation. On January 6, 2012, the Board forwarded Licensee a copy of L.M.'s complaint and requested a response to the complaint as well as a complete copy of L.M.'s patient record, x-rays, a certification of records signed and dated by Licensee and other information helpful to the case. The Board received a letter dated January 11, 2012. The letter stated "enclosed please find the necessary information/records regarding [L.M.]. You will also find enclosed documentation/responses to an attorney and an insurance company from an earlier date." Licensee's January 11, 2012 letter also stated that L.M. needed extensive dental work and "all work was completed." Licensee also stated "I always conduct myself as a professional and feel excellent work was completed on [L.M.] with an excellent outcome." The Board also received Licensee's signed Certification of Records on January 31, 2012. However, the response and records contained no x-rays or photos which L.M.'s record identified. The Board called and spoke with Jeana at Licensee's office on February 2, 2012. Jeana stated that there were images and she would download them Monday, February 6 and send them. Licensee's notes also reflected that a Dr. Raska treated L.M. The records also included a September 21, 2011 request made by L.M. to Licensee to release all his records to himself at his home address as well as to release them to the law firm of Ward Hollingshead in Washington, Missouri. The records also included a September 27, 2011 request made by L.M. to Licensee to release all his records to himself at his home address. Next, the records included an October 20, 2011 letter from Jeremy D. Hollingshead, the attorney for L.M. stating that Ward Hollingshead had been retained by L.M. to represent him for injuries and damages as a result of Licensee's dental work. The letter also stated that Licensee should forward the letter to her insurance carrier. Also included was a November 2, 2011 letter from Licensee to Jeremy Hollingshead which included "[L.M.]'s patient ledger from January 11, 2009 through October 6, 2011." The letter also stated that "there were no injuries and no damages and all visits and procedures are documented and treatment is signed and/or initialed by [L.M.]" The records also included a

November 30, 2011 letter from Licensee to Shasta Administrative Services for JELD-WEN Inc regarding L.M. The letter stated "with regard to your enclosed notice, please find information concerning the above referenced patient. Please note there is no ill fitting or poorly made neuromuscular dentures, [L.M.] liked the look of his old dentures better[.]" The records also contained a December 21, 2011 letter from Shasta Administrative Services. The letter was a claim overpayment second request, the first request having been issued November 18, 2011. The letter stated that L.M. filed a claim related to ill fitting/poorly made neuromuscular dentures and requesting that Licensee repay $1500 to JELD-WEN Inc. for the claim. The records finally contained a January 3, 2012 letter from Licensee to Shasta Administrative Services denying to make the overpayment. The letter stated that there were not ill fitting or poorly made dentures for L.M. It also stated that there was no overpayment "after reviewing our files. All services were rendered as you can see by the enclosed copy of [L.M.'s] patient ledger." Further, the letter from Licensee stated that L.M. informed her that he did not like the "look" of his old dentures but did not indicate they were ill fitting or poorly made because "they are not." She stated in the letter that L.M. just liked his old dentures better and she informed him he would receive no refund for that. On February 2, 2012, the Board sent correspondence to Dr. Raska's office requesting copies of L.M.'s records. The Board also telephoned Licensee's office on that date requesting the x-rays and photos. On February 9, 2012, the Board received the x-rays from Licensee's office. However, the x-rays were not of readable quality and the photographs referenced in the patient record were not included. The Board contacted Licensee's office again and her office manager stated she would talk to Licensee but that they had been having trouble getting the x-rays off the ICat machine. The office manager stated she would email them to the Board. The Board received the email on March 8, 2012. Additionally, on February 9, 2012, Dr. Raska contacted the Board and stated that he did not have L.M.'s records because he was working for Licensee at the time so his notes should be in her patient record. He stated he performed an upper left sinus lift on L.M. and Licensee performed it on the right side. The Board received no additional records from Licensee.

19. On or about March 17, 2010, the Board received a complaint regarding Licensee from J.M. J.M. stated that Licensee's "consultation coordinator" Linda Miller, also a dental hygienist, advised J.M. that he needed a full mouth extraction with full denture implants and determined the cost. J.M. also alleged that Miller stated that Licensee would honor the package he and Miller agreed upon which was for $17,000. J.M. stated he immediately made a down payment of $5,000. J.M. stated that Licensee's staff merely informed him he would

need someone to bring him to the appointment and pick him up. Nothing was in writing and no one stated he would need overnight monitoring. He stated that on September 2, 2009, he arrived at Licensee's practice for the full mouth extraction and denture implants and was told it would be completed that day. The first dose of Novocain and Diazepam were given to J.M. at 9:30 a.m. J.M. also alleged that several hours into the procedure, Licensee administered additional Novocain injections and a second dose of Diazepam. At 5:30 p.m., staff told J.M. that they had called his ride which would be there at about 6:00 p.m. J.M. was not informed that all the implants were not in place but after eight and a half hours in the chair, J.M. stated he was ready to leave. J.M. stated he repeatedly asked to talk to Licensee because more than thirty minutes had passed since his ride was supposed to be there. Licensee's staff repeatedly told J.M. she would talk to him "in just a minute." J.M. stated that after an hour and a half with no explanation, J.M. stated that his ride was supposed to have arrived forty-five minutes ago, that he had not eaten in 32 hours and had not had water in 12 hours. J.M. stated that if no one could explain why he was still there, he would leave. J.M. stated the staff gave him a bottle of water which he poured down his shirt since the Novocain had not yet worn off. One of Licensee's assistants gave him a surgical shirt to put on but J.M. stated that Licensee would not let him walk through the waiting room in it so he took it off and walked through without a shirt. He stated that Licensee then called the police. J.M. stated that Licensee informed the police he was impaired and should be detained. J.M. stated that the police arrived and that he was not the one who was crazy. J.M. stated that Licensee called him screaming on September 3, 2009 and asking if he was bipolar. J.M. stated Licensee told him that he needed a psychiatric evaluation before she would work on him again. She denied giving the second dose of Diazepam. However, Licensee's assistant Tom did admit to administering the Diazepam to J.M. According to J.M., Tom stated "I just administer it, I didn't prescribe it." He stated that Licensee contacted his personal physician to inquire about his mental health. J.M. stated that Licensee will not complete the work and only provided him with ill fitting temporary dentures. J.M. stated that he saw another dentist, Dr. Kirk Quigless in September. He stated Dr. Quigless offered to contact Licensee to try and work something out. Dr. Quigless informed J.M. that Licensee would not continue his work but would give him a full refund. J.M. stated that when he contacted Licensee's office, Tom stated Licensee would not give a refund and would have "never said she would." J.M. stated he never got to speak to Linda Miller again because Tom told him she no longer worked there. J.M. stated that Licensee sold him temporary dentures with a "grossly mis-matched bite" and the bottom denture will not stay in to talk or eat. J.M. stated he

cannot eat normally or everyday foods. He stated he did not imagine he would end up toothless five months later. He stated that Clear Choice dental offered to correct and finish the work for $60,000 and Dr. Kent Splaingard would do the work correctly for $20,000 if he can use the implants Licensee put in. J.M. stated that Dr. Splaingard stated he had good bones and there was no reason to remove his front teeth. He stated Dr. Splaingard would at least give him something he could eat in but it could cost more than $20,000. J.M. stated Dr. Splaingard had difficulty in getting his records from Licensee who gave reasons including her fax machine was broken, Dr. Splaingard's was broken, they did not get the request, there was no return address on the request and J.M. had to come pick them up personally.

20. As a result of J.M.'s complaint, the Board initiated an investigation. During his February 17, 2012 visit to Licensee's practice, Investigator Davidson also spoke with Licensee about J.M.'s complaint. Licensee stated that she remembered J.M. well. She stated that Linda Miller was a patient care coordinator who no longer worked there. She stated that it was J.M. who wanted the full mouth extraction even though Licensee told him they could save his teeth. Licensee stated J.M. requested moderate sedation because he was nervous. Licensee stated she told him he would need someone to drive him to and from the appointment and he stated his neighbor would do so. Licensee stated that J.M. received instructions for the day of the procedure and one was to not take any other medications before coming to the appointment because he would be given prescription medications when he arrived. Licensee stated that she was not aware at the time, but apparently J.M. had taken Xanax before he arrived. Licensee stated that when asked J.M. stated he'd had no medications or anything to eat or drink. Licensee stated she sedated him with Hydroxyzine and Lorazepam. She stated she did the full mouth extraction, placed a total of eight implants – six upper and two lower – and placed the immediate dentures. She stated that after she placed immediate dentures, she likes to give the patient a little something to eat to see how the dentures do. She stated that she gave J.M. something to eat and then he asked to use the restroom. Licensee stated they called his ride and when she arrived, Licensee stated her staff started giving her directions about how to care for J.M. The neighbor stated she was only a neighbor and could not watch him. Licensee stated she started trying to call family members to see if someone could come get him and stay with him. She stated no one was available to come and "it was like none of the family wanted to help him." She stated J.M. was getting agitated because it was taking so long and he didn't understand why he could not just go home. Licensee stated that when she tried to tell J.M. that someone

needed to watch him, J.M. became violent, took off his shirt and threw it at her. Licensee stated she went to call his regular doctor who allegedly informed Licensee that he has tried to help him but J.M. does not come to his appointments. Licensee stated she asked Tom, her treatment coordinator, to call 911 because when she tried to dial it, the telephone did not work. While they were waiting for the police, Licensee stated that J.M. told her receptionist that he had taken two Xanax before his appointment. Licensee stated the police removed J.M. but she did not know what they did with him. Licensee stated that she did not give J.M. any Diazepam, she gave Lorazepam, and that no one else gave a second dose either as she was the only one who could get medications out of the safe. She stated that she would not treat J.M. without a release from his doctor and that J.M. had called stating he was going to sue her.

21. On or about June 14, 2010, the Board received an application for a deep sedation/general anesthesia (DSGA) site certificate from Licensee. On June 17, 2010, the Board also received an application for enteral conscious sedation permit from Licensee. On June 22, 2010, Board Investigator Joseph Sears travelled to Licensee's practice to conduct a site inspection for the permit as well as an infection control inspection. Investigator Sears identified two violations: the hygienists' forearms were not covered as required by the Centers for Disease Control regulations and the spore testing was not being performed weekly, it was allegedly being performed monthly. However, in reviewing the records, Investigator Sears determined that spore testing of the practice's autoclave had only been done three times since November 16, 2009. Investigator Sears directed Licensee to correct the violations. Licensee provided the Board records stating she had corrected the violations.

22. During Investigator Davidson's February 12, 2012 visit to Licensee's practice, he conducted an infection control inspection. Investigator Davidson noticed that the previous report showed that her staff did not wear forearm coverings and that there was a lack of evidence related to the autoclave spore testing. Investigator Davidson's inspection report stated Licensee was going to find out why that happened. Licensee stated that she recalled the previous inspection and instruction on weekly autoclave testing. She stated that the violation had been corrected. Investigator Davidson then conducted the infection control inspection. In reviewing the records, Investigator Davidson noted that they had been done weekly from June 2010 when Investigator Sears inspected until November 14, 2011 at which time the testing was performed every two weeks. She stated she did not know who was doing the testing now but would find out.

23. Section 332.052, RSMo states, in relevant part:

> 1. Dentists shall maintain an adequate and complete patient record for each patient and may maintain electronic records provided the record-keeping format is capable of being printed for review by the board.

24. Section 332.181(3), RSMo states, in relevant part:

> 3. All persons once licensed to practice dentistry in Missouri shall renew his or her license to practice dentistry in Missouri on or before the license renewal date and shall display his or her license for each current licensing period in the office in which he or she practices.

25. Regulation 19 CSR 30-1.048 states, in relevant part:

> (2) Each individual practitioner shall maintain a record of the date, full name and address of the patient, the drug name, strength, dosage form and quantity for all controlled substances prescribed or administered. This record may be maintained in the patient's medical record. When the controlled substance record is maintained in the patient's medical record and the practitioner is not the custodian of the medical record, the practitioner shall make the controlled substance record available as required in 19 CSR 30-1.041 and 19 CSR 30-1.044.
>
> ...
>
> (4) A registrant who transfers a controlled substance to or receives a controlled substance from another registrant shall maintain a written record of the transfer which contains the following information: the date of transfer, drug name, strength, dosage form, quantity, name, address and registration number of the transferring registrant and the name, address and registration number of the receiving registrant.
>
> ...
>
> (6) A prescription may not be issued for an individual practitioner to obtain controlled substances for dispensing or administering to patients.

26. Regulation 19 CSR 30-1.041 states in relevant part:

> (1) Persons Required to Keep Records.
>
> ...
>
> (B) Required individual practitioners and institutional practitioners are required to keep records with respect to controlled substances which are prescribed, administered or dispensed.

27. Regulation 19 CSR 30-1.034 states in relevant part:

> (1) Physical Security.
>
> (A) Controlled substances listed in Schedules I and II shall be stored in a securely locked, substantially constructed cabinet.

(B) Controlled substances listed in Schedules III, IV and V shall be stored in a securely locked, substantially constructed cabinet. However, pharmacies may disperse these substances throughout the stock of noncontrolled substances in such a manner as to obstruct the theft or diversion of the controlled substances.

28. Regulation 19 CSR 30-1.042 states, in relevant part:

(2) Initial Inventory Date.

(A) Every person required to keep records who is registered with the Department of Health after May 1, 1971, and who was not registered previously shall take an inventory of all stocks of controlled substances on hand on the date s/he first engages in the manufacture, distribution or dispensing of controlled substances.

...

(3) Annual Inventory Date. After the initial inventory is taken, the registrant shall take a new inventory of all stocks of controlled substances on hand at least once a year. The annual inventory may be taken on any date that is within one year of the previous annual inventory.

29. Regulation 20 CSR 2110-2.110 states, in relevant part:

(7) Any announcement or advertisement of services by a dentist implying specialty areas which are not recognized by the American Dental Association (ADA) must include a disclaimer. Specialty areas not recognized by the ADA include, but are not limited to: cosmetic dentistry, implantology, implant dentist and temporomandibular joint (TMJ) therapy. These or other terms which imply a specialty area not recognized by the ADA must be accompanied by a disclaimer that is clearly legible with print equal to or larger than the announcement of services, and clearly audible with speech volume and pace equal to the announcement of services. The disclaimer shall state: "(list specialty areas not recognized by the ADA) (is/are) specialty area(s) not recognized by the ADA that requires no specific education training to advertise this service." Dentists may advertise specialty areas not recognized by the ADA without a disclaimer if training in the non-recognized specialty area(s) was an integral part of a post-graduate program accredited by the Commission on Dental Accreditation (CODA).

(8) Without possessing a deep sedation/general anesthesia permit, licensees shall not advertise such terms as sleep dentistry, snooze dentistry, and twilight sleep. The terms sleep dentistry, snooze dentistry and twilight dentistry may not be used in the announcement or advertisement of conscious sedation services.

30. Regulation 20 CSR 2110-2.071(5) states:

Renewal shall be contingent upon the licensee holding a current certification in basic life support (BLS) or advanced cardiac life support (ACLS), or certification equivalent to BLS or ACLS.

31. Regulation 20 CSR 2110-2.120 states, in relevant part:

(2) A registered and currently licensed dentist may not delegate to a dental assistant or certified dental assistant, as defined in subsections (1)(B) and (C) respectively, the performance of the following procedures:

(A) Diagnosis, including interpretation of dental radiographs and treatment planning;
(B) Cutting of tooth structure;
(C) Surgical procedures on hard and soft tissues including, but not limited to, the removal of teeth and the cutting and suturing of soft tissues;
(D) The prescription, injection and parenteral administration of drugs;
(E) The final bending of archwire prior to ligation;
(F) The scaling of teeth; and
(G) Administration of nitrous oxide-oxygen analgesia except that a dental assistant or certified dental assistant may assist in the administration of and monitor nitrous oxide-oxygen analgesia with specific training as provided in section (3) of this rule.

(3) A dental assistant or certified dental assistant may assist the administration of and monitor nitrous oxide analgesia under direct supervision if s/he—

(A) Has successfully completed formal certified training in a course approved by the Missouri Dental Board; and
(B) Has successfully passed an approved competency test regarding the clinical and didactic training; or
(C) Has been certified in another state to assist the administration and monitor nitrous oxide subsequent to equivalent training and testing. The dental assistant may qualify to perform this function by presenting proof of competence of this equivalent training and testing to the Missouri Dental Board;
(D) The responsibility of the dental assistant or certified dental assistant shall be to provide the Missouri Dental Board proof of competence; and
(E) Upon presentation to the dental board of proof of competency that the dental assistant or certified dental assistant has complied with the requirements imposed by subsections (3)(A), (B) or (C) of this rule, and remitted the appropriate fee as specified in 4CSR 110-2.170, the Missouri Dental Board will issue the appropriate certification to the dental assistant or certified dental assistant.

(4) A currently licensed dentist may delegate, under direct supervision, functions listed in subsection (4)(D) of this rule to a certified dental assistant or a dental assistant subsequent to submission to the Missouri Dental Board of the following satisfactory proof of competence:

(A) After June 1, 1995, all certified dental assistants graduating from accredited dental assisting programs in Missouri will have competency testing for all functions listed in subsection (4)(D) of this rule and may be delegated those functions by a currently licensed dentist;
(B) Certified dental assistants graduating prior to June 1, 1995, or from programs outside Missouri, may be delegated the functions in subsection (4)(D) of this rule with proof of

competence issued by their educational institutions and may be delegated other specific functions if they have completed an approved course, passed an approved competency examination, and can provide proof of competency as defined in subsection (1)(D);

(C) Dental assistants, as defined in subsection (1)(B), may be delegated any specific function listed in subsection (4)(D) of this rule if they have successfully completed a basic dental assisting skills mastery examination approved by the board, completed an approved course, passed an approved competency examination, and can provide proof of competence as defined in subsection (1)(D);

(D) Functions delegable upon successful completion of competency testing are—

1. Placement of post-extraction and sedative dressings;
2. Placing periodontal dressings;
3. Size stainless steel crowns;
4. Placing and condensing amalgam for Class I, V, and VI restorations;
5. Carving amalgam;
6. Placing composite for Class I, V, and VI restorations;
7. Polishing the coronal surfaces of teeth (air polisher);
8. Minor palliative care of dental emergencies (place sedative filling);
9. Preliminary bending of archwire;
10. Removal of orthodontic bands and bonds;
11. Final cementation of any permanent appliance or prosthesis;
12. Minor palliative care of orthodontic emergencies (that is, bend/clip wire, remove broken appliance);
13. Making impressions for the fabrication of removable prosthesis;
14. Placement of temporary soft liners in a removable prosthesis;
15. Place retraction cord in preparation for fixed prosthodontic impressions;
16. Making impressions for the fabrication of fixed prosthesis;
17. Extra-oral adjustment of fixed prosthesis;
18. Extra-oral adjustment of removable prosthesis during and after insertion; and
19. Placement and cementation of orthodontic brackets and/or bands; and

(E) Upon request by the Missouri Dental Board, the licensed and supervising dentist must provide copies of proof of competence of dental auxiliaries.

(5) A currently licensed dentist may delegate under direct supervision to a dental assistant or certified dental assistant any functions not specifically referenced in sections (2)–(4) of this rule and not considered either the practice of dentistry or the practice of dental hygiene as defined in sections 332.071 and 332.091, RSMo, and 4 CSR 110-2.130.

(6) The licensed dentist is responsible for determining the appropriateness of delegation of any specific function based upon knowledge of the skills of the auxiliary, the needs of the patient, the

RECEIVED
JAN 21 2016
MISSOURI DENTAL BOARD

SETTLEMENT AGREEMENT BETWEEN MISSOURI DENTAL BOARD AND RUTH C. GOMES, D.M.D.

Come now Ruth C. Gomes, D.M.D. ("Licensee") and the Missouri Dental Board ("Board") and enter into this settlement agreement for the purpose of resolving the question of whether Licensee's license as a dentist will be subject to discipline.

Pursuant to the terms of § 536.060, RSMo[1], the parties hereto waive the right to a hearing by the Administrative Hearing Commission of the State of Missouri ("AHC") regarding cause to discipline the Licensee's license, and, additionally, the right to a disciplinary hearing before the Board under § 621.110, RSMo.

Licensee acknowledges that she understands the various rights and privileges afforded her by law, including the right to a hearing of the charges against her; the right to appear and be represented by legal counsel; the right to have all charges against her proven upon the record by competent and substantial evidence; the right to cross-examine any witnesses appearing at the hearing against her; the right to present evidence on her own behalf at the hearing; the right to a decision upon the record by a fair and impartial administrative hearing commissioner concerning the charges pending against her and, subsequently, the right to a disciplinary hearing before the Board at which time she may present evidence in mitigation of discipline; and the right to recover attorney's fees incurred in defending this action against her license. Being aware of these rights provided her by operation of law, Licensee knowingly and voluntarily waives each and every one of these rights and freely enters into this settlement agreement and agrees to abide by the terms of this document, as they pertain to her.

Licensee acknowledges that she has received a copy of the investigative report and other documents relied upon by the Board in determining there was cause to discipline her license, along with citations to law and/or regulations the Board believes was violated.

For the purpose of settling this dispute, Licensee stipulates that the factual allegations contained in this settlement agreement are true and stipulates with the Board that Licensee's license, numbered 2005038976 is subject to disciplinary action by the Board in accordance with the provisions of Chapters 621 and 332, RSMo.

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[1] All statutory references are to Missouri Revised Statutes 2000, as amended, unless otherwise indicated.

Joint Stipulation of Fact and Conclusions of Law

1. The Missouri Dental Board ("Board") is an agency of the State of Missouri created and established pursuant to § 332.021, RSMo, for the purpose of executing and enforcing the provisions of Chapter 332.

2. Licensee Ruth C. Gomes, D.M.D. ("Licensee") is licensed by the Board as a dentist, License No. 2005038976. Licensee's Missouri license was at all times relevant herein, and is now, current and active.

3. The Board and Licensee entered into a settlement agreement, effective October 18, 2012, placing Licensee's dental license on probation for four years (the "2012 Settlement Agreement").

4. On January 30, 2012, the Board received a complaint regarding the conduct of Licensee from patient S.K.

5. S.K. saw Licensee regarding implants to replace lower anterior teeth and upper teeth; the prosthesis was going to be fixed bridges supported by implants.

6. On February 10, 2012, the Board received a complaint regarding the conduct of Licensee from patient L.B.

7. L.B. saw Licensee regarding TMJ discomfort, and Respondent told L.B. that she needed an orthotic and needed all of her teeth crowned.

8. The Board conducted an investigation of each of the complaints against Licensee.

9. As part of the 2012 Settlement Agreement rights, an infection control inspection was conducted on July 8, 2014.

10. The guidelines of the Centers for Disease Control and Prevention ("CDC") provide that correct functioning of sterilization cycles should be verified for each sterilizer by the periodic (at least weekly) use of biological monitoring, also known as spore testing, and that a practitioner should also perform biological monitoring: whenever a new type of packaging material or tray is used; after training new sterilization personnel; after a sterilizer has been repaired; and after any change in the sterilizer loading procedures. Biological indicators are the most accepted means of monitoring the sterilization process, because rather than merely determine whether the physical and chemical conditions necessary for sterilization are met (which is what steam indicators do) biological indicators directly determine whether the most resistant microorganisms (e.g., Geobacillus or Bacillus species) are present after the sterilization process,

11. As a result of the infection control inspection, the Board determined that Licensee was using only steam indicators in the sterilization process and was not also performing biological monitoring/spore testing to confirm that the organisms had actually been eradicated. When this was brought to the attention of Dr. Gomes, she resumed spore testing, and those tests indicated that in fact the organisms had been eliminated, and she has used spore testing ever since.

12. As part of the Board's investigation, the Board obtained records from another dentist, B.B., regarding his treatment of L.B., following L.B.'s care by Licensee. The Board also received a written opinion from B.B., stating that Licensee's care of L.B. did not meet the minimum standard of care.

13. As part of the Board's investigation, the Board obtained records from another dentist, S.S., regarding his treatment of S.K., following S.K.'s care by Licensee. The Board also received a written opinion from S.S., stating that Licensee's care of S.K. did not meet the minimum standard of care.

14. With regard to patient S.K., the Board's investigation revealed:

a. that Licensee's records were inaccurate and incomplete;

b. that Patient S.K. suffered from pain and numbness and required extensive care to address the problems created by Licensee, including removal of all upper implants placed by Licensee;

c. that Licensee's dental care of S.K. failed to meet the minimum standard of care in that the implants placed by Licensee penetrated the patient's sinus, resulting in numbness, infection and failure of the implants;

d. that Licensee's dental care of S.K. failed to meet the minimum standard of care in that the records and radiographs revealed that the implants placed by Licensee were penetrating the patient's sinus, but Licensee failed to identify and treat the problem.

15. With regard to patient L.B., the Board's investigation revealed:

a. that Licensee delayed her treatment of L.B., leaving the patient in pain for weeks;

b. that Licensee did not return L.B.'s calls;

c. that three of L.B.'s crowns came off and that the bridge became loose;

d. that patient L.B. suffered from pain and was required care to address the problems created by Licensee;

e. that Licensee's dental care of L.B. failed to meet the minimum standard of care, in that Licensee did not prepare the crowns with proper retention;

16. Section 332.052, RSMo states, in relevant part:

> 1. Dentists shall maintain an adequate and complete patient record for each patient and may maintain electronic records provided the record-keeping format is capable of being printed for review by the board.

17. Licensee's conduct as described in paragraphs 9 through 11 constitutes failure to follow the most recognized method of confirming sterilization to maintain her office or offices, laboratory, equipment and instruments in a safe and sanitary condition, and properly guard against contagious, infectious or communicable diseases or the spread thereof and failure to maintain his or her office or offices, laboratory, equipment and instruments in a safe and sanitary condition in violation of § 332.321.2(16,17), RSMo, for which Licensee is subject to discipline, although the biological spore tests conducted after raising the issue with Dr. Gomes did indicate that the eradication predicted by the steam tests had in fact occurred.

18. Licensee's conduct as described in paragraphs 4 through 15 constitutes improper record keeping in violation of § 332.052, RSMo for which Licensee is subject to discipline.

19. Licensee's conduct in providing dental services as described in paragraphs 4 through 15 above constitutes failure in her performance and duties of a licensed dentist for which the Board has cause to discipline Licensee's license pursuant to § 332.321.2(5), RSMo.

20. Licensee's conduct in providing dental services as described in paragraphs 4 through 15 above constitutes a violation of professional trust or confidence in the performance and duties of a licensed dentist for which the Board has cause to discipline Licensee's license pursuant to § 332.321.2(13), RSMo.

21. Cause exists for the Board to take disciplinary action against Licensee's license under § 332.321.2(5), (6), (13), (16) and (17), RSMo, which states in pertinent part:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any permit or license required by this chapter or any person who has failed to renew or has surrendered his or her permit or license for any one or any combination of the following causes:
>
> . . .
>
> (5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by this chapter;

(6) Violation of, assisting, or enabling any person to violate, any provision of this chapter, or any lawful rule or regulation adopted pursuant to this chapter;

...

(13) Violation of professional trust or confidence;

...

(16) Failure or refusal to properly guard against contagious, infectious or communicable diseases or the spread thereof;

...

(17) Failing to maintain his or her office or offices, laboratory, equipment and instruments in a safe and sanitary condition

Joint Agreed Disciplinary Order

22. Based upon the foregoing, the parties mutually agree and stipulate that the following shall constitute the disciplinary order entered by the Board in this matter under the authority of § 621.045.3, RSMo 2000:

The terms of discipline shall include that the dental license, license number 2005038976, be placed on **PROBATION** for a period of five (5) years ("disciplinary period"). During Licensee's probation, Licensee shall be entitled to engage in the practice of dentistry under Chapter 332, RSMo, provided she adheres to all of the terms of her Settlement Agreement.

I. During the disciplinary period, Licensee shall not perform any implant procedure on a patient until after the following conditions have been met:

A. Licensee shall successfully complete fifty (50) hours of continuing education in the area of dental implant placement and restorations through Oral Health Enrichment in Cleveland, Ohio. Following completion of the 50 hours of education as detailed above from Oral Health Enrichment, Licensee shall take and pass a written outcome assessment test on the education with a score of at least 80%. Licensee shall submit documentation to the Board showing completion of the education and outcome assessment test within thirty (30) days of completion of these requirements.

B. Skills assessment. Licensee shall successfully complete a clinical skills assessment in the area of dental implant placement and restorations at Oral Health Enrichment in Cleveland, Ohio. Licensee shall submit documentation to the Board showing completion of the clinical skills assessment within thirty (30) days of completion of this requirement.

II. GENERAL REQUIREMENTS

A. During the first twelve (12) months of the disciplinary period, Licensee shall submit documentation to the Board's office every month showing that she is conducting weekly biological monitoring of her sterilization equipment.

B. Licensee shall meet with the Board or its representatives at such times and places as required by the Board after notification of a required meeting.

C. Licensee shall keep the Board apprised of her current home and work addresses and telephone numbers. Licensee shall inform the Board within ten days of any change of home or work address and home or work telephone number.

D. Licensee shall comply with all provisions of the Dental Practice Act, Chapter 332, RSMo; all applicable federal and state drug laws, rules, and regulations; and all federal and state criminal laws. "State" here includes the state of Missouri and all other states and territories of the United States.

E. During the disciplinary period, Licensee shall timely renew her license and timely pay all fees required for licensing and comply with all other board requirements necessary to maintain Licensee's license in a current and active state.

F. If at any time during the disciplinary period, Licensee removes herself from the state of Missouri, ceases to be currently licensed under provisions of Chapter 332, or fails to advise the Board of her current place of business and residence, the time of her absence, unlicensed status, or unknown whereabouts shall not be deemed or taken as any part of the time of discipline so imposed in accordance with § 332.321.6, RSMo.

G. During the disciplinary period, Licensee shall accept and comply with unannounced visits from the Board's representatives to monitor his compliance with the terms and conditions of this Settlement Agreement.

H. If Licensee fails to comply with the terms of this Settlement Agreement, the Board may impose such additional or other discipline that it deems appropriate, (including imposition of the revocation).

I. This Settlement Agreement does not bind the Board or restrict the remedies available to it concerning any other violation of Chapter 332, RSMo, by Licensee not specifically mentioned in this document.

III. ADDITIONAL REQUIREMENTS

A. Licensee shall not allow her license to lapse.

B. Licensee shall notify, within 15 days of the effective date of this Settlement Agreement, all hospitals, nursing homes, out-patient centers, surgical centers, clinics, and all other facilities where Licensee practices or has privileges of Licensee's disciplinary status. Notification shall be in writing and Licensee shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative.

23. The parties to this Agreement understand that the Missouri Dental Board will maintain this Agreement as an open record of the Board as provided in Chapters 332, 610, and 324, RSMo.

24. This Agreement resolves the current complaint filed at the Administrative Hearing Commission (15-0118 DB), the probation violation complaint filed with the Missouri Dental Board (DB-15-002-PV), and any other matter known to the Board as of the execution date of this order.

LICENSEE

Ruth C. Gomes, D.M.D.

Date_____

BOARD

1/12/16

Brian Barnett,
Executive Director
Missouri Dental Board

Date 1/21/2016

> requirements of the task and whether proof of the competence is required.
>
> (7) Pursuant to section 332.031.2., RSMo, the dentist is ultimately responsible for patient care. Nothing contained in the authority given the dentist by this rule to delegate the performance of certain procedures shall in any way relieve the supervising dentist from liability to the patient for negligent performance by a dental assistant or certified dental assistant.

32. Licensee's conduct as described in paragraphs 3 through 22 in certain circumstances constitutes improper delegation of duties in violation of regulation 20 CSR 2110-2.120 for which Licensee is subject to discipline.

33. Licensee's conduct as described in paragraphs 3 through 22 in certain circumstances constitutes violation of state and federal drug laws as described in paragraphs 15 through 18 for which Licensee is subject to discipline.

34. Licensee's conduct as described in paragraphs 3 through 22 in certain circumstances constitutes violation of the Board's advertising requirements in violation of § 332.321.2(14) and 20 CSR 2110-2.110, RSMo for which Licensee is subject to discipline.

35. Licensee's conduct as described in paragraphs 3 through 22 in certain circumstances constitutes improper record keeping in violation of § 332.052, RSMo for which Licensee is subject to discipline.

36. Licensee's failure to post her license at her practice location is a violation of § 332.181, RSMo for which Licensee is subject to discipline.

37. Licensee's failure to have a current BLS or ACLS certification despite attesting she had one is a violation of 20 CSR 2110-2.071(5) for which Licensee is subject to discipline.

38. Licensee's conduct in providing dental services to her patients F.R., J.M., C.B. and L.M., as described in paragraphs 3 through 22 above in certain circumstances constitutes misconduct, misrepresentation or dishonesty in the performance and duties of a licensed dentist for which the Board has cause to discipline Licensee's license.

39. Cause exists for the Board to take disciplinary action against Licensee's license under § 332.321.2(5), (6), (10), (14) and (15), RSMo, which states in pertinent part:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621, RSMo, against any holder of any permit or license required by this chapter or any

person who has failed to renew or has surrendered his or her permit or license for any one or any combination of the following causes:

...

(5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by this chapter;

(6) Violation of, assisting, or enabling any person to violate, any provision of this chapter, or any lawful rule or regulation adopted pursuant to this chapter;

...

(10) Assisting or enabling any person to practice or offer to practice, by lack of supervision or in any other manner, any profession licensed or regulated by this chapter who is not registered and currently eligible to practice pursuant to this chapter;

...

(14) Use of any advertisement or solicitation that is false, misleading or deceptive to the general public or persons to whom the advertisement or solicitation is primarily directed. False, misleading or deceptive advertisements or solicitations shall include, but not be limited to:

(a) Promises of cure, relief from pain or other physical or mental condition, or improved physical or mental health;

...

(c) Any misleading or deceptive claims of patient cure, relief or improved condition; superiority in service, treatment or materials; new or improved service, treatment or material; or reduced costs or greater savings. Nothing herein shall be construed to make it unlawful to use any such claim if it is readily verifiable by existing documentation, data or other substantial evidence. Any claim that exceeds or exaggerates the scope of its supporting documentation, data or evidence is misleading or deceptive;

...

(f) Any announcement containing any of the terms denoting recognized specialties, or other descriptive terms carrying the same meaning, unless the announcement clearly designates by list each dentist not licensed as a specialist in Missouri who is sponsoring or named in the announcement, or employed by the entity sponsoring the announcement, after the following clearly legible or audible statement: "Notice: the following

dentist(s) in this practice is (are) not licensed in Missouri as specialists in the advertised dental specialty(s) of ...;"

(g) Any announcement containing any terms denoting or implying specialty areas that are not recognized by the American Dental Association;

(15) Violation of the drug laws or rules and regulations of this state, any other state or the federal government[.]

Joint Agreed Disciplinary Order

40. Based upon the foregoing, the parties mutually agree and stipulate that the following shall constitute the disciplinary order entered by the Board in this matter under the authority of § 621.045.3, RSMo 2000:

The terms of discipline shall include that the dental license, license number 013634, be placed on **PROBATION** for a period of four (4) years ("disciplinary period"). During Licensee's probation, Licensee shall be entitled to engage in the practice of dentistry under Chapter 332, RSMo, provided she adheres to all of the terms of her Settlement Agreement.

I. EDUCATIONAL REQUIREMENTS

A. Licensee shall take and pass the Board's jurisprudence examination within the first twelve (12) months of Licensee's period of probation. Licensee shall contact the Board office to request a current law packet and permission to sit for the jurisprudence examination no less than thirty (30) days prior to the date Licensee desires to take the examination. Licensee shall submit the required re-examination fee to the Board prior to taking the examination. Failure to take and pass the examination during the first twelve (12) months of the disciplinary period shall constitute a violation of this agreement.

II. GENERAL REQUIREMENTS

A. Licensee shall meet with the Board or its representatives at such times and places as required by the Board after notification of a required meeting.

B. Licensee shall keep the Board apprised of her current home and work addresses and telephone numbers. Licensee shall inform the Board within ten days of any change of home or work address and home or work telephone number.

C. Licensee shall comply with all provisions of the Dental Practice Act, Chapter 332, RSMo; all applicable federal and state drug laws, rules, and regulations; and all federal and state criminal laws. "State" here includes the state of Missouri and all other states and territories of the United States.

D. During the disciplinary period, Licensee shall timely renew her license and timely pay all fees required for licensing and comply with all other board requirements necessary to maintain Licensee's license in a current and active state.

E. If at any time during the disciplinary period, Licensee removes herself from the state of Missouri, ceases to be currently licensed under provisions of Chapter 332, or fails to advise the Board of her current place of business and residence, the time of her absence, unlicensed status, or unknown whereabouts shall not be deemed or taken as any part of the time of discipline so imposed in accordance with § 332.321.6, RSMo.

F. During the disciplinary period, Licensee shall accept and comply with unannounced visits from the Board's representatives to monitor his compliance with the terms and conditions of this Settlement Agreement.

G. If Licensee fails to comply with the terms of this Settlement Agreement, in any respect, the Board may impose such additional or other discipline that it deems appropriate, (including imposition of the revocation).

H. This Settlement Agreement does not bind the Board or restrict the remedies available to it concerning any other violation of Chapter 332, RSMo, by Licensee not specifically mentioned in this document.

III. ADDITIONAL REQUIREMENTS

A. Licensee shall not allow her license to lapse.

B. Licensee shall notify, within 15 days of the effective date of this Settlement Agreement, all hospitals, nursing homes, out-patient centers, surgical centers, clinics, and all other facilities where Licensee practices or has privileges of Licensee's disciplinary status. Notification shall be in writing and Licensee shall, contemporaneously with the giving of such notice, submit a copy of the notice to the Board for verification by the Board or its designated representative.

41. The parties to this Agreement understand that the Missouri Dental Board will maintain this Agreement as an open record of the Board as provided in Chapters 332, 610, and 324, RSMo.

42. This Agreement resolves the April 2, 2009 C.B. complaint, the November 12, 2009 Dr. Antoine complaint, the December 10, 2009 Dr. Waxler complaint, the 2011 L.M. complaint, the 2010 C.L. complaint, the 2010 F.R. complaint, the 2010 J.M. complaint and the 2012 infection control violations. The Board retains jurisdiction to investigate and seek discipline for any other complaints filed against Licensee with the Board.

43. The terms of this settlement agreement are contractual, legally enforceable, and binding, not merely recital. Except as otherwise provided herein, neither this settlement agreement nor any of its provisions may be changed, waived, discharged, or terminated, except by an instrument in writing signed by the party against whom the enforcement of the change, waiver, discharge, or termination is sought.

44. Licensee, together with her heirs and assigns, and her attorneys, do hereby waive, release, acquit and forever discharge the Board, its respective members and any of its employees, agents, or attorneys, including any former Board members, employees, agents, and attorneys, of, or from, any liability, claim, actions,

causes of action, fees, costs and expenses, and compensation, including but not limited to, any claims for attorney's fees and expenses, including any claims pursuant to § 536.087, RSMo, or any claim arising under 42 U.S.C. § 1983, which may be based upon, arise out of, or relate to any of the matters raised in this case, its settlement, or from the negotiation or execution of this settlement agreement. The parties acknowledge that this paragraph is severable from the remaining portions of this settlement agreement in that it survives in perpetuity even in the event that any court of law deems this settlement agreement or any portion thereof to be void or unenforceable.

45. If no contested case has been filed against Licensee, Licensee has the right, either at the time the settlement agreement is signed by all parties or within fifteen days thereafter, to submit the agreement to the Administrative Hearing Commission for determination that the facts agreed to by the parties to the settlement agreement constitute grounds for denying or disciplining the license of the licensee. If Licensee desires the Administrative Hearing Commission to review this Agreement, Licensee may submit this request to: Administrative Hearing Commission, Truman State Office Building, Room 640, 301 W. High Street, P.O. Box 1557, Jefferson City, Missouri 65101.

46. If Licensee has requested review, Licensee and Board jointly request that the Administrative Hearing Commission determine whether the facts set forth herein are grounds for disciplining Licensee's license and issue findings of act and conclusions of law stating that the facts agreed to by the parties are grounds for disciplining Licensee's license. Effective the date the Administrative Hearing Commission determines that the agreement sets forth cause for disciplining Licensee's license, the agreed upon discipline set forth herein shall go into effect.

LICENSEE

Ruth C. Gomes, D.M.D.

Date 9/12/12

BOARD

Brian Barnett,
Executive Director
Missouri Dental Board

Date 10/3/12