BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

In The Matter Of:

DAVID H. MOORE, D.D.S.)
(License No. 5518)) **CONSENT ORDER**

THIS MATTER is before the North Carolina State Board of Dental Examiners (Board) as authorized by G.S. 90-41.1(b) for consideration of a Consent Order in lieu of a formal administrative hearing.

Subsequent to an investigation conducted by the Board's Investigative Panel and allegations arising therefrom having been presented to David H. Moore, D.D.S. (Respondent), at settlement conferences on June 8, 2004 and February 12, 2005, the Respondent enters into this Consent Order. While Respondent does not admit for any purposes the allegations contained in this Consent Order, in order to avoid additional proceedings, the Respondent agrees not to contest the allegations set forth within this Consent Order and does furthermore agree to the provisions and sanctions contained herein. Respondent further agrees that any breach or violation of this Consent Order shall constitute an admission of the findings of facts and conclusions of law as pertains to the allegations contained herein.

FINDINGS OF FACT

1. The specific allegations are affixed hereto as Attachment 1, and incorporated as if fully set forth herein.

CONCLUSIONS OF LAW

1. Respondent has stipulated that such allegations, if proven, are legally sufficient to support findings and conclusions that he is in violation of G.S. 90-41 as specified in the Findings of Fact. Furthermore, Respondent has stipulated that, solely for the purposes recited herein, Respondent will not contest the allegations set forth in this Order, which allegations are previously incorporated in this Order, as if fully set forth herein, as findings of fact.

℘ ℘ ℘ ℘

WHEREFORE, based upon the foregoing Findings of Fact and Conclusions of Law, and pursuant to the authority set forth in G.S. §90-41(a), it is **ORDERED** as follows:

1. License number 5518 issued to Respondent for the practice of dentistry in North Carolina is suspended for a period of three (3) years. Respondent shall surrender his license and current renewal certificate to the Board at its offices on or before January 13, 2006. Failure to return his original license and current renewal certificate to the Board is a violation of this Order and is subject to further discipline.

2. With Respondent's consent, his license to practice dentistry shall, on the one hundred eighty-first (181st) day following the surrender of his license, be conditionally restored provided that he adhere to the probationary terms and conditions as outlined below for as long as he holds a license to practice dentistry in North Carolina. During this term of suspension, Respondent may, with the Board's

prior approval, lease his dental office and equipment. Any lease approved by the Board must be in writing and must disclose fully all material terms of the transaction. *In no event, shall any such lease allow operation of a dental practice on behalf of or for the benefit of Respondent.*

(a) Respondent shall violate no provision of the Dental Practice Act or the Board's Rules;

(b) Respondent shall neither direct nor permit any of his employees to violate any provision of the Dental Practice Act or the Board's Rules;

(c) Respondent shall allow the Board or its authorized agent to inspect and observe his office, conduct random patient chart review, and interview his employees and co-workers at any time during regular office hours;

(d) Respondent shall abide by all terms and conditions of his contract with the North Carolina Caring Dental Professionals (CDP). Respondent shall sign a release with the Caring Dental Professionals permitting them to submit monthly reports to the Board regarding his progress in the program;

(e) Respondent shall renew his contract in sufficient time prior to its expiration in order to provide continuous coverage. Respondent agrees that if at any time an assessment and/or

inpatient treatment is recommended, he will abide by such recommendation and will not function as a dentist until released by the Board to do so;

(f) Respondent shall not possess or use any controlled substances, alcohol or any other mood altering substance unless prescribed for him in the usual course of professional treatment.

(g) Respondent shall limit his pediatric practice to an average of thirty (30) hours per week in any given month. He must see patients in an unrestricted area with a minimum of one or two dental assistants present. Parents of the patients will be invited to be present during all appointments. Respondent will limit his practice to seeing:

(1) Office patients who are:

a. Recall patients who have an established history of cooperation;

b. Initial appointment patients who only require radiographs, prophylaxis and examinations;

c. Cooperative aged children in unrestricted view;

d. Non-cooperative patients who will be treated under nitrous oxide or sedation and monitored by a CRNA

(2) Hospital Patients at Presbyterian Hospital or Carolinas Medical Center under general anesthesia and monitored by staff anesthesiologists.

(h) Respondent shall not treat non-cooperative patients except under sedation and monitoring as described in paragraph (g) above;

(i) Respondent and/or any other dentist or CRNA under his employ shall not render any patient unconscious (deep sedation or general anesthesia) while utilizing a conscious sedation permit;

(j) Respondent's employees shall be authorized to unilaterally report to the Board regarding Respondent's conduct;

(k) Respondent shall establish a fund for each staff member that covers the staff member's salary for a period of up to six weeks, should any staff member report Respondent for a violation of the Dental Practice Act, with that report resulting in Respondent losing his license for two years and six months as set out in this Order;

(l) Immediately, upon entry of this Order, Board Staff shall have a face-to-face discussion with all of Respondent's staff so that they are fully aware of all of the problematic behaviors that he has displayed, the mechanism by which they would report him and the necessity of prompt reporting of such behavior;

(m) Respondent shall, within one (1) year from the date of this Order, complete six (6) hours of continuing education in the subject of ethics in dental practice. This requirement shall be in addition to the continuing education required by the Board for the renewal of Respondent's dental license. *No course shall be accepted in satisfaction of this continuing education requirement unless the course has been approved by the Board in writing before Respondent takes it.* Respondent shall submit to the Board's Deputy Operations Officer written proof of satisfactory completion of any approved course;

(n) Respondent shall, within thirty (30) days from the date of this Order, reimburse the Board for the costs associated with this investigation and settlement conference in the amount of $15,512.00.

3. If Respondent fails to comply with any provision of this Order or breaches any term or condition thereof, the Board shall promptly schedule a public Show Cause Hearing to allow Respondent an opportunity to show cause as to why Respondent's license should not be immediately suspended per the terms of this Order. If as a result of the Show Cause Hearing, the Board is satisfied that Respondent failed to comply or breached any term or condition of this Order, the provisional restoration of Respondent's license shall be rescinded and upon written

demand, Respondent shall immediately surrender his license and current renewal certificate to the Board for two years and six months. This sanction shall be in addition to and not in lieu of any sanction the Board may impose as a result of future violations of the Dental Practice Act or of the Board's Rules.

This the 13 day of January, 2006.

THE NORTH CAROLINA STATE
BOARD OF DENTAL EXAMINERS

BY: Terry W. Friddle

Terry W. Friddle
Deputy Operations Officer

STATEMENT OF CONSENT

I, DAVID H. MOORE, D.D.S., do hereby certify that I have read the foregoing Consent Order in its entirety and that I do freely and voluntarily admit, exclusively for the purposes of this disciplinary proceeding and any other disciplinary or licensure proceedings before this Board, that there is a factual basis for the allegations set forth therein, that these factual allegations, if proven, are legally sufficient to support findings and conclusions that I am in violation of G.S. Section 90-41(a)(2), (6), (11), (12) (13), (17), (21) and (26) and I will not contest the factual allegations therein should further disciplinary action be warranted in this matter, and that I assent to the terms and conditions set forth therein. I hereby express my understanding that the Board will report the contents of this Consent Order to the National Practitioner Data Bank and that this Consent Order shall become a part of the permanent public record of the Board.

This the 13TH day of January, 2006.

DAVID H. MOORE, D.D.S.

ATTACHMENT 1
FINDINGS OF FACT

1. The North Carolina State Board of Dental Examiners is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding under the authority granted it in Chapter 90 of the North Carolina General Statutes (the Dental Practice Act) and the Rules and Regulations of the North Carolina State Board of Dental Examiners.

2. Respondent is licensed to practice dentistry in North Carolina and is the holder of License Number 5518, originally issued by the Board on June 2, 1986 and duly renewed through the current year.

3. The Respondent was at all times relevant hereto licensed to practice dentistry in North Carolina and was subject to the Dental Practice Act and the rules promulgated there under.

4. At all relevant times, Respondent was engaged in the practice of pediatric dentistry in Charlotte, North Carolina.

SEDATION

5. During 2003 and 2004, Respondent routinely left pediatric patients unattended during the administration of I.V. Sedation.

6. The standard of care for dentists licensed to practice in North Carolina during 2003 and 2004 required that a dentist adequately monitor pediatric patients during the administration of I.V. Sedation.

7. Respondent violated the standard of care by failing to adequately monitor pediatric patients in his practice during the administration of I.V. Sedation, which constituted a violation of G.S. §90-41(a)(12).

8. Respondent administered general anesthesia to Morgan-Grace Fisher, Alexander Breen, Patrick Carter, Sarah Pozzi, Santiago Morris, Noah Brozo, Dylan Martin, Bellamy Finney, Nayely Hernandez, Vinh Anh Tran, Roland Grant, Omar Lawson, Charles Smalley, Rachel Nabors, and Zachary DeVore. Respondent does not have a general anesthesia permit. Administering general anesthesia without a valid permit violated 21 NCAC 16Q .0201(a), which constituted a violation of G.S. §90-41(a)(6).

9. Respondent failed to adequately monitor Morgan Grace Fisher, Alexander Breen, Santiago Morris, Noah Brozo, Sarah Pozzi and Caroline Marvin pre-operatively, intra-operatively or post-operatively after the administration of general anesthesia/sedation.

10. The standard of care for dentists licensed to practice in North Carolina in 2003 and 2004 required that a dentist adequately monitor pediatric patients after the administration of sedation pre-operatively, intra-operatively and post-operatively.

11. Respondent violated the standard of care by failing to adequately monitor pediatric patients in his practice after the administration of general anesthesia/sedation, which constituted a violation of G.S. §90-41(a)(12).

12. Respondent failed to monitor the patient's temperature and/or respiratory rate during the administration of general anesthesia/sedation for Dakota Weddington, Jarrod Honeycutt, Dylan Martin, Chase Smith, Bellamy Finney, Nayely Hernandez, Vinh Anh Tran, Joseph Wilson, Roland Grant, Brandon Bennett, Jacob Watts, Elijah Liberacki, Kyle Lester, Turner Pearce, Elizabeth Whitney, Omar Lawson, Cameron Hankins, Charles Smalley, Savannah Andavazo, Rachel Nabors, Zachary DeVore and Kwesi Littlejohn.

13. The standard of care for dentists licensed to practice in North Carolina in 2003 and 2004 required that a dentist monitor a patient's temperature and respiratory rate during the administration of general anesthesia/sedation.

14. Respondent violated the standard of care by failing to document the patient's temperature and/or respiratory rate during the administration of general anesthesia/sedation for Dakota Weddington, Jarrod Honeycutt, Dylan Martin, Chase Smith, Bellamy Finney, Nayely Hernandez, Vinh Anh Tran, Joseph Wilson, Roland Grant, Brandon Bennett, Jacob Watts, Elijah Liberacki, Kyle Lester, Turner Pearce, Elizabeth Whitney, Omar Lawson, Cameron Hankins, Charles Smalley, Savannah Andavazo, Rachel Nabors, Zachary DeVore and Kwesi Littlejohn, which constituted a violation of G.S. §90-41(a)(12).

15. Respondent's patient records were incomplete and inadequate for patients receiving sedation in that Respondent routinely failed to state the reason(s) sedation was being utilized, failed to routinely include signed informed consent forms, and failed to routinely note the patient's condition at the time of discharge and whether the discharge criteria had been met.

16. Respondent's records for Dakota Weddington, Jarrod Honeycutt, Chase Smith, Bellamy Finney, Bradley Barbee, Nayely Hernandez, Vinh Anh Tran, Joseph Wilson, Roland Grant, Jacob Watts, Kyle Lester, Christopher Greeson, Turner Pearce, Elizabeth Whitney, Omar Lawson and Savannah Andavazo failed to document behavior or other indications for the use of sedation.

17. Respondent failed to obtain signed informed consent forms for the use of sedation for Jarrod Honeycutt, Dylan Martin, Nayely Hernandez, Christopher Greeson, Kyle Lester, Turner Pearce, Elizabeth Whitney, Omar Lawson and Kwesi Littlejohn.

18. Respondent's patient records for Jarrod Honeycutt, Caroline Marvin, Chase Smith, Bradley Barbee, Joseph Wilson, Brandon Bennett, Jacob Watts, Elijah Liberacki, Kyle Lester, Turner Pearce, Elizabeth Whitney, Cameron Hankins, and Savannah Andavazo failed to note the patient's condition at discharge following the administration of sedation.

19. The standard of care for dentists licensed to practice in North Carolina in 2003 and 2004 required that a dentist maintain complete and adequate patient

records for patients receiving sedation that included the reason(s) sedation was being utilized, signed informed consent forms, and a notation of the patient's condition at the time of discharge and whether the discharge criteria had been met.

20. Respondent violated the standard of care by failing to maintain complete and adequate patient records for patients receiving sedation in his practice that included the reason(s) sedation was being utilized, signed informed consent forms, and a notation of the patient's condition at the time of discharge and whether the discharge criteria had been met, which constituted a violation of G.S. §90-41(a)(12).

FRAUD

21. Ana L. Nina was a dental patient at Respondent's Medicaid dental practice, a Small World Clinic, on June 29, 2002. Respondent billed for and subsequently received payment from Medicaid for the following restorations:

a. DL on tooth #3 when only an O was performed
b. MOB on tooth #3 when only an O was performed
c. MOB on tooth #4 when only an O was performed
d. DL on tooth #4 when only an O was performed
e. DL on tooth #5 when only an O was performed
f. MOB on tooth #5 when only an O was performed
g. MOF on tooth #10 when no restorations were performed
h. DL on tooth #12 when only an O was performed
i. MOB on tooth #12 when only an O was performed
j. DL on tooth #14 when only an O was performed
k. MOB on tooth #14 when only an O was performed
l. DL on tooth #19 when only an OF was performed
m. MOB on tooth #20 when only an O was performed
n. DL on tooth #21 when only an O was performed
o. MOB on tooth #21 when only an O was performed

p. DL on tooth #28 when only an O was performed
q. MOB on tooth #28 when only an O was performed
r. DL on tooth #29 when only an O was performed
s. MOB on tooth #29 when only an O was performed
t. DL on tooth #30 when only an OF was performed
u. MOB on tooth #30 when only an OF was performed

22. Andy A. Martinez was a dental patient at Respondent's Medicaid dental practice, a Small World Clinic, on June 29, 2002. Respondent billed for and subsequently received payment from Medicaid for the following restorations:

a. DL on tooth #2 when only an O was performed
b. MOB on tooth #2 when only an O was performed
c. MOB on tooth #3 when only an O was performed
d. DL on tooth #3 when only an O was performed
e. DL on tooth #4 when only an O was performed
f. MOB on tooth #4 when only an O was performed
g. MOB on tooth #5 when only an O was performed
h. DL on tooth #5 when only an O was performed
i. MOB on tooth #12 when only an O was performed
j. DL on tooth #12 when only an O was performed
k. MOB on tooth #13 when only an O was performed
l. DL on tooth #13 when only an O was performed
m. MOB on tooth #14 when only an O was performed
n. DL on tooth #14 when only an O was performed
o. DL on tooth #15 when no restorations were performed
p. MOB on tooth #15 when no restorations were performed
q. DL on tooth #18 when only an O was performed
r. MOB on tooth #18 when only an O was performed
s. DL on tooth #19 when only an O was performed
t. MOB on tooth #19 when only an O was performed
u. MOB on tooth #20 when only an O was performed
v. DL on tooth #20 when only an O was performed
w. MOB on tooth #21 when only an O was performed
x. DL on tooth #21 when only an O was performed
y. MOB on tooth #28 when only an O was performed
z. DL on tooth #28 when only an O was performed
aa. MOB on tooth #29 when only an O was performed
bb. DL on tooth #29 when only an O was performed
cc. MOB on tooth #30 when only an O was performed

dd. DL on tooth #30 when only an O was performed
ee. MOB on tooth #31 when only an O was performed
ff. DL on tooth #31 when only an O was performed

23. Carla M. Martinez was a dental patient at Respondent's Medicaid dental practice, a Small World Clinic, on June 29, 2002. Respondent billed for and subsequently received payment from Medicaid for the following restorations:

a. DL on tooth #2 when only an O was performed
b. MOB on tooth #2 when only an O was performed
c. MOB on tooth #3 when only an OL was performed
d. DL on tooth #3 when only an OL was performed
e. DL on tooth #4 when only an O was performed
f. MOB on tooth #4 when only an O was performed
g. MOB on tooth #5 when only an O was performed
h. DL on tooth #5 when only an O was performed
i. MOB on tooth #12 when only an O was performed
j. DL on tooth #12 when only an O was performed
k. MOB on tooth #13 when only an O was performed
l. DL on tooth #13 when only an O was performed
m. MOB on tooth #14 when only an O was performed
n. DL on tooth #14 when only an O was performed
o. DL on tooth #15 when only an O was performed
p. MOB on tooth #15 when only an O was performed
q. DL on tooth #18 when only an O was performed
r. MOB on tooth #18 when only an O was performed
s. DL on tooth #19 when only an O was performed
t. MOB on tooth #19 when only an O was performed
u. MOB on tooth #20 when only a DO was performed
v. DL on tooth #20 when only a DO was performed
w. MOB on tooth #21 when only an O was performed
x. DL on tooth #21 when only an O was performed
y. MOB on tooth #28 when only an O was performed
z. DL on tooth #28 when only an O was performed
aa. MOB on tooth #29 when only an O was performed
bb. DL on tooth #29 when only an O was performed
cc. MOB on tooth #30 when only an O was performed
dd. DL on tooth #30 when only an O was performed
ee. MOB on tooth #31 when only an O was performed
ff. DL on tooth #31 when only an O was performed

24. Madeline Mendez was a dental patient at Respondent's Medicaid dental practice, a Small World Clinic, on July 13, 2002. Respondent billed for and subsequently received payment from Medicaid for the following restorations:

a. DL on tooth #2 when only an O was performed
b. MOB on tooth #2 when only an O was performed
c. MOB on tooth #3 when only an O was performed
d. DL on tooth #3 when only an O was performed
e. DL on tooth #4 when only an O was performed
f. MOB on tooth #4 when only an O was performed
g. MOB on tooth #5 when only an O was performed
h. DL on tooth #5 when only an O was performed
i. MOB on tooth #12 when only an O was performed
j. DL on tooth #12 when only an O was performed
k. MOB on tooth #13 when only an O was performed
l. DL on tooth #13 when only an O was performed
m. MOB on tooth #14 when only an O was performed
n. DL on tooth #14 when only an O was performed
o. DL on tooth #15 when only an O was performed
p. MOB on tooth #15 when only an O was performed
q. DL on tooth #18 when only an O was performed
r. MOB on tooth #18 when only an O was performed
s. DL on tooth #19 when only an OF was performed
t. MOB on tooth #19 when only an OF was performed
u. MOB on tooth #20 when only an O was performed
v. DL on tooth #20 when only an O was performed
w. MOB on tooth #21 when only an O was performed
x. DL on tooth #21 when only an O was performed
y. MOB on tooth #28 when only an O was performed
z. DL on tooth #28 when only an O was performed
aa. MOB on tooth #29 when only an O was performed
bb. DL on tooth #29 when only an O was performed
cc. MOB on tooth #30 when only an OF was performed
dd. DL on tooth #30 when only an OF was performed
ee. MOB on tooth #31 when no restorations were performed
ff. DL on tooth #31 when no restorations were performed

25. Felix Almonte was a dental patient at Respondent's Medicaid dental practice, a Small World Clinic, on August 17, 2002. Respondent billed for and subsequently received payment from Medicaid for the following restorations:

a. MOB on tooth #3 when only an O was performed
b. DL on tooth #3 when only an O was performed
c. MOB on tooth #5 when only an O was performed
d. DL on tooth #5 when only an O was performed
e. MOB on tooth #12 when only an O was performed
f. DL on tooth #12 when only an O was performed
g. MOB on tooth #14 when only an O was performed
h. DL on tooth #14 when only an O was performed
i. DL on tooth #19 when only an OF was performed
j. MOB on tooth #19 when only an OF was performed
k. MOB on tooth #21 when only an O was performed
l. DL on tooth #21 when only an O was performed
m. MOB on tooth #28 when only an O was performed
n. DL on tooth #28 when only an O was performed
o. DL on tooth #29 when only an O was performed
p. MOB on tooth #30 when only an OF was performed
q. DL on tooth #30 when only an OF was performed

26. Joshua A. Delgado was a dental patient at Respondent's Medicaid dental practice, a Small World Clinic, on August 3, 2002. Respondent billed for and subsequently received payment from Medicaid for the following restorations:

a. OBL on tooth #3 when only an O was performed
b. OBL on tooth #4 when only an O was performed
c. OBL on tooth #5 when only an O was performed
d. OBL on tooth #12 when only an O was performed
e. OBL on tooth #13 when only an O was performed
f. OBL on tooth #14 when only an O was performed
g. OBL on tooth #19 when only an OF was performed
h. OBL on tooth #20 when only an OF was performed
i. OBL on tooth #21 when only an O was performed
j. OBL on tooth #28 when only an O was performed
k. OBL on tooth #29 when only an O was performed
l. OBL on tooth #30 when only an O was performed

m. OBL on tooth #31 when only an O was performed

27. Christie P. Lainez was a dental patient at Respondent's Medicaid dental practice, a Small World Clinic, on June 29, 2002. Respondent billed for and subsequently received payment from Medicaid for the following restorations:

a. MOB on tooth #3 when only an O was performed
b. DL on tooth #3 when only an O was performed
c. MOB on tooth #14 when only an O was performed
d. DL on tooth #14 when only an O was performed
e. DL on tooth #19 when only an OF was performed
f. MOB on tooth #19 when only an OF was performed
g. MOB on tooth #29 when only an O was performed
h. DL on tooth #29 when only an O was performed
i. MOB on tooth #30 when only an OF was performed
j. DL on tooth #30 when only an OF was performed

28. Pedro Aguirre was a dental patient at Respondent's Medicaid dental practice, a Small World Clinic, on July 13, 2002. Respondent billed for and subsequently received payment from Medicaid for the following restorations:

a. MOB on tooth #3 when no restoration was performed
b. DL on tooth #3 when no restoration was performed
c. MOB on tooth #14 when no restoration was performed
d. DL on tooth #14 when no restoration was performed
e. DL on tooth #19 when no restoration was performed
f. MOB on tooth #19 when no restoration was performed
g. MOB on tooth #30 when no restoration was performed
h. DL on tooth #30 when no restoration was performed
i. OB on tooth A when an MO was performed
j. L on tooth A when an MO was performed
k. OB on tooth B when only an O was performed
l. L on tooth B when only an O was performed
m. OB on tooth C when only an FA was performed
n. L on tooth C when only an FA was performed
o. OB on tooth J when no restoration was performed
p. L on tooth J when no restoration was performed
q. OB on tooth T when no restoration was performed

r. L on tooth T when no restoration was performed

29. Carlos C. Garcia was a dental patient at Respondent's Medicaid dental practice, a Small World Clinic, on July 13, 2002. Respondent billed for and subsequently received payment from Medicaid for the following restorations:

a. MOB on tooth #3 when only an O was performed
b. DL on tooth #3 when only an O was performed
c. MOB on tooth #5 when no restoration was performed
d. DL on tooth #5 when no restoration was performed
e. FIL on tooth #8 when no restoration was performed
f. FIL on tooth #9 when no restoration was performed
g. DL on tooth #12 when no restoration was performed
h. MOB on tooth #12 when no restoration was performed
i. MOB on tooth #14 when only an O was performed
j. DL on tooth #14 when only an O was performed
k. MOB on tooth #19 when only an O was performed
l. DL on tooth #19 when only an O was performed
m. MOB on tooth #21 when no restoration was performed
n. DL on tooth #21 when no restoration was performed
o. MOB on tooth #30 when only an O was performed
p. DL on tooth #30 when only an O was performed

30. Respondent's actions in billing Medicaid for services not rendered constituted obtaining a fee through fraud, misrepresentation or deceit, a violation of G.S. §90-41(a)(11).

OWNERSHIP – SMALL WORLD CLINIC

31. Respondent owned and operated a dental clinic known as the Small World Clinic which provided dental treatment for the Latino community in Charlotte, North Carolina, focusing on pediatric patients. Respondent entered into a verbal contract with Dionne Alexander, a North Carolina licensed dental hygienist,

whereas Respondent agreed to pay Ms. Alexander 20% of the gross revenues collected at the Small World Clinic for the first day of operation and 12% of the gross revenues for each day of operation thereafter.

32. G.S. §90-29(b)(11) states that a person shall be deemed to be practicing dentistry in this State who..... "Owns, manages, supervises, controls or conducts, either himself or by and through another person or other persons, any enterprise wherein any one or more of the acts or practices set forth in subdivisions (1) through (10) above are done, attempted to be done, or represented to be done."

33. Ms. Alexander shared in the ownership and profits of the Small World Clinic. Ms. Alexander is not a North Carolina licensed dentist. Respondent's contract with Ms. Alexander constituted a violation of G.S. §90-41(a)(6)

PATIENT ABUSE

34. Respondent routinely physically abused his pediatric patients by slapping, choking, shaking, pinching, banging their heads against the chairs and pushing them.

35. Respondent routinely physically abused his pediatric patients by pressing down on the patient's chest, tapping on the patient's head with his fingers, hooking his fingers under and behind the patient's upper teeth and pulling the patients upright on the dental chair, and pulling female patients down in the chair by pulling on their ponytails. On one occasion, Respondent pulled a female

patient off of the dental chair by her head and neck and slammed her against the window in the operatory.

36. Respondent routinely physically abused his pediatric patients by hitting them on the forehead with his fist, jerking patients out of the dental chair, pulling patients up in the dental chair by their upper anterior teeth, and hitting them on their chest area when misbehaving.

37. Respondent routinely physically abused his pediatric patients by pulling their hair, grabbing them out of the dental chair by their necks, dragging them and shoving them under a table to put them in "time-out", squeezing their temples, banging them on the foreheads, squeezing their arms, and pulling patients up in the dental chair by their upper anterior teeth.

38. Respondent pulled Katherine Parker's hair during dental treatment.

39. On April 10, 2003, Chase Fraley was a pediatric patient in Respondent's practice. During this appointment, Respondent choked Chase and left physical marks on the child's neck and face.

40. On July 20, 1999, Luke Robbins was a pediatric patient in Respondent's practice. During this appointment, Respondent scratched Luke's neck and left a physical mark on the child's neck.

41. The standard of care for dentists licensed to practice dentistry in North Carolina between 1999 and 2004 required that a dentist use appropriate pediatric

patient management techniques to manage pediatric patients during dental treatment.

42. Respondent violated the standard of care by failing to use appropriate pediatric management techniques to manage pediatric patients during dental treatment as described in Findings of Fact 32 – 38.

43. Respondent's actions as described in Findings of Fact 32 – 38 constituted violations of G.S. §90-41(a)(12).

MISUSE OF AUXILIARIES

44. In 2003 and 2004, Respondent regularly directed and allowed Dental Assistants in his employ to perform the following dental hygiene and dental functions:

i. place flowable composite
ii. cement orthodontic appliances
iii. administer nitrous oxide
iv. adjust restorations
v. place and adjust crowns
vi. take impressions
vii. perform prophylaxis
viii. use high speed handpiece
ix. take radiographs without certification

45. Respondent's actions in directing and allowing Dental Assistants in his employ to perform the functions listed in Paragraph 44 constituted violations of G.S. §90-41(a)(6), (13), and (21).

SUBSTANCE ABUSE

46. In May of 2003, Respondent entered Talbott Recovery Campus for an assessment, and subsequently entered treatment at Fellowship Hall on June 7, 2003 for alcohol dependence. Respondent was discharged from Fellowship Hall on July 3, 2003.

47. On October 30, 2003, Respondent entered Metro Atlanta Recovery Residences (MARR) with a diagnosis of Alcohol Dependence. Respondent remained in treatment at MARR until March 5, 2004. Respondent has a diagnosis of Alcohol Dependence which impairs his ability to practice dentistry and constitutes a violation of G.S. §90-41(a)(2) and G.S. §90-41(a)(6).

THOMAS C. EWING, JR.

48. Thomas C. Ewing, Jr. was a patient under Respondent's care from November 1992 through August of 2003.

49. Respondent diagnosed Thomas Ewing with Class II occlusion and on July 23, 1998, initiated orthodontic treatment.

50. Respondent initiated orthodontic treatment for Thomas without taking study models or photographs, both intraoral and facial.

51. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Thomas Ewing required that a dentist have minimum diagnostic records including intraoral and facial photographs, study

models and a cephalometric radiograph, with accompanying analysis, prior to initiating orthodontic treatment.

52. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by failing to take or have available to him intraoral and facial photographs or study models of Thomas Ewing prior to initiating orthodontic treatment, which constituted a violation of G.S. §90-41(a)(12).

53. Respondent failed to inform Thomas Ewing's parents of all options available regarding orthodontic treatment to correct a Class II occlusion. No mention was made of maxillary extractions or surgery.

54. After five years of orthodontic treatment by Respondent, Thomas Ewing still had a Class II occlusion. Respondent failed to inform Thomas Ewing's parents that Thomas had a compromised orthodontic result.

55. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Thomas Ewing required that a dentist inform patients and/or parents of minor patients of all treatment options available prior to initiating orthodontic treatment and to inform patients and/or parents of minor patients when a compromised orthodontic result will occur.

56. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by failing to inform Thomas Ewing's parents of all treatment options available prior to initiating orthodontic treatment and by failing

to inform Thomas Ewing's parents that Thomas had a compromised orthodontic result, which constituted a violation of G.S. §90-41(a)(12).

BRIDGETTE EWING

57. Bridgette Ewing was a patient under Respondent's care from November 1992 through August of 2003.

58. Respondent diagnosed Bridgette with a Class I occlusion and on December 21, 2001, initiated orthodontic treatment.

59. Respondent initiated orthodontic treatment for Bridgette without taking study models or photographs, both facial and intraoral.

60. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Bridgette required that a dentist have minimum diagnostic records including facial and intraoral photographs, study models and a cephalometric radiograph, with accompanying analysis, prior to initiating orthodontic treatment.

61. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by failing to take or have available to him facial photographs or study models of Bridgette Ewing prior to initiating orthodontic treatment, which constituted a violation of G.S. §90-41(a)(12).

CLAIRE ROBB

62. Claire Robb was a patient under Respondent's care from October 22, 2001 through July 28, 2003.

63. Respondent diagnosed Claire with a Skeletal Class II occlusion, brachyfacial vertical pattern, missing #20 with #K ankylosed and adequate upper and lower arch length. On October 22, 2001, Respondent met with Claire's father to discuss the treatment proposal and financial responsibility. The plan called for two phases of treatment, the first addressing the Class II malocclusion, opening the bite and aligning Claire's teeth. Headgear was not discussed at this appointment. Orthodontic records were taken and Respondent initiated phase one of Claire's orthodontic treatment.

64. Respondent initiated orthodontic treatment for Claire without taking study models or photographs, both intraoral and facial.

65. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Claire required that a dentist have minimum diagnostic records including intraoral and facial photographs, study models and a cephalometric radiograph, with accompanying analysis, prior to initiating orthodontic treatment.

66. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by failing to take or have available to him intraoral and facial photographs or study models of Claire Robb prior to initiating orthodontic treatment, which constituted a violation of G.S. §90-41(a)(12).

67. On December 10, 2001, Respondent placed upper and lower brackets and banded Claire's molars a week later. On January 30, 2002, Respondent

discussed Claire wearing headgear 24 hours a day. Claire refused to wear the appliance to school and it was agreed that she would not have to wear the appliance during school hours. On February 27, 2002, Respondent removed all lower brackets, leaving the bands in place. Claire remained in treatment with Respondent until March of 2003, at which time Respondent removed the upper brackets, leaving the upper and lower bands in place and recommending the continued use of headgear. Respondent did not provide Claire with any type of retention following the removal of her appliances.

68. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Claire Robb required that a dentist inform the patient/parent when there is a change from the original treatment plan following the placement of orthodontic appliances

69. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by failing to inform the Robbs of a change in Claire's treatment plan following the placement of her orthodontic appliances, which constituted a violation of G.S. §90-41(a)(12).

70. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Claire Robb required that a dentist inform the patient/parents about treatment progress during the treatment period.

71. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by failing to inform the Robbs of Claire's

treatment progress during the treatment period, which constituted a violation of G.S. §90-41(a)(12).

72. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Claire Robb required that a dentist provide some type of retention following the removal of the maxillary and mandibular appliances.

73. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by failing to provide Claire Robb with some type of retention following the removal of her maxillary and mandibular appliances, which constituted a violation of G.S. §90-41(a)(12).

ZANE AL-KOOR

74. Zane Al-Koor was a patient under Respondent's care from April 15, 2004 through August 17, 2004.

75. On August 17, 2004, Zane presented to Respondent's practice for the restoration of teeth numbers A and B.

76. During Zane's treatment, Respondent pinched and squeezed Zane's cheeks and arms leaving marks on Zane's right eye area, left cheek and both arms. Respondent used a mouth prop during Zane's treatment which caused unnecessary bleeding. Respondent repeatedly used inappropriate language with Zane such as telling him to "shut-up." Respondent restrained Zane by straps across his arms and

legs while strapped to the dental chair. Respondent failed to obtain parental consent to restrain Zane during this dental appointment.

77. The standard of care for dentists licensed to practice dentistry in North Carolina at the time Respondent treated Zane Al-Koor required that a dentist not pinch and squeeze a patient's cheeks and arms during dental treatment, not inappropriately use a mouth prop such that makes a patient's gums bleed, not use inappropriate language when speaking to a pediatric patient, and not restrain a pediatric patient unless appropriate consent has been obtained.

78. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by pinching and squeezing Zane's cheeks and arms during dental treatment which resulted in marks being left; by inappropriately using a mouth prop which resulted in Zane's gums bleeding; by using inappropriate language while speaking to Zane such as "shut-up", and by failing to obtain appropriate parental consent prior to restraining Zane, which constituted a violation of G.S. §90-41(a)(12).