

NEVADA STATE BOARD
of
DENTAL EXAMINERS



FORMAL HEARING

JULY 13, 2018

1:00 P.M.

PUBLIC BOOK

Renotice of Hearing

1 **BEFORE THE NEVADA STATE BOARD OF DENTAL EXAMINERS**

2
3 NEVADA STATE BOARD OF DENTAL
4 EXAMINERS,

5 Complainant,

6 vs.

7 ERIKA J. SMITH, DDS,

8 Respondent.

Case No. 5627-0003

**(Consolidated Case Nos.: 5627-1247;
5627-1326; 5627-1385; 5627-1386;
5627-1391; 6527-0002)**

CORRECTED

RENOTICE OF HEARING

(to clarify 1:00 p.m. start time only)

Date of Hearing: 07/13/18

Time of Hearing: 1:00 pm

9
10
11 **TO: ERIKA J. SMITH, DDS, Respondent; and**

12 **TO: LAWRENCE SEMENZA, ESQ., Attorney for Respondent.**

13
14 **PLEASE BE ADVISED** that on or about the 2nd day of March, 2018, an Amended
15 Complaint was filed with the Nevada State Board of Dental Examiners (the "Board") which, in
16 part, makes allegations that could result in disciplinary action against your license issued by the
17 Board.
18

19 **NOTICE IS HEREBY GIVEN**, pursuant to NRS 631.360, that the Board has scheduled
20 a public hearing to consider the allegations contained in the Amended Complaint. The public
21 hearing concerning the above-referenced matter will occur on the following date and time at the
22 following location:

23
24 **DATE : Friday, July 13, 2018, and daily thereafter until concluded**

25 **TIME : 1:00 p.m. on July 13, 2018;**
26 **9:00 a.m. daily thereafter until concluded**

27 **LOCATION : Nevada State Board of Dental Examiners**
6010 S. Rainbow Blvd., Suite A1
28 **Las Vegas, Nevada 89118**

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YOU ARE ADVISED that the hearing will be held pursuant to Nevada Revised Statutes (“NRS”) Chapters 233B, 622A, and 631, and the Nevada Administrative Code (“NAC”) Chapter 631. The purpose of the hearing is to consider evidence regarding the allegations in the Amended Complaint and to determine whether Respondent should be subject to discipline pursuant to NRS and NAC Chapters 631.

YOU ARE FURTHER ADVISED that the hearing is to be an open meeting pursuant to Nevada’s Open Meeting Law and may be attended by the public. During the hearing, the Board may choose to go into closed session to consider the character, alleged misconduct, professional competence or physical or mental health of Respondent. A verbatim record will be made by a court reporter. You are entitled to a copy of the transcript, at your cost, of the open and closed portions of the hearing.

YOU ARE FURTHER ADVISED that you have the right to answer the Amended Complaint within twenty (20) days of service of the Amended Complaint. You have the right to appear and to be heard at the hearing in your defense, either personally or through counsel of your choice, at your cost. Respondent is advised that she is encouraged to retain counsel, and that review, advice and representation by counsel is in her best interest.

YOU ARE FURTHER ADVISED that, at the hearing, the Board has the burden of proving the allegations in the Amended Complaint. The Board may, and intends to, call witnesses and offer exhibits and evidence regarding the allegations in the Complaint. Respondent also has the right to call and examine witnesses, offer exhibits/evidence, and cross-examine opposing witnesses on any matter relevant to the issues involved. Respondent has the right to request that the Board issue subpoenas to compel witnesses to testify and/or present evidence on your behalf. When making a request to the Board for issuance of a subpoena, you

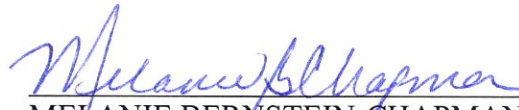
1 may be required to demonstrate the nature and relevance of the witness' testimony and/or
2 evidence.

3
4 **YOU ARE FURTHER ADVISED** that, if a violation is found and discipline is imposed,
5 the Board may also recover reasonable attorney's fees and costs pursuant to NRS 622.400.

6 DATED this 10th day of May, 2018.

7 NEVADA STATE BOARD OF DENTAL EXAMINERS

8
9 By:



10 MELANIE BERNSTEIN-CHAPMAN
11 Board Counsel

12 Nevada State Board of Dental Examiners

13 **CERTIFICATE OF SERVICE**

14
15 I certify that on the 10th day of May, 2018, I caused the above and foregoing
16 **CORRECTED RENOTICE OF HEARING (to clarify 1:00 p.m. start time only)** to be
17 served by placing a true and correct copy of the same in the United States Mail, at Las Vegas,
18 Nevada, via First Class and Certified Mail-Return Receipt Requested, postage fully prepaid,
19 addressed to the following:
20

21
22 Lawrence Semenza, Esq.
23 3753 Howard Hughes Pkwy #200
24 Las Vegas, Nevada 89169
25 Attorney for Respondent

26 

27 Patricia A. Quinn, Legal Secretary
28 The Nevada State Board of Dental Examiners

Amended Complaint

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STATE OF NEVADA
BEFORE THE BOARD OF DENTAL EXAMINERS

NEVADA STATE BOARD OF DENTAL
EXAMINERS,

Complainant,

vs.

ERIKA J. SMITH, DDS,

Respondent.

Case No. 5627-0003

(Consolidated Case Nos.: 5627-1247;
5627-1326; 5627-1385; 5627-1386;
5627-1391; 5627-1483; 5627-1574)

AMENDED COMPLAINT

Complainant, the Nevada State Board of Dental Examiners (hereinafter referred to as the "Board"), by and through its attorney, Melanie Bernstein Chapman, Esq, hereby issues this Amended Complaint against Respondent, Erika J. Smith, DDS (hereinafter referred to as "Respondent" or "Dr. Smith"), and alleges as follows:

GENERAL ALLEGATIONS

Parties and Jurisdiction

1. The Board is empowered to enforce the provisions of Chapter 631 of the Nevada Revised Statutes ("NRS"). NRS 631.190.

2. The Board, pursuant to NRS 631.190(6), keeps a register of all dentists and dental hygienists licensed in the State of Nevada; said register contains the names, addresses, license numbers, and renewal certificate numbers of said dentists and dental hygienists.

3. On November 1, 2007, the Board issued Respondent a dental license (#5627).

4. Respondent is licensed by the Board and, therefore, has submitted herself to the disciplinary jurisdiction of the Board.

History of Board Actions

5. On July 18, 2012, Respondent, with advice of counsel, freely and voluntarily entered into a *Corrective Action Stipulation Agreement* with the Board in Case No. 11-02285 which, in pertinent part, provides:

1
2 1. On June 6, 2011, the Board notified Respondent of a verified complaint
3 received from Sunshine Flores on behalf of Minor, Shawn Wainwright. On June
4 20, 2011, the Board received an answer to the complaint filed on behalf of the
5 Respondent by Andras F. Babero, Esq.

6 2. Based upon the limited investigation conducted to date, Disciplinary
7 Screening Officer, Bradley Roberts, DDS, applying the administrative burden of
8 proof of substantial evidence as set forth in *State, Emp. Security v. Hilton*
9 *Hotels*, 102 Nev. 606, 608, 729 P.2d 497, 498 (1986); and see *Minton v. Board of*
10 *Medical Examiners*, 110 Nev. 1060, 881 P. 2d 1339 (1994), see also NRS
11 233B.135(3)(e), but not for any other purpose, including any other subsequent
12 civil action, finds there is substantial evidence that Respondent failed to maintain
13 proper records of pediatric patient Shawn Wainwright in violation of NAC
14 631.230(1)(c).

15 3. Applying the administrative burden of proof of substantial evidence as
16 set forth in *State, Emp. Security v. Hilton Hotels*, 102 Nev. 606, 608, 729 P.2d
17 497, 498 (1986); and see *Minton v. Board of Medical Examiners*, 110 Nev. 1060,
18 881 P. 2d 1339 (1994), see also NRS 233B.135(3)(e), Respondent without
19 admitting to the opinion of the Disciplinary Screening Officer contained in
20 paragraph 2, acknowledges for settlement purposes only, if this matter were to
21 proceed to a full board hearing, substantial evidence exists that Respondent failed
22 to maintain proper records of pediatric patient Shawn Wainwright in violation of
23 NAC 631.230(1)(c).

24 Id., at 1:20 to 2:12 (emphasis in original). In part, the *Corrective Action Stipulation Agreement*
25 (Case No. 11-02285) approved by the Board on July 18, 2012, required Respondent's dental
26 practice be monitored for a period of twelve (12) months subject to certain conditions (id., pgs.
27 4-6), including requiring Respondent to obtain an additional supplemental education as follows:
28 six (6) hours related to Pediatric Diagnosis & Treatment Planning; six (6) hours relations to
Pediatric anesthesia and/or sedation; and six (6) hours related to Record Keeping. Id., at 4:18-
24.

29 6. On September 18, 2015, Respondent, with advice of counsel, freely and
30 voluntarily entered into a second *Corrective Action Non-Disciplinary Stipulation Agreement* with
31 the Board in Case No. 74127-02832 which, in pertinent part, provides as follows with regards to
32 patients Sherry West, Timothy Carlo, and Timothy Wigchers:

33 3. Based upon the limited investigation conducted to date, DSO,
34 Bradley Roberts, DDS, believes for this matter and not for any other
35

1 purpose, including any subsequent civil action, Respondent violated NAC
2 631.230(1)(c) with respect to treatment rendered to patient, Sherry West:

3 A. Respondent's delivery of four (4) quadrants of
4 scaling and root planing was unacceptable. Respondent
5 completed (4) quadrants of scaling and root planing in just
6 over one (1) hour. Respondent's daily schedule indicates
7 the patient was only scheduled for one (1) hour to complete
8 four (4) quadrants of scaling and root planning. Respondent's daily schedule also indicates Respondent
9 scheduled several other procedures immediately after
10 treating this patient.

11 B. Respondent prepared Teeth #7, 8, 9, and 10 for
12 porcelain fused to metal crowns during a scheduled one (1)
13 hour appointment. At the end on the one (1) hour
14 appointment Respondent commenced treatment on the next
15 patient. At the next (1) hour appointment Respondent
16 permanently cemented crowns on Teeth # 7, 8, 9, and 10.
17 The next day the crown for tooth #10 came loose while the
18 patient was eating and the crown was swallowed.
19 Respondent took a new impression to replace the
20 swallowed crown for tooth #10 and while doing so the
21 other three (3) permanently cemented crowns detached in
22 the impression for the new crown for tooth #10. Those
23 three (3) crowns, Teeth #7, 8, and 9 were again cemented
24 permanently by Respondent. Respondent refused to deliver
25 the replacement crown for Tooth #10 because Respondent
26 wanted payment prior to completing treatment.
27 Respondent's crowns placed on Teeth #7, 8, and 9 were ill-
28 fitting due to open and short margins as observed by the
DSO and recorded in the notes of the subsequent treating
dentist.

5. Based upon the limited investigation conducted to date, DSO,
Bradley Roberts, DDS, believes for this matter and not for any other
purpose, including any subsequent civil action, Respondent violated NAC
631.230(1)(c) with respect to treatment rendered to patient, Timothy
Carlo:

A. Respondent's build-ups performed on Teeth #13, 14
and 18 were unacceptable. Respondent left decay under the
buildups performed on Teeth #13, 14 and 18. The
remaining decay is noted by the subsequent treating dentist.

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B. Respondent's failed to take periapical radiographs of the teeth that were prepared. Without such radiographs, Respondent could not know if the teeth in question had any periapical pathology that would indicate the need for endodontic therapy.

C. After placing temporary crowns on Teeth #13 and 14 the patient complained of discomfort and sensitivity. Despite knowing of the patient's compliant, Respondent failed to take periapical radiographs to determine if Teeth #13, and 14 may require endodontic treatment.

7. Based upon the limited investigation conducted to date, DSO, Bradley Roberts, DDS, believes for this matter and not for any other purpose, including any subsequent civil action, Respondent violated NAC 631.230(1)(c) with respect to treatment rendered to patient, Timothy Wigchers:

A. Respondent failure to complete treatment because of the patient's financial inability was unacceptable.

B. Respondent record keeping for this patient was unacceptable. The patient's record indicates charges for crowns already completed. The patient's record reflect charges for treatment on dates when the patient was not even in the office. The patient's records failed to indicate the payments made by the patient. Respondent's records for this patient do not memorialize any of the conversations with patient regarding insurance problems.

Id., ¶ 3 at 2:25 to 3:14, ¶5 at 4:5-16, and ¶ 7 at 5:2-10, respectively. In part, the *Corrective Action Non-Disciplinary Stipulation Agreement* (Case No. 74127-02832) approved by the Board on September 18, 2015, required Respondent's dental practice be monitored for a period of twelve (12) months subject to certain conditions (id., pgs. 5-9), including requiring Respondent to obtain an additional supplemental education as follows: ten (10) hours re: scaling and root planning; ten (10) hours re: crowns; and ten (10) hours re: record keeping and billing practices (id., at 7:7-11), and that Respondent retake the jurisprudence test. Id., at 9:4-14.

7. On November 20, 2015, pursuant to agenda item 5(e), the Board granted

1 Respondent's request to amend Paragraph 9(E) of the September 18, 2015, *Corrective Action*
2 *Non-Disciplinary Stipulation Agreement* whereby an installment payment plan was implemented.

3 8. On July, 18, 2016, the Board issued an Order suspending Respondent's dental
4 license in the State of Nevada for failing to comply with Paragraph 9(E) of the September 18,
5 2015, *Corrective Action Non-Disciplinary Stipulation Agreement* as amended by the November
6 20, 2015 amendment.

7 9. On December 1, 2016, at the request of Dr. Smith, Dr. Smith appeared before the
8 Board at a public meeting to request the reinstatement of her dental license in the State of
9 Nevada upon submitting the reinstatement fee of \$300.00 and agreeing to reimburse the Board
10 the default reimbursed investigation costs in the amount of \$1,660.50 within six (6) months from
11 the date of the reinstatement of her dental license. In addition, the tolled monitoring time was
12 noted to commence upon the date of the reinstatement of the license for 135 days.

13 Patient, Geraldine Marchand

14 10. Subsequent to entering into the above-referenced *Corrective Action Stipulation*
15 *Agreement* in Case No. 11-02285 and the *Corrective Action Non-Disciplinary Stipulation*
16 *Agreement* in Case No. 74127-02832, Respondent, via a *Notice of Complaint & Request for*
17 *Records* dated September 22, 2015, was notified of the verified complaint of patient, Geraldine
18 Marchand.

19 11. On October 7, 2015, the Board received from Respondent's then-attorney
20 Respondent's written response (w/enclosures), dated October 7, 2015, to Ms. Marchand's
21 verified complaint, a copy of which was provided to Ms. Marchand on October 9, 2015.

22 12. On November 12, 2015, the Board received dental records from Dr. John Quinn
23 regarding Ms. Marchand, copies of which were provided to Respondent and Ms. Marchand on
24 November 17, 2015.

25 Patient, Sharon Linthicum

26 13. Subsequent to entering into the above-referenced *Corrective Action Stipulation*
27 *Agreement* in Case No. 11-02285 and the *Corrective Action Non-Disciplinary Stipulation*
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1 *Agreement* in Case No. 74127-02832, Respondent, via a *Notice of Complaint & Request for*
2 *Records* dated June 20, 2016, was notified of the verified complaint of patient, Sharon
3 Linthicum.

4 14. On August 23, 2016, the Board sent Respondent correspondence advising, in part,
5 that on June 20, 2016, it sent via certified mail the above-referenced verified complaint of Ms.
6 Linthicum to the address Respondent had on file with the Board (i.e., 1430 Calvada Blvd, Suite
7 300-400, Pahrump, Nevada 98048) and advised that the Board had not yet received
8 Respondent's factual answer and requested dental records of Ms. Linthicum.

9 15. On September 2, 2016, the Board received Respondent's letter dated August 30,
10 2016, which, in part, addressed the Board's August 23, 2016, letter and requested that that
11 verified complaint be resent to 2550 E. Desert Inn Road, #248, Las Vegas, Nevada 989121.

12 16. On September 6, 2016, the Board sent Respondent correspondence which, in part,
13 addressed Respondent's August 23, 2016, letter and which noted that on July 9, 2016, via the
14 online portal, Respondent removed her above-referenced Pahrump dental office address. Another
15 copy of the Notice of Complaint and supporting documents concerning the verified complaint of
16 patient, Sharon Linthicum was enclosed with the September 6, 2016 letter sent to Respondent
17 from the Board.

18 17. On September 20, 2016, the Board advised Respondent her request for an
19 extension to and including October 14, 2016, to file an answer to the verified complaint of Ms.
20 Linthieum was granted.

21 18. On September 26, 2016, the Board received a copy of dental records from Albert
22 Ruezga, DDS regarding Ms. Linthicum, copies of which were provided to Respondent and Ms.
23 Linthicum on September 28, 2016.

24 19. On October 14, 2016, the Board received Respondent's written response dated
25 October 13, 2016, to Ms. Linthicum's verified complaint, a copy of which was provided to Ms.
26 Linthicum on October 28, 2016. Respondent's October 14, 2016 written response with
27 enclosures did not include any x-ray and/or billing records which Respondent's response states
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1 are not available "because the computers were destroyed during the move of my office."

2 Jeffrey Holmes

3 20. Subsequent to entering into the above-referenced *Corrective Action Stipulation*
4 *Agreement* in Case No. 11-02285 and the *Corrective Action Non-Disciplinary Stipulation*
5 *Agreement* in Case No. 74127-02832, Respondent, via a *Notice of Complaint & Request for*
6 *Records* dated January 7, 2016, was notified of the verified complaint of Jeffrey Holmes.

7 21. On February 3, 2016, the Board received Respondent's attorney's written
8 response (w/enclosure) dated February 1, 2016, relative to the verified complaint of Mr. Holmes,
9 a copy of which was sent to Mr. Holmes on February 9, 2016.

10 Patient, Michelle Pedro

11 22. Subsequent to entering into the above-referenced *Corrective Action Stipulation*
12 *Agreement* in Case No. 11-02285 and the *Corrective Action Non-Disciplinary Stipulation*
13 *Agreement* in Case No. 74127-02832, Respondent, via a *Notice of Complaint & Request for*
14 *Records* dated May 28, 2016 was notified of the verified complaint of patient, Michelle Pedro.

15 23. On June 18, 2016, the Board received Ms. Pedro's additional supplemental
16 information dated June 18, 2016, a copy of which was sent to Respondent on June 24, 2016.

17 24. On June 27, 2016, the Board sent Respondent correspondence advising, in part,
18 that on May 28, 2016, it sent via certified mail the above-referenced verified complaint of Ms.
19 Pedro to the address Respondent had on file with the Board (i.e., 1430 Calvada Blvd, Suite 300-
20 400, Pahrump, Nevada 98048) and advised that the Board had not yet received Respondent's
21 factual answer and requested dental records of Ms. Pedro.

22 25. On July 15, 2016, the Board received Respondent's written response, to Ms.
23 Pedro's verified complaint, a copy of which was provided to Ms. Pedro on July 21, 2016.
24 Respondent's July 15, 2016 written response with enclosures did not include any x-ray and/or
25 billing records which Respondent's response states are not available "because the computers
26 were destroyed during the move of my office."

27 26. On July 18, 2016, the Board received a copy of dental records from Albert
28

1 Ruezga, DDS regarding Ms. Pedro, copies of which were provided to Respondent and Ms. Pedro
2 on July 19, 2016.

3 27. On or about October 7, 2016, the Board received Ms. Pedro's additional
4 supplemental information, a copy of which was sent to Respondent on October 14, 2016.

5 Patient, Joseph Pedro III

6 28. Subsequent to entering into the above-referenced *Corrective Action Stipulation*
7 *Agreement* in Case No. 11-02285 and the *Corrective Action Non-Disciplinary Stipulation*
8 *Agreement* in Case No. 74127-02832, Respondent, via a *Notice of Complaint & Request for*
9 *Records* dated May 28, 2016, was notified of the verified complaint of patient, Joseph Pedro III.

10 29. On June 27, 2016, the Board sent Respondent correspondence advising, in part,
11 that on May 28, 2016, it sent via certified mail the above-referenced verified complaint of Mr.
12 Pedro to the address Respondent had on file with the Board (i.e., 1430 Calvada Blvd, Suite 300-
13 400, Pahrump, Nevada 98048) and advised that the Board had not yet received Respondent's
14 factual answer and requested dental records of Mr. Pedro.

15 30. On July 15, 2016, the Board received Respondent's written response to Mr.
16 Pedro's verified complaint, a copy of which was provided to Mr. Pedro on July 21, 2016.
17 Respondent's July 15, 2016 written response with enclosures did not include any x-ray and/or
18 billing records which Respondent's response states are not available "because the computers
19 were destroyed during the move of my office."

20 31. On June 18, 2016, the Board received Mr. Pedro's additional supplemental
21 information dated June 18, 2016, a copy of which was sent to Respondent on June 24, 2016.

22 32. On July 25, 2016, the Board received Mr. Pedro's additional supplemental
23 information dated July 25, 2016, a copy of which was sent to Respondent on July 25, 2016.

24 Patient, Brittnee Smith

25 33. Subsequent to entering into the above-referenced *Corrective Action Stipulation*
26 *Agreement* in Case No. 11-02285 and the *Corrective Action Non-Disciplinary Stipulation*
27 *Agreement* in Case No. 74127-02832, Respondent, via a *Notice of Complaint & Request for*
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1 *Records* dated March 3, 2017, was notified of the verified complaint of patient, Brittnee Smith.

2 34. On April 7, 2017, the Board received Respondent's written response to Ms.
3 Smith's verified complaint, a copy of which was provided to Ms. Smith on April 11, 2017.

4 35. On April 24, 2017, the Board received a copy of dental records from Jeff Moxley,
5 DDS regarding Ms. Smith, copies of which were provided to Respondent and Ms. Smith on
6 April 24, 2017.

7 Patient, Jennifer Rutledge

8 36. Subsequent to entering into the above-referenced *Corrective Action Stipulation*
9 *Agreement* in Case No. 11-02285 and the *Corrective Action Non-Disciplinary Stipulation*
10 *Agreement* in Case No. 74127-02832, Respondent, via a *Notice of Complaint & Request for*
11 *Records* dated December 17, 2017, was notified of the verified complaint of patient, Jennifer
12 Rutledge.

13 37. On or about January 2, 2018, the Board sent Respondent correspondence
14 advising, in part, that on December 7, 2017, it sent via certified mail the above-referenced
15 verified complaint of Ms. Pedro to the address Respondent had on file with the Board (i.e., 2550
16 E. Desert Inn Road, #248, Las Vegas, Nevada 89121) and advised that the Board had not yet
17 received Respondent's factual answer and requested dental records of Ms. Rutledge.

18 38. On January 17, 2018, the Board received a copy of dental records from Bryson
19 LeMone, DDS regarding Ms. Rutledge, copies of which were provided to Respondent and Ms.
20 Rutledge on January 25, 2018.

21 39. At no time has Respondent provided a response to the verified complaint of Ms.
22 Rutledge.

23 Informal Hearing

24 40. On December 30, 2016, via certified mail, return receipt requested, and regular
25 mail, Respondent was provided with a Notice of Informal Hearing regarding the verified
26 complaints of Geraldine Marchand, Sharon Linthicum, Jeffry Holmes, Michelle Pedro, Joseph
27 Pedro III, the *Corrective Action Stipulation Agreement* (Case No. 11-02285) which was
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1 approved by the Board on July 18, 2012, and the *Corrective Action Non-Disciplinary Stipulation*
2 *Agreement* (Case No. 74127-02832) which was approved by the Board on September 18, 2015.

3 41. The Notice of Informal Hearing set the informal hearing for 10:00 a.m. on Friday,
4 February 24, 2017, at the offices of Morris, Polich & Purdy, LLP, 3800 Howard Hughes
5 Parkway, Suite 500, Las Vegas, Nevada 89169.

6 42. In part, the Notice of Informal Hearing indicated pursuant to NAC 631.250(1), the
7 Disciplinary Screening Officer shall not limit the scope of the investigation to the matters set
8 forth in the authorized investigation noted above, "but will extend the investigation to any
9 additional matters which appear to constitute a violation of any provision of Chapter 631 of the
10 Nevada Revised Statutes or the regulations contained in Chapter 631 of NAC of this Chapter."

11 43. Included with the Notice of Informal Hearing was a Subpoena Duces Tecum
12 dated December 27, 2016, addressed to Respondent which, in pertinent part, provides:

13 WE COMMAND YOU, that all and singular, business and excuses being set
14 aside, appear at **Morris Polich & Purdy, LLP, 3800 Howard Hughes**
15 **Parkway, Suite 500, Las Vegas, Nevada 89169**, on the **24th day of February**
16 **2016**, at the hour of **10:00 am** to produce the following documents:

17 1. Any and all records regarding patients *Jeffrey Holmes,*
18 *Geraldine Marchand, Joseph Pedro, III, Michelle Pedro and*
19 *Sharon Linthieum*, including, but not limited to, billing records,
20 laboratory work orders, prescription slips, insurance records
21 (including any correspondence or billing submitted to an insurance
provider), health history, charts notes, informed consents, daily
patient schedules for the dates of treatment, day sheets,
radiographs, treatment plans and patient logs; and

22 Id., pg. 1 (emphasis in original).

23 44. On January 20, 2017, Respondent was also personally served with a copy of the
24 above-referenced Notice of Informal Hearing and Subpoena Duces Tecum.

25 45. On February 23, 2017, the Board received Respondent's correspondence dated
26 February 22, 2017 which, in part, addressed the fact that Respondent received the Notice of
27 Informal Hearing and Subpoena Duces Tecum. Respondent's correspondence also advised she
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1 would not be attending the informal hearing. Respondent's February 23, 2017 correspondence
2 was accompanied by certain records for Geraldine Marchand, Sharon Linthicum, Michelle
3 Pedro, and Joseph Pedro III. Respondent's February 23, 2017 correspondence did not request a
4 continuance of the Informal Hearing noticed for February 24, 2017.

5 46. In attendance at the February 24, 2017, informal hearing was Bradley Roberts,
6 DDS, Disciplinary Screening Officer, the Board's Executive Director, Debra-Shaffer-Kugel, and
7 the Board's attorney, John A. Hunt, Esq. Respondent did not attend the Informal Hearing.

8 47. Following the informal hearing, written findings of fact and conclusions were
9 drafted, pursuant to NRS 631.363(3). *See Findings and Recommendations of the Informal*
10 *Hearing Held Pursuant to NRS 631 and NAC 631 & Consent of Erika J. Smith, DDS, to the*
11 *Findings and Recommendations Pursuant to NRS 631.363(5)* dated May 19, 2017 (hereinafter
12 "FR&C"). The FR&C were forwarded to Respondent for review and consent by Respondent,
13 pursuant to NRS 631.363(5). Respondent did not consent to the FR&C.

14 48. On February 9, 2018, the investigations into the verified complaints of the
15 patients described herein and the FR&C were reviewed by the Review Panel appointed pursuant
16 to SB 256. As to all of the patients described herein, the Review Panel found that there is a
17 preponderance of the evidence to support the FR&C and/or that there is a preponderance of the
18 evidence to support a conclusion that the Respondent violated one or more provisions of NRS
19 Chapter 631 and/or NAC Chapter 631, and that this matter shall proceed pursuant to NRS
20 631.360 and/or NAC 631.255.

21 49. NRS 631.3475 provides, in pertinent part:

22 **NRS 631.3475 Malpractice; professional incompetence; disciplinary action in**
23 **another state; substandard care; procurement or administration of controlled**
24 **substance or dangerous drug; inebriety or addiction; gross immorality; conviction**
25 **of certain crimes; failure to comply with certain provisions relating to controlled**
26 **substances; failure to obtain certain training; certain operation of medical facility.**
The following acts, among others, constitute unprofessional conduct:

- 27 1. Malpractice;
 - 28 2. Professional incompetence;
- ***

- 1 4. More than one act by the dentist or dental hygienist constituting substandard care in
2 the practice of dentistry or dental hygiene;

3 50. NRS 631.3485 provides, in pertinent part:

4 **NRS 631.3485 Violation of chapter or regulations; failure to pay fee for license;
5 failure to make health care records available for inspection and copying.** The
6 following acts, among others, constitute unprofessional conduct:

- 7 1. Willful or repeated violations of the provisions of this chapter;
8 2. Willful or repeated violations of the regulations of the State Board of Health, the
9 State Board of Pharmacy or the Board of Dental Examiners of Nevada;

4. Failure to make the health care records of a patient available for inspection and
10 copying as provided in NRS 629.061.

11 51. NRS 631.349 provides, in pertinent part:

12 **NRS 631.349 Examples of unprofessional conduct not complete list or
13 authorization of other acts; Board may hold similar acts unprofessional conduct.**

14 The acts described in NRS 631.346 to 631.3485, inclusive, must not be construed as a
15 complete list of dishonorable or unprofessional conduct, or as authorizing or permitting
16 the performance of other and similar acts, or as limiting or restricting the Board from
17 holding that other or similar acts constitute unprofessional or dishonorable conduct.

18 **I.**
ALLEGATIONS/CLAIMS REGARDING RESPONDENT'S
TREATMENT OF PATIENT, GERALDINE MARCHAND

19 52. The Board repeats and realleges the allegation contained in paragraphs 1 through
20 51 and reincorporates the same as if fully set forth herein.

21 53. Respondent's treatment of Patient, Geraldine Marchand, violated NRS
22 631.3475(1), (2), (4), and/or NRS 631.3485(1) and (4), and/or NRS 631.349 in the following
23 respects:

24 A. Respondent recommended the extraction of Tooth #24.
25 Respondent has not provided any radiographic evidence which would
26 have justified the recommendation for extraction of Tooth #24. Of note,
27 the subsequent treating dentist's periodontal chart shows Tooth #24 had no
28 more than 4mm pocketing. Further, the subsequent treating dentist's
radiograph of Tooth #24 does not provide any radiographic evidence to

1 support Respondent's recommendation for extraction of Tooth #24.

2 B. Respondent claims to have performed four (4) quadrants of scaling
3 and root planing. A review of Respondent's daily schedule for the day this
4 patient received treatment indicates Respondent would have allegedly
5 performed four (4) quadrants of scaling and root planing in less than 1.5
6 hours since Respondent had scheduled another patient for treatment
7 commencing 1.5 hours for the time Respondent commenced treatment on
8 this patient. Also, the Patient in this complaint has provided testimony the
9 four (4) quadrants of scaling and root planing she was billed for was
10 performed in less in 1.5 hours. Performing four (4) quadrants of scaling
11 and root planing in less than 1.5 hours is below the standard of care.
12 Respondent's records for this Patient are void of the existence of a
13 periodontal chart. Further the subsequent treating dentist's periodontal
14 chart for this Patient corroborates the need for this patient to receive four
15 (4) quadrants of scaling and root planing just two (2) months after
16 Respondent allegedly performed four (4) quadrants of scaling and root
17 planing. The radiographs taken by the subsequent treating dentist show
18 sub gingival calculus deposits present that clearly should have been
19 removed by Respondent just two (2) months earlier when Respondent
20 allegedly performed four (4) quadrants of scaling and root planing on this
21 Patient.

22 C. The composite fillings performed by Respondent on Teeth #4, #5,
23 #12, and #13 were below the standard of care. The radiographs taken by
24 the subsequent treating dentist clearly indicate large amounts of excessive
25 composite that was left interproximally on Teeth #4, #5, #12, and #13. It
26 does not appear Respondent made any effort to remove this extra filling
27 material, nor did Respondent advise the Patient of the presence of the
28 excess filling material.

D. The resulting treatment that was below the standard of care caused
the Patient to endure unnecessary pain, suffering, and additional cost to
have Respondent's substandard treatment corrected.

E. The complaint of this Patient involves similar treatment and/or
involves similar issues which were at-issue in the two prior corrective
action stipulations which Respondent entered into freely and voluntarily,
with the advice of counsel.

F. Respondent failed to produce a complete copy of this Patient's
records.

II.
ALLEGATIONS/CLAIMS REGARDING RESPONDENT'S
TREATMENT OF PATIENT, SHARON LINTHICUM

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3 54. The Board repeats and realleges the allegation contained in paragraphs 1 through
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5 53 and reincorporates the same as if fully set forth herein.

6 55. Respondent's treatment of Patient, Sharon Linthicum, violated NRS 631.3475(1),
7 (2), (4), and/or NRS 631.3485(1) and (4), and/or NRS 631.349 in the following respects:

8 A. On April 21, 2016, Respondent extracted Teeth #2, #3, #13¹, #14,
9 #15, #18, #20, #21, #27, #29 and #30. The extractions performed by
10 Respondent on Teeth #2, #3, #13, #14, #18, #28, and #30 were below the
11 standard of care. Respondent's lack of skill, knowledge, and training
12 resulted in Respondent leaving root tips in the extraction sites of Teeth #2,
13 #3, #13, #14, #18, #28, and #30. Further, Respondent's records are void of
14 any notation that the roots tips were present post extraction. Respondent
15 failed to take postoperative radiographs which would have confirmed or
16 dismissed the presence of the multiple remaining root tips. Of note,
17 although Respondent did not take any postoperative radiographs,
18 Respondent provided a copy of a referral to an oral surgeon with specific
19 teeth listed which needed additional treatment. It is the Disciplinary
20 Screening Officer's opinion that Respondent fabricated this referral after
21 she received records from the subsequent treating dentist. Further,
22 although admittedly not a handwriting expert, it is the Disciplinary
23 Screening Officer's opinion that the written chart notes submitted by
24 Respondent have been fabricated based upon the belief that the written
25 chart notes submitted by Respondent all appear be written at the same
26 time. Unlike other patient records reviewed, there are no initials on any of
27 the notes submitted for this patient. Also, void in this patient chart is any
28 notation for the Patient's next visit (unlike other patient chart notes; for
example, the chart notes of patient, Geraldine Marchand, always reference
when the next visit is supposed to be conducted). The subsequent treating
dentist has provided radiographs corroborating the presence of root tips in
the extraction sites for Teeth #2, #3, #13, #14, #18, #28, and #30. The
subsequent treating dentist has provided testimony that Respondent's
incomplete treatment consisted of leaving root tips and bone spurs (due to
incomplete alveoplasty) which resulted in the patient experiencing an
active infection and an ill-fitting prosthesis. This Patient has given

¹ Dr. Smith's records indicate that she removed tooth #12 but subsequent dentist's records show that it was actually tooth #13. Therefore, for ease of reference, tooth #13 is referenced.

1 testimony Respondent never informed her of the remaining root tips.

2 B. Respondent's fabrication of an Upper Partial (teeth #2, #3, #13,
3 #14 & #15) and Lower Partial (teeth #18, #19, #20, #21, #28, #29, #30, &
4 #31) are below the standard of care. The Lower Partial could not be seated
5 which caused this Patient to experience unnecessary pain and suffering.
6 The Upper Partial had no occlusion with a large gap beneath it on the
7 tissue side of the prosthesis resulting in the left side being in hyper-
8 occlusion.

9 C. Respondent, without notification, abandoned this Patient which is
10 below the standard of care. Respondent, within only a few days of
11 performing the extractions, closed her office with no notice which resulted
12 in this Patient being unreasonably denied the ability to seek postoperative
13 surgical care.

14 D. The resulting treatment which was below the standard of care
15 caused the Patient to endure unnecessary pain, suffering, and additional
16 cost to have Respondent's substandard treatment corrected.

17 E. Respondent failed to produce a complete copy of this patient's
18 records.

19 F. The complaint of this Patient involves similar treatment and/or
20 involves similar issues which were at-issue in the two prior corrective
21 action stipulations which Respondent entered into freely and voluntarily,
22 with the advice of counsel.

23 III.
24 ALLEGATIONS/CLAIMS REGARDING RESPONDENT'S
25 CONDUCT RELATIVE TO JEFFREY HOLMES

26 56. The Board repeats and realleges the allegation contained in paragraphs 1 through
27 55 and reincorporates the same as if fully set forth herein.

28 57. NRS 631.348(6) provides:

NRS 631.348 Misleading statements; false advertising; fraud in securing license; practice under misleading name; submitting fraudulent claim to insurer; failure to notify insurer of forgiven debt. The following acts, among others, constitute unprofessional conduct:

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6. Submitting a false or fraudulent claim for payment to an insurer for dental services rendered; or

58. Respondent's conduct relative to Jeffrey Holmes violated NRS 631.348(6) and/or NRS 631.3485(1), and/or NRS 631.349 in the following respects:

A. Respondent willfully and/or repeatedly submitted false and/or fraudulent claims for payment to Medicaid relative to Jeffrey Holmes. Respondent submitted eleven (11) claims for payment on August 22, 2015 (totaling \$1,332.90) for treatment Respondent never rendered to this Patient. Respondent submitted the eleven (11) claims without even examining this patient. Patient has provided testimony that although he had contacted Respondent regarding possible treatment, he cancelled his appointment with Respondent and thus never presented to Respondent for examination or treatment. On or about September 4, 2015, Respondent received payment for the eleven (11) false and/or fraudulent claims Respondent had submitted to Medicaid. The Patient has provided testimony he made repeated attempts to obtain a reimbursement/refund from Respondent. To date, Respondent has not responded to this Patient's inquiries regarding the matter and his request for a reimbursement/refund. However, it should be noted Respondent on January 14, 2016, advised the Nevada Medicaid Surveillance and Utilization Review unit (SUR) that Respondent wanted the false and/or fraudulent eleven (11) claims relative to this Patient be deducted from future payments to be paid to Respondent.

B. The resulting actions of Respondent have caused this Patient to endure unnecessary pain, suffering and delay of his necessary dental treatments.

C. The complaint of Mr. Holmes involves similar issues which were at-issue in the two prior Corrective Action Stipulations which Respondent entered into freely and voluntarily, with the advice of counsel.

IV.
ALLEGATIONS/CLAIMS REGARDING RESPONDENT'S
TREATMENT OF PATIENT, MICHELLE PEDRO

59. The Board repeats and realleges the allegation contained in paragraphs 1 through 58 and reincorporates the same as if fully set forth herein.

60. Respondent's treatment of Patient, Michelle Pedro, violated NRS 631.3475(1), (2), (4), and/or NRS 631.3485(1) and (4), and/or NRS 631.349 in the following respects:

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2 A. The extractions performed by Respondent on Teeth #3, #5, #29
3 and #31 were below the standard of care. Respondent's lack of skill,
4 knowledge, and training resulted in Respondent leaving root tips in the
5 extraction sites of Teeth #3, #5, #29 & #31. In addition, there were bone
6 spurs due to an incomplete alveoplasty. Further, Respondent did not
7 inform this Patient of the presence of the root tips until the Patient
8 complained of post-operative problems within days of the extractions.

9 B. Respondent failed to take postoperative radiographs which would
10 have confirmed or dismissed the presence of the multiple remaining root
11 tips.

12 C. Respondent, without notification, abandoned this Patient which
13 was below the standard of care. Respondent, within a week of performing
14 the extractions, closed her office with no notice which resulted in this
15 Patient being unreasonably denied the ability to seek postoperative
16 surgical care.

17 D. The resulting treatment which was below the standard of care
18 caused the Patient to endure unnecessary pain, suffering, and additional
19 cost to have Respondent's substandard treatment corrected.

20 E. Respondent failed to produce a complete copy of this Patient's
21 records.

22 F. The complaint of this patient involves similar treatment and/or
23 involves similar issues which were at-issue in the two prior corrective
24 action stipulations which Respondent entered into freely and voluntarily,
25 with the advice of counsel.

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V.
ALLEGATIONS/CLAIMS REGARDING RESPONDENT'S
TREATMENT OF PATIENT, JOSEPH PEDRO III

61. The Board repeats and realleges the allegation contained in paragraphs 1 through
60 and reincorporates the same as if fully set forth herein.

62. Respondent's treatment of Patient, Joseph Pedro III, violated NRS 631.3475(1),
(2), (4), and/or NRS 631.3485(1) and (4), and/or NRS 631.349 in the following respects:

1 A. The partial (teeth #23, #24, #25 & #26) fabricated by Respondent
2 for this Patient was below the standard of care. The occlusion is
3 unacceptable and there is little or no retention.

4 B. The resulting treatment that was below the standard of care caused
5 this Patient to endure unnecessary pain, suffering and additional cost to
6 have Respondent's substandard treatment corrected.

7 C. Respondent, without notification, abandoned this Patient, which
8 was below the standard of care. Respondent, within only a few days of
9 fabricating the partial for this Patient, closed her office with no notice
10 which resulted in this Patient being unreasonably denied the ability to seek
11 postoperative surgical care.

12 D. Respondent failed to produce a complete copy of this Patient's
13 records.

14 E. The complaint of this patient involves similar treatment and/or
15 involves similar issues which were at-issue in the two prior corrective
16 action stipulations which Respondent entered into freely and voluntarily,
17 with the advice of counsel.

18 **VI.**
19 **ALLEGATIONS/CLAIMS REGARDING RESPONDENT'S**
20 **TREATMENT OF PATIENT, BRITTNEE L. SMITH**

21 63. The Board repeats and realleges the allegation contained in paragraphs 1 through
22 62 and reincorporates the same as if fully set forth herein.

23 64. Respondent's treatment of Patient, Brittnee L. Smith, violated NRS 631.3475(1),
24 (2), (4), and/or NRS 631.3485(1), and/or NRS 631.349 in the following respects:

25 A. Respondent used inadequate anesthesia for a surgical extraction on
26 tooth #17.

27 B. Respondent drilled into the distal root of tooth #18 causing damage
28 that can only be repaired with extensive treatment (extraction and implant
placement or root canal and hemisection of the distal root).

C. Respondent did not make an immediate referral to a specialist after
she was aware of the damage that she caused to tooth #18.

1 D. Respondent made no follow-up to check on the patient after less
2 than optimal treatment was performed, until the patient made complaint to
3 the office.

4 E. Respondent's record keeping is below the standard of care in that
5 the patient states that she returned to the office the day following the
6 attempted extraction to get stronger pain medication but there is no
7 notation of this in the records that were received.

8 F. The complaint of this patient involves similar treatment and/or
9 involves similar issues which were at-issue in the two prior corrective
10 action stipulations which Respondent entered into freely and voluntarily,
11 with the advice of counsel.

12 **VII.**
13 **ALLEGATIONS/CLAIMS REGARDING RESPONDENT'S**
14 **TREATMENT OF PATIENT, JENNIFER RUTLEDGE**

15 65. The Board repeats and realleges the allegation contained in paragraphs 1 through
16 64 and reincorporates the same as if fully set forth herein.

17 66. Respondent's treatment of Patient, Jennifer Rutledge, violated NRS 631.3475(1),
18 (2), (4), and/or NRS 631.3485(1), and/or NRS 631.349 in the following respects:

19 A. Respondent failed to fill fillings on teeth #s 28, 29 and 30 properly
20 in that, when the fillings on teeth #s 28, 29 and 30 were done the
21 occlusion was not checked and equilibrated properly, therefore leaving the
22 teeth in hyper-occlusion.

23 B. Respondent failed to polish or smooth the teeth properly, and was
24 reportedly in a rush to complete the procedures.

25 C. Respondent failed to ensure that the restorations were properly
26 bonded.

27 D. Respondent's failure to properly bond the restorations left the
28 patient with pain and discomfort until the fillings were replaced by Dr.
LeMone six months after Respondent's treatment.

E. The complaint of this patient involves similar treatment and/or
involves similar issues which were at-issue in the two prior corrective
action stipulations which Respondent entered into freely and voluntarily,
with the advice of counsel.

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2 F. Respondent failed to produce a complete copy of this Patient's
3 records.

4 **VIII.**
5 **ALLEGATIONS/CLAIMS REGARDING FAILURE TO COMPLY**
6 **WITH SUBPOENA DUCES TECUM**

7 67. The Board repeats and realleges the allegation contained in paragraphs 1 through
8 66 and reincorporates the same as if fully set forth herein.

9 68. As noted above, included with the Notice of Informal Hearing was a Subpoena
10 Duces Tecum dated December 27, 2016, addressed to Respondent which, in pertinent part,
11 provides:

12 WE COMMAND YOU, that all and singular, business and excuses being set
13 aside, appear at **Morris Polich & Purdy, LLP, 3800 Howard Hughes**
14 **Parkway, Suite 500, Las Vegas, Nevada 89169, on the 24th day of February**
15 **2016, at the hour of 10:00 am to produce the following documents:**

16 1. Any and all records regarding patients ***Jeffrey Holmes,***
17 ***Geraldine Marchand, Joseph Pedro, III, Michelle Pedro and***
18 ***Sharon Linthieum,*** including, but not limited to, billing records,
19 laboratory work orders, prescription slips, insurance records
20 (including any correspondence or billing submitted to an insurance
21 provider), health history, charts notes, informed consents, daily
22 patient schedules for the dates of treatment, day sheets,
23 radiographs, treatment plans and patient logs; and

24 Id., pg. 1 (emphasis in original).

25 69. On January 20, 2017, Respondent was personally served with a copy of the
26 Notice of Informal Hearing and Subpoena Duces Tecum.

27 70. Respondent has failed to produce all records commanded in the Subpoena Duces
28 Tecum which is deemed unprofessional conduct in violation of NRS 631.3485(4) and/or NRS
631.349.

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IX.
ALLEGATIONS/CLAIMS REGARDING
RESPONDENT'S ADDRESS INFORMATION

71. The Board repeats and realleges the allegation contained in paragraphs 1 through 70 and reincorporates the same as if fully set forth herein.

72. NAC 631.150 provides:

NAC 631.150 Filing of addresses of licensee; notice of change; display of license. (NRS 631.190, 631.350)

1. Each licensee shall file with the Board the addresses of his or her permanent residence and the office or offices where he or she conducts his or her practice.

2. Within 30 days after any change occurs in any of these addresses, the licensee shall give the Board a written notice of the change. The Board will impose a fine of \$50 if a licensee does not report such a change within 30 days after it occurs.

3. The licensee shall display his or her license and any permit issued by the Board, or a copy thereof, at each place where he or she practices.

[Bd. of Dental Exam'rs, § XVI, eff. 7-21-82] — (NAC A 9-6-96; R066-11, 2-15-2012)

73. Respondent failed to update her permanent residence and dental office within 30 days from the occurrence as set forth in NAC 631.150. It is documented through a processor server that Dr. Smith has not lived at the residence on file, i.e., 8829 Martin Downs Place Las Vegas Nevada 89130 since at least January 3, 2017.

74. In addition, pursuant to a complaint filed with the Board by patient Brittnee L. Smith on February 7, 2017, it is referenced that Responded treated said patient at the office doing business as Dental Center of Nevada located at 601 5 Rancho Drive Ste B—I 5 Las Vegas, Nevada 89106 (office of Felipe Palaeracio, DDS) on January 7, 2017.

1 75. As of February 23, 2017, Respondent failed to provide an office address as set
2 forth in NAC 631.150. Further, due to the failure to update an office address, the Board was not
3 informed Respondent was actively practicing dentistry in the State of Nevada and this failure to
4 provide an office location has impeded the Board's ability to monitor Respondent's practice
5 pursuant to the operative Corrective Action Stipulation Agreement.
6

7 76. As of March 2, 2018, Respondent has failed to provide an office address or an
8 address of permanent residence as required by NAC 631.150.
9

10 **X.**
ALLEGATIONS/CLAIMS REGARDING
RESPONDENT'S FAILURE TO NOTIFY THE BOARD REGARDING THE CONSENT
ORDER RESPONDENT ENTERED INTO WITH THE TEXAS STATE BOARD OF
DENTAL EXAMINERS ON NOVEMBER 8, 2013
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14 77. The Board repeats and realleges the allegation contained in paragraphs 1 through
15 76 and reincorporates the same as if fully set forth herein.

16 78. NAC 631.155 provides, in pertinent part:

17 **NAC 631.155 Licensee to notify Board of certain events. (NRS 631.190)**
18 Each licensee shall, within 30 days after the occurrence of the event, notify the
19 Board in writing by certified mail of:

20 ***

21 3. The suspension or revocation of his or her license to practice dentistry or the
22 imposition of a fine or other disciplinary action against him or her by any agency
23 of another state authorized to regulate the practice of dentistry in that state;

24 79. On or about November 8, 2013, Respondent entered into a Consent Order with
25 the Texas State Board of Dental Examiners ("Texas Consent Order").

26 80. Responded failed to notify the Board of the Texas Consent Order, in violation of
27 NAC 631.155.
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- (a) Costs of an investigation.
- (b) Costs for photocopies, facsimiles, long distance telephone calls and postage and delivery.
- (c) Fees for court reporters at any depositions or hearings.
- (d) Fees for expert witnesses and other witnesses at any depositions or hearings.
- (e) Fees for necessary interpreters at any depositions or hearings.
- (f) Fees for service and delivery of process and subpoenas.
- (g) Expenses for research, including, without limitation, reasonable and necessary expenses for computerized services for legal research.

85. This action relates to the Board, a regulatory body, undertaking action as part of its investigative, administrative, and disciplinary proceedings against Respondent as to the enforcement of provisions of chapter 631 of the Nevada Revised Statutes and/or chapter 631 of the Nevada Administrative Code which the Board has the authority to enforce and, therefore, NRS 622.400(1) is satisfied.

86. That, as a result of NRS 622.400(1) being satisfied, as alleged immediately above, should NRS 622.400(1)(a) or (b) be satisfied, the Board recover from Respondent its attorney's fees and costs.

Wherefore, it is prayed:

1. That the Board conduct a formal hearing regarding the above-referenced matters constituting violations of the provision of chapter 631 of the NRS and/or NAC 631;
2. That, upon conclusion of said hearing, the Board determine what, if any, disciplinary action it deems appropriate pursuant to NRS 631.350, and any other applicable provision of chapter 631 of the NRS and/or NAC;

1 3. That, to the extent the Board deems appropriate, the Board should assess against
2 Respondent attorney's fees and costs incurred by reason of the investigation, administration,
3 prosecution, and hearing of this matter as provided by law;

4 4. That, to the extent the Board deems appropriate, the Board should impose a fine
5 upon Respondent in an amount deemed appropriate, pursuant to NRS 631.350(1)(c);

6 5. That, to the extent the Board deems appropriate, the Board should order that
7 Respondent reimburse any at-issue patient(s), pursuant to NRS 631.350(1)(l);

8 6. That to the extent the Board deems appropriate, the Board should issue a public
9 reprimand upon Respondent, pursuant to NRS 631.350(1)(e), based upon any findings of
10 Respondent's violations of the above-referenced provisions of chapter 631 of the Nevada
11 Revised Statutes and Nevada Administrative Code; and

12 7. That, to the extent the Board deems appropriate, the Board should take other and
13 further action as may be just and appropriate, provided for and allowed pursuant to relevant
14 authority.

15 Respectfully submitted this 2 day of March, 2018.

16 **Nevada State Board of Dental Examiners**

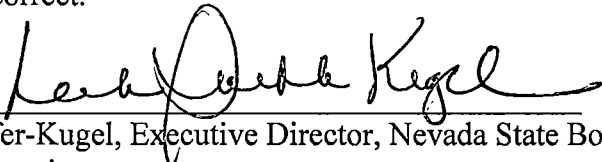
17 By Melanie Bernstein Chapman
18 Melanie Bernstein Chapman, Esq.
19 6010 S Rainbow Blvd, Suite A-1
20 Las Vegas, Nevada 89118
21 ph. (702) 486-7044; fax (702) 486-7046
22 Attorney for the Board

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VERIFICATION

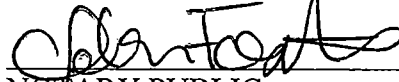
STATE OF NEVADA)
)
COUNTY OF CLARK) SS:

The foregoing Complaint has been prepared from information known to me or communicated to me and/or the Board and its staff and/or upon the information available and as referenced in the Complaint and any exhibit(s). Based on such information, it is believed the allegations in the Complaint are true and correct.

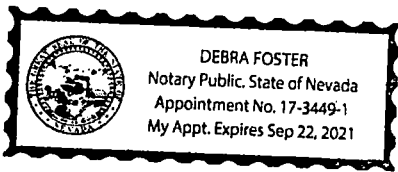


Debra Shaffer-Kugel, Executive Director, Nevada State Board of Dental Examiners

SUBSCRIBED and SWORN to before me
this 2 day of March, 2018.



NOTARY PUBLIC
(notary seal)



Certificate of Service

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STATE OF NEVADA

BEFORE THE BOARD OF DENTAL EXAMINERS

NEVADA STATE BOARD OF DENTAL EXAMINERS,

Complainant,

vs.

ERIKA J. SMITH, DDS,

Respondent.

Case No. 5627-0003
(Consolidated Case Nos.: 5627-1247;
5627-1326; 5627-1385; 5627-1386;
5627-1391; 5627-1483; 5627-1574)

CERTIFICATE OF SERVICE

I hereby certify that on the 12th day of April 2018, I caused a true and accurate copy of the below referenced documents (previously served on March 2, 2018) to be re-served by placing a true and correct copy of the same in the U.S. regular mail, postage prepaid, AND via certified mail, return receipt requested, from Las Vegas, Nevada, to the Respondent at the below referenced address:

Lawrence Semenza, Esq.
3753 Howard Hughes Pkwy #200
Las Vegas, Nevada 89169
Attorney for Respondent

The documents re-served with this Certificate of Service are as follows:

1. Review Panel Findings dated February 9, 2018;
2. Amended Complaint in the matter of *Nevada State Board of Dental Examiners vs. Erika J. Smith, DDS*, dated March 2, 2018;
3. Fingerprint Instructions and Packet pursuant to NRS 622.360

By Patricia J. Quinn
Patricia Quinn
Nevada State Board of Dental Examiners