

NEVADA STATE BOARD of DENTAL EXAMINERS

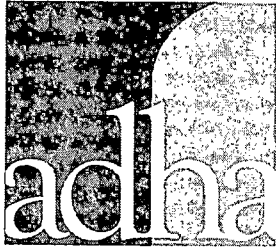


PUBLIC COMMENT

Board Meeting

**Friday, January 17, 2020 &
Saturday, January 18, 2020**

Public Comment from
Jessica Woods, RDH



Nevada

Dental Hygienists' Association



January 15, 2020

Nevada Dental Hygienists' Association
4132 S. Rainbow Blvd. #236
Las Vegas, NV 89103-3106

RE: January 17-18, 2020 Agenda – New Business item “Appoint Members/Agents to the Committee on Public Health” (Item 12o)

To: Nevada State Board of Dental Examiners

On behalf of NDHA, I would like to commend the Nevada State Board of Dental Examiners for recognizing and addressing the oral public health concerns of Nevadans. The creation of the Committee of Public Health will be an asset to the Boards functions.

Being that the position of State Dental Hygiene Officer is currently vacant, I would request that the Board consider to appointment an interim Registered Dental Hygienist to carry out the duties for the Committee until the position is filled.

NDHA would like to express support to have Ms. Lancette VanGuilder, RDH appointed to this seat on the Committee of Public Health. Ms. VanGuilder is well-versed in activities pertaining to public oral health, especially for rural and tribal communities, and would represent the northern part of the state to provide for a more geographically diverse Committee.

Respectfully,

Jessica L. Woods, MPH, RDH
President, Nevada Dental Hygienists' Association

Public Comment from
Lancette VanGuilder, RDH

October 28, 2019/ 1st submission

January 15, 2020/2nd submission



COMMUNITY DENTAL CONNECTIONS
Your Partner in Wellness

To: Nevada State Board of Dental Examiners

From: Lancette VanGuilder, RDH, BS

RE: Approval of New Public Health Program and Endorsements for Lancette VanGuilder

Thank you, in advance, for your consideration for a new public health program for our state, Community Dental Connections. After working for Future Smiles, I am beyond excited to return to my role in public health and serving vulnerable populations in our state and I appreciate the opportunity to submit my complete packet to you for approval. I apologize that I am unable to attend this weekend's meeting since I am out of state working and I humbly ask for your support to allow me to help meet the needs of many Nevadans.

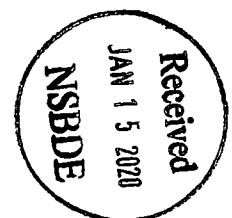
I have spent the majority of my life either living in, advocating for or serving rural and underserved communities in Nevada. I have 25 years of experience as a registered dental hygienist (22 in Nevada) and have advocated for public health and the dental hygiene profession on the state and national level for over the last two decades. I have served on various professional boards for nearly all of my 25 years as well, including the American Dental Hygienists Association. Currently, I work in private practice with Sierra Smiles, I am an international continuing education speaker for dentists, dental hygienists and dental therapists and serve as a professional educator and key opinion leader. In 2018, I invested more in to my education and received my certificate of nonprofit management from the University of Nevada, Reno. I am hoping that my vast knowledge of public health, rules and regulations, clinical expertise and leadership prove that I meet the qualifications to start a new program and ensure my commitment to public health and safety. At this time, I have secured equipment, necessary supplies and have some grant money to fund the beginning of the program. In addition, I have a local school waiting for me to get approval to serve high risk teens, ages 14-20.

I have submitted the requirements for the approval of the new program and the endorsement request to allow me to work with the program, as well as a request to be added to His Heart as a volunteer. This provides me the opportunity for a broad reach in my public health work.

While I am hopeful that the application will be approved as submitted, I understand there is a slight possibility that you may have a question. Unfortunately, I am teaching a couple of continuing education courses to dentists and dental hygienists in Indianapolis during the same time as the board meetings and I will be unavailable to take a call. Thank you, in advance, for your consideration and I look forward to hearing I can continue my public health work.

Respectfully Submitted,

Lancette VanGuilder, RDH, BS



Public Comment from
Caryn Solie, RDH

January 15, 2020

Nevada State Board of Dental Examiners

Regarding: January 17 and 18, 2020 agenda item 12*o

As a former member of the State Board of Dental Examiners, I congratulate you on your appointments and appreciate your service to the citizens of our state.

The Public Health Committee will be a valuable asset to the work of the Board. Item 12*o of your agenda is to appoint the members of that committee, currently there is no State Dental Hygiene Officer, and it is likely to remain unfilled for some time. I would request that a Registered Dental Hygienist be named to serve in the interim for that position. This would allow for fair and equal representation for the professions and the Board.

I would ask the Board to consider Samantha Sturges for that interim position.

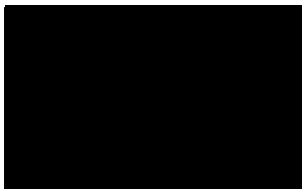
It is fair to assume that the Public Health Committee will be tasked with drafting the regulations for dental therapy/therapists, pursuant to SB366. I would like to offer myself to assist with the committee at that time, as I worked as a non-paid lobbyist and representative of NDHA on SB366 and know the bill language thoroughly.

I wish you well in all of your deliberations and commitment to safe oral healthcare for all Nevadans.

Thank you for your considerations of my recommendations.

Respectfully,

Caryn Solie, RDH



NDHA/ADHA member

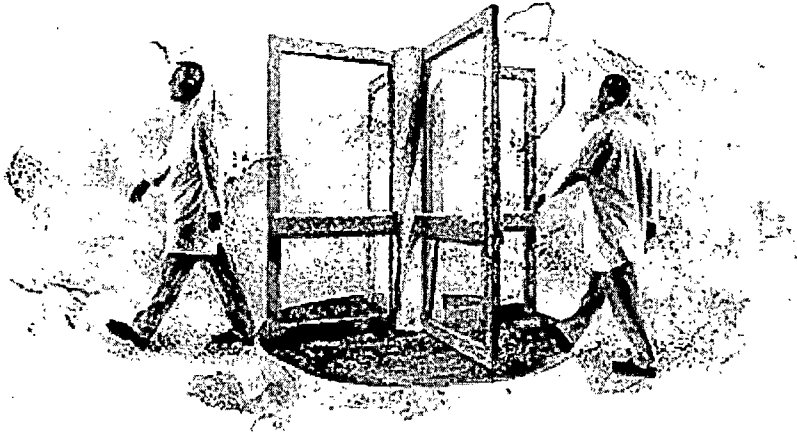


Article for Public Comment from
William Pappas regarding agenda
item 12(a)

Deadly Dentistry: Beating the System

By Brooks Egerton | Staff Writer Published December 9, 2015

Part 4 of 7



Nevada disciplined dentist for deaths, but it didn't matter in Texas

- 1. The traveler
- 2. The professor
- 3. The official

Updated on 12/17: Revised to say three states use a service to monitor dentists' disciplinary records.

LAS VEGAS — Two casino workers suffocated after Dr. Craig Morris sedated them. Nevada dental enforcers began investigating, and the oral surgeon gave up his right to sedate anyone else in 2012. But what happened in Vegas stayed in Vegas. Morris simply told Texas his record was clean and practiced freely near Austin and Houston, according to records obtained by *The Dallas Morning News*.

Dangerous dentists are crossing state lines and starting over around the country, we found, despite a federal information-sharing system that's intended to limit their mobility.

States must report health care disciplinary actions to the U.S. government's National Practitioner Data Bank. However, they sometimes avoid disclosure by calling an action nondisciplinary.

And they aren't required to ever check the Data Bank. Texas, for example, has been granting dental licenses without using it, although that's about to change.

Kelly Parker, recently hired as executive director of the Texas State Board of Dental Examiners, said that "once I was alerted to this issue, I immediately implemented the requirement."

You as an ordinary citizen, meanwhile, can see only anonymous records in the federal database.

States can sign up for constant, automatic checking at \$3 a year per health care provider. But federal officials told us that only three states use this service to monitor any dentists. And only one of those states, Oregon, says it monitors all of its dentists this way.

“It is something we may explore in the future,” said Texas dental board spokeswoman Lara Anton.

For now, a board employee is assigned to study lists of dentists who’ve been disciplined each month around the nation. The lists don’t identify all states in which the dentists hold licenses, so the employee must manually check each name for a possible Texas connection.

The American Association of Dental Boards compiles the lists and tells recipients to keep them confidential, even though they summarize public records. We obtained copies of the lists — and found that they failed to include actions that some states had taken.





JAN 15 2020
NSBDE

Morris lost his right to sedate patients in Nevada because of the deaths. But he faced no restrictions for years in Texas, where he has worked for the Carus Dental chain in Killeen (shown here) and the Houston area. He denies wrongdoing. (Andy Jacobsohn/Staff Photographer)

‘Doesn’t make sense’

In interviews, Morris said he felt terrible about the Las Vegas deaths but wasn’t at fault.

“Trust me, you still second-guess yourself,” he told us. “It’s a devastating occurrence that I hope no one ever, ever has to experience.”

Morris also denied responsibility for injuries suffered by several other patients. All told, the harm has led to confidential legal settlements and one court judgment totaling over \$2 million.

If he had correctly filled out an online form when renewing his Texas license last year, the state might have made specific inquiries about him to the National Practitioner Data Bank or elsewhere. But Morris clicked “no” when asked whether he’d been disciplined elsewhere.

“It was inadvertent,” he told us. “I don’t have anything to hide.”

Morris said a Texas dental board official alerted him to the misstatement in the latter part of 2015. “I addressed the issue,” he said, “and I don’t think it is an issue any more.”

He said the official was a board member — in other words, a gubernatorial appointee, not an agency employee. He would not identify the person.

Advertisement

Nycia Deal, the agency’s top lawyer, said Morris’ account “doesn’t make sense.” The agency’s ethics policy prohibits board members, in most situations, from communicating privately with someone whose conduct is a “matter before the board.”

Deal said that if Morris’ account were true, “that’s a big problem.”

Morris and other dentists whose cases we reviewed obtained licenses in multiple states before getting in trouble. Once they came under investigation, they moved.

We also identified dentists who secured a license in one state after another state found them unfit.

Take the case of Dr. Thomas Teich, who served prison time for bilking insurers and was long barred from practice in Arizona. Regulators there said he endangered patients with the fraud and had “a history of cocaine dependence.”

Then, in 2002, California licensed Teich even though he disclosed his past. State officials called their decision a “mistake” — after learning that patients had been illegally sedated at his suburban Los Angeles office, leading to one death.

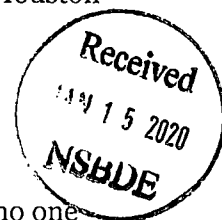
Teich surrendered his license in 2014. We could not locate him or his lawyer for comment.

Missouri has granted licenses to at least two dental castoffs in recent years, while publishing limited summaries of their past misdeeds.

One had been shut out of three other states, for reasons ranging from personal drug abuse to oversedating patients. The other’s history included alcohol abuse, arson, attacking police and failing to aid a patient he’d injured.

Broken jaws

Morris obtained his Texas license in 1997, after a decade of basic and advanced training at Meharry



School of Dentistry, in Nashville, Tenn. He went to work near Fort Hood, the massive Army post in Central Texas, and got a Nevada license in 2000.

Then he moved to Las Vegas, where malpractice allegations soon dogged him.

The legal trail started in 2002, when a patient suffered a broken jaw and severed nerve while Morris extracted teeth. A lawsuit accused him of botching repair of the injuries, leading to severe long-term pain and more surgeries.

Later that year, Morris' boss accused him of safety breaches and fired him. One issue was failure to protect a patient's airway with a gauze "throat pack," Dr. Eric Skinner wrote in a termination letter.

"What if, because there was no throat pack, the patient should aspirate a tooth?" said the letter, which was disclosed in the lawsuit. "There would be no defense."

The letter said Morris also verbally abused assistants, let one of them remove teeth, and failed to document patients' vital signs.

He started his own Las Vegas-based practice. Soon, according to another lawsuit, he failed to diagnose a post-surgical infection, leading to "dead bone," a broken jaw and "lengthy intravenous antibiotic therapy."

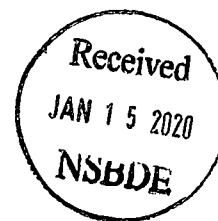
Morris denied wrongdoing in both broken-jaw cases. They resulted in out-of-court financial settlements. He told us that insurers often believe it's cheaper to settle than fight and can act without a client's permission.

Insurers must report malpractice payments to the National Practitioner Data Bank, and Nevada regulators could see information about the two jawbreak cases. But the State Board of Dental Examiners took no public action against Morris.

The board should not have allowed him to keep treating patients, Skinner told us.

He was "a bomb waiting to go off," the now-retired dentist said. "I wouldn't let him work on my dog."

Advertisement





Kaila Foster suffered a facial burn when Morris treated her in California before the Las Vegas deaths.
(Family photo)

Burned face

Morris' earning opportunities grew over the years. He sometimes flew back to Texas to perform surgeries. He became a part-time instructor at the University of Nevada's dental school in Las Vegas.

In 2008, he obtained a dental license in California and began taking jobs there, too. Kaila Foster was one of his patients, in the Sacramento suburb of Folsom.

She was supposed to have her four wisdom teeth pulled in July 2008, before starting her senior year in high school.

Foster's mom, Tamara Kurtovich, said she met Morris for the only time as he prepared to administer sedation. Soon, an aide came to the waiting room and told her to park by the back door.

A dental assistant brought out Foster in a wheelchair. Only one tooth had been extracted.

"She was so doped up she couldn't walk," Kurtovich told us. "She was crying."

They settled the teen into the car. Then, she recalled, the assistant said, "Oh, by the way, she accidentally was burned a little on the face."

Kurtovich said she got behind the wheel and “looked over at her and was like, ‘Oh my God.’ ”

Morris had “allowed a hand-piece to become overheated,” according to records in a lawsuit she filed. “This drill contacted plaintiff’s lip, gums and chin causing a severe facial burn with permanent scarring.”

In a court filing, Morris denied wrongdoing. He told us the burn was small and “not malpractice.”

The dentist said he lacked insurance in California and personally paid to settle the case, according to Kurtovich’s lawyer, Todd Osborne. Morris told us that he did have insurance but chose to pay a small settlement himself.

Foster said she endured teasing “about being the Joker’s cousin” — a reference to the Batman character’s scarred face. The cruelty faded with time, as did the burn mark.

But, she added, “I’ll always have it.”



Suba, a casino maintenance worker, had a fatal heart attack after Morris sedated him. (Family photo)

First death

Rene Suba was a 57-year-old casino maintenance man whose quick smile had fallen victim to oral disease. He was in pain. And one morning in March 2011, relatives told us, he suddenly decided to have his 12 remaining natural teeth pulled.

Come on in, said a Las Vegas dental office where he'd been treated before. There's an oral surgeon contractor available this afternoon.

Dental records say Morris initially gave Suba an intravenous injection of five milligrams of Versed, a potent sedative. That's twice the recommended maximum initial dose for a healthy adult receiving no other sedatives, according to a drug package warning.

Suba was getting another sedative, nitrous oxide gas. Also, he told Morris he had asthma and high blood pressure that medication controlled, the dental records note.

Trust me, you still second-guess yourself. It's a devastating occurrence that I hope no one ever, ever has to experience."

Dr. Craig Morris on how he felt after the Las Vegas deaths

Excessive doses of Versed "may result in respiratory depression, airway obstruction and/or arrest," the warning says. Dental patients and others undergoing upper-airway procedures "are particularly vulnerable."

Suba vomited a clear liquid after the first extraction, according to dental records. It's unclear why, although both sedatives are known to nauseate a small percentage of patients. Morris suctioned the fluid, but Suba began struggling to breathe.

Morris injected a drug to counteract the Versed, provided artificial respirations and gave Suba puffs from an inhaler, the records say. Yet his oxygen levels kept falling. Morris called 911 after about 16 minutes, concluding that the patient was having a severe asthma attack.

Suba died after nine days in a coma, surrounded by his wife and three daughters. Two autopsies concluded that he had suffered a heart attack, but they disagreed about why.

First, a doctor associated with the Subas' funeral home performed an autopsy without seeing the dental records. She concluded that Suba had died naturally, with clogged arteries causing the heart attack.

Then the county medical examiner ruled the death an accident. His report said asthma, potentially exacerbated by the sedatives, led to oxygen deprivation. That, in turn, caused the heart attack.

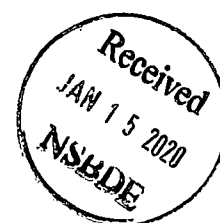
Eventually, Nevada's dental board described a third scenario: that Suba had struggled to breathe because he'd inhaled vomit — and didn't receive appropriate emergency treatment.

His relatives said that, given the divergent explanations, they couldn't find a lawyer to represent them. They received no compensation from the dentist.

Morris told us that he injected "a very small amount of anesthesia." Death, he said, stemmed from heart and lung problems "that I was not aware of."

Advertisement





Kimberly Ortiz, a casino security guard, choked to death on gauze after Morris sedated her. (Family photo)

Second death

In May 2011, two months after Suba's death, Nevada's dental board told Morris it was investigating. Meanwhile, another of his patients had been injured: a boy at a Dallas-area office from whom four teeth were mistakenly pulled.

Morris unquestioningly followed faulty instructions from a referring dental office, said the patient's lawyer, Rodney Gappelberg. He should have asked about "removing healthy and descended molars in a teen undergoing orthodontic treatment and leaving untouched the wisdom teeth-molars that are routinely extracted."

The dentist told us: "I did only what they asked me to do." The dental offices paid an undisclosed amount to settle a resulting lawsuit, while he paid nothing.

As the Nevada investigation continued, two more patients were harmed in the first half of 2012.

First, a Las Vegas man's jaw broke during a wisdom tooth extraction. He was left in pain for hours because the dentist lacked proper repair supplies, a lawsuit alleged. Morris didn't file a response and was recently found liable by default.

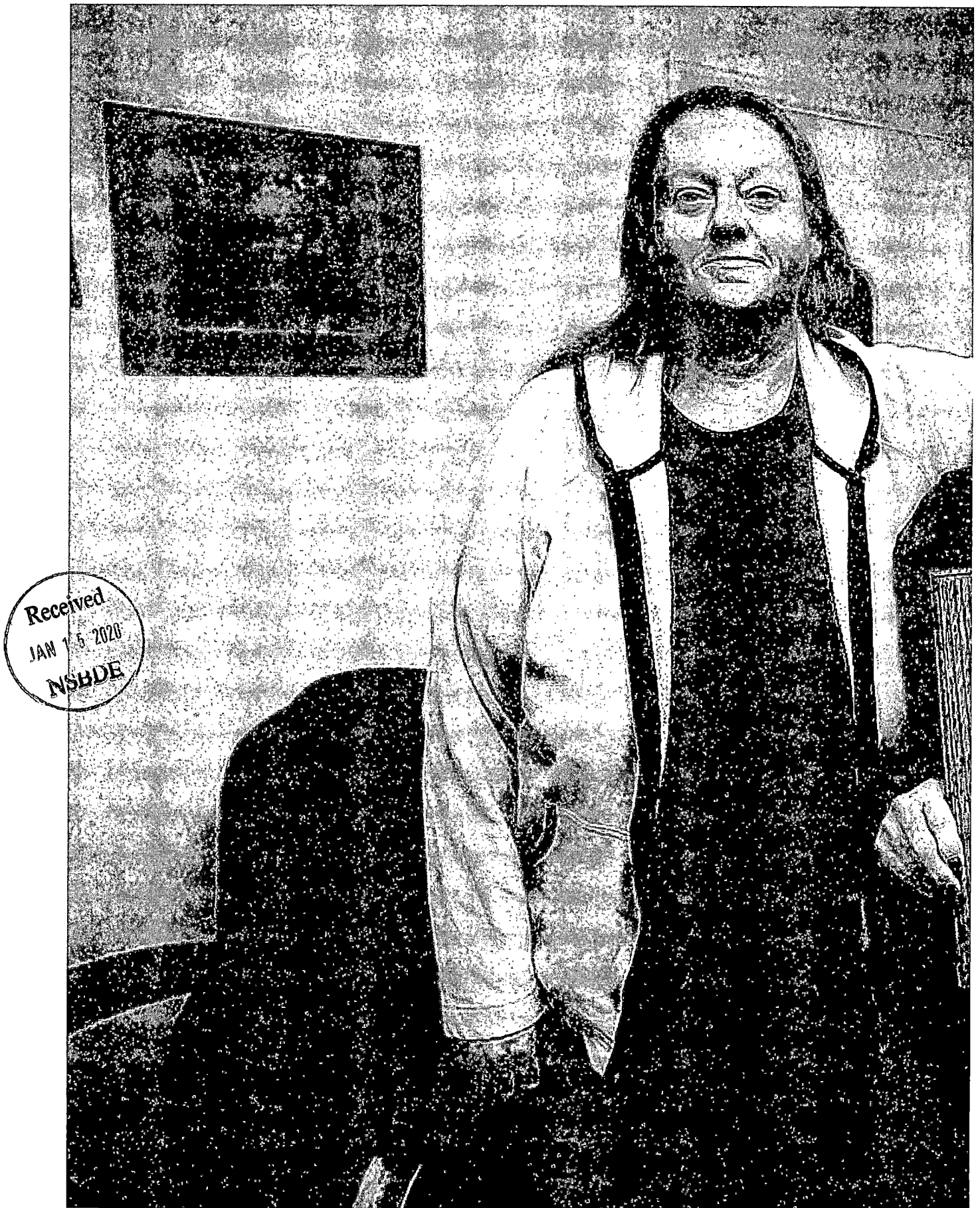
He told us he relied on his malpractice insurer to handle that case. "If they didn't respond," Morris said, "I have nothing to do with that."

Then another Las Vegas extraction led to the death of Kimberly Ortiz, a feisty 29-year-old casino security guard who lived with her young son and her grandmother.

She choked to death on gauze.

Morris blamed this death on paramedics. He said he called 911 when Ortiz began struggling to breathe because of "a reaction to a medication I gave — again, a very small amount."





Authorities didn't disclose the first death to Ortiz's mother and grandmother, Deborah Dean and Irene

Evans. They received this plaque of honor from the victim's employer. (Michael Ainsworth/Staff Photographer)

The dentist told us that he removed the only gauze he'd put in her mouth. Then, "when EMS transported the patient, they put the gauze in there because she was bleeding."

Ortiz died at a hospital the next day.

The death certificate, signed by the medical examiner, makes no mention of paramedics' actions. It lists the dental office as the place of injury. And Morris' insurance company paid a settlement without a lawsuit being filed.

Nevada's investigation expanded because of Ortiz's death. And in July 2012, Morris gave up his sedation license.

"What the board basically said is that if you voluntarily surrender the license," Morris told us, "it is not reportable to the National Practitioner Data Bank." So other states couldn't see what had happened, even if they tried.

States must report surrenders that occur after health care workers know they're facing disciplinary investigation, database rules say.

But the Nevada dental board's executive director, Debra Shaffer-Kugel, said no surrender occurred. She said Morris' permit was instead "unconditionally relinquished" — a term that has no legal definition in Nevada.

"Our board is compliant," Shaffer-Kugel told us. Data Bank officials said they would conduct an inquiry.

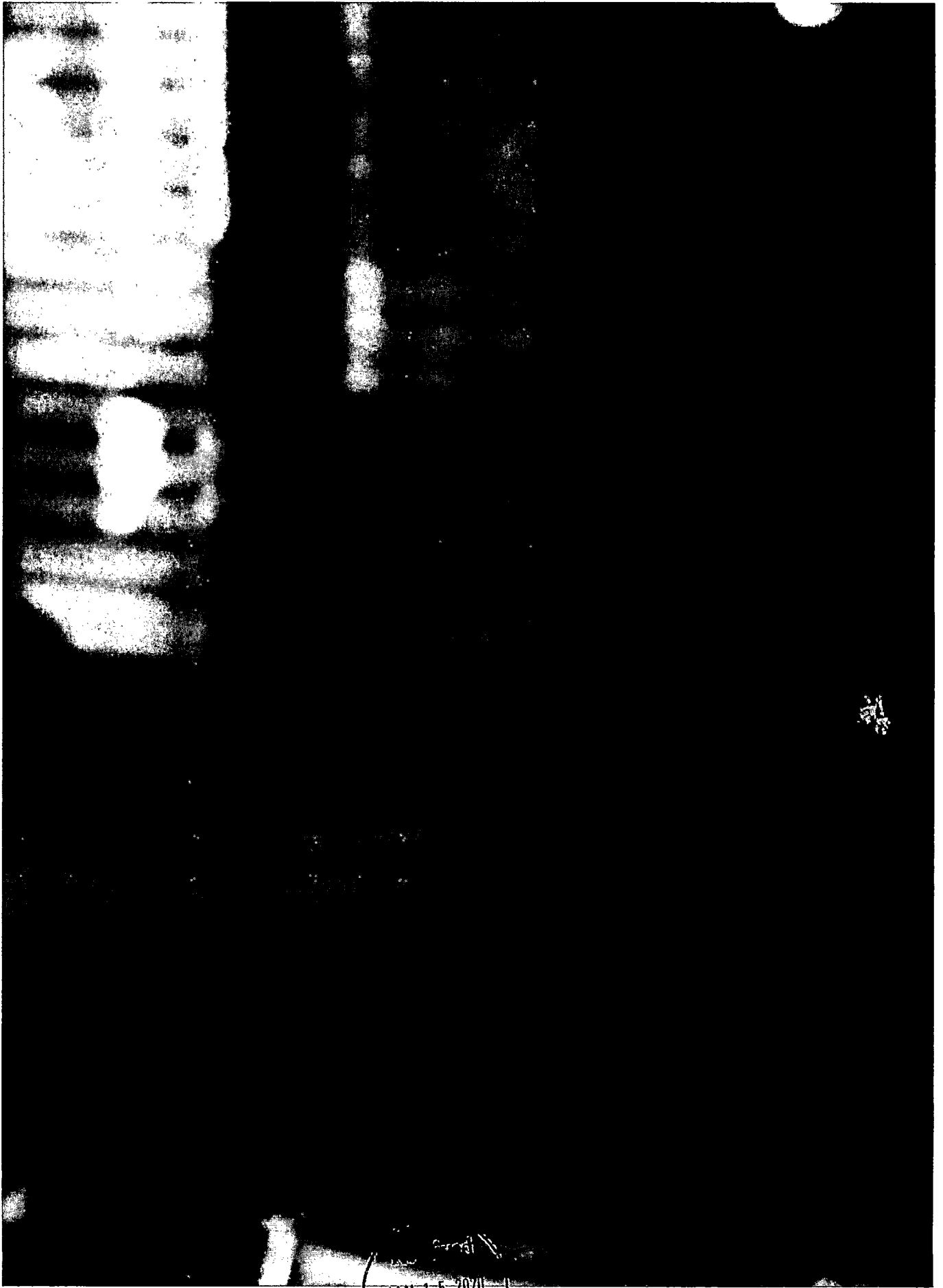
We found that many other states also use terms that are considered non-disciplinary, allowing them to avoid reporting to the federal database. For example, Arizona has sent dentists "letters of concern" that tell them to "only write prescriptions appropriate for dental treatment" and "be more aware of IV sedation failure."

The only consequence for not reporting is being publicly identified as noncompliant. Nevada, like almost all other states, is currently listed as being in good standing.

It should have filed a report about Morris in 2012, said Robert Oshel, a former associate director for research at the Data Bank.

Not doing so "may have made it easier for the board to get the dentist to agree to stop practicing in Nevada," he told us. But "it put the residents of all other states at some degree of risk."





JAN 15 2020
NSBDE

Suba's widow, Julieta Suba, recalled why he wanted his teeth replaced with dentures: "He said he couldn't smile" any more because of oral disease. (Michael Ainsworth/Staff Photographer)

'We were shaking'

Morris has been working in recent years for the Carus Dental chain, which has offices in the Austin and Houston areas. Its president, Dr. M. Ray Scott, did not respond to our interview requests.

In early 2014, Nevada's dental board signed a public disciplinary deal with Morris. It cited "substantial evidence" that he mismanaged both death cases. Alleged violations included failure to monitor or record vital signs, using inappropriate doses of rescue drugs, not inserting a breathing tube and not calling 911 promptly.

Morris agreed to wait 18 months before seeking a new anesthesia permit, to pay about \$25,000 in investigative costs, and to take 10 hours of supplemental education. If practicing in Nevada, he must be on probation for four years and take emergency-management classes annually during that time.

Two of Suba's daughters attended the meeting at which board members approved the deal. Only then did they learn of the second death, and only by poring over a 19-page legal document in a room full of strangers.

"We were in complete shock," Justine Suba said, "to the point we were shaking."

Relatives of Ortiz did not attend. No one told them of the first death until several months later, when we called.

Ortiz's mother wondered how things might have turned out if the state's initial investigation had gone faster or been public. "Maybe I could have talked her into doing something else," Deborah Dean said.

Morris didn't go to the meeting, either. His attorney did, though, and she answered a board member's question about how Texas would learn of the disciplinary action.

She "indicated that Dr. Morris is required to report it to Texas" and that Nevada would notify the federal Data Bank, meeting minutes say.

Nevada suspended Morris' dental license in early 2015, citing failure to comply with the supplemental-education requirement. He told us that he had complied, was unaware of the suspension and would seek to undo it.

This action did not appear on the monthly lists that Texas says it checks, although the underlying 2014 deal did. Morris' record in this state remained spotless until mid-November. Then, after we began asking questions, his license here was also suspended.

Texas dental board officials accused the dentist of fraud for failing to disclose his discipline in Nevada over the deaths. Letting him continue treating patients, the suspension order says, "would constitute a clear, imminent or continuing threat."

But three weeks later, in early December, Morris remained on the Carus Dental website. We called to inquire, and a receptionist said he was still working there.

Editor's note: *Because of incorrect information provided by federal officials, an earlier version of this story mistakenly reported that no states use the National Practitioner Data Bank's constant, automatic service to monitor their dentists.*

Author: Brooks Egerton

Editor: Dave Hiott

Producer: Jon McClure



Copy Editor: Jane Baskett

Photographers: Michael Ainsworth, Andy Jacobsohn, Tom Fox, Vernon Bryant and Brian Elledge

Photo Editor: Guy Reynolds

Video: Brian Elledge, Michael Ainsworth and David Guzman

Data Editor: Daniel Lathrop

Illustrations: Michael Hogue

Designers: John Hancock and Michael Apuan

