NEVADA STATE BOARD of DENTAL EXAMINERS

Notice of Formal Hearing

April 6, 2018

11:00 a.m.

PUBLIC BOOK

BEFORE THE NEVADA STATE 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; 6527-0002)

NOTICE OF FILING OF AMENDED COMPLAINT & NOTICE OF HEARING

Date of Hearing: 04/06/18
Time of Hearing: 11:00 am

TO: ERIKA J. SMITH, DDS, Respondent

PLEASE BE ADVISED that on or about the 2nd day of March, 2018, an Amended Complaint was filed with the Nevada State Board of Dental Examiners (the "Board") which, in part, makes allegations that could result in disciplinary action against your license issued by the Board. A copy of said Amended Complaint is attached to this Notice which is being mailed via U.S. regular mail, postage prepaid, and via certified mail, return receipt requested, to the address(es) on file with the Board as reported by Respondent.

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

DATE	**:**	**Friday, April 6, 2018, and daily thereafter until concluded**
TIME	**:**	**11:00 a.m.**
LOCATION	**:**	**Nevada State Board of Dental Examiners** **6010 S. Rainbow Blvd., Suite A1** **Las Vegas, Nevada 89118**

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. 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 to 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 the Board for issuance of a subpoena, you may be required to demonstrate the nature and relevance of the witness' testimony and/or evidence.

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CERTIFICATE OF SERVICE

I certify that on the 2nd day of March, 2018, I caused the above and foregoing **NOTICE OF HEARING** to be served by placing a true and correct copy of the same in the United States Mail, at Las Vegas, Nevada, via First Class and Certified Mail-Return Receipt Requested, postage fully prepaid and via certified mail, return receipt requested addressed to the following:

Erika J. Smith, DDS (Personal and Confidential)
2550 E. Desert Inn Road, #248
Las Vegas, Nevada 89121
Respondent

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

Angelica Bejar
The Nevada State Board of Dental Examiners

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

DATED this 2nd day of March, 2018.

NEVADA STATE BOARD OF DENTAL EXAMINERS

By: _____
DEBRA SHAFFER-KUGEL, Executive Director

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. On June 6, 2011, the Board notified Respondent of a verified complaint received from Sunshine Flores on behalf of Minor, Shawn Wainwright. On June 20, 2011, the Board received an answer to the complaint filed on behalf of the Respondent by Andras F. Babero, Esq.
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> 2. Based upon the limited investigation conducted to date, Disciplinary Screening Officer, Bradley Roberts, DDS, applying the administrative burden of proof of substantial evidence as set forth in State, Emp. Security v. Hilton Hotels, 102 Nev. 606, 608, 729 P.2d 497, 498 (1986); and see Minton v. Board of Medical Examiners, 110 Nev. 1060, 881 P. 2d 1339 (1994), see also NRS 233B.135(3)(e), but not for any other purpose, including any other subsequent civil action, finds there is substantial evidence that Respondent failed to maintain proper records of pediatric patient Shawn Wainwright in violation of NAC 631.230(1)(c).
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> 3. Applying the administrative burden of proof of substantial evidence as set forth in State, Emp. Security v. Hilton Hotels, 102 Nev. 606, 608, 729 P.2d 497, 498 (1986); and see Minton v. Board of Medical Examiners, 110 Nev. 1060, 881 P. 2d 1339 (1994), see also NRS 233B.135(3)(e), Respondent without admitting to the opinion of the Disciplinary Screening Officer contained in paragraph 2, acknowledges for settlement purposes only, if this matter were to proceed to a full board hearing, substantial evidence exists that Respondent failed to maintain proper records of pediatric patient Shawn Wainwright in violation of NAC 631.230(1)(c).

Id., at 1:20 to 2:12 (emphasis in original). In part, the *Corrective Action Stipulation Agreement* (Case No. 11-02285) approved by the Board on July 18, 2012, required Respondent's dental practice be monitored for a period of twelve (12) months subject to certain conditions (id., pgs. 4-6), including requiring Respondent to obtain an additional supplemental education as follows: 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.

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

> 3. 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, Sherry West:

> A. Respondent's delivery of four (4) quadrants of scaling and root planing was unacceptable. Respondent completed (4) quadrants of scaling and root planing in just over one (1) hour. Respondent's daily schedule indicates the patient was only scheduled for one (1) hour to complete four (4) quadrants of scaling and root planning. Respondent's daily schedule also indicates Respondent scheduled several other procedures immediately after treating this patient.
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> B. Respondent prepared Teeth #7, 8, 9, and 10 for porcelain fused to metal crowns during a scheduled one (1) hour appointment. At the end on the one (1) hour appointment Respondent commenced treatment on the next patient. At the next (1) hour appointment Respondent permanently cemented crowns on Teeth # 7, 8, 9, and 10. The next day the crown for tooth #10 came loose while the patient was eating and the crown was swallowed. Respondent took a new impression to replace the swallowed crown for tooth #10 and while doing so the other three (3) permanently cemented crowns detached in the impression for the new crown for tooth #10. Those three (3) crowns, Teeth #7, 8, and 9 were again cemented permanently by Respondent. Respondent refused to deliver the replacement crown for Tooth #10 because Respondent wanted payment prior to completing treatment. Respondent's crowns placed on Teeth #7, 8, and 9 were ill-fitting due to open and short margins as observed by the DSO and recorded in the notes of the subsequent treating dentist.

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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.

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 endontic 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.

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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

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

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

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

Patient, Geraldine Marchand

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

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

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

Patient, Sharon Linthicum

13. Subsequent to entering into the above-referenced *Corrective Action Stipulation Agreement* in Case No. 11-02285 and the *Corrective Action Non-Disciplinary Stipulation*

Agreement in Case No. 74127-02832, Respondent, via a *Notice of Complaint & Request for Records* dated June 20, 2016, was notified of the verified complaint of patient, Sharon Linthicum.

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

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

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

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

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

19. On October 14, 2016, the Board received Respondent's written response dated October 13, 2016, to Ms. Linthicum's verified complaint, a copy of which was provided to Ms. Linthicum on October 28, 2016. Respondent's October 14, 2016 written response with enclosures did not include any x-ray and/or billing records which Respondent's response states

are not available "because the computers were destroyed during the move of my office."

Jeffrey Holmes

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

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

Patient, Michelle Pedro

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

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

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

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

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

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

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

Patient, Joseph Pedro III

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

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

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

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

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

Patient, Brittnee Smith

33. Subsequent to entering into the above-referenced *Corrective Action Stipulation Agreement* in Case No. 11-02285 and the *Corrective Action Non-Disciplinary Stipulation Agreement* in Case No. 74127-02832, Respondent, via a *Notice of Complaint & Request for*

Records dated March 3, 2017, was notified of the verified complaint of patient, Brittnee Smith.

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

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

Patient, Jennifer Rutledge

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

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

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

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

Informal Hearing

40. On December 30, 2016, via certified mail, return receipt requested, and regular mail, Respondent was provided with a Notice of Informal Hearing regarding the verified complaints of Geraldine Marchand, Sharon Linthicum, Jeffry Holmes, Michelle Pedro, Joseph Pedro III, the *Corrective Action Stipulation Agreement* (Case No. 11-02285) which was

approved by the Board on July 18, 2012, and the *Corrective Action Non-Disciplinary Stipulation Agreement* (Case No. 74127-02832) which was approved by the Board on September 18, 2015.

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

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

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

> WE COMMAND YOU, that all and singular, business and excuses being set aside, appear at **Morris Polich & Purdy, LLP, 3800 Howard Hughes Parkway, Suite 500, Las Vegas, Nevada 89169**, on the **24th day of February 2016,** at the hour of **10:00 am** to produce the following documents:
>
> > 1. Any and all records regarding patients ***Jeffrey Holmes, Geraldine Marchand, Joseph Pedro, III, Michelle Pedro and Sharon Linthieum,*** including, but not limited to, billing records, laboratory work orders, prescription slips, insurance records (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

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

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

45. On February 23, 2017, the Board received Respondent's correspondence dated February 22, 2017 which, in part, addressed the fact that Respondent received the Notice of Informal Hearing and Subpoena Duces Tecum. Respondent's correspondence also advised she

would not be attending the informal hearing. Respondent's February 23, 2017 correspondence was accompanied by certain records for Geraldine Marchand, Sharon Linthicum, Michelle Pedro, and Joseph Pedro III. Respondent's February 23, 2017 correspondence did not request a continuance of the Informal Hearing noticed for February 24, 2017.

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

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

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

49. NRS 631.3475 provides, in pertinent part:

> **NRS 631.3475 Malpractice; professional incompetence; disciplinary action in another state; substandard care; procurement or administration of controlled substance or dangerous drug; inebriety or addiction; gross immorality; conviction of certain crimes; failure to comply with certain provisions relating to controlled substances; failure to obtain certain training; certain operation of medical facility.** The following acts, among others, constitute unprofessional conduct:
>
> 1. Malpractice;
> 2. Professional incompetence;
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> ***

4. More than one act by the dentist or dental hygienist constituting substandard care in the practice of dentistry or dental hygiene;
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50. NRS 631.3485 provides, in pertinent part:

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

1. Willful or repeated violations of the provisions of this chapter;
2. Willful or repeated violations of the regulations of the State Board of Health, the 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 copying as provided in NRS 629.061.

51. NRS 631.349 provides, in pertinent part:

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

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

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

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

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

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

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

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

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

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

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

A. On April 21, 2016, Respondent extracted Teeth #2, #3, #13[1], #14, #15, #18, #20, #21, #27, #29 and #30. The extractions performed by Respondent on Teeth #2, #3, #13, #14, #18, #28, and #30 were below the standard of care. Respondent's lack of skill, knowledge, and training resulted in Respondent leaving root tips in the extraction sites of Teeth #2, #3, #13, #14, #18, #28, and #30. Further, Respondent's records are void of any notation that the roots tips were present post extraction. Respondent failed to take postoperative radiographs which would have confirmed or dismissed the presence of the multiple remaining root tips. Of note, although Respondent did not take any postoperative radiographs, Respondent provided a copy of a referral to an oral surgeon with specific teeth listed which needed additional treatment. It is the Disciplinary Screening Officer's opinion that Respondent fabricated this referral after she received records from the subsequent treating dentist. Further, although admittedly not a handwriting expert, it is the Disciplinary Screening Officer's opinion that the written chart notes submitted by Respondent have been fabricated based upon the belief that the written chart notes submitted by Respondent all appear be written at the same time. Unlike other patient records reviewed, there are no initials on any of the notes submitted for this patient. Also, void in this patient chart is any 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.

testimony Respondent never informed her of the remaining root tips.

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

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

D. The resulting treatment which 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. Respondent failed to produce a complete copy of this patient's records.

F. 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.

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

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

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:
>
> ***

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:

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

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

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

D. The resulting treatment which 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. Respondent failed to produce a complete copy of this Patient's records.

F. 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.

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:

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

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

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

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

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.

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

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

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

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

B. Respondent drilled into the distal root of tooth #18 causing damage 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.

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

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

F. 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.

VII.
ALLEGATIONS/CLAIMS REGARDING RESPONDENT'S TREATMENT OF PATIENT, JENNIFER RUTLEDGE

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

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

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

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

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

D. Respondent's failure to properly bond the restorations left the 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.

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

VIII.
ALLEGATIONS/CLAIMS REGARDING FAILURE TO COMPLY WITH SUBPOENA DUCES TECUM

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

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

> WE COMMAND YOU, that all and singular, business and excuses being set aside, appear at **Morris Polich & Purdy, LLP, 3800 Howard Hughes Parkway, Suite 500, Las Vegas, Nevada 89169**, on the **24th day of February 2016,** at the hour of **10:00 am** to produce the following documents:
>
> > 1. Any and all records regarding patients ***Jeffrey Holmes, Geraldine Marchand, Joseph Pedro, III, Michelle Pedro and Sharon Linthieum,*** including, but not limited to, billing records, laboratory work orders, prescription slips, insurance records (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

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

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

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

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.

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

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

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

77. The Board repeats and realleges the allegation contained in paragraphs 1 through 76 and reincorporates the same as if fully set forth herein.

78. NAC 631.155 provides, in pertinent part:

> **NAC 631.155 Licensee to notify Board of certain events.** (NRS 631.190) Each licensee shall, within 30 days after the occurrence of the event, notify the Board in writing by certified mail of:
>
> ***
>
> 3. The suspension or revocation of his or her license to practice dentistry or the imposition of a fine or other disciplinary action against him or her by any agency of another state authorized to regulate the practice of dentistry in that state;

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

80. Responded failed to notify the Board of the Texas Consent Order, in violation of NAC 631.155.

81. On or about December 6, 2016, the Board independently became aware of the Texas Consent Order and provided Dr. Smith correspondence advising her of the reporting requirements of NAC 631.155.

82. Dr. Smith failed to within 30 days after the occurrence of the event, notify the Board in writing by certified mail of the suspension or revocation of her license to practice dentistry or the imposition of a fine or other disciplinary action against her by any agency of another state authorized to regulate the practice of dentistry in that state and, therefore, violated NAC 631.155.

XI.
ALLEGATIONS/CLAIMS
RECOVERY OF ATTORNEY'S FEES AND COSTS

83. The Board repeats and realleges every allegation contained in paragraphs 1 through 82 and reincorporates the same as if fully set forth herein.

84. NRS 622.400 provides:

> 1. A regulatory body may recover from a person reasonable attorney's fees and costs that are incurred by the regulatory body as part of its investigative, administrative and disciplinary proceedings against the person if the regulatory body:
>
> > (a) Enters a final order in which it finds that the person has violated any provision of this title which the regulatory body has the authority to enforce, any regulation adopted pursuant thereto or any order of the regulatory body; or
> >
> > (b) Enters into a consent or settlement agreement in which the regulatory body finds or the person admits or does not contest that the person has violated any provision of this title which the regulatory body has the authority to enforce, any regulation adopted pursuant thereto or any order of the regulatory body.
>
> 2. As used in this section, "costs" means:

(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;

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

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

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

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

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

Respectfully submitted this 2 day of March, 2018.

Nevada State Board of Dental Examiners

By _____

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

VERIFICATION

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

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)

DEBRA FOSTER
Notary Public, State of Nevada
Appointment No. 17-3449-1
My Appt. Expires Sep 22, 2021