IN THE MATTER OF	*	BEFORE THE MARYLAND
GARY E. WARNER, D.D.S	*	STATE BOARD OF
Respondent	*	DENTAL EXAMINERS
License Number: 12139	*	Case Number: 2014-100

* * * * * * * * * * * * *

CONSENT ORDER

On December 7, 2016, the Maryland State Board of Dental Examiners (the "Board") charged **GARY E. WARNER, D.D.S.,** (the "Respondent"), License Number 12139, with violating the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. I ("Health Occ. I") §§ 4-101 *et seq.* (2014 Repl. Vol.).

Specifically, the Board charged the Respondent with violating the following provisions of the Act under Health Occ. I § 4-315 and Md. Code Regs. ("COMAR") 10.44.30 *et seq.*:

> **Health Occ. I § 4-315. Denials, reprimand, probations, suspension, and revocations— Grounds.**
>
> (a) *License to practice dentistry* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may ... reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; [and]
>
> (20) Violates any rule or regulation adopted by the Board[.]
>
> **COMAR 10.44.30.02 General Provisions for Handwritten, Typed and Electronic Health Records.**
>
> I. A dental record shall contain:

. . .

(7) Medical and dental histories which shall be updated at each visit[.]

K. Dental records shall:

. . .

(2) Be detailed[.]

COMAR 10.44.30.03 Clinical Charts.

A. Each patient's clinical chart shall include at a minimum the following:

. . .

(3) Treatment plans that are signed and dated by both the treating dentist and the patient;

. . .

(5) Diagnosis and treatment notes;

. . .

(7) Post operative instructions;

. . .

(10) Identification of medications prescribed, administered, dispensed, quantity, and direction for use;

. . .

(12) Radiographs of diagnostic quality;

(13) Periodontal charting;

(14) Laboratory work authorization forms and correspondence to and from laboratories;

(15) Informed consent; [and]

. . .

(18) Details regarding referrals and consultations[.]

COMAR 10.44.30.04 Financial Records.

A. Financial records shall be considered part of the dental records but shall be maintained separately from the patient's clinical chart.

B. Financial records shall include at a minimum the following:

(1) Complete financial data concerning the patient's account, including:

(a) Each amount billed to or received from the patient or third-party payor; and

(b) The date of each bill and each payment;

(2) Copies of all claim forms submitted to third-party payors by the dentist or by the dentist's agent or employee; and

(3) Payment vouchers received from third-party payors.

COMAR 10.44.30.05 Violations.

Failure to comply with this chapter constitutes unprofessional conduct and may constitute other violations of law.

On May 17, 2017, a Case Resolution Conference was held before a committee of the Board. As a resolution of this matter, the Respondent agreed to enter into this public Consent Order consisting of the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

The Board makes the following Findings of Fact:

I. BACKGROUND

1. At all times relevant, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in

Maryland on or about April 10, 1997, under License Number 12139. The Respondent's license is current through June 30, 2017.

2. At all times relevant, the Respondent practiced general dentistry at a dental practice in Forrestville, Maryland.

3. The Board initiated an investigation of the Respondent after receiving a complaint, on or about November 8, 2013, from a patient ("Patient A"),[1] who alleged that in 2013 the Respondent performed a root canal therapy on her tooth without her signed consent, placed crowns on her teeth that came off repeatedly and were unaesthetic, and failed to respond to her when she complained. Patient A also alleged that the Respondent's office staff members behaved rudely and unprofessionally towards her.

II. BOARD INVESTIGATION

4. In the course of its investigation, the Board subpoenaed Patient A's dental chart and eight additional patient dental charts from the Respondent and submitted them to a licensed dentist (the "Board Expert") for a practice review. Based on his review, the Board Expert determined that the Respondent exhibited a pattern of deficiencies in his record keeping practices.

A. Summary of Deficiencies

5. The Respondent's record keeping practices with respect to Patients A through I were deficient for reasons including:

a) Failing to document and retain diagnostic quality x-rays;

b) Failing to document periodontal charting;

c) Failing to document review of patient medical history;

[1] To protect confidentiality, the name of the Complainant, patients, other dentists or dental practices will not be identified by name in this document.

d) Failing to document written informed consent;

e) Failing to document providing post-operative instructions;

f) Failing to document treatment plans that are signed and dated by the treating dentist and patient;

g) Failing to document the prescriptions provided, the medical necessity for the prescriptions, the quantity and the instructions for use;

h) Failing to retain laboratory work authorizations;

i) Failing to document specialty referrals;

j) Failing to document all treatment rendered in sufficient clinical detail; and

k) Failing to retain patient financial and insurance records.

B. Patient-Specific Allegations

Patient A

6. Patient A, then in her early 40s, initially saw the Respondent on or about April 18, 2013, with complaints of a chipped Tooth # 8 as a result of an epileptic seizure. The Respondent performed a comprehensive oral evaluation and dental prophylaxis, and took one periapical and four bitewing radiographs. The Respondent then performed a root canal therapy ("RCT") on Tooth # 8. The Respondent, however, failed to document: a treatment plan signed and dated by him and Patient A; a review of Patient A's medical history; periodontal charting; and a written informed consent for the procedures. Moreover, the radiographs the Respondent took were not of diagnostic quality. The Respondent wrote prescriptions for Motrin 800 mg and Penicillin VK 500 mg to Patient A on this date but failed to document the prescriptions' medical necessity, quantity and instructions for use.

7. On or about July 16, 2013, the Respondent performed a crown buildup and seated a temporary crown on Tooth # 8. The Respondent also ordered a permanent crown for Tooth # 8 but failed to retain the laboratory work authorization.

8. Patient A returned on or about August 15, 2013, for seating of the permanent crown on Tooth # 8. After seating the permanent crown, Patient A complained about the crown's shape, shade and contour. As the Respondent was not in the office, another dentist from the Respondent's Practice re-cemented the temporary crown on Tooth # 8 and rescheduled Patient A to see the Respondent on another date.

9. Over the next several visits between August 15, 2013, and September 10, 2013, Patient A's temporary crown came off and had to be re-cemented, and the Respondent also remade a permanent crown for Tooth # 8. Finally, the Respondent seated the permanent crown on or about September 10, 2013. The Respondent noted in the patient chart that Patient A was "very satisfied" and hugged the Respondent.

10. Subsequent to the seating of the permanent crown, Patient A contacted the Respondent and complained about the shade of the permanent crown. The Respondent directed Patient A to go to the dental laboratory for another remake of the crown. In his written response to the Board, dated January 26, 2014, the Respondent stated that he also referred Patient A to a local oral surgeon.

11. The Respondent's dental record for Patient A failed to include: diagnostic quality radiographs, periodontal charting, written informed consent, laboratory work authorizations, referral to oral surgeon or financial/insurance records.

12. The Respondent's record keeping practices with respect to Patient A were deficient for reasons including:

a) Failing to provide diagnostic quality radiographs;

b) Failing to document periodontal charting;

c) Failing to document review of medical history;

d) Failing to document written informed consent;

e) Failing to document a treatment plan that is signed and dated by the Respondent and Patient A;

f) Failing to document the medical necessity for prescribing Motrin 800 mg and Penicillin VK 500 mg and their quantity and instructions for use;

g) Failing to retain laboratory work authorizations;

h) Failing to document his referral of Patient A to an oral surgeon;

i) Failing to document all treatment referenced in the Respondent's written response with respect to Patient A;

j) Failing to document the treatment he provided to Patient A in sufficient clinical detail; and

k) Failing to retain Patient A's financial and insurance records.

Patient B

13. Patient B, then in her mid-50s, initially presented to the Respondent on or about January 30, 2013, for teeth extraction and dentures. The Respondent performed a comprehensive oral evaluation and dental prophylaxis, and took five periapical radiographs. The Respondent's treatment plan for Patient B, which was not dated and signed by the Respondent and Patient B, included extraction of Tooth #s 4, 8, 12, 13 and 20 due to advanced periodontal disease, and fabrication of upper and lower partial dentures. During this visit, the Respondent extracted Tooth #s 12 and 13. The Respondent, however, failed to document a review of Patient B's medical history,

written informed consent, periodontal charting, local anesthetic used, post-operative instructions and clinical details regarding the extractions.

14. On or about April 10, 2013, Patient B returned for extractions of Tooth #s 4, 8 and 20. The Respondent noted in the progress notes that he extracted Tooth #s 4, 8 and 20, and planned for an upper partial denture and lower full denture. The Respondent, however, failed to document a review of Patient B's medical history, written informed consent, clinical details regarding the extractions and post-operative instructions.

15. Patient B returned on or about April 17, 2013, for scaling and root planing procedures. The Respondent noted that Patient B's tissues were healing within normal limits and that he re-took an alginate impression. For this visit, the Respondent failed to document a review of Patient B's medical history, detail clinical notes and periodontal charting regarding the scaling and root planing procedures.

16. The Respondent's progress notes for April 19, 2013, simply stated, "F, MP." The Respondent failed to document a review of medical history and detailed clinical notes.

17. On or about May 26, 2013, the Respondent seated the upper partial denture and lower complete denture on Patient B. Patient B returned on or about October 21, 2013, for a limited examination and denture adjustment.

18. The Respondent's record keeping practices with respect to Patient B were deficient for reasons including:

a) Failing to document periodontal charting;

b) Failing to document review of medical history;

c) Failing to document written informed consent;

d) Failing to document a treatment plan that is signed and dated by the Respondent and Patient B;

e) Failing to retain laboratory work authorizations;

f) Failing to document treatment in sufficient clinical detail;

g) Failing to document post-operative instructions; and

h) Failing to retain Patient B's financial and insurance records.

Patient C

19. Patient C, then in his early 50s, initially presented to the Respondent on or about December 4, 2013, with complaints of pain, abscess and toothache. The Respondent reviewed Patient C's medical and dental history, performed a full mouth debridement and took one panoramic, four bitewing and two periapical radiographs. Patient C's chart that the Respondent provided to the Board, however, did not include a panoramic radiograph. The Respondent also issued prescriptions for Penicillin VK 500 mg and Motrin 800 mg but failed to document the medical necessity for the prescriptions. Patient C exhibited advanced periodontal disease, but the Respondent failed to document periodontal charting. The Respondent further failed to document a treatment plan signed and dated by him and Patient C.

20. On or about December 18, 2013, Patient C presented for extraction of Tooth # 32. The Respondent noted that he extracted Tooth # 32 and issued a prescription for Motrin 800 mg. The Respondent failed to document a review of Patient C's medical history, written informed consent, clinical details regarding the procedures performed, the quantity and direction for use of the prescribed medication, and post-operative instructions.

21. Patient C returned on or about December 27, 2013, and presented with a dry socket associated with the extraction of Tooth # 32. The Respondent performed a limited oral examination and noted Patient C had dry socket at Tooth # 32. For this visit, the Respondent failed to document a review of Patient C's medical history and detail clinical notes regarding his examination of Patient C.

22. The Respondent saw Patient C again on or about December 30, 2013, to remove the dry socket gauze.

23. The Respondent's record keeping practices with respect to Patient C were deficient for reasons including:

a) Failing to document periodontal charting;

b) Failing to retain Patient C's panoramic radiograph;

c) Failing to document a review of Patient C's medical history;

d) Failing to document a treatment plan signed and dated by the Respondent and Patient C;

e) Failing to document written informed consent;

f) Failing to document the medical necessity for prescription medications;

g) Failing to document the quantity and directions for use of the Motrin 800 mg he prescribed on or about December 18, 2013;

h) Failing to document treatment in sufficient clinical detail;

i) Failing to document post-operative instructions; and

j) Failing to retain Patient C's financial and insurance records.

Patient D

24. Patient D, then in her late 30s, initially saw the Respondent on or about February 25, 2013, complaining of Tooth # 8. The Respondent performed a

comprehensive oral evaluation and took four periapical radiographs. The Respondent formulated a treatment plan, which included extractions, restorative procedures and upper and lower dentures. The Respondent's treatment plan, however, was not signed and dated by him and Patient D. The Respondent extracted Tooth # 8, placed a silk suture, and prescribed Motrin 800 mg and Penicillin VK 500 mg to Patient D. The Respondent, however, failed to document a review of Patient D's medical history, written informed consent, periodontal charting, clinical details regarding the extraction, the local anesthetic used and post-operative instructions. Moreover, the Respondent failed to document the medical necessity, quantity and directions for use for the medications he prescribed.

25. Patient D returned on or about March 7, 2013, and the Respondent extracted Tooth #s 1, 3 and 13. For this visit, the Respondent failed to document a review of Patient D's medical history, written informed consent, clinical details regarding the extractions and post-operative instructions.

26. On or about March 13, 2013, the Respondent saw Patient D for extraction of Tooth # 12. The Respondent noted a routine extraction of Tooth # 12 but failed to document a review of Patient D's medical history, written informed consent, clinical details regarding the extraction and post-operative instructions.

27. On or about March 18, 2013, Patient D returned to have an impression taken to fabricate her upper and lower partial dentures. The Respondent noted in the progress notes "Alginate Impression taken." The Respondent, however, failed to document clinical details regarding the prosthetic procedure and failed to retain the laboratory work authorization for the dentures.

28. Patient D's chart showed that the Respondent took final impressions of upper and lower partial dentures on or about March 25, 2013, and seated the partial dentures on or about April 24, 2013.

29. The Respondent's record keeping practices with respect to Patient D were deficient for reasons including:

a) Failing to document a review of Patient D's medical history;

b) Failing to document written informed consent;

c) Failing to document periodontal charting;

d) Failing to document the medical necessity for prescribing Motrin 800 mg and Penicillin VK 500 mg on February 25, 2013, and their quantity and directions for use;

e) Failing to document treatment in sufficient clinical detail;

f) Failing to document post-operative instructions;

g) Failing to document the dates radiographs were taken;

h) Failing to retain laboratory work authorizations; and

i) Failing to retain Patient D's financial and insurance records.

Patient E

30. Patient E, then in her early 60s, initially presented to the Respondent on or about November 19, 2013, with complaints of a "chipped molar tooth." The Respondent performed a limited oral evaluation and took one periapical and one bitewing radiograph. For this visit, the Respondent's progress notes failed to document that he reviewed Patient E's medical history, or clinical details of his examination.

31. Patient E returned the next day, on or about November 20, 2013, for a surgical extraction of Tooth # 14 and preparation of a temporary bridge for Tooth #s 12,

13, 14 and 15. The Respondent failed to document: a review of Patient E's medical history; obtaining written informed consent for extraction of Tooth # 14; post-operative instructions; and clinical details regarding the extraction and temporary bridge preparation.

32. On or about December 11, 2013, the Respondent performed a crown and bridge procedure on Patient E but failed to document in detail the procedure performed. The Respondent also issued a prescription to Patient E for Motrin 800 mg (#16) but failed to document the medical necessity for the prescription.

33. The Respondent brought Patient E back on or about April 15, 2014, to try in the new bridge. The Respondent noted, however, that the bridge did not fit and he had to take a new impression. For this visit, the Respondent failed to document a review of Patient E's medical history and clinical details regarding the visit.

34. The Respondent's record keeping practices with respect to Patient E were deficient for reasons including:

a) Failing to document a review of Patient E's medical history;

b) Failing to document written informed consent;

c) Failing to document the medical necessity for prescribing Motrin 800 mg (#16) to Patient E on or about December 11, 2013;

d) Failing to document clinical details regarding treatment performed;

e) Failing to document post-operative instructions; and

f) Failing to retain Patient E's financial and insurance records.

Patient F

35. Patient F, then in his early 60s, initially saw the Respondent on or about March 28, 2013, for a comprehensive oral evaluation. The Respondent took nine periapical radiographs and formulated a treatment plan to include a full mouth debridement, extraction of 11 teeth, and seating of an complete upper denture and a partial lower denture. For this visit, the Respondent failed to document a review of Patient F's medical history, detailed clinical notes regarding the visit and a treatment plan signed and dated by him and Patient F.

36. On or about May 9, 2013, the Respondent took an alginate impression of Patient F.

37. Patient F returned on or about May 13, 2013, and the Respondent took a final impression for an immediate upper denture and partial lower denture. For this visit, the Respondent failed to document a review of Patient F's medical history and failed to retain laboratory work authorizations for the dentures.

38. On or about July 3, 2013, the Respondent performed a scaling and root planing of Patient F's lower left and right quadrant, and took a bite registration. For this visit, the Respondent failed to document a review of Patient F's medical history and detailed clinical notes of the visit.

39. In a progress note dated July 31, 2013, the Respondent noted that a wax try in was completed.

40. On or about August 28, 2013, the Respondent extracted Tooth #s 6, 7, 8, 9, 10, 13, 21, 23, 24, 25 and 26, and seated the complete upper denture and partial lower denture. For this visit, the Respondent failed to document a review of Patient F's

medical history, written informed consent, post-operative instructions and detailed clinical notes regarding the visit.

41. Patient F returned on or about September 3 and 24, 2013, for post-operative visits.

42. On or about November 4, 2013, the Respondent took four periapical radiographs of Patient F but failed to document them in Patient F's progress notes.

43. The Respondent's record keeping practices with respect to Patient F were deficient for reasons including:

a) Failing to document written informed consent;

b) Failing to document a treatment plan signed and dated by the Respondent and Patient F;

c) Failing to document a review of Patient F's medical history;

d) Failing to document treatment in sufficient clinical detail;

e) Failing to document post-operative instructions;

f) Failing to retain laboratory work authorizations; and

g) Failing to retain Patient F's financial and insurance records.

Patient G

44. Patient G, then in her mid 20s, initially saw the Respondent on or about November 6, 2013, for a comprehensive oral evaluation, dental prophylaxis and oral hygiene instructions. The Respondent took four bitewing radiographs and formulated a treatment plan that included resin composite restorations of Tooth #s 12, 13 and 19, and RCT and crowning of Tooth # 30. For this visit, the Respondent failed to document a treatment plan signed and dated by him and Patient G.

45. Patient G returned on or about December 23, 2013, for RCT on Tooth # 30. For this visit, the Respondent failed to document a review of Patient G's medical history and the medical necessity for the RCT, such as patient symptoms or diagnostic test findings. Furthermore, the Respondent failed to document whether he used a rubber dam for the RCT and how he determined the working distance, as there were no working distance radiographs or the use of an electronic apex locator.

46. On or about January 10, 2014, the Respondent continued the RCT on Tooth # 30 and performed a buildup with absolute dentin. For this visit, the Respondent failed to document a review of Patient G's medical history and whether he used a rubber dam when performing the procedures.

47. The Respondent's record keeping practices with respect to Patient G were deficient for reasons including:

a) Failing to document review of Patient G's medical history;

b) Failing to document written informed consent;

c) Failing to document treatment in sufficient clinical detail; and

d) Failing to retain Patient G's financial and insurance records.

Patient H

48. Patient H, then in her early 60s, initially saw the Respondent on or about March 25, 2010, for a limited examination. The Respondent took a periapical radiograph and noted that Patient H had decay on Tooth # 7. The Respondent smoothed out Tooth # 7 and noted that he "informed [patient] of other areas of concern." The Respondent, however, failed to document a review of Patient H's medical history and what the "other areas of concern" were.

49. On or about April 9, 2010, Patient H returned for a follow-up, where the Respondent performed composite restorations on Tooth #s 7 and 8. For this visit, the Respondent failed to document a review of Patient H's medical history, the quantity of epinephrine used and clinical details regarding the medical necessity for the composite restorations.

50. On or about April 29, 2010, the Respondent performed a comprehensive oral evaluation and dental prophylaxis. The Respondent took one panoramic and two bitewing radiographs of Patient H, and performed composite restorations of Tooth #s 20, 21, 28 and 29. For this visit, the Respondent failed to document a review of Patient H's medical history, periodontal charting and detailed clinical notes regarding the medical necessity of the procedures performed. Moreover, the Respondent failed to retain the panoramic radiograph he took.

51. On or about May 17, 2010, the Respondent performed additional composite restorations of Tooth #s 5, 6, 9 and 10. For this visit, the Respondent failed to document a review of Patient H's medical history and detailed clinical notes regarding the medical necessity of the procedures performed.

52. On or about May 25, 2010, the Respondent performed a buildup and seated an all-ceramic crown on Tooth # 4. For this visit, the Respondent failed to document a review of Patient H's medical history, written informed consent, laboratory authorizations and detailed clinical notes regarding the medical necessity of the procedures performed. The Respondent also failed to document that he took two periapical radiographs of Patient H, which were found in Patient H's chart.

53. The Respondent noted in Patient H's chart "Redo impression for Crown #4" on June 15, 2010, and "5 DO composite filling" on July 22, 2010. During these visits, the Respondent failed to document a review of Patient H's medical history and detailed clinical notes regarding the medical necessity of the procedures performed.

54. On or about May 25, 2011, Patient H saw the Respondent for a periodic oral evaluation and dental prophylaxis. The Respondent took four bitewing radiographs of Patient H. For this visit, the Respondent failed to document a review of Patient H's medical history and periodontal charting.

55. Patient H returned on or about June 1, 2011, and the Respondent performed a composite restoration of Tooth # 3. For this visit, the Respondent failed to document a review of Patient H's medical history and detailed clinical notes regarding the medical necessity for the procedure.

56. On or about October 7, 2011, Patient H saw the Respondent for a periodic oral evaluation and dental prophylaxis. The Respondent took one periapical and four bitewing radiographs. The Respondent noted that Patient H was interested in bleaching and veneers of Tooth #s 6, 7, 8, 9 and 10, and that he took an impression for temporary upper veneers. For this visit, the Respondent failed to document a review of Patient H's medical history, written informed consent, periodontal charting and detailed clinical notes regarding the method of bleaching. Moreover, the Respondent failed to retain two of the bitewing radiographs. Only two bitewing radiographs dated October 7, 2011, were found in Patient H's chart.

57. On or about October 27, 2011, the Respondent seated porcelain veneers on Tooth #s 6, 7, 8, 9 and 10. For this visit, the Respondent failed to document a

review of Patient H's medical history and detailed clinical notes regarding the procedure. Additionally, the Respondent failed to retain laboratory work authorizations.

58. On or about April 19, 2012, Patient H saw the Respondent for seating of a temporary bridge involving Tooth #s 11, 12, 13 and 14. The Respondent extracted Tooth # 13 and seated the temporary bridge. For this visit, the Respondent failed to document a review of Patient H's medical history, written informed consent, post-operative instructions and detailed clinical notes regarding the procedures performed. The Respondent also failed to retain laboratory work authorizations for the temporary bridge. The Respondent prescribed Tylenol #3 and Penicillin VK 500 mg to Patient H but failed to document the medical necessity for issuing the antibiotics prescription. On or about May 17, 2012, the Respondent seated the bridge.

59. The Respondent noted in Patient H's chart "5 All Ceramic Crown D2740" on May 31, 2012. The Respondent, however, failed to document a review of Patient H's medical history, written informed consent and detailed clinical notes regarding the procedure performed. Additionally, the Respondent failed to retain laboratory authorization for the ceramic crown.

60. On or about August 16, 2012, Patient H saw the Respondent for a dental prophylaxis. For this visit, the Respondent failed to document a review of Patient H's medical history and periodontal charting.

61. On or about September 6 ,2012, Patient H returned for a follow-up, and the Respondent noted, "Seat Veneer #10w/ veneer cement." The Respondent, however, failed to document a review of Patient H's medical history and his clinical notes lacked sufficient details regarding the procedure.

62. On or about July 18, 2013, Patient H presented to the Respondent with complaints of displaced veneers. The Respondent noted in part, "PVS imp taken for new veneer #8. Temp made veneer used flowable. Sent to lab A-2 shade. Limited oral exam." The Respondent, however, failed to document a review of Patient H's medical history and failed to retain laboratory authorizations.

63. On or about July 29, 2013, the Respondent saw Patient H for a dental prophylaxis. For this visit, the Respondent failed to document periodontal charting.

64. On or about August 22, 2013, Patient H returned for a follow-up, and the Respondent performed composite restorations of Tooth #s 20 and 21. For this visit, the Respondent failed to document a review of Patient H's medical history and his clinical notes lacked sufficient details regarding the procedure.

65. In an entry dated November 13, 2013, the Respondent noted "8 All Ceramic Crown D2740." The Respondent, however, failed to document a review of Patient H's medical history and his clinical notes lacked sufficient details regarding the procedure.

66. Patient H returned on or about February 26, 2014, for a dental prophylaxis. For this visit, the Respondent failed to document a review of Patient H's medical history and periodontal charting.

67. On or about May 13, 2014, the Respondent performed a limited oral evaluation and re-cemented the veneer on Tooth # 9. For this visit, the Respondent failed to document a review of Patient H's medical history and his clinical notes lack sufficient details regarding the procedures performed.

68. The Respondent's record keeping practices with respect to Patient H were deficient for reasons including:

a) Failing to document review of Patient H's medical history;

b) Failing to document written informed consent;

c) Failing to document periodontal charting;

d) Failing to document the medical necessity for prescribing Tylenol #3 and Penicillin VK 500 mg on or about April 19, 2012;

e) Failing to document the medical necessity of procedures performed;

f) Failing to document treatment performed in sufficient clinical details;

g) Failing to document post-operative instructions;

h) Failing to retain laboratory authorizations;

i) Failing to retain radiographs taken; and

j) Failing to retain Patient H's financial and insurance records.

Patient I

69. Patient I, then in his 50s, initially saw the Respondent on or about July 24, 2012, for a comprehensive oral evaluation and a full mouth debridement. The Respondent took one periapical and four bitewing radiographs. The Respondent noted that Patient H had an abscess associated with Tooth # 30, which needed to be extracted after antibiotic treatment. The Respondent prescribed Penicillin VK 500 mg and Motrin 80 mg. For this visit, the Respondent failed to document a review of Patient I's medical history and periodontal charting. The Respondent also failed to retain the radiographs taken during the visit. Finally, the Respondent failed to document the quantity of Motrin and Penicillin prescribed and their instructions for use.

70. Patient I returned on or about August 2, 2012, for a surgical extraction of Tooth # 30. For this visit, the Respondent failed to document a review of Patient I's medical history, written informed consent, post-operative instructions and detailed clinical notes regarding the extraction.

71. On or about November 28, 2012, the Respondent performed RCT on Tooth # 31 and a composite restoration of Tooth # 32. For this visit, the Respondent failed to document a review of Patient I's medical history, written informed consent and detailed clinical notes regarding the medical necessity for the procedures performed.

72. On or about December 5, 2012, Patient I returned for further RCT and crown buildup of Tooth # 31. The Respondent also took a full mouth radiograph. For this visit, the Respondent failed to document a review of Patient I's medical history and failed to retain the radiographs for the full mouth series.

73. On or about December 14, 2012, the Respondent performed composite restorations of Patient I's Tooth # 1, 14 and 15. For this visit, the Respondent failed to document a review of Patient I's medical history and his clinical notes lacked sufficient details regarding the medical necessity of the procedures performed.

74. The Respondent's record keeping practice with respect to Patient I was deficient for reasons including:

a) Failing to document a review of Patient I's medical history;

b) Failing to document written informed consent;

c) Failing to document post-operative instructions;

d) Failing to document the medical necessity, quantity and instructions for use of the prescriptions issued;

e) Failing to document periodontal charting;

f) Failing to document treatment performed in sufficient clinical details;

g) Failing to retain radiographs taken; and

h) Failing to retain Patient I's financial and insurance records.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's record keeping deficiencies with respect to Patients A through I, as described above, constitute, in whole or in part: behaving dishonorably or unprofessionally, or violating a professional code of ethics pertaining to the dentistry profession, in violation of Health Occ. I § 4-315(a)(16); and violating any rule or regulation adopted by the Board, *i.e.* COMAR 10.44.30 *et seq.*, in violation of Health Occ. I § 4-315(a)(18).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby:

ORDERED that the Respondent is **REPRIMANDED;** and it is further

ORDERED that the Respondent is placed on **PROBATION** for a minimum period of **EIGHTEEN (18) MONTHS**. During the probationary period, the Respondent must comply with the following terms and conditions:

1. **Within six (6) months** of the date of this Consent Order, the Respondent shall enroll in and successfully complete Board-approved in-person course(s) consisting of six (6) credit hours in dental recordkeeping. The Respondent shall be responsible for submitting written documentation to the Board of his successful completion of the course(s). The Respondent understands and agrees that he may not use this coursework to fulfill any requirements mandated for licensure renewal. The Respondent shall be solely responsible for furnishing the Board with adequate written

verification that he has completed the course(s) according to the terms set forth herein.

2. **Within sixty (60) days** of the date of this Consent Order, the Respondent shall pay a fine in the amount of **One Thousand dollars ($1,000.00)** payable to the Maryland State Board of Dental Examiners.

3. The Respondent is subject chart reviews by the Board. The Board, at its discretion, may conduct office visits for the purpose of chart review to ensure that the Respondent is in compliance with recordkeeping standards.

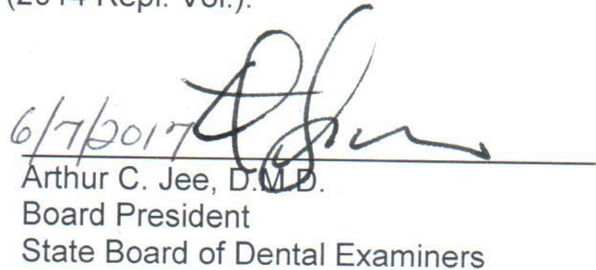
4. The Respondent shall comply with the Maryland Dentistry Act and all laws, statutes and regulations pertaining thereof.

AND IT IS FURTHER ORDERED that after the conclusion of **EIGHTEEN (18) MONTHS** from the date of this Consent Order, the Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board, or a designated Board committee. The Board, or designated Board committee, may grant the termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and it is further

ORDERED that if the Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing if there is a genuine dispute as to the underlying material facts, or an opportunity for a show cause hearing before the Board otherwise, may impose any sanction which the Board may have imposed in this case, including additional probationary terms and conditions, a reprimand, suspension, revocation and/or a monetary penalty; and it is further

ORDERED that the Respondent shall be responsible for all costs incurred in fulfilling the terms and conditions of this Consent Order; and it is further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Provisions, §§ 4-101 *et seq.* (2014 Repl. Vol.).



6/7/2017

Arthur C. Jee, D.M.D.
Board President
State Board of Dental Examiners

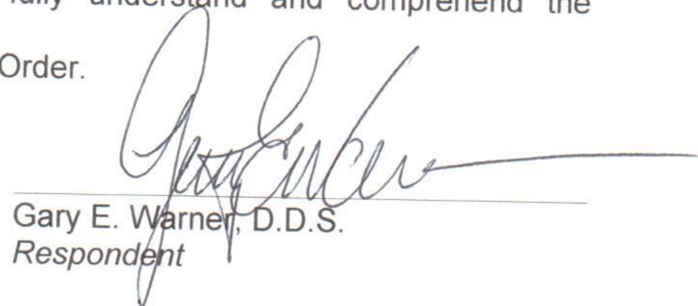
CONSENT

I, Gary E. Warner, D.D.S., acknowledge that I am represented by counsel and have consulted with counsel before entering into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that might have followed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

6/2/2017
Date



Gary E. Warner, D.D.S.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF ANNE ARUNDEL

I HEREBY CERTIFY that on this 2nd day of June, 2017, before me, a Notary Public of the foregoing State and City/County personally appear Gary E. Warner, D.D.S., and made oath in due form of law that signing the foregoing Consent Order was his voluntary act and deed.

AS WITNESSETH my hand and notary seal.

Margaret E. Maguire
Notary Public

My commission expires: Sept 21, 2019