IN THE MATTER OF	*	BEFORE THE MARYLAND
JESSE WEAVER, D.D.S.	*	STATE BOARD OF
RESPONDENT	*	DENTAL EXAMINERS
License Number: 7164	*	Case Number: 2013-226

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

CONSENT ORDER

On or about June 1, 2016, the Maryland State Board of Dental Examiners (the "Board") charged **Jesse Weaver, D.D.S., License Number 7164** (the "Respondent"), under the Maryland Dentistry Act (the "Act"), Md. Code Ann. Health Occ. I. ("Health Occ.") §§ 4-101 *et seq.* (2014 Repl. Vol.) and the regulations adopted by the Board, found at Md. Code Regs. ("COMAR") §§ 10.44.01 *et seq.*

Specifically, the pertinent provisions of law are as follows:

Health Occ. § 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;
>
> (20) Violates any rule or regulation adopted by the Board;

COMAR § 10.44.23.01 Unprofessional or Dishonorable Conduct.

> C. The following shall constitute unprofessional or dishonorable conduct in the practice of dentistry, dental hygiene, or dental radiation technology:
>
> (6) Performing a dental procedure without first obtaining informed consent from the patient or the patient's legal representative;

(8) Committing any other unprofessional or dishonorable act or omission in the practice of dentistry, dental hygiene, or dental radiation technology [.]

COMAR § 10.44.30.02 General Provisions for Handwritten, Typed, and Electronic Health Records.

B. Dental records shall include:

(1) A patient's clinical chart as described in Regulation .03 of this chapter;

...

K. Dental records shall:

(2) Be detailed;

(3) Be legible;

...

(5) Document all data in the dentist's possession pertaining to the patient's dental health status;

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;

(4) Patient's complaints;

(5) Diagnosis and treatment notes;

...

(7) Post operative instructions;

...

(9) In-person conversations, telephone conversations, and other correspondence with the patient or their representative;

...

(12) Radiographs of diagnostic quality;

...

(15) Informed consent;

...

(18) Details regarding referrals and consultations;

(19) Patient complaints pertaining to the dentist and staff, and their manner of resolution;

COMAR § 10.44.30.05 Violations.

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

On or about September 7, 2016, a Case Resolution Conference ("CRC") was held at the Board's offices. Following the CRC, the Respondent and the Board agreed to enter into this Consent Order.

FINDINGS OF FACT

The Board finds the following facts.

Background

1. At all times relevant to the charges, 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 March 27, 1980, under License Number 7164. The Respondent's license is current through June 30, 2018.

2. At all times relevant to the charges, the Respondent operated a dental practice at 4205 Liberty Heights Avenue, Baltimore, Maryland 21207.

3. On or about October 2, 2013, the Board issued an Advisory Letter to the Respondent. While the Advisory Letter did not constitute formal discipline, it advised the Respondent that based on a patient complaint and subsequent investigation by the Board, the Board had determined the following:

   (a) The Respondent's recordkeeping was inadequate;

   (b) The Respondent failed to maintain original radiographs; and

   (c) The Respondent failed to appropriately perform diagnostic examination on a patient's tooth.

4. The Advisory Letter warned the Respondent that in the event of similar allegations in the future, the Board could consider the Advisory Letter as an aggravating factor in determining an appropriate sanction.

5. On or about October 15, 2013, the Respondent executed a Letter of Agreement by which the Respondent agreed to improve his recordkeeping practices in accordance with the Board's recordkeeping requirements, as described in the Advisory Letter.

Complaint

6. On or about May 20, 2013, prior to the issuance of the Advisory Letter, the Board received a written complaint (the "Complaint") from a former patient of the Respondent ("Patient A").[1]

7. Among other allegations, the Complaint alleged that while performing a dental procedure with a hand piece, the Respondent had caused a laceration on her tongue and failed to promptly inform her. Patient A reported that she noticed the laceration when she saw that her tongue was bleeding directly after the procedure. When Patient A complained to the Respondent, he recommended that she gargle with saltwater.

8. Based on the Complaint, the Board initiated an investigation.

Board investigation

9. On or about June 17, 2013, in furtherance of its investigation, the Board issued a subpoena to the Respondent for Patient A's records and requested a narrative response to the Complaint.

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[1] To ensure confidentiality, the names of patients or other individuals will not be disclosed in this charging document. The Respondent may obtain the identity of any patient or individual referenced herein by contacting the administrative prosecutor.

10. The Board also obtained records from eight additional patients of the Respondent, and assigned an expert (the "Expert") to review the records obtained.

Expert's Findings

11. On January 29, 2015, the Board received a report from the Expert detailing his opinions regarding the Respondent's treatment.

12. According to the Expert's review, the Respondent's records show that on January 21, 2013, the Respondent performed root canal therapy (RCT) for Patient A on tooth #14. One month later, on February 21, 2013, the Respondent completed a second RCT for Patient A, this time on tooth #19.

13. The Expert found that there was a "significant lack of clinical notations in all" of the Respondent's records for Patient A. Specifically, he noted the following deficiencies in the Respondent's recordkeeping:

(a) No documentation of chief complaint;

(b) No diagnostic tests to support treatment rendered;

(c) No documentation of appropriate informed consent for treatments;

(d) No description of the procedure;

(e) No description of materials used;

(f) No description of complications;

(g) Failure to identify medicaments used;

(h) No documentation of the injury caused to Patient A's tongue; and

(i) Radiographs missing or of poor diagnostic quality.

14. In addition, a review of Patient A's Hospital records supported Patient A's Complaint that her tongue was lacerated to approximately 0.8 cm in depth on February 14, 2013 during the Respondent's completion of two fillings, and that Respondent had

failed to adequately document the extent and nature of that injury in his records as required by COMAR § 10.44.30.03.

15. The Expert also reviewed the records for eight other patients and noted consistent failures to perform proper recordkeeping. For example, there were failures to document diagnosis and failures to maintain diagnostic quality radiographs. In addition, the Respondent's records were frequently illegible.

16. The Expert noted that the recordkeeping deficiencies "greatly hindered an adequate review of all patient records," and that "instances of unnecessary and substandard treatment ... could not be conclusively determined due to the limitations of the patient records."

17. On or about April 13, 2015, the Respondent was provided with a copy of the Expert's report and invited to provide a response. In his response, the Respondent stated that based on the Expert's report, he had instituted a "corrective action plan" in order to:

(a) Document exams and diagnosis;

(b) Take preoperative x-rays and post operative x-rays when necessary; and

(c) Refer all endodontic treatments to specialists.

Interview with the Respondent and Additional Materials

18. On or about July 7, 2015, the Board's investigator conducted an interview with the Respondent at the Board's offices. The Respondent's attorney was present and consulted with the Respondent during the interview.

19. During the interview, the Respondent acknowledged that there were deficiencies in his recordkeeping practices and furthermore acknowledged that he had

not completely complied with the Board's June 17, 2013 subpoena seeking dental records of his pateints.

20. During the interview, Respondent also claimed to have attempted to refer Patient A for RCT treatment; however, he acknowledged that there was no documentation to support this claim.

21. On or about July 23, 2015, the Board's investigator provided the Expert with copies of the Respondent's written response to the Expert's report, a transcript of the interview with the Respondent, and a binder of materials submitted by the Respondent to the Board at the time of the interview.

22. On or about August 13, 2015, the Expert submitted an addendum to his report stating that after a review of the additional materials, his opinions as stated in his original report remained unchanged.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent's conduct, as described above, constitutes violations of the Act and the regulations adopted by the Board as cited above. Specifically, the Respondent's violations of the Act and the regulations are as follows:

A. The Respondent's performance of dental procedures, including RCT, on Patient A without first obtaining appropriate informed consent:

    a. Constitutes behaving dishonorably or unprofessionally, in violation of Health Occ. § 4-315(a)(16); and

    b. Violates a rule or regulation adopted by the Board, in violation of Health Occ. §4-315(a)(20), specifically COMAR § 10.44.23.01C(6) (performing a dental procedure without first obtaining informed consent from the patient or the patient's legal representative).

B. The Respondent's failure to create and maintain legible, detailed, and comprehensive dental records for Patient A and the other patients, as described above:

a. Constitutes behaving dishonorably or unprofessionally, in violation of Health Occ. § 4-315(a)(16); and

b. Violates a rule or regulation adopted by the Board, in violation of Health Occ. §4-315(a)(20), specifically: COMAR §§ 10.44.30.02B(1) (dental records shall include a patient's clinical chart as described in COMAR § 10.44.30.03); 10.44.23.01C(8) (committing any other unprofessional or dishonorable act or omission in the practice of dentistry); 10.44.30.02K(2) (dental records shall be detailed); 10.44.30.02K(3) (dental records shall be legible); 10.44.30.02K(5) (dental records shall document all data in the dentist's possession pertaining to the patient's dental health status); 10.44.30.03A(3) (each patient's clinical chart shall include treatment plans that are signed and dated by both the treating dentist and the patient); 10.44.30.03A(4) (each patient's clinical chart shall include patient's complaints); 10.44.30.03A(5) (each patient's clinical chart shall include diagnosis and treatment notes); 10.44.30.03A(7) (each patient's clinical chart shall include post operative instructions); 10.44.30.03A(9) (each patient's clinical chart shall include in-person conversations, telephone conversations, and other correspondence with the patient or their representative); 10.44.30.03A(12) (each patient's clinical chart shall include radiographs of diagnostic quality); 10.44.30.03A(15) (each patient's clinical chart shall include informed consent); 10.44.30.03A(18) (each patient's clinical chart shall include details regarding referrals and consultations); and 10.44.30.03A(19) (each patient's clinical chart shall include patient complaints pertaining to the dentist and staff, and their manner of resolution).

ORDER

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

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

ORDERED that the Respondent is fined in the amount of **$5000 (FIVE THOUSAND DOLLARS)**; however, of this amount, four thousand dollars ($4000) is hereby **STAYED**, so that only one thousand ($1000) due within 60 days of the effective date of this Consent Order. In addition to any other sanctions imposed, the stay shall be lifted and the remaining four thousand dollars ($4000) shall be due within 60 (sixty)

days upon a finding by the Board that the Respondent has violated the Consent Order; and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a minimum period of **TWENTY-FOUR (24) MONTHS,** commencing on the effective date of the Consent Order, and continuing until the Respondent successfully completes the following conditions:

1. Within 6 (six) months of the effective date of the consent order, the Respondent shall, at his own expense, successfully complete a course, approved by the Board in advance, equivalent to at least six (6) continuing education (C.E.) credits, focusing on dental recordkeeping; and the Respondent shall submit written verification that satisfies the Board of the successful completion of the course within 30 days of completion of each course;

2. At its discretion, the Board may conduct up to three (3) record reviews of the Respondent's patient records. Each record review shall be conducted by a Board-designated expert who shall review the records of a selection of patients whom the Respondent has treated after completing the course mentioned above. The Board designee shall personally select the records of the patients on site at the Respondent's practice, and may do so at either a scheduled or unannounced visit at one of the following time periods: Wednesdays, 4:30 p.m. to 6:00 p.m.; and Saturdays 9:00 a.m. to 12:00 p.m. During these time periods, the Respondent shall be present at his office at **2300 Garrison Blvd., Baltimore, Maryland 21216**. If the Respondent will not be present during at the office during these time periods, he shall notify the Board beforehand, unless he is unable to do so by reason of a documented emergency or illness.

3. The Respondent shall not perform any endodontic treatments; and

4. The Respondent shall comply with the Maryland Dentistry Act.

And it is further

ORDERED that no part of the training or education that the Respondent receives in connection with this Consent Order may be applied to his required continuing

education credits, and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, and any of its agents or employees, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that after a minimum of twenty-four (24) months from the effective date of the 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. The Board shall grant termination if the Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending investigations, outstanding complaints related to the charges, or violations of this Consent Order; and it is further

ORDERED that if the Respondent violates any of the terms or conditions of the Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or an evidentiary hearing if there is a genuine dispute of fact, may impose an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty; and it is further

ORDERED that this Consent Order is a Final Order of the Board and a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., Gen. Prov. §§ 4-101 et seq. (2014).

11/16/2016
Date

Ronald F. Moser, D.D.S., President
Maryland State Board of Dental Examiners

CONSENT

By this Consent, I, Jesse Weaver, D.D.S., acknowledge that I have consulted with legal counsel at all stages of this matter. I understand that this Consent Order will resolve the Charges against me and forfeit my right to a formal evidentiary hearing on the Charges. By this Consent, I agree to be bound by the terms of this Consent Order. I acknowledge under oath that I in fact committed the specific violations as set forth above. I acknowledge under oath the accuracy of the Findings of Fact and the validity of the Conclusions of Law contained in this Consent Order. I acknowledge that for all purposes, the Findings of Fact and Conclusions of Law will be treated as if proven in 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 Findings of Fact and Conclusions of Law. 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 waive my right to any appeal in this matter. I affirm that I have asked and received satisfactory answers to all my questions regarding the language, meaning, and terms of this Consent Order. I sign this Consent Order voluntarily and without reservation, and I fully understand and comprehend the language, meaning, and terms of this Consent Order.

11/2/2016

Date

Jesse Weaver, D.D.S.
Respondent

NOTARY

STATE OF Maryland

CITY/COUNTY OF: Baltimore

I HEREBY CERTIFY that on this 2nd day of November, 2016, before me, a Notary Public of the State and County aforesaid, personally appeared Jesse Weaver, D.D.S., and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Michele J. Rogers
Notary Public

My commission expires: