

BEFORE THE IOWA DENTAL BOARD

IN THE MATTER OF :

JAY R. BUCKLEY, D.D.S.

RESPONDENT

FINDINGS OF FACT,
CONCLUSIONS OF LAW,
DECISION AND ORDER

On February 1, 2013, the Iowa Dental Board (Board) filed a Notice of Hearing and Statement of Charges against Jay R. Buckley, D.D.S. (Respondent) alleging the following two counts:

Count I: Willful or repeated violations of the rules of the Board by failing to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as required or recommended by the Centers for Disease Control of the United States Department of Health and Human Services (CDC), in violation of 650 IAC 30.4(35).

Count II: Willful or repeated violations of the rules of the Board by failing to maintain sanitary conditions for a dental office by not properly sterilizing dental hand pieces, in violation of 650 IAC 30.4(17)

The hearing was held before the Board on May 10, 2013 in the Board's Conference Room at 400 SW 8th Street, Des Moines, Iowa. The following members of the Board presided at the hearing: Steve Bradley, D.D.S., Chairperson; Steven Fuller, D.D.S.; Thomas Jeneary, D.D.S.; Kaaren Vargas, D.D.S.; Matthew McCullough, D.D.S.; Mary Kelly, R.D.H.; Diane Meier and Lori Elmitt, Public Members. Respondent appeared and was represented by attorney Steven P. Wandro. Assistant Attorney General Theresa O'Connell Weeg represented the state. Administrative Law Judge Margaret LaMarche assisted the Board in conducting the hearing. The hearing was recorded by a certified court reporter and was closed to the public at Respondent's request, pursuant to Iowa Code section 272C.6(1) and 650 IAC 51.20(13). Following the hearing, the Board convened in closed executive session, pursuant to Iowa Code section 21.5(1)(f)(2013), to deliberate their decision. The Board directed the administrative law judge to draft their Findings of Fact, Conclusions of Law, Decision and Order, in conformance with their deliberations.

THE RECORD

The record includes the testimony of Brian Sedars, Pamela Gibson, Amanda Hayner, Heather Andrews, and Respondent. The record also includes State Exhibits 1-19 (See Exhibit Index for description) and Respondent Exhibits A-C.

FINDINGS OF FACT

1. Respondent was issued Iowa dental license number 6782 on July 1, 1982. Respondent's license is current and will expire on August 31, 2014. Respondent practices as a general dentist in Des Moines, Iowa. In addition to his office practice, Respondent also provides dental care at several nursing homes using two mobile dental care units. Respondent currently provides dental care at nursing homes three mornings a week. At the time that the complaint was filed in this case, Respondent was providing dental care at nursing homes five mornings a week. Respondent's staff currently includes one registered dental assistant (Heather Andrews) and a receptionist (Janis). At the time of the complaint, Respondent employed two registered dental assistants, Pamela Gibson and Amanda Hayner. (Respondent testimony; State Exhibits 6, 7)

2. The Board has formally disciplined Respondent's dental license on two prior occasions.

a) On December 1, 1999, the Board filed a first Statement of Charges, which charged Respondent with failure to maintain a reasonably satisfactory standard of competency in the practice of dentistry and unprofessional conduct based on a failure to fully explain his treatment regimen and obtain patient authorization before beginning treatment. The Statement of Charges noted that the Board had received fifteen complaints against Respondent since 1983 and that the Board previously sent Respondent four letters of warning or admonition. (State Exhibit 1)

On February 16, 2000, Respondent and the Board entered into a Stipulation and Consent Order to resolve the first Statement of Charges. Respondent's license was placed on probation for a period of five years. In part, Respondent agreed to undergo a comprehensive clinical assessment by a college of dentistry to determine his level of competency and to complete a course of study. (State Exhibit 2)

On February 16, 2005, Respondent was released from probation and the conditions established in the February 16, 2000 Stipulation and Consent Order. (State Exhibit 3)

b) On August 28, 2008, the Board filed a second Statement of Charges alleging that Respondent obtained a fee by fraud or misrepresentation and further alleging that Respondent failed to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as required or recommended by the Centers for Disease Control (CDC). It was alleged, in part, that Respondent was not sterilizing all dental hand pieces between patients. (State Exhibit 4)

On April 15, 2009, Respondent and the Board entered into a Stipulation and Consent Order to resolve the second Statement of Charges. Respondent's dental license was placed on probation for a period of two years, subject to terms and conditions. In part, Respondent was required to submit his written office protocol for infection control to the Board for its approval. The written office protocol was required to establish how Respondent would incorporate his in-office infection control standards while providing dental services in nursing homes and out of office settings. Respondent was also required to submit to random practice review by Board consultants to ensure that he was complying with the approved written protocol for infection control. Respondent was also required to pay a civil penalty of \$1,000. (State Exhibit 5)

3. On July 12, 2012, the Board received a complaint from Pamela Gibson, R.D.A. alleging that Respondent was violating infection control standards by wearing the same gloves for more than one patient after washing the gloves for 10 seconds with soap and water. Ms. Gibson also reported that Respondent did not give his staff sufficient time to adequately clean the operatories between patients. Ms. Gibson had been employed by Respondent as a dental assistant since 1996. (State Exhibits 7, 8; Gibson testimony)

4. On July 24, 2012, Board Investigator Brian J. Sedars made an unannounced visit to Respondent's dental office to perform an infection control inspection and to speak with Respondent's staff. Respondent assigned dental assistant Amanda Hayner to assist Brian Sedars during his inspection. Brian Sedars conducted the inspection using a "Clinical Asepsis Office Assessment Form for Dental Offices" that was developed by the Board. This form incorporates the CDC's guidelines for infection control in dental offices. Mr. Sedars took contemporaneous handwritten notes during his inspection and later prepared a written investigative report. (Sedars testimony; State Exhibits 7, 9, 11)

During the inspection, Brian Sedars personally observed and documented the following infection control deficiencies:

a) *Failure to Heat-Sterilize all Critical Instruments.* The CDC requires all critical dental instruments to be cleaned and heat sterilized before each use. (State Exhibit 9, p. 4) If

the hand piece can be removed from the motor (e.g. low speed hand pieces) then the attached hand pieces are removed and heat sterilized in an autoclave. The motor is not heat sterilized. If the hand piece cannot be detached from the motor (e.g. high speed hand pieces) then the entire hand piece, including the motor, must be heat sterilized. During the inspection, Brian Sedars asked Amanda Hayner to clean an operatory that had just been used by Respondent. Brian Sedars observed Ms. Hayner using a surface disinfectant to wipe down both the slow speed and high speed hand pieces in the operatory. Ms. Hayner told Sedars that the hand pieces had not been used on the previous patient. When specifically asked about the protocol for sterilizing the hand pieces, Ms. Hayner responded that they were wiped down between patients but were not run through the autoclave. (Sedars testimony; State Exhibit 7, p. 1)

b) *Reuse of Single Use Disposable Items.* The CDC requires all single use disposable items to be used only once and then properly disposed of. (State Exhibit 9, p. 4) Brian Sedars observed that Respondent's dental office was reusing single use disposable items like high volume suction ends and saliva ejectors after cold-sterilizing them. Mr. Sedars observed that some of these items, which are typically bright white, were dingy and discolored. Ms. Hayner told Sedars that these items were cold sterilized and then reused. (Sedars testimony; State Exhibit 7, p. 1)

c) *No Mechanical Indicators for Sterilization Process.* The CDC recommends the use of mechanical, chemical, and biological monitors, according to the manufacturer's instructions, to ensure the effectiveness of the sterilization process. (State Exhibit 9, p. 6) The CDC further recommends the use of mechanical and chemical indicators for each unwrapped sterilization cycle. (State Exhibit 7, p. 5) Brian Sedars observed that no mechanical indicators were being used when staff processed instruments in the autoclave. The mechanical indicators change color when the items are sterile. Without the mechanical indicators, staff cannot be assured that the instruments are in fact sterile. (Sedars testimony; State Exhibit 7, p. 2)

d) *Storing Sterilized Instruments Unwrapped.* The CDC recommends that sterilized critical instruments should not be stored unwrapped. (State Exhibit 9, p. 5) Bagging or wrapping the sterilized instruments ensures that they do not become contaminated and further allows staff to determine which instruments are sterile and which are not. At the time of the inspection, Respondent's staff was sterilizing instruments without bags and storing sterilized instruments unwrapped. (Sedars testimony; State Exhibit 7, p.2)

5. Following his inspection, Brian Sedars informed staff members Amanda Hayner and Pamela Gibson that dental hand pieces needed to be sterilized and placed in bags with a mechanical indicator to show they had been properly processed. Both of them

told Sedars that while they believed that the hand pieces needed to be heat sterilized, Respondent had instructed them not to do so because it would "ruin the hand pieces." Sedars told Gibson and Hayner that all hand pieces needed to be heat sterilized and bagged when not in use. (Sedars testimony; State Exhibit 7, p. 2, Exhibit 11)

When she testified at hearing, Amanda Hayner explained that when she was hired, she was not initially trained to sterilize all instruments between patients. A few months later, however, she was instructed that instruments must be sterilized between patients. This was presumably after the Board's second Statement of Charges was filed against Respondent. Ms. Hayner further testified that Respondent tended to leave her alone and that she continued to sterilize hand pieces after each patient by placing all of the used hand pieces in a drawer and later autoclaving them. This testimony was inconsistent, however, with the cleaning process that Ms. Hayner demonstrated for Brian Sedars. It was also inconsistent with both prior and later statements that she made to Brian Sedars. Amanda Hayner also testified that she had heard Respondent tell Pamela Gibson that autoclaving "cut down the life of hand pieces" and that she should just spray and wipe them down. (Hayner testimony)

6. Brian Sedars also met individually with Amanda Hayner and Pamela Gibson during his visit to Respondent's dental office on July 24, 2012, and he asked each of them about Respondent's protocol for changing gloves.

- Amanda Hayner told Sedars that Respondent changed gloves between patients at the office but would sometimes wash his gloves when treating members of the same family. Ms. Hayner reported that Respondent changed gloves between patients at the nursing home when she was his assistant. Ms. Hayner also told Sedars that Gibson had told her that Respondent would sometimes reuse gloves at the nursing home, but Hayner had not witnessed him washing gloves.
- Pamela Gibson told Sedars that Respondent changed his gloves while treating patients in his office but would reuse gloves at the nursing homes. She further reported that if they did not have enough hand pieces for the procedures at the nursing home, Respondent would change the bur but reuse the hand piece. She also reported that Respondent would take disposable items out of the trash for reuse.
- Pamela Gibson gave Brian Sedars her phone, on which she had recorded some of her conversations with Respondent. Mr. Sedars made a copy of one of the recordings, which was an apparent staff meeting between Respondent, Pamela Gibson, and Amanda Hayner. During this meeting, Ms. Gibson complained to

Respondent about his practice of not changing gloves between patients at the nursing home. Ms. Gibson can be heard saying "I want gloves changed between patients." Respondent can be heard responding "I can change them if it bothers you, but if I change my gloves you will have to move faster between patients." Respondent also refers to "the science that's been done." He also states that "it will be faster because I won't spend 10 seconds washing my gloves." During the meeting, Respondent and Ms. Gibson accuse each other of being rude and disrespectful. Respondent can be heard stating "I will make you feel better. I will change my gloves between patients." (State Exhibit 12)

(Sedars testimony; State Exhibit 7, pp. 2-3; Exhibit 11)

7. Brian Sedars also discussed the deficiencies that he found during his inspection with Respondent.

- Respondent told Sedars that gloves were changed between each patient.
- When Mr. Sedars asked Respondent why his hand pieces were not being sterilized, Respondent replied that high speed hand pieces were being sterilized but "according to microbiology, it is impossible for the slow speed to become contaminated."¹ When Mr. Sedars advised Respondent that the CDC requires all hand pieces to be sterilized, Respondent stated that was not his understanding. Respondent told Sedars that his staff must be lying if they said that no hand pieces were being sterilized. He further stated that, the last he knew, the hand pieces were being autoclaved. Respondent could not explain why the hand pieces were not bagged. Mr. Sedars advised Respondent that he must ensure that all hand pieces were sterilized with an indicator and bagged.
- When Mr. Sedars asked Respondent about why single use items were being reused after cold sterilization, Respondent replied that this was how he was taught in dental school. Respondent admitted that the items he used in dental school were made of metal and could be sterilized. Mr. Sedars told Respondent that he had observed a bag of visibly dirty disposable items right next to a bag of new suction tips in his office.

¹ At hearing, Respondent claimed that he was referring only to the slow speed motor in this statement and not to the slow speed attachments. This self-serving testimony was less credible than Brian Sedars' testimony and documentation of the actual statements that Respondent made to him and the context of those statements. In addition, Respondent also testified about his undergraduate degree in microbiology, which he (mistakenly) believes provides him with special expertise in microbiology.

Following the July 24, 2012 inspection, Brian Sedars contacted Pamela Gibson, who confirmed that Respondent had corrected the deficiencies identified during the inspection. (State Exhibit 7, p. 3; Exhibit 11)

8. On September 13, 2012, Respondent called Brian Sedars and told him that all of the deficiencies identified during the inspection had been corrected. Respondent reported that all instruments were being bagged, single use items were disposed of, and heat indicators were being run with each load in the autoclave. Brian Sedars asked Respondent to provide written confirmation of the corrections. Mr. Sedars also asked Respondent if all hand pieces were now being sterilized, and Respondent replied "they always have been." Mr. Sedars told Respondent that his staff stated otherwise and reminded Respondent that he previously stated that slow speeds were not being sterilized because "they couldn't be contaminated." Respondent told Mr. Sedars that there must have been a misunderstanding when Amanda Hayner showed him how they clean hand pieces. Finally, Mr. Sedars asked Respondent if he used a different protocol for changing gloves when he was in nursing homes, and Respondent replied "not at all." This response was inconsistent with the admissions that Respondent made on the recording provided by Pamela Gibson. (Sedars testimony; State Exhibit 7, p. 4)

Immediately after this conversation, Brian Sedars spoke to Amanda Hayner and asked her about the sterilization of hand pieces in the office. Ms. Hayner told Sedars that she is now sterilizing all hand pieces in the office, but prior to his inspection the hand pieces were not being sterilized, per Respondent's instructions. (Sedars testimony; State Exhibit 7, p. 4)

9. On September 20, 2012, Respondent faxed a letter to Brian Sedars to confirm that his office had implemented the recommendations made by Sedars during the July 24, 2012 inspection. Respondent included a copy of his office policy on sterilization, which he claimed had been reviewed with Amanda Hayner and Pamela Gibson before the July 24, 2012 inspection and again after the inspection. Respondent claimed that the indicating tape was misplaced during Mr. Sedars' visit but that Amanda could tell if the item had been autoclaved because the bag becomes crinkly and is no longer smooth. He also claimed that every slow speed attachment that was used or out of its "crinkly" bag was autoclaved each day before being used on another patient. The claim that all hand pieces were autoclaved between patients was inconsistent with prior statements made by Amanda Hayner, Pamela Gibson, and Respondent. (Sedars testimony; State Exhibit 10)

In his letter, Respondent further reported that the office now sleeves all items left out in the treatment rooms. He also reported that the slow and high speed attachments, including motors, are sprayed, wiped, and sprayed if they have not been used (still covered with the sleeve) and if the slow speed attachment is used, it is autoclaved. The slow speed motor is not autoclaved but is sprayed, wiped, and sprayed. They no longer daily autoclave the slow speed attachments that are out but unused in the treatment rooms because they are now covered. He further reported that items that can be autoclaved are autoclaved and those that are single use are being disposed of after being used. (State Exhibit 10)

10. On September 24, 2012, Amanda Hayner called Brian Sedars to tell him that Respondent had fired Pamela Gibson. Amanda Hayner also told Sedars that Respondent had hired a new dental assistant, who was later identified as Heather Andrews. During this phone call and also in testimony at hearing, Amanda Hayner reported that Respondent told Heather Andrews not to sterilize all hand pieces but to wipe them down. Hayner testified that she heard this from Andrews and that she told Andrews to sterilize all hand pieces. (Sedars, Hayner testimony; State Exhibit 7, p. 4)

Heather Andrews, R.D.A. testified on behalf of Respondent at hearing. She explained that she started working for Respondent on September 12, 2012 and was still employed by him on the date of the hearing. Ms. Andrews had worked only a few days before Pamela Gibson was fired. Ms. Andrews denied that Respondent had ever told her to sterilize hand pieces by spraying and wiping them down. She testified that they were autoclaving all hand pieces using bags and indicator tape. She further testified that Respondent always changed gloves and washed his hands between patients, both at the office and at the nursing home, and that single use disposable items were not reused. They have had OSHA in-service meetings in the office with Respondent serving as the instructor for the staff. (Testimony of Heather Andrews) Respondent was not aware that annual OSHA training must be conducted by a qualified trainer. (Respondent testimony)

11. Pamela Gibson worked for Respondent from January 8, 1996 until September 10, 2012, when she was fired. Respondent contends that Gibson was fired for coming to work in inappropriate attire and without her dental assistant certificate and for arguing with him when he asked her to change her clothes and get her certificate. Ms. Gibson denies that she was dressed inappropriately and contends she was fired for improper reasons, including filing the complaint with the Board. Ms. Gibson was awarded unemployment compensation following a hearing. She has also sued Respondent for wrongful discharge in Polk County District Court. (Sedars, Gibson, Respondent testimony; State Exhibit 7, p. 4, Exhibits 14-16)

12. Amanda Hayner was first hired by Respondent in 2007. The husbands of Hayner and Gibson were cousins, and the two couples were living together when Hayner was initially hired. Respondent helped Amanda Hayner get her general education degree (GED) and her dental assistant certificate, which she appreciated very much. Ms. Hayner and Ms. Gibson were very close at one time but grew more distant as they continued to work together. Respondent often held Hayner up as an example while criticizing Gibson, and Gibson resented this. By the time of the hearing before the Board, Hayner and Gibson were no longer close and only saw each other at family functions. (Hayner, Gibson testimony)

Amanda Hayner left her job with Respondent on January 31, 2013, reportedly due to job stress, including the stress of training the new dental assistant, Heather Andrews. Ms. Hayner testified that she was also concerned that her license might be in jeopardy with the Board if she continued to work for Respondent and further deficiencies were found. After she quit her job, Ms. Hayner applied for unemployment benefits, but her unemployment claim was denied following a hearing. (Hayner testimony; Respondent Exhibit C)

13. Respondent submitted his written Office Sterilization and Disinfection Policy (Respondent Exhibit A), which he had submitted for Board approval in 2008 following the inspection that led to the second Statement of Charges. Respondent testified that he gave the written policy to each of his staff at the time it was approved and told them to follow the sterilization procedures indefinitely. Respondent also testified that the written policy was posted in the sterilization area in his office. Respondent testified that he had seen staff complying with this written policy "for years" and further testified that he had seen hand pieces in the autoclave. (Respondent testimony)

Respondent also submitted the manufacturer's "Handpiece Infection Control and Maintenance Guide," and testified that it was also posted in the sterilization area. (Respondent testimony; Respondent Exhibit B)

In his testimony at hearing, Respondent denied that he ever used the same pair of gloves on more than one patient at a nursing home. Respondent testified that the only time that he washed gloves was before he helped transfer a patient to a wheelchair and then he would throw the gloves away before treating the next patient. This testimony was not credible in light of the clear admissions made by Respondent during the recorded staff meeting with Ms. Gibson and Ms. Hayner. On the recording, Respondent admits that he did not always changing gloves between patients at the nursing home. (Respondent testimony; State Exhibit 12)

Respondent testified that the bags were taken off the hand pieces and the indicator tape had mysteriously disappeared from the sterilization room the day that Brian Sedars appeared to conduct the inspection and implied that Pamela Gibson was responsible for this. Brian Sedars' visit was unannounced and there is no indication that Gibson knew he was coming that day. This testimony by Respondent was self-serving and not credible. (Respondent testimony)

CONCLUSIONS OF LAW

The Board is authorized to discipline a licensed dentist for willful or repeated violations of Board rules. Iowa Code section 153.34(4)(2011, 2013) Notwithstanding Iowa Code section 272C.3, license discipline may include a civil penalty not to exceed ten thousand dollars.² Pursuant to 650 IAC 30.4, the Board is authorized to impose one or more of the disciplinary sanctions set forth in 650 IAC 30.2, including the imposition of civil penalties not to exceed \$10,000, based on the following grounds:

17. Failure to maintain adequate safety and sanitary conditions in a dental office.

...

35. Failure to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as required or recommended by the Centers for Disease Control of the United States Department of Health and Human Services.

The preponderance of the evidence established that Respondent repeatedly and willfully failed to maintain safety and sanitary conditions in his dental practice, in violation of Iowa Code section 153.34(4)(2011) and 650 IAC 30.4(17). [Count I] The preponderance of the evidence further established that Respondent repeatedly and willfully failed to comply with standard precautions for preventing and controlling infectious diseases and managing personnel health and safety concerns related to infection control, as required or recommended by the Centers for Disease Control of the United States Department of Health and Human Services, in violation of Iowa Code section 153.34(4)(2011) and 650 IAC 30.4(35). [Count II]

The preponderance of the evidence established that in Respondent's dental practice, dental hand pieces were not always properly sterilized between patients, critical

² Iowa Code section 153.34(2011,2013)

instruments were not always bagged for sterilization or for storage, instruments were routinely autoclaved without using any mechanical indicators, and single use disposable items such as high volume suction ends and saliva ejectors were being cold sterilized and reused. In addition, at times Respondent washed but did not change his gloves between patients that he treated at the nursing homes. These findings of violation are supported by the credible observations, documentation, and testimony of the Board's investigator and by credible reports and testimony from two of Respondent's employees. Moreover, during a recorded meeting with staff, Respondent made repeated admissions that he did not always change gloves between nursing home patients.

Respondent's statements and testimony denying the violations were filled with inconsistencies and self-serving statements. Although Respondent clearly had a contentious relationship with Pamela Gibson, the Board was not persuaded that their difficult relationship caused Ms. Gibson to fabricate allegations of unsanitary conditions in Respondent's dental practice or that Pamela Gibson and Amanda Hayner conspired against Respondent.³

In determining an appropriate sanction in this case, the Board considered the critical importance of proper sanitation and infection control to patient health and safety, the number and nature of the violations, and Respondent's history of prior discipline for similar issues. *See* 650 IAC 30.3.

DECISION AND ORDER

IT IS THEREFORE ORDERED that Respondent Jay Buckley, D.D.S shall pay a civil penalty of five thousand dollars (\$5000) within 30 days of the date of this Decision and Order.

IT IS FURTHER ORDERED that Respondent's license to practice dentistry in the state of Iowa shall be placed on probation for a period of five (5) years, subject to the following terms and conditions:

- A. Within sixty (60) days of this Decision and Order and annually thereafter, Respondent shall retain the services of an outside Infection Control Trainer, approved by the Board, to provide infection control training to

³ As a registered dental assistant, Pamela Gibson had an ongoing duty to report Respondent's violations to the Board. Iowa Code section 272C.9(2)

Respondent and his staff. Respondent shall provide written verification to the Board that the required training was conducted.

- B. Within sixty (60) days of this Decision and Order, Respondent shall enter into a written agreement with another licensed dentist, who will serve as Respondent's Practice Monitor for infection control. Respondent must submit the name of the Practice Monitor and a copy of the written monitoring agreement to the Board for its approval. At a minimum, the agreement shall provide for the Practice Monitor to randomly visit Respondent's dental office to review Respondent's procedures for sanitation and infection control and for his compliance with the CDC recommendations or requirements for standard precautions to prevent and control infectious diseases. The Practice Monitor shall utilize the OSAP/CDC checklist during the random visits and shall provide quarterly written reports to the Board no later than the first day of January, April, July and October of each calendar year of probation.
- C. Respondent shall submit quarterly written reports on the form provided by the Board no later than the first day of January, April, July and October of each calendar year. The reports shall detail Respondent's compliance with all of the terms of this Order.
- D. Respondent shall be responsible for all costs associated with compliance with this Order.
- E. Respondent shall upon reasonable notice, and subject to the provisions of 650 Iowa Administrative Code 31.6 appear before the Board at the time and place designated by the Board.
- F. Periods of residence or practice outside of the state of Iowa shall not apply to the duration of this Order unless Respondent obtains prior written approval from the Board. Periods in which Respondent does not practice dentistry and/or he fails to comply with the terms established in this Order shall not apply to the duration of this Order unless Respondent obtains prior written approval from the Board within fourteen (14) days of the change.
- G. Notice of any change of practice location must be provided to the Board within fourteen (14) days.

- H. Any violation of the terms of this Decision and Order will result in additional and more severe discipline, up to and including license revocation.

IT IS FURTHER ORDERED, pursuant to Iowa Code section 272C.6 and 650 IAC 51.35 that the Respondent shall pay \$75.00 for fees associated with the disciplinary hearing and any costs calculated by the executive director within thirty (30) days of receipt of the notice of costs.

Dated this 2nd day of July, 2013.

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Steven Bradley, D.D.S.

Chairperson

Iowa Dental Board

cc: Theresa O'Connell Weeg, Assistant Attorney General, Hoover Building (LOCAL)

Steven P. Wandro, Wandro & Associates, P.C., 2501 Grand Avenue, Suite B, Des Moines, Iowa 50312 (CERTIFIED)

Judicial review of the board's decision may be sought in accordance with the terms of Iowa Code chapter 17A and Iowa Code section 153.33(5)(g) and (h).