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STATE OF WISCONSIN
BEFORE THE DENTISTRY EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
STANLEY W. GRESHAM, D.D.S., RESPONDENT.	:	ORDER 0000371

[Division of Enforcement Case # 06 DEN 072]

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Stanley W. Gresham, D.D.S.
220 S. Suffolk Street
Ironwood, MI 49938

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Dentistry Examining Board
Department of Regulation & Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Dentistry Examining Board. The Board has reviewed the attached Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Stanley W. Gresham, D.D.S., (D.O.B.: May 11, 1949) is duly licensed as dentist in the state of Wisconsin (license # 4573-15). This license was first granted on February 22, 1994.

2. Respondent's most recent address on file with the Wisconsin Dentistry Examining Board is 220 S. Suffolk Street, Ironwood, Michigan 49938.

3. At all times relevant to this action, Respondent was working as a dentist at his office in Ironwood, Michigan.

Allegations relating to Patient M.S.

4. On July 29, 2005, Patient M.S. initially presented to the Respondent for examination and treatment. Respondent took x-rays that day which reflected multiple restorations, however he did not document on the tooth chart in the examination record the existence of any existing restorations. The Respondent also failed to document the clinical findings of the initial examination. Specifically, he failed to record the general condition of the teeth, the condition of the mucosa, inflammation level of the gingival tissue, oral cancer exam findings and bite information.

5. On August 19, September 16, and September 20, 2005, Patient M.S. presented to the Respondent for treatment. On those dates, the Respondent used non-standard notations to document either treatment needed or work performed on Patient M.S.'s teeth such that the notes would not be decipherable to a subsequent treating dentist.

6. Respondent's treatment notes are also unclear with regard to the date that certain work was performed. Specifically, the Respondent documented treatment to teeth #23, 26, 28 and 32, however it is not clear as to whether that treatment was performed on September 16 or September 20, 2005. In addition, Respondent failed to document the material used for the filling (either composite or amalgam) in the restorations on these teeth.

7. Respondent's conduct as described in paragraphs 4-6 fell below the minimum standards of competence established in the profession in the following respects:

a. Respondent failed to document existing restorations found during Patient M.S.'s initial examination and failed to document the clinical findings of the initial exam;

b. Respondent failed to adequately document with standard notations the work performed on Patient M.S.'s teeth;

c. Respondent failed to accurately document the dates that treatment was performed and the materials used for restorations on September 16 and 20, 2005;

Allegations relating to Patient D.R.

8. On June 11, 2003, Patient D.R. initially presented to the Respondent for examination and treatment. Respondent failed document on the tooth chart in the examination record the existence of any existing restorations. The Respondent also failed to document the clinical findings of the initial examination. Specifically, he failed to record the general condition

of the teeth, the condition of the mucosa, inflammation level of the gingival tissue, oral cancer exam findings and bite information.

9. On June 30, 2003, July 16 and 31, 2003, March 22, 2004, August 3, 2005, and January 31, 2006, Patient D.R. presented to the Respondent for treatment. Respondent's treatment notes are also unclear with regard to the dates that certain work was performed. In addition, when treatment is documented, the Respondent used non-standard notations to document either treatment needed or work performed on Patient D.R.'s teeth such that the notes would not be decipherable to a subsequent treating dentist.

10. In addition, Respondent failed to document the material used for the filling (either composite or amalgam) in the restorations on teeth where the records reflect that such work was performed.

11. Patient D.R.'s x-rays taken at the Respondent's office are not all dated.

12. X-rays taken by Respondent on July 31, 2003 are of poor diagnostic quality in that multiple cone cuts occur due to the x-ray film not being lined up properly with the x-ray beam. These x-rays were not re-done.

13. Respondent's conduct as described in paragraphs 8-12 fell below the minimum standards of competence established in the profession in the following respects:

a. Respondent failed to document existing restorations found during Patient D.R.'s initial examination and failed to document the clinical findings of the initial exam;

b. Respondent failed to adequately document with standard notations the work performed on Patient D.R.'s teeth;

c. Respondent failed to accurately document the materials used for restorations;

d. Respondent failed to date all of Patient D.R.'s x-rays;

e. Respondent took x-rays on July 31, 2003 which were of poor diagnostic quality and failed to re-take the x-rays.

Allegations relating to Patient C.G.

14. On August 4, 2005, Patient C.G. initially presented to the Respondent for examination and treatment. Respondent failed document on the tooth chart in the examination record the existence of any existing restorations. The Respondent also failed to document the clinical findings of the initial examination. Specifically, he failed to record the general condition of the teeth, the condition of the mucosa, inflammation level of the gingival tissue, oral cancer exam findings and bite information.

15. The Respondent's August 4, 2005 note fails to document the material used for the filling (either composite or amalgam) in the restorations on teeth where the records reflect that work was performed.

16. X-rays taken on August 4, 2005 reveal that decay is present on the distal surface of tooth 13, however, the Respondent failed to document the presence of decay on that tooth.

17. On September 1 and October 3, 2005, Patient C.G. presented to the Respondent for treatment. Respondent's treatment notes are also unclear with regard to the dates that work was performed. In addition, when treatment is documented, the Respondent used non-standard notations to document either treatment needed or work performed on Patient C.G.'s teeth such that the notes would not be decipherable to a subsequent treating dentist.

18. The Respondent's record for October 3, 2005 reflects that Carbostesin was used as an anesthetic but the Respondent failed to indicate the dosage used.

19. X-rays taken by the Respondent on October 3, 2005 are of poor diagnostic quality in that there are large cone cuts that obscure teeth. The x-rays were not re-done.

20. Respondent's conduct as described in paragraphs 14-19 fell below the minimum standards of competence established in the profession in the following respects:

a. Respondent failed to document existing restorations found during Patient C.G.'s initial examination and failed to document the clinical findings of the initial exam;

b. Respondent failed to adequately document with standard notations the work performed on Patient C.G.'s teeth;

c. Respondent failed to accurately document the dates that treatment was performed and the materials used for restorations on August 4, 2005;

d. Respondent failed to note that x-rays taken on August 4, 2005 revealed decay present on the distal surface of tooth 13;

e. Respondent failed to adequately document the dosage of Carbostesin used on October 3, 2005 during treatment of Patient C.G.;

f. Respondent took x-rays on October 3, 2005 which were of poor diagnostic quality and failed to re-take the x-rays.

Allegations relating to Patient T.S.

21. On July 17, 2002, Patient T.S. initially presented to the Respondent for examination and treatment. Respondent failed document on the tooth chart in the examination record the existence of any existing restorations. The Respondent also failed to document the clinical findings of the initial examination. Specifically, he failed to record the general condition

of the teeth, the condition of the mucosa, inflammation level of the gingival tissue, oral cancer exam findings and bite information.

22. The Respondent's treatment notes cover a period from July of 2002 through September of 2009. Respondent's treatment notes are unclear with regard to the dates that certain work was performed. In addition, when treatment is documented, the Respondent used non-standard notations to document either treatment needed or work performed on Patient T.S.'s teeth such that the notes would not be decipherable to a subsequent treating dentist.

23. The Respondent's treatment notes frequently fail to document the materials used for restorations.

24. Several of the Respondent's records in 2005 reflect that Carbostesin was used as an anesthetic but the Respondent failed to indicate the dosages used.

25. Respondent's conduct as described in paragraphs 21-24 fell below the minimum standards of competence established in the profession in the following respects:

a. Respondent failed to document existing restorations found during Patient T.S.'s initial examination and failed to document the clinical findings of the initial exam;

b. Respondent failed to adequately document with standard notations the work performed on Patient T.S.'s teeth;

c. Respondent failed to accurately document the dates that treatment was performed and the materials used for restorations;

d. Respondent failed to adequately document the dosages of Carbostesin used during treatment of Patient T.S.

CONCLUSIONS OF LAW

1. The Wisconsin Dentistry Examining Board has jurisdiction to act in this matter, pursuant to Wis. Stat. § 447.07(3), and is authorized to enter into the attached Stipulation and Order, pursuant to Wis. Stat. § 227.44(5).

2. The conduct of Respondent as described in paragraphs 4 - 6, 8 - 12, 14 - 19 and 21 - 24, above, constitutes violations of Wis. Stat. §§ 447.07(3)(a), 447.07(3)(h), and Wis. Admin. Code § DE 5.02(5).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. Stanley W. Gresham, D.D.S., is hereby REPRIMANDED.

IT IS FURTHER ORDERED that:

2. Respondent shall, within six (6) months from the date of this Order, successfully complete the American Association of Dental Boards record-keeping course. Respondent must demonstrate that he has successfully passed the exam which accompanies the on-line record-keeping course. The course attended in satisfaction of this requirement may not be used to satisfy the statutory continuing education requirements for licensure.

3. Respondent shall, within six (6) months from the date of this Order, successfully complete a minimum of four (4) hours of continuing education in the area of radiographic technique and diagnosis. The course(s) attended in satisfaction of this requirement may not be used to satisfy the statutory continuing education requirements for licensure.

4. Respondent shall be responsible for locating any continuing education program. The Board or its designee must approve all continuing education programs prior to Respondent enrolling in, attending, or completing a continuing education program. Respondent shall send a Certificate of Completion for each continuing education program to the Department Monitor upon successful completion of each continuing education program. Respondent shall be responsible for any and all costs of any continuing education program.

5. Respondent shall, within ninety (90) days from the date of this Order, pay COSTS of this proceeding in the amount of ONE THOUSAND FIVE HUNDRED DOLLARS ($1,500). Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817
Fax (608) 266-2264

6. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs as set forth above, the Respondent's license (# 4573-15) may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs.

7. This Order is effective on the date of its signing.

Wisconsin Dentistry Examining Board

By: Jan K Barbeau DDS
A Member of the Board

9/1/10
Date