BEFORE THE ARIZONA STATE BOARD OF DENTAL EXAMINERS

IN THE MATTER OF: **Robert Craig Janisse, D.D.S.,** Holder of License No. D008564 For the Practice of Dentistry In the State of Arizona.	Case No. 202300482 **INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER FOR SUMMARY SUSPENSION OF LICENSE**

INTRODUCTION

The above-captioned matter came before the Arizona Board of Dental Examiners ("Board") for review on October 25, 2024. After reviewing relevant information and deliberating, the Board voted to institute proceedings for a summary action against the license held by Robert Craig Janisse, D.D.S., ("Respondent"). Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License No. D008564, under its authority in A.R.S. §§ 32-1263.02(E) and 41-1092.11(B), pending formal hearing proceedings pursuant to A.R.S. § 41-1092.01 *et seq*. or other Board action.

INTERIM FINDINGS OF FACT

1. The Board has the authority for the regulation and control of the practice of dentistry in the State of Arizona.

2. Respondent is the holder of License No. D008564, issued on August 14, 2012, for the practice of Dentistry in the State of Arizona. Respondent also holds a permit to administer conscious sedation issued pursuant to A.A.C. R4-11-1302 ("1302 Permit").

3. The Board initiated case no. 202300482 against Respondent after receiving a complaint filed by KH, a dental hygienist who formerly worked for Respondent,

alleging that Respondent placed a non-sterile tool in a patient's mouth to assist with the removal of an implant.

4. On November 24, 2021, Respondent performed a crown preparation and build-up on tooth no. 30 on patient AR, a medically compromised patient with high blood pressure and HIV.

5. Respondent administered IV sedation to AR during the November 24, 2021, treatment. According to AR's sedation record, AR was sedated for 1.5 hours. Respondent failed to record intra-operative vital signs, blood pressure readings and pulse oximeter readings in AR's sedation record. Respondent also failed to record AR's pre-operative, intra-operative and post-operative respiratory rates in AR's sedation record.

6. On August 4, 2022, AR presented to Respondent for upper and lower left quadrant scaling and root planing and the placement of fillings in teeth nos. 10, 14, 18, 20 and 21.

7. Respondent administered IV sedation to AR during the August 4, 2022, treatment. According to AR's sedation record, AR was sedated for 3 hours. Respondent failed to record intra-operative vital signs, blood pressure readings and pulse oximeter readings in AR's sedation record. Respondent also failed to record AR's pre-operative, intra-operative and post-operative respiratory rates in AR's sedation record.

8. On November 7, 2023, AR presented to Respondent for the extraction of teeth nos. 2, 3, 4, 5, 6, 7, 8, 10, 11, 12 13, 14, and 15; bone graft placement in the extraction sites; implant placement in teeth nos. 3, 4, 7, 10, 12, 13, 14, and 15 sites; the removal of the implant in the tooth no. 9 site with bone graft placement, and upper right and upper left alveoplasty. Respondent noted in AR's treatment notes from September 7, 2023 that AR "came in to discuss [treatment] needed vs All on 4 options. He is ready to take out his teeth and have a good looking smile." There is no clinical evidence supporting the extraction of all AR's lower teeth and the placement of implants.

Specifically, the radiographs show that the majority of the teeth extracted were restorable and contained long, healthy roots and only mild bone loss.

9. Respondent administered IV sedation to AR during the November 7, 2023, treatment. According to AR's sedation record, AR was sedated for 8 hours. Respondent administered a total of 30 mg of Versed, 175 mg of Fentanyl, and 50 mg of Benadryl to AR over the course of the treatment. The amount of sedation exceeded the amount necessary to achieve conscious sedation. Respondent failed to record intra-operative pulse oximeter and heart rate readings and recorded only two blood pressure readings in AR's sedation record. Respondent also failed to record AR's pre-operative, intra-operative and post-operative respiratory rates in AR's sedation record.

10. Respondent had difficulty removing the implant from the tooth no. 9 site with surgical forceps. Respondent admittedly left the operatory to retrieve a non-sterile channel lock plier (a non-dental tool) from a toolbox in another room that he placed in AR's mouth to pull the implant out. AR was sedated at the time he left the office. Respondent did not inform AR that he used the non-sterile tool.

11. During the Board's investigation of case no. 202300482, Respondent reported to the Board's investigator that during AR's November 7, 2023 treatment, an instrument slipped and poked Respondent's finger. Respondent admittedly left the operatory a second time while the patient was sedated and went to wash his hands and replace his glove in another room. Respondent then returned to continue AR's treatment. Respondent did not inform AR of the incident.

12. On December 27, 2023, AR presented to Respondent for the extraction of teeth nos. 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31; bone graft placement in the extraction sites; placement of implants in the teeth nos. 19, 21, 23, 26, 29, and 30 sites; lower right and lower left alveoplasty, and upper and lower denture reline. There is no clinical evidence supporting the extraction of all AR's lower teeth and the placement

of implants. Specifically, the radiographs show that the majority of the teeth extracted were restorable and contained long, healthy roots and only mild bone loss.

13. Respondent administered IV sedation to AR during the December 27, 2023 treatment. According to AR's sedation record, AR was sedated for 7 hours. Respondent administered a total of 24 mg of Versed, 200 mg of Fentanyl, and 50 mg of Benadryl to AR over the course of the treatment. The amount of sedation exceeded the amount necessary to achieve conscious sedation. In addition, Respondent failed to record intra-operative vital signs, blood pressure readings and pulse oximeter readings in AR's sedation record. Respondent also failed to record AR's pre-operative, intra-operative and post-operative respiratory rates in AR's sedation record.

14. During the Board's investigation of case no. 202300482, the Board's investigator requested Respondent to submit evidence of CPR and/or ACLS certification for Respondent and his dental assistants. Respondent did not submit any documentation in response.

15. The standard of care requires a dentist to use sterile instruments when performing treatment in a patient's oral cavity. Respondent deviated from the standard of care because he placed a non-sterile channel lock plier in AR's oral cavity to remove the implant in the tooth no. 9 site.

16. The standard of care requires a dentist to have the proper instruments available to perform dental surgical procedures, especially when a procedure is done on a patient under IV sedation. Respondent deviated from the standard of care because he did not have the proper tool in the operatory when he was removing the implant from AR's tooth no. 9 site on November 7, 2023.

17. The standard of care requires a dentist who is treating a patient under IV sedation to remain with the patient and continuously supervise the patient from the initiation of the IV sedation until the termination of the sedation. Respondent deviated

from the standard of care because on November 7, 2023, he left the operatory two times while AR was under IV sedation.

18. The standard of care requires a dentist with a 1302 permit to administer sedation consistent with the scope of the permit. Respondent deviated from the standard of care because the amount of sedation he administered to AR on November 7 and December 27, 2023 exceeded the scope of his 1302 permit because the amounts of sedation medication exceeded the level necessary to achieve conscious sedation.

19. The standard of care requires a dentist to provide treatment that is clinically justified, notwithstanding a patient's preference for specific treatment. Respondent deviated from the standard of care because the extractions of AR's upper and lower teeth and the placement of implants were not clinically justified. Respondent performed the procedures based on AR's direction when radiographs show restorable teeth.

20. The standard of care requires a dentist to inform a patient of an incident that occurs during treatment that may create the potential for cross-contamination. Respondent deviated from the standard of care because he failed to inform AR on November 7, 2023 that he used a non-sterile channel lock plier to remove an implant and that Respondent was poked by an instrument that slipped during treatment. Both of these instances created a risk to AR of cross-contamination.

21. As a 1302 Permit holder, Respondent is required to maintain a sedation record for every patient who receives IV sedation that includes pre-operative, intra-operative, and post-operative pulse oximeter documentation and pre-operative, intra-operative, and post-operative blood pressure and vital sign documentation. Respondent's sedation records for AR are inadequate because on November 24, 2021, August 4, 2022, November 7, 2023, and December 27, 2023, he failed to document: 1) intra-operative vital signs, pulse oximeter readings and blood pressure readings (with the

exception of two blood pressure readings on November 7, 2023), and 2) pre-operative, intra-operative and post-operative respiratory rates.

22. Pursuant to Board rule, a 1302 permit holder is required to employ at least one staff member who holds a current course completion confirmation in cardiopulmonary resuscitation (CPR) health care provider level. Although requested, Respondent failed to submit evidence of a staff member who is CPR certified.

23. The Board's investigator found that Respondent's conduct posed potential harm to AR. Respondent's use of a non-sterile tool in AR's mouth created the potential transfer of harmful microorganisms that could have resulted in infection or death. AR is HIV positive which can weaken his immune system, making it harder for his body to fight infection; Respondent's failure to remain in the operatory and continuously supervise AR while under sedation posed the risk that Respondent missed the signs of hypoxia or other emergency medical situation that can occur at any moment while a patient is sedated; failure to monitor and document AR's pulse oximeter and blood pressure readings and AR's respiratory rates posed the risk that an emergency medical situation could have gone undetected, which could lead to death.

INTERIM CONCLUSIONS OF LAW

1. The Board has jurisdiction over the subject matter hereof and over Respondent, holder of License No. D008564 for the practice of dentistry in the State of Arizona.

2. The conduct and circumstances described in the Interim Findings of Fact constitute unprofessional conduct as defined in the following sections of A.R.S. § 32-1201.01:

(14): "Committing any conduct or practice that constitutes a danger to the health, welfare or safety of the patient or the public."

(24): "Failing or refusing to maintain adequate patient records" as required by A.A.C. R4-11-1302(E)(1).

Such unprofessional conduct constitutes grounds for disciplinary action, including suspension or revocation of Respondent's dental license, pursuant to A.R.S. § 32-1263(A)(1).

FINDING OF PUBLIC EMERGENCY AND ORDER

Based on the foregoing Interim Findings of Fact and Interim Conclusions of Law, set forth above, the Board finds that the public health, safety and welfare imperatively requires emergency action pursuant A.R.S. §§ 32-1263.02(E) and 41-1092.11(B).

IT IS THEREFORE ORDERED THAT:

1. Respondent's license to practice dentistry in the State of Arizona, License No. D008564, is **SUMMARILY SUSPENDED** effective upon service of this Order, pending a formal hearing pursuant to Title 41, chapter 6, article 10.

2. The Interim Findings of Fact and Interim Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this Order.

3. The Board will refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be promptly instituted and determined, unless stipulated and agreed otherwise by Respondent.

IT IS FURTHER ORDERED that such suspension shall remain in effect until the conclusion of the formal hearing and a final decision and order issued by the Board.

DATED this 28 day of October, 2024.

ARIZONA STATE BOARD OF
DENTAL EXAMINERS

Ryan Edmonson
Executive Director

Original of the foregoing filed
this 28 day of October, 2024 with the:

Board of Dental Examiners
1740 W. Adams Street, Suite 2470
Phoenix, AZ 85007

Copy of the foregoing sent via certified mail, return receipt requested
this 28 day of October, 2024 to:

Robert Craig Janisse, DDS
2615 N 4th St
Suite 6
Flagstaff AZ 86004

Copies of the foregoing sent via interoffice mail
this 28 day of October, 2024 to:

Seamus Monaghan
Assistant Attorney General SGD/LES
Arizona Attorney General's Office
2005 N. Central Ave.
Phoenix, AZ 85004

By: April Romero