

a history of sleep apnea which she had unsuccessfully attempted to treat with a CPAP machine.

5. Thereafter, the Respondent obtained permission from CT's medical physician to do dental work using Triazolam. There was no discussion about the amount of sedation to be used.

6. On July 25, 2012, CT presented for a root canal on tooth # 30, crown preparations on teeth # 30 and #31 and sealants on 28 and 29. At the beginning of the appointment, the Respondent administered two tablets of .25 mg Halcion and two 25 mg capsules of Hydroxyzine.

7. During the July 25 appointment, CT snored occasionally and several times her breathing became obstructed and shallow. When instructed by staff to breathe deeply through her nose, she was able to respond.

8. Toward the end of the July 25 appointment, CT became fidgety and the Respondent administered another .25 mg of Halcion.

9. Following the procedures, CT was slow to waken and the Respondent administered 2 ml of Flumazenil to speed CT's recovery.

10. On August 15, 2012, CT returned to the Respondent's office for delivery of the crowns on teeth # 30 and # 31.

11. On October 17, 2012, when CT returned to the office for a routine periodontal examination, the Respondent detected infection and a 9 mm pocket in the area of tooth # 31, which she determined was caused by an impacted tooth # 32. The Respondent advised CT to schedule an appointment for extraction of the tooth.

12. On October 30, 2012, CT returned for the extraction. At 8:35 a.m., the Respondent administered three tablets of .25 mg Halcion to CT. She began the extraction procedure at 9:30 a.m. and completed the surgery at about 10:15 a.m.

13. During the surgery, CT's blood oxygen saturation levels fluctuated several times and at one point dropped to 30%.

14. The Respondent was aware of the fluctuations in CTs' vital signs but did not stop the procedure. Near the end of the surgery, an assistant pointed out that CT had turned blue and suggested that EMS be called. The Respondent rejected the suggestion, stating that she was nearly finished and wished to complete the surgery.

15. After Respondent completed the extraction, CT was placed upright, but remained non-responsive and did not resume breathing. The Respondent administered two doses of Flumazenil, to no avail.

16. In her report to the Board, the respondent indicated that she and her staff placed CT on the floor and immediately began CPR, when in actuality, CPR was not initiated until the fire department arrived.

17. EMS arrived shortly after the fire department and took over treatment of CT, who was transferred to a local hospital.

18. CT never regained consciousness and was declared dead on November 2, 2012.

19. An autopsy performed on November 4, 2012 determined that CT died of an overdose of Halcion.

20. CT was not a good candidate for oral sedation, given her severe apnea and her adverse reaction at the July 25, 2012 appointment.

21. The Respondent failed to promptly recognize that CT was in distress at the October 30, 2012 appointment and failed to take or direct prompt, effective rescue measures.

Based upon the foregoing Findings of Fact and the consent of the parties hereto, the Dental Board enters the following:

CONCLUSIONS OF LAW

1. The North Carolina State Board of Dental Examiners has jurisdiction over the subject matter of this action and over the person of the Respondent.

2. The standard of care for dentists licensed to practice dentistry in North Carolina as of October 2012 required dentists to recognize patients who are not good candidates for oral sedation and refrain from administering oral sedation to such patients.

3. Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by failing to recognize that CT was not a good candidate for oral surgery, thereby engaging in negligence within the practice of dentistry, a violation of G.S. §§ 90-41(a)(12).

4. The standard of care for dentists licensed to practice dentistry in North Carolina as of October 2012 required dentists to promptly recognize when a sedated patient is in distress and to take or direct prompt, appropriate rescue measures.

5. The Respondent violated the standard of care for dentists licensed to practice dentistry in North Carolina by failing to promptly recognize that CT was in distress and to take or direct prompt appropriate rescue measures, thereby

engaging in negligence within the practice of dentistry, a violation of G.S. §§ 90-41(a)(6) and (a)(12).

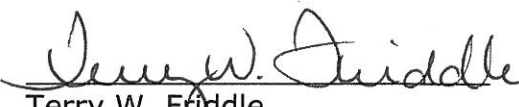
Based upon the foregoing Findings of Fact and Conclusions of Law and with the consent of the parties hereto, it is ORDERED as follows:

ORDER OF DISCIPLINE

License Number 5408 issued to Respondent for the practice of dentistry in North Carolina is hereby permanently revoked effective September 30, 2013. Respondent hereby agrees never to apply for or seek the return or renewal of her North Carolina dental license.

This the 18 day of September, 2013.

THE NORTH CAROLINA STATE
BOARD OF DENTAL EXAMINERS

By: 
Terry W. Friddle
Deputy Operations Officer

STATEMENT OF CONSENT

I, Toni K. Mascherin, D.D.S., do hereby certify that I have read the foregoing Consent Order in its entirety and that I do freely and voluntarily consent to the Findings of Fact, Conclusions of Law, Order of Discipline and the terms and conditions set forth herein. By signing this Statement of Consent I hereby express my understanding that the Board will report the contents of this Consent Order to the National Practitioner Data Bank and that this Consent Order shall become a part of the permanent public record of the Board. I also expressly agree never to seek the renewal or return of my North Carolina dental license.

This the 16th day of August, 2013.

Toni K Mascherin D.D.S.
TONI K. MASCHERIN, D.D.S.