

**SBDE NOS. 2014-00829; 2014-00842; 2014-00915**

**IN THE MATTER OF** § **BEFORE THE EXECUTIVE COMMITTEE**  
§  
**KENDRA U. BEHRAM, DDS** § **OF THE TEXAS STATE BOARD OF**  
§  
**TEXAS DENTAL LICENSE 26115** § **DENTAL EXAMINERS**

**ORDER OF TEMPORARY SUSPENSION**

On the 19<sup>th</sup> day of July, 2016, an Executive Committee of the State Board of Dental Examiners (Executive Committee) met in an emergency meeting to hear evidence and information in the above-styled case pursuant to section 263.004 of the Texas Occupations Code.

The Executive Committee heard evidence and information that the continued practice of dentistry by Kendra U. Behram, D.D.S., License No. 26115, would constitute a clear, imminent or continuing threat to a person's physical health or well-being.

The Executive Committee finds, based on the evidence and information presented and the factual and legal bases stated in the Petition for Temporary Suspension, attached and incorporated herein, that the continued practice of dentistry by Kendra U. Behram, D.D.S., would constitute a clear, imminent or continuing threat to a person's physical health and well-being.

IT IS, THEREFORE ORDERED that the license, and any and all related permits, issued to Kendra U. Behram, D.D.S., is hereby temporarily suspended pursuant to Section 263.004 of the Texas Occupations Code. This Order is final and effective as of the date of signing.

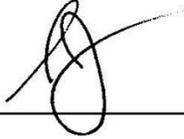
This matter shall be set for a hearing before the State Office of Administrative Hearings not later than the 30<sup>th</sup> day after the date the license, and any and all related permits, are suspended by the Order. At that time, the State Board of Dental Examiners will present evidence to show that the license of Kendra U. Behram, D.D.S. should remain suspended.

During the suspension period referred to above, Respondent SHALL NOT practice dentistry as defined under Section 251.003, Texas Occupations Code, and is prohibited from performing those acts, procedures, and treatments specified under Section 251.003(a)(1)-(10), Texas Occupations Code, in effect at the time of ratification of this Order and any amendments thereafter. Section 251.003(a)(1) and (4) are excepted from this requirement.

Respondent, during this emergency suspension period, may perform only administrative tasks limited exclusively to: opening mail, referring patients, and accepting payments on accounts. During the period of suspension, Respondent SHALL NOT delegate any clinical tasks to any employee or auxiliary and SHALL NOT allow any employee or auxiliary, if any, to practice outside the scope of their permitted duties as defined by the Dental Practice Act and rules and regulations of the Board.

STATE BOARD OF DENTAL EXAMINERS

SIGNED this 19<sup>th</sup> day of July, 2016.

A handwritten signature in black ink, consisting of a large, stylized 'S' followed by a horizontal line that extends to the right and then loops back down to cross the 'S'.

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Steven J. Austin, D.D.S.  
Presiding Officer  
Texas State Board of Dental Examiners

IN THE MATTER OF	§	BEFORE THE EXECUTIVE COMMITTEE
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KENDRA U. BEHRAM, DDS	§	OF THE TEXAS STATE BOARD OF
	§	
TEXAS DENTAL LICENSE 26115	§	DENTAL EXAMINERS

**PETITION FOR TEMPORARY SUSPENSION**

Now comes the Staff of the State Board of Dental Examiners (SBDE) and files this Petition for Temporary Suspension (Petition) against Kendra U. Behram, DDS, holder of Texas Dental License No. 26115 (Respondent), based on alleged violations of the Dental Practice Act (the Act), Tex. Occ. Code §§ 251.001 *et seq.* and Board Rules, 22 Tex. Admin. Code §§ 101.1 *et seq.*

In support of this Petition and based upon reasonable information and belief, Staff states the following:

**JURISDICTION**

1. The SBDE has authority and jurisdiction over Respondent's dental license pursuant to Tex. Occ. Code §§ 251.001 *et seq.* and 22 Tex. Admin. Code §§ 101.1 *et seq.*
2. Respondent's dental license was in full force and effect at all dates and times material and relevant to this Petition.
3. Section 263.004 of the Act requires the SBDE or an executive committee of the SBDE to temporarily suspend a person's license if it determines that the continued practice of dentistry by the person would constitute a clear, imminent, or continuing threat to the person or another person's physical health or well-being.

**FACTUAL ALLEGATIONS**

**I**

1. On or about November 13, 2013, Respondent failed to use proper diligence in her practice and failed to meet the minimum standard of care during the dental treatment of minor patient 1, as follows.

- a. Respondent over-sedated minor patient 1 while performing five pulpotomies and five stainless steel crowns. Respondent did not make any sedation records for this patient, but according to eye witness accounts, the sedation resulted in severe respiratory distress for the patient, requiring resuscitation.
- b. Respondent failed to appropriately respond to the emergency created by the over-sedation of minor patient 1. During the procedure the minor patient's oxygen saturation went as low as 45% and her lips turned blue. Respondent did not have oxygen available in the operatory before starting the procedure and did not allow her assistants to call emergency services. Respondent attempted resuscitation by placing the patient's head in her lap and rubbing her torso and was successful.
- c. Respondent failed to appropriately monitor minor patient 1 while under sedation. Respondent and staff were not aware for how long the minor patient had stopped breathing before attempting resuscitation.
- d. Respondent failed to maintain a functioning defibrillator in her office.
- e. Respondent scheduled the sedation appointment for 12 p.m. in spite of the requirement for the patient to have no food or drink after midnight before the appointment, which risked dehydration of the minor patient.
- f. Respondent failed to make, maintain, or keep any sedation record for the patient, and Respondent failed to make, maintain, or keep adequate patient records for the patient. Specifically:
  - i. Respondent failed to adequately take an initial medical history;
  - ii. Respondent failed to record a clinical assessment of the hard or soft tissue evaluation;
  - iii. Respondent failed to take radiographs;
  - iv. Respondent failed to record a diagnosis;
  - v. Respondent failed to record a treatment plan with recommendations and options; and
  - vi. Respondent's informed consent forms failed to include the specific treatment this patient received, and they were not in Spanish when it was necessary in order for the parent to be informed.

The conduct described above constitutes a violation of Tex. Occ. Code § 263.002(a) (4), (9), (10); and 22 Tex. Admin. Code §§ 108.7, (1), (2)(A), (3), (4)(A), (B), (D), (6), (9) (eff. to Sept. 2014), 108.8(a), (b)(4), (5), (c)(1), (2), (3), (4), (5), (6), (7), (8), (12); 110.5(c)(1), (2), (3), (5), (6), 7(C).

- 2. On or about November 13, 2013, Respondent engaged in unprofessional and dishonorable conduct that has become established through professional experience as likely to disgrace, degrade, or bring discredit upon the licensee and the dental profession during the dental treatment of minor patient 1. Specifically, Respondent failed to advise the parent of minor patient 1 that the patient had stopped breathing during the procedure and had to be

resuscitated. Additionally, Respondent ordered her staff not to disclose the event to the parent.

The conduct described above constitutes a violation of Tex. Occ. Code § 263.002(a)(3), (10); and 22 Tex. Admin. Code §§ 108.2(d), 108.9 (11).

## II

1. During the time period from August 6, 2013, through August 13, 2014, Respondent failed to meet the minimum standard of care and engaged in fraud and dishonorable conduct during the dental treatment of minor patient 2. Specifically:
  - a. Respondent failed to document or advise the parent of minor patient 2 that the patient had multiple impacted supernumerary teeth adjacent to and around the patient's unerupted tooth number 9.
  - b. During the extraction of primary tooth F, Respondent attempted a complex extraction of a supernumerary tooth, without the necessary skill level to do so. The patient should have been referred to an oral surgeon because of several supernumerary teeth that would also require removal. In the process of extraction of the supernumerary tooth, Respondent inadvertently extracted un-erupted tooth number 9. Respondent then re-implanted tooth number 9 but failed to advise the patient's guardian that this occurred, and failed to refer the patient to an oral surgeon and orthodontist even though this situation made a referral highly necessary for the future health of patient's tooth number 9.
  - c. On February 10, 2014, Respondent over-treated the minor patient when she performed two surface restorations on 11 molars (seven primaries) in a single appointment, when the clinical and diagnostic information did not support the necessity of the treatment. The minor patient was 12 years old with no history of cavities prior to that appointment, and Respondent eventually extracted all seven primary molars a year later on April 23, 2015.
  - d. Respondent failed to make, maintain, and keep adequate records for minor patient 2. Specifically:
    - i. Respondent failed to adequately take an initial medical history;
    - ii. Respondent failed to obtain written informed consent that is adequate for pediatric patients and failed to obtain a specific written informed consent for the removal of an impacted supernumerary tooth. Additionally, Respondent failed to list or describe the medications used on the sedation consent form, and there was no evidence Respondent provided written instructions to the parent related to sedation;
    - iii. Respondent failed to record the type or amounts of sedation medication used on the patient;

- iv. Respondent failed to record the amount of local anesthetic used on the patient;
- v. Respondent failed to adequately maintain a time oriented sedation record, and failed to record post operative vitals prior to discharging the patient;
- vi. Respondent failed to adequately record a clinical assessment of the hard and soft tissues;
- vii. Respondent failed to record diagnoses;
- viii. Respondent failed to record the number of supernumerary teeth and failed to record the complication involving the inadvertent extraction of tooth number 9; and
- ix. Respondent failed to adequately document in her progress notes the treatment performed specific to the complete bony extraction she performed on the supernumerary tooth;

The conduct described above constitutes a violation of Tex. Occ. Code § 263.002(a)(3), (4), (5), (9), (10); and 22 Tex. Admin. Code §§ 108.2(a)(b)(1), (d), (e), 108.7, (1), (2)(A), (3), (6), (9) (eff. to Sept. 2014), 108.8(a), (b)(4), (5), (c)(1), (2), (3), (4), (5), (6), (7), (8), (12), 108.9(2)(B), (11).

2. During the time period from June 26, 2014, through August 10, 2014, Respondent engaged in unprofessional and dishonorable conduct that has become established through professional experience as likely to disgrace, degrade, or bring discredit upon the licensee and the dental profession. Specifically, Respondent fabricated record entries of minor patient number 2 while responding to a SBDE investigation.
  - a. On June 26, 2014, SBDE Investigators obtained patient records for minor patient 2 during an unannounced inspection of Respondent's office while investigating Case No. 2014-00829. Minor patient 2's records contained numerous omissions and deficiencies, which were later changed or added.
  - b. On August 10, 2014, Respondent submitted a narrative response to SBDE investigators. This response indicated that minor patient 2's records and several other records were edited numerous times over months, and sometimes over a year from the time of treatment to include information initially omitted.

The conduct described above constitutes a violation of Tex. Occ. Code § 263.002(a)(3), (10); and 22 Tex. Admin. Code §§ 108.1(1), 108.9(6), (11).

### III

1. On or about February 4, 2013, Respondent fell below the minimum standard of care during the dental treatment of minor patient 3 as follows:
  - a. Respondent over-sedated minor patient 3. Minor patient 3 was 17 months old and weighed 20 pounds for non-emergent care.

- b. Respondent overdosed minor patient 3 with local anesthesia. Respondent administered two carpules of 2% Lidocaine with Epinephrine and one carpule of Septocaine.
- c. Respondent performed five anterior surface fillings on minor patient 3. The minor patient should have received stainless steel crowns and pulpotomies or extractions due to the decay evident on the radiographs.

The conduct described above constitutes a violation of Tex. Occ. Code § 263.002(a)(4), (10); and 22 Tex. Admin. Code §§ 108.7 (eff. to Sept. 2014).

- 2. During the time period from February 21, 2014, through August 10, 2014, Respondent fell below the minimum standard of care during the dental treatment of minor patient 3, failed in her duty of fair dealing, engaged in fraud, dishonorable conduct, and failed to cooperate with a SBDE investigation. Specifically:
  - a. Respondent fabricated record entries for the patient while responding to a SBDE investigation.
    - i. On June 26, 2014, SBDE Investigators obtained patient records for minor patient 3, during an unannounced inspection of Respondent's office while investigating Case No. 2014-00829. Minor patient 3's records contained numerous omissions and deficiencies, which were later changed or added.
    - ii. On August 10, 2014, Respondent submitted a narrative response to SBDE investigators. This response indicated that minor patient 3's records and several other records were edited numerous times over months, and sometimes over a year from the time of treatment to include information initially omitted.
  - b. On February 21, 2014, Respondent recorded in the chart that minor patient 3 weighed 55.8 pounds, but did not update the medical history or make any relevant notes in the chart pertaining to a 35.8 pound weight gain from the February 4, 2013 entry indicating that patient 3 weighed only 20 pounds. Respondent administered 10 mg of Midazolam on February 21, 2014, which would be an overdose if the child gained weight within normal limits. One of the two record entries from February 4, 2013, or February 21, 2014 is likely a fabrication based upon similar gross inaccuracies found in several other patient charts reviewed by SBDE investigators.
  - c. Respondent never performed a thorough and comprehensive examination on minor patient 3. Instead the patient had multiple appointments that could have been avoided had a proper examination been initially performed. Minor patient 3 was reportedly seen by Respondent nine times in one year. Four palliative examinations and one limited examination were performed within days of the patient receiving treatment without corresponding notes in the chart to verify if the patient was actually seen by Respondent.

- d. Respondent fraudulently billed minor patient 3's insurance carrier for IV sedation, when Respondent used non-IV sedation for the appointments on February 4, 2013, and February 21, 2014.

The conduct described above constitutes a violation of Tex. Occ. Code § 263.002(a)(3), (4), (5), (9), (10); and 22 Tex. Admin. Code §§ 108.1(1), 108.2(a)(b)(3), (e), 108.7, (1), (2), (2), (3)(A), (B), (6), (9) (eff. to Sept. 2014), 108.9(2)(B), (6), (11).

#### IV

Respondent has engaged in a pattern of practice of consistently failing to meet the standard of care in the dental treatment and administration of sedation/anesthesia to minor patients and consistently failing to use proper diligence in her professional practice. This pattern of practice places Respondent's patients at significant risk of harm and has resulted in repeated, serious issues in Respondent's treatment of minor patients. Respondent's continued practice of dentistry constitutes a clear, imminent, and continuing threat to a person's physical health and well-being.

#### LEGAL AUTHORITY

1. The conduct described above constitutes a violation of Tex. Occ. Code § 263.002(a)(3), (4), (5), (9), (10); and 22 Tex. Admin. Code §§ 108.1(1), 108.2(a)(b)(1), (d), (e), 108.7, (1), (2)(A), (B), (3), (4)(B), (D), (6), (9), 108.8(a), (b)(4), (5), (c)(1), (2), (3), (4), (5), (6), (7), (8), (12), 108.9(2)(B), (6), (11).
2. Section 263.004 of the Act authorizes the SBDE to temporarily suspend a person's license if his or her continued practice of dentistry constitutes a clear, imminent, or continuing threat to a person's well-being.

#### PRAYER

Staff requests that the Executive Committee of the SBDE determine that Respondent has engaged in conduct that shows that the continued practice of dentistry by Respondent would constitute a clear, imminent, or continuing threat to a person's health or well-being. Staff further requests that the Executive Committee enter an *Order of Temporary Suspension* suspending Texas Dental License No. 26115, pursuant to Section 263.004 of the Texas Occupations Code.

Filed this \_\_\_\_\_ day of July, 2016.

Respectfully submitted,

TEXAS STATE BOARD OF  
DENTAL EXAMINERS



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