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STATE OF NEW JERSEY
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF DENTISTRY

IN THE MATTER OF THE SUSPENSION OR REVOCATION OF THE LICENSE OF **John Vecchione, D.D.S.** **License No. 22DI02217300** TO PRACTICE DENTISTRY IN THE STATE OF NEW JERSEY	Administrative Action **VERIFIED COMPLAINT**

Christopher S. Porrino, Attorney General of New Jersey, by Pavithra Angara, Deputy Attorney General, with offices located at 124 Halsey Street, Fifth Floor, Newark, New Jersey, by way of Verified Complaint, says:

GENERAL ALLEGATIONS

1. Complainant, Christopher S. Porrino, Attorney General of New Jersey, is charged with enforcing the laws of the State of New Jersey, pursuant to N.J.S.A. 52:17A-4(h), and is empowered

to initiate administrative disciplinary proceedings against persons licensed by the New Jersey State Board of Dentistry (hereinafter the "Board") pursuant to N.J.S.A. 45:1-14 et seq.

2. The Board is charged with the duty and responsibility of regulating the practice of dentistry in the State of New Jersey pursuant to N.J.S.A. 45:6-1 et seq. and N.J.S.A. 45:1-14 et seq.

3. Pursuant to N.J.S.A. 45:1-22, the Board may enter an order of temporary suspension pending a plenary hearing on an Administrative Complaint upon a palpable showing by the Attorney General of a clear and imminent danger to the public health, safety and welfare.

4. John Vecchione, D.D.S. (hereinafter "Respondent") is an oral surgeon, licensed to practice as a dentist in the State of New Jersey, with an active license number of 22DI02217300.

5. Between 2012 and 2014, fifteen patients underwent oral surgery procedures, with each patient receiving intravenous anesthesia, at Respondent's Budd Lake dental office and contracted a bacterial infection resulting in endocarditis.

6. Initials are used in this Complaint to protect the identities of the patients referenced herein. The identities of the patients are known to the Respondent and have been made known to the Board of Dentistry.

COUNT I

7. Complainant repeats and realleges the General Allegations above as if fully set forth herein.

8. On November 14, 2014, the Enforcement Bureau ("EB") investigators, Department of Health ("DOH") officials as well as the local Mount Olive Health officials performed an unannounced inspection of Respondent's Budd Lake office, which revealed deficiencies in Respondent's infection control practices. (Consent Order, Filed July 7, 2016, Bates Stamp AG01-09, attached as Exhibit A to the Certification of Pavithra Angara, DAG (hereinafter "Angara Cert.").

Specifically, the deficiencies found in Respondent's office included the multiple uses of single use vials of Propofol, use of common alcohol pumps, prefilled syringes of medications which included Controlled Dangerous Substances ("CDS"), expired and open vials of medication, non-sterile preparation of instruments and poor documentation of medication units used and wasted. (Angara Cert., Exhibit A, AG03). Respondent was made aware of the deficiencies resulting from this inspection. (Department of Health Letter, dated December 1, 2014, Bates Stamp AG56 to AG66, attached as Exhibit D to "Angara Cert.").

9. On January 13, 2015, the EB investigators, DOH officials and experts in the fields of oral surgery and infectious disease performed a second unannounced inspection of Respondent's Budd Lake office, which again revealed areas in need of improvement with regard to Respondent's infection control practices. (Angara Cert., Exhibit A, AG03-04). Specifically, the additional areas of improvement included maintenance of daily narcotics logs, timely disposal of outdated medication, development and implementation of additional written policies and procedures on infection control and providing for an appropriate space for medication storage and preparation areas. (Angara Cert., Exhibit A, AG04). Respondent was made aware of the additional areas of improvement resulting from this inspection. (Enforcement Bureau Report, dated January 16, 2015, Bate Stamp AG67 to AG85, attached as Exhibit E to "Angara Cert.").

10. On March 12, 2015, a DOH approved infection prevention consultant evaluated Respondent's office and found additional areas for improvement which included, reviewing all documentation, sterilization and disinfection procedures, obtaining copies of Centers for Disease Control and Prevention ("CDC") Guidelines and making them accessible to clinical staff, monitoring hand hygiene and implementing appropriate needle safety techniques. (Angara Cert., Exhibit A, AG04-AG05).

11. On July 7, 2016, Respondent entered into an Interim Consent Order agreeing to implement additional changes to his office including: maintenance of daily narcotics logs including amounts of medication units used and wasted, timely disposal of outdated medication, development and implementation of written policies and procedures on infection control, implementation of appropriate needle safety techniques, providing an adequate space for clean medication preparation areas, minimal usage of multi-dose vials, implementation of single-use sterile alcohol pads, use of strict aseptic technique when handling medications and adherence with CDC recommendations on water line maintenance, biofilm and water quality for oral surgical and non-surgical procedures. (Angara Cert., Exhibit A, AG06-07). Respondent also agreed to provide the Board with a monthly report including: up-to-date copies of all written policies and procedures on infection control and aseptic technique, a current monthly narcotics log and verification of all the changes implemented in his office. (Angara Cert., Exhibit A, AG07).

12. On July 20, 2016, DOH released a final report of investigation titled: "Outbreak of Enterococcus Faecalis[1] Endocarditis Associated with an Oral Surgery Practice." (DOH Final Report, dated July 20, 2016, Bates Stamp AG10-20, attached as Exhibit B to "Angara Cert."). According to the DOH report, the national incidence rate of all endocarditis cases in the United States is estimated to be 15 cases per 100,000 persons per year, with only 1.5 of those cases being the enterococcal species of endocarditis. (Angara Cert., Exhibit B, AG18). However, based on the number of cases identified as associated with Respondent's practice, the incidence rate of enterococcal endocarditis at his practice was 372.7 cases per 100,000 persons, which is 248 times greater than the national incidence rate. (Angara Cert., Exhibit B, AG18). DOH concludes in their report that species of

1 Enterococci are gram-positive organisms that typically inhabit the gastrointestinal and genitourinary systems of humans. The genus enterococcus includes more than 17 species, with E. faecalis and E. faecium being the most prevalent species cultured from humans. E. Faecalis is not a usual component of oral flora. (Angara Cert., Exhibit B, AG10).

enterococcus are not part of the normal oral flora and is not commonly associated with bacteremias following oral surgery and that this particular enterococcus faecalis was most likely introduced into the patients' bloodstreams through breaches of infection prevention practices during the administration of intravenous sedation at the practice. (Angara Cert., Exhibit B, AG18).

13. Additionally, DOH noted that injection safety breaches that have been previously associated with outbreaks of infections that were also observed at Respondent's practice included, but were not limited to: the use of single use vials of medication for multiple patients, use of multiple use vials of medication in the direct patient care area, storage and use of unwrapped syringes, pre-drawing of medications in advance of the procedure, use of non-sterile products, storage of medications in a locker in the staff bathroom and poor hand hygiene. (Angara Cert., Exhibit B, AG18).

14. With regard to injection safety breaches, DOH found that the administration of intravenous anesthetics, specifically propofol, without adhering to a strict aseptic technique, can cause serious bacterial infections. (Angara Cert., Exhibit B, AG18). Propofol is a lipid-based product that supports microbial growth by enabling a contaminant to replicate within the product, resulting in serious infections following unsanitary injection practices. (Angara Cert., Exhibit B, AG18).

15. Respondent was made aware of the July 20, 2016 report on July 21, 2016, when Respondent and his counsel attended a meeting at a DOH facility in Trenton, New Jersey during which DOH officials reviewed the results of the DOH investigation and findings and provided Respondent with a copy of the July 20, 2016 DOH final report. (DOH Meeting Agenda, dated July 21, 2016, Bates stamp AG86 to AG87, attached as Exhibit F to "Angara Cert.").

16. On August 19, 2016, the EB investigators and DOH officials performed a third unannounced inspection of Respondent's Budd Lake office, which again revealed deficiencies in Respondent's infection control practices. (Enforcement Bureau Report, dated August 22, 2016, Bates Stamp AG21-55, attached as Exhibit C to "Angara Cert."). Specifically, this inspection found deficiencies including but not limited to: lack of written infection control program/protocols and policies and procedures, lack of infection disease consultant or designated coordinator for the practice, lack of daily CDS logs, lack of a clearly defined separate area where staff processes and wraps instruments, failure to use sterile water or sterile saline during surgical procedures, failure to use surface barriers on switches, lights and connections to hoses, and overall improper infection control and needle safety practices by staff, including but not limited to: the failure to use strict aseptic technique when handling medications, improper handling and storage of multi-dose vials, non-sterile preparation of instruments and the improper handling and disposal of needles and syringes. (Angara Cert., Exhibit B, AG24-25, 38-54).

17. Additionally, Respondent has not provided the Board with a monthly report of: up-to-date copies of all written policies and procedures on infection control and aseptic technique, a current monthly narcotics log and verification of all the changes implemented in his office as required by the terms of his July 7, 2016 Interim Consent Order. (Angara Cert., Exhibit A).

18. The results of the inspection indicate that Respondent has failed to comply with the July 7, 2016 Consent Order as well as CDC Infection Control Practices for Dentistry as required by N.J.A.C. 13:30-8.5.

19. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

20. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

21. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with Occupational Safety and Health Administration ("OSHA") regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Recommended Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

22. Respondent's failure to abide by the July 7, 2016 Consent Order results in a violation of his duty to cooperate with a Board Order constituting professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

23. Respondent's conduct as alleged herein palpably demonstrates that his continued practice as a dentist in New Jersey presents a clear and imminent danger to the public health, safety, and welfare warranting the immediate temporary suspension of his license pursuant to N.J.S.A. 45:1-22.

COUNT II

24. Complainant repeats and realleges the General Allegations and the allegations of the preceding Count as if fully set forth herein.

25. On June 3, 2013, Respondent performed an extraction of tooth #30 on patient J.D. and administered intravenous anesthetic agents, including propofol. J.D. is a 55 year old male with cardiac history of mitral valve prolapse.

26. A few months later, on October 30, 2013, J.D. was admitted to Saint Claire's Hospital after complaints of fever since his oral surgery procedure. J.D. was diagnosed with bacterial endocarditis after an echocardiogram showed vegetation in the aortic valve and blood cultures

returned positive for enterococcus faecalis. J.D. was treated with antibiotics and discharged on November 4, 2013.

27. On November 5, 2013, J.D. was readmitted to Saint Clare's Hospital after complaints of weakness and drooping of his right leg. During this admission, J.D.'s enterococcal aortic valve endocarditis was confirmed with a treatment plan of continued antibiotics and possible heart surgery to repair the aortic valve.

28. On November 8, 2013, J.D. was transferred to Morristown Medical Center for heart surgery and underwent an aortic valve replacement due to the bacterial endocarditis.

29. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed J.D. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

30. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

31. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

32. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with Occupational Safety and Health Administration ("OSHA") regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT III

33. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

34. On August 21, 2014, Respondent performed extractions of tooth #s 2, 3, 14, 15 and 16 on patient J.B. and administered intravenous anesthetic agents, including propofol. J.B. is a 51 year old male with no prior cardiac history.

35. A few months later, on November 6, 2014, J.B. was admitted to Saint Clare's Hospital after complaints of nausea, vomiting, fever and weight loss since his oral surgery procedure. J.B. was diagnosed with endocarditis of the aortic heart valve after an echocardiogram showed vegetation in the aortic valve and blood cultures returned positive for enterococcus faecalis.

36. J.B. was treated with IV antibiotics and was discharged on November 17, 2014.

37. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed J.B. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

38. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

39. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

40. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to

blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT IV

41. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

42. On September 25, 2013, Respondent performed a tissue biopsy on patient M.C. and administered intravenous anesthetic agents, including propofol. M.C. is a 68 year old female with a cardiac history of mitral valve prolapse.

43. Approximately one month later, on October 26, 2013, M.C. was admitted to Saint Claire's Hospital after complaints of fever, chills, night sweats and weight loss since her oral surgery procedure. M.C. was diagnosed with acute bacterial endocarditis after an echocardiogram showed possible vegetation and blood cultures returned positive for enterococcus faecalis.

44. M.C. was treated with intravenous antibiotics and was discharged on October 31, 2013.

45. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed M.C. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

46. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

47. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

48. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT V

49. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

50. On January 23, 2013, Respondent performed an extraction of tooth #18 on patient T.L. and administered intravenous anesthetic agents, including propofol. T.L. was a 54 year old male with no prior cardiac history.

51. A few months later, T.L. was admitted to St. Clare's hospital after complaints of fever, night sweats and weight loss since his oral surgery procedure. T.L. was diagnosed with mitral and aortic valve endocarditis after an echocardiogram showed vegetation on the mitral and aortic valves and blood cultures returned positive for enterococcus faecalis. On May 20, 2013, T.L. was transferred to Morristown Medical Center for a heart valve replacement surgery.

52. On May 22, 2013, T.L. underwent an aortic and mitral valve replacement and was discharged to a rehabilitation center for neurocognitive rehab and antibiotic therapy.

53. On November 5, 2013, T.L. died as a result of a post-operative infection of the heart, with the underlying cause of death being complications of enterococcus endocarditis.

54. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed T.L. to a risk of harm of contracting a bacterial infection, resulting in endocarditis.

55. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

56. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

57. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT VI

58. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

59. On December 20, 2012, Respondent performed an extraction of tooth #9 on patient G.N. and administered intravenous anesthetic agents, including propofol. G.N. is a 73 year old male with no prior history of a heart condition.

60. Approximately one month later, on January 25, 2013, G.N. was admitted to Manatee Memorial Hospital in Florida after complaints of fever, weakness and back pain since his oral surgery procedure. G.N. was diagnosed with bacterial endocarditis after blood cultures returned positive for enterococcus faecalis.

61. G.N. was treated with intravenous antibiotics and was discharged to a rehabilitation facility on February 14, 2013.

62. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water

quality and medication preparation, exposed G.N. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

63. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

64. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

65. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT VII

66. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

67. On June 20, 2014, Respondent performed an extraction of tooth #s 1, 16, 17 and 32 on patient M.J. and administered intravenous anesthetic agents, including propofol. M.J. is a 31 year old male with no prior cardiac history.

68. A few months later, on October 5, 2014, M.J. was admitted to Hackensack Hospital after complaints of weakness, dizziness and nausea since his oral surgery procedure. M.J. was diagnosed with bacterial endocarditis after blood cultures returned positive for enterococcus faecalis.

69. M.J. was treated with intravenous antibiotics and was discharged on October 10, 2014.

70. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water

quality and medication preparation, exposed M.J. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

71. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

72. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

73. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT VIII

74. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

75. On July 8, 2013, Respondent performed an extraction of tooth #s 1, 16, 17 and 32 on patient S.B. and administered intravenous anesthetic agents, including propofol. S.B. is a 21 year old female with no prior cardiac history.

76. On September 5, 2013, S.B. was admitted to Robinson Memorial Hospital in Ohio after complaints of fever and memory loss since her oral surgery procedure. S.B. was diagnosed with bacterial endocarditis after blood cultures returned positive for enterococcus faecalis.

77. On September 9, 2013, S.B. underwent heart surgery for an aortic valve repair due to the bacterial endocarditis.

78. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed S.B. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

79. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

80. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

81. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT IX

82. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

83. On July 31, 2014, Respondent performed a tissue biopsy on patient D.W. and administered intravenous anesthetic agents, including propofol. D.W. is a 72 year old female with a cardiac history of hypertension and coronary artery disease.

84. In 2014, D.W. was admitted to the hospital after complaints of fever, chills and sweats since her oral surgery procedure. D.W. was diagnosed with bacterial endocarditis after an echocardiogram showed vegetation of her heart valve and blood cultures returned positive for enterococcus faecalis.

85. On December 9, 2014, D.W. was admitted to Morristown Medical Center for urgent heart surgery and underwent an aortic valve replacement due to the bacterial endocarditis.

86. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed D.W. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

87. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

88. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

89. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT X

90. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

91. On June 27, 2014, Respondent performed an extraction of tooth #s 1 and 16 on patient R.D. and administered intravenous anesthetic agents, including propofol. R.D. is a 25 year old male with no prior history of a cardiac condition.

92. A few months later, on October 9, 2014, R.D. was admitted to Saint Claire's Hospital after complaints of a fever since his oral surgery procedure. R.D. was discharged the same day with fever medication.

93. On October 16, 2014, R.D. was admitted to Morristown Medical Center after complaints of a fever, night sweats and weight loss. R.D. was diagnosed with mitral valve bacterial endocarditis after an echocardiogram showed vegetation on the heart valve and blood cultures returned positive for enterococcus faecalis.

94. On March 5, 2015, R.D. underwent heart surgery at New York Presbyterian for a mitral valve repair as a result of the bacterial endocarditis.

95. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed R.D. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

96. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

97. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

98. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT XI

99. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

100. On April 4, 2013, Respondent performed extractions of tooth #s 1, 16, 16A and 29A on patient N.S. and administered intravenous anesthetic agents, including propofol. N.S. is a 21 year old male with no prior history of a cardiac condition.

101. A few months later, on June 25, 2013, N.S. was admitted to Morristown Medical Center after complaints of abdominal pain since his oral surgery procedure. N.S. was diagnosed with mitral valve endocarditis after blood cultures returned positive for enterococcus faecalis. N.S. was treated with antibiotics and discharged on July 3, 2013.

102. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed N.S. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

103. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

104. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

105. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT XII

106. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

107. On September 5, 2012, Respondent performed an implant procedure on patient G.D. and administered intravenous anesthetic agents, including propofol. G.D. is a 24 year old male with no prior history of cardiac disease.

108. On May 24, 2013, G.D. was admitted to Saint Claire's Hospital after complaints of a fever since his oral surgery procedure. G.D. was diagnosed with bacterial endocarditis after blood cultures returned positive for enterococcus faecalis.

109. On May 30, 2013, G.D. was discharged after receiving intravenous antibiotics and a referral to a cardiothoracic surgeon for heart surgery to repair the mitral valve due to the infection caused by the bacterial endocarditis.

110. In September 2013, G.D. underwent heart surgery to repair the mitral valve due to the bacterial endocarditis.

111. On October 26, 2013, G.D. presented to the emergency room with a fever and was diagnosed with a throat infection. G.D. was given penicillin and discharged the same day.

112. On November 22, 2013, G.D. presented to the emergency room with a fever and an elevated heart rate. G.D. was given intravenous antibiotics and discharged the same day.

113. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed G.D. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

114. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

115. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

116. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT XIII

117. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

118. On July 18, 2014, Respondent performed extractions of tooth #s 1, 16, 17 and 32 on patient Z.H. and administered intravenous anesthetic agents, including propofol. Z.H. is a 24 year old male with no prior history of a cardiac condition.

119. A few months later, on October 17, 2014, Z.H. was admitted to Valley Hospital after complaints of fever, nausea and vomiting since his oral surgery procedure. Z.H. was diagnosed with acute bacterial endocarditis after a blood culture returned positive for enterococcus faecalis.

120. On October 25, 2014, Z.H. was discharged with a six week course of antibiotics, but follow-up indicated that Z.H.'s condition had worsened, requiring heart surgery to replace the aortic valve due to the bacterial endocarditis.

121. On November 10, 2014, Z.H. underwent an aortic valve replacement due to the bacterial endocarditis and was discharged on November 17, 2014.

122. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed Z.H. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

123. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

124. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

125. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT XIV

126. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

127. On May 7, 2014, Respondent performed extractions of tooth #s 1, 16, 17 and 32 on patient K.S. and administered intravenous anesthetic agents, including propofol. K.S. is 19 year old male with no prior history of a cardiac condition.

128. A few months later, on October 1, 2014, K.S. was admitted to Morristown Medical Center after complaints of fatigue, night sweats and abdominal pain since his oral surgery procedure. K.S. was diagnosed with bacterial endocarditis after blood cultures returned positive for enterococcus faecalis.

129. K.S. was given intravenous antibiotics and was referred for a cardiology consultation for possible heart surgery due to the bacterial endocarditis.

130. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed K.S. to a risk of harm of contracting a bacterial infections resulting in endocarditis.

131. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

132. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

133. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT XV

134. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

135. On April 19, 2013, Respondent performed extractions of tooth #s 1, 16, 17 and 32 on patient J.C. and administered intravenous anesthetic agents, including propofol. J.C. is a 50 year old female with a cardiac history of mitral valve prolapse.

136. On June 6, 2013, J.C. was admitted to Morristown Medical Center after complaints of a fever that started approximately one week after her oral surgery procedure. J.C. was diagnosed

with bacterial endocarditis after an echocardiogram showed an endocardial lesion and blood cultures returned positive for enterococcus faecalis. J.C. was discharged on June 10, 2013 to follow-up as an outpatient.

137. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed J.C. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

138. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

139. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

140. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

COUNT XVI

141. Complainant repeats and realleges the General Allegations and the allegations in each of the previous counts as if fully set forth herein.

142. On August 27, 2013, Respondent performed an extraction of tooth #18 on patient C.D. and administered intravenous anesthetic agents, including propofol. C.D. is an 80 year old male with a prior cardiac history of coronary artery disease.

143. On September 30, 2013, C.D. was admitted to Morristown Medical Center after complaints of shortness of breath and chest pain since his oral surgery procedure. C.D. was diagnosed with aortic valve endocarditis after an echocardiogram showed vegetation on the aortic valve. C.D. was given intravenous antibiotics and a cardiac surgery consultation.

144. On October 3, 2013, C.D. went into cardiogenic shock and underwent emergency heart surgery for an aortic valve replacement due to the bacterial endocarditis. C.D. was discharged on October 24, 2013.

145. Respondent's failure to adhere to CDC Infection Control Practices for Dentistry, which includes practices in infection control, aseptic technique, injection safety, hand hygiene, water quality and medication preparation, exposed C.D. to a risk of harm of contracting a bacterial infection resulting in endocarditis.

146. The actions of Respondent described herein constitute gross negligence, malpractice or gross incompetence which endangered the life, health, welfare or safety of any person and/or repeated acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(c) and (d).

147. The actions of Respondent described herein constitute professional or occupational misconduct pursuant to N.J.S.A. 45:1-21(e).

148. The actions of Respondent described herein constitute a violation of N.J.A.C. 13:30-8.5, which requires licensees to comply with OSHA regulations concerning occupational exposure to blood or other potentially infectious materials, as well as the CDC Infection Control Practices for Dentistry, and as such provide basis for discipline pursuant to N.J.S.A. 45:1-21(h).

WHEREFORE, Complainant respectfully demands the entry of an order against Respondent, John Vecchione, D.D.S., as follows:

1. Temporarily suspending Respondent's license to practice as a dentist in the State of New Jersey pending the disposition of a plenary hearing on this Verified Administrative Complaint;

2. Suspending or revoking the Respondent's license to practice as a dentist in the State of New Jersey following a plenary hearing;

3. Assessing civil penalties against Respondent for each and every separate unlawful act as set forth above, pursuant to N.J.S.A. 45:1-25;

4. Requiring Respondent to pay costs, including investigative costs, attorney's fees and costs, expert and fact witness fees and costs, costs of trial, and transcript costs, pursuant to N.J.S.A. 45:1-25;

5. Ordering such other and further relief as the Board of Dentistry shall deem just and appropriate under the circumstances.

CHRISTOPHER S. PORRINO
ATTORNEY GENERAL OF NEW JERSEY

By: _____
Pavithra Angara
Deputy Attorney General

Dated: August 23, 2016